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	04/28/2026

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the residents' right to privacy during personal care for 1 resident (Resident #1) of 12 residents (Resident #1) reviewed for privacy and confidentiality.The facility failed to ensure Resident #1's privacy curtain was used and the door to his room was closed when CNA A was providing incontinent care. This failure could place residents at risk of feeling embarrassed and diminishing the resident's quality of life.Findings Included:Record review of Resident #1's face sheet, dated 04/28/2026, reflected a [AGE] year-old male admitted to the facility on [DATE] with the following diagnoses: Parkinson's disease (progressive neurological disorder that primarily affects movement), Multiple Sclerosis (autoimmune disease that affects the nervous system), protein-calorie malnutrition (inadequate intake of both protein and calories), type 2 diabetes mellitus with hyperglycemia (high blood sugar), major depressive disorder (mental health disorder characterized by persistent depressed mood), and muscle weakness.Record review of Resident #1's Quarterly MDS Assessment, dated 02/11/2026, reflected Resident #1 had a BIMS score of 13 indicating intact cognitive response. Resident #1 was dependent on staff for the following ADLs: toileting hygiene, and lower and upper body dressing.Record review of Resident #1's Comprehensive Care Plan, revised on 01/11/2026, reflected Resident #1 was on an anti-depression medication related to major depressive disorder (recurrent mild). Intervention: Use the resident preferred name. Identify yourself at each interaction. Face the resident when speaking and make eye contact. Reduce any distractions- turn off TV, radio, and close the door. The resident understands consistent, simple, directive sentences. Provide the resident with necessary cues- stop and return if agitated. The care plan also revealed Resident #1 had an ADL self-care performance deficit related to Parkinson's and multiple sclerosis. Interventions were Report any changes to the nurse. Use short, simple instructions: Encourage the resident to fully participate as possible as tolerated with each interaction. Praise all effort at self-care. During an observation of hall one on 04/28/2026 at 4:08a.m., CNA A was providing incontinent care to Resident #1. CNA A had the resident's room door open and did not pull the privacy curtain therefore exposing Resident #1 who was nude from the waist down.During an interview with CNA A on 04/28/2026 at 4:16a.m., she said she had been trained on resident rights. She said she just did her certification three months ago. She said she did not remember what was covered in the training. She said the policy for providing privacy when providing incontinent care was that staff were to knock and pull the privacy curtain depending on the care she was providing. She also said she was supposed to close the door to the resident's room. She said all staff were responsible for providing the resident with privacy. She said if staff did not provide privacy to the resident, the resident may feel exposed or unsafe. She said the nurse monitored to ensure staff were providing privacy during care. She said the nurse monitored through observation. She said she did not have a reason for not providing privacy to Resident #1.During an interview with Resident #1 on 04/28/2026 at 7:20a.m., he said staff often leave his door open when providing care on the night shift. He said he wanted staff to pull the curtain and close the door every time he was provided with incontinent care. He said it upset him when staff changed him and did not close the door or pull the curtain closed.During an interview with the ADON on 04/28/2026 at 8:18a.m., she said she had been (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	trained on resident rights. She said she had the training in the last month. She said the policy was that staff were to have the curtain pulled and the door always closed when providing incontinent care. She said whoever provided care to the resident was responsible for providing privacy. She said if staff did not provide privacy during incontinent care the resident may feel embarrassed. She said all the directors monitored to ensure that staff were providing privacy when giving incontinent care. She said the directors monitored by walking up and down the halls. She said she did not know why CNA A did not close the door or pull the curtain when she provided incontinent care to Resident #1.During an interview with the DON on 04/28/2026 at 8:42a.m., she said she had been trained on resident rights. She said she last had the training in September 2025. She said the policy was that all staff were to provide privacy to the resident when giving care. She said the aides were responsible for providing privacy to the resident when providing incontinent care. She said the resident would feel embarrassed if staff did not provide privacy during incontinent care. She said if a resident was alert, oriented or not cognitive it did not matter, staff were to provide privacy to the resident. She said the DON and ADON monitored to ensure staff are providing privacy when doing incontinent care. She said the DON and ADON monitored through observations. She said she thought CNA A did not take the time and thought about what she was doing when she did not close the door or the privacy curtain when providing incontinent care.During an interview with the ADM on 04/28/2026 at 1:05p.m., she said she had not been trained on incontinent care. She said her expectation on incontinent care was that the residents are provided with incontinent care as needed. She said her expectation was that staff provide the resident with privacy while getting incontinent care. She said the nursing staff that was providing care for the resident at the time was responsible for providing privacy. She said the resident may not feel particularly good or embarrassed. She said the nurses, ADON and DON monitored to ensure staff are providing privacy during incontinent care. She said the ADON, DON and Nurses monitored during rounds, and competency check offs. She said she did not know why CNA A did not provide privacy to Resident #1. Record review of Perineal Care Policy dated 03/03/2026 revealed The purposes of this procedure are 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:1. Place the equipment on the bedside stand. Arrange the supplies so they can be easily reached.2. Explain procedure to resident.3. Provide privacy4. Wash hands and apply gloves. Toilet resident if on toileting program (even if wet) and or remove brief.5. Place bed protector under resident's buttocks. Record review of Resident Rights Policy dated 03/06/2026 revealed The following rights are guaranteed to residents of Texas nursing facilities under federal law and Texas law. Facilities are required to protect and promote these rights for every resident. Privacy and Confidentiality To privacy during personal care, visits, and phone calls.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to make sure that drugs were stored properly, and only authorized persons have access for 3 of 5 medication carts (MC #1, MC #2, and MC #3) reviewed for drug storage.The facility failed to ensure MC #1, was locked, medications secured, and not accessible to other staff, residents, or visitors.The facility failed to ensure MC #2, was locked, medications secured, and not accessible to other staff, residents, or visitors.The facility failed to ensure MC #3, was locked, medications secured, and not accessible to other staff, residents, or visitors.This failure could place residents at risk of having unauthorized access to medications, decreased effectiveness of medication, or missing medications.Findings included:During an observation on 04/28/2026 at 4:00a.m., revealed MC #1, MC #2, and MC #3, were along the wall on the nurses' station and unlocked. LVN B walked right past all three medication carts and did not lock them. MC #1, MC #2, and MC #3 contained residents' prescription drugs, over the counter medications, and narcotics in a locked box.During an interview with LVN B on 04/28/2026 at 04:13a.m., he said he had been trained on medication storage. He said the policy was staff must lock the medication carts any time the nurse was not in the cart or out of sight of the cart. He said the nurse was responsible for locking the medication cart. He said if staff left the medication cart unlocked and unattended someone could steal medication. He said all staff monitored to ensure that the medication carts were locked. He said staff monitored the medication carts through observation. He said he left the medication cart unlocked because he was monitoring them. He said he did not see the surveyor taking pictures and opening the drawers on the medication carts. He said the medication carts should have been locked.An observation of the nurses' station on 04/28/2026 at 4:49a.m., revealed MC #3 was unlocked. There were no staff members around or near the medication cart. Two residents were up in their wheelchairs about 50 feet from the medication cart.During an interview with LVN C on 04/28/2026 at 4:57a.m., he said he had been trained on medication storage. He said the training covered safety. He said the policy for the medication carts were safety first. He said he was responsible for ensuring the medication cart was locked. He said he had a key, and he was only on the locked down unit for two minutes. He said he could not see MC #3 from behind the secured door. He said he understood that when he left the medication cart alone someone could do anything with the medication cart. He said all staff monitored to ensure the medication carts were locked. He said they monitored because the nurses have the key. He said he left the cart unlocked for three minutes to give some medicine to a resident. He said the best thing to do was to lock the medication cart.Observation of hall four on 04/28/2026 at 5:27a.m., revealed that LVN B was in a residents room with the door cracked open and the medication cart was along the wall unattended and unlocked.During an interview with the ADON on 04/28/2026 at 8:15a.m., said she had been trained on medication administration. She said she last had the training in March. She said the medication cart policy was that the carts should always be locked if the nurse or medication aide was not standing in front of them. She said the nurse or medication aide assigned to the cart was responsible for locking the medication cart. She said a lot can happen if the cart was left unlocked and unattended. She said of course anyone could get into the medication carts. She said the DON, ADON and ADM monitored to ensure the carts were locked. She said the DON, ADON and ADM monitored through observation. She said she did not know why LVN B and LVN C kept leaving the medication carts unlocked.During an interview with the DON on 04/28/2026 at 08:31a.m., she said she had been trained on medication storage. She said the policy was that the medication cart was to be locked when staff were not in or around the medication cart. She said the person who was on the medication cart was responsible for ensuring the medication cart was locked. She said if the medication cart was left unlocked and unattended a resident could get into the cart and take medications that did not belong to them. She (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	said the DON and ADON monitored to ensure staff were locking the medication cart. She said the ADON and DON monitored by doing observations. She said she did not know why LVN B and LVN C left the medication carts unlocked.During an interview with the ADM on 04/28/2026 at 1:01p.m., revealed she had not been trained on medication administration. She said her expectation was for the medication carts to be always locked when not attended. She said the person who utilized the cart at that time was responsible for locking the cart. She said if left unattended and unlocked someone who was not authorized would have access to the cart. She said the DON and ADON should be monitoring to ensure the carts are locked. She said the DON and ADON monitored through rounds. She said she did not know why LVN B and LVN C left the medication carts unlocked.Record review of Storage of Medications Policy dated 06/24/2025 revealed The facility stores all drugs and biologicals in a safe, secure, and orderly manner. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light, and humidity controls. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use. Unlocked medication carts are not left unattended.