

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325062	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2026
NAME OF PROVIDER OR SUPPLIER Paloma Springs Healthcare LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 North Silver Street T OR C, NM 87901	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and observation, the facility failed to ensure medical records were complete and accurate for 1 (R #18) of 3 (R #16, R #17, and R #18) residents reviewed for behavioral health treatment when staff failed to: Document R #18's behaviors. Document side effects (any unintended effect of a medication) from R #18's anti- anxiety medication (used to treat anxiety symptoms). These deficient practices could likely cause staff to not have the most accurate resident information and adversely impact the care staff provides. The findings are: A. Record review of the facility's Behavior Management Policy, revised January 2026, revealed the following: 1. When a resident exhibits adverse behavioral symptom (e.g., crying, yelling, hitting, biting, etc.), licensed nursing staff will document the behaviors in the medical record, noting the time the behavior(s) occur, antecedent events, possible causal factors and interventions attempted. 2. Nursing staff will document the resident's response to medication, including behaviors and side effects on the Medication Administration Record (MAR). B. Record review of R #18's admission Record, no date, revealed the following: 1. R #18 was admitted to the facility on [DATE]. 2. R #18 had the following diagnoses: a. Senile degeneration of brain (an older, non-specific term for age-related cognitive decline that leads to dementia). b. Dementia, unspecified severity, with agitation. c. Anxiety disorder (persistent, excessive fear or worry that interferes with daily life). d. Delirium (a serious, sudden-onset state of severe confusion characterized by disorganized thinking, inattention, and fluctuating awareness of one's surroundings). e. Disorientation (a temporary altered mental state where a person struggles to recognize time, place, or personal identity). f. Altered mental status (a broad, nonspecific term describing a change in a person's baseline awareness, cognition, or arousal). C. On 06/24/26 at 12:38 PM, an observation and interview with R #18 revealed the following: 1. R #18 did not appear to be in any distress. 2. R #18 was confused about where she was or why she was there. D. Record review of R #18's physician's orders revealed the following: 1. An order dated 01/26/26 and discontinued on 06/09/26, for lorazepam 2 milligrams per milliliter (mg/ml) by mouth one time a day for anxiety or agitation. 2. An order dated 06/09/26, for haloperidol lactate (Haldol, used to rapidly control acute psychotic episodes, severe agitation, and aggression) 0.5 ml my mouth one time a day for agitation. E. Record review of R #18's nursing progress notes revealed the following: 1. On 06/08/26, staff documented the Social Services Director was asked to follow up with R #18 due to behaviors. Staff did not document what behaviors R #18 was exhibiting. 2. On 06/09/26, staff documented an order was received for Haldol due to R #18's increased behaviors. Staff did not document what behaviors R #18 was exhibiting, which required an order for Haldol to be given daily. 3. Staff did not document why the order for daily lorazepam was discontinued on 06/09/26. F. On 06/25/26 at 11:21 AM, during an interview, RN #18 stated the following: 1. R #18 was frequently confused. 2. R #18 was frequently agitated (he did not specify what agitated R #18). G. On 06/25/26 at 11:26 AM, during an interview, CNA #16 stated the following: 1. R #18 would go into other people's rooms because she thought her family member (FM) or her things were in there. 2. R #18 was difficult to redirect when she was agitated. 3. He told the nurse whenever R #18 was agitated. H. Record review of R #18's MAR, dated (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 325062
		If continuation sheet Page 1 of 2

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	June 2026, revealed the following:1. Staff documented R #18 had no behaviors between 06/01/26 and 06/24/26.2. Staff did not document any side effects from anti-anxiety medication. 1. On 06/25/26 at 11:37 AM, during a joint interview, ADON #1 and ADON #2 stated the following: 1. When one of R #18's FM's would visit her, R #18 would cry, yell, and scream if anyone got near her FM. 2. R #18's FM would visit her almost every day. 3. Lorazepam was making R #18 drowsy so the provider changed the order to Haldol. 4. Haldol did not make R #18 drowsy and she seemed to have a better quality of life. 5. They confirmed staff did not document R #18's behaviors in progress notes or TAR. 6. They confirmed staff did not document that lorazepam was making R #18 drowsy. 7. They confirmed staff were expected to document all resident behaviors and interventions in the medical record. 8. They confirmed staff were expected to document side effects of medication in the medical record.		