

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675490	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/25/2026
NAME OF PROVIDER OR SUPPLIER  Golden Villa		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews and record review, the facility failed to maintain clinical records on each resident that were complete and accurately documented in accordance with accepted professional standards and practices for 1 (Resident #1 of 14 residents reviewed for accuracy and completeness of clinical records. 1.The facility failed to document the blood pressure and heart rate for parameters established by the physician for administering Resident #1's carvedilol (blood pressure medication) 8 PM dose from 3/1/26-3/19/26. This failure could place residents receiving blood pressure medications at risk of experiencing unsafe drops in blood pressure and heart rate.Findings included:Record review of Resident #1's face sheet dated 3/25/26 indicated she was [AGE] years old and admitted to the facility on [DATE]. Resident #1 had diagnoses including heart failure, heart disease, and hypertension (high blood pressure).Record review of Resident #1's admission MDS assessment dated [DATE] indicated she had a BIMS of 9, which indicated she had moderate cognitive impairment. The MDS indicated Resident #1 required substantial staff assistance for most ADLs.Record review of Resident #1's undated Care Plan indicated the resident had hypertension, which placed her at risk for stroke (blockage or bleed of blood vessels in the brain, killing brain cells), heart disease . required monitoring, medication management, lifestyle support, and safety interventions. The interventions included administering antihypertension medications (lower blood pressure) as ordered, check and document blood pressure per MD order, hold (do not give) medication and notify MD per facility protocol if blood pressure was below ordered parameters.Record review of Resident #1's Physician Order Report dated 3/01/26 - 3/31/26 revealed an order for carvedilol 3.125 mg 1 tablet by mouth every 12 hours at 8 AM and 8 PM, with special instructions to hold (not give) for systolic blood pressure (top number) less than 105, diastolic blood pressure (bottom number) less than 60, and a heart rate less than 60, with a start date of 2/24/26. There was an order to monitor vital signs daily-if medication was held, notify the nurse- hold parameters per medication once daily between 6 AM to 6 PM, with a start date of 2/24/26.Record review of Resident #1's Nursing MAR dated 3/01/26-3/31/26 revealed an order for carvedilol 3.125 mg 1 tablet by mouth every 12 hours at 8 AM and 8 PM, with special instructions to hold for systolic blood pressure less than 105, diastolic blood pressure less than 60, and a heart rate less than 60, with a start date of 2/24/26. There were no blood pressures or heart rates documented for the 8 PM dose administration from 3/01/26 through 3/19/26.During an interview on 3/25/26 at 11:20 AM, the DON said when a medication, such as a blood pressure medication, with vital sign (blood pressure and heart rate) parameters set by the physician, the vital signs would be documented on the MAR. The DON said there was not a place for a second set of vital signs related to Resident #1's 8 PM carvedilol dose on the 3/1/26-3/31/26 MAR and there should have been. The DON said there were vital signs on some of the nurses' notes in the night shift section, but there was no real way to tell what time the vital signs were taken in context to the medication being administered. The DON said Resident #1's MAR was missing a place for the documentation of the second dose (8 PM) of carvedilol and the vital signs that were documented on nurse's notes were not timed, so there again, there was no way to know when the vital signs were (continued on next page)</p>

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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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>taken in context to the medication being administered.During an interview on 3/25/26 at 3:39 PM, MA A said she had worked at the facility since 1994. MA A said she normally worked the 2 PM to 10 PM shift. MA A said when she administered medications with parameters for blood pressure and pulse rates, she documented the blood pressure and pulse rate on the MAR. MA A said if the medication was ordered more than once daily there would be a place to document the blood pressure and heart rate with each medication administration on the MAR. MA A said if the resident's blood pressure or pulse was out of parameters and the medication was not given, there would be a circle around her initials to indicate it was not given. MA A observed Resident #1's MAR for the month of March 2026 and said there was not a place to document her blood pressure or pulse for her Carvedilol 8 PM dose. MA A said the S was her initial on the MAR. MA A said she knew she had checked Resident #1's blood pressure and pulse before she administered her carvedilol 8 PM dose. MA A said if the blood pressure and heart rate were not documented, it was like she did not check the resident's blood pressure of pulse (heart rate). MA A said if the blood pressure and pulse were not documented, there was no way to tell if the medication was given within the parameters set by the physician. MA A said if the blood pressure and pulse were not documented, they would not be able to see how many times the resident's blood pressure or pulse were low and the medication was given. MA A said if the medication was given without checking the blood pressure or pulse, they could be out of parameters, and the resident's blood pressure could drop and could place the resident in serious danger.During an interview on 3/25/26 at 3:53 PM, the DON said when it was discovered there was no place to document the blood pressure and heart rate on Resident #1's MAR for her 8 PM carvedilol dose, they started an audit of all the MARs and was prepping an in-service for nursing and will get that tightened up. The DON said once they go to the electronic medical record, it would eliminate a lot of the issues with the paper charts. The DON said if the staff were not checking the resident's blood pressure and/or heart rate when administering blood pressure medications, they would not know if the medication needed to be held (not given) and it could bottom out the resident's blood pressure, cause injuries, falls, and it needed to be fixed. The DON said he thought there may have been an issue with the way their orders linked blood pressure medication and vital signs in their system and somehow may have unlinked.Record review of the facility's policy titled Administering Medications dated revised April 2019, indicated . Medications were administered in a safe and timely manner, and as prescribed . medications were administered in accordance with prescriber orders . the following information was checked/verified for each resident prior to administering medications . vital signs, if necessary .</p>		