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	07/27/2025

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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (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	07/27/2025

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 0697 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews the facility failed to ensure pain management was provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 (Resident #77) out of 6 residents reviewed for pain management. The facility failed to ensure Resident #77's pain medications were administered timely prior to traveling in an ambulance to the dialysis facility on 07/23/25 when he rated his pain as an 8 out of 10 pain scale. This failure could place Resident #77 and other residents at risk of not receiving timely pain management care which could result in prolonged pain and diminished quality of life. Findings included: Record review of Resident #77's face sheet dated 07/23/25 revealed a [AGE] year-old male readmitted to the facility on [DATE], initially admitted on [DATE] and originally admitted on [DATE]. His diagnoses included fracture of the shin bones of left and right leg, COPD (chronic obstructive pulmonary disease - a lung condition caused by damage to the airway), end stage renal disease (kidneys no longer function adequately requiring dialysis or transplant), cirrhosis of the liver (abnormal liver function), Osteoarthritis (degeneration of joint cartilage and bone), hypotension, heart failure, depression, anxiety, chronic pain syndrome and dependence on renal dialysis. Record review of Resident #77's quarterly MDS dated [DATE] revealed a BIMs score of 14 out of 15 indicating intact cognition. He had no behaviors or rejection of care. He used a wheelchair for mobility. Pain intensity over the last 5 days was rated at a 6 out of 10, with zero being no pain and 10 being the worst pain ever imagined. Further review revealed he was taking antianxiety and opioid medications. Record review of Resident #77's undated care plan revealed: Focus - Resident #77 was at risk for increased pain and further decreased circulation as evidenced by venous ulcers to bilateral lower extremities. Interventions included - give medications per order. Focus - Resident #77 was on pain medication therapy Oxycodone r/t disease process. Interventions included - administer analgesic medications as ordered by physician. Monitor/document side effects and effectiveness every shift. Focus - Resident #77 had chronic pain r/t neuropathy. Interventions included: anticipate the resident's need for pain relief and response immediately to any complaint of pain. Focus - Resident #77 had episodes of manipulative behaviors as evidenced by pain med seeking behavior and at risk for further episodes. Interventions included - distract resident with activities based on resident's preferences, notify MD/RP of behaviors. Focus - Resident #77 at risk for further skin breakdown r/t left lower leg, closed surgical on 6/10/25. Interventions included - observe for pain, give medication per order, check for relief. Focus - Resident #77 needs dialysis r/t renal failure, M/W/F. Interventions included - work with resident to relieve discomfort for side effects of the disease and treatment.Focus - Resident #77 was at risk for shortness of breath, chest pain, elevated blood pressure, infected access site, dry/itchy skin as evidenced by diagnosis of ESRD. Dialysis schedule: 3 times per week on M/W/F. Pick up time: 7:00AM, revised on 02/04/25. No recent revisions were made. Record review of Resident #77's order summary report of active orders as of 07/23/25 revealed orders for: -Oxycodone HCL oral tablet 10mg every 12 hours at 9:00AM and 9:00PM for pain management, order date 07/10/25. -Oxycodone HCL oral tablet 5mg every 6 hours as needed for pain, order date 06/24/25. -Hydrocodone-Acetaminophen oral tablet 10-325mg one tablet every 6 hours as needed for pain, order date 07/02/25. -Methocarbamol 750mg every 12 hours at 9:00AM and 9:00 PM for muscle relaxer, order date 06/10/25 - May go to dialysis on: Monday, Wednesday, Friday at 7:00 AM, order date 06/10/25.Record review of Resident #77's completed orders revealed and order started 06/10/25 for taper dose of Oxycodone HCL 10mg: give 4 tablets by mouth every 12 hours for pain for 6 days, 1 tablet for 7 days; give 3 tablets by mouth every 12 hours for pain for 7 days, 1 tablet for 7 days; give 2 tablets by mouth every 12 hours for pain for 7 days, 1 tablet for 7 day; give 1tablets by mouth every 12 hours for pain for 7 days, 1 tablet for 7 day. The end date for the order was 07/08/25. Record review of Resident #77's June 2025 MAR/TAR revealed pain assessments were completed every shift and pain scores were zero to 5 out of 10. Record review of Resident #77's July 2025 MAR revealed the Oxycodone HCL 10mg to be given every 12 hours, due at 8:00 AM was not given on 7/2/25 and 7/14/25. Further review revealed the Methocarbamol 750mg tablet every 12 hours at 9:00 AM and 9:00 PM for muscle relaxer was not given at 9:00 AM on 07/02/25, 07/14/25 and 07/23/25 and to refer to the progress notes for both Oxycodone HCL 10mg and Methocarbamol 750mg. Record review of Resident #77's Administration progress note revealed on 07/02/25 at 8:29 AM, MA-F noted the resident was at dialysis. On 07/14/25 at 11:52 AM, CNA-H

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	07/27/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 4 residents (Resident #77) reviewed for pharmacy services.MA-B failed to administer Sevelamer (a phosphate binder used to control high phosphorus levels in residents on dialysis) as instructed on the pharmacy label.This failure could place residents who receive medications at risk of not receiving the intended therapeutic benefit of the medications. Findings included:Record review of Resident #77's face sheet dated 07/23/25 revealed a [AGE] year-old male readmitted to the facility on [DATE], initially admitted on [DATE] and originally admitted on [DATE]. His diagnoses included fracture of the shin bones of left and right leg, end stage renal disease (kidneys no longer function adequately requiring dialysis or transplant), Osteoarthritis (degeneration of joint cartilage and bone), anxiety, and dependence on renal dialysis.Record review of Resident #77's quarterly MDS dated [DATE] revealed a BIMs score of 14 out of 15 indicating intact cognition. Section I - Active Diagnoses included renal failure.Record review of Resident #77's undated care plan indicated a plan of care that included: Focus - Resident #77 was receiving dialysis for ESRD and at risk for symptoms including dry/itchy skin. Interventions included to give medications as ordered.Record review of Resident #77 active orders as of 07/23/25 revealed an order for Sevelamer HCL 800mg, take 3 tablets by mouth with meals for phosphorous control.Record review of Resident #77's July 2025 MAR/TAR indicated MA-B administered Sevelamer 800mg, 3 tablets on 07/23/25 at 8:00 AM. Further review revealed the MAR included give 800mg by mouth with meals for control of phosphorous level, take 3 tablets.Observation and interview on 07/23/25 at 6:55 AM, revealed Resident #77 was scratching his back and front of body using a back scratcher. His skin was dry. He stated he takes the phosphate binder Sevelamer with meals.Observation of medication pass on 07/23/25 at 7:45 AM, revealed MA-B administered Sevelamer Carbonate 800mg, three tablets to Resident #77. The pharmacy label instructions were to take with meals. MA-B did not administer with food.In a telephone interview on 7/25/25 at 9:40AM, RN-A was the nurse in charge of Resident #77 on 7/23/25 and was unaware that Resident #77 received the Sevelamer without food and that the orders should have been followed.A telephone interview was attempted on 07/26/25 at 9:00AM with MA-B. A message was left on voicemail to return surveyor call. Received no call back.Record review of the facility policy and procedure for Administering oral medications, revised October 2010, read in part: The purpose of this procedure is to provide guidelines for the safe administration of oral medications. Preparation 1. Verify that there is a physician's medication order for the procedure.Steps in the Procedure.6. Check the label on the medication and confirm the medication name and dose with the MAR.

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	07/27/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. (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	07/27/2025

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 0760 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 that residents were free of significant medication error for 1 of 6 residents (Resident #77) reviewed for medication administration.The facility failed to ensure Resident #77 received the correct controlled substance for pain medication as ordered by the physician leading to multiple opioid administrations between 06/12/25 and 07/26/25.-Resident #77's narcotic sheets for Oxycontin ER 10mg contained documented sign out dates from 06/12/25 to 07/26/25. There were no physician orders for Oxycontin ER 10mg.-Resident #77's narcotic sheet for Oxycodone IR 10mg one tablet every 12 hours contained documented sign out dates that did not match the instructions on the pharmacy label. These failures could place other residents at risk of medication errors, opioid overdose, CNS depression, respiratory distress and death.Findings included:Record review of Resident #77's face sheet dated 07/23/25 revealed a [AGE] year-old male readmitted to the facility on [DATE], initially admitted on [DATE] and originally admitted on [DATE]. His diagnoses included fracture of the shin bones of left and right leg, COPD (chronic obstructive pulmonary disease) (a lung condition caused by damage to the airway, end stage renal disease (kidneys no longer function adequately requiring dialysis or transplant), cirrhosis of the liver (abnormal liver function), Osteoarthritis (degeneration of joint cartilage and bone), hypotension, heart failure, depression, anxiety, chronic pain syndrome and dependence on renal dialysis. Record review of Resident #77's quarterly MDS dated [DATE] revealed a BIMs score of 14 out of 15 indicating intact cognition. He had no behaviors or rejection of care. He used a wheelchair for mobility. Pain intensity over the last 5 days was rated at a 6 out of 10, with zero being no pain and 10 being the worst pain ever imagined. Further review revealed he was taking antianxiety and opioid medications. Record review of Resident #77's order summary report of active orders as of 07/23/25 revealed orders for: -Oxycodone HCL oral tablet 10mg every 12 hours for pain management, order date 07/10/25. -Oxycodone HCL oral tablet 5mg every 6 hours as needed for pain, order date 06/24/25. -Hydrocodone-Acetaminophen oral tablet 10-325mg one tablet every 6 hours as needed for pain, order date 07/02/25. - Resident #77 had no documented orders for Oxycodone ER 10mg.-Hydrocodone/Acetaminophen 10/325mg, one tablet every 6 hours as needed for pain-Methocarbamol 750mg, one tablet every 12 hours for muscle relaxer-Gabapentin 100mg, 2 tablets every Monday, Wednesday, Friday after dialysis for neuropathy (condition that damages nerves and can cause pain) Record review of Resident #77's completed physician's order for tapering of Oxycodone HCL(IR) 10mg ordered on 06/10/25 revealed: - 4 tablets every 12 hours for 7 days, start date 06/11/25. - 3 tablets every 12 hours for 7 days, start date 06/17/25. - 2 tablets every 12 hours for 7 days, start date 06/24/25. - 1 tablet every 12 hours for 7 days, 07/01/25 and end date 07/08/25. Record review of Resident #77's Pharmacy Controlled Substance Prescriptions revealed: - 06/09/25 a prescriber from the hospital ordered Oxycontin (Oxycodone) ER 10mg to start on 6/09/25 included taper orders. -On 06/10/25 the pharmacy dispensed Oxycontin ER 10mg and this was used by the facility on 06/12/25 to 06/27/25. -On 06/10/25, Resident #77's physician ordered Oxycodone HCL(IR) 10mg, with taper orders to start 06/11/25 and end 07/08/25. -On 06/24/25 the pharmacy dispensed Oxycontin ER 10mg (instead of Oxycodone HCL(IR) 10mg). Oxycontin was used by the facility 06/28/25 to 07/26/25. Record review of Resident #77's narcotic sign sheets revealed: - Oxycontin ER 10mg, with the taper orders (4 tablets every 12 hours for 7 days, 3 tablets every 12 hours for 7 days, 2 tablets every 12 hours for 7 days, 1 tablet every 12 hours for 7 days) was signed out 06/12/25 to 06/27/25. The hospital physician was listed as the prescriber on the pharmacy label and not Resident #77's facility Physician. -Oxycontin ER 10mg, received on 06/24/25, had instructions on the label for the above taper orders, doses were signed out on 06/28/25 to 07/26/25. The hospital physician was listed as the prescriber on the pharmacy label and not Resident #77's facility Physician. - Oxycodone IR 10mg every 12 hours, received on 07/04/25, and doses were signed out on 07/04/25 and signed out on various dates through to 07/23/25. The signed dates were inconsistent with the instructions on the pharmacy label and not given every 12 hours. Record review of Resident #77's June and July 2025 MARs printed on 07/23/25 indicated nursing staff documented administration of Oxycodone HCL 10mg taper orders starting 06/11/25 to 07/08/25 then continued documenting twice daily until 07/26/25 except for 07/10/25, 07/11/25, 7/15/25, 07/21/25 when only one dose daily was administered. Resident #77 had no order listed on the MARs for Oxycontin ER 10mg taper orders. Record review of Resident #77's July 2025 MAR printed on 07/25/25 indicated nursing staff documented the administration of Oxycodone HCL 10mg 1 tablets every 12 hours for 7 days: -07/01/25

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	07/27/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, in accordance with State and Federal laws, store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys for one of four medication carts reviewed for storage of medications. RN-M failed to ensure the 200 Hall nurse medication cart was locked when unattended. This deficient practice could place residents at risk for loss of biologicals and place residents at risk of access to hazards.Findings included:In an observation and interview on 07/23/25 at 5:15 AM, revealed the 200 Hall Nurse Medication Cart was in the hallway positioned just outside the entrance to a resident's open room. The medication cart was unattended and unlocked, the lock was visibly not engaged. The medication cart contained a variety of medications labeled with Resident names and over-the-counter medications. The controlled substances were locked within the medication cart. RN-M was observed walking from one end of the hall towards the medication cart. RN-M stated she was called away to get something and forgot to lock the cart. RN-M stated the medication cart should be locked when unattended otherwise a confused resident could open the cart and take the medications. RN-M stated it was facility protocol to lock the cart before walking away and leaving the area.In an interview on 07/26/25 at 9:15 AM, the DON stated the nurse or medication aide assigned to the medication cart was responsible to make sure the cart is secure and not accessible to anyone who was not authorized access. The DON stated she would conduct a 1:1 in-service for medication storage.

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	07/27/2025

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 - Few	Provide and implement an infection prevention and control program. (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	07/27/2025

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 - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to 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 one of 5 residents (Resident #112). -CNA-K failed to properly clean Resident #112 during incontinent care.-CNA-K failed to perform hand hygiene between glove changes.-CNA-K and LVN-L failed to put on a gown prior to incontinent care for Resident #112 who was in Enhanced Barrier Precaution (EBP). These failures could place residents at risk of urinary tract infections (UTI), discomfort, skin breakdown and decreased quality of life. Findings included: Record review of Resident #112's face sheet dated 07/25/25 revealed a [AGE] year-old admitted to the facility on [DATE]. His diagnoses included sepsis (a blood infection), anemia (reduced number of red blood cells), dementia, and contractures of the lower left leg. Record review of Resident #112's admission assessment effective date 07/16/25 indicated Resident #112 had no difficulty making himself understood and had no difficulty understanding others. Resident #112 had a urinary catheter and the resident or family reported recurrent urinary tract infections. Resident #112 required limited assistance of one person for bed mobility. Record review of Resident #112's undated care plan revealed the resident was at risk for decline in ADL functions, initiated on date 07/17/25. The goal was for the resident to be well dressed, groomed, clean, odor free and will not decline in ADL functioning over the next 90 days. Interventions included staff assistance for bed mobility, toileting and personal hygiene. The resident was at risk for skin breakdown and injury. The goal was for resident's skin to remain clean/dry, intact without evidence of breakdown over the next 90 days. Interventions included weekly assessment of skin and as needed and report any breakdown to MD/RP. The resident had a urinary catheter in place and was at risk for increased UTIs and skin breakdown. The goal was for the urinary catheter to remain patent and the resident to not develop incidents of UTIs and skin breakdown. Interventions included urinary catheter care as ordered. The resident had had wound to the tailbone and to the lower legs. The goal was for the resident's skin to remain clean/dry, healing with no further complications. Interventions included to perform treatment per MD order. Record review of Resident #112's July 2025 MAR/TAR revealed wound care to the sacrum was performed daily. Observation and interview of incontinent care on 07/22/25 at 3:29 PM revealed Resident #112 had a urinary catheter and a catheter anchor was in place for security. Resident #112 had a PICC line (peripherally inserted central catheter) to the inner upper right arm, the dressing was clean/dry/intact and dated 07/11. LVN-L was assisting CNA-K with the procedure. CNA-K and LVN-L washed their hands at the sink and put on clean gloves. CNA-K and LVN-L did not put on gowns. CNA-K and LVN-L opened Resident #112's brief, the resident had a large amount of soft-loose stool. CNA-K began by using cleansing wipes to remove all the stool around the groin and scrotum. CNA-K removed her used gloves, did not hand sanitize, put on clean gloves, then used clean wipes to cleanse the lower abdomen and penis. Resident #112 was rolled to his right side. CNA-K used clean wipes to clean all the stool from the rectum and buttocks. CNA-K removed her used gloves, did not hand sanitize, then put on clean gloves. The resident had a small wound to the sacrum. CNA-K applied barrier cream to the surrounding skin. CNA-K removed the used gloves, did not wash her hands and put on clean gloves then positioned the clean brief, secured the brief and covered the resident with bed sheets. CNA-K and LVN-L removed their gloves, washed theirs hands and gathered the garbage bags to remove from the room. LVN-L stated she forgot to put on a gown because she was so excited to do the nailcare just prior to incontinent care. LVN-L stated the resident was to be in EBP for the wounds, PICC line and indwelling urinary catheter and the reason was so not to introduce any new infections to the resident. In an interview on 7/22/25 at 3:50PM, CNA-K stated EBP was for residents with open wounds and urinary catheters CNA-K stated she should have put on a gown as well as gloves prior to starting the procedure but she was nervous and forgot. CNA-K stated she should have started cleaning the lower abdomen, then the groin and penis area first but she did not because she wanted to get all the stool cleaned up first. She stated she was taught to clean from penis first it should have been cleaned first because she should not have gone from dirty area to clean, and the rationale was to help prevent infections and cross-contamination. CNA-K stated she should have removed dirty used gloves and hand sanitization or wash hands, but she was nervous and forgot. CNA-K stated the risk to the resident was cross-contamination and infection. In an interview on 7/25/25 at 3:15 PM, the DON stated a gown, and gloves were to be worn

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	07/27/2025

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 0921 Level of Harm - Potential for minimal harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 1 of 1 facility reviewed for environmental concerns.The facility failed to properly dispose of waste in the appropriate receptacles. Two red cylindrical 32-gallon containers with white letters on the outside of it reading Infectious Waste: Biohazard containing unknown waste were located outside of the facility. This deficient practice could place residents, staff, and the public at risk of being exposed to potentially hazardous waste.The findings included: Observation on 07/22/2025 at 1:51 PM revealed 1 red, cylindrical, 32-gallon container without a lid, and with white letters on the outside of it reading Infectious Waste: Biohazard was located outside of the facility near the generator. The container held red bags of unknown origin and water. The container appeared to have been outside exposed to the weather for some time as some of the red bags were deteriorated. Observation on 07/22/2025 at 1:53 PM revealed 1 red, cylindrical, 32-gallon container without a lid, and with white letters on the outside of it reading Infectious Waste: Biohazard located outside of the facility near a storage shed. The container had various items of trash along with red biohazard bags. During an Interview on 07/24/2025 10:30 AM with the ADON/IP, she reported when asked about the facility process regarding use of the red biohazard bags, they only used the bags for residents in isolation. They kept the biohazard box with the red bag liner in the resident's room if they were on isolation. Once the bag needed to be removed, they closed the box lid and removed the box from the room. The box was taken to the Medical Waste room. They had a contract service that picked up the boxes from the medical waste room. The boxes and bags were not taken outside the building by staff. She was not aware of any biohazard containers outside of the building and said there was no reason to take it outside when it was picked up by the service inside the building. They don't use red garbage bins for disposal, and she did not know why there were red biohazard containers outside the building.Observation on 7/24/25 at 10:33 AM of the Medical Waste room revealed an unlocked closet with Medical Waste noted on the door. The room contained biohazard boxes and red biohazard bags. There were approximately 30 folded, unused boxes, 3 boxes filled and closed, and 1 box, lined with a red bag was open for use.During an interview on 07/25/2025 11:37 AM with the Administrator about biohazard containers located outside the building, he reported he did not know what was inside of them or how long they had been there. They had been emptied and discarded. During an interview on 07/25/2025 11:40am with the Maintenance Director, he reported he did not know how long the containers were there, probably for years. He did not know what was in the containers and reported that they were not used for biohazard disposal. The bags were disintegrating from being outside and they were not able to tell what the contents had been. The red containers have been disposed of in the dumpster.