STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676422	A. Building B. Wing	02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palomino Place	3160 Gus Thomasson Road Mesquite, TX 75150

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35152 Based on observations, record review, and interviews, the facility failed to ensure an environment that was free of accident hazards and that each resident received adequate supervision to prevent elopement for 1 (Resident #1) of 6 residents reviewed for quality of care. 1. The facility failed to ensure Resident #1 was provided with adequate supervision to prevent him from eloping from the facility on 01/22/2024. 2. The facility failed to ensure staff recognized Resident #1 eloped and recognize Resident #1 as a resident of the facility when Resident #1 was encountered outside the 500 Hall door. 3. RN A failed to follow their elopement response policy when the 500 Hall door alarm sounded. The facility concluded Resident #1 eloped through the facility's 500 Hall exit and staff did not conduct a thorough search of the facility and its grounds when the alarm sounded. A past non-compliance Immediate Jeopardy (IJ) situation was identified on 02/13/24 at 11:30 AM. The Immediate Jeopardy began on 01/22/2024 and ended on 01/25/2024. The facility remained out of compliance at a scope of isolated and a severity of no actual harm with a potential for more than minimal harm while they completed in-service training and evaluated the effectiveness of their corrective systems. The facility had corrected the non-compliance before the surveyor began. These failures placed residents at risk of harm and/or serious injury. Findings included: Record review of Resident #1's Face Sheet dated 02/13/2024 reflected an [AGE] year old male admitted to the facility with diagnoses that included Atrial Fibrillation (irregular and rapid heart rhythm, Cirrhosis of the Liver (liver damage where healthy cells are replaced with scar tissue), Heart failure (heart muscle don't pump blood as it should), Papilledema associated with increased intracranial pressure (optic disc swelling), and Dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676422	A. Building B. Wing	02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palomino Place	3160 Gus Thomasson Road Mesquite, TX 75150

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's MDS assessment dated [DATE] reflected he had a BIMS score of 2 indicating severe cognitive impairment. He was sometimes understood and sometimes able to understand others. The MDS Assessment indicated he performed walking with supervision or touching assistance and used a walker to ambulate. Wandering behaviors were not exhibited. Record review of Resident #1's Care Plan dated 11/10/2023 reflected the following entry: [Resident #1] has a language barrior he speaks Spanish . Interventions: Allow adequate time to express self, complete word or sentence if unable to do so. Ask simple questions that can be answered YES or NO. [Resident #1] is oriented to self only and has a diagnosis of dementia . Record review of Resident #1's Nursing Admission Assessment, dated 11/01/2023, reflected, no risk of elopement, [Resident #1] is able to make decisions regarding tasks of daily living, decisions are consistent and reasonable. Record review of the Elopement Risk assessment dated [DATE] reflected, Moderate risk, patient ambulate or propels self. Patient may go outdoors on occasion but makes no attempts to leave grounds. Record review of the Elopement Risk assessment dated [DATE] reflected, No risk, [Resident #1] is able to make decisions regarding tasks of daily living, decisions are consistent and reasonable. Record review of the Monitoring patient location and activity log, dated 01/22/2024 through 01/26/2024 reflected, Resident #1 was monitored for location and activity every 15 minutes, for three days. Record review of Resident #1's Psychosocial wellbeing assessment dated [DATE], reflected, [Resident #1] needs redirection to environment due to him trying to find his daughter and disorientation. Diagnosis of dementia. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676422	A. Building B. Wing	02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palomino Place	3160 Gus Thomasson Road Mesquite, TX 75150

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's Provider Investigation Report, dated 01/26/2024, reflected the following: On 01/22/2024 at 4:00 AM [Resident #1] was noted outside of the facility. When Resident #1 was noted outside employee that did not recognize him called 911. Resident #1 was noted to be confused and could not tell the nurse his name. He stated he was looking for his daughter and was not trying to leave but got confused about the time. He was retunred to the facility and placed on frequent monitoring with no negative outcomes or attempts of exit seeking. Staff will continue to monitor patient for any wondering or confusion. The incident was reported to the state, physician and family notified, medication management competed with staff, staff safe surveys completed, and resident safe surveys completed. An elopement risk assessment was completed on 01/22/2024 which indicated moderate risk; rounds checklist was completed, staff in-servicing began on elopment and abuse and neglect began on 1/22/24. RN A received coaching and counseling, dated 01/23/2024 for failure to perform a proper search and identify a resident who was in her care for over two months. A performance improvement plan was initiated on 01/22/2024 the elopement risk procedure was not followed properly. Changes implemented included: 1. Completed in-service to all employees on looking outside before turning the alarm off. 2. Door alarm checks were completed immediately to ensure all door alarms are functioning appropriately. 3. Review of door alarm checks from maintenance to show the alarms have been checked. 4. Review of all elopement assessments to ensure that all patients have a completed assessment. 5. Review of assessment for [Resident #1] showed he was not a risk on admission. New assessment completed to show at risk due to the elopement. 6. Patient on frequent monitoring for 72 hours to ensure safety. All staff were re-educated on the following: The process for when the door alarm sounds and there is a potential elopement. The the importance of checking outside the door where alarm has sounded for any presence of a resident who could have gone out that door. Facility grounds need to be evaluated for any presence of a resident who could have gone out the door alarming. All rooms thoroughly checked to ensure that residents are accounted for. Turning on resident's room lights and ensuring the resident is in the right bed. If resident is not in bed, checking restrooms, under beds, behind door unlocked, and locked. Record review of Resident #1's progress notes revealed the following entries: *01/22/2024 7:04 AM: Patient was noted standing outside the door of 500 Unit. He was unable to communicate and could not say his name. No staff on duty was able to identify him when they were alerted, He was offered a warm blanket and police called. When police arrived, patient was brought inside and then searched. He was identified with a piece of paper in his possession bearing his name. Patient was then taken back into his room and made comfortable. Warm drink was offered, and PRN Tylenol 325mg 2 tabs administered. VS: 118/59, HR 69, temp. 97.4, RR 18. DON, Administrator, and [physician] notified. Patient's POA also notified. Patient is comfortably resting in his bed at this Ume and is now placed on frequent monitoring, signed by RN A. *01/22/2024 20:56 PM: SW met with bedside to assess mood and behavior with staff assistance for translation. Pt pleasant, confused, Pt did not recall opening door this weekend. He reports not wanting to leave but wants to know where his daughter ls. Pt easily redirected. [Psych] referral in process for assessment/med management as appropriate, signed by the Social Worker. *01/24/2024 2:51 AM: Patient is resting comfortably in his bed with call light and water within reach. Pt continued on every 15 minutes frequent monitoring, signed by LVN B. *01/25/2024 1:22 AM: Patient in his bed with call light and water within reach. Pt continued on every 15 minutes frequent monitoring, signed by LVN B. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676422	A. Building B. Wing	02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palomino Place	3160 Gus Thomasson Road Mesquite, TX 75150

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 02/13/2024 at 9:50 AM, the Administrator and the DON stated Resident #1 eloped from the facility. They were not sure of the time but estimated it to be after 2:00 AM. They said they were notified at 4:00 PM by RN A. The DON stated RN A told her she heard the door alarm sound but did not know the exact time. She said RN A told her she looked down the hall and saw a CNA in the hall and thought they had opened the door. The DON said a short time later RN A was rounding on 500 hall and saw a man outside the 500-hall door. She said RN A told her she did not recognize the man outside the door but did check resident rooms on 500 hall and found no one was missing. The DON said RN A did not turn the lights on in each resident room to ensure everyone was in their bed. She said RN A then called the nurse from another hall to come to the 500-hall door because she was afraid to open the door for the man standing outside. The DON said CNA C and CNA D came to the hall and did not recognize Resident #1 standing outside the door. She stated CNA C called the police who arrived a short time later and were able to identify Resident #1 when one of the officers spoke Spanish to him. The DON said RN A did not follow the facility's Elopement Response Policy because she did not turn on the lights in resident rooms to ensure everyone was in their bed and staff did not search the perimeter of the facility when the alarm sounded. The Administrator stated the door alarms were working because they sounded. He said the Maintenance director checked and logged the alarms regularly. He said the alarms were checked the morning of 01/22/2024 and they worked, which led him to believe staff did not follow the elopement protocol. The DON said Resident #1 was not an elopement risk and had not displayed any elopement behavior since he had been admitted . She said Resident #1 was confused at times. The DON stated she counseled RN A on the elopement protocol and initiated neglect and elopement protocol in-services. She said Resident #1 was reassessed as a moderate elopement risk and placed on 15-minute checks for three days. The DON said staff should be able to identify residents in the facility. She said resident pictures are in each clinical record. She stated a step-by-step elopement protocol could be found at each nurses' station. An observation on 02/13/2024 at 10:45 AM in the 500 hall, at the exit door, revealed the alarm sounded when opened by the state surveyor. Five staff were observed running to the exit. Staff were observed checking rooms and exit the door to round the perimeter of the facility. When they were done, they turned off the door alarm. In an interview, interpreted by CNA E, on 02/13/2024 at 11:00 AM, Resident #1 revealed he recalled leaving the facility but did not recall where he was going. He said he liked the facility and staff. He said he was able to walk on his own and used a walker but liked to stay in his room. Resident #1 was able to answer questions appropriately however did appear to have problems remembering past events. In an interview on 02/13/2024 at 11:10 AM, Resident #1's roommate said he did not recall Resident #1 leaving the facility recently. He said Resident #1 usually stayed in the room. He stated staff checked on both residents constantly and had no concerns. In an interview on 02/13/2024 at 1:15 PM, CNA C stated she had worked the night when Resident #1 eloped. She said she did not work on the 500 hall, but staff came to get her to see if she could identify a man who was outside the 500 hall exit door. She said she did not know the man but did call the police because she could not be sure who the man was. She stated she did not recall the exact time but thought it to be about 2:30 AM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676422	A. Building B. Wing	02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palomino Place	3160 Gus Thomasson Road Mesquite, TX 75150

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone interview on 02/13/2024 at 2:50 PM, RN A stated she did hear the 500 hall door alarm sound on 01/22/2024 but could not recall the time. She said she did not immediately go to the door because she saw a CNA in the hall and thought they had opened the door. She said she did not know who the CNA was because the CNA who regularly worked with her on the 500 hall had called in. She said later when she went down the hall she saw a man outside the door on the 500 hall. She said she did not know the man and was afraid to open the door. She said she did call for other staff to come to the door to see if they knew the man, but they did not. She said she checked the rooms on the 500 hall for missing residents but did not turn the lights on in each room. She said when she looked in Resident #1's room she thought she saw his leg on the bed and moved on. She said the police were called and they found a paper in Resident #1's pocket identifying him. She said she checked the computer, and he was a resident. She said they brought Resident #1 into the facility, and she assessed him. She said she contacted the DON after that but did not know the time. She said she was reprimanded for not following the elopement protocol and in serviced on the policy. In a telephone interview on 02/13/2024 at 3:10 PM, the Maintenance Director said he checked and logged the door alarms regularly. He said he checked the alarms on all the doors when he came to the facility on [DATE] and they were all engaged and working. He said the staff must have turned off the alarm when it went off when Resident #1 exited the facility. In an interview on 02/13/2024 at 1:15 PM, the staffing coordinator stated she completed all the in servicing for all staff. She said she in-serviced on the elopement protocol, and where to find the step-by-step instructions. She said she also in-serviced staff on using the language line for interpreters when residents did not speak English, and the importance of knowing the residents in the facility. In a telephone interview on 02/13/2024 at 5:30 PM, CNA D said he worked on the night Resident #1 eloped from the facility. He said he worked on another hall but was called to see if he knew the man standing outside the door. He said he did not. He said he never worked on the 500 hall which was why he did not recognize him. He said the police came and they found out Resident #1's name and RN A checked the computer and realized he was a resident of the facility. On 01/13/23 at 12:00 PM, a search via WorldWeather revealed the temperature on 01/22/2024 at 2:00 AM in Dallas County, was 34 degrees F. The facility took the following actions to correct the non-compliance prior to the investigation: Record review of the following in-services dated 01/22/2024 through 01/25/2024 reflected,Ongoing checking exit doors and responding to door alarms, rounding every two hours, check outside before shutting off door alarms, Google translate of communication needs to be used, call the Administrator if a resident is exit seeking, ADLs, call lights, responding to safety alarms, doors, fire, abuse, neglect, elopement protocol, and customer service. Attached sign-in sheets reflected staff from all shifts completed the trainings which included return-demonstrations for resetting door alarms and elopement protocols. Record review of the facility's completed door alarms checks confirmed they had been completed regularly on 1/12/24, 1/15/24, 1/16/24, 1/17/24, 1/18/24, 1/19/24, 1/22/24, 1/23/24, 1/24/24, 1/25/24, and 1/26/24. The door alarms were working properly on 01/22/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676422	A. Building B. Wing	02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palomino Place	3160 Gus Thomasson Road Mesquite, TX 75150

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of documentation of emergency IDT meeting was held on 01/22/2024 which addressed the following: 1. Completed in-service to all employees on looking outside before turning the alarm off. 2. Door alarm checks were completed immediately to ensure all door alarms are functioning appropriately. 3. Review of door alarm checks from maintenance to show the alarms have been checked. 4. Review of all elopement assessments to ensure that all patients have a completed assessment. 5. Review of assessment for [Resident #1] showed he was not a risk on admission. New assessment completed to show at risk due to the elopement. 6. Patient on frequent monitoring for 72 hours to ensure safety. 7. All the Staff re-educated on the process for when the door alarm sounds and there is a potential elopement. Reiterate to all nursing staff the importance of checking outside the door where alarm has sounded for any presence of a resident who could have gone out that door. 8. Facility grounds are evaluated for any presence of a resident who could have gone out the door alarming. All rooms are thoroughly checked to ensure that all residents are accounted for. Which means turning on the resident's room lights and ensuring the resident is in the right bed. If the resident is not in bed, checking restrooms, under beds, behind door unlocked, and locked. Record review of Resident #1's latest elopement risk dated 01/26/2024 revealed he was not an elopement risk. Record review of RN A's counseling on the elopement protocol and initiated neglect and elopement protocol in-services, dated 01/23/2024. Interviews on 02/13/2024 from 10:30 AM to 5:30 PM with RN A, LVN B, CNA C, CNA D, CNA E, MA F, MA G, LVN H, LVN I, CNA J, Social Worker, and Nutritional Services Director who worked multiple shifts, revealed they had received in-service training between 01/22/2024 and 01/25/2024. They stated the training had included return demonstrations of how to properly secure the exit doors and reset the alarms. They were able to accurately summarize how to use google translate, the elopement protocol, secure the doors, and report any alarm reactivations to management. Record review of the facility's Elopement Response Protocol, dated May 2016, reflected, Upon the occurrence of an elopement or a suspected elopement, the following steps must be immediately taken: 1. Conduct a thorough search of the Facility and its grounds. 2. If the Patient is not found within 15 minutes notify the Executive Director, DON, Regional Director of Operations, Regional Director of Clinical Services, Chief Clinical Officer, and Director of Operations. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676422	A. Building B. Wing	02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palomino Place	3160 Gus Thomasson Road Mesquite, TX 75150

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Notify the Patient's responsible party and Attending Physician. 4. Notify the local police department. 5. Notify the Department of Aging and Disability (DADS) [PHONE NUMBER] in accordance with the DADS Guidelines for Reportable Incidents. 6. Organize search teams composed of Facility, regional and corporate staff to search the vicinity of the Facility on a continuous basis. Search teams should conduct their searches in one-hour shifts and cover defined areas identified on a street map. Unless the specific circumstances dictate otherwise, searches should begin with an area that consists of a circle with a one-mile diameter with the Facility at its center and then expand to incrementally broader areas. 7. Report hourly to the Chief Clinical Officer, Regional Director of Clinical Services, Director of Operations, and the Regional Director of Operations until the Patient is located or you are directed to report at a different frequency. 8. If the Patient is not located within 8 hours, or if the Patient is not located during a search of the facility, facility grounds, and immediate vicinity, and there is a circumstances that place the patient's health, safety, and or welfare at risk, the report must be made as soon as the facility becomes aware the Patient is missing and cannot be located, and discuss approval from the Director of Operations and the Chief Clinical Officer for the engagement of an outside private detection agency to assist in the search. 9. A complete head to toe nursing assessment must be completed upon return of the Patient In addition, the physician and responsible party must be notified and document. 10. Based on the elopement risk; the Patient may be discharged .