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	07/30/2025

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 0686 Level of Harm - Actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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 0686 Level of Harm - Actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing for 1 (Resident #1) of 3 residents reviewed for pressure ulcers.CNA A and CNA B failed to reposition Resident #1 as required by her orders and care plan on 07/30/25.The facility failed to ensure that Resident #1 did not develop 2 stage III wounds while at the facility. This failure could place residents with pressure wounds at risk of the wound worsening, leading to increased pain, infection, delayed healing, serious complications including sepsis, reduced mobility, and a lower quality of life.Findings included:Record Review of Resident 1's quarterly MDS assessment, dated 06/26/25, revealed she was a [AGE] year-old female, admitted to the facility on [DATE]. Resident #1 was sometimes understood and sometimes was able to understand. The resident was dependent on staff to roll her from left to right. Her diagnoses included diabetes, neurogenic bladder (an injury or disease interrupts the electrical signals between your nervous system and bladder function), multiple sclerosis (can cause muscle weakness, vision changes, numbness and memory issues). The resident used a Foley catheter. The resident had one Stage IV pressure ulcer present on admission.Record Review of Resident #1's Care Plans, revised on 06/26/25, reflected,1. Pressure Ulcer Prevention in place to prevent any additional skin alterations. Facility interventions included: Turn and reposition every 2 hours and as needed. Keep body in good alignment.2. Resident has current skin concerns: Stage IV pressure ulcer to sacrum.Facility interventions included:Monitor areas for increase breakdown and signs and symptoms of infection. Report to Physician. Record Review of Resident #1's Order Summary Report, dated 07/02/25, reflected:1. Nursing Intervention: Turn and reposition every 2 hours every shift.Review of Resident #1's Wound Evaluation and Management Summary reflected:6/26/25 Stage IV Pressure Ulcer Sacrum - Greater than 157 days. 5.5 CM x 6.0 CM x 2.0 CM. Surgical Debridement of the wound performed. No wounds on the Left Buttock or Right ButtockWound Progress: Not at goal due to need more time.7/10/25 Stage IV Pressure Ulcer Sacrum - 5.5 CM x 5.0 CM x 3. 0 CMWound progress: Exacerbated due to patient non-compliant with wound care.Left buttock Deep Tissue Injury - Greater than 7 days. 3.5 CM x 4.0 CM X 0.2 CMEstimated Time to Heal: 4-6 monthsRight buttock Deep Tissue Injury - Greater than 7 days. 3.0 CM x 3.0 CM x 0.2 CMEstimated Time to Heal: 4-6 months7/17/25 Stage IV Pressure Ulcer Sacrum - 7.0 CM x 5.0 CM x 3.0 CM. Surgical Debridement of the wound performed. Wound Progress: At goalLeft buttock Stage III - 4.0 CM x 2.0 CM x 0.2 CMWound Progress: Not at goal due to need more time.Right buttock Stage III - 5.5 CM x3.0 x 0.2 CM. Surgical Debridement of the wound performed. Wound Progress: Not at goal due to need more time.An observation and interview on 07/30/25 at 10:22 AM revealed the WCN was preparing to do wound care for Resident #1. The resident was lying in bed with the head of bed slightly elevated. CNA A was assisting the WCN and said she last repositioned Resident #1 between 6:15 AM - 6:20 AM. She said she did not reposition the resident at the 8:00 AM time frame, because she was busy passing trays. CNA A said the risk to the resident if she was not repositioned every 2 hours was that she could get more breakdown. CNA A said there were no other residents who were not repositioned every 2 hours. Resident #1 was turned to her right side. Her sacrum and buttocks was covered with 3 drainage soiled dressings, dated 07/29/25. The WCN said the resident had the wounds for less than a year and the WCP came to the facility on Thursdays. The WCN removed the dressings. The sacral wound was large and deep, about the size of 1/2 a baseball. There was slough (slough in wound healing refers to dead tissue within a wound, often appearing as a yellow, tan, or white fibrous material. Slough can cover the wound bed and impede the healing process if not properly managed) The sacral wound was a Stage IV. The resident had a Stage III wound on each buttock that was red and open. There was no slough. The WCN said the resident wounds had improved. The WCN said the resident had previously had a wound vac that was removed due to worsening of the sacral wound. The deep sacral wound was packed lightly with calcium alginate. The WCN debrided and covered all 3 wounds with calcium alginate and foam dressings. An interview on 07/30/25, at 12:40 PM with CNA A revealed staffing was sufficient for the morning shift on 07/30/25. She said she always tried to keep her residents repositioned and the DON expected that all residents were repositioned before passing ice. CNA A said there was a routine the CNAs followed that allowed 2 CNAs to pass trays, and 2 CNAs to reposition residents. CNA A said there was an issue the morning of 07/30/25, because it took two staff to change one resident. CNA A said she did

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for 1 (Resident #1) of 2 residents reviewed for catheter care. The facility failed to ensure Resident #1 had a catheter anchor in place during wound care on 07/30/25. This failure could place residents with foley catheters at risk for pulling and/or trauma to the bladder and urethra. Findings included: Record Review of Resident 1's quarterly MDS assessment, dated 06/26/25, revealed she was a [AGE] year-old female, admitted to the facility on [DATE]. Resident #1 was sometimes understood and sometimes was able to understand. The resident was dependent on staff to roll her from left to right. Her diagnoses included diabetes, neurogenic bladder (an injury or disease interrupts the electrical signals between your nervous system and bladder function), multiple sclerosis (can cause muscle weakness, vision changes, numbness and memory issues). The resident used a Foley catheter. Record Review of Resident #1's Care Plans, not dated, reflected,1. Foley catheter for urinary retention, at risk for infection.Facility interventions included: Ensure leg strap or other method in place to secure catheter. Record Review of Resident #1's Order Summary Report, dated 06/03/25, reflected: Foley Catheter: Check and Change Catheter Anchor if needed every shiftAn observation and interview on 07/30/25 at 10:22 AM revealed the WCN was preparing to do wound care for Resident #1. Resident #1 was lying in bed with the head of bed slightly elevated and she had a Foley catheter. The resident did not have a catheter anchor in place. The staff assisted to turn her to her right side. There was a risk for the catheter to pull during wound care. CNA A said she last saw the catheter anchor in place at around 6:15 AM and without one the resident was at risk of the catheter getting pulled. The WCN said the resident had a catheter anchor in place on 07/29/25. The WCN said it was important to have a catheter anchor in place to prevent pulling on the catheter. The WCN said she would get a catheter anchor off of the medication cart and place it on the resident. An interview on 07/30/25 at 4:55 PM with the DON revealed she did not know why Resident #1 did not have a catheter anchor in place during wound care on 07/30/25. The DON said the CNAs and nurses were responsible for checking to make sure it was in place. The DON said the risk to the resident was it could be pulled or cause trauma. Record review of the facility policy, Foley Catheter Insertion, Female Resident, revised October 2010, reflected: Steps in the Procedure.25.Tape catheter to inner thigh or secure with leg band.