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	05/13/2026

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 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** Based on interviews and record review, the facility failed to provide pharmaceutical services that included the accurate acquiring and receiving of all drugs and biologicals to meet the needs of each resident for 1 (Resident #1) of 3 residents. The facility failed to ensure that Resident #1 received his Theophylline medication on 4/25/26 as prescribed on the medication reconciliation physician orders signed and dated 4/24/26. The deficient practice could result in exacerbation of the resident's condition and disease process. Findings included: Record review of Resident #1's face sheet, dated 05/11/26, reflected the resident was a [AGE] year-old male, with an admission date of 4/24/26. Resident #1 had diagnoses of bronchiectasis (lung condition where the airways become permanently damaged, widened, and scarred) with (acute (sudden onset or severe)) exacerbation, dyspnea (shortness of breath or difficulty breathing), acute (sudden onset or severe) respiratory failure, hypercapnia (abnormally elevated level of carbon dioxide in the bloodstream), and chronic obstructive pulmonary disease (a progressive, irreversible lung condition that restricts airflow, making it hard to breathe) with (acute (sudden onset or severe)) lower respiratory infection. Record review of Resident #1's comprehensive MDS assessment dated [DATE], reflected as follows:Resident #1 had a BIMS score of 14 indicating cognitively intact. Section J11 Shortness of Breath (dyspnea) indicated shortness of breath or trouble breathing when lying flat. Section O - Special Treatments, Procedures, and Programs indicated on oxygen therapy and receiving respiratory therapy. Record review of Resident #1's undated care plan reflected the following:Has risk for altered respiratory status/Difficulty Breathing r/t Dx's Bronchiectasis, acute respiratory failure, COPD, pulmonary edema, pulmonary hypertension. Date Initiated: 04/27/2026 Revision on: 05/07/2026. Administer medication/puffers as ordered. Monitor for effectiveness and side effects. Date Initiated: 04/27/2026.Record review of a physician order on EMR for Resident #1 dated 4/26/26 reflected Theophylline ER Capsule Extended Release 24 Hour 100 MG Give 4 capsule by mouth one time a day for Shortness of Breath ordered date 4/26/26 and start date 4/27/26. Record review of a Medication Reconciliation for Resident #1 from hospital, signed by admitting MD and dated 4/24/26 reflected the following:Continue theophylline 100 mg/24 hours oral capsule extended release 400 mg oral daily - last administered on 4/24/26 at 9:01 am. Record review of written documentation dated 4/24/26 to 5/11/26 provided by Resident #1's family member reflected last dose of Theophylline given at hospital on 4/24/26 at 5:00 p.m. and Resident #1 was admitted to the nursing facility around 7:30 p.m. Record review of Progress Notes dated 4/27/26 reflected that RN C received Theophylline 24 ER 200 mg capsule from family member. 109 capsules inside bottle. Record review of a physician order on EMR for Resident #1 dated 4/27/26 reflected Theophylline ER Capsule Extended Release 24 Hour 200 MG Give 2 capsule by mouth two times a day for Shortness of Breath ordered date 4/26/26 and start date 4/27/26.Record review of Resident #1's Medication Administration Record for April 2026 revealed Theophylline ER Capsule Extended Release 24 Hour 100 MG Give 2 capsule by mouth two times a day for Shortness of Breath -Order Date- 04/27/2026 -D/C Date- 04/30/2026. Theophylline shown administered from 4/27/26 to 4/30/26.In an interview on 5/12/26 at 8:50 a.m., Resident #1 said when he first arrived at the facility Friday, (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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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/24/26, they were not ready for him. He said the facility did not have the Theophylline he was prescribed available. Resident #1 said they provided both doses of Theophylline medication at the hospital on 4/24/26 prior to arriving at the facility. Resident #1 said he recalled not taking the Theophylline medication the next day, Saturday, 4/25/26. Resident #1 said his family member brought his Theophylline medication from home and he began taking the medication as prescribed, but they were informed by the facility he could not do that. The facility informed Resident #1 they must obtain approval and orders from his MD, then the facility would administer the medication to him. Resident #1 said the Theophylline medication was important because it helped prevent shortness of breath.In a telephone interview on 5/12/26 at 11:00 a.m., LVN A said the only concern regarding Resident #1's Theophylline was that the doctor ordered it as a 400 mg tablet once a day. LVN A said the DON had her call Resident #1's doctor, and he said it was fine and ok for him to take the tablet once daily versus two in the morning and two at night, as long as it totaled 400 mg. LVN A said they set up an appointment for Resident #1 to talk to his doctor, so he could inform Resident #1 there was no difference because it was an extended release. LVN A said they did not always have all the medications available at the facility upon a resident's admission. LVN A said they would ask residents if they had their own medications available to use them until they obtain the medications from the pharmacy. LVN A said Resident #1 began taking his own medications because he wanted to take his own medications. LVN A said the pharmacy sent his medication the following afternoon. LVN A said the medications might have come in after 10 pm and at that time he was taking his own medications, so they could not give both. LVN A said she did not work Saturday 4/25/26 and Sunday 4/26/26, but she felt everything regarding Resident #1's medications upon admission was taken care of. LVN A said there would not be a negative effect because the resident took his own medication over the weekend. In an interview on 5/12/26 at 11:53 a.m., LVN B said for Resident #1, she did not recall what medications he had on his medication reconciliation list or if there was a concern with the medication Theophylline. LVN B did not recall if she worked with Resident #1 over the weekend. LVN B said she did not recall hearing a medication was brought in from home by Resident # 1's family member or that family member and Resident #1 administered a medication on their own. LVN B said when she administered medications, she let the resident know what medications she was going to administer. LVN B said she always compared the blister packet with the MAR and orders, which was how she ensured the right patient, the right medication, the right dose, the right route, and the right time. LVN B said they received in-services about medication administration and entering orders. LVN B said she did not recall if she worked the weekend with Resident #1. LVN B said she did not recall any concerns that Resident #1 did not take a dose of his Theophylline medication over the weekend, so there would be no adverse effects. In an interview on 5/12/26 at 12:30 p.m. RN C said when a resident was admitted to the facility, they receive the admission information from the receiving entity prior to the resident's arrival. RN C said when they received report, the discharging entity would inform them when the resident was ready to be discharged to the facility. RN C said usually when a resident was discharged from the hospital they arrived during the night shift. RN C said if the facility did not have a medication for a resident, they would get the medication from the facility's Pyxis (automated medication dispensing system) until the pharmacy could provide the medication. RN C said she was not sure if Theophylline was a medication that was usually stocked in Pyxis or not. RN C said she remembered giving Resident #1 his own medication from home when she obtained the order from the MD. Record review of progress note indicated medication from home and MD order received.RN C said they usually received medication orders from the pharmacy that same day, even on the weekends because the pharmacy's cut off times were 10:00 or 11:00 p.m. RN C said they received medications from the pharmacy every single day. RN C said she remembered they were waiting for the pharmacy to send the Theophylline for Resident #1. RN C said she was not sure if the wait was due to any questions with orders received. RN C said she did not know anything more about Resident #1's medications. RN C said Resident #1 never disclosed to her that he did not receive his (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Theophylline medication over the weekend. RN C said she did not know if Resident #1 took his own medication on the weekend without staff knowing. RN C said if the resident missed a dose of Theophylline, it could cause an exacerbation of shortness of breath, but she did not recall any exacerbations of shortness of breath while she had worked with him. RN C said when she administered medications, she let the resident know it was time to administer their medications. She would verify the information on the MAR with the orders and would verify the right patient, the right medication, the right time, the right dose, and the right route. RN C said she would then prepare the medication accordingly and administer to the resident explaining what it was for.In a telephone interview on 5/13/26 at 11:10 a.m. The Pharmacist said Resident #1's prescription for Theophylline came into the pharmacy on 4/24/26 after 7:00 p.m. and they had a cut off time from their wholesaler. The Pharmacist said their wholesalers were also not available the weekend, so the medication Theophylline came into the pharmacy Monday morning. The pharmacist said as per the delivery slip, Theophylline 400 mg 1 tablet a day was ordered for Resident #1 on 4/24/26 and it was delivered to the facility on 4/28/26 at 6:55 pm. The Pharmacist said they normally delivered medications to the facility twice a day. The pharmacist said the medication Theophylline was not a common drug placed in the e-kit (emergency kit) because it was not considered emergent. The pharmacist checked their report and informed me Theophylline was not available in the facility's e-kit.In a telephone interview on 5/13/26 at 11:56 a.m. the MD said Resident #1 was receiving 200 mg Theophylline twice a day at home. The MD said there was a problem with the Theophylline not going to be delivered on time, so since the family member had the Theophylline medication at home, they gave Resident #1 his own medication on the weekend. The MD said on Monday, 4/27/26 the pharmacy delivered the Theophylline tablet 400 mg one time a day. The MD said the dose was the same, but the family member had questions about it, so he explained it. The MD said he requested Theophylline levels to ensure everything was fine and were pending the results. The MD said he was informed by nursing staff at the facility that the resident received all his doses of Theophylline during the weekend due to the wife bringing the medication from home, so he was not aware if Resident #1 missing any doses. The MD said if Resident #1 did miss one day of the Theophylline medication, there would be no implications or adverse effects.In an interview on 5/13/26 at 4:30 p.m., the DON said the nurses knew when there was no medication available for a resident, they informed the family to see if the family could bring their own medication so there was no delay. The DON said she cannot 100% say that was the case with Resident #1. The DON said after she reviewed all the information, it appeared as if Resident #1 did not receive his Theophylline on 4/25/26. The DON said if Theophylline were given for prevention of shortness of breath, there could potentially be shortness of breath if Resident #1 was not given the medication. The DON said Resident #1 absolutely should not have missed any dose of the medication. The DON said she contacted the pharmacist and provided them with her contact information so they could contact her if there was a medication they did not have. Prior to that, when medications were signed in, the nurses would sign off, and they placed the medication on the requisition form. The DON said it would be the responsibility of the next shift nurse to ensure all medications were received, contacted pharmacy to get status update, and if the medication was not going to come in during their shift, they needed to notify the MD so he could decide on a plan B. The DON said nurses should have also notified their DON.In an interview on 5/13/26 at 5:19 p.m., the Operations Manager said after review of the documentation, it seemed the medication Theophylline was not given on 4/25/26. The Operations Manager said there should not have been a missed dose of the Theophylline.Record review of the undated Medication Administration - Oral Policy / Procedure revealed: Policy:It is the policy of this facility to accurately prepare. Administer and document oral medications.13. Any irregularity in pouring or administering must be reported to the doctor.15. All medication administration will be documented on medication administration record.Record review of the Pharmacy Services Policy / Procedure revealed: PolicyIt is the policy of this facility to employ or obtain the services of a licensed pharmacist to provide consultation on all aspects of pharmacy (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	services in the facility, establish a system of records of receipt and disposition of all controlled drugs is maintained and periodically reconciled, to enable accurate reconciliation. PurposeThe pharmacist is responsible for helping the facility obtain and maintain timely and appropriate pharmaceutical services that support resident's healthcare needs, that are consistent with current standards of practice, and that meet state and federal requirements.6. Strive to assure that medications are requested, received, and administered in a timely manner as ordered by the physician.

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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	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 interview and record review, the facility failed to maintain medical records in accordance with accepted professional standards and practices that were complete, accurately documented, readily accessible, and systematically organized for 1 (Resident #1) of 3 residents reviewed for accurate medical records. The facility failed to accurately document the administration of Theophylline on Resident #1's MAR on 4/27/26. This deficient practice could place residents at risk of having incomplete or inaccurate records and residents receiving delayed or inadequate treatment or care.The findings include:Record review of Resident #1's face sheet, dated 05/11/26, reflected the resident was a [AGE] year-old male, with an admission date of 4/24/26. Resident #1 had diagnoses of bronchiectasis (lung condition where the airways become permanently damaged, widened, and scarred) with (acute (sudden onset or severe)) exacerbation, dyspnea (shortness of breath or difficulty breathing), acute (sudden onset or severe) respiratory failure, hypercapnia (abnormally elevated level of carbon dioxide in the bloodstream), and chronic obstructive pulmonary disease (a progressive, irreversible lung condition that restricts airflow, making it hard to breathe) with (acute (sudden onset or severe)) lower respiratory infection. Record review of Resident #1's comprehensive MDS assessment dated [DATE], reflected as follows:Resident #1 had a BIMS score of 14 indicating cognitively intact. Section J11 Shortness of Breath (dyspnea) indicated shortness of breath or trouble breathing when lying flat. Section O - Special Treatments, Procedures, and Programs indicated on oxygen therapy and receiving respiratory therapy. Record review of Resident #1's undated care plan reflected the following:Has risk for altered respiratory status/Difficulty Breathing r/t Dx's Bronchiectasis, acute respiratory failure, COPD, pulmonary edema, pulmonary hypertension. Date Initiated: 04/27/2026 Revision on: 05/07/2026. Administer medication/puffers as ordered. Monitor for effectiveness and side effects. Date Initiated: 04/27/2026.Record review of a physician order on EMR for Resident #1 dated 4/26/26 reflected Theophylline ER Capsule Extended Release 24 Hour 100 MG Give 4 capsule by mouth one time a day for Shortness of Breath ordered date 4/26/26 and start date 4/27/26.Record review of a physician order on EMR for Resident #1 dated 4/27/26 reflected Theophylline ER Capsule Extended Release 24 Hour 200 MG Give 2 capsule by mouth two times a day for Shortness of Breath ordered date 4/26/26 and start date 4/27/26.Record review of Resident #1's Medication Administration Record for April 2026 revealed Theophylline ER Capsule Extended Release 24 Hour 100 MG Give 4 capsule by mouth one time a day for Shortness of Breath -Order Date- 04/26/2026 6:27 p.m. -D/C Date- 04/27/2026 3:17 p.m. Theophylline administered on 4/27/26. Record review of Resident #1's Medication Administration Record for April 202026. Theophylline ER Capsule Extended Release 24 Hour 100 MG Give 2 capsule by mouth two times a day for Shortness of Breath -Order Date- 04/27/2026 3:17 p.m. -D/C Date- 04/30/2026 5:41 p.m. Theophylline administered on 4/27/26 to 4/30/26.In an interview on 5/12/26 at 12:30 p.m. RN C said RN said when administering medications, she will let the resident know it was time to administer their medications. She will verify the information on the MAR with the orders and will verify the right patient, right medication, right time, right dose, and right route. RN Said she would then prepare the medication accordingly and give to resident explaining what it was for. RN C said she remembered they were waiting for the pharmacy to send the Theophylline medication for Resident #1. RN C said she was not sure if the wait was due to any questions with orders received. RN C said she remembered giving Resident #1 his own medication from home when she obtained the order from the MD. Record review of progress note indicated medication from home and MD order received. RN C said she recalls only giving him 2 capsules in the morning. RN C said she recalled Resident #1 told her that was what he received at the hospital. RN C said she knew he was going to receive another dose in the evening. RN C said she was not sure why it would show marked as administered 4 capsules in the morning on the MAR. RN C said (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she knew Resident was being administered his home medication of Theophylline of 2 capsules (100 mg each capsule) twice a day. RN C said she never administered Resident #1 4 capsules. RN C said placing inaccurate documentation could cause residents to receive inaccurate medication dosing.In an interview on 5/13/26 at 4:30 p.m., The DON said after she reviewed the MAR and the orders, it looked like RN C DC'd the order for Theophylline 400 mg once a day and it just did not delete. The DON said it was obvious that RN C knew and administered only 2 capsules of Theophylline because RN C was the one who received and input the orders from the MD. The DON said at times when an old order was removed, it just stayed in the EMR. The DON said she doesn't know why that happened. The DON said RN C may have accidentally deleted the order after she had already entered her signature on the old order. The DON said she was certain RNC would not give Resident #1 4 capsules instead of 2. The DON said RN C should have accurately verified the orders against the MAR. If not, it would reflect inaccurate medication dosing.Record review of the Physician Orders Policy / Procedure review date of 8/2022 revealed: .Procedures:6. Medication, treatment or related procedure orders are transcribed in the eMAR, eTAR accordingly.Record review of the undated Medication Administration - Oral Policy / Procedure revealed: Policy:It is the policy of this facility to accurately prepare. Administer and document oral medications.13. Any irregularity in pouring or administering must be reported to the doctor.15. All medication administration will be documented on medication administration record.