STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675490	A. Building B. Wing	06/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Villa	1104 S William St Atlanta, TX 75551

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 - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review the facility failed ensure staff provided pharmaceutical services such as dispensing and administering all drugs to meet the needs of each resident for 3 of 4 staff reviewed for pharmacy services. (LVN A, LVN B, and MA) 1.On 06/20/25, 5 clear medication cups were found with 5 different residents' medications in a resident's room. 2.On 06/24/25, LVN A's medication cart had 15 clear medication cups with 15 different resident names written on them and their medications pre- popped from the medication blister pack in those cups. 3.On 06/24/25, LVN B's medication cart had 2 paper medication cups with two different resident names written on the bottom of the cups with pre popped medication from the medication blister pack in those cups. 4.On 06/24/25, MA C's medication cart had 3 clear medication cups with no names on them with , but resident medications were pre popped from the medication blister pack in the cups. These findings could place residents at risk of receiving the wrong medications. Findings included: 1. Record review of an employee concern form dated 6/20/25 indicated the Administrator had received a report that medications were found in cups stacked within each other. It appeared the medication were intended to be administered and somehow forgotten. The Medical Director was notified and identified residents were put-on 24-hour monitoring for any changes, the responsible parties were notified, and in service education on Medication Administration was conducted. Classroom meetings were scheduled for 6/24/25. During an interview on 6/24/25 at 6:40 a.m. the Administrator said he had written an employee concern about medications found in a room. He said they had identified the residents and their medications. He said the nurse they thought was responsible had been terminated. They had called the physician, the families and placed the residents in question on a 24-hour monitoring. He said he had not seen the medications himself but understood there was a picture floating around. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of an in-service training report dated 6/20/25 indicated the topic was Medication Administration. When administering medications to residents it is your responsibility to ensure the resident takes the prescribed medications. It is the facility policy to never leave medications at bedside unattended for the resident to take later. This deficient practice could possibly put the residents at risk for medical complications. Record review of a picture dated 6/20/25 at 1:27 a.m. showed 5 different clear cups of medications with medications sitting on a bed side table. The clear cups had residents' names written on them. 2.During an observation and interview on 6/24/25 at 5:10 a.m. LVN A said she had the medication cart for 300 hall, 500 hall, and 600 hall. Observation of the top drawer of the medication cart were stacked cups of medications in different compartments in the drawer. LVN A said she had pre popped the medications from the medication blister pack. She said medications for the 300- hall with 5 different cups with 5 different resident names written on them. The cups had various shapes, sizes, colors, and numbers of medications. The cups she displayed for the 500-hall were 7 different cups with different resident names. The cups had various shapes, sizes, colors, and numbers of medications. The 600-hall had 3 different medication cups with three different resident names. The cups had various shapes, sizes, colors, and numbers of medications. LVN A said she knew she was not supposed to pre pop the medications. During an interview on 6/24/25 at 5:15 a.m. the ADON said the staff should not pre pop medications from the blister pack before they were ready to administer them. She said resident medications should not be dispensed prior to the time of administration . 3.During an observation and interview on 6/24/25 at 5:28 a.m. LVN B said she was finished passing medications. Observation of the top drawer of the 100-hall medication cart revealed there were two white paper medication cups with one pill each in the cups. She said they were her last two morning medications. LVN B had the names written on the bottom of the cups. She said she had tried to give the medications but was unable to do so and had not disposed of them yet. She said she was not supposed to pre pop medications from the blister pack prior to administration. 4.During an observation and interview on 6/24/25 at 10:20 a.m. MA D was passing medications on the 500 hall. Observation of top drawer of her medication cart had 3 clear cups of resident medications with no names. She said they were medications for 3 of the residents on the hall. She also said she knew she was not supposed to pre pop the medications from the blister pack prior to administration. Record review of an in service dated 6/24/25 indicated the MA was educated on medication pass and proper steps for medication administration. The MA was not to pre pop medications ever. That was against regulations, provide privacy, obtain vitals, and administer medication at the time of medication pass. Pre popping medications could cause a medication error or a mistake to happen. It was signed by MA C. Record review statement dated 6/24/25 indicated the DON had verbally educated LVN A and LVN B that pre preparing medication was not allowed at the facility. Both nurses verbalized their understanding, and the statement was signed by the DON. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility Administering Medications policy last revised April 2019 indicated medications are administered in a safe and timely manner as prescribed. The individual administering the medications checked the label three times to verify the right resident, the right medication, right dosage, right time, and right method(route) of administration before giving the medications.