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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>676422   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                       | (X3) DATE SURVEY COMPLETED<br><br>02/01/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Palomino Place   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3160 Gus Thomasson Road<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |  |  |
| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35747</p> <p>Based on observation, interview, 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 #1) of 6 residents reviewed for pharmacy services.</p> <p>The facility failed to ensure employees with access to controlled medication properly counted the inventory of the controlled medications. LVN A and LVN B did not adequately count the inventory on their medication cart, and it was later discovered that 120 tablets of Oxycodone (a controlled narcotic drug), belonging to Resident #1, was missing from the medication cart. The medications were never located.</p> <p>The noncompliance was identified as past noncompliance (PNC). The noncompliance began on 10/09/24 and ended on 10/11/24. The facility had corrected the noncompliance before the investigation began.</p> <p>This failure placed residents at risk for unrelieved pain due to their medication not being readily available.</p> <p>Findings included:</p> <p>Review of Resident #1's Face Sheet, dated 10/09/24, reflected he was a [AGE] year-old male, who admitted to the facility on [DATE], with diagnoses including hyperlipidemia (a condition in which there are high levels of fats in the blood), muscle spasm of back (a sudden, involuntary contraction of the muscles in your back, causing a sharp, painful tightness or twinge, often triggered by overuse, injury, poor posture, or lifting heavy objects, and can feel like a sudden locking up of the back muscles, limiting movement), and pain (an unpleasant sensory and emotional experience that signals potential or actual tissue damage).</p> <p>Review of Resident #1's Physician's Orders, dated 02/01/25, reflected he was prescribed Oxycodone 15mg tablet orally every four hours as needed (for pain). The start date of this medication was 09/26/24.</p> <p>(continued on next page)</p> |  |  |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Review of the facility's Provider Investigation Report, dated 10/14/24, reflected on 10/09/24, Resident #1's prescription medication of Oxycodone 15mg was noted to be missing (120 tablets were identified as missing). Resident #1's medication was delivered on 10/03/24 (126 tablets), and he was given the medication on 10/05/24 (2 tablets), 10/06/24 (2 tablets), 10/07/24 (1 tablet), and 10/08/24 (1 tablet). The medications were counted on 10/08/24 at 10:00PM (at shift change), but neither nurse who completed the medication count (LVN A and LVN B) could confirm if the blister packs (a form of tamper-evident packaging where an individual pushes individually sealed tablets through the foil in order to take the medication) of medication were there at the time of the count, nor could they remember the last time the medication was seen. It was noted that Resident #1 had not missed a dose of medication, as there was still a blister pack of Oxycodone (prescribed to him) on the medication cart that was being used. All appropriate parties, including the police department, were notified of the missing medication. LVN A and LVN B, who both denied diverting the medications, were suspended pending the outcome of the investigation. Staff statements revealed all individuals who had access to the medication denied taking the medication and/or knowing how the medication went missing. Drug testing revealed all individuals who had access to the medication tested negative for any substances, including Oxycodone. The facility was unable to determine who diverted the medication or how the medication went missing. To prevent further occurrences, the facility implemented a new form for shift count where nurses were required to count the blister packs as well as the individual sheets. There was also a new policy implemented in which the nurses were required to make a copy of all paperwork upon delivery of new narcotics and provide it to nurse management. The facility ordered new medication for Resident #1, at the cost of the facility. Facility staff were in-serviced on procedures for receiving narcotics, narcotic count protocol, the implementation of new narcotic count sheets with card counts, and controlled substance accountability. LVN A and LVN B both received a final warning/action plan due to their failure to ensure narcotics were accounted for during shift change. All staff were in-serviced on the facility's new policies and procedures.</p> <p>Review of the facility's in-service logs, dated from 10/09/24 to 10/11/24, reflected facility staff were in-serviced on procedures for receiving narcotics, narcotic count protocol, the implementation of new narcotic count sheets with card counts, and controlled substance accountability.</p> <p>Review of personnel files for LVN A and LVN B reflected they both received a written final warning/action plan, dated 10/09/24, for failing to count narcotics according to facility policy.</p> <p>Observations of five separate medication carts on 02/01/25 from 11:00AM to 12:00PM, including a review of narcotic logs and count sheets, reflected no evidence of a current drug diversion. It appeared as though facility staff were following the facility's policies and procedures to prevent a drug diversion. These observations were completed with CMA C, LVN D, LVN E, and LVN F.</p> <p>During interviews with multiple staff members (with CMA C, LVN D, LVN E, LVN F, and LVN G) on 02/01/25 from 11:00AM to 12:00PM, they each stated they had been in-serviced on pharmacy services. They were knowledgeable of the facility's policies and procedures related to acquiring, receiving, dispensing, labeling, storing, and administering medications. They were able to verbalize the facility's policies and procedures related to the prevention of drug diversion, including the new policies and procedures implemented as a result of the incident involving Resident #1's prescription medication of Oxycodone (such as what procedures to take when narcotics were received from the pharmacy as well as the procedure for counting medications).</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During interviews with the Administrator on 02/01/25 at 12:48PM and 3:20PM, he stated a drug diversion occurred with Resident #1's prescription medication of Oxycodone 15mg. The Administrator stated 120 tablets of this medication went missing from the medication cart. He stated a search of the facility, including all medication carts and the drug destruction area, revealed the medication was unable to be located. A review of the facility's staffing schedule, as well as Resident #1's MAR/TAR and narcotic logs, revealed the medication had to have gone missing on either 10/08/24 or 10/09/24. Potential perpetrators included LVN A and LVN B, as they were the last individuals to have access to and complete the narcotic count prior to the medication being identified as missing. However, both LVN A and LVN B were unable to recall if the blister packs of medication were on the cart during their narcotic count. The Administrator stated Resident #1 still had Oxycodone on the cart that was being given as prescribed, so he did not miss any scheduled doses or have any adverse effects. The police department was notified of the drug diversion. LVN A and LVN B were suspended pending the outcome of the investigation. Staff statements revealed all individuals who had access to the medication denied taking the medication and/or knowing how the medication went missing. Drug testing revealed all individuals who had access to the medication tested negative for any substances, including Oxycodone. The facility was unable to determine who diverted the medication. To prevent further occurrences, the facility implemented a new form for shift count where nurses were required to count the blister packs as well as the individual sheets. There was also a new policy implemented in which the nurses were required to make a copy of all paperwork upon delivery of new narcotics and provide it to nurse management. The facility ordered new medication for Resident #1, at the cost of the facility. Facility staff were in-serviced on procedures for receiving narcotics, narcotic count protocol, the implementation of new narcotic count sheets with card counts, and controlled substance accountability. LVN A and LVN B both received a final warning/action plan due to their failure to ensure narcotics were accounted for during shift change. The Administrator stated a potential risk of drug diversion was that the resident may not receive his or her prescribed dose of medication.</p> <p>During an interview with the Director of Nursing on 02/01/25 at 1:17PM, she stated a confirmed drug diversion occurred with Resident #1's prescription medication of Oxycodone 15mg. The Director of Nursing stated as a result of the facility's investigation, new policies were implemented to include: a new form for shift count where nurses were required to count the blister packs as well as the individual sheets and a new policy implemented in which the nurses were required to make a copy of all paperwork upon delivery of new narcotics and provide it to nurse management. The Director of Nursing was monitoring this for timely and proper completion by staff to ensure the prevention of another drug diversion. The Director of Nursing stated a potential risk of drug diversion was that the resident may not receive his or her prescribed dose of medication.</p> <p>On 02/01/25 at 3:47PM, the surveyor attempted to contact LVN B via telephone. The surveyor left a voice message requesting a return telephone call.</p> <p>On 02/01/25 at 3:50PM, the surveyor attempted to contact LVN A via telephone. The surveyor left a voice message requesting a return telephone call.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Review of the facility's Narcotic Receipt Procedures and Narcotic Count Protocol Policy, undated, reflected, . The new procedure for receiving Narcotic has become more defined. From this point forward, ALL narcotics forms (there are 3 in total) MUST be signed by 2 Nurses. Those 3 forms include: the delivery manifest, the Class II-V Delivery Record, and the Narcotic Count Sheet (maybe pink or white). Once you have made a copy of these three forms, they are to be stapled together and placed under the ADON's/DON's office door immediately. When counting the narcotics on the oncoming shift, you MUST give the name of the patient, the name of the medication, the strength of the medication, and the quantity of medication on hand. THERE ARE NO EXCEPTIONS TO THE PROCESS. YOU WILL FOLLOW THIS PROTOCOL TO HELP PREVENT ANY MEDICATION FROM BEING MISPLACED OR TAKEN .</p> |  |  |