STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675233	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Care at Golfcrest	6150 S Loop East Houston, TX 77087

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not 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 out of 4 staff (CNA A) and 2 of 3 residents (Resident #3 and Resident #4) reviewed for infection control.CNA A failed to place Resident #3's Hoyer transfer sling and bed sheets in the appropriate linen barrel after use and placed them in the rubbish bin at the resident's bedside.CNA A failed to place Resident #4's bed blanket in the appropriate linen barrel and tried to replace it on the resident's bed after it had been lying on the floor. These failures could place residents at risk for cross contamination, infection and decline in health. Findings include: Resident #3Record review of Resident #3's admission Record revealed she was a [AGE] year old female who admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis of sepsis (a systemic infection with life threatening organ dysfunction), quadriplegia (a medical condition characterized by the partial or complete loss of movement and sensation in all four limbs), cerebral edema (a condition where excessive fluid accumulates in the brain tissue, causing it to swell), methicillin-resistant staphylococcus aureus (a strain of bacteria that is resistant to the antibiotic methicillin and other similar antibiotics), tracheostomy status (a surgical procedure that creates an opening in the front of the neck into the windpipe for breathing), pressure ulcer of sacral region, stage 4 (a severe wound that involves full-thickness skin and tissue loss with exposed underlying structures like muscle, tendon, ligament, cartilage or bone), and gastrostomy (a surgical procedure that creates an opening in the abdominal wall directly into the stomach that allows a tube to be inserted into the stomach for feeding). Record review of Resident #3's Modified admission MDS dated [DATE] revealed she had a Staff Assessment for Mental Status (SAMS) and was coded as being severely impaired in cognitive skills for daily decision making. She was dependent on staff for assistance with all ADLs. Record review of Resident #3's physician order summary dated active orders as of 10/08/2025 revealed the following order: enhanced barrier precautions for wounds, and had a start date of 9/13/2025, with no stop date. Interview and observation on 10/7/25 at 11:55 a.m., with LVN A who came to Resident #3's bedside to view the linens stuffed inside the resident's bedside rubbish bin, LVN A said she was not sure what the linens were or how they got there, but they did not belong in the bin because that was not the correct place for dirty or clean linens. LVN A said Resident #3 was at increased risk for infection because of her medical conditions and the linens could be a source of infection if they left in the room improperly. LVN A left to retrieve CNA A, the Administrator and the DON. Observation and interview on 10/7/25 at 12:08 p.m., with the Administrator, DON and CNA A in Resident #3's room, CNA A said she was assigned to Resident #3 and did not know how the items ended up in the rubbish bin at the resident's bedside and that they did not belong there. CNA A was asked to remove the items inside the trash bin which revealed a soiled Hoyer lift sling and a soiled yellow stained white bedsheet. Both items appeared to be wet and saturated with liquid. CNA A repeated that the items did not belong in the rubbish bin and that she did not know how the items got inside the trash bin. CNA A tried to bring a linen barrel to Resident #3's bedroom door to remove the linens but the Administrator and DON arrived at the resident's room prior to the removal of the items. The DON removed the bundled items with her gloved hands, that CNA A had placed back into the bedside trash bin and said it was a soiled Hoyer sling used for resident transfers and a soiled bedsheet. The DON said they did not belong inside a resident's bedside trash bin because it could spread infection if not handled and disposed of properly. The DON said the IP would do an immediate reeducation with assigned staff member CNA A. The Administrator asked what the items were and when shown the soiled linens, by the DON said they did not belong inside the trash bin and he and the DON would speak with the staff member involved and retrain them because staff had been trained on how to handle and dispose of linens properly as part of infection control training. The Administrator said leaving soiled linens in a trash bin in any resident room could spread infection. CNA A was observed speaking with the DON, LVN A and the Administrator while she began removing the soiled linens out of the trash bin and placing them in the required linen receptacle. Resident #4 Record review of Resident #4's admission Record revealed he was an [AGE] year-old male who admitted to the facility on [DATE] and readmitted to the facility 9/17/25 with a diagnosis of acute and chronic respiratory failure (a condition where a person with an underlying chronic respiratory disease experiences a sudden and severe worsening of their breathing), colostomy (a surgical operation in which a piece of the

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0919 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 the facility was adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from each resident's bedside.Based on observation, interview and record review, the facility failed to ensure the facility was adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from each resident's bedside for 1 out of 10 (Resident #2) of the residents reviewed for call-lights. The facility failed to ensure Resident #2 had a functioning call light, the call light was empty inside the device, presenting only the white outer coating. This failure could lead to residents not being able to request and receive prompt medical care and result in injury and harm.Findings included:Record review of Resident #2's face sheet, dated, reflected an [AGE] year-old female originally admitted to the facility on [DATE] and last re-admitted [DATE] with a diagnosis of (a systemic infection with life threatening organ dysfunction), quadriplegia (a medical condition characterized by the partial or complete loss of movement and sensation in all four limbs), cerebral edema (a condition where excessive fluid accumulates in the brain tissue, causing it to swell), methicillin-resistant staphylococcus aureus (a strain of bacteria that is resistant to the antibiotic methicillin and other similar antibiotics), tracheostomy status (a surgical procedure that creates an opening in the front of the neck into the windpipe for breathing), pressure ulcer of sacral region, stage 4 (a severe wound that involves full-thickness skin and tissue loss with exposed underlying structures like muscle, tendon, ligament, cartilage or bone), and gastrostomy (a surgical procedure that creates an opening in the abdominal wall directly into the stomach that allows a tube to be inserted into the stomach for feeding).Record review of Resident 's Modified admission MDS dated [DATE] revealed she had a Staff Assessment for Mental Status (SAMS) and was coded as being severely impaired in cognitive skills for daily decision making. She was dependent on staff for assistance with all ADLs.Record review of Resident #2's physician order summary dated active orders as of 10/08/2025 revealed the following order: enhanced barrier precautions for wounds, and had a start date of 9/13/2025, with no stop date. Record review of Resident #2's care plan reflected she was at risk for falls, aspiration related to feeding tube in place, respiratory distress, impaired communication, self-isolation, shortness of breath, chest pain, elevated blood pressure. --Receiving (In-house dialysis) She was also care-planned for self-care deficits related to ADLs and requires total assistance for bathing, dressing, eating, mobility, and risk further decline due to trach placement and cognition.Observation and attempted interview on 10/07/2025 at 11:25 a.m., Resident #2 was in bed with contracted hand near call light exposing an empty hold where the push device would be located inside the outer white casing. The resident was not able to be interviewed and did not respond to questions. Interview and observation on 10/07/25 at 12:08 p.m., the Administrator and DON, employed at the facility since January 2025, he said maintenance and the nursing staff should check to make sure the call lights were in good condition before they were placed within reach for the resident for them to use. The Administrator said if the call button being functioning the residents would not be able to alert staff for assistance or harm. The Administrator said that residents might need medication, and if they did not have their call light within reach there could be a multitude of things that could go wrong. The Administrator said the call light in Resident #2's room will be changed and staff provided in services. He picked up the call light to observe the push button portion of the call button missing. The DON, she said all residents should always have call light with reach. The DON observed the call light laying on the resident's bed. The DON said it is a safety issue in case the resident needed to request care. The DON said immediate reeducation with staff and maintenance would occur. Interview on 10/08/25 at 12:25 p.m., CNA A employed at the facility for seven months, she said the expectation is to check residents every two hours or as needed. She stated she did not know Resident #2's call light was not functioning. She stated she is aware Resident #2 was a nonverbal resident, and she is only mobile with assistance. She stated she was made aware the call light was not working on 10/07/2025. She stated she knows she was supposed to check the call lights. She said that it was on staff for not checking her call light to know it was broken. She said she had been working with Resident #2 for a month and a half. Interview on 10/07/25 at 12:34 p.m., CNA B, employed at the facility for two years, stated she was not aware of Resident #2 call light being broken. She said that Resident #2 was not a resident room that she works with often. She said all its staff can check for call button function. She