

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 12/11/2025
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.			
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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** Based on observation, interview, and record review the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 5 (Resident #38, Resident #80, Resident #90, Resident# 57 and Resident #18) of 16 residents reviewed for quality of life The facility failed to ensure: Resident #38 had his nails cut and cleaned. Resident #80 had her fingernails cleaned and trimmed and chin hair shaved. Resident #18 has his fingernails trimmed. Resident #90 had her fingernails cleaned and trimmed. Resident #57 had her fingernails trimmed and her chin hair shaved. These failures could place residents at risk for not receiving necessary care and services and a decreased quality of life. Findings include: 1- Resident #38 Record review of Resident #38's quarterly MDS assessment, dated 09/07/25, reflected a [AGE] year-old male with an admission date of 01/30/25. Resident #38 had a BIMS score of 14 which indicated he was cognitively intact. He required substantial to maximum assistance for personal hygiene and had not refused care. He had functional limitation in range of motion upper extremities on one side and bilateral limitation on lower extremities. Diagnoses included diabetes, cerebral vascular accident (stroke) and hemiplegia (paralysis on one side of the body). She had not received occupational therapy (therapy that focuses on regaining dexterity and strength in fine motor skills) or restorative nursing services in the 7 days look back period. Record review of Resident #38's care plan dated 08/06/25 reflected, The resident had Diabetes Mellitus and is currently receiving a low concentrated sweets diet. Goal. Resident is to have no complications related to diabetes. Interventions. nurse to monitor/document foot care needs and cut long nails. Focus. dated 09/19/25. ADL self-care performance deficit related to hemiplegia. Left resting hand splint 6-8 hours every day. Intervention. Apply left resting hand splint 6-8 hours a day as ordered. Skin Inspection: Observe for redness, open areas, scratches, cuts, bruise and report changes to the Nurse. Record review of Resident #38's CNAs Task list dated 10/02/25 did not list personal hygiene as a task to be provided. In an observation and interview on 09/30/2025 at 12:05 PM Resident #38 was observed lying in bed. Resident #38 had contracted left hand with a resting palm splint in place. His nails on his left hand were approximately an inch in length, jagged and dirty. His thumb nail on his right hand was about an inch in length and very jagged. He stated he needed them trimmed badly. He stated no one had offered to trim his nails. An observation on 10/01/2025 at 9:20 AM revealed Resident #38 up in his wheelchair sitting in the common area next to the nurse's station. The resident was dressed for the day. He had the resting palm Splint on his left hand. All of his nails on his left hand remained long and jagged as well as his right-hand thumb nail. He stated they cleaned him up last night but did not trim his nails. In an interview and observation on 10/01/2025 at 10:00 AM with CNA G she stated she was assigned to Resident #38 today. She stated nursing, Physical therapy or restorative was who put the splints on the residents. She stated she had helped get him up today. She stated today was his shower day on the 2-10 p.m. shift. In an observation made with CNA G of Resident #38's nails, she stated she had not noticed his nails and stated they did need to be trimmed. She stated the nurses were responsible for trimming the diabetics nails and stated she thought he was diabetic. In an observation and interview on 10/01/2025 at 10:05 AM LVN E observed Resident #38 nails and stated (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 676422	Facility ID: 676422 If continuation sheet Page 1 of 19

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	offering ADLs including nailcare for hospice residents on as needed basis. The DON stated his expectation was that nail care should be provided every shower day and as needed. He stated that both CNAs and Nurses were responsible for doing nail care on all residents; except Nurses were responsible for nailcare for diabetic residents. He stated that dirty, long fingernails could cause skin irritation and unwanted facial hair could cause residents to feel unkempt and loss of dignity. He stated as the DON he conducted daily rounding on residents along with the Assistant Director of Nursing. He stated that he will provide in-service to staff regarding ADL care and ensure that ADL care tasks for all residents were carried out daily. In a follow up interview with the DON on 10/02/2025 at 03:30 PM he stated that going forward they were placing a list of all the diabetics in the nurse's binder for each hall so they would be aware of which resident they were responsible for nail care. He stated in addition their daily angel rounds would include looking at each of the residents' nails and their overall hygiene to ensure their ADLs were being met. He stated the DON and ADONs would be responsible for follow up and ensuring those tasks were carried out. Review of the facility policy titled Care of Fingernails/ toenails, revised September 2010 reflected, Purpose: The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. 1. Nail care includes daily cleaning and regular trimming.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview and record review the facility failed to ensure that a resident who needed respiratory care, including tracheostomy care and tracheal suctioning, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan and the resident's goals and preferences for two of three residents (Resident #50, and Resident #26) reviewed for respiratory care. 1.The facility failed to ensure LVN K maintained sterile/aseptic technique during tracheostomy care (a surgical opening in the neck providing a direct airway through the trachea) for Resident #50 on 10/02/25. 2. The facility failed to ensure Resident #26's had a physician order prior to administering oxygen on 9/30/25. These failures could place residents at risk for respiratory infections and at risk of receiving an incorrect amount of oxygen. Based on observation, interview and record review the facility failed to ensure that a resident who needed respiratory care, including tracheostomy care and tracheal suctioning, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan and the resident's goals and preferences for two of three residents (Resident #50, and Resident #26) reviewed for respiratory care. 1.The facility failed to ensure LVN K maintained sterile/aseptic technique during tracheostomy care (a surgical opening in the neck providing a direct airway through the trachea) for Resident #50 on 10/02/25. 2. The facility failed to ensure Resident #26's had a physician order prior to administering oxygen on 9/30/25. These failures could place residents at risk for respiratory infections and at risk of receiving an incorrect amount of oxygen.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 7 of 15 residents (Resident #72, Resident #73, Resident #79, Resident #80, Resident # 78, Resident # 21 and Resident #39) reviewed for infection control. 1. The facility failed to ensure CNA F and RA D utilized Enhanced Barrier Precautions and performed hand hygiene before and after checking Resident #72 for incontinence on 10/01/25. 2. The facility failed to ensure CNA F changed her gloves and performed hand hygiene while providing incontinence care for Resident #73 and failed to ensure both CNA F and RA D used enhanced barrier precautions and failed to perform hand hygiene before leaving the resident's room on 10/01/25. 3. The facility failed to ensure CNA F and RA D performed hand hygiene and glove changes during a check and change of Resident #79's brief on 10/01/25. 4. The facility failed to ensure LVN E followed the manufacture's recommendations for disinfecting the glucometer after obtaining fingerstick blood sugars for Resident #80 and Resident # 78 on 09/30/25. 5. The facility failed to ensure LVN B followed the manufacture's recommendations for disinfecting the glucometer after obtaining fingerstick blood sugars for Resident # 21 on 09/30/25. 6. The facility failed to ensure MA I prepared Resident #39's medication without cross contaminating his medications on 10/01/25. These failures could place residents at risk of cross-contamination and the development of infection. Findings include: 1. Record review of Resident #72's care plan, initiated 08/19/25, reflected a [AGE] year-old male with an admission date of 05/30/25. The care plan reflected the resident required enhanced barrier precautions related to his feeding tube, and he was incontinent of bowel and urine and required checks for incontinence and brief changes. An observation on 10/01/2025 at 11:00 a.m. revealed CNA F and RA D making their check and change rounds on Resident #72. Signage was posted outside of Resident #72's room which indicated Enhanced Barrier Precautions were required. Both staff entered the room without performing hand hygiene or putting on gowns. Both staff put on gloves and CNA F pulled the cover back which revealed the resident had a g-tube in place with a dressing, dated 10/01/25. CNA F unfastened the resident's brief to reveal he had not voided. CNA F with the assistance of RA D rolled the resident on his side to reveal he was dry and clean, and his skin was intact. The staff rolled the resident back onto his back and refastened the brief. The staff repositioned the resident in the bed, adjusted his covers and the boot splints on both his feet. Both staff removed their gloves and left the room without performing hand hygiene and walked down hallway to check Resident #73. 2. Record review of Resident #73's quarterly MDS assessment, dated 09/01/25, reflected a [AGE] year-old female with an admission date of 02/28/24. The facility staff evaluated her cognition as severely cognitively impaired. She was dependent for all ADLs and was frequently incontinent of urine and always incontinent of bowel. Resident #73 received all nutrition through a feeding tube. Resident #73 had active diagnoses which included Huntington's Disease (an inherited condition in which nerve cells in the brain break down over time) and aphasia (language disorder that affects a person's ability to speak). In an observation on 10/01/2025 at 11:05 a.m. revealed CNA F and RA D used the hand sanitizer outside of Resident #73's room and put on gloves but no gowns. The signage posted revealed that the resident was on enhanced barrier precautions. Both staff entered the room and CNA F stated she would have to get the nurse to turn off the G-tube pump. CNA F left the room and returned with the DON who entered the room gownned and gloved and CNA F entered with gloves on, but no gown. The DON turned off the G-Tube pump and disconnected the enteral feeding from the G-tube. The DON removed his gown and gloves, performed hand hygiene and left the room. CNA F then unfastened the resident's brief, which revealed she was wet and had a soft bowel movement. CNA F turned the resident onto her left side with RA D's assistance, without first cleaning the resident's perineal area. CNA F wiped the anal area from front (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for the blood glucose reading. LVN E disposed of the lancet and test strip and returned to the medication cart and placed the glucometer on top of the medication cart. She performed hand hygiene put on gloves and determined the amount of insulin the resident required, drew it up and administered the insulin to the resident. LVN E disposed of the needle, removed her gloves and performed hand hygiene. LVN E then pushed the medication cart to Resident #78's room to obtain her fingerstick blood sugar. LVN E opened a few packets of alcohol prep pads and wiped down the glucometer, put on gloves and entered the resident's room and obtained a blood sample to determine the residents' blood glucose levels. LVN E returned to the medication cart, placed the glucometer on the medication cart, performed hand hygiene and drew up the amount of insulin the resident required and administered the insulin. In an interview with LVN E on 09/30/25 at 11:05 a.m. she stated she was not aware she had to clean the glucometer with a bleach wipe or germicidal wipe rated for disinfected. LVN E stated she always used an alcohol prep pad. LVN E opened her medication cart and revealed she had bleach wipes and germicidal wipes on her cart and stated she would start using these to sanitize the glucometer. 5. During a medication pass observation on 09/30/25 at 11:10 a.m. revealed LVN B was at the medication cart preparing to check Resident # 39's blood sugar levels via a fingerstick blood sugar. LVN B retrieved the glucometer from the medication cart and wiped it down with an alcohol prep pad. LVN B sanitized her hands, put on gloves and entered the resident's room. LVN B pricked the residents' fingers, obtained the blood sample for the blood glucose reading. LVN B disposed of the lancet and test strip and returned to the medication cart and placed the glucometer on top of the medication cart. She performed hand hygiene put on gloves and determined the amount of insulin the resident required, primed the insulin and dialed in the amount of insulin required and administered it to the resident. LVN B disposed of the needle, removed her gloves and performed hand hygiene and opened a few packets of alcohol prep pads and wiped down the glucometer. In an interview with LVN B on 09/30/25 at 11:20 a.m., she stated she was not aware she had to clean the glucometer with a bleach wipe or germicidal wipe rated for disinfected. LVN B stated no one instructed them they could not use an alcohol prep pad. LVN E opened her medication cart and revealed she had bleach wipes and germicidal wipes on her cart and stated she would start using these to sanitize the glucometer. 6. During medication observation on 10/01/25 at 08:41 a.m., MA I was observed at the medication cart. MA I performed hand hygiene and entered Resident #39's room to obtain his blood pressure. MA I returned to the medication cart, put on a pair of gloves, and sanitized the blood pressure cuff with a bleach wipe. MA I put on gloves and opened the medication cart with her gloved hands and pulled out eight blister packs and proceeded to pop the medication into her gloved hand and then placed each tablet into the medication cup. After each medication MA I used her gloved hand to maneuver the mouse of her computer to pull up the medication she was administering and typed in the medication. In an interview on 10/01/25 at 08:50 a.m., MA I stated she was taught she was not supposed to touch the medication with her bare hands, so that was why she put on gloves. She stated she could see once she touched the mouse and computer keyboard her gloved hand was no longer clean. She stated she should pop the pill directly into the medication cup. In an interview on 10/02/25 at 03:40 p.m. with the DON, he stated staff had never been taught to punch medications into a gloved hand. He stated they were taught to punch the medication directly into the medication cup without touching the medication to prevent cross contamination. He stated the staff also had training on disinfecting multiple use equipment such as glucometers, blood pressure cuffs etc. and they were taught to use germicidal wipes and allow the equipment to air dry for the appropriate kill time to ensure the equipment was effectively disinfected. He stated not using the proper disinfectant ran the risk of cross contamination of blood borne pathogens from resident to resident. Record review of the facility's policy titled, Handwashing/Hand hygiene, dated August 2019, reflected The facility considers hand hygiene the primary means to prevent the spread of infection. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections. Before and after direct contact with residents. before moving from a contaminated body site to a clean body site (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	during resident care.After contact with a resident intact skin.After removing gloves.Before and after entering isolation precaution settings. Record review of the facility's policy titled, Enhanced Barrier Precautions, dated August 2022, reflected Enhanced Barrier Precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents.EBP employ targeted gown and glove use during high contact resident care activities when contact precautions no not otherwise apply.Examples of high-contact resident care activities requiring the use of gown and gloves for EBP's include.device care or use (.feeding tube.)EBPs remain in place for the duration of the residents stay or until resolution.or discontinuation of the indwelling medical device that places them at increased risk.Staff are trained prior to caring for resident on EBPs.Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required. Record review of the facility's, undated, manufactures guidelines for cleaning and disinfecting the Assure prism multi-blood glucose monitoring system reflected, To minimize the risk of transmitting bloodborne pathogens, the cleaning and disinfection procedures should be performed as recommended in the instruction below.Only wipes with EPA registration.have been validated for use in cleaning and disinfecting the meter.Clorox (bleach) germicidal wipes.Sani-Cloth germicidal wipes.Each time the cleaning and disinfecting procedure is performed, two wipes are needed: one wipes to clean the meter and a second wipe to disinfect the meter.Wipe the entire surface of the meter using the towelette at least three times vertically and three times horizontally to clean blood and other body fluids from meter.Repeat above steps with a new towelette to disinfect the meter.Meter surfaces must remain wet according to contact times listed in the wipe manufacturer's instructions. Once complete, wipe meter dry Record review of the facility's policy titled, Administering Medication, dated December 2012, reflected .Staff shall follow established facility infection control procedures.for the administration of medications.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary and comfortable environment for 1 of 8 residents (Resident #64) in that: Resident # 64's refrigerator in her room had food that was moldy and spoiled half-filled cup of coffee on 9/30/2025. This failure could place resident at risk for a diminished quality of life and a diminished clean, homelike environment. The findings include: Record review of Resident # 64 Quarterly MDS dated [DATE] reflected, Resident #64 was an [AGE] year-old female admitted to the facility on [DATE]. Resident #64 was on Hospice care. Resident #64 BIMS score was 0 which indicated she had severe cognitive impairment. Her pertinent diagnoses included Hypertension (high blood pressure), Diabetes Mellitus (an increased blood glucose levels), Hyperlipidemia (high blood lipid levels), and non-Alzheimer's dementia (cognitive decline that is not caused by Alzheimer's disease). In an observation on 09/30/2025 at 12:21 PM revealed Resident #64 had a refrigerator in the room. The refrigerator had residents have half-filled coffee drink that was spoiled and disposable box of food that was not dated or labeled. In an observation on 10/1/25 at 9:10 AM Resident #64's refrigerator in her room revealed a to-go container of food with no date or label on it and half-filled spoiled coffee cup. In an interview attempted on 10/1/25 at 9:11 AM with Resident #64 revealed she was not able to answer any of the surveyor's questions. In an observation and interview on 10/01/2025 at 9:13 AM along with CNA L revealed that CNA L stated that the refrigerator belonged to Resident #64. She proceeded to open the refrigerator and observed a to-go food container and half-filled coffee cup. She opened the box, and the food inside the box had white and green fungus-like substance on it. CNA L stated that the food was moldy and spoiled. She stated that the coffee inside the cup looked frothy and spoiled. CNA L stated that cleaning refrigerators was joint responsibility of CNAs and Housekeeping staff. She stated that she had not checked the refrigerator for weeks. She added that the resident's family may be bringing food from outside for her. She stated that the risk to the resident with moldy food in the refrigerator was the possibility of resident getting sick and mold growing within the refrigerator. In an interview 10/01/2025 at 9:16 AM with LVN B revealed that she does not usually check refrigerator in resident rooms since she thought it was the responsibility of housekeepers and CNAs. She stated that risks of spoiled food in resident refrigerator can lead to a risk of food poisoning and decreased quality of life. In an interview on 10/01/2025 at 9:21 AM with the DON stated that his expectation was both housekeeping and nursing staff should check resident refrigerator daily to ensure they are clean and free of spoiled food. He stated that the risk of having moldy and spoiled food was possible food borne illness and diminished quality of life. In an interview on 10/02/2025 at 3:14 PM with the Housekeeping Supervisor stated that it was the responsibility of the housekeeping staff to check and clean resident refrigerators daily. He stated that he was aware of spoiled food in Resident #64's refrigerator on 10/01/25 and provided in-service to his staff regarding regular cleaning of refrigerators on the same day. He stated that the Housekeeper forgot to check Resident #64's refrigerator. He stated that the risk of eating spoiled food was Residents can get sick and moldy food in the refrigerator can lead to decreased quality of life. In an interview on 10/02/2025 at 3:35 PM with Housekeeper M revealed that she cleaned Resident # 64's room on Tuesday 6/20/25. She stated that she forgot to check resident #64's refrigerator. She stated that she received an in-service on checking and cleaning refrigerators daily, as needed. She added that the risk of spoiled, moldy food in resident refrigerator can lead to residents getting sick and possibility of mold spreading in the room. Record review of the facility's policy titled Homelike Environment, revised February 2021 reflected the following, Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review, the facility failed to complete an assessment that accurately reflects a resident's status for 1 of 5 residents (Resident #26) reviewed for accuracy of assessments. The facility failed to accurately complete Resident #26's Quarterly MDS Assessment related to the need for oxygen therapy. The facility failed to accurately complete Resident #26's Quarterly MDS Assessment related to the discontinued use of anti-coagulant therapy. This failure could place the resident at risk of not having met her needs. Findings included Record review of Resident #26's admission record dated 10/1/25 reflected a [AGE] year-old female with an original admission date of 2/28/25 and readmission date of 7/21/25. Pertinent diagnoses included Dementia, End Stage Renal Disease (a condition in which the kidneys lose the ability to remove waste and balance fluids), Metabolic Encephalopathy (a condition where the brain does not receive enough oxygen or nutrients, leading to changes in brain function, and Paroxysmal Atrial Fibrillation (a heart rhythm disorder where the hearts chambers beat irregularly and rapidly). Record review of Resident #26's Quarterly MDS assessment, dated 9/1/25 reflected resident was moderately cognitively impaired and had a BIMS of 11. Section N reflected resident continued anti-coagulant therapy. Section O reflected resident did not require oxygen while residing at the facility. Record review of Resident #26's Order Summary Report dated 10/1/25, reflected no physician order for anti-coagulants and no order to administer oxygen. Record review of Resident #26's Order Recap Report dated 8/1/25-10/31/25 reflected Eliquis Oral Tablet 2.5 with a start date of 7/26/25 and end date of 8/14/25. Record review of Resident #26's person-centered care plan, effective 3/2/25 reflected .COPD Resident #26 HAS : Potential for ineffective airway exchange and infection related to dx of COPD. STATUS: Active (Current) COPD: Resident #26 will have respiratory rate within normal limits and be free of s/s of respiratory distress. STATUS: Active (Current) COPD: Administer bronchodilators, aerosol treatments, nebulizers, and oxygen 2-6 lpm and monitor status. STATUS: Active (Current) Nursing COPD: Administer medications as ordered and monitor for side effects. STATUS: Active (Current). Record review of Resident #26's person-centered care plan updated on 9/2/25 reflected .Focus: Resident #26 is on anticoagulant therapy Eliquis for long term therapy Date Initiated: 09/02/2025 Revision on: 09/02/2025. Goal: Resident #26 will be free from discomfort or adverse reactions related to anticoagulant use through the review date. Date Initiated: 09/02/2025 Revision on: 09/02/2025 Target Date: 10/04/2025. Interventions: Administer ANTICOAGULANT medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT. Date Initiated: 09/02/2025 Revision on: 09/02/2025 [NAME]/family/caregiver teaching to include the following: Take/give medication at the same time each day, Use soft toothbrush, Use electric razor, Avoid activities that could result in injury, take precautions to avoid falls, Signs/symptoms of bleeding, Avoid foods high in Vitamin K. These include greens such as spinach and turnips, asparagus, broccoli, cabbage, Brussels sprouts, milk and cheese. Date Initiated: 09/02/2025 Revision on: 09/02/2025 Daily skin inspection. Report abnormalities to the nurse. Date Initiated: 09/02/2025 Revision on: 09/02/2025 Labs as ordered. Report abnormal lab results to the MD. Date Initiated: 09/02/2025 Revision on: 09/02/2025 Monitor/document/report PRN adverse reactions of ANTICOAGULANT therapy: blood tinged or red blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, SOB, loss of appetite, sudden changes in mental status, significant or sudden changes in v/s. Date Initiated: 09/02/2025 Revision on: 09/02/2025. Observation of Resident #26 in her room on 9/30/25 at 10:16am revealed resident was asleep and had oxygen on via nasal cannula. The concentrator was set at 2 liters per minute. In an interview with Resident #26 on 9/30/25 at 1:37pm revealed she had been receiving oxygen as needed. She stated staff would check her oxygen levels before turning on the oxygen machine. In an interview with CNA A on 10/1/25 at (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1:18pm revealed she had observed Resident #26 with oxygen on at bedside almost daily. In an interview with LVN B on 10/1/25 at 2:02pm revealed Resident #26 required oxygen. LVN B stated Resident #26 should have 2-3 liters per minute of oxygen when her oxygen levels were low. The oxygen was ordered by the physician. LVN B stated Resident #26 was no longer taking anti-coagulants, as the doctor had discontinued them. She was unsure when they were discontinued. LVN B stated she did not update MDS assessments and was not familiar with what needed to be on them. In an interview with the MDS Coordinator on 10/2/25 on 11:13am revealed she was not the MDS Coordinator responsible for updating Resident #26's MDS but was the only MDS Coordinator at the facility, as the one that was responsible for Resident #26's recently left the position. The MDS Coordinator stated she had completed Significant Change MDS for many reasons, some of the reason were when residents had a significant weight loss, 2 or more changes in their care, significant weight gain and if they start or end dialysis or hospice. When it was time to update the resident's Quarterly MDS Assessments she would look at the whole file, it was like starting a new MDS assessment. She stated some of the things she reviewed were ADL documentation, medications, doctors' notes, doctor's orders and progress notes. She would identify Anticoagulant therapy and mark it on an MDS if a resident was prescribed an Anticoagulant. The MDS Coordinator stated Aspirin would not be classified as an anti-coagulant but it would be categorized as an antiplatelet. Once a resident was removed from anti-coagulant therapy, she would update it on the next quarterly MDS assessment. The MDS Coordinator reviewed Resident #23's medical file and she stated anti-coagulant therapy should not have been marked on her 9/1/25 MDS assessment because her anti-coagulant had been discontinued since August. If it is documented the resident was on oxygen she would have noted it on the MDS and a Care Plan as well. MDS Nurse were responsible for completing the CAA sections of the MDS and the nurses were responsible to complete sections pertaining to acute needs. The MDS Coordinator stated there was no risk to the resident of an incorrect MDS because it is used for payment purposes. The MDS was used to accurately complete the care plan. She stated she used RAI manual to completed MDS assessments. In an interview with the DON on 10/2/25at 2:54pm revealed when a resident was administered oxygen it should be noted in the MDS Assessment. When a resident started or stopped anti-coagulant the MDS should have reflected it accurately. The MDS coordinators were responsible for accurately completing the MDS assessments for each resident. The DON was not sure of the risk to the resident of an inaccurate MDS assessment. In an interview with the Administrator on 10/2/25 at 3:01pm revealed the MDS assessments were completed by the designated MDS coordinators for long term or rehab residents. The MDS nurse responsible for Resident #26's MDS recently left the facility and they were using a traveling MDS nurse from the corporate office to help with the MDS assessment for the long term residents. The administrator stated he was not familiar with what needed to go on an MDS assessment. Record review of the facility's policy Electronic Transmission of the MDS revised November 2019 reflected .8. The MDS coordinator is responsible for ensuring that appropriate edits are made prior to transmitting MDS data and that feedback and validation reports from each transmission are maintained for historical purposes and for tracking. Record review of CMS's RAI Version 3.0 Manual effective October 2024 reflected .N0415E2 Anticoagulant: check if there is an indication noted for all anticoagulant medications taken by the resident any time during the observation period (or since admission/entry or reentry if less than 7 days). O0110C1 Oxygen Therapy code continuous or intermittent oxygen administered via mask, cannula, etc., delivered to a resident to relieve hypoxia in this item. Code oxygen use in Bi-level Positive Airway Pressure/Continuous Positive Airway Pressure (BiPAP/CPAP) here. Do not code hyperbaric oxygen for wound therapy in this item. This item may be coded if the resident places or removes their own oxygen mask, cannula. O0110C2, Continuous check if oxygen therapy was continuously delivered for 14 hours or greater per day, O0110C3, Intermittent check if oxygen therapy was intermittent (i.e. not delivered continuously for at least 14 hours per day). O0110C4, High-concentration check if oxygen was provided via a high concentration delivery system.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to include in the care plan services that will be provided to the resident for 1 (Resident #40) of 10 residents reviewed for comprehensive care plans. The facility failed to ensure Resident #40 was care planned for ADLs. This failure could put Residents at risk of receiving unnecessary treatments, not receiving care or services and further decline of their physical health. Findings included: Record review of a face sheet dated 10/02/25 revealed Resident #40 was an [AGE] year old female admitted on [DATE] with diagnoses including cerebral infraction (interruption of blood flow to the brain), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), acute respiratory failure with hypoxia (the lungs fail to adequately exchange oxygen from the air into the bloodstream), dementia (a decline in cognitive function), and unspecified lack of coordination (impaired balance or coordination). Record review of the most recent MDS dated [DATE] indicated Resident#40 was cognitively intact with a BIMS score of 12. Record review of Resident #40's comprehensive care plan dated 05/19/25 reflected no plan of care for goals and interventions for ADLs. During an interview on 10/01/25 at 1:10 p.m., the MDS Coordinator revealed she did not know the reason ADLs were not included in the care plan. The MDS Coordinator stated ADLS should have been included in the care plan so that CNAs would have known the residents needs. She stated the MDS Coordinator was responsible for writing the care plans. During an interview on 10/2/25 at 2:25 p.m., the DON stated ADLs were needed so staff would know how to take care of the residents. The DON stated it was important to have interventions to reflect the accurate needs of the residents. In an interview with the Administrator on 10/2/25 at 3:01pm revealed the MDS Coordinators and charge nurses were responsible for updating care plans. Review of the facility's policy Care Plans - Comprehensive revised September 2010 .1. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develop and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. 2. The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS. 3. Each resident's comprehensive care plan is designed to: a. Incorporate identified problems areas; b. incorporate risk factors associated with identified problems; .e. reflect treatment goals, timetables and objectives in measurable outcomes; f. Identify the professional services that are responsible for each element of care; g. aide in preventing or reducing declines in the resident's functional status and/or functional levels.		

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care by qualified persons according to each resident's written plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to have the comprehensive care plan reviewed and revised by qualified persons after each assessment for 1 (Resident #26) of 10 residents reviewed for comprehensive care plans. The facility failed to update Resident #26's care plan to reflect doctor's orders to discontinue anticoagulant therapy on 8/14/25. This failure could put Residents at risk of receiving unnecessary treatments, not receiving care or services and further decline of their physical health. Findings included: Record review of Resident #26's admission record dated 10/1/25 reflected a [AGE] year-old female with an original admission date of 2/28/25 and readmission date of 7/21/25. Pertinent diagnoses included Dementia, End Stage Renal Disease (a condition in which the kidneys lose the ability to remove waste and balance fluids), Metabolic Encephalopathy (a condition where the brain does not receive enough oxygen or nutrients, leading to changes in brain function, and Paroxysmal Atrial Fibrillation (a heart rhythm disorder where the hearts chambers beat irregularly and rapidly). Record review of Resident #26's Quarterly MDS assessment, dated 9/1/25 reflected resident was moderately cognitively impaired and had a BIMS of 11. Section N reflected resident continued anti-coagulant therapy. Record review of Resident #26's Order Summary Report dated 10/1/25, reflected no physician order for anti-coagulants. Record review of Resident #26's Order Recap Report dated 8/1/25-10/31/25 reflected Eliquis Oral Tablet 2.5 with a start date of 7/26/25 and end date of 8/14/25. Record review of Resident #26's person-centered care plan updated on 9/2/25 reflected .Focus: Resident #26 is on anticoagulant therapy Eliquis for long term therapy Date Initiated: 09/02/2025 Revision on: 09/02/2025. Goal: Resident #26 will be free from discomfort or adverse reactions related to anticoagulant use through the review date. Date Initiated: 09/02/2025 Revision on: 09/02/2025 Target Date: 10/04/2025. Interventions: Administer ANTICOAGULANT medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT. Date Initiated: 09/02/2025 Revision on: 09/02/2025 family/caregiver teaching to include the following: Take/give medication at the same time each day, Use soft toothbrush, Use electric razor, Avoid activities that could result in injury, take precautions to avoid falls, Signs/symptoms of bleeding, Avoid foods high in Vitamin K. These include greens such as spinach and turnips, asparagus, broccoli, cabbage, Brussels sprouts, milk and cheese. Date Initiated: 09/02/2025 Revision on: 09/02/2025 Daily skin inspection. Report abnormalities to the nurse. Date Initiated: 09/02/2025 Revision on: 09/02/2025 Labs as ordered. Report abnormal lab results to the MD. Date Initiated: 09/02/2025 Revision on: 09/02/2025 Monitor/document/report PRN adverse reactions of ANTICOAGULANT therapy: blood tinged or red blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, SOB, loss of appetite, sudden changes in mental status, significant or sudden changes in v/s. Date Initiated: 09/02/2025 Revision on: 09/02/2025. In an interview with the MDS Coordinator on 10/2/25 at 11:13am revealed she was not the MDS Coordinator responsible for updating Resident #26's care plan but was the only MDS Coordinator at the facility, as the one that was responsible for Resident #26's care plan recently left the position. Once a resident was removed from anti-coagulant therapy, the MDS coordinator would update the care plan to reflect discontinued anticoagulant therapy. She reviewed Resident #26's care plan and noted anti-coagulant therapy was still in the care plan dated 9/2/25. She stated anticoagulant therapy should have been removed from Resident #26's care plan because Eliquis was discontinued prior to the update of the care plan. The risk to the resident of not having had an accurate care plan was staff would not know how to care for the resident appropriately. She stated they had a traveling MDS coordinator who was helping her with the care plans until they hired a new MDS coordinator. She stated nursing staff could have updated the care plans as well. In an interview with LVN B on 10/2/25 at 12:12pm revealed Resident #26 was no longer taking anti-coagulant medications. LVN B stated the MDS Coordinator was responsible for updating the care plans. In an (continued on next page)		

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview with RN C on 10/2/25 at 11:51am revealed nurses did not update care plans, as they were only responsible for Baseline Care plans. In an interview with the Administrator on 10/2/25 at 3:01pm revealed the MDS Coordinators and charge nurses were responsible for updating care plans. Review of the facility's policy Care Plans - Comprehensive revised September 2010 .1. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develop and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. 2. The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS. 3. Each resident's comprehensive care plan is designed to: a. Incorporate identified problems areas; b. incorporate risk factors associated with identified problems; .e. reflect treatment goals, timetables and objectives in measurable outcomes; f. Identify the professional services that are responsible for each element of care; g. aide in preventing or reducing declines in the resident's functional status and/or functional levels.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 12/11/2025
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)		
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, based on the comprehensive assessment of the resident, a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for one of three residents (Resident #73) reviewed for incontinence care. The facility failed to ensure CNA F and RA D provided appropriate perineal care for Resident #73 when they failed to clean the resident's perineal area, separate the labia and wash downward and clean the inner thighs and groin area on 10/01/25. This failure could place residents at risk for the development and/or worsening of urinary tract infections and skin breakdown. Record review of Resident #73's quarterly MDS assessment, dated 09/01/25, reflected a [AGE] year-old female with an admission date of 02/28/24. The facility staff evaluated her cognition as severely cognitively impaired. She was dependent for all ADLs and was frequently incontinent of urine and always incontinent of bowel. The resident received all nutrition through a feeding tube. Resident #73's active diagnoses included Huntington's Disease (an inherited condition in which nerve cells in the brain break down over time) and aphasia (language disorder that affects a person's ability to speak) Record review of Resident #73's care plan, initiated on 09/24/25, reflected [Resident #73] has bladder and bowel incontinence she is dependent on staff for all incontinence care needs .Interventions.Clean peri-care with each incontinence episode .Monitor for signs and symptoms of urinary tract infections. In an observation on 10/01/2025 at 11:05 a.m. revealed CNA F and RA D used hand sanitizer outside of Resident #73's room and put on gloves but no gowns. Both staff entered the room and CNA F unfastened the residents brief, revealing she was wet and had soft bowel movement. CNA F turned the resident onto her left side with RA D's assistance without first cleaning the resident's perineal area. CNA F wiped the anal area from front to back, revealing a small nickel sized open area near her anus. CNA F stated she needed to get the treatment nurse to see the area. CNA F placed a clean brief under the resident, still wearing soiled gloves, and covered the resident. CNA F removed her gloves and left the room without performing hand hygiene. Within a few minutes, CNA F returned to the room with the Treatment nurse who was gownned and gloved. CNA F, again only put on gloves. The Treatment Nurse assessed the area and told the staff to put barrier cream on it for now. She stated she would notify the physician. CNA F stated the resident was still having bowel movement and again wiped her anal area from front to back to remove the bowel movement. Wearing the same gloves CNA F put barrier cream on the resident's anal area and rolled her back onto the brief and both staff fastened the brief without ever cleaning the resident's perineal area. Both staff repositioned the resident removed their gloves and left the room without performing hand hygiene. In an interview with CNA F and RA D on 10/01/25 at 11:35 a.m., CNA F stated she was supposed to wipe from front to back when performing incontinence care. She stated she thought she could clean the resident's peri area from the back, but stated she could not clean the inner thighs, pubic area or open the resident labia to ensure all fecal matter was removed. RA D stated they should have cleaned her front area first before rolling her on her side to clean her anal area. They both stated by failing to provide proper incontinence care it placed the resident at risk of urinary tract infections. In an interview with the DON on 10/03/2025 at 03:40 p.m., he stated any time the staff provided incontinence care he expected the residents to be cleaned properly, and the staff were to clean the peri-area from front to back and then progress to the anal area. He stated there was no way to ensure a resident was thoroughly cleaned by cleaning them only from the back side. He stated that by not cleaning properly it placed the resident at a high risk of urinary tract infections. He stated they did annual skills checks on the staff and monitored proper care by doing spot checks with the staff throughout the year. Record review of the Facility's policy titled, Incontinence care Protocol, dated September 2024, reflected Maintain the Patient in a clean and dry sated and prevent (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	complications of incontinence by maintain and providing incontinent care to the patient a regular interval. Incontinent care will be provided after each incontinent episode.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles and in compliance with the state laws and regulations, which included the appropriate accessory and cautionary instructions and the expiration date when applicable for the facility's one of two (Whirlaway med room) medication rooms reviewed for storage. The facility failed to ensure a vial of Tuberculin Purified protein derivative (substance used for skin test for tuberculosis), that was opened and used, was dated and stored in its original package in the medication room refrigerator. This failure could place residents at risk of diminished effectiveness and not receiving the therapeutic benefits of the medications. The findings include: An observation on 09/30/2025 at 9:30 a.m. of the medication room refrigerator on Whirlaway hall with the DON revealed an undated opened vial of Tuberculin Purified protein derivative stored in a bag labeled hep lock solution (a very diluted heparin solution used to flush maintain patency of intravenous lines). In an interview with the DON on 09/30/25 at 09:44 a.m., he stated the Tuberculin Purified protein derivative had to be dated when opened. He stated once it was opened it would only be good for 30 days. He stated the risk of not dating it once opened was the potential for false positive or an inaccurate test, which could lead to a missed infection. He stated all the nurses performed the Tuberculin skin test on any new admission and whoever opened the vial was responsible for dating. He stated all medications should be stored in their original containers to prevent mixing up medications. He stated the pharmacy consultant came monthly and checked for outdated medications, and stated the nurses were always supposed to check the date before using any medication. Record review of the facility's policy titled Storage of Medications, dated April 2007, reflected . Drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received. The nursing staff shall be responsible for maintaining medication storage. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed .		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure residents toileting facilities were adequately equipped to allow residents to call for assistance for 2 Residents (Resident #57 and Resident #64) of 16 residents reviewed for residents' call systems. The facility failed on 09/30/2025 to ensure the call light system was accessible to a resident, lying on the floor in the shared residents' toilets located inside the residents' rooms when the call lights were missing the pull strings, for: Resident #57 and Resident #64 This failure could place residents in the facility at risk of being unable to have a means of directly contacting caregivers from their restroom. Findings included: Observation on 09/30/25 at 12:12 PM revealed residents' toilet call light pull string was missing for Resident #57 and Resident #64 in their shared toilet. In an interview and observation on 10/01/2025 at 9:16 AM with CNA L stated that the cord for the bathroom call light was missing. She stated that she had not noticed the missing cord earlier. She stated that she will let the maintenance personnel know about the missing cord. She added that the risk of not having a call light within reach can lead to the possibility of a fall and the resident not being able to get help on time. In an interview on 10/01/2025 at 9:40 AM with the Maintenance supervisor revealed, he was informed about the missing call light string in the bathroom by the DON just before the interview and he has fixed the issue. He stated he did not know about the missing call lights string before and relies on multidisciplinary team including CNAs, housekeepers, Nurses to let him know regarding any maintenance request. He stated the risk to the resident was a possible fall without any help for hours. In an interview and observation on 10/01/25 at 9:21 PM with the DON stated call light string was supposed to be within the reach of the resident. He stated missing call lights string was a safety concern. In an interview on 10/2/25 3:02 PM with the Administrator stated the call light string should be within resident reach, at all times so they could call for help when they need it. He stated missing string for the bathroom call light could be a safety issue. He added that it was an interdisciplinary approach to ensure residents were safe and any repairs needed should be communicated with maintenance promptly. He stated that there is no specific policy regarding call light strings, however for resident safety, call light should always be in resident's reach. Review of the facility policy titled Call System: Resident, revised September 2022 [NAME] .1. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor.		