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	04/15/2025

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 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** 47573 Based on interviews and record review the facility failed develop and implement a comprehensive person-centered care plan for each resident, consistent with resident needs, that included measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs, for 1 (Resident #1) of 5 residents reviewed for care plans. The facility failed to develop a comprehensive person-centered care plan for Resident #1 to address her behaviors (e.g. not offloading, not wearing heel protectors, weight bearing, refusing to attend dialysis, drinking soda or too much fluid, and not following dietary recommendations such as eating fried chicken). This failure could place the residents at risk of not receiving appropriate interventions and care to meet their current needs as indicated on the comprehensive care plans. The findings included: Record review of Resident #1's face sheet dated 04/09/25 reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses that included: fracture of orbital floor (skull fracture), muscle weakness, unsteadiness on feet, type 2 diabetes (high levels of sugar in blood), end stage renal disease, edema (fluid retention, swelling in the body's tissues), hypertension, heart disease, heart failure, peripheral vascular disease (narrowing/blocking of the blood vessels outside of the heart), and dependence on renal dialysis. Record review of Resident #1's MDS assessment dated [DATE] reflected Resident #1 had a BIMS score of 15, indicating intact cognition. Resident #1 was at risk of developing pressure ulcers. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's care plan dated 04/09/25 reflected Resident #1 had renal failure related to end stage disease. Date initiated: 01/30/25. Resident #1 needed dialysis related to ESRD . Date initiated: 01/30/25. Resident #1 had a nutritional problem or potential nutritional problem related to risk for malnutrition due to diagnoses. Date initiated: 01/30/25. Interventions included: diet as ordered by MD - renal diet, regular texture with thin liquids and 1.5 liter fluid restriction. Resident had arterial ulcer of the left heel. Date initiated: 03/21/25. Right medial 4th toe and right medial 5th toe. Date initiated: 03/24/25. Right lateral ankle and left lateral ankle. Date initiated: 03/29/25. Interventions included: antibiotics, arterial doppler to bilateral lower extremities, labs, heel protectors, treatment per order, and observe/report to MD changes in status. Resident #1's care plan did not reflect behaviors (not offloading, not wearing heel protectors, weight bearing, refusing to attend dialysis, drinking soda or too much fluid, and not following dietary recommendations such as eating fried chicken). Interview with CMA F on 04/15/25 at 11:00 AM revealed CMA F said Resident #1 was getting wound care but Resident #1 was not keeping on her heel protectors like she was supposed to in order for her feet to not have pressure. CMA F said Resident #1 removed the heel protectors and was always sitting up in her chair. Interview with RN C on 04/15/25 at 3:25 PM revealed RN C said Resident #1 was on a fluid restriction because she received dialysis, but Resident #1 was always asking for ice. RN C said she explained to Resident #1 that ice melted into water and that could cause fluid overload but Resident #1 was very adamant that she wanted ice. RN C said Resident #1 called the dialysis center herself and canceled her treatment appointments. RN C said she explained to Resident #1 the importance of her receiving dialysis but she was still able to make those decisions and refused to go. RN C said they ordered waffle boots (heel protectors) and therapy evaluated Resident #1 to help address Resident #1's wounds. RN C said therapy indicated that Resident #1 should not bear weight on her feet because the wounds were getting worse. RN C said Resident #1 was non-complaint and tried to stand on her feet especially when her family took her out on pass. RN C said they explained the importance of not bearing weight to Resident #1 and her family, but they did not know if they followed the recommendations when they took Resident #1 out on pass. RN C said Resident #1's family brought her food all the time such as fried chicken, crackers, or food from restaurants that were unhealthy and did not aid in wound healing. Interview with the ADON on 04/15/25 at 3:55 PM revealed the ADON said Resident #1 had arterial wounds on her heels. The ADON said Resident #1 had very poor circulation and had diabetes. The ADON said Resident #1 received dialysis but she drank sodas and did not like to stay off her feet or offload. The ADON said she would place a pillow under Resident #1's feet to help relieve pressure but Resident #1 would remove the pillow. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DON on 04/15/25 at 5:10 PM revealed the DON said Resident #1's family brought her outside food such as food from a steak house and fried chicken which had too much sodium. The DON said Resident #1 received dialysis and refused to follow the renal diet or fluid restrictions. The DON said they ensured to document and explained the risks of not following the diet. The DON said Resident #1 liked to drink sodas and liked ice. The DON said they explained the limit on the fluids but Resident #1 still asked her family to bring her what she wanted. The DON said the wounds Resident #1 had were arterial wounds. The DON said Resident #1 had the offloading booties (heel protectors) but she did not leave the booties on. The DON said they explained the importance of her wearing them. The DON said Resident #1 was educated that the booties were to help prevent the wounds from getting worse. The DON said she was informed maybe of one time that Resident #1 refused to go to dialysis but she was unsure if it was more than that or if there was a history of Resident #1 refusing dialysis. The DON said Resident #1's non-compliance with care should have been care planned. The DON said those behaviors of noncompliance would place residents at risk for their condition to worsen, not improve, or other adverse effects, so they should have ensured the behaviors were care planned. The DON said it was important for Resident #1's behaviors to be care planned so that staff were aware and knew what to do if Resident #1 exhibited behaviors. The DON said the care plan would have reflected the interventions implemented specific for Resident #1's behaviors such as to redirect, re-educate, and document that she was made aware of the adverse effects of being noncompliant. The DON said if it was not care planned, maybe it was not communicated to the IDT. The DON said any changes noted such as noncompliance with care were noted by staff and should have been communicated with the team so that they could have developed interventions and updated the care plan. The DON said she was not sure why Resident #1's behaviors were not care planned. The DON said the renal diet, fluid restriction, heel protectors, offloading, and dialysis were important for wound healing. The DON said if the behaviors were not care planned, that could result in Resident #1's condition worsening. Record review of the facility's Comprehensive Person-Centered Care Planning policy dated December 2023 reflected - Policy: It is the policy of this facility that the interdisciplinary team shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet the resident's medical, nursing, mental, and psychosocial needs that are identified. 5. The resident has the right to refuse or discontinue treatment. In the event that a resident refuses certain services posing a risk to resident's health and safety, the comprehensive care plan will identify care or service declined, the associated risks, IDT's effort to educate the resident and resident representative and any alternate means to address risk.