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	08/22/2024

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on observation, interview, and record review, the facility failed to provide the necessary services for residents who were unable to carry out activities of daily living to maintain good grooming and personal hygiene for 1 (Resident #203) of 8 residents reviewed for quality of life. The facility failed to ensure Resident #203's hair was washed while she was at the facility. This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity and a decreased quality of life. Findings include: 1. Record review of Resident #203's Admission MDS assessment dated [DATE], reflected Resident #203 was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included Parkinson's disease and diabetes. Resident #203 had a BIMS score of 9 which indicated Resident #203's cognition was moderately impaired. Resident #203 was totally dependent on staff for bathing/showering. Review of Resident #203's Comprehensive Care Plan, dated 08/09/24, reflected the resident required the shower chair and assistance of one staff for grooming. An observation and interview on 08/20/24 at 9:57 AM with Resident #203 revealed she was seated in her wheelchair in her room. Her hair looked oily. She said she had not received a shower since she arrived on 08/09/24 and her hair had not been washed. She said staff would clean her body, but not wash her hair. A follow-up observation and interview 08/22/24 at 10:47 AM with Resident #203, revealed she still had not had her hair washed. She said her hair felt oily and itchy. An interview on 08/22/24 at 11:07 AM with CNA A revealed she said she showered Resident #203 on 08/21/24 and her bathing schedule was Monday, Wednesday, and Friday. She said the resident did not ask for her to be washed and she forgot to ask her. CNA A said she did not wash the resident's hair. She said the resident could get lice if she did not get her hair washed. CNA A said the resident had a care plan but it did not include washing the resident's hair. (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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 08/22/24 at 12:33 PM with the ADON revealed hair washing during bathing was to be completed if the resident wanted it . The ADON said she did not know that Resident #203 had not had her hair washed since she was admitted on [DATE]. She said Resident #203 had a shower in her room. Record review of the facility policy, Bath-Shower, not dated, reflected: Procedure o Wash your hands, gather equipment. o Explain procedure to patient and provide privacy. o Adjust temperature of water before placing Patient under shower. Check temperature; water should not be above 105-110 degrees F. o Encourage Patient to do as much of his/her own care as possible; supervise and assist Patient as necessary. o Wash face and shampoo hair; rinse well.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on observation, interviews, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 1 (Resident #45) of 8 residents reviewed for pharmacy services. The facility failed to document on the Medical Administration Record and Treatment Administration Record for August 2024 that Resident #1 was receiving Hydrocodone 10 mg-acetaminophen 325 mg (pain medicine). These failures could place residents at risk for medication errors, ineffective relief from pain medication, and drug diversion of controlled substances. Findings included: Record review of Resident #45's quarterly MDS assessment, dated 07/25/24, revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included: non-Alzheimer's dementia and diabetes. Resident #45 had severely impaired cognition. Resident #45 was receiving scheduled pain medicine with no documentation of pain. Review of Resident #45's Care Plan, not dated, reflected: Resident #45 had risk for pain. Facility interventions included: Assess level of comfort/discomfort and identify comfort goal. Assess and monitor pain medications are adequately managing pain and signs/symptoms of complications. Review of Resident #45's August 2024 Physician Orders, reflected: Hydrocodone 10 mg-acetaminophen 325 mg tablet every six hours as needed for pain. There was not an order for Hydrocodone 7.5 mg-acetaminophen 325 mg every six hours as needed for pain. Review of Resident #45's August 2024 Medication Administration Records and Treatment Administration Records reflected there were no documented doses of Hydrocodone 10 mg-acetaminophen 325 mg or Hydrocodone 7.5 mg-acetaminophen 325 mg tablet. There was also no documentation that the resident had any pain. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and record review of Resident #45's August 2024 Narcotic Count Record Sheet reviewed on 08/22/24 with the DON reflected: Hydrocodone 10 mg-acetaminophen 325 mg: 08/10/24 7:00 PM - Unknown Nurse 08/11/24 8:00 AM, 2:00 PM, 8:00 PM - Unknown Nurse 08/12/24 - Unable to read time. - LVN E 08/13/24 - Unable to read time - LVN E 08/14/24, Unable to read time, Unable to read time - Unknown Nurse 08/15/24 7:00 PM - LVN E 08/16/24 Unable to read time - LVN E 08/17/24 8:00 AM, 2:00 PM, 8:00 PM - Unknown nurse 08/18/24 8:00 AM, 2:00 PM, 8:00 PM - Unknown nurse 08/19/24 5:00 PM - LVN E 08/20/24 2:00 PM - LVN E 08/21/24 9:00 PM - Unknown Nurse 08/22/24 9:00 AM - LVN G Hydrocodone 7.5 mg-acetaminophen 325 mg: 08/01/24 9:00 PM - LVN E 08/09/24 4:00 PM - LVN E 08/10/24 5:00 AM - Unknown Nurse 08/10/24 1:00 PM - Unknown Nurse Narcotic Count Record sheet reflected that the narcotic medication was signed out on that document to be administered to the resident. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 08/22/24 at 10:20 AM of Resident #1 revealed she was seated in her wheelchair at the nurse station. Resident #1 complained of abdominal pain and told ADON F that she was hurting. The ADON said she would get her nurse. The resident said, They never help me. My stomach hurts bad. I'm hurting right here. Resident pointed to right side of abdominal pain. LVN G approached the resident and said she medicated her not even 2 hours ago. The resident was pushed to her room. The ADON assessed her and said the plan was to call the physician. An interview on 08/22/24 at 2:45 PM with LVN E revealed she medicated Resident #1 anytime she complained of pain because she had an order for Hydrocodone. LVN E said she only documented the medication administration on the narcotic count log. LVN E said she assessed the resident for pain when she administered the medication but did not document it because she only documented on the narcotic count log. The narcotic count on the cart was correct . An interview on 08/22/24 at 3:26 PM with the DON revealed Resident #1 received pain medication the morning of 08/22/24. She said she was not aware that staff did not document the administration of the hydrocodone on the MAR/TAR or progress notes. The DON said she did not know why the resident had a narcotic count log for a 10 mg dose of hydrocodone and a 7.5 mg dose of hydrocodone. She said there was a risk to the resident if she was only receiving a 7.5 mg dose of hydrocodone because she would not be getting the full ordered dose. The DON said the nurse was supposed to document on the MAR/TAR and progress note if they administered a dose of medication , but she did not know they were not documenting it. The DON looked at the narcotic count log and said she recognized LVN E's name and she planned to talk to her. An interview on 08/22/24 at 3:57 PM with the Physician revealed Resident #1 was new to his caseload and he had not reviewed her medical records yet. He said the nurses should not be administering hydrocodone 7. 5mg because there was no order for it. The Physician said the resident was at risk if she did not receive the ordered dose of the medication and if staff did not document the dose they were administering. He said she could be double-dosed and staff might not document side effects from the medication. Review of the facility policy, Medications, dated November 2017, reflected: 2. The details of administration of each PRN medication for a Patient/Resident, including the time of administration, must be noted along with the reason for giving the medication and the effectiveness of the medication.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #45) of 8 residents observed for infection control. CNA B failed to perform hand hygiene or change her gloves after providing incontinence care for Resident #45. This failure could place residents at risk for healthcare associated cross contamination and infections. Findings included: Record review of Resident #45's quarterly MDS assessment, dated 07/25/24, revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included: non-Alzheimer's dementia, diabetes, and neurogenic bladder (inability to control urine) . Resident #45 had severely impaired cognition was completely dependent on staff for toileting. Resident #45 was always incontinent of bladder and bowel. Review of Resident #45's Care Plan, not dated, reflected: Resident #45 had a self-care deficit with extensive assistance required with bathing, hygiene, dressing, and grooming related to impaired mobility and impaired cognition. An observation on 08/21/24 at 1:05 PM revealed resident #45 was lying in bed. CNA D and CNA B entered the resident's room. The resident's brief was on the floor. CNA B and CNA D positioned the resident in bed and gathered their supplies for incontinence care. CNA B performed hand hygiene and put on gloves. CNA B cleaned the resident and prepared to put a clean brief on the resident. CNA B did not perform hand hygiene or change her gloves after cleansing the resident. CNA B used her soiled gloves to put a clean brief on the resident. The resident was repositioned for comfort. An interview on 08/21/24 at 1:20 PM with CNA B revealed she said she was supposed to perform hand hygiene after cleaning the resident and before putting on a clean brief. She said it was important not to touch clean items with soiled gloves. An interview on 08/21/24 at 2:00 PM with the DON revealed staff were supposed to perform hand hygiene after cleaning for incontinence care and before putting on clean brief. She said that it was important to prevent infection. Record review of the facility policy, Infection Control, dated November 2017, reflected: 1. The facility must establish an infection prevention and control program (IPCP) that must include: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all patients . 37193