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	05/22/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents had the right to be free from abuse for 1 of 5 residents (Resident #1) reviewed for abuse.The facility failed to ensure Resident #1 was protected from Resident #2 who entered her room and engaged in non-consensual sexual contact with her on 5/21/2026.The failure placed residents at experiencing fear, emotional distress, and unwanted sexual contact, placing residents at risk for abuse and psychological harm.Findings include: Review of Resident #1's Quarterly MDS Assessment, dated 04/15/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. She had a BIMS score of 10 which indicated moderate cognitive impairment. She had diagnoses that included: vascular dementia with mood disturbance (memory and thinking problems caused by a reduced blood flow or small strokes in the brain, along with emotional changes like irritability, sadness, mood swings, or agitation), depression (persistent sadness, low motivation, loss of interest, hopelessness, or emotional heaviness), anxiety (excessive worry, nervousness, fear, restlessness, or feeling on edge), and insomnia (trouble falling asleep, staying asleep, or getting restful sleep). Record review of Resident #1's Annual Care Plan, dated 04/10/26, noted a dependence on staff for activities of daily living, a risk of falls, impaired hearing and vision, and at risk of depression. Record review of Resident #2's admission MDS Assessment, dated 03/26/26, reflected an [AGE] year-old male who admitted to the facility on [DATE]. He had a BIMS score of 6, which indicated severe cognitive impairment. He had diagnoses that included: Parkinsonism (the brain has trouble controlling body movement) and mood disorder due to known physiological condition (an illness or physical condition affects mood and emotions). The MDS Assessment did not indicate any behavioral issues such as wandering or rejection of care. Record review of Resident #2's Care Plan, dated 03/20/26, reflected he required one person assist for all activities of daily living due to impaired cognition, general weakness, and Parkinson's Disease. The plan reflected Resident #2 had impaired cognitive function/impaired thought process. The plan reflected Resident #2 would often get out of his wheelchair and attempted to ambulate unassisted which resulted in 3 actual falls occurring on 4/1/26, 4/7/26, and 5/4/26. The plan reflected Resident #2 received melatonin (a supplement to help fall asleep) for difficulty falling or staying asleep. Record review of Resident #2' progress note dated 5/22/26, reflected an incident that occurred at approximately 11:45 PM on 5/21/26. The note reflected that nursing staff were responding to call lights on the 800 hall. Staff members observed Resident #2 lying in Resident #1's bed. Staff members immediately separated the two residents and completed head to toe assessments. Resident #2's brief was intact. Attempt to notify Resident #2's family member was made and a message was left. Resident #2 was placed on one-on-one direct observation. Record review of Resident #2's progress note dated 5/22/26, reflected contact was made with Resident #2's family member. It reflected the family member was made aware of Resident # 2's immediate discharge notice and agreed to pick him up from the facility today. During an interview and observation with Resident #1 on 05/22/26 at 12:32 PM, Resident #1 was observed lying in her bed. Resident #1 resided on the 800 hall. She reported last night she was lying in bed attempting to go to (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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	sleep when Resident #2 entered her room and shut the door. Resident #1 stated Resident #2 got into her bed and laid next to her and placed his hand over her brief and attempted to move the brief out of the way. Resident #1 stated he was not able to get the brief off or move it out of the way. Resident #1 stated she began yelling at Resident #2 to get off of her and was also yelling for help. Resident #1 stated the police arrived and removed Resident #2 out of the bed. Resident #1 stated she did not think staff could hear her because her door was shut. Resident #1 stated he was not taken to jail and believed he should have been. She stated she was feeling nervous and was worried he would come back. She stated she was also just feeling nervous overall as it was a scary situation. Resident #1 stated she was offered to be transferred to the hospital, and she did not want to go. She reported she had no physical injuries from the incident Resident #1 stated she was unaware that Resident #2 was being discharged . She stated knowing he would be leaving made her feel safer. She stated after the incident happened she spoke with the facility social worker. During an interview with Resident #3 on 05/22/26 at 12:40 PM, she stated she was Resident #1's roommate. She stated she was lying in bed last night when Resident #2 entered their room. She stated the curtain was drawn between her bed and Resident #1's bed so she did not see anything. She stated she heard Resident #1 say she was scared and she asked her why. She said Resident #1 told her there was a man on top of her and trying to get in her pants and rape her. She stated she pushed her call light button and instead of waiting for staff she called 911 and an officer arrived within about 5 minutes of her calling. During an observation and attempted interview on 05/22/26 at 1:00 PM, Resident #2 was observed sleeping in his room. A male staff member was observed sitting in the room with the resident for one-on-one monitoring. After attempts to speak to the resident, he did not fully wake up. On 5/22/26, attempts to make contact with the responding officer were made at 12:25 PM, 2:15 PM, and 3:20 PM and were unsuccessful. During an interview with CNA A on 05/22/26 at 2:27 PM, she reported she observed Resident #2 wandering toward the 800 hall prior to the incident. She reported Resident #2 resided on the 600 hall. She reported she redirected Resident #2 toward the nurses station around 11:30 PM. She stated she then received a light notification and had to leave the area. CNA A reported she left Resident #2 parked near the nurses station and approximately five minutes later police arrived in response to a 911 call reporting a man in Resident #1's room. She reported there were no nurses at the nurse station at that time. She reported the two nurses were providing patient care. CNA A reported she followed behind the officer into Resident #1's room where she said she saw Resident #2 lying next to Resident #1 on his side. She reported it appeared Resident #2 was trying to give her hug, she reported she did not see where his hands where. She denied hearing yelling for help prior to the officer arriving. During an interview with LVN B on 05/22/26 at 2:40 PM, she reported she was at the nurse station when she saw a police officer rushing toward the 800 hall. She reported she followed the officer to Resident #1's room where she observed Resident #2 on top of Resident #1 in her bed. She reported Resident #1 was yelling get him off of me please. LVN denied hearing yelling for help prior to the officer arriving. She denied seeing Resident #2 at the nurse station prior to police arrival. She reported she was responding to a call light prior to police arrival. During an interview with Resident #2's family member on 05/22/26 at 3:30 PM, she reported she was notified of the incident by the administrator. She reported she was not aware of Resident #2 having a history of sexual inappropriate behaviors or wandering. She reported Resident #2 was picked up from the facility on 05/22/26 and went home. During an interview with the SW on 05/22/26 at 2:00 PM, she reported she was notified by the administrator of the incident and immediately completed a trauma assessment with Resident #1. She reported Resident #1 appeared saddened during the interview. The SW reported she requested counseling and psychiatric services for Resident #1. The SW reported Resident #1 had a telehealth session with a therapist today. The SW reported she completed safe surveys on all residents today with no concerns reported. The SW reported she spoke to Resident #2's family member today who reported they were bringing him home from the facility today. The SW reported she had helped arrange in-home services for Resident #2. Record review of Resident #1's Trauma (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Assessment, dated 5/22/26, reflected no prior history of trauma. The assessment reflected no current symptoms of trauma. During an interview on 05/22/26 at 4:00 PM, with the Regional [NAME] President, she reported Resident #2 was taken home around 3:00 PM today. She reported Resident #2 did not have a history of wandering or sexual aggression. She reported Resident #2 was admitted from a hospital and none of his records indicated any concerning behaviors. She reported the facility did not have any residents that wandered. She stated if a resident was found to display wandering behaviors, they would place them on one-on-one observation until they were able to find appropriate alternative placement. She reported the police did not take Resident #2 into custody because of his health conditions. During an interview with the Regional Director of Clinical Services on 05/22/26 at 5:21 PM, she reported Resident #2 was discharged home. She reported his family member arrived to the facility around 3 PM and took him home. She reported the resident was immediately removed from Resident #1's room and placed on one-on-one observations after the incident. She reported Resident #2's physician was notified and requested a urine analysis test to screen for a UTI due to a change in his behavior. During an interview with the administrator on 05/22/26 at 4:50 PM, he reported he was notified of the incident last night immediately after it happened. He reported he began calling Resident #2's family to initiate an immediate discharge. He stated he was unable to get a hold of the family as it was around midnight. He stated a family member returned his call today and the incident was explained to them and the reason for immediate discharge. He stated the family agreed to pick Resident #2 up which they did today around 3 PM. He stated Resident #2 was immediately placed on one-on-one observation until he was discharged . He reported if a resident was wandering, they would be placed on one-on-one supervision and be discharged from the facility. The administrator reported Resident #1 had a head-to-toe assessment completed with no observable injuries. He reported that the SW completed a trauma assessment with Resident #1 and her physician and family were notified of the incident. He reported Resident #1 was offered to be taken to the hospital and declined. He reported in-service training began on all night shift staff on 05/21/26 for behavioral management and de-escalation techniques and managing inappropriate sexual behaviors. The administrator reported the facility was responsible for ensuring residents remained safe from abuse by other residents in the facility. Record review of the facility Abuse, Neglect and Exploitation policy dated 10/01/2025 reflected in part. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology and/ or resident to resident altercations and encounters. Sexual Abuse is non-consensual sexual contact of any type with a resident. The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse. The facility will develop and implement written policies and procedures that: Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property