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	10/30/2024

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 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** 44317 Based on interview and record review, the facility failed to ensure that the medical record was complete and accurately documented for 1 of 4 residents (Resident #1) reviewed for clinical records. The facility failed to document nursing progress notes, assessments, or transfer documents when Resident #1 was transferred to the acute care hospital on 10/28/24. This failure could place residents at risk for not receiving appropriate care due to incomplete information in the chart. Findings included: Review of Resident #1's admission MDS assessment, dated 10/04/24, Section A (Identification Information) reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Section I (Active Diagnoses) reflected diagnoses including hypertension (high blood pressure), peripheral vascular disease, (disorder of the blood vessels outside of the heart, often decreased blood flow to the limbs) renal insufficiency (poor kidney function), diabetes mellitus (a condition that affects the way the body processes blood sugar), cerebrovascular accident (stroke), and subacute osteomyelitis right ankle and foot (a chronic infection of bone). Section C (Cognitive Patterns) reflected a BIMS score of 9 indicating moderately impaired cognition. Section M (Skin Conditions) reflected an infection of the foot and surgical wounds. Review of Resident #1's electronic medical record reflected there were no assessments completed on 10/28/24. Review of Resident #1's electronic medical record reflected there were no progress notes written 10/28/24 that reflected the resident's status, a change in status, or an emergent condition that warranted transfer to the acute hospital. There was no progress note that reflected the provider was notified nor an order to transfer to the acute hospital received. Review of Resident #1's electronic medical record reflected there was no physician order to transfer the resident to the acute hospital. Review of Resident #1's electronic medical record reflected a progress note dated 10/28/24 at 9:00 PM, written by LVN A, Ambulance transportation here to take resident to [name] ER. RP notified. (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
	675406	A. Building B. Wing	10/30/2024

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/30/24 at 10:45 AM, the DON stated Resident #1 had wounds, and despite the interventions, the wounds had not improved. The plan had been to send the resident back to the hospital where the surgical team would request a consult from the vascular team. She stated the resident went to the ED then was admitted to the hospital. She stated the MDS nurse monitored completion of assessments but no one monitored the progress notes. During a telephone interview on 10/30/24 at 4:03 PM, LVN A stated she was told EMS was scheduled to take the resident to the hospital so he could see the surgeon. She stated when EMS arrived, the resident was awake. I told him where he was going and told him I would call his family . She stated when a resident was sent out of the facility, the nurse was expected to write a note and complete an assessment. She stated, I didn't do it. She stated it was a busy time and she was going to go back later to complete the documentation but did not. She stated not documenting could lead to a lack of communication, not knowing the baseline or if changes occurred. During a telephone interview on 10/30/24 at 4:12 PM, LVN B stated she had contacted the surgeon about the wounds not improving and the surgeon said to send him to the ER. She stated EMS showed up but before they got to the resident, they received an emergent call so they left stating they should be back around 7 or 8:00 PM. She stated she left the facility around 7:30 PM and EMS had not yet returned. She stated she could not remember if she documented the conversation with the surgeon. She stated, I know I should have written a note, usually I do. She stated when a resident was sent out to the hospital, the nurse was expected to complete a transfer note. She stated the nurses were expected to document changes in the resident's condition. During an interview on 10/30/24 at 4:30 PM, the DON stated it was her expectation that documentation was completed accurately and timely. She expected the documentation to depict a good view of the resident. She stated not documenting in the resident's medical record could lead to staff not knowing if the resident had a change, was declining, or improving. The lack of communication or documentation could lead to a delay in care. During an interview on 10/30/24 at 4:37 PM, the ADM stated he expected accurate documentation and timely. He stated, When time is of the essence and trying to get someone transferred out, there is the human error aspect. He stated the nurses were aware of the documentation expectations. He stated delay of care would be the biggest negative outcome of not documenting in the resident's medical record. Review of the facility policy revised July 2017 and titled, Charting and Documentation reflected in part, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. 2. The following information is to be documented in the resident medical record: a. Objective observations: d. Changes in the resident's condition: e. Events, incidents or accidents involving the resident.