STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675406	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Years Nursing and Rehabilitation Center	318 Chambers St Marlin, TX 76661

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47795 Based on interviews and record review, the facility failed to ensure the right to be free from misappropriation of resident property for one of 1 of 3 (Resident # 2) reviewed for misappropriation. The facility failed to prevent a diversion (misappropriation) of Resident's #2's Ativan 0.5 mg, 60 tablets (an anti-anxiety medication) received from the pharmacy on 5/22/2024 at 12:17 am and reported missing 5/22/2024 during the day shift. This failure could place residents at risk for decreased quality of life, unrelieved pain, misappropriation of property, and dignity. The non-compliance was identified as Past non-compliance, the facility had corrected the non-compliance before the survey began. Findings included: Review of Resident # 2's faced sheet printed `5/22/2024 revealed a [AGE] year-old male admitted on [DATE] with diagnosis that include Alzheimer's disease (A progressive disease that destroys memory and other important mental functions) , Cognitive communication deficit (a communication difficulty caused by a cognitive impairment, this impairment can affect any aspect of communication, including verbal and nonverbal language, ,speaking, listening, reading writing and social interaction) and palliative care(specialized medical care for people living with a serious illness) Review of Resident's #2's of admission MDS dated [DATE] revealed a BIMS score of 3 which can indicate a serve cognitive impairment, Resident was receiving hospice care. Review of Resident # 2's physician orders dated 6/3/2024 revealed order written on 5/5/2024 Ativan 0.5 mg Po PRN Q 4 hours for anxiety. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the provider investigation report dated 5/31/2024 reflected, on 5/22/2024 at 12: 17 am the pharmacy delivered 60 (sixty) tablets of Ativan 0.5 mg for Resident # 2, packing slip from the pharmacy was signed by LVN A as received. Medication was noticed as missing, on the next shift. A search of the facility's medication rooms and medication carts and the medication was not located. The report reflected no injury or harm to the resident as medication was available in the emergency medication kit and the facility replaced the missing medication after the investigation was completed, the facility notified Hospice, the responsible party, the medical director, and the police. Statements were obtained and staff were drug tested . The investigation findings confirmed the drug diversion. Review of the pharmacy packing slip dated 5/22/2024 reflected Ativan 0.5 mg 60 tablets was delivered to the facility and signed as received by LVN A Review of the Business card left by the responding police officer reflected, Case No: 24-002740. Review of Inservice dated 5/22/2024 reflected that all LVN and RN's were inserviced on Controlled Substance that included the process for accepting scheduled medications from the pharmacy. Review of LVN A employee file reflected an counseling on 5/24/2024 for not following the controlled substance policy. During a phone interview on 6/3/2024 am 12:55 PM with the local police department desk sergeant, the investigator on the case was working night shift this week, left message for return phone call. No return phone call received prior to exit. During phone interview on 6/3/2024 at 1:00 PM LVN A stated that she does not remember getting the Ativan for Resident # 2 when the medication was delivered on 5/22/2024. She remembers receiving the other medication that she signed for as she had to lock it up in the refrigerator. She was not sure why she signed for the medication if she didn't see it, she stated it was her usual practice to verify each medication prior to signing the delivery receipt. She stated she was counseled on not following the Controlled substance policy after being inserviced on it. During an interview with LVN B on 6/3/2024 at 1:30 PM she was inserviced on accepting controlled substances from the pharmacy and was able to verbalize the process for accepting scheduled medications from the pharmacy. During an interview with DON on 6/3/2024 at 2:00 PM stated they did not identify a perpetrator or find the missing medications. He stated he was not sure the medication was even delivered, as the receiving nurse does not recall putting the medication in the lock box. After the medication was discovered missing, the facilities medication rooms and cart were searched, pharmacy was notified and stated since the medication was signed for, they would not be doing an investigation. There was no narcotic sign out sheet, which was delivered with the medication found. She stated that all staff were drug tested with negative results. He stated the medication and the sign out sheet were never located, and the medication was replaced by the facility. He stated that the medication was available in the emergency drug kit, so no doses were missed, there was no adverse reaction to the resident. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy Controlled Substances revised November 2022 reflected 3. Controlled substances are counted upon deliver. The nurse receiving the medication, along with the person delivering the medication, must count the controlled substances together. Both individuals sign the designated controlled substance record The facility course of action prior to surveyor entrance included: 1. Review of in-service conducted on 5/23/204 revealed all licensed staff were in-serviced on controlled substances that included the process for accepting controlled substance from the pharmacy. 2. Interview with DON on 6/3/2024 at 2 PM. LVN A was consoled on 5/23/2024 for not following policy and procedure. 3. Interview with DON on 6/3/2024 at 2 PM medication was replaced by the facility on 5/30/204.

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47795 Based on observation, interview and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible and each resident received adequate supervision to prevent accidents for 1 of 10 residents (Resident #1) reviewed for accidents and supervision. The facility failed to prevent Resident #1 from eloping on 05/21/2024. The non-compliance was identified as PNC. The Immediate Jeopardy (IJ) began on 5/21/2024 and ended on 5/22/2024 The facility had corrected the non-compliance before the survey began. This deficient practice could place residents who were elopement risks at-risk of harm, serious injury, or death. The findings were: Record review of Resident # 1's face sheet, dated 6/3/2024, reflected a [AGE] year-old male admitted to the facility on [DATE] and discharged on [DATE] with diagnosis that includes Schizophrenia (a disorder that affects a person's ability to think, feel and behave clearly.), Type 2 Diabetes Mellitus (A long term condition in which the body has trouble controlling blood sugar and using it for energy) and , Mild intellectual disabilities (is a neurodevelopmental disorder that affects intellectual functions and daily living skills,) Record review of Resident's # 1 Admission MDS, dated [DATE] reflected a BIMS revealed resident was not appropriate for an evaluation as resident in rarely/ never understood. Section E revealed wandering occurred to 1 to 3 days, with no significant risk of getting to a potentially dangerous place. Record review of Resident # 1's wandering/elopement risk assessment tool dated 5/2/204 had a score of 7 (moderate risk} , resident ambulates independently and a history of wandering behaviors, no history of elopement from home or previous facility. Review of Resident #1's care plan dated 5/3/2024 reflected problems of wandering and risk for elopement with interventions that include a wander guard and redirection for the exit doors. Review of Resident #1's orders dated 5/2/2024 reflected an order for signaling device is use, Signaling Device: Change electronic monitoring device according to manufacture's recommendations and PRN if noted non-functional, and Signaling Device: check electronic monitoring device via testing machine every day, every night shift for wandering/exit seeking. Review of Resident #1's Treatment Record for the month of May 2024, reflected Signaling device check done daily on night shift. Observation on 5/2/2024 at 12:45pm of the alarm response at the front door of the facility reflected the wander guard functional and sufficiently loud to alert the staff of a potential elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on 6/3/2024 at 1:00 PM LVN A stated if a resident was not able to not be located a code pink was called a code Pink after searching the facility, they are to notify the Administrator, DON, and responsible party. A search of the ground was then completed and if not found the local police are notified. She stated there was a pink binder at both nurse's station with all resident's that are at risk of elopement with there picture and face sheet. She stated they had an elopement drill, and they were in-services on the elopement policy and protocol and abuse and neglect. During an interview on 6/3/2024 at 1:15 PM with CNA B stated that if she could not find a resident, she would let the charge nurse know and help with the search, she is not sure when, but a some point the nurse will notify the administrator, DON and family members. If there is a missing resident, they will call a CODE PINK then we start making sure all of my resident are accounted for and then help the others to look for theirs. We had a drill a couple of weeks ago, along with an in-service on elopement and abuse and neglect. The Abuse coordinator lithe administrator,and if he is not here, she would let the charge nurse and the DON know. During an interview on 6/3/2024 at 2:00 PM with the DON he stated saw Resident #1 in the dining room at 5:45 PM looking for some more to eat. The DON stated he received a phone call at 6 PM that a off duty employee had seen the resident in the parking lot of a local grocery store, about a block away and brought him back to the facility. The wander guard did go off when the resident returned to the building. He stated they were unable to determine how the resident left the building, placed him on one to one and moved him to a sister facility with a secure unit. The front door is now locked at all times with a code for entrance and exit, delay exit is still active. at the time of the incident, it was unlocked till 8 PM for visiting hours and there was no one at the desk after PM. During an interview on 6/3/2024 at 2:30pm with Maintenance director reported they have done an code Pink elopement drill on both shifts since the incident, the Fire safety company has come out and tested the doors with sensors on them and verified they are working and increased the sensitivity and the volume of the alarm. Record review of policy Wandering/ Elopement revised March 2019 reflected 3. If a resident is missing, initiate the elopement/missing resident emergency procedure: a. Determine if the resident is out on an authorized leave or pass. b. If the resident was not authorized to leave, initiate a search of the building, and premises and c If the resident is not located notify the administrator, and the director of nurses, the resident's legal representative, the attending physician, law enforcement officials and (as necessary) volunteer agencies. The DON was notified on 6/3/2024 at 5:45 PM that a past non-compliance Immediate Jeopardy had been identified due to the above failures. The facility course of action prior to surveyor entrance included: Record review of Resident # 1 Progress notes, he was initial placed on 1:1 supervision and moved to a sister facility with a secure unit, on 5/21/2024 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility contacted the alarm company, who increased the volume and sensitivity for the alarm system on 5/22/2024 confirmed with invoice of work dated 6/3/2024. Record review of Provider instigation revealed all residents with wander guards were checked for functioning, Interview with DON on 6/3/2024 at 4:00pm the facility has standing MD orders on all residents with a wander guard has the device checked daily on the nightshift, that include placement, function with a testing device and skin assessment under the device. Interview with Maintenance director stated that immediately after the elopement incident, the front doors to the facility were locked with entry and exit code required 24 hours a day, previously they were unlocked till 8 PM with no one at the desk after PM. Review of In-services reflected the facility had an elopement drill on 5/22/2024 for all staff members on both shifts. Record review of an In-service training dated 5/22/2024, related to elopement and abuse and neglect revealed 50 out of 50 staff member's signatures. Interview were conducted with 17 employees on 6/3/2024 between 10 am and 4 PM, which consisted of LVN's (2) Medication Aides(1), CNA's (4), Physical therapist, Physical therapy assistance (3) Occupational therapist, Certified Occupational therapy assistance (2), Speech Therapist and Housekeepers (2) on 6/3/2024 from 10:00 am to 2:00 PM revealed they had received in-services on Elopement Response, All were able to state the key elements of the elopement policy which included If a resident is missing, initiate the elopement/missing resident emergency procedure: a. Determine if the resident is out on an authorized leave or pass. b. If the resident was not authorized to leave, initiate a search of the building, and premises and c If the resident is not located notify the administrator, and the director of nurses, the resident's legal representative, the attending physician, law enforcement officials and (as necessary) volunteer agencies.