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	04/15/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations, interviews, and record review, the facility failed to ensure residents had the right to a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and supports for daily living safely for 8 of 19 resident A-Beds (1201-A, 1202-A, 1205-A, 1207-A, 1209-A, 1211-A, 1213-A, and 1215-A) reviewed for environment.The facility failed to ensure resident rooms 1201-A, 1202-A, 1205-A, 1207-A, 1209-A, 1211-A, 1213-A, and 1215-A had a covering or door on their closets. This deficient practice could place residents at risk of their personal belongings being seen, touched, or stolen. The findings were:Observations of the facility from 04/13/26-04/15/26, beginning at 9:38 am, revealed rooms 1201-A, 1202-A, 1205-A, 1207-A, 1209-A, 1211-A, 1213-A, and 1215-A had no covering or door on their closets. The A-bed closets were located in the rooms adjacent to the hallway door. Anyone entering the rooms could easily rub against the exposed clothing. Anyone passing by the rooms in the hallway could easily touch or remove the exposed clothing. In an interview with Resident #19 on 04/13/26 at 8:50 am, she said she did not like her closet open because she did not want people to be looking at her things.In an interview with the OM on 04/14/26 at 1:30 pm, she said the open closet doors had been that way for a while. She said she was not sure how long the A-Bed closets had been without doors, but maybe 2-3 months. She said contractors were ordering doors to be placed on the open closets. She said she had not considered the residents who owned the clothes to be at risk for infection control, since the open closets were adjacent to the hallway door; anyone could pass by, touch the clothes, or even take them. She said she would have the contractors place temporary curtains until solid doors were placed. In an interview with the DON on 04/14/26 at 3:24 pm, she said she had worked at the facility since February 2025. She said the A-Bed closets had never been covered, and she did not know why. She said it never crossed her mind that the clothing could be contaminated or removed by someone passing by in the main hallway. She said the residents could get sick from cross-contamination, and they would be at high risk because of the potential organism and because the aged residents were already compromised. She said the A- Bed closets were getting durable curtains hung as of today. She said the building was undergoing renovation beginning around 6 months ago. In an interview with the ADM on 04/15/26 at 11:00 am, she said all the A-Beds in the 1200 hall had no curtains or doors because they had been taken down in preparation for reconstruction. She said the rooms had been painted and did not know why all the curtains were removed at the same time. She said the contractors should have taken them down as needed. She said she had worked at the facility since July 2024, and the A-Beds had curtains then. She said the building was bought in 2019, and the 1200-hall was like that (meaning the A-Beds had curtains covering the residents' clothes in their closets). She said she did not know why the closets had doors on one side (b) and curtains on the other (a). In an interview with LS and MS on 04/15/26 at 1:30 pm, LS said she worked at the facility for 4 years. She said the curtains on the A-Bed resident rooms had been removed about 2-3 months ago when reconstruction started. MS said at first, there were plastic accordion-type sliding doors on the A-Bed closets, and 3 years ago, the administrator at the time had them removed and replaced with curtains and rods. They both said no one questioned it when the resident's clothing was exposed. LS (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	said none of the residents complained to her about their closets after the curtains were taken down. MS said there was an order placed for wooden closet doors for the A-Beds to match the B-Bed closets. There were no contractors available during the survey. The ADM provided an invoice/sales receipt # 20847 dated 02/25/26 that indicated 12, 6x9 ft. panels (doors) had been ordered and was stamped paid.The facility was unable to provide a policy for a homelike environment.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to send a copy of the residents' discharge notice, prior to discharge, to the representative of the Office of State Long-Term Care (LTC) Ombudsman of the residents' transfer or discharge and the reasons for the move for 2 of 2 (Resident #1 and Resident #53) reviewed for residents' discharge.1. Resident #1 was discharged to the hospital on 1/11/26 without a notice to the LTC state ombudsman.2. Resident #53 was discharged home on [DATE] without a notice to the LTC state ombudsman.These failures could place residents at risk of not knowing their rights and receiving the services of the state LTC Ombudsman.Findings were:1. Record review of Resident #1's admission record dated 4/14/26 revealed Resident #1 was a [AGE] year-old female with diagnoses of urinary tract infection, muscle weakness, cirrhosis of the liver, type II diabetes mellitus with hyperglycemia (high blood sugar levels), morbid (severe) obesity, hypertension (high blood pressure) and sepsis (life threatening infection which can damage tissues and organs throughout the body). Record review of Resident #1's MDS dated [DATE] revealed a BIMS score of 14 indicating intact cognition. Section Q indicates Resident #1's discharge goal is to discharge to the community and active discharge planning is already occurring for Resident #1. Record review of Resident #1's care plan reflects Resident #1 wishes to return/be discharged home. Date initiated: 01/06/2026. Establish a pre-discharge plan with the resident, family/caregivers and evaluate progress and revise plan as needed. Date Initiated: 01/06/2026. Record review of Resident #1's electronic medical record revealed a progress note dated 1/11/26 stating Resident #1 had been discharged to the hospital. Record review of Resident #1's electronic medical record from 1/5/26 to 4/15/26 revealed no evidence of notice given to the LTC Ombudsman pertaining to Resident #1's discharge to the hospital. During an interview on 4/14/26 at 4:15 p.m. the SSD said she had been working at the facility since 1/27/26. She said she initially was not aware that she needed to notify the ombudsman whenever a resident was discharged from the facility until recently this month. She said once she learned that it was a requirement, she sent the ombudsman an email with the list of names of all the residents that had been discharged home since she started working at the facility. She said she was informed she was required to send a monthly list to the ombudsman of residents discharged home. She said she was not aware that the ombudsman was not notified or resident's discharges since October of last year. She said she did not get information for residents who were hospitalized , return anticipated and never returned. She said she was not aware of Resident #1's discharge on [DATE] since she started working at facility on 1/27/26. She said the prior SSD was working at the time. She said the ombudsman would need to be informed of Resident #1's discharge to the hospital because it was a discharge that was anticipated to return and never did. She said residents could miss out on any follow ups if the facility was not aware of the discharges. She would not directly answer what the outcome would be if the ombudsman was not notified. During an interview on 4/15/26 at 12:44 p.m. the ADM said she was not aware the ombudsman had not received notifications of resident's discharges since October 2025. She said the ombudsman should have been notified if Resident #1 was discharged to hospital in January 2026 with a return (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	anticipated and did not return. She said she was not sure what the negative outcome of not notifying the ombudsman of resident discharges would be because the ombudsman did not divulge that information to them. During an interview on 4/14/26 at 3:11 p.m. the state managing local LTC Ombudsman stated she had not received any discharge notices from the facility since 10/3/25. 2. Record review of Resident #53's admission Record dated 04/15/26 revealed an [AGE] year old male with an admission date of 03/04/26. Resident #53 had a diagnoses of Chronic Systolic (Congestive) Heart Failure (heart muscle doesn't pump blood as well as it should), Peripheral Vascular Disease (blockage in the blood vessel outside the heart) and Presence of Cardiac Pacemaker (implanted device that regulates the heart rhythm). Record review of Resident #53's MDS discharge date d 03.20.26 revealed Resident #53 was Independent in Cognitive Skills for daily Decision making. Section Q indicated Discharge Plan was activated and already occurred for Resident #53 to return to the community. Record review of Resident #53's Discharge Summary & Post-Discharge Plan of Care dated 03.20.26 revealed Resident #53 was discharged home on 03.20.26. Record review of Resident #53's Plan of Care dated initiated: 03/05/26 revealed Resident #53 wished to return/discharged home. Discharge goals were to return home within next review date. Record review of Resident #53's electronic medical record from 03/04/26 to 03/20/26 revealed no evidence of notice given to the LTC Ombudsman pertaining to Resident #53's discharge to home. During an interview on 04/14/26 at 4:16 am the SSD stated she started sending notifications earlier this month via email to the Local Ombudsman. The SSD said she was overseen by a corporate office licensed social worker but was not informed of notifying the Local Ombudsman. During an interview on 04/15/26 at 2:37 pm the Administrator stated she was not aware the local ombudsman had not been notified of resident discharges from the facility. She said she was not aware that the facility was required to be sending the Local ombudsman resident discharge notifications. She said she was not aware the previous SSD had stopped sending notifications and did not know why she had stopped. In an Email communication on 04/14/26 at 3:32 pm, the Ombudsman revealed that she had not received any resident discharge notices from the facility since 10/3/25. Record review of the facilities policy titled Criteria for Transfer and Discharge, date revised: April 2024 stated:Procedure: .2.a. The facility will notify State Long-Term Care Ombudsman of discharges.b. The notice shall be made when resident is transferred or discharged or as soon as practicable before transfer or discharge when: . An immediate transfer or discharge is required by the resident's urgent need; or A resident has not resided in the facility for 30 days.9. If the Facility determines that a resident, who was transferred with an expectation of returning to the Facility cannot return to the Facility, this constitutes a discharge and this policy shall apply.