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	12/18/2025

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 0677 Level of Harm - Actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (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

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	12/18/2025

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 0677 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to ensure a Resident who is unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 34 residents (Resident #1) reviewed for ADL.The facility's 3rd shift nursing staff failed to or ignored Resident #1's call light in a timely manner, which has consistently occurred throughout a period of time [January 2025 through December 2025], leaving Resident #1 needing assistance for incontinent care for several hours.Resident #1 felt neglected, belittlement, and shame due to the facility's failure. These failures could cause residents to experience compromised dignity, comfort, and place residents at risk for skin infection. Findings included: Record review of Resident #1's undated Face Sheet dated revealed she was a [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted [DATE] with Resident #1 had an active diagnosis of CHF (heart muscle can't pump enough blood to meet the body's needs causing fluid buildup), Hypertension (Blood pushes too hard against artery walls), Diabetes (body doesn't make enough insulin in the body), Stroke (blood flow in brain is cut off), COPD (lung blockage), Parkinsonism (Neurological condition that causes tremors, and balance issues). Record Review of Resident #1's Care Plan dated 5/9/25 revealed the following:Focus: Resident #1 is at risk for decline in ADL functions and injury (Date Initiated: 11/17/24; Revision on 11/17/24).Goal: Resident #1 will be well dressed, groomed, clean, odor free and will have no decline in ADL functioning over the next 90 days (Date initiated: 11/17/24; Revision on 9/29/25; Target date 1/15/26).Interventions: Ensure call light is within reach answer promptly (Date initiated: 11/17/24). Record review of Resident #1's MDS dated [DATE] revealed she has a BIMS score of 15, which means a person's cognitive is intact, indicating normal thinking and memory with little to no impairment and totally dependent on staff for most of her ADL's, which are incontinent care (bathing, and changing,), rolling from left to right from a lying position, and personal hygiene. Record review of FM A's email dated 12/17/2025, revealed documentation of dates [starting from January 2025 thru December 2025] and times of various events provided by FM A, revealed nursing staff consistently ignored or refused to acknowledge Resident #1's call light for continent care, and when management staff were notified. The following dates were: 02/18/25, 03/01/25, 03/18/25, 04/05/25, 04/16/25, 04/28/25, 07/18/25, 07/24/25, 08/6/25, 08/19/25, 08/19/25 at 2:00am, 09/2/25 at 8:00am, 09/10/25, 09/11/25, 10/20/25 at 1:10am, 11/11/25, 11/21/25, 11/29/25, 12/4/25 at 9:00pm, 12/5/25 at 6:50pm, and 12/7/25 at 7:50pm.Record review of Facility's Incident report dated 12/17/25 does not reveal call lights not being answered.During an interview on 12/17/25 at 9:29 with FM #A stated the issues are mainly the night shift. FM A stated the night shift nurses leave resident sitting in her diapers because they don't answer the call button. He stated nurses will come in the room and just turn the call light off and leave right out without providing any care. FM A stated night nursing staff refuses to change or clean Resident #1 when she wets herself. FM A stated he has reached out to the administrator and has been told not to text his personal phone. FM A stated 02/18/25 nurses refused to change Resident #1 when she asked just before 11:00am saying she needed to wait till after lunch to be served. FM A stated on 03/18/25 at about 2:20am Resident #1 had called saying she asked to be changed, and a nurse or CNA said, it hasn't even been 2 hours and told her No. And turn the call light off and leave. An hour later 2 more nurses came in asking what's wrong she said she needed to be changed, and they said gimme a minute, turned the light off, and left and an hour after that she called saying she had been sitting in cold piss for over 3 hours. FM A stated on 04/16/25 Resident #1 called at 10:40pm saying she can't get anyone in her room to change her and that she had been asking since 6:30pm and that when she calls from her cell phone a nursing staff member picks up phone and says, ok and hangs up. FM A stated [DATE], Resident #1 called him at 3:10am crying cause she couldn't get changed saying she hadn't been changed since 9:00pm. I called the facility and was placed on hold with station #2 for 30 minutes and never got ahold of anyone. FM A stated Resident #1 called again at 3:50am during this call and someone finally came into the room to change her. FM stated Resident #1 should not be sitting in a soaked diaper with bedsores for hours. During an interview on 12/17/25 at 10:25am with Resident #1 she stated she has had a lot of issues with nursing staff, specifically on the 3rd shift, who refuse to answer her call light and give her incontinent care, by changing her diaper leaving her in urine and sometimes feces for hours. She stated the issues with her ill treatment by nursing staff began in January 2025 and has continued till this date. Resident #1 stated she's left in bed soaked because the third shift will not answer her calls or if they come into her

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	12/18/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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	12/18/2025

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 0689 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 failed to ensure residents received adequate supervision to prevent accidents for 3 of 34 residents (Residents #10, #11, and #12,) reviewed for accidents and supervision. 1. The facility failed to ensure Residents #10, #11, and #12 were supervised while smoking on 12/18/2025 at 5:09 AM. 2. The facility failed to ensure Residents #10, #11, and #12 smoking supplies were stored securely when they were observed smoking unsupervised on 12/18/2025 at 5:09AM. These deficient practices could place residents at risk of burns causing injury or harm. Findings include: Record review of a Face Sheet for Resident #10 revealed an [AGE] year-old female admitted to the facility on [DATE]. Her diagnosis included Unspecified Dementia (a severe decline in mental abilities, like memory, thinking, and reasoning, significant enough to disrupt daily life and activities), Mild protein-malnutrition (involves subtle but significant nutrient deficiency), hyperlipidemia (a condition with too many fats in the blood, often call high cholesterol), bipolar disorder (a mental health condition causing extreme mood swings from emotional highs to lows, affecting energy, judgement, and behavior), hypertensive heart disease (damage to the heart from long-term high blood pressure (hypertension) causing the heart muscle to thicken as it works harder), cognitive communication deficit, schizoaffective disorder (a serious mental illness blending symptoms of schizophrenia (hallucinations, delusions, disorganized thinking) with those of a mood disorder), and major depressive disorder (a serious mood disorder causing persistent sadness, hopelessness, and loss of internet in activities). Record review of Resident#10's Quarterly MDS dated [DATE] revealed a BIMS score of 08 which indicated a cognition level of moderately impaired. Record review of Resident#10's undated care plan revealed a focus that Resident#10 was a tobacco smoker and is at risk for injury, encourage resident to wear a smoke apron. Interventions stated instruct encourage resident to wear a smoke apron while smoking, keep smoking material at nurses' station, review smoking policy w/ resident annually and PRN with concerns. Record review of a Face Sheet for Resident #11 revealed an [AGE] year-old female admitted to the facility on [DATE]. Her diagnosis included Hemiplegia and hemiparesis following cerebral infarction affecting right non dominant side (damage to the brain's left hemisphere, impacting movement, coordination, balance, and potentially cognition), Atherosclerotic heart disease of native coronary artery without angina pectoris (plaque buildup in your hearts arteries that isn't causing chest pain yet), Heart failure, presence of cardiac pace maker, hyperlipidemia (a condition with too many fats in the blood, often call high cholesterol), hypokalemia (having low levels of potassium in your blood), Contracture, right hand. Record review of Resident#11's Quarterly MDS dated [DATE] revealed a BIMS score of 07 which indicated a cognition level that was severely impaired. Record review of Resident#11's undated care plan revealed a focus that Resident#11 was a tobacco smoker and is at risk for injury' required to wear a smoke apron related to contractures; refuses to wear a smoke apron. Interventions stated keeping smoking material at nurses' station; require supervision while smoking, required to wear a smoke apron. The care plan revealed another focus of . Smoking on patio for social interaction, resident requires direction assistance to attend; resident appears to be pre-occupied with smoking; episodes of not following the smoking policy. The residents' goal revealed resident will remain compliant with smoking policy and injury free. Interventions stated post activity calendar in room where resident can see, Remind/invite resident to scheduled activities of choice/interest; encourage resident to wear a smoke apron. Record review of a Face Sheet for Resident #12 revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnosis included type 2 diabetes mellitus, hereditary and idiopathic neuropathy, unspecified (refers to peripheral nerve damage where the cause isn't definitively genetic), hyperlipidemia (a condition with too many fats in the blood, often call high cholesterol), Unspecified Dementia (a severe decline in mental abilities, like memory, thinking, and reasoning, significant enough to disrupt daily life and activities). Record review of Resident#12's Quarterly MDS dated [DATE] revealed a BIMS score of 04 which indicated a cognition level that was severely impaired. Record review of Resident#12's undated care plan revealed a focus that Resident#12 was a tobacco smoker and is at risk for injury, encourage the resident to wear a smoke apron. Interventions stated encourage residents to wear a smoking apron while smoking. Keep smoking material at nurse's station. Observation on 12/18/25 at 5:09 AM of 3 (Resident #10, #11, and #12) residents smoking unsupervised in the smoking area. In an interview/observation on 12/18/25 at 5:10 AM; Resident #10 was observed smoking in the smoking area unsupervised with no apron on. Resident #10 stated the residents have smoke times but reported that they