STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455672	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure resident medical records were kept in accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are complete and accurately documented for 1 of 4 residents (Resident #1) reviewed for clinical records. The facility failed to ensure the ADON entered the verbal physician orders that she took from the nurse practitioner immediately in Resident #1's records on 03/19/2026. This failure could place residents at risk for incorrect treatment decisions, evaluation, and treatment plans compromising patient safety due to insufficient information records.Findings include: Record review of Resident #1's face sheet, dated 04/11/2026, reflected a 74 -year-old male who was admitted to the facility on [DATE], with an original admission date of 03/15/2024. Resident #1 had diagnoses which included Congestive Heart Failure (a chronic condition where the heart doesn't pump blood as efficiently as it should, leading to blood backing up and fluid buildup in the lungs, legs, and body), Acute Respiratory Failure (a life-threatening, sudden condition where your lungs cannot get enough oxygen into the blood or remove carbon dioxide from it), and Chronic Obstructive Pulmonary Disease (a progressive, treatable, but incurable lung disease that causes chronic airflow restriction, making it hard to breathe). Record review of Resident #1's Quarterly MDS assessment, dated 03/19/2026, reflected he scored an 8 on his BIMS, which reflected he was moderately cognitively impaired. Record review of Resident #1's Progress Note, entered by the ADON, dated 03/19/2026, reflected new verbal orders received from the nurse practitioner, stat Chest Xray, stat EKG, and Stat Troponin. Record review of Resident #1's Physician's Orders, dated 03/19/2026, reflected Troponin order was entered by RN A, Chest Xray entered by the ADON, and the EKG was entered by RN A. Theses orders were to be entered by the ADON and not by RN A. In an interview on 04/11/2026 at 10:10 a.m. with the ADON, stated she was the person who took the verbal orders from the nurse practitioner on 03/19/2026. She stated RN A was Resident #1's floor nurse and she delegated those orders to him. The ADON stated whoever took the verbal order was responsible for entering them into the resident's record. She stated she was extra set of hands at the time and was not Resident #1's nurse. The ADON stated she should have entered all the orders in Resident #1's record because she was the one who took the verbal orders from the nurse practitioner. She stated the negative outcome of not entering the order in the record when getting the verbal order was that it could cause delays in treatment. Attempted interview with RN A on 04/11/2026 at 10:33 a.m., was unsuccessful. Left voicemail to return call. In an interview on 04/11/26 at 11:57 a.m., the DON stated staff that took the verbal order and was responsible for entering it in the resident's record. The ADON was supposed to enter verbal orders of stat Troponin, stat Chest Xray, and the stat EKG since she was the one who took these orders from the nurse practitioner. She only entered the stat Chest Xray order and delegated the Troponin and EKG orders to be entered by RN A. The order should have the physician's name, instructions, date, and time the order was given. The DON stated that the negative outcome for not entering the order after receiving the verbal order may delay necessary interventions and potentially lead to further deterioration in the resident's condition. In an interview via phone on (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: 455672	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2026

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/11/2026 at 12:13 p.m., RN A stated he was the nurse for Resident #1 on 03/19/2026. RN A stated he did not take the orders from the nurse practitioner. He stated the ADON told him the Troponin and the Chest Xray needed to be ordered. RN A stated he entered these orders and called the lab as well. He stated the person who took the verbal order was the one responsible for entering it in the resident's record. RN A stated the negative outcome of not following policy would be a delay in care. In an interview on 04/11/2026 at 1:30 p.m., LVN B stated the person who received the verbal order was responsible for entering it in the residents' records. The order should have the medication name, residents' name, frequency, dosage, time and date. LVN B stated the negative outcome of not entering the order when you received the verbal order would be an immediate decline in residents' condition. Record review of the facility's policy titled, Physician Orders, dated August 2022, reflected Policy: It is the policy of this facility that drugs shall be administered only upon the written order of a person duly licensed and authorized to prescribe such drugs. It is the policy of this facility to accurately implement orders in addition to medication orders (treatment, procedures) only upon the written order of a person duly licensed and authorized to do so in accordance with the residents plan of care . Procedures: 5.Verbal orders must be recorded immediately in the residents' chart by the person receiving the order and must include the date and time of the order.