STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676097	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Creek Healthcare and Rehabilitation Center	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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for one (Resident #1) of ten residents reviewed for care plans. The facility failed to ensure a comprehensive care plan was developed for Residents #1 that addressed physician ordered orthopedic devices, behaviors involving orthopedic devices, and an ordered sitter during scheduled dialysis. This failure could place residents at risk for not attaining the highest practicable well-being possible. Findings Include:Review of Resident #1's face sheet, dated 08/06/25, reflected a [AGE] year-old female, admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including dependance on renal dialysis (occurs when a person's kidneys are no longer able to adequately filter waste and excess fluid from the blood, necessitating regular dialysis treatments to sustain life), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), and unspecified psychosis not due to a substance or known (indicates a psychotic disorder where the cause is not clearly identified as being due to substance use or a medical condition). Review of Resident #1's care plan, revised on 04/03/25, reflected Resident #1 needed dialysis related to renal failure. Resident #1's care plan did not reflect the dialysis MD order that required Resident #1 have a sitter during her dialysis treatments. Resident #1's care plan did not reflect her orders for ordered orthopedic devices of resting hand splint and palm protector on LUE or behaviors involving orthopedic devices. Review of Resident #1's Resident Assessment and Care Screening MDS dated [DATE] reflected a BIMS score of 8 indicating moderate cognitive impairment. Review of Resident #1's physical therapy order, dated 05/22/23, reflected Resident #1 was to wear resting hand splint on left hand don (to put on, specifically clothing or equipment) after breakfast and doff (to take off, specifically clothing or equipment) after lunch as tolerated. Resident #1 was also ordered skin checks by nursing, pre and post wear, and report any changes immediately every day and evening shift. Review of Resident #1's physical therapy order, dated 07/06/25, reflected Resident #1 was to wear palm protector on LUE. [NAME] splint after lunch and doff splint before dinner and skin checks pre and post splint wear and report any concerns immediately every day and evening shift for therapy.Review of Resident #1's MD dialysis order dated 12/19/24 reflected patient must be accompanied by a sitter for all dialysis treatments for safety. Interview on 08/06/25 at 11:08 am with a Dialysis Nurse A, via telephone, from Resident #1's dialysis clinic, reflected the dialysis MD said Resident #1 needed a sitter during her dialysis treatments because Resident #1 pulled out her needle and had been sent to the hospital because she lost a lot of blood. The dialysis nurse said sometimes Resident #1 had a sitter from the facility and sometimes the sitter was a family member. The dialysis nurse said Resident #1 missed 2 dialysis appointments (she said she could not recall the dates) because Resident #1 did not have a sitter, and they sent Resident #1 back to the facility without dialysis. She said if Resident #1 missed treatments Resident #1 could have a buildup of potassium and increased confusion because of toxin build up and an increase in fluid overload. She said she was not informed by the facility of any negative side effects because of Resident #1's missed dialysis appointments, and she said that she was not concerned about Resident #1 and fluid overload because Resident #1 was usually underweight when she was weighed at dialysis.Interview on 08/06/25 at 1:14 pm with the OTA revealed Resident #1's orthopedic devices were ordered to prevent future contractions, problems with skin integrity, and to not lose hand range of motion. Interview on 08/07/25 at 2:06 pm with CNA reflected Resident #1 was constantly taking off her orthopedic devices and he informed the nurses of this behavior. Interview on 08/06/25 with LVN B at 12:38 pm reflected a care plan was how the facility was caring for residents and should be very detailed. She said the LVNs and DON were responsible for resident care plans. LVN B said Resident #1 did tend to rip off the orthopedic devices. She said it was a part of her job to report Resident #1 was not wearing her orthopedic devices and this behavior needed to be care planned. She said care planning was important for residents to get the proper care they needed and avoid a negative effect. Interview on 08/06/25 at 3:33 pm with the MDS Coordinator revealed she was the person who was overall responsible for the care plans. She said a care plan paints a picture of what the resident needs. She said a care plan should absolutely be person centered and include resident behaviors and diagnoses. She said she worked the floor sometimes doing resident care. She stated staff talked about resident behaviors in the

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident with limited mobility received appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable for one of five residents (Resident #1) reviewed for quality of care.The facility failed to ensure Resident #1, on 08/06/25, was wearing her physical therapy ordered resting hand splint for left hand. This failure could place residents at risk of not maintaining the mobility necessary maintain the highest practicable well-being. Findings Include:Review of Resident #1's face sheet dated 08/06/25 reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dependance on renal dialysis (occurs when a person's kidneys are no longer able to adequately filter waste and excess fluid from the blood, necessitating regular dialysis treatments to sustain life), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), and unspecified psychosis not due to a substance or known (indicates a psychotic disorder where the cause is not clearly identified as being due to substance use or a medical condition).Review of Resident #1's care plan reflected Resident #1 had a care plan focus revision dated 04/21/2025 of activities of daily living self-care performance deficit related to history of CVA (a medical term for stroke) with increased weakness impaired cognition. Intervention dated 04/18/2025 monitor/document/report to medical doctor as needed signs and symptoms of immobility: contractures forming or worsening.Review of Resident #1's Resident Assessment and Care Screening MDS dated [DATE] reflected a BIMS score of 8 indicating moderate cognitive impairment. Review of Resident #1's physical therapy order dated 05/22/23, no discontinued date, reflected Resident #1 was to wear resting hand splint on left hand don (to put on, specifically clothing or equipment) after breakfast and doff (to take off, specifically clothing or equipment) after lunch as tolerated and skin checks by nursing pre and post wear and report any changes immediately every day and evening shift.Review of Resident #1's eMAR dated 08/06/25 documented by LVN B for Resident #1 to wear resting hand splint on left hand don (to put on, specifically clothing or equipment) after breakfast and doff (to take off, specifically clothing or equipment) after lunch as tolerated and skin checks by nursing pre and post wear and report any changes immediately every day and evening shift reflected hand splint applied to left hand. Observation on 08/06/25 at 12:10 pm with LVN B of Resident #1's left hand reflected no hand splint.Interview on 08/06/25 at 12:38 pm with LVN B reflected facility policy was that nurses documented in the eMAR that a treatment had been administered after it had been administered. She stated she did not put Resident #1's resting hand splint on her left hand but documented that she had done so. LVN B said usually the aides were good and knew when to put on resident orthopedic devices. She said she charted it was on, but it was off, and she should have made sure it was on. She said it was her responsibility to make sure that Resident #1's orthopedic hand splint was on Resident #1 because obviously it was not. She said if Resident #1's hand splint was not applied; Resident #1 could suffer a hand contracture. Interview on 08/06/25 at 1:14 pm with the OTA revealed Resident #1's orthopedic devices were ordered to prevent future contractions, problems with skin integrity, and to not lose hand range of motion. Interview on 08/07/25 at 2:06 pm with CNA reflected Resident #1 was constantly taking off her orthopedic devices and he informed the nurses of this behavior.Interview on 08/06/25 at 4:21 pm with the ADON reflected nurses document in the eMAR after resident care had been done and on completion of the task. A potential problem of not confirming that a task had been completed was mis-documentation of records and giving the wrong information to oncoming staff, resident injury, or medication error. It was the responsibility for the nursing administration, the ADON and the DON to make sure that all nurses are documenting properly in resident eMAR. Interview on 08/06/25 at 4:21 pm with ADON C reflected nurses documented in the eMAR after care had been given to the resident. It was a problem when you documented that care had been done when it had not been done because that was falsifying documentation. She said the negative effect of documenting care that was not received would be that the resident would not get the most proper or efficient care. She said it was the responsibility of everyone to make sure that the residents' care was documented accurately. Interview on 08/06/25 at 4:58 pm with the DON reflected it was important that nurses did not document care that a resident did not receive. It was not good nursing care or quality of care to document care that you did not give to a resident. The negative effect of documenting care was given when it was not given was that it could affect MD orders and

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure, in accordance with accepted professional standards and practices, that the facility maintained medical records on each resident that were accurately documented for one of five residents (Resident #1) reviewed for medical records.The facility failed to accurately document Resident #1's application of her orthopedic device and dialysis wound dressing removal.This failure could place residents at risk of not identifying or receiving care, for unassessed changes in conditions and improper documentation of treatments.Findings Include:Review of Resident #1's face sheet dated 08/06/25 reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dependance on renal dialysis (occurs when a person's kidneys are no longer able to adequately filter waste and excess fluid from the blood, necessitating regular dialysis treatments to sustain life), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), and unspecified psychosis not due to a substance or known (indicates a psychotic disorder where the cause is not clearly identified as being due to substance use or a medical condition).Review of Resident #1's care plan revised on 04/03/25 reflected Resident #1 needed dialysis related to renal failure.Review of Resident #1's Resident Assessment and Care Screening MDS dated [DATE] reflected a BIMS score of 8 indicating moderate cognitive impairment. Review of Resident #1's face sheet dated 08/06/25 reflected a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dependance on renal dialysis (occurs when a person's kidneys are no longer able to adequately filter waste and excess fluid from the blood, necessitating regular dialysis treatments to sustain life), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), and unspecified psychosis not due to a substance or known (indicates a psychotic disorder where the cause is not clearly identified as being due to substance use or a medical condition).Review of Resident #1's care plan revised on 04/03/25 reflected Resident #1 needed dialysis related to renal failure.Review of Resident #1's Resident Assessment and Care Screening MDS dated [DATE] reflected a BIMS score of 8 indicating moderate cognitive impairment. Review of Resident #1's order dated 05/22/23, no discontinued date, reflected Resident #1 was to wear resting hand splint on left hand don (to put on, specifically clothing or equipment) after breakfast and doff (to take off, specifically clothing or equipment) after lunch as tolerated and skin checks by nursing pre and post wear and report any changes immediately every day and evening shift.Review of Resident #1's eMAR dated 08/06/25 documented by LVN B for Resident #1 to wear resting hand splint on left hand don (to put on, specifically clothing or equipment) after breakfast and doff (to take off, specifically clothing or equipment) after lunch as tolerated and skin checks by nursing pre and post wear and report any changes immediately every day and evening shift reflected hand splint applied to left hand. Observation on 08/06/25 at 12:10 pm with LVN B of Resident #1's left hand reflected no hand splint.Review of Resident #1's order dated 04/09/24 reflected remove dressing from AV Fistula (an abnormal connection between an artery and a vein) site left arm post dialysis the following day of Resident #1's dialysis. Record review of Resident #1's progress note by LVN A dated Wednesday 06/09/25 reflected Resident returned from dialysis via EMS, Resident did not receive dialysis due to family not showing up. Resident stable and in good spirits. Record review of Resident #1's eMAR dated Thursday 06/10/25 documented by LVN A reflected dressing was removed from AV Fistula (an abnormal connection between an artery and a vein) site left arm post dialysis.Record review of Resident #1's progress note by LVN A dated Thursday 07/07/25 reflected Notified by EMS transporters that resident was refusing to go with them to be transported to dialysis. Spoke with resident, she stated she was tired and would not go to dialysis today.Record review of Resident #1's eMAR dated Friday 07/08/25 documented by LVN A reflected dressing was removed from AV Fistula (an abnormal connection between an artery and a vein) site left arm post dialysis.Record review Resident #1's progress note by the DON dated Monday 07/11/25 reflected Resident unable to dialyze, returned to facility. Notified daughter and MD, resident in stable condition.Record review of Resident #1's eMAR dated Wednesday 07/12/25 documented by LVN A reflected dressing was removed from AV Fistula (an abnormal connection between an artery and a vein) site left arm post dialysis.Interview on 08/06/25 at 12:38 pm with LVN B reflected facility policy was that nurses documented in the eMAR that a treatment had been administered after it had been administered. She stated she did not put Resident #1's resting hand splint on her left hand but documented that she had done so. LVN