STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455672	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Palms Rehabilitation and Retirement	2101 Treasure Hills Blvd Harlingen, TX 78550

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45737 Based on interviews and record reviews the facility failed to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (which included to the State Survey Agency) in accordance with State law through established procedures for 1 of 4 residents (Resident #1) reviewed for reporting alleged allegation of abuse. The facility did not report, within 2 hours, when Resident #1 was found with altered mental status and a 1/4 empty bottle of rubbing alcohol on 06/19/24 at around 4:00pm - 6:00 PM. This failure could place residents at risk for undetected abuse, neglect and/or decline in feelings of safety and well-being. The findings were: Record review of Resident #1's face sheet, dated 06/24/24, revealed the resident was a [AGE] year-old male who was initially admitted to the facility on [DATE] with diagnoses that included: pulmonary hypertension (high blood pressure that affects the arteries in the lungs and in the heart), acute (severe and sudden onset) and subacute (recent onset, somewhat rapid change) endocarditis (inflammation of the heart valve), type 2 diabetes mellitus (high blood sugar) without complications, peripheral vascular disease, end stage renal disease (when kidneys no longer work as they should to meet the body's needs), nicotine dependence (need for nicotine that you cannot stop) Record review of Resident #1's admission minimum data set assessment (MDS), dated [DATE], revealed Resident #1 had a BIMS score of 14, indicating no cognitive impairment. The MDS assessment reflected Resident #1's independence level for eating was set up (helper sets up or cleans up; resident completed activity). (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's change in condition dated 06/19/24 at 6:12 PM completed by the ADON stated, unknown amount of rubbing alcohol missing from original bottle/consumed and stated the ADON was notified by dialysis center that resident had a large bottle of rubbing alcohol 1/2 bottle was empty, patient noted to be having altered mental stated when assessed and poison control called. Change in condition documentation stated Resident #1 was recommended to be sent to the emergency room for evaluation and treatment as per poison control and the FNP. Record review of Resident #1's nursing notes with an effective date of 06/20/24 at 3:46 am by LVN A revealed the nurse spoke to a nurse from the hospital who notified her that Resident #1 would be admitted for alcohol poisoning. Record review of Resident #1's hospital record dated 06/19/24 stated Resident #1 was seen on 06/19/24 and stated Resident #1 had stated he drank about 1/4 of rubbing alcohol because he wanted to get drunk. Hospital records revealed Resident #1 had an ethanol level of <10 mcg/ml on 06/19/24. Record Review of TULIP (HHSC online incident reporting application) on 06/24/24 at 6:30 PM revealed a self-report received by the facility on 06/20/24 at 3:09 PM, more than 2 hours after facility identified Resident #1 with a 1/4 empty bottle of alcohol and altered mental status. During an interview with Resident #1 on 06/24/24 at 12:55 PM while at the hospital he stated while at the facility he had 2 bottles of rubbing alcohol that he would keep with him or on the counter. Resident #1 stated he did not know if staff had seen the rubbing alcohol bottles but stated he did not have them hidden and had them in plain sight, but no one had said anything. Resident #1 then stated a lot of people would see the rubbing alcohol bottles but he did not recall exactly who. Resident #1 stated he used the rubbing alcohol for his legs since they were dry. Resident #1 stated he had not drank any and did not remember where he got it from. Resident #1 stated he was not sure If when he arrived at the facility they went over his inventory and completed an inventory sheet. Resident #1 stated upon admission the facility did not go over checking in any items that were brought in with himself or his responsible party. Resident #1 stated upon admission the facility had not explained to him or his responsible party items that were not allowed in the facility. During an interview and record review on 06/19/24 at 1:05 PM with Resident #1's Hospital Nurse he stated Resident #1 was admitted for some sort of ingestion of rubbing alcohol. Resident #1's Hospital Nurse reviewed his resident list that had their diagnosis and pointed to Resident #1 diagnoses, which read, isopropyl alcohol poisoning. During an interview with the ADN on 06/24/24 at 1:26 PM she stated on 6/19/14 at around 4 or 5 PM she was notified by the dialysis center that they had found a bottle of rubbing alcohol with Resident #1 on 06/18/24 while he was at dialysis. ADON stated this prompted her to go to Resident #1's room immediately where she found a bottle of rubbing alcohol that had about 1/4 missing and Resident #1 very lethargic, not coherent, and slumped over. ADON stated she did not see Resident #1 consume any of the rubbing alcohol but asked Resident #1 If he had consumed any and he stated he did not know if something was put in a cup at bedside. ADON stated she called poison control because it was a substance. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LVN A on 06/25/24 at 3:22 PM she stated the Interim Administrator/Clinical Resource was the abuse coordinator and stated any nurse who witnessed abuse was responsible for reporting any allegations of abuse, neglect, or exploitation to state agencies as well as reporting it to their ADON/DON. LVN A stated they had a couple of hours to report. LVN A stated on 06/20/24 sometime after 2:00 am she called the hospital to check the status of Resident #1 and was informed he was probably getting admitted for alcohol poisoning, but they were not sure due to pending lab results. LVN A stated she notified the ADON as soon as she hung up with the hospital. LVN A stated as far as reporting to stated agencies she was not sure if she could report it herself as that was usually taken care of by the abuse coordinator. LVN A stated she had been trained over this topic within the last month and stated trainings were either provided but the abuse coordinator or the DON. LVN A stated facility policy was to report as soon as you see something happening and stated in this situation, she did follow her policy. LVN A stated not reporting allegations of abuse, neglect or exploitation within the appropriate time frames could cause resident to injure themselves or overdose. During a follow up interview with the ADON on 06/24/24 at 4:36 PM she stated the Interim Administrator/Clinical Resource was the abuse coordinator and was responsible for reporting any allegations of abuse, neglect, or exploitation to state agencies along with DONs or Administrators from their sister facilities being responsible as well. The ADON stated they had a 2-hour window to report. The ADON stated she did not know the timeline of the facility submitted self-report but stated it should have been reported within 2 hours because Resident #1 ingested something. The ADON stated herself and staff had been trained over reporting and the appropriate time frames and stated their facility policy also stated to report within a 2-hour window. The ADON stated when she found Resident #1 with altered mental status and a bottle of rubbing alcohol in his room she reported to the Interim Administrator/Clinical Resource after she had assessed Resident #1 and called poison control to let her know she would be sending Resident #1 out to hospital. The ADON stated she reported to the Interim Administrator/Clinical Resource on 06/19/24 at around 4:30 PM-6:00 PM, closer to 6:00 PM. The ADON stated she was also notified by LVN A on 06/20/24 at 4:43 am that Resident #1 had been admitted with a diagnoses of alcohol poisoning and stated at around 6:00 am she had notified the Interim Administrator/Clinical Resource and a DON from a sister facility. The ADON stated not appropriately reporting allegations of abuse, neglect and exploitation could cause bodily injury or death. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Interim Administrator/Clinical Resource on 06/24/24 at 5:42 PM she stated she was the abuse coordinator and was responsible for reporting any allegations of abuse, neglect, or exploitation to state agencies. The Interim Administrator/Clinical Resource stated the reporting time depended on their assessment and would be either 2 hours or 24 hours and stated they reported on a 24-hour time frame based off provider letter 19-17. The Interim Administrator/Clinical Resource stated on 06/19/24 at around 6:00 PM was when she was notified by the ADON of the dialysis center finding rubbing alcohol with Resident #1 the previous day 06/18/24, at this time the Interim Administrator/Clinical Resource was also notified of the ADON finding a bottle of rubbing alcohol in Resident #1's room and the results of the assessment completed by the ADON on Resident #1. The Interim Administrator/Clinical Resource stated she informed the ADON to call poison control and to send Resident #1 out. The Interim Administrator/Clinical Resource stated she submitted self-report on 06/20/24 at around 2:00 PM. The Interim Administrator/Clinical Resource stated she did not report with 2 hours because they were getting hearsay information from dialysis and stated no one at the dialysis center had witnessed Resident #1 ingest anything. The Interim Administrator/Clinical Resource stated after explanation by Surveyor B she agreed the situation was a more urgent situation and should have been reported within 2 hours. The Interim Administrator/Clinical Resource stated herself and staff had been trained over reporting and the appropriate time frames and stated staff was last trained over the topic within the last 30 days. The Interim Administrator/Clinical Resource stated she was not notified by LVN A when she got information that Resident #1 was admitted with a diagnosis of alcohol positioning and stated she was not sure if LVN A had notified the ADON. The Administrator stated the negative impact of not appropriately reporting allegations of abuse, neglect and exploitation within the appropriate time frame depended on the severity and stated if it was severe enough it could cause a negative impact. During an interview with the Interim Administrator/Clinical Resource on 06/25/24 at 5:24 PM she stated the following in services was all they were able to find. Record review of facility training dated 04/04/24 revealed the ADON had been trained over abuse and neglect. Record review of facility training dated 06/20/24 revealed LVN A had been trained over reporting abuse and neglect. Record review of the Interim Administrator/Clinical Resource's training transcript revealed she had completed a training titled, Obligation to Report Abuse Letter for Staff on 09/29/2023. Record review of facility policy titled Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment with a review date of 12/2023 specified, Procedure: 1. In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility will: a. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately but not later than two (2) hours after the allegation is made if the events that cause the allegation involves abuse or results in serious bodily injury.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45737 Based on interview, and record review, the facility failed to ensure that the resident environment remained as free of accident hazards as is possible and each resident received adequate supervision and assistance devices to prevent accidents for 1 of 4 residents (Resident #1) reviewed for accidents and hazards. The facility failed to ensure Resident #1's environment remained free of hazards. On 06/19/24 at around 4:00pm - 6:00pm Resident #1 was found by the ADON with altered mental status and a bottle of rubbing alcohol that was 1/4 empty on a dresser at the foot of his bed after Medical Records staff had found 2 bottles of alcohol in residents room earlier in the morning. This deficient practice could place the residents at risk for harm, or serious injury. The findings were: Record review of Resident #1's face sheet, dated 06/24/24, revealed the resident was a [AGE] year-old male who was initially admitted to the facility on [DATE] with diagnoses that included: pulmonary hypertension (high blood pressure that affects the arteries in the lungs and in the heart), acute (severe and sudden onset) and subacute (recent onset, somewhat rapid change) endocarditis (inflammation of the heart valve), type 2 diabetes mellitus (high blood sugar) without complications, end stage renal disease (when kidneys no longer work as they should to meet the body's needs), and nicotine dependence (need for nicotine that you cannot stop). Record review of Resident #1's admission minimum data set assessment (MDS), dated [DATE], revealed Resident #1 had a BIMS score of 14, indicating no cognitive impairment. The MDS assessment reflected Resident #1's independence level for eating was set up (helper sets up or cleans up; resident completed activity). Record review of Resident #1's change in condition dated 06/19/24 at 6:12pm completed by the ADON stated, unknown amount of rubbing alcohol missing from original bottle/consumed and stated the ADON was notified by dialysis center that resident had a large bottle of rubbing alcohol 1/2 bottle was empty, patient noted to be having altered mental stated when assessed and poison control called. Change in condition documentation stated Resident #1 was recommended to be sent to the emergency room for evaluation and treatment as per poison control and the FNP. Record review of Resident #1's nursing notes with an effective date of 06/20/24 at 3:46 am by LVN A revealed the nurse spoke to a nurse from the hospital who notified her that Resident #1 would be admitted for alcohol poisoning. Record review of Resident #1's hospital record dated 06/19/24 stated Resident #1 was seen on 06/19/24 and stated Resident #1 had stated he drank about 1/4 of rubbing alcohol because he wanted to get drunk. Hospital records revealed Resident #1 had an ethanol level of <10 mcg/ml on 06/19/24. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview with Resident #1 on 06/24/24 at 12:55pm while at the hospital he stated while at the facility he had 2 bottles of rubbing alcohol that he would keep with him or on the counter. Resident #1 stated he did not know if staff had seen the rubbing alcohol bottles but stated he did not have them hidden and had them in plain sight, but no one had said anything. Resident #1 then stated a lot of people would see the rubbing alcohol bottles but he did not recall exactly who. Resident #1 stated he used the rubbing alcohol for his legs since they were dry. Resident #1 stated he had not drank any and did not remember where he got it from. Resident #1 stated he was not sure If when he arrived at the facility they went over his inventory and completed an inventory sheet. Resident #1 stated upon admission the facility did not go over checking in any items that were brought in with himself or his responsible party. Resident #1 stated upon admission the facility had not explained to him or his responsible party items that were not allowed in the facility. During an interview and record review on 06/19/24 at 1:05 pm with Resident #1's Hospital Nurse he stated Resident #1 was admitted for some sort of ingestion of rubbing alcohol. Resident #1's Hospital Nurse reviewed his resident list that had their diagnosis and pointed to Resident #1 diagnoses, which read, isopropyl alcohol poisoning. During an interview with Medical Records on 06/24/24 at 4:21 pm she stated during her morning rounds that were completed before 8:30 am on 06/19/24 she found 2 bottles of rubbing alcohol in Resident #1's room. She stated there was 1 bottle of rubbing alcohol on his bed side table and another on his nightstand. Medical Records stated she did not know how full they were but stated Resident #1 was able to reach both. Medical Records stated Resident #1 should not have any bottles of rubbing alcohol. Medical Records stated she explained the regulations to Resident #1 and informed him that those items were not allowed. Medical Records stated she removed both bottles of rubbing alcohol and gave them to Resident #1's family member and explained that they were not allowed. Medical Records stated she did not know who brought in the rubbing alcohol bottles to Resident #1 and had not asked why he had them. Medical Records stated Resident #1 had not had rubbing alcohol bottles during her previous morning rounds unless they had been hidden. Medical Records stated she had not been made aware prior of anything related to Resident #1 having rubbing alcohol and stated no staff had mentioned seeing rubbing alcohol in his room. Medical Records stated she had not observed Resident #1 ingest any of the rubbing alcohol. Medical records stated she monitored and ensured residents did not bring in non-permitted by removing anything she saw that was not permitted. Medical Records stated she believed residents were educated when they were admitted over what's not permitted, she stated upon admission the admission coordinator would complete an inventory sheet for residents and would notify the resident if anything was brought in to go to the nurse's station and update their inventory sheet. Medical Records stated she had been trained over non permitted items and procedures to identify/prevent them from entering within the last month and stated some procedures used were completing their rounds, inventory sheets and informing residents and their family what Is and is not allowed. Medical Records stated having rubbing alcohol could negatively impact residents because not only could they drink it but stated because its medication he could be overdosing himself. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview with the ADON on 06/24/24 at 1:26pm she stated on 6/19/14 at around 4 or 5pm she was notified by the dialysis center that they had found a bottle of rubbing alcohol with Resident #1 on 06/18/24 while he was at dialysis. The ADON stated this prompted her to go to Resident #1's room immediately where she found a bottle of rubbing alcohol that had about 1/4 missing and Resident #1 very lethargic, not coherent, and slumped over. The ADON stated she did not see Resident #1 consume any of the rubbing alcohol but asked Resident #1 If he had consumed any and he stated he did not know if something was put in a cup at bedside. ADON stated she called poison control because it was a substance. During a follow up interview and record review with the ADON on 06/24/24 at 4:36pm she stated she had not seen Resident #1 with rubbing alcohol until identified on 06/19/24. The ADON stated when she found the bottle of rubbing alcohol, she asked to remove the bottle of alcohol that was located on the dresser at the foot of the bed and asked Resident #1 if he had consumed any to which he responded he was not sure If he did or not because he couldn't see. The ADON stated during previous interactions with Resident #1 he was alert and orientated and stated during their interaction on 06/19/24 he was a different person and stated, something was wrong. Resident #1 did not disclose to the ADON who brought him the rubbing alcohol and stated he did not know how long he had it. The ADON was not sure how long Resident #1 had the rubbing alcohol in his possession and stated she was aware that they had removed some rubbing alcohol from his room earlier and stated he should not have had the rubbing alcohol. The ADON stated no staff had mentioned seeing rubbing alcohol in his room. The ADON stated to monitor and ensure residents do not bring in non-permitted items they educate both residents and their families, complete an inventory of their belongings was completed upon admission. At this time the inventory sheet was reviewed with no rubbing alcohol identified. The ADON stated the IDT (interdisciplinary team) and staff had been in serviced on things that were permitted and not permitted such as cigarettes and lighters but was unsure the last time any 1 on 1 or Inservice had been provided. The ADON stated the procedures used to identify and prevent any non-permitted items from entering the facility was more of a check list over what the residents could and could not have, removing items, and notifying family. The ADON stated having rubbing alcohol could be deadly if consumed or could alter their mental status. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview and record review on 06/24/24 at 5:42pm with the Interim Administrator/Clinical Resource she stated she had not met Resident #1 but stated she was informed that Medical Records had found a bottle of rubbing alcohol, removed it and spoke to family member for Resident #1 about it not being allowed in Resident #1's room and about stopping at the nurses station to check in any other items he brought. the Interim Administrator/Clinical Resource was also aware that the ADON had found a bottle of rubbing alcohol but stated she had not been told where it was found and stated she just knew that all 3 found bottles were in Resident #1's room. The Interim Administrator/Clinical Resource stated Medical Records checked the room because it was her daily rounds and the ADON checked the Resident #1's room after being notified by dialysis center that they had found a bottle of rubbing alcohol on him the previous day 06/18/24. The Interim Administrator/Clinical Resource stated Resident #1 was hospitalized . The Interim Administrator/Clinical Resource reviewed hospital records and stated Resident #1 had impression of isopropyl alcohol poisoning and ethanol levels less than 10. The Interim Administrator/Clinical Resource stated staff had not seen Resident #1 with any rubbing alcohol previously and had not seen him ingest any rubbing alcohol but stated he should not have had the bottle of rubbing alcohol. The Interim Administrator/Clinical Resource stated Resident #1 had not stated who brought the rubbing alcohol to him or when. The Interim Administrator/Clinical Resource stated they monitored and ensured non permitted items were not in residents' possession or brought in by doing visual checks, asking questions if they have a suspicion, completing their angel rounds (daily rounds completed by leadership team) and completing inventory. The Interim Administrator/Clinical Resource stated Resident #1 did have an inventory sheet completed when admitted and no bottle of rubbing alcohol was identified. The Interim Administrator/Clinical Resource stated all staff was being trained over non permitted items and started that training on 06/21/24 and stated previously it had only been covered with the leadership team. The Interim Administrator/Clinical Resource stated having rubbing alcohol could negatively impact the residents if ingested it could cause stomach, gastritis and burning of the esophagus. Record review of facility in services revealed Medical Records and the ADON had both been trained over How to conduct proper angel rounds, state prep on 04/12/2023. Record review of the facility's admission packet section titled, FACILITY RULES, REGUALTIONS, POLICIES AND PROCEDURES included verbiage that stated, All residents are required to comply with the Facility's Resident Policies and Procedures, including the Facility Prohibition Against Illegal and Recreational Drugs. The section titled, PERSONAL AND OTHER PROPERTY stated, The facility reserves the right to require certain personal property to be removed from the premises: (i) for safe keeping, or (ii) if the use or possession of the personal property infringes on the rights, health, or safety of other residents.