

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676097	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/08/2025
NAME OF PROVIDER OR SUPPLIER  Golden Creek Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2100 Dover Crossing Lane Navasota, TX 77868	

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 0609  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.  (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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure that all alleged violations involving injuries of unknown source were reported immediately, but not later than 2 hours after events to the State Survey Agency for 1 (Resident #1) of 4 residents reviewed for injury of unknown origin. The facility failed to report to HHSC when Resident #1 was found with a head laceration of unknown origin requiring staples on [DATE]. This failure placed residents at risk of abuse and neglect. Findings included: Review of the undated face sheet for Resident #1 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included dementia. It also reflected he was on hospice and expired on [DATE]. Review of the quarterly MDS for Resident #1 dated [DATE] reflected a BIMS score of 00, indicating severe cognitive impairment. It reflected he had physical and verbal behavior symptoms four to six days out of the seven-day assessment period. It also reflected he had fallen once with and once without injury since admission. Review of the care plan for Resident #1 dated [DATE] reflected the following: The resident is Moderate risk for falls r/t Confusion, Unaware of safety needs, Wandering. Review of progress notes for Resident #1 dated [DATE] at 9:15 PM and documented by RN A reflected the following: CNA found resident sleeping in bed in next room. Had 3.5 by 1/2cm laceration on back of head which had been bleeding. Resident unable to verbalize how he got the injury. Blood was also found on floor by nightstand of other bed in room. Resident would not stand to move back to his room so was placed in wheelchair to move him. Notified MD who ordered send to ER, called on call nurse then on call [nurse practitioner] who said OK to send. Called DON then EMS. Notified RP of findings and plan. She questioned how he keeps falling and why he isn't being watched. Told her he is being watched and had been sleeping in own bed approximately 30 to 60 minutes prior. Requested to be notified when he returns. She called back few minutes later questioning about what room he had been in and color of female. Explained to her there were 2 females in room, the white one by door was in her bed, and he was sleeping in bed by window which was empty. Due to resident medical condition, she was unable to tell anything about incident. Review of an incident report dated [DATE] and completed by RN A included the text of the above progress note and the following: Injuries Observed at time of incident- No injuries observed at time of incident. Injuries Observed Post-Incident- No injuries observed post incident. Notifications: nurse practitioner, DON, MD, and RP. Review of ER records for Resident #1 dated [DATE] reflected the following: Scalp laceration. The four staples need to be removed in 7 days. OK to give Tylenol 1000 mgs every six hours as needed for pain. CT Brain and CT-C Spine negative for intracranial bleed and fracture. Review of progress notes for Resident #1 dated [DATE] at 1:19 AM reflected the following: Resident returned to the facility @ 0100 (1:00 AM). He is stable. No bleeding from the laceration back of the head. Staples to be removed in 7 days. Tylenol 1000 mg prescribed PRN for pain. All parties notified of his return to the facility. Review of assessments for Resident #1 reflected neurological checks performed for 72 hours after returning from the hospital on [DATE]. Review of the HHSC database on [DATE] reflected a facility-reported incident called in on [DATE] in which Resident #1 presented with a scalp laceration of unknown origin on [DATE] and received one staple. There was no facility reported incident for the scalp laceration of unknown origin discovered on [DATE] which required four staples. During an interview on [DATE] at 12:30 PM, a FM for Resident #1 stated she had received a call from the facility notifying her that Resident #1 had been found in another resident's (empty) bed with a laceration to his head and had been taken to the ER, where he had received staples to his head laceration. An attempt was made to interview RN A on [DATE] at 1:00 PM. A voicemail was left but no return call had occurred as of [DATE]. During an interview on [DATE] at 1:05 PM, CNA B stated she had worked a double that day and had been in rounds all afternoon. She stated she had just done a round and seen Resident #1 in his room less than an hour before, and then she did some documentation at the nurse's station and then came back down to do another round and found Resident #1 in another resident's empty bed with a big cut on his head. She stated she reported to the nurse on duty and Resident #1 went to the hospital. She stated she was off work by the time Resident #1 came back, but she found out he did get staples. She stated he was hard to predict, and they had to put eyes on him once per hour. She stated he might sit still in his room for a couple hours and then suddenly, he would be ready to walk. CNA B stated he refused to be accompanied or to use any mobility equipment, and they tried everything to keep him from walking unassisted, but he would curse and sometimes even physically assault the aides when they tried to assist him. During an interview on [DATE] at 2:44 PM the ADM who stated she</p>		