

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676422	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/27/2025
NAME OF PROVIDER OR SUPPLIER  Palomino Place		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and record reviews, 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 one (Resident #1) of three residents reviewed for pharmacy services. The facility failed to ensure Resident #1, who was NPO, did not receive a medication by mouth. The failure could place residents at risk for aspiration, choking, and death. An IJ was identified on 08/26/25. The IJ template was provided to the facility on [DATE] at 4:49 PM. While the IJ was removed on 08/27/25, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimum harm because all staff had not been trained on the Plan of Removal. Findings included: Record review of Resident #1's quarterly MDS assessment dated [DATE], reflected she was a [AGE] year-old female who admitted to the facility on [DATE]. She was sometimes able to understand others and sometimes able to make herself understood. The resident's diagnoses included diabetes and multiple sclerosis (multiple sclerosis is an autoimmune disease that affects the central nervous system, leading to a range of symptoms due to the immune system attacking the nerve fibers.) The resident had a feeding tube. Record review of Resident #1's August 2025 Order Summary Report reflected: Start Date: 06/03/25 NPO diet Start Date: 06/03/25 G Tube - Flush before and after medication administration. Every shift Flush G Tube with 50 ml water before and after medication administration. Start Date: 06/03/25 G-Tube - May mix and flush each medication with 5 - 10 ml's of Water. Record review of Resident #1's August 2025 Medication Administration Record reflected on 08/22/25, RN B administered all 7:00 AM and 9:00 AM medications including Eliquis via Resident #1's feeding tube. Record review of Resident #1's FNP note reflected: 08/22/25 10:09 AM Physician- Progress Note Late Entry: Note Text: Subjective: Resting in bed, has a pill in her mouth. Reports the nurse gave her a pill and she is unable to swallow. I removed pill and notified nurse and DON - patient is NPO. Educated nurse on medication distribution and notified DON of error. An interview on 08/26/25 at 1:35 PM with the FNP revealed on 08/22/25 Resident #1 told her there was a pill in her mouth. The FNP said she removed the pill from Resident #1's mouth and pill was intact. The FNP said the resident did not have adverse effects. The FNP said the risk to the resident was she could have aspirated. The FNP said she notified LVN A of the error and the DON. The FNP said she told the DON to educate the nurses. A follow-up interview on 08/26/25 at 1:55 PM with the FNP revealed LVN A told her the pill in Resident's #1 mouth was the Eliquis that he gave her. An interview on 08/26/25 at 2:35 PM revealed LVN A said he did not give Resident #1 a pill by mouth. He said he was supposed to be receiving orientation but was assigned a hall to work. LVN A said he administered Resident #1's medications by feeding tube. LVN A said he worked a full shift on 08/22/25. An interview on 08/26/25 at 4:10 PM with RN B revealed she was working at the facility the morning of 08/22/25. RN B said she did not know why LVN A would deny administering medications orally to Resident #1. RN B said she saw LVN A go into Resident #1's room at unknown time and then leave the room. RN B said LVN A told her that he tried to give Resident #1 a medication by mouth because he did not know the resident had a feeding tube. RN B said LVN A told her that it was a speech therapist who told him not to give Resident #1 a pill by mouth. RN B said she told LVN A that it was very important to follow the rights of giving medication, including route. RN B said she saw LVN A later that shift and he was counting the medication cart with another nurse. RN B said LVN A called later and said he was not coming back to work at the facility. RN B said she saw the DON and told her to do 1:1 training with LVN A. RN B said she only passed a couple of medications to residents, and she saw LVN A documenting under her name. She said she told LVN A not to document under his name. RN B said she thought it was a speech therapist who had talked to LVN A, not the FNP. An interview on 08/26/25 at 2:30 PM with the DON revealed there were 5 residents who were NPO. She said she was not there when Resident #1 was given a pill by mouth. The DON said she was told by RN B that LVN A gave Resident #1 a pill by mouth instead of by feeding tube and the FNP removed it. The DON said she was told by RN B that the FNP counseled LVN A. The DON said she did not talk to LVN A about the incident. The DON said LVN C was placed to work with LVN A for the rest of the shift. The DON said LVN A did not know the residents at the facility but knew the system of working at the facility and was a transfer from a sister facility. The DON said she saw LVN A and LVN C talking during the shift. The DON said she did not tell LVN C about the incident. The DON said she was supposed to in-service LVN A and she attempted to call him, but he declined all calls. The DON said</p>		