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	07/03/2024

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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 50360 Based on observation, interview, and record review, the facility failed to ensure the resident's right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility for 1 of 1 full recertification survey (Survey A) reviewed for survey results. The facility failed to post the results of Survey A dated 04/27/23 in a public area for all residents and visitors to view on 07/01/24. This failure placed residents at risk of not having all the information necessary to make decisions about living at the facility. Findings included: During a confidential interview with 11 anonymous residents, all 11 agreed they had not ever seen the results of any of the previous State Agency inspections or noticed them posted or advertised in any public area around the facility. Seven of the 11 residents interviewed stated they would have wanted to view the survey results and wanted to know how they could do so. Observation on 07/01/24 at 03:11 PM revealed no survey results posted in any public area anywhere in the facility. During an interview on 07/01/24 at 04:02 PM, the ADM stated he had just begun working at the facility a few weeks prior, and he thought the survey results book had been posted in a bracketed wire file folder hung outside his office door, but he had confirmed it was not hung there. He stated he was responsible for ensuring the survey results were available for residents, staff, and visitors to read. He stated the potential negative impact of not having survey results available was people would not know what was going on in their home. Review of facility policy dated April 2017 and titled Examination of Survey Results reflected the following: Survey reports and plans of correction are readily accessible to the resident, family members, resident representatives and to the public. Policy Interpretation and Implementation 1. Residents may examine the results of the most recent survey of the facility conducted by federal or state surveyors, as well as any plans of correction in effect. (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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A copy of the most recent survey report and any plans of correction are kept in a binder in the residents' day room. 3. Survey reports, certifications, complaint investigations and plans of correction for the preceding three years are available for any individual to review upon request. 4. Information concerning the rights to examine, the location of and how to request preceding years' survey reports and plans of correction (and related materials as noted above) are posted on the resident bulletin board and at each nurses' station.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50360 Based on observation, interview, and record review, the facility failed to ensure that residents receive treatment and care based on the comprehensive assessment of a resident and in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 16 Residents reviewed for quality of care The facility failed to perform Resident #33's left fifth toe wound treatment as ordered on 07/01/24. This failure placed residents at risk of worsening infection, sepsis, and amputation. Findings included: Review of the undated face sheet for Resident #33 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included congestive heart failure (long-term condition that happens when your heart can't pump blood well enough to give your body a normal supply), type two diabetes mellitus, morbid obesity, need for assistance with personal care, difficulty in walking, long-term use of anticoagulants, and venous insufficiency (malfunction of venous walls and/or valves in systemic circulation, especially in the legs, that result in peripheral pooling of blood known as stasis). Review of the quarterly MDS assessment for Resident #33 dated 05/22/24 reflected a BIMS score of 15, indicating an intact cognitive response. It reflected that she did not have an infection or other wound of the foot during the lookback period (seven days of data from which the assessment results are drawn). Review of laboratory culture results for Resident #33 dated 06/25/24 reflected MRSA was detected in a sample taken from the fluid filled blister on her left fifth toe on 06/24/25. Review of the care plan for Resident #33 dated 07/01/24 reflected the following: Altered skin integrity non pressure related to: Right 5th toe fluid filled blister. Affected area will heal without complications through next review date. o Antibiotic ointment per MD order o Evaluate need for pain reliever prior to cleansing or dressing changes o Monitor for signs and symptoms of infection such as swelling, redness, warm, discharge, odor notify physician of significant findings o Notify practitioner if symptoms worsen or do not resolve o Treatments as ordered (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o Weekly Wound evaluation Review of physician orders for Resident #33 reflected an order for Mupirocin External Ointment 2 % (Mupirocin) Apply to Left small toe topically every day shift for Staph infection for 10 Days with a start date of 06/25/24 and an end date of 07/05/24. Review of the June 2024 and July 2024 TAR for Resident #33 reflected the following treatment was documented on 06/30/24 and 07/01/24 by LVN A: Mupirocin External Ointment 2 % (Mupirocin) Apply to Left small toe topically every day shift for Staph infection for 10 Days. Observation and interview on 07/02/24 at 09:16 AM revealed Resident #33 seated in her easy chair with her feet elevated. She had a sign on her door indicating contact precautions were in place, and her left foot was wrapped in gauze. The date 06/30/24 was written on a piece of white tape on the gauze. Resident #33 stated she had a blister on her foot and was receiving wound treatment for it. She stated she thought she had gotten wound treatment the day before but was not completely sure. She stated it had not been done that day. She stated the wound did not hurt. During observation and an interview on 07/02/24 at 11:05 AM, the DON was preparing to administer medications to Resident #33. She stated she had not yet been in Resident #33's room and had not seen the bandage on her foot. The DON went into Resident #33's room and returned within a few moments. She stated the bandage on Resident #33's left foot was dated 06/30/24. She stated she needed to check the orders to determine why the bandage was documented as changed on 07/01/24 but still dated 06/30/24. During an interview on 07/02/24 at 02:00 PM, the DON stated she had determined the wound treatment for Resident #33's fifth left toe had not been completed by LVN A. She stated LVN A had made a mistake and thought she completed the treatment so had signed the TAR to indicate as such, but she could not find the notes that the treatment had been done. The DON stated it was only her second day at the facility, and she had not developed a system for monitoring to ensure wound care was completed, but she had already started in-servicing the staff on the failure. She stated the potential impact of not receiving antibiotic ointment on a skin infection was worsening infection. Observation on 07/02/24 at 03:00 PM revealed LVN B provided the wound treatment to Resident #33's blister to the left fifth toe. Observation of the wound revealed a large fluid-filled blister the size of the entire fifth (pinky) toe. The blister membrane was intact, and the fluid inside it was slightly serous (clear with a slight yellow). The fifth toe was almost completely obscured by the blister. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/02/24 at 04:18 pm, LVN A stated yesterday, 07/01/24, was her first day back at the facility after a leave of absence. She stated she was not familiar with all the wounds in the building but normally, she kept track of her treatments by looking at the TARs for all of her residents and handwriting the orders down on a piece of paper. She stated she then documented her notes about the wound on the paper and entered all of it into the system when she was done. She stated she did not pull a report of treatments; she just went through and looked at all of her residents. LVN A stated she had Resident #33 on her list and had no excuses for not performing the treatment. She stated there were four or five new residents after coming back, and she was getting to know them, and she was not in the groove of things. LVN A stated she had a new admission after 03:00 PM on 07/01/24 and she got distracted and marked Resident #33's treatment as done when it was not. LVN A stated the orders for Resident #33's blister were to cleanse with normal saline and apply mupirocin. LVN A stated she was trained to complete all her treatments as ordered and to only document in the EMR if she completed the treatment. She stated the potential impact of the treatment not being done as ordered was the infection could become worse, Resident #33 could get sick and possibly even die. During an interview on 07/03/24 at 02:00 PM, the ADM provided policy on Medication and Treatment Orders, but these were not relevant to the failure. There was no other policy that was specifically relevant to the failure.