

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/12/2026
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)		
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to ensure all drugs and biologicals used in the facility were labeled and stored in accordance with professional standards for 2 of 8 medication carts (200 Hall Medication Cart and 300 Hall Medication Cart) reviewed for drugs and biologicals. The facility failed to ensure the 200 Hall Medication Cart and the 300 Hall Medication Cart were properly secured when Medication Aide A left the facility and left them unlocked and unattended on 06/12/2026. This failure could place residents at risk of not receiving drugs and biologicals as needed, medication errors, medication misuse, and drug diversion. Findings included: During an observation and interview on 06/12/2026 at 3:52 PM, 200 Hall Medication Cart and 300 Hall Medication Cart were noted at the nurse's station unlocked and unattended. Staff members were observed walking by the unlocked medication carts. A resident was also observed standing next to the unlocked medication carts. The DON approached the medication carts and locked them. The DON stated he was not aware that the medication carts were left unlocked and unattended. The DON said he was unsure of who the medication carts were assigned to. The DON went to get the master keys from his office and the Staffing Scheduler. When the DON opened the 200 Hall Medication Cart, the keys for the medication carts (200 Hall and 300 Hall) were noted to be in the top drawer. The DON and Staffing Scheduler counted both carts. The DON then said Medication Aide A was assigned to both medication carts. The DON said he did not see a problem with the two medication carts being unlocked and unattended because the medications carts were now locked and had been counted down. During an interview on 06/12/2026 at 04:10 PM, the Staffing Scheduler said MA A had told her she had an emergency and had to leave the building and would be right back. The Staffing Scheduler said she was responsible for oversight of the MA. The Staffing Scheduler said she expected Medication Aide A to have counted down the assigned medication carts with the charge nurse and hand over the keys prior to leaving the facility. The Staffing Scheduler said she had not realized the MA A had left the facility without following the proper procedures. The Staffing Scheduler said she expected all staff to ensure the medication carts were locked when unattended. The Staffing Scheduler said the medication cart keys were to stay secured by the assigned staff member to prevent misappropriation and/or a drug diversion. The Staffing Scheduler said it was important to ensure the medication carts were locked when leaving unattended to prevent misappropriation, drug diversion, or residents not receiving their medications timely. The Staffing Scheduler said she believed the ADON conducted random rounds to check to ensure the medication carts were secured. During an interview on 06/12/2026 at 04:20 PM, the ADON said the nurses were responsible for ensuring the medication carts were locked. The ADON said if the medication cart was left unlocked somebody could access the medications or treatments in it. The ADON said the clinical staff did random walk throughs in the halls to verify the medication carts were locked appropriately. During an interview on 06/12/2026 at 4:55 PM, MA A said she had a family emergency and had to leave the facility quickly. MA A said she should have counted the medication carts down with the charge nurse and turned over the keys to her at that time but did not. MA A said it was important for the medication (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 675490	Facility ID: 675490 If continuation sheet Page 1 of 2

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cart to be locked because they had dementia patients, and someone could go and take stuff. MA A said that it was dangerous for the medication cart to be left unlocked. During an interview on 06/12/2026 at 04:50 PM, the Corporate Consult Regional Nurse said medication carts should be locked when not within eyesight. The Corporate Consult Regional Nurse said she expected DON/ADONS to monitor for proper storage of medications and locked medication carts by walking down the hallways daily, and providing education if errors were observed. The Corporate Consult Regional Nurse said unlocked medication carts could result in somebody getting into the medication cart, medications getting stolen, and a resident who did not know could take medications they should not be taking. During an interview on 06/12/2026 at 04:55 PM, the Administrator said he expected the staff to follow the rules and lock the medication carts when leaving unattended. The Administrator said unlocked medication carts placed the residents at risk of taking the medications and the staff could also take the medications as well. Record review of the facility's policy, Storage of Medications, dated 04/2017, indicated, The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. 7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.'		