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	11/21/2024

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45737 Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 6 residents (Residents #6), reviewed for pharmaceutical services, in that: The facility failed to ensure Resident #6 had his physician ordered Ceftriaxone sodium (antibiotic) available on 01/31/24. This failure could place residents at risk for not receiving medication as ordered. The findings included: Record review of Resident #6's face sheet, dated 11/21/24, revealed the resident was a [AGE] year-old male who was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses that included: acute (sudden) respiratory failure (abnormal levels of oxygen and carbon dioxide in the blood) with hypoxia (not enough oxygen to the body), diabetes mellitus due to underlying condition with hyperglycemia (high blood sugar), essential (primary) hypertension, (blood pressure that is higher than normal), acute kidney failure (a sudden decline in kidney function that can range from minor to complete kidney failure) urinary tract infection (bladder infection, an illness in any part of the urinary tract), site not specified. Record review of Resident #6's admission Minimum Data Set assessment, dated 02/03/24, revealed Resident #6 had a BIMS score of 14 indicating cognition was intact. Resident #6's MDS also revealed he was taking an antibiotic. Record review of Resident #6's care plan, with an initiation date of 01/31/24 stated Resident #6 was on antibiotic therapy related to sepsis and had an intervention to administer medication as ordered. Record review of Resident #6's physician's orders, retrieved on 11/2/24, revealed an order for cefTRIAXone Sodium Injection Solution Reconstituted 2GM with start date on 01/31/24 with scheduled time of 4:00pm. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #6's January 2024 medication administration record revealed RN A documented a 7 on Resident #6's scheduled ceftriaxone on 01/31/24 at 4:00pm which indicated Other/ See Nurse Notes. Record review of Resident #6's medication administration note regarding his order for ceftriaxone that was written by RN A on 01/31/24 at 7:47 PM stated, medication not in facility faxed to pharm. During an interview with Pharmacy Tech B on 11/20/24 at 4:33pm she stated the order for Ceftriaxone had an order date of 01/31/24 at 12:43pm and a printed date of 01/31/24 at 8:06PM. Pharmacy Tech C stated they received the order on 02/01/24 at 9am and sent out the medication STAT and stated it was delivered to the facility on [DATE] at 12:08pm. During an interview and record review of the pulled pyxis inventory with Pharmacy Director C on 11/20/24 at 4:51pm he stated 2 vials of ceftriaxone were pulled from the pyxis on 02/01/24 at 8:31am and stated there had not been any restock noted and stated the medication was in the pyxis the entire time and was there on 01/30/24. During an interview with Pharmacy Director C on 11/21/24 at 10:21am he stated he did not think there was any negative impact on a resident if they missed one dose of an antibiotic. Pharmacy Director C stated the antibiotic would need to be started as soon as possible. During an interview on 11/20/24 at 2:19pm with RN A she stated they didn't really have anyone appointed to be responsible for ensuring newly admitted residents had their medications available as ordered. RN A stated it would be up to the admitting nurse to speak to the ADON. RN A stated if a resident was admitted in the middle of the night, and they needed a medication and had an order for a medication later that day then they would need to check the pyxis and put in the order as soon as the order had arrived. RN A stated if the medication is due right then and there and was not available then they needed to contact the MD. RN A stated she recalled Resident #6 and stated he had either a midline or picc line. RN A believed Resident #6 had been on antibiotics but was unsure how far into his stay that was. RN A was unable to recall if Resident #6's antibiotics were available or not. RN A explained the note she wrote on 01/31/24 at 7:47pm about medication not being available and faxing information to the pharmacy. RN A stated that was what they needed to do if the medication was not available in the pyxis and stated that it probably was not available. RN A stated the pharmacy they used made deliveries 2 times a day. RN A stated she was unable to pinpoint if she had contacted the MD about Resident #6's antibiotic medication not being available or any alternative options. RN A stated the nurses were responsible for notifying the MD about medication not being available and any alternative options. RN A stated it was important for residents to get their antibiotics because they were on it due to some sort of infection. RN A stated if residents did not get their antibiotics as ordered it could negatively impact their health and cascade into other problems. RN A stated the previous ADON D used to audit their admissions and make sure they weren't missing any assessments or medications. RN A stated she had been trained during orientation on ensuring residents had their physician ordered medications available and what to do if they did not. RN A stated she did not know the facility policy for ensuring residents had access to their physician ordered medications off the top of her head but stated she did know it had to be done as fast as possible and stated when NPs wrote orders they wanted them done then. RN A stated because she didn't know the exact policy, she was not sure if she followed her facility policy or not. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of clock in times on 1/30/24 revealed both LVN E and LVN F worked at the time of Resident #6's admission. Record review of Resident #6's admitting assessments on 01/30/24 revealed LVN E completed them. During an interview with LVN E on 11/20/24 at 6:04pm she stated she did not recall Resident #6. LVN E stated the nurses and whoever had done the admission was responsible for ensuring residents had their medications available as ordered. LVN E stated if a resident was admitted at night, she would go through the pyxis to check if they had the medication available and if it was not available then she would call the pharmacy to see how quickly they could get it. LVN E stated if she is doing an admission, she needs to verify all the medication with the MD and once they got clarification on the medications such as IV medications, she would then have to fax the IV orders, batch orders and resident face sheet over to the pharmacy otherwise the pharmacy could not send over the medication. LVN E stated she did have access to the pyxis. LVN E stated she did not recall anything about Resident #6 or his admission and was unable to answer if he had his antibiotics available at the time of admission. LVN E stated she was not sure what time the pharmacy delivered during the day but stated they did deliver at night around 8:30pm/9pm. LVN E stated if residents didn't get their antibiotics as ordered they won't get better and could get worse. LVN E stated management would check to ensure residents had their ordered medications available. LVN E stated she had been trained over ensuring residents had their physician ordered medication available and the procedures to get them if not available. LVN E stated she followed her facility policy regarding ensuring residents had access to their physician ordered medication. During an interview with LVN F on 11/21/24 at 12:47pm he stated he did not recall Resident #6 and stated that he was taught to put the orders in the system and wait until the medication got delivered. LVN F stated he had been taught that if they did not have the medication to check the pyxis and if it was not found there then to contact the pharmacy to see what was going on and if not then they had to write a medication administration note and document that they were pending the medication. LVN F stated from what he understood it was the ADON or DON who monitored to ensure residents had their ordered medication available but was not sure of how that process was done. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 11/21/24 at 2:20pm she stated she was not employed at the facility when Resident #6 was a resident and stated she started working at the facility on 08/04/24 and was not familiar with Resident #6. The DON stated based off what she saw in the chart Resident #6 was admitted on [DATE] and had orders for ceftriaxone on 01/31/24 and was scheduled at 4:00pm but RN A put a note that medication was not in the facility and was faxed to the pharmacy. The DON stated Resident #6 was then given a dose of his ceftriaxone on 02/01/24. The DON stated it was everyone's responsibility including the admitting nurse and the all the shifts after to ensure Resident #6 had his antibiotic available. The DON stated she did not see any documentation of them trying to get the medication. The DON stated the process staff should follow was to put in the orders and it would go to the pharmacy but also to send over IV medication orders via fax otherwise the pharmacy would not get it. The DON stated she was not sure if that was the same process previously. The DON stated staff should also check the pyxis and if it's not there then they should be calling the MD to see if they need to put the medication on hold or give something different that they may have available. The DON stated all nursing staff should have access to the pyxis. The DON stated she was not able to review the pyxis inventory from 01/31/24 and was only told by pharmacy staff that the medication Ceftriaxone was pulled on 01/31/24 but stated she had not seen that. The DON was not sure if staff checked the pyxis or reached out to the MD about any substitutes for Resident #6's medication and stated all she knew is what she saw in the chart. The DON stated it was important to ensure residents were provided their medication as scheduled to continue the course and follow it to get rid of any infection and because they did not want any adverse reaction. The DON stated it was important for the staff to be trained on checking the pyxis in order to get the medication for their residents and to start or continue their medication and not have any breakage in the medication. The DON was not sure if RN A and LVN E had been trained over checking the pyxis of procedures to follow when medication was not available. The DON stated they did not have a policy for verifying residents' medications were available and stated it was more of a procedure that they provided staff during orientation than a policy. The DON was unable to answer if staff followed their procedure and stated at that time she had no idea what they did because nothing was documented. The DON stated not getting a dose of antibiotic could throw off a medication regimen and may prolong the infection. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/21/24 at 5:58pm with the Clinical Resource she stated Resident #6 was admitted on [DATE] and had an order for ceftriaxone that started on 01/31/24 with a scheduled dose at 4:00pm that was not given. The Clinical Resource stated RN A documented on 01/31/24 at 7:47pm that medication was not in the facility, and she faxed information to the pharmacy. The Clinical Resource stated the admitting nurse is responsible for inputting the order and if there are any IV orders then they need to be faxed and stated the following nurse should make sure the pharmacy received it. The Clinical Resource stated LVN E was the admitting nurse. The Clinical Resource stated the process to check if medication was available was to fax the orders to the pharmacy and then check if the medication as available in the pyxis and if not then to contact the physician for a different medication. The Clinical Resource stated all nursing staff had access to the pyxis. The Clinical Resource stated she was unable to review inventory that was in the pyxis on 01/31/24. The Clinical Resource stated she did not know if staff checked the pyxis for Resident #6's medication or if they contacted the MD. The Clinical Resource stated it was important to ensure residents were provided their medications as scheduled so that they did not miss a dose. The Clinical Resource stated it was important for staff to be trained on checking the pyxis so that patients could get their medications. The Clinical Resource stated she saw a training for LVN E but could not find the training for RN A regarding procedures to follow when medication was not available. The Clinical Resource stated she could not find a policy regarding what should be completed when verifying resident's medications were available and stated it was more of a process. The Clinical Resource stated after looking at Resident #6's record he had already received 8 or 10 doses of his medication and she didn't know if he would be negatively impacted by not getting a dose but did state it was important for him to get his entire dose. During an interview on 11/21/24 at 5:58pm The Clinical Resource stated she could not find the training for RN A regarding procedures to follow when medication was not available. Record review of LVN E's nurse training skills check list dated 09/10/23 revealed she had been evaluated by a previous DON. LVN E's skills list did not have the met or not met sections checked off but did have a date of 9/10 on the side of the following titles, What medications can be found in the first dose machine (as applicable -Ekit) with a description of how to access first dose machine, Facility policy for medication unavailability, Pharmacy process and medication ordering/reordering process, and Demonstrated competency in transcribing new admissions orders. During an interview with the DON on 11/21/24 at 2:20pm she stated they did not have a policy for verifying residents' medications were available and stated it was more of a procedure. During an interview with the Clinical Resource on 11/21/24 at 5:58pm she stated she could not find a policy regarding what should be completed when verifying resident's medications were available and stated it was more of a process.