

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 06/04/2025
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure residents were free from abuse for 1 of 7 residents (Resident #17) reviewed for resident abuse.</p> <p>The facility failed to ensure Resident #17's was free from abuse when LVN J yanked Resident #17's left arm on 05/22/25.</p> <p>This failure could place residents at risk of physical harm, mental anguish, or emotional distress.</p> <p>The findings included:</p> <p>1. Record review of Resident #17's face sheet dated 06/02/25 indicated Resident #17 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of parkinsonism, unspecified (a group of neurological conditions that share symptom similar to those of parkinson's disease), repeated falls, unspecified, dementia (a group of thinking and social symptoms that interferes with daily functioning), generalized osteoarthritis (a form of osteoarthritis where three or more joints are affected), myalgia (a medical term that refers to muscle pain) and fibromyalgia (a chronic condition that causes widespread musculoskeletal pain, fatigue and other symptoms).</p> <p>Record review of Resident #17's MDS assessment dated [DATE] indicated, Resident #17 was understood others made herself understood. The MDS assessment indicated Resident #17 had a BIMS score of 08, which indicated Resident #17 had severe cognitive impairment. Resident #17 required maximal assistance with ADL's care.</p> <p>Record review of Resident #17's care plan, dated on 10/03/24, indicated Resident #17 complaints of chronic pain related to fibromyalgia (a chronic condition that causes widespread musculoskeletal pain, fatigue and other symptoms), osteoarthritis (a form of osteoarthritis where three or more joints are affected) and migraines (a common neurological condition).</p> <p>Record review of incident and accident report for Resident #17 dated 05/22/25, completed by ADON indicated that there was pain in left arm.</p> <p>(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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #17's x-ray of left shoulder, dated 05/23/25, indicated comparison: A comparison was made to prior study dated 11/12/24. Findings: The left shoulder x-ray reveals no signs of signs of acute fractures or dislocation, severe glenohumeral joint osteoarthritis with marked narrowing of the glenohumeral joint space (the area the humeral head (the ball of the shoulder joint) and the glenoid fossa(the socket in the shoulder blade), subchondral sclerosis (a condition characterized by the hardening of bone tissue immediately beneath the cartilage surface in a joint), and osteophytes (a bony growth that develops on the edge of a bone) is noted. The acromioclavicular joint (a small joint in the clavicle) is comparatively normal. Anatomic alignment (positioned to align with the natural anatomical axes of the bones) is maintained, and the soft tissue appear normal.</p> <p>2. Record review of Resident #26's face sheet, dated 06/04/25, indicated reflected she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included heart failure (a chronic condition in which the heart is unable to pump blood effectively), and shortness of breath.</p> <p>Record review of LVN J's personnel file on 06/03/25 indicated hire date of 02/18/25. The facility had performed background check and employee misconduct search. No concerns were identified.</p> <p>Record review of in-services on 06/03/25 at 11:01 A.M., indicated on 5/22/2025 performed over Training Report Proper Transfer Techniques, Indicators of Abuse and Neglect and Reporting, Reporting Abuse and Neglect and Abuse Prohibition Policy.</p> <p>During an observation and interview on 06/02/25 at 2:20 P.M., Resident #17 was sitting up in her wheelchair in her room. She said someone had been mean and abusive to her in the facility. She said she was no longer there and her name was LVN J. She said LVN J was constantly in her face and abusive to her. She yanked on her when she asked her not to. She said she would constantly yank on her left arm. She said she does not know if the facility took care of the issue with LVN J being mean to her. She said she does feel safe in the facility.</p> <p>During an interview on 06/02/25 at 2:35 P.M., Resident #26 was sitting up in wheelchair her in room. Resident #26 said she saw the incident with Resident #17 and LVN J. She said LVN J yanked Resident #17 left arm one time in an abusive manner; when LVN J came back in to give Resident #17 her pain medication. She said Resident #17 could be dramatic and a little impatient at times. She said the ADM did investigate the incident and called the police. She said her and Resident #17 does not know what happened to LVN J. She said they just know LVN J does not work there anymore and the ADM told them she would never come back in their room again.</p> <p>During an interview on 06/03/25 at 10:16 A.M., Resident #17 said it hurt her when LVN J yanked her left arm and she asked her to stop. She said her arm hurt a few days after the incident, but it was hurting her before LVN J yanked it and she knew that. She said they gave her a pain pill for the pain in her arm.</p> <p>During an interview on 06/03/25 at 10:39 A.M., [NAME] Director of Clinical Operations said LVN J was on suspension at this time. She said the facility investigate the incidents then we let the surveyors do their investigations before the facility made the finalize determination before we contact the employee. She said based on the facility investigation of the incident; the facility findings were unconfirmed and they did safe surveys.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a phone interview on 06/03/25 at 10:52 A.M., LVN J said Resident #17 was lying crossway in the bed when she scooped her up from the back and raised her up from the back then gave her, her pain medicine. LVN J said she folded Resident #17's arms in front of her before turning her in bed to turn her like she was taught 20 years ago in nursing school before repositioning a resident. LVN J said she was aware of Resident #17's left arm was hurting that was why she was trying to be careful with her. She stated Resident #17 always complained of pain in her left arm. She said there was no reason why she would be mean to Resident #17. LVN J said she would never be mean to Resident #17.</p> <p>During an interview on 06/04/2025 at 1:02 P.M., the DON said the incident with Resident #17 he did not believe that LVN J abused her. He said he understood that Resident #26 was a witness, but he just does not believe LVN J intentionally tried to hurt Resident #17. He said the facility had done safe surveys, in servicing and employee evaluation. He said he does not condone abuse of a resident and if a staff commits abuse he felt they should be reprimanded.</p> <p>During an interview on 06/04/2025 at 1:33 P.M., the ADM said the incident with Resident #17 anytime her shoulder was touched voiced by her family member she was sensitive to that shoulder. He said he could not say if the nurse did a correct transfer technique or not. He said Resident #17's roommate Resident #26 did collaborate her story that LVN J pulled her left arm. He said Resident #17 had lived at the facility three times and she had never had an experience like that before. He said he interviewed 10 employees that had interactions with LVN J and 3 safe surveys on all 6 halls on LVN J and they all came back with no negative findings. He said he had done some in-services with staff, Resident #17 goes to counseling, he sent the social worker to talk to her after the incident and she seemed to be doing fine.</p> <p>Record Review of facility policy titled, Abuse Prevention and Prohibition dated July 10, 2019. Policy indicated, These policies apply to all staff, consultants, contractors, volunteers and caretakers who have direct care responsibilities and provide care services on behalf of the facility. protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements The resident has the right to be free from abuse, neglect, exploitation and misappropriation of resident property.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure each resident's environment remained free of accidents and hazards for 2 of 21 residents (Resident #38 and Resident #4) reviewed for accident hazards.</p> <ol style="list-style-type: none"> The facility failed to prevent Resident #38 from having antimicrobial antiseptic skin cleanser in her room. The facility failed to ensure CNA B performed a safe mechanical lift transfer for Resident #4. <p>This failure could place residents at risk for injury, harm, and impairment.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Record review of Resident #38's Face Sheet indicated she was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included Dementia (a general term for the loss of mental abilities that affect daily life), Atrial Fibrillation (an irregular and often rapid heart rhythm that begins in the heart's upper chambers), Hyperlipidemia (a condition where there are high levels of lipids (fats) in the blood, including cholesterol and triglycerides). <p>Record review of Resident #38's quarterly MDS dated [DATE] revealed that the resident had a BIMS score of 10 which indicates Resident #38 had moderate cognitive impairment. The MDS also revealed, Resident #38, is understood and understands others. Shows that Resident #38 requires supervision and setup with activities of daily living.</p> <p>Record review of Resident #38's Care Plan revealed a problem initiation on 3/05/2025 Resident #38 is at risk for multi drug resistant organisms.</p> <p>During an observation and interview on 6/2/25 at 9:17 a.m. Resident #38 was observed to have an antimicrobial antiseptic skin cleanser in their bedroom. She said she did not know who placed the bottle in her room or what it was used for.</p> <p>During an observation on 6/3/25 at 2:50 p.m., a bottle of antimicrobial antiseptic skin cleaner was observed in the same location it was observed on 6/2/25 in rResident #38's bedroom.</p> <p>During an interview on 6/3/25 at 2:55 p.m., LVN A said that she did not know that Resident #38 had the bottle of antimicrobial antiseptic skin cleaner in their room. She said it was probably left from a procedure that Resident #38 recently had. She said that this was a prohibited item in a resident room and should not be there.</p> <p>During an interview on 6/4/25 at 1:00 p.m., the Director of Nurses said that residents should not have antimicrobial antiseptic skin cleanser in their rooms as it was against facility policy, and it could place the resident at risk of harm if they used it improperly. He said it was the responsibility of all staff to ensure prohibited items are not in resident's rooms.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/4/25 at 1:06 p.m., the Administrator said residents could not have antimicrobial antiseptic skin cleanser in their room as it could be harmful to them if they drank it. He said that a resident with dementia could get ahold of a prohibited item and misuse it as well. He said that all staff are responsible to remove prohibited items from resident's rooms.</p> <p>Requested a policy from the Administrator regarding prohibited chemicals in resident rooms on 6/4/25 . Policies provided did not address this specific deficiency.</p> <p>2. Record review of Resident #4's face sheet dated 6/03/25 indicated he was [AGE] years old and admitted to the facility on [DATE]. Resident #4 had diagnoses which included dementia (forgetfulness), heart disease, diabetes (high blood sugar), hemiplegia (complete or severe loss of motor function on one side of the body), and cerebrovascular disease (condition impacting the brain's blood vessels and blood flow resulting in brain tissue death).</p> <p>Record review of Resident #4's quarterly MDS dated [DATE] indicated Resident #4 had a BIMS of 6 which indicated he had severe cognitive impairment. The MDS indicated Resident #4 was dependent on staff for chair to bed transfers.</p> <p>Record review of Resident #4's undated Care Plan indicated he was at risk for falls, and he required assistance of 2 staff members with mechanical lift transfers for safety.</p> <p>During an observation on 6/03/25 at 1:15 PM, CNA B performed a mechanical lift transfer from Resident #4's wheelchair to his bed and was assisted by CNA C. The lift pad was already positioned under Resident #4 in his wheelchair. CNA B spread the legs of the mechanical lift into the wide position and positioned the mechanical lift over Resident #4's wheelchair. CNA B and CNA C attached the lift pad to the mechanical lift sling and locked the wheels. CNA B then raised Resident #4 up out of his wheelchair and CNA C moved his wheelchair back as CNA B was pulling the mechanical lift backwards and CNA B moved the mechanical lift legs to the narrow position and then turned Resident #4 to the right. CNA B then pushed Resident #4 while suspended in the mechanical lift toward his bed with the lift legs in the narrow position guided by CNA C and positioned Resident #4 over his bed. CNA B then locked the wheels and lowered Resident #4 onto the bed with the mechanical lift legs in the narrow position.</p> <p>During an interview on 6/03/25 at 1:40 PM, CNA C said she had worked at the facility since February 2025 and normally worked on the 6 AM to 2 PM shift. CNA C said the mechanical lift legs should be in the wide position to go around the wheelchair and the wheels should be locked. CNA C said the legs of the mechanical lift should be opened in the wide position during the transfer of the resident to keep him more secure and easier to transfer. CNA C said the mechanical lift legs should be in the wide position when transferring a resident to keep the mechanical lift from falling over and hurting the resident.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/03/25 at 1:55 PM, CNA B said she had worked at the facility since January 2024 and normally worked on the 6 AM to 2 PM shift. CNA B said she was not sure what the purpose of spreading the legs of the mechanical lift to the wide position. CNA B said the process of using the mechanical lift was as follows: position the resident in the lift pad/sling, open the legs of the mechanical lift wide to move the lift around the resident's wheelchair, then attach the lift pad to the mechanical lift, ensure the resident is comfortable and everything was good, raise the resident up to clear the wheelchair, then unlock the wheels of the mechanical lift and pull the lift back away from the wheelchair, then put mechanical lift legs in (narrow position) and move the resident to over the bed and make sure the resident was appropriately positioned and then lower to the bed, assisted by someone else to stabilize the mechanical lift. CNA B said she did not know why the mechanical lift legs should be spread to the wide position but could find out and let the surveyor know. CNA B said she did not want to just make an assumption and tell the wrong thing .</p> <p>During an interview on 6/04/25 at 9:50 AM, the DON said the mechanical lift base legs should be in the wide position during the transferring and moving of the resident. The DON said when the resident's room allows, the mechanical lift base/legs should be in the wide position for stability, so it does not throw the resident and for safety reasons. The DON said if the mechanical lift base/legs were not in a wide base position, the whole machine could tip over and cause injury to the resident.</p> <p>During an interview on 6/04/25 at 10:08 AM, the ADM said he would expect staff to follow the mechanical lift policy and the lift legs should be in the wide position for safety of the resident during the mechanical lift transfer. The ADM said the staff did not follow the facility's process with the mechanical lift transfer by not moving the resident with the mechanical lift legs in the wide position. The ADM said by the staff not putting the mechanical lift legs in the wide position, it could have caused the mechanical lift to not be balanced and it could have tipped over and injured the resident.</p> <p>Record review of the facility's CNA Performance and Skills Evaluation of CNA B dated 12/31/24 had a S marked which indicated CNA B had a performed the procedure satisfactory . CNA B had demonstrated the procedure for using the [NAME] and [NAME] II (Mechanical Lifts) . 7. Standing next to the individual, position lift in front of, or over the individual opening the legs of the lift to their widest position . 11. Standing next to the individual, use the UP button on the hand control to slowly raise the lift to the height necessary to clear surface . 12. Once clear of the surface, lower the individual until the feet are at the top of the lift base and transfer to desired location (Lift legs remain open) .</p> <p>Record review of the facility's undated policy titled Transfer, Two Person Hoyer (Mechanical) Lift indicated . the purpose was to safely get resident from one surface to another when the resident was unable/unwilling to bear weight on his or her lower extremities and could not be safely transferred using the two-person total lift . position wheelchair so that can maneuver the lift safely from bed to over the chair . lock wheels/brakes . position lift over the bed . spread the legs of the lift to the widest position to maintain a broad base of support . slowly guide the lift away from the chair and position lift above the chair . reverse the procedure to return the resident to bed .</p> <p>Record review of Patient Lifts by the U.S. Food and Drug Administration (FDA), (Patient Lifts FDA) was accessed on 6/05/25 indicated . the FDA has compiled a list of best practices that, when followed, can help mitigate the risks associated with patient lifts . users should . keep the base (legs) of the patient lift at maximum open position and situate the lift to provide stability .</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Best Practices for Using Patient Lifts by the U.S. Food and Drug Administration (FDA), Best Practices For Using Patient Lifts (fda.gov) was accessed on 6/05/25 indicated . patient lifts were designed to lift and transfer patients from one place to another . found improper use of patient lifts have led to patient falls . resulted in head traumas, fractures, deaths . can mitigate risks by doing the following . receive training and understand how to operate the lift . keep the base (legs) of the patient lift in the maximum open position .		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals, and preferences for 3 of 8 residents (Resident #10, Resident #26 and Resident #83) reviewed for respiratory care and services.</p> <ol style="list-style-type: none"> The facility failed to cover the nasal cannula tubing with a bag on an oxygen concentrator machine that was not in use for Resident #10 and Resident #83. The facility failed to cover the face mask with a bag on nebulizer machine that was not in use for Resident #26. <p>This failure could place residents at risk for developing respiratory complications.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Record review of Resident #10's face sheet, dated 06/04/25, indicated reflected he was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included flail chest (a traumatic disorder that happens when three or more ribs located next to each other are fractured in two or more places). <p>Record review of Resident #10's quarterly MDS assessment dated [DATE] indicated Resident #10 understood and understood others. Resident #10's BIMS 12 score of which indicated moderate cognitive impairment. Resident #10 required maximal assistance with ADL's.</p> <p>Record review of Resident #10's physician orders dated 03/14/25 for Resident #10 indicated oxygen 1 liter per minute via nasal cannula every shift 6:00 AM- 6:00 PM and 6:00 PM- 6:00 AM with diagnosis multiple fracture of ribs, unspecified side, subsequent encounter for fracture with routine healing.</p> <p>Record review of Resident #83's face sheet, dated 06/04/25, indicated reflected he was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included heart failure (a chronic condition in which the heart is unable to pump blood effectively), chronic obstructive pulmonary disease with (acute) exacerbation (a group of lung diseases that cause persistent airflow obstruction and breathing problems) acute respiratory failure (occurs when the lungs cannot properly exchange gases), asthma (a condition in which a person's airways become inflamed, narrow and swell. and produce extra mucus, which makes it difficult to breath), sepsis (a widespread infection causing organ failure and dangerously low blood pressure), pneumonia (infection that inflames air sacs in one or both lungs, which fill with fluid) and pulmonary hypertension (a type of high blood pressure that effects arteries in the lungs and in the heart).</p> <p>Record review of Resident #83's quarterly MDS assessment dated [DATE] indicated Resident #83 was understood and understood others. Resident #83's BIMS score of 11 which indicated moderate cognitive impairment. Resident #83 required maximal assistance with ADL's.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #83's physician orders dated 03/14/25 for Resident #83 indicated oxygen at 2 liters per minute via nasal cannula every shift 6:00 AM- 6:00 PM and 6:00 PM- 6:00 AM.</p> <p>During an observation and interview on 06/02/25 at 10:37 A.M., Resident #83 was sitting up in her wheelchair in her room. She had oxygen in place via a nasal cannula from a portable oxygen tank on the back of her wheelchair. Resident #83 nasal cannula was over her concentrator and not covered with a plastic bag. Resident #83 said she usually wore oxygen.</p> <p>During an observation and interview on 06/02/25 at 10:49 A.M., Resident #10 was sitting up in her wheelchair in her room. She had oxygen in place via a nasal cannula from a portable oxygen tank on the back of her wheelchair. Resident #10 nasal cannula on her concentrator was not covered with a plastic bag and almost touching the floor. Resident #83 said she usually wore oxygen.</p> <p>2. Record review of Resident #26's face sheet, dated 06/04/25, indicated reflected she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included heart failure (a chronic condition in which the heart is unable to pump blood effectively), and shortness of breath.</p> <p>Record review of Resident #26's quarterly MDS assessment dated [DATE] indicated Resident #26 was understood and understood others. Resident #26's BIMS score of 15 which indicated cognitively intact. Resident #26 required supervision with ADL's.</p> <p>During an observation and interview on 06/02/25 at 2:35 P.M., Resident #26 was sitting up in her wheelchair in her room. Her nebulizer and mask were sitting on her nightstand. The mask was not covered in a bag. Resident #26 said she used the nebulizer when she needed it.</p> <p>During an interview on 06/04/2025 at 9:24 A.M., CNA H said the nurses were responsible for changing the nasal cannula tubing and ensuring the nasal cannula tubing were in bags when the concentrators were not in use. She said the aides were responsible for ensuring the tubing was in the bag if the nasal cannula was not in use as well. She said most of the time the nurse normally handled the nebulizer masks and if they were not in a bag, she would notify the nurse, so they could determine if they needed to be changed. She said a negative effective of the nasal cannula or a nebulizer mask not in a bag was it could be exposed to bacteria, and it could exposed to the floor.</p> <p>During an interview on 06/04/2025 at 9:37 A.M., CNA I said the nurses were responsible for ensuring the residents nasal cannula were in a bag. She said if she saw a nasal cannula without a bag she would report it to the nurse. She said she would notify the nurse if she saw a nebulizer mask was not in a bag. She said a negative effect of a nasal cannula or nebulizer mask tubing not in a bag could cause cross contamination and put the resident at risk for infection.</p> <p>During an interview on 06/04/2025 at 9:44 A.M., the ADON she said the night shift nurses were responsible for ensuring that the concentrators and portable oxygen tanks nasal cannulas have bags on them. She said the graveyard nurses were responsible for ensuring nebulizers machine tubing mask had bags. She said a negative effect of not having the nasal cannula tubing and nebulizer masks covered with bags was an infection control issue.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/04/2025 at 1:02 P.M., the DON said our night shift were responsible for a lot of our change outs of the resident oxygen tubing and masks. He said it falls on all shifts to make sure the nasal cannulas and nebulizer masks were in the bags . He said a negative effect of the nasal cannula and nebulizer masks not in a bag would be infection.</p> <p>During an interview on 06/04/2025 at 1:33 P.M., the ADM said the nightshift nurses should be changing the nasal cannula tubing, masks for nebulizers out weekly and applying the bags to the tubing. He said the nurse should be putting the nasal cannulas and nebulizers masks in bags to prevent infection and respiratory infections.</p> <p>Record review of the facility's policy, Oxygen Administration, revised on October 2010, s indicated: .The purpose of this procedure is to provide guidelines for safe oxygen administration .</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide food that was palatable and attractive for 7 of 8 residents (Resident's #9, #11, #33, #42, #49, #57, and #84) reviewed for palatable food.</p> <p>The facility failed to provide food that was palatable and attractive to Resident #9, #11, #33, #42, #49, #57, and #84 who complained the food was bland, mushy, and overcooked, and the same foods were served over and over.</p> <p>These failures could place residents who ate food from the kitchen at risk of weight loss, altered nutritional status, and diminished quality of life.</p> <p>The findings included:</p> <p>1. Record review of a face sheet dated 06/04/25 revealed Resident #9 was an [AGE] year-old female and was admitted to the facility on [DATE] with diagnoses of dementia (memory loss), risk for protein-calorie malnutrition, and vitamin deficiency.</p> <p>Record review of the quarterly MDS assessment dated [DATE] revealed Resident #9 was understood and understood others. The MDS revealed Resident #9 had a BIMS score of 11, which indicated moderate cognitive impairment.</p> <p>During an interview on 06/02/25 at 9:57 AM, Resident #9 stated the food was not served appealing. Resident #9 stated the vegetables were cooked too long and were full of water. Resident #9 stated the fried food were cooked hard and tough to eat. Resident #9 stated her bacon that morning was tough to chew, and she threw it back up . Resident #9 stated the facility staff were aware of the food complaints but nothing the food had not gotten better.</p> <p>2. Record review of a face sheet dated 06/03/25 revealed Resident #11 was a [AGE] year-old female and was admitted to the facility on [DATE] with diagnoses of stroke, protein-calorie malnutrition, and vitamin deficiency.</p> <p>Record review of an annual MDS assessment dated [DATE] revealed Resident #11 was understood and understood others. The MDS revealed Resident #11 had a BIMS score of 10, which indicated moderate cognitive impairment.</p> <p>During an interview on 06/02/25 at 11:39 a.m., Resident # 11 said the food was terrible. She said there was no taste to it, and it was always overcooked. She said she was tired of being served the same things over and over.</p> <p>3. Record review of a face sheet dated 06/03/2024 revealed Resident #33 was a [AGE] year-old female and was admitted to the facility on [DATE] with diagnoses of heart failure, vitamin deficiency, and unspecified nutritional deficiency.</p> <p>Record review of a quarterly MDS assessment dated [DATE] revealed Resident #33 was understood and understood others. The MDS revealed Resident #19 had a BIMS score of 14 which indicated the resident had intact cognition.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 06/02/25 at 9:45 a.m., Resident #33 said the food was not good. She said they talk about it every council meeting. She said they serve the same thing over and over. She said the staff do not honor their likes and dislikes. She said the dietician did bring her some seasoning, but it has not helped. She said the other night they were served Reuban sandwiches and people just do not like that. She said usually the food was way over cooked.</p> <p>4. Record review of a face sheet dated 06/04/25 revealed Resident #42 was an [AGE] year-old female and was admitted to the facility on [DATE] with diagnoses of dementia (memory loss), protein-calorie malnutrition, and vitamin deficiency.</p> <p>Record review of the quarterly MDS assessment dated [DATE] revealed Resident #42 was understood and understood others. The MDS revealed Resident #42 had a BIMS of 07, which indicated severe cognitive impairment.</p> <p>During an interview on 06/02/25 at 9:57 AM, Resident #42 stated the food was terrible and the staff did not try to make it better. Resident #42 stated it was not fit to eat, and she was unable to tell what the food was at times. Resident #42 stated the vegetables were cooked too long and were full of water. Resident #42 stated she rarely received a hot meal.</p> <p>During an observation and interview on 06/02/25 at 12:05 p.m., Resident #42 was sitting up in bed with a meal tray in front of her. Resident #42 said she was not going to eat because her roommate was going to bring her back a burger. The squash, vegetables had standing liquid on the tray (approximately 0.5 inches) and appeared mushy. Resident #42 stated the temperature of the food felt fine.</p> <p>5. Record review of a face sheet dated 06/03/25 revealed Resident #49 was a [AGE] year-old female and was admitted to the facility on [DATE] with diagnoses of depression, vitamin deficiency, and protein-calorie malnutrition.</p> <p>Record review of an admission MDS assessment dated [DATE] revealed Resident #49 was understood and understood others. The MDS revealed Resident #27 had a BIMS score of 09 which indicated the resident had moderate impaired cognition.</p> <p>During an interview on 06/02/25 at 10:00 a.m., Resident #49 said the food was just not good. She said she does not eat chicken, corn dogs, and hot dogs but she was still served those items. She said the food did not taste good.</p> <p>6. Record review of a face sheet dated 06/03/25 revealed Resident #57 was an [AGE] year-old male and was admitted to the facility on [DATE] with diagnoses of stroke, unspecified protein-calorie malnutrition, and anemia (a condition characterized by a lower-than-normal number of red blood cells, or a reduced amount of hemoglobin in red blood cells, resulting in a reduced oxygen-carrying capacity of the blood).</p> <p>Record review of a quarterly MDS assessment dated [DATE] revealed Resident #57 was understood and understood others. The MDS revealed Resident #57 had a BIMS score of 7 which indicated the resident had severely impaired cognition.</p> <p>During an interview on 06/02/25 at 10:05 a.m., Resident #57 said the food did not taste good at all. He said they serve the same thing over and over and he really gets tired of it.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>7. Record review of a face sheet dated 06/04/25 revealed Resident #84 was a [AGE] year-old female and was admitted to the facility 02/06/25 with diagnoses of pressure ulcers (wounds) and protein calorie malnutrition.</p> <p>Record review of the quarterly MDS assessment dated [DATE] revealed Resident #84 was understood and understood others. The MDS revealed Resident #84 had a BIMS score of 11, which indicated moderately impaired cognition.</p> <p>During an interview on 06/02/25 at 11:13 a.m., Resident #84 stated the facility repeated the same foods over and over again. Resident #84 stated the facility served mashed potatoes with every meal.</p> <p>Record review of the grievance log, dated between December 2024 and May 2025, revealed the following:</p> <ol style="list-style-type: none"> On 12/30/24 Resident #292 was unhappy with the food quality. Resident #292 stated the food had no flavor and was very bland. On 03/25/25 Resident #74 stated she was unhappy with the flavoring of the foods, and everything tasted like [an Italian restaurant]. On 04/18/25 Resident #44 stated the breakfast was awful and too much junk was sent out. He said it was wasteful. On 04/21/25 Resident #27 stated she was unhappy the kitchen did not send her preferred list for supper. On 05/01/25 Resident #61 stated her burger for supper had cheese and she did not want cheese on her burger. On 05/19/25 Resident #44 stated eggs were no good over the weekend . <p>Record review of the resident council minutes, dated between December 2024 and May 2025, revealed the following:</p> <ol style="list-style-type: none"> On 12/30/24, old business discussed revealed hall trays were being served cold to residents. The minutes reflected the issue was resolved as in-service education was provided. On 01/20/25, new business discussed revealed all residents stated they were sick of eating the same food over and over, every day. The cook over seasoned the food or does not season the food at all. Beans and soup were served cold, right out of the can. On 02/27/25, new business discussed revealed dietary staff were still serving the same food over and over. The cook cooked veggies to mush and burned grilled cheese, cookies, and rolls. The minutes revealed no one liked the chicken cordon blue, or to eat English peas for every meal. On 03/31/25, new business discussed revealed the seasoning on the food items such as greens and vegetables were too hot for them to eat. The minutes revealed dietary staff to pay closer attention to their cards before sending out trays such as dislikes. <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5. On 04/30/25, new business discussed revealed a few residents were not getting what they asked for during lunch and dinner.</p> <p>6. On 05/29/25, new business discussed revealed breakfast had become one of the least favorite meals of the day. Same food was served a lot.</p> <p>During a resident council group interview on 6/3/2025 at 10:29 a.m. with Resident's #33, #49, #55, #58, #61 revealed the kitchen serves chicken two or three times a day. The resident council said the kitchen serves instant mashed potatoes and green beans too much. The resident council said the vegetables were mushy and were so hot that you could not eat them as if they were overcooking the vegetables until they fell apart. They said the kitchen staff were not paying attention to items that were disliked as they served the items anyway. Resident #61 stated she did not like cheese, and she was constantly served cheese. The resident council said food tasted fine, but they did not like the variety, consistency, and texture of the food.</p> <p>During an observation and interview on 06/03/25 at 12:00 p.m., a meal tray was sampled with the Dietary Manager and 5 surveyors. The tray consisted of country fried steak, Brussel sprouts, mashed potatoes, a roll, and pudding with marshmallows and graham crackers. The country fried steak with white gravy had good flavoring but the breading was soggy. The Brussel sprouts were mushy and overcooked. The Dietary Manager said she agreed the breading on the steak was soggy and the Brussel sprouts were mushy and over cooked. When asked if the facility served mashed potatoes every day, the Dietary Manager said they did almost every day. She said the potatoes were fortified.</p> <p>During an interview on 06/04/25 at 9:44 a.m., the Dietary Manager said she talked to residents about their preferences and their food concerns . She said, there are some that you just cannot please. She said she was aware of complaints from resident council and there had been grievances concerning food complaints. She said she had talked to the cooks, and they had been in-serviced by the dietician. She said the cooks, just don't listen. She said a resident not liking the food could cause them to lose weight.</p> <p>During an interview on 06/04/25 at 11:42 a.m., the Dietary Manager said she did not have a food palatability policy.</p> <p>During an interview on 06/04/25 at 1:07 p.m., the Administrator stated he was aware of the food complaints made by the residents. The Administrator stated the facility recently hired a new cook that was working hard to improve the food taste and quality. The Administrator stated he believed the food has gotten better since the new cook has started. The Administrator stated the Dietician was providing education and going over meal preparation with the dietary staff. The Administrator stated the facility had started serving more fresh fruits and added seasoning packets to the meal trays. The Administrator stated the Dietary Manager was responsible for overseeing the day-to-day activities in the kitchen. The Administrator stated it was important to ensure the food tasted and looked appetizing to ensure the resident's nutritional needs were met. The Administrator stated meals were also part of the resident's socialization activities and it was important for the residents to enjoy the meal services.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of a Summary Report of Meeting held by the dietician on 03/31/25 indicated 9 staff members were in-service on menus and nutritional adequacy. The in-service indicated, .menus are developed and is prepared to meet resident choices including nutritional, religions, cultural, and ethnic needs while using national guidelines .</p> <p>Record review of an In-service held by the dietician on 10/15/24 indicated, .recipes must be followed to ensure that foot item is tasty, cooked properly, and is appealing .</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards in 1 of 1 kitchen reviewed for food service safety.</p> <ol style="list-style-type: none"> The facility failed to ensure all food items were labeled and dated in the walk-in cooler and the walk-in freezer. The facility ensure that the Activity Director Assistant wore a hair net when entering the kitchen and 2 male staff members wore facial hair coverings while assisting with meal preparation. The facility failed to the shelf above the stove top and parts of the oven were clean. <p>These failures could place residents at risk of foodborne illness and food contamination.</p> <p>Findings include:</p> <p>Record review of an R. D. (Registered Dietician) Consultation Report dated 12/30/24 indicated, .Oven, microwave, range top need cleaning .</p> <p>Record review of a Summary Report of Meeting dated 03/31/25 indicated 9 dietary staff members were trained on Food Safety, Menus and Nutritional Adequacy, Infection Control Practices, and Employee Hygiene. The training indicated, .Uses hair restraints and beard guards properly .Practices the first-in, first-out method of inventory rotation .Keeps the refrigerator/freezer clean .Wraps, dates, and labels all foods properly . Demonstrates personal responsibility for maintaining safe and sanitary conditions .Cleans and sanitizes food surfaces thoroughly .</p> <p>During an observation on 06/02/25 at 8:50 a.m., revealed a foul smell in the walk-in cooler. Inside the cooler were 15 foam bowls with lids that were not dated or labeled. Some of the bowls contained a fluffy white food item and some contained unknown fruits. There was 1 small plastic food container containing a round bread with an unknown meat and a yellow slice of an unknown food item inside. There was one plastic container with an unknown cubed meat with no date or label. There was one plastic bag containing unknown chopped nuts with no date or label.</p> <p>During an observation and interview 06/02/25 at 8:56, revealed inside the walk-in freezer there were 2 plastic bags containing unknown oblong brown food item with no date or label. There was 1 bag with an unknown breaded food item with no date or label. There was 1 plastic bag containing a light brown square food item with no date or label. There was 1 plastic bag with an unknown beige food item with no date or label. There was 1 plastic bag with an unknown beige stick shaped food item with no date or label. There was 1 bag of beige, small, unknown smaller food sticks with no date or label. The dietary manager said there was a female staff member that usually kept everything dated or labeled in the freezer and she had been out for surgery. She said there had been a male worker that would not listen that had been doing the job. She said he had just quit, and the other staff worker would be back and take care of the freezer.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an observation on 06/03/25 at 10:45 a.m., revealed both doors on the front of the oven had a brown, greasy build up around the handles and along a long metal piece above the oven doors. There was a brown greasy build up around two of the knobs above the oven door. There was a large brown area built up on the backsplash behind the stove top. There was a dirty greasy build up on the shelf above the stove. There appeared to be drops of grease hanging from the shelf above the stove. The drops were over the stove top where food was being prepared.</p> <p>During an observation on 06/03/25 at 10:49 a.m., Activity Director Assistant entered approximately 4 feet into the kitchen while food was being prepared without a hairnet on.</p> <p>During an interview on 06/03/25 at 10:53 a.m., the Activity Director Assistant said she did not know she had to wear a hair net when she was just stepping into the kitchen. She said she stepped in the kitchen every day without a hairnet to carry in menus. She said no one had ever told her that she had to wear a hair net and did not know where they were.</p> <p>During an interview on 06/03/25 at 11:00 a.m., Dietary Aide D said dietary staff had told the Activity Director Assistant that she needed to wear a hair net in the kitchen in the past.</p> <p>During an observation and interview on 06/03/25 at 11:17 a.m., revealed Dietary Aide E present in the kitchen assisting with meal service. He had a mustache and hair on his chin. He did not have on a facial hair covering. He said he did not wear a facial hair covering because it made him sweat. He said, I am not all about getting all sweaty. It makes me itch.</p> <p>During an observation and interview on 06/03/25 at 11:21 a.m., revealed Dietary Aide F present in the kitchen assisting with meal service. He had a mustache and hair on his chin. He did not wear a facial hair covering. He said he never wore a facial hair covering. He said the only time he wore anything on his face was when he had a cold, and he would wear a mask .</p> <p>During an observation and interview on 06/04/25 at 9:40 a.m., revealed both doors on the front of the oven had a brown, greasy build up around the handles and along a long metal piece above the oven doors. There was a brown greasy build up around two of the knobs above the oven door. There was a large brown area built up on the backsplash behind the stove top. There was a dirty greasy build up on the shelf above the stove. There appeared to be drops of grease hanging from the shelf above the stove. The drops were over the stove top where food was being prepared. The drops were easily wiped off with a finger and were wet and greasy to the touch. [NAME] G was cooking the noon meal on the stove under the shelf. She said the drops were caused by steam from the cooking meal.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 06/04/25 at 9:44 a.m., the Dietary Manager said she expected all facility staff to wear hair nets as soon as they enter the kitchen. She said they used to have beard coverings. She said she had not realized Dietary Aide F even had facial hair. She said she had personally told all staff, including the Activity Director Assistant to not enter the kitchen without a hairnet. She said there used to be a sign on the door that said, Kitchen Employees Only. She said staff not wearing hair coverings could cause hair to get into the resident's food. She said when it rained water puddled in the walk-in cooler. She said the water came in from somewhere outside of the cooler. She said she felt like the water reacted with the floor and caused the foul smell. She said the floor was rusty in places. She said the staff member that usually cleaned the cooler just started back after being on leave and she had just not had a chance to do everything. She said the foam bowls in the cooler was food that had been prepared for the next meal and been placed in the cooler to keep the food cool. She said she thought it was whipped cream and some fruit. She said the foam bowls should have been dated and labeled. She said the cooks were responsible for dating and labeling the foods as they were put away. She said she expected all food to be dated and labeled. She said food not being dated, staff would not know how long it had been in there. She said food not being dated would need to be thrown away and if served it could cause a resident to get sick. She said food not being labeled could cause residents to get spoiled food. She said all equipment including the stove, oven, and the shelf above the stove should be wiped off and cleaned daily. She said the staff that stocked the kitchen, and the cooks should be keeping the equipment clean. She said she did have a cleaning schedule and it was hanging right outside of her door. She said equipment not being clean could make a resident sick and cause their food to be contaminated.</p> <p>During an observation on 06/04/25 at 11:50 a.m., revealed a cleaning schedule hanging on the wall outside of the Dietary Manager's office. The cleaning schedule was for 05/26/25 - 06/08/25. The daily cleaning schedule included cleaning the refrigerator and range. The schedule did not indicate documentation that any staff had completed any daily cleaning task for 05/26/25 - 06/04/25. The weekly cleaning schedule included Range top, Refrigerators - Clean and organize, Freezer - Clean and organize, and undershelves - clean. The schedule did not indicate documentation that any staff had completed any weekly cleaning task for 05/26/25 - 06/04/25.</p> <p>During an interview on 06/04/25 at 1:20 p.m., the Administrator said he expected staff to follow the policy for hairnets. He said no one wants to find a hair in their food. He said once a staff member enters the kitchen, they should have on a hair net. He said he had never heard about water leaking into the walk-in cooler. He said dietary staff were responsible for storing food according to policy. He said they learn all of this when they got their certificates. He said food items not having a date could cause out of date items to be served and cause food borne illness. He said food not having a label could cause staff to not know what the food was. He said it could cause a resident to be served something they dislike or have an allergy too. He said he expected everything in the freezer to be dated and labeled. He said not knowing how long a food item had been in the freezer could lead to freezer burn and ruin the nutritional value of the food. He said the cook was supposed to clean the oven every shift and they had to keep the grease build up off of the equipment. He said grease build up could cause a fire.</p> <p>Record review of a Food Receiving and Storage facility policy last revised 07/2014 indicated, .Foods shall be received and stored in a manner that complies with safe food handling practices .Food Services, or other designated staff, will maintain clean food storage areas at all times .All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date) .</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Golden Villa		STREET ADDRESS, CITY, STATE, ZIP CODE 1104 S William St Atlanta, TX 75551	
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Record review of a Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices facility policy dated 10/2008 indicated, .Food Services employees shall follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness .Hair nets or caps and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils and linens .</p> <p>Record review of a Sanitation of Food Service Department facility policy dated 2005 indicated, .The Food service staff shall maintain the sanitation of the food service department through compliance with a written, comprehensive cleaning schedule .A cleaning schedule shall be posted weekly for all cleaning tasks, and employees will initial tasks as completed .</p> <p>Review of a 2022 Food Code for the U.S. Food and Drug Administration indicated, .2-402 Hair restraints . food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food . Annex 4. Establish First-In-First Out (FIFO) Procedures. Product rotation is important for both quality and safety reasons. First-In-First-Out (FIFO) means that the first bath of product prepared and placed in storage should be the first one sold or used. Date marking food as required by the Food Code facilitates the use of a FIFO procedure in refrigerated, ready-to-eat, TCS (temperature control storage) foods. The FIFO concept limits the potential for pathogen growth, encourages product rotation, and documents compliance with time/temperature requirement .</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 22 residents (Residents #4) reviewed for infection control practices.</p> <p>The facility failed to ensure CNA B did not contaminate Resident #4, Resident #4's clothing, clean brief, clean incontinent pad, bedding, and bed remote after CNA B had performed incontinent care.</p> <p>These failures could place residents at risk for cross contamination, at an increased risk of infection, and the spread of infection.</p> <p>Findings included:</p> <p>Record review of Resident #4's face sheet dated 6/03/25 indicated he was [AGE] years old and admitted to the facility on [DATE]. Resident #4 had diagnoses which included dementia (forgetfulness), heart disease, diabetes (high blood sugar), hemiplegia (complete or severe loss of motor function on one side of the body), and cerebrovascular disease (condition impacting the brain's blood vessels and blood flow resulting in brain tissue death).</p> <p>Record review of Resident #4's quarterly MDS dated [DATE] indicated Resident #4 had a BIMS of 6 which indicated he had severe cognitive impairment. The MDS indicated Resident #4 required substantial assistance of staff for toileting hygiene and most ADLs. The MDS indicated Resident #4 was always incontinent of urine and bowel.</p> <p>Record review of Resident #4's undated Care Plan indicated he was at risk for skin breakdown related to episodes of bowel and bladder incontinence.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 6/03/25 beginning at 1:15 PM, CNA B performed incontinent care assisted by CNA C. Upon entering Resident #4's room, CNA B and CNA C washed their hands and donned (put on) gloves. Then CNA C pulled Resident #4's bed away from the wall and CNA C went between the wall and Resident #4's bed. CNA B placed a trash bag at the end of bed. CNA B and CNA C removed Resident #4's pants by rolling him back and forth. CNA B then opened Resident #4's brief and pushed it down between his legs and then used a washcloth with soap and water to clean Resident #4's front perineal (private) area, folding to a clean area of the washcloth with each wipe. CNA B then used a washcloth with water only to rinse the soap off Resident #4's front perineal area and then dried his front perineal area with a towel. CNA B then rolled Resident #4 toward the wall by placing same gloved hands used to perform incontinent care to his front perineal area on his shoulder and hip. CNA C held Resident #4 facing the wall while CNA B cleansed his bottom perineal area. CNA B then asked CNA C to go get additional washcloths and towels. While CNA C stepped out of Resident #4's room, CNA B, without changing her gloves and/or performing hand hygiene, rolled a clean incontinent pad and brief and placed on his bed. CNA B then used her same gloved hands to push Resident #4 over further by placing her same gloved hand on the back of his shirt, then dried his back perineal area with a towel, and then pushed a clean brief under him. CNA B then removed her soiled gloves and put on new gloves (she did not perform hand hygiene) and placed a clean incontinent pad under Resident #4's clean brief. CNA B then cleaned Resident #4's front perineal area again because he had urinated again and then dried him. CNA B then used the same gloved hands placed on Resident #4's shoulder and hip to pull him toward her, fastened his brief, then removed his t-shirt from over his head. CNA B, using the same gloved hands, then grabbed his hands and pulled his hands through the sleeves of a gown, tied the gown string around his neck, and then pulled the gown down over his body and covered with a sheet. CNA B, using the same gloved hands, then used Resident #4's bed remote to put the head of the bed down and CNA B and CNA C used the clean incontinent pad to pull Resident #4 up in bed. CNA B then removed her gloves and used the bed remote to let Resident #4's bed back down.</p> <p>During an interview on 6/03/25 at 1:40 PM, CNA C said she had worked at the facility since February 2025 and normally worked on the 6 AM to 2 PM shift. CNA C said staff should change their gloves and sanitize their hands after every procedure during incontinent care, after cleaning the front perineal (private) area, change gloves and sanitize hands, then clean the back perineal area, and change gloves and sanitize hands. CNA C said staff should change gloves and sanitize their hands after performing incontinent care and before handling clean items, such as the resident's clothes, bedding, and bed remote. CNA C said whatever was just cleaned off the resident would be transferred back onto the resident if staff did not change their gloves and sanitize their hands. CNA C said CNA B did not change her gloves or sanitize her hands after performing incontinent care and before touching the resident's clothes, bedding, and bed remote. CNA C said CNA B transferred bacteria back to Resident #4 and could cause him an infection. CNA C said CNA B just transferred and cross-contaminated Resident #4's room and bedding and anything CNA B touched without changing her gloves or sanitizing her hands. CNA C said anytime staff touch anything dirty they should change gloves and sanitize their hands.</p> <p>During an interview on 6/03/25 at 1:55 PM, CNA B said she had worked at the facility since January 2024 and normally worked on the 6 AM to 2 PM shift. CNA B said she should have changed her gloves and sanitized her hands anytime when going from a dirty area to a clean area during incontinent care. CNA B said she did not change her gloves or perform hand hygiene after cleaning Resident #4's front perineal (private) area and did not follow the proper steps. CNA B said she could transfer germs that she cleaned off Resident #4 to anywhere she touched in his room. CNA B said not changing her gloves or sanitizing her hands after performing incontinent care and then touching the resident, his clothing, bedding, and bed remote, could make him sick. CNA B said it was an infection control issue.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/04/25 at 9:50 AM, the DON said staff should change their gloves and sanitize their hands when going from a dirty area to a clean area when performing incontinent care. The DON said staff should remove their gloves and sanitize their hands and after cleaning the resident and before touching the resident's cloths, sheets, linens, and stuff like that. The DON said by not changing her gloves and performing hand hygiene appropriately, CNA B placed the resident at risk of infection and cross-contaminated his room.</p> <p>During an interview on 6/04/25 at 10:08 AM, the ADM said he expected staff to follow the facility's hand hygiene policy and change gloves per their policy during incontinent care. The ADM said staff should not touch the bedding, resident, or anything clean after performing incontinent care with the same gloves used during the incontinent care. The ADM said not changing gloves after performing incontinent care and then touching the resident, his bedding, and other items in the resident's room, could cause transmission of germs and a major infection for the resident. The ADM said it was an infection control issue.</p> <p>Record review of the facility's CNA Performance and Skills Evaluation of CNA B dated 12/31/24 had a S marked in the columns which indicated CNA B had satisfactory performed the procedures of perineal care, dressing and undressing resident, infection control- using/understanding universal precautions, used correct hand washing techniques, handled linen clean and dirty correctly, understood/used personal protective equipment .</p> <p>Record review of the facility's undated policy titled Infection Control Policy indicated . the facility had established and maintained an infection control program designed to provide a safe, sanitary and comfortable environment . to help prevent development and transmission of disease and infection . all employees were required to wash their hands after each direct resident contact for which hand washing was indicated by accepted professional practice .</p> <p>Record review of the facility's policy titled Perineal Care dated revised October 2010 indicated . the purpose of this procedure was to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition . steps in the procedure . wash and dry your hands thoroughly . fold the bedspread or blanket toward the foot of the bed . fold the sheet down to the lower part of the body . put on gloves . for a male resident . wash perineal area (private area) starting with the urethra (opening at head of penis) working outward . wash and rinse the rectal area thoroughly . remove gloves and discard . wash and dry hands thoroughly . reposition the bed covers, make the resident comfortable . wash and dry your hands thoroughly .</p> <p>Record review of the facility's policy titled Handwashing/Hand Hygiene dated revised August 2015 indicated . the facility considered hand hygiene the primary means to prevent the spread of infections . all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors . wash hands with soap and water for the following situations . when hands are visually soiled . use alcohol-based hand rub . or soap and water in the following situations . before and after direct contact with residents . before moving from a contaminated body site to a clean body site during resident care . after contact with blood or bodily fluids . after contact with objects in the immediate vicinity of the resident . the use of gloves does not replace hand washing/hand hygiene . integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections .</p>		