

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675469	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2025
NAME OF PROVIDER OR SUPPLIER Harmony Care at Floresville		STREET ADDRESS, CITY, STATE, ZIP CODE 1811 Sixth St Floresville, TX 78114	

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)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866</p> <p>Based on interview and record review, the facility failed to ensure residents' right to formulate an advance directive for 2 of 20 residents (Resident #20 and #62) reviewed for advanced directives, in that:</p> <ol style="list-style-type: none"> 1. Resident #20's DNR was not signed twice by the physician. 2. Resident #62's DNR was not signed twice by the physician. <p>These deficient practices could place residents at-risk of having their end of life wishes dishonored, and of having CPR performed against their wishes.</p> <p>The findings were:</p> <ol style="list-style-type: none"> 1. Record review of Resident #20's face sheet, dated [DATE], revealed the resident was admitted to the facility on [DATE] with diagnoses including: fibromyalgia (long-term condition that involves widespread body pain and tiredness), hypothyroidism (condition in which thyroid gland does not produce enough thyroid hormone), and Covid-19. <p>Further review of Resident #20's facesheet revealed, Advance Directive: DNR.</p> <p>Record review of Resident #20's annual MDS, dated [DATE], revealed a BIMS score of 15 which indicated intact cognition.</p> <p>Record review of Resident #20's care plan, updated [DATE], revealed, Advance Directive: DNR.</p> <p>Record review of Resident #20's physician orders revealed an order dated [DATE], DNR.</p> <p>Record review of Resident #20's OOH-DNR form revealed it had been signed twice by the resident and two witnesses, but only signed once by the physician. Further review revealed the physician's signature was missing from the bottom of the form which instructions read All persons who have signed above must sign below, acknowledging that this document has been properly completed.</p> <p>(continued on next page)</p>

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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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Record review of Resident #62's face sheet, dated [DATE] revealed an admitted [DATE] with re-admission on [DATE] and diagnoses which included: Chronic Obstructive Pulmonary Disease with acute Exacerbation (COPD) (a sudden worsening of respiratory symptoms in COPD which is a lung disease that blocks airflow and makes it difficult to breathe); Acute Respiratory Failure; Vascular Dementia (Problems with memory, reasoning, judgement and other though processes caused by brain damage from impaired blood flow to brain).</p> <p>Record review of Resident #62's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 indicating intact cognition.</p> <p>Record review of Resident #62's Care Plan revised [DATE] revealed a focus area for code status of DNR, and included intervention to Make sure code status is signed by appropriate parties and in the medical record</p> <p>Record review of Resident #62's Order Summary Report dated [DATE] revealed order for DNR - No CPR dated [DATE].</p> <p>Record review of Resident #62's OOH-DNR revealed the resident signed the form on [DATE], the two witnesses signed the DNR form on [DATE], and the Physician signed the Physician statement on [DATE], but on the bottom of the form which reads All persons who have signed above must sign below, acknowledging that this document has been properly completed the Physician's signature is missing.</p> <p>During an interview with the Social Work Designee on [DATE] at 12:27 p.m., the Social Work Designee confirmed Resident #20's DNR was not signed twice by the physician and confirmed Resident #62's DNR was not signed twice by the physician. The Social Work Designee further confirmed that the missing signatures invalidated the documents and could result in the residents' end of life wishes being dishonored.</p> <p>Review of the facility policy, DNR, undated, revealed, While we are awaiting all the signature requirements for the OOH DNR .</p> <p>Review of the Texas Department of State Health Services (DSHS) website at https://www.dshs.texas.gov/sites/default/files revealed Health professionals can refuse to honor a DNR if they think: The form is not signed twice by all who need to sign it or is filled out incorrectly.</p> <p>41651</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34788</p> <p>Based on interview and record review, the facility failed to ensure the assessment accurately reflected the resident's status for 1 of 6 residents (Resident #42) whose assessments were reviewed, in that:</p> <p>Resident #42's quarterly MDS assessment incorrectly documented the resident as not receiving an antipsychotic medication.</p> <p>This failure could place residents at-risk for inadequate care due to inaccurate assessments.</p> <p>The findings were:</p> <p>Record review of Resident #42's face sheet, dated 03/19/2025, revealed an admitted [DATE] and, a readmitted [DATE] with diagnoses that included: Hemiplegia (Paralysis of one side of the body), Type 2 diabetes mellitus (high level of sugar in the blood), Hyperlipidemia (Elevated level of any or all lipids(fat) in the blood), Bipolar disorder (Mental disorder characterized by periods of depression and periods of abnormally elevated mood) and Anxiety disorder (A group of mental illnesses that cause constant fear and worry).</p> <p>Record review of Resident #42's Physician orders and Medication administration record for February 2025 revealed an order for: Seroquel (an antipsychotic) Oral Tablet 200 MG(Quetiapine Fumarate) Give 1 tablet by mouth two times a day related to Bipolar Disorder. Resident #42 had received Seroquel in the month of February 2025.</p> <p>Record review of Resident #42's Quarterly MDS, dated [DATE], revealed the assessment indicated Resident #42 did not receive an antipsychotic.</p> <p>During an interview with the MDS coordinator on 03/21/2025 at 1:21 p.m., the MDS coordinator verbally confirmed Resident #42's quarterly MDS was coded as the resident not receiving an antipsychotic when Resident #42 had received Seroquel (an antipsychotic). The MDS coordinator revealed she did not know why the Seroquel was not coded as an antipsychotic. She verbally confirmed Seroquel was an antipsychotic and should have been coded as an antipsychotic. The MDS coordinator revealed the RAI was used as reference for the MDS and she had access electronically to the RAI on her computer.</p> <p>Record review of, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual,Version 1.18. 11, October 2023, revealed, N0415A1. Antipsychotic: Check if an antipsychotic medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days)).</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866</p> <p>Based on observation, interview and record review the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care for 2 (Residents #188 and #195) of 8 residents reviewed for baseline care plans.</p> <ol style="list-style-type: none"> 1. The facility failed to include Resident #188's risk for falls and epilepsy in his baseline care plan. 2. The facility failed to include Resident #195's oxygen therapy and wound care in his baseline care plan <p>This failure could result in residents not receiving needed care and treatment.</p> <p>Findings Included:</p> <ol style="list-style-type: none"> 1. Record review of Resident #188's face sheet dated 03/21/2025 revealed he was a [AGE] year-old man who was admitted to facility on 03/06/2025 with diagnoses which included: Epilepsy (a disorder where nerve cell activity in brain is disturbed causing seizures); alcoholic cirrhosis of liver (chronic liver damage leading the scarring and liver failure) and muscle weakness. <p>Observation on 03/18/2025 at 09:42 a.m. in Hall 600, revealed a female resident coming into the hallway, yelling he fell , and pointing to Resident #188's room. Resident #188 was observed to be sitting on the floor next to his bed resting against the wall, with his wheelchair next to him. Facility staff immediately went to assess.</p> <p>Interview with Resident #188 on 03/18/2025 at 10:08 a.m. revealed that he stated that he fell because he had the wheels on his wheelchair turned wrong, but stated he had locked the brakes and can transfer himself to his wheelchair. He stated he did not use the call light for help because he can transfer by himself. Resident #188 stated that this was his second fall since he arrived at the facility, noting the first time he fell he got caught up in the leg supports of the wheelchair and fell . He stated they did x-rays and nothing was broken. Resident #188 stated he gets seizures sometimes, but that was not why he fell . Resident #188 stated after his first fall they moved his bed, started him on physical therapy and asked him to use his call light.</p> <p>Record review of Resident #188's 5-day MDS assessment dated [DATE] revealed a BIMS score of 14, indicating intact cognition and was assessed as needing partial/moderate assistance (helper does less than half the effort, helping to lift, hold or support trunk or limbs) for transfers and sit to stand.</p> <p>Record review of Resident #188's Care Plan initiated 03/11/2025 revealed there were no focus or problem areas that addressed his risk for falls, actual falls or epilepsy.</p> <p>(continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility incident log revealed Resident #188 had a witnessed fall on 03/08/2025 and an unwitnessed fall on 03/18/2025.</p> <p>Interview on 03/21/2025 at 1:31 p.m. with the MDS Coordinator revealed that she was responsible for completing the initial, quarterly and annual Care Plans, but Nurse management, the DON, was responsible for revising the Care Plan for acute changes, such as falls or changes in health. The MDS Coordinator stated that Resident #188's falls and epilepsy should have been addressed in his Care Plan so that all staff had information on his care, and to coordinate his care.</p> <p>During an interview with ADON-E on 03/21/2025 at 2:11 p.m., ADON-E stated that all resident falls were reviewed and discussed by the team in morning meetings, and remembered Resident #188's falls were discussed by the team, and that they had agreed to have him evaluated by physical therapy, educated him on using his call light to ask for help, to make sure his call light was always in reach, and to provide him with non-slip socks. ADON-E further stated that his risk for falls and actual falls should have been addressed in his Care Plan. She noted that although his baseline care plan was completed before his first fall, it should have been revised to reflect his falls and epilepsy, to reflect changes that occurred prior to the development of his Comprehensive Care Plan. ADON-E stated that the DON was responsible for revising Care Plans for acute changes such as falls, however she noted the DON had just resigned the day before. ADON-E stated that not revising the Care Plan could result in residents not receiving the best possible care.</p> <p>2. Record review of Resident #195's face sheet dated 03/18/2025 revealed a 77- year- old man admitted to the facility on [DATE] with diagnoses which included: Congestive Heart Failure (a chronic condition in which the heart doesn't pump blood as well as it should); and COPD (Chronic Obstructive Pulmonary Disease; a chronic inflammatory lung disease that causes obstruction of airflow to the lungs with symptoms that include shortness of breath, chronic cough, wheezing and excess mucus production</p> <p>Record review of Resident #195's EHR revealed his Admission MDS assessment was still in progress.</p> <p>Record review of Resident #195's Order Summary dated 03/18/2025 revealed orders including:</p> <p>-May use oxygen @2L per NC to maintain sats >90% as needed</p> <p>-Left buttock: Cleanse with dakin's [a wound care solution used to kill bacteria in and on the wound without damaging healing skin], pat dry, skin prep to peri-wound, apply hydrofera blue [an antibacterial wound care dressing], cover with hydrocolloid dressing [type of bandage that protects and promotes wound healing] every day shift every Tues, Thu, Sat</p> <p>- Right buttock: Cleanse with dakin's, pat dry, skin prep to peri-wound, apply hydrofera blue, cover with hydrocolloid dressing. every day shift every Tue, Thu, Sat</p> <p>Record review of Resident #195's Care Plan initiated 3/18/2025 revealed there was only one focus area RESISTANT TO CARE, in which oxygen therapy and wound care were mentioned, but only to the extent that he has a history of refusing wound care and refusing to allow staff to change his oxygen tubing. There were no focus areas regarding his need for oxygen therapy and skin impairment, to include interventions specifically addressing those areas of need.</p> <p>(continued on next page)</p>

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 03/18/2025 at 11:12 a.m., during initial tour revealed Resident #195 lying in his bed, receiving oxygen via nasal cannula set at 2L. There was no date written on the tubing or humidifier container. Further observation revealed there was a used humidifier bottle with a small amount of water left inside and connected tubing and nasal cannula sitting out on Resident #195's chest of drawers, with the tubing hanging down towards the floor.</p> <p>Interview with LVN-G on 03/18/2025 at 11:22 a.m. revealed Resident #195 had only been at the facility a few weeks, but she stated that he has used oxygen therapy since he arrived and is often resistant to his oxygen tubing and humidifier bottle being changed out and removed from his room. LVN-G further stated Resident #195 was usually compliant with using the oxygen, he just didn't want anything removed from his room.</p> <p>During an interview with the MDS Coordinator on 03/21/2025 at 1:31 p.m., the MDS Coordinator stated Resident #195's Baseline Care Plan was completed within 48-hours and could be found under the assessment tab in EHR, but also stated his Baseline Care Plan did not include his use of oxygen or need for wound care, and stated these needs should have been included in his Baseline Care Plan. The MDS Coordinator stated she did not know how it was missed, but not having these needs addressed in his Care Plan could result in him not having all his minimum health care needs being addressed.</p> <p>Record review of facility policy titled Care Plans-Baseline (undated) revealed The Interdisciplinary Team will review the healthcare practitioner's orders (e.g., dietary needs, medications, routine treatment, etc.) and implement a baseline care plan to meet the resident's immediate care needs including but not limited to: a. Initial goals based on admission orders; b. Physician Orders; c. Dietary orders; d. Therapy services, e. Social services .</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34788</p> <p>Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and time frames to a meet resident's medical, nursing, mental, and psychosocial needs for 1 of 6 residents (Resident #36) reviewed for care plans, in that:</p> <p>The facility failed to develop a comprehensive person-centered care plan to address Resident #36's indwelling catheter care requirements.</p> <p>This deficient practices could affect residents who require an indwelling catheter by not having their needs met and putting them at risk of being inappropriately cared for.</p> <p>The finding were:</p> <p>Record review of Resident #36's face sheet, dated 03/21/2025, revealed the resident was admitted to the facility on [DATE] and, readmitted [DATE] with diagnoses that included: Dementia (decline in cognitive abilities), Anxiety disorder (A group of mental illnesses that cause constant fear and worry), Major depressive disorder (mental disorder characterized by at least two weeks of pervasive low mood, low self-esteem, and loss of interest or pleasure), Hypertension (High blood pressure).</p> <p>Record review of Resident #36's Significant change MDS, dated [DATE], revealed the resident had memory problem and was severely cognitively impaired. The resident required total care with his activities of daily living. Further review revealed Resident #36 was coded as having an indwelling catheter and was always incontinent of bowel.</p> <p>Record review of Resident #36's Care Plan, revised 03/18/2025, revealed the resident was not care planned for indwelling catheter care.</p> <p>Observation on 03/21/2025 at 12:01 p.m. revealed Resident #36 had an indwelling catheter.</p> <p>During an interview with the MDS coordinator on 03/21/2025 at 1:21 p.m., The MDS coordinator confirmed Resident #36 had an indwelling catheter and should have been care planned for indwelling catheter care. She revealed not care planning the indwelling catheter could cause the resident to not receive the care she needed.</p> <p>Record review of the facility's policy titled, Care plan, comprehensive person-centered undated, revealed, A comprehensive, person centered care plan that includes measurable objective and timetable to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. [.] The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866</p> <p>Based on observation, interview, and record review, the facility failed to ensure that residents who need respiratory care were provided such care consistent with professional standards of practice for 1 (Resident #195) of 3 residents reviewed for respiratory care.</p> <p>The facility failed to ensure Resident #195's used oxygen tubing and nasal cannula were disposed of and not left in the resident's room.</p> <p>This failure could place residents on respiratory therapy at risk for respiratory compromise and infection.</p> <p>Findings included:</p> <p>Record review of Resident #195's face sheet dated 03/18/2025 revealed a [AGE] year old man admitted to the facility on [DATE] with diagnoses which included: Congestive Heart Failure (a chronic condition in which the heart doesn't pump blood as well as it should); and COPD (Chronic Obstructive Pulmonary Disease; a chronic inflammatory lung disease that causes obstruction of airflow to the lungs with symptoms that include shortness of breath, chronic cough, wheezing and excess mucus production</p> <p>Record review of Resident #195's Admission MDS assessment dated [DATE] revealed a BIMS score of 10 indicating moderate cognitive impairment.</p> <p>Record review of Resident #195's Order Summary dated 03/18/2025 revealed orders including:</p> <p>-Change O2 tubing and humidifier PRN excessive soiling and weekly every night shift every Sun; and</p> <p>-May use oxygen @2L per NC to maintain sats >90% as needed</p> <p>Observation on 03/18/2025 at 11:12 a.m., during initial tour revealed Resident #195 lying in his bed, receiving oxygen via nasal cannula set at 2L. Further observation revealed there was a used humidifier bottle with a small amount of water left inside and connected tubing and nasal cannula sitting out on Resident #195's chest of drawers, with the tubing hanging down towards the floor.</p> <p>During an interview and observation with LVN-G on 03/18/2025 at 11:22 a.m., LVN-G stated that oxygen tubing and humidifier bottles should be changed once a week by night shift Nurses. If tubing and humidifier bottles are not changed regularly it could cause infection. LVN-G also stated that the used oxygen tubing and humidifier bottle should not have been left in Resident #195's room, as it could be a source of infection, but she noted Resident #195 will often become upset when staff try to remove equipment from his room. LVN-G attempted to remove the used oxygen tubing and humidifier bottle from the top of his chest of drawers, but Resident #195 became verbally upset, telling her not to take those items, they belonged to him.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the DON on 03/20/2025 at 2:31p.m. revealed that oxygen tubing and humidifier bottles should be changed weekly and when needed, She stated not changing the tubing and humidifier bottle and properly disposing of the used oxygen tubing and humidifier bottle could result in growth of organisms and risk for infection.</p> <p>Record review of the facility policy titled Oxygen Administration revised 02/13/2007 revealed under the Goals section The resident will be free from infection. Further review revealed</p> <p>Change the tubing (including any nasal prongs or mask) that is in use on one patient when it malfunctions or becomes visibly contaminated.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866</p> <p>Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments and permit only authorized personnel to have access to the keys for 1 (Resident #195) of 8 residents reviewed for Medication storage.</p> <p>1. The facility failed to ensure Resident #195 did not have a jar of mentholated ointment (a topical analgesic and decongestant) at the bedside.</p> <p>This deficient practice could place residents at risk of medication misuse or drug diversion.</p> <p>The findings included:</p> <p>1. Record review of Resident #195's face sheet dated 03/18/2025 revealed a [AGE] year old man admitted to the facility on [DATE] with diagnoses which included: Congestive Heart Failure (a chronic condition in which the heart doesn't pump blood as well as it should); and COPD (Chronic Obstructive Pulmonary Disease; a chronic inflammatory lung disease that causes obstruction of airflow to the lungs with symptoms that include shortness of breath, chronic cough, wheezing and excess mucus production.</p> <p>Record review of Resident #195's Admission MDS assessment dated [DATE] revealed a BIMS score of 10 indicating moderate cognitive impairment.</p> <p>Record review of Resident #195's Order Summary dated 03/18/2025 revealed there was no order for mentholated ointment and no order stating he could self-medicate.</p> <p>Record review of Resident #195's Care Plan revealed no indication regarding his ability to self-administer his medications.</p> <p>Observation on 03/18/2025 at 11:12 a.m., during initial tour revealed Resident #195, was lying in his bed with a small jar of mentholated ointment in plain view on the resident's pillow.</p> <p>During an observation of Resident #195's room and interview with LVN-G on 03/18/2025 at 11:22 a.m., the jar of mentholated ointment was now in plain sight on Resident #195's bedside table. LVN-G stated that the jar of mentholated ointment should not be on Resident #195's bedside table or pillow, that he was not assessed as being able to self-medicate and the mentholated ointment was not one of his prescribed medications. LVN-G stated she had not seen the mentholated ointment in his room before and did not know where he had obtained it, but stated if it was left out, then either Resident #195 could possibly misuse it by placing it in his eyes or eating it, or another resident could walk by and take it.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675469	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2025
NAME OF PROVIDER OR SUPPLIER Harmony Care at Floresville		STREET ADDRESS, CITY, STATE, ZIP CODE 1811 Sixth St Floresville, TX 78114	
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the DON on 03/20/2025 at 2:31p.m., the DON stated that medicated over-the-counter medications should not be left out unsecured where residents could access them, as this could result in Resident #195 possibly misusing the medication or other residents accessing it. The DON stated this was not one of his prescribed medications and did not know how he had gained access to it, possibly his family brought it to him.</p> <p>Record review of the facility policy titled Storage of Medications (undated) revealed The facility shall store all drugs and biologicals in a safe, secure, and orderly manner.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>41651</p> <p>Based on observation and interview, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed, in that:</p> <ol style="list-style-type: none"> 1. Access to the handwashing sink was blocked by two rolling carts. 2. There was a sand-like substance on top of the dish sanitizing machine. <p>These deficient practices could result in residents consuming meals and/or snacks prepared in an unsanitary manner.</p> <p>The findings were:</p> <p>Observation on 03/18/2025 at 10:25 a.m. revealed that the hand-washing sink in the kitchen was blocked by a rolling cart with plate covers in front of the sink and a rolling cart with food trays next to it.</p> <p>During an interview with the Dietary Manager on 03/18/2025 at 10:27 a.m., the Dietary Manager stated the rolling carts should not have been stored in a manner which blocked access to the handwashing sink. The Dietary Manager further stated that kitchen staff moved the carts prior to washing their hands, and then put the carts back in front of and beside the sink.</p> <p>Observation on 03/21/2025 at 10:28 a.m., revealed the presence of numerous sand-like particles on top of the dish sanitizer machine. Further observation revealed the machine was accessed via a side cover which slid up and down and came into contact with the sand-like particles and could potentially cause the particles to come into contact with dishes and utensils utilized to prepare and serve meals and snacks for residents.</p> <p>During an interview with the Dietary Manager on 03/21/2025 at 10:28 a.m., the Dietary Manager confirmed the presence of numerous sand-like particles on top of the dish sanitizer machine, and confirmed the particles could potentially come into contact with dishes and utensils utilized to prepare and serve meals and snacks for residents.</p> <p>During an interview with the Administrator on 03/21/2025 at 2:50 p.m., the Administrator stated the facility did not have a policy regarding Dietary Services.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866</p> <p>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 disease and infection for 7 of 21 residents (Residents #12, #35, #70, #39, #80, #190 and, #198) reviewed for infection control:</p> <ol style="list-style-type: none"> 1. The facility failed to ensure CNA-D sanitized her hands in between feeding and assisting Residents #35, #39 and #70 with their meal on 03/18/2025. 2. The facility failed to ensure RN-E followed EBP when administering G-tube medication to Resident #190 on 03/19/2025. 3. The facility failed to ensure MA-F sanitized the blood pressure cuff in between use with Residents #80 and #12 on 03/20/2025. 4. a. The facility failed to ensure CNA A washed or sanitized her hands, before touching resident #198's clean brief and after touching the soiled resident's brief. b. The facility failed to ensure EBP were implemented or used while CNA A and CNA B provided high-contact resident activities, including: catheter care for Resident #198. <p>These failures could place residents at-risk for infection due to improper care practices.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Observation on 03/18/2025 at 11:40 a.m. in the South Building dining room revealed CNA-D feeding Resident #35 on one side of the dining table, occasionally using the edge of Resident #35's clothing protector to wipe her mouth and bringing her cup to her mouth to assist with drinking. Further observation revealed that in-between feeding Resident #35, CNA-D assisted Resident #70 who was seated immediately to her left at the end of the table, by removing her used food bowls handing her a spoon, putting sugar in her tea and stirring the tea. Then midway through the meal, without sanitizing her hands prior, CNA-D was observed to move her chair to sit next to Resident #39, who was sitting across the table to assist Resident #39 with setting up her utensils and scooping her food. After assisting Resident #39 with set-up and observing that she was scooping her food on her own, CNA-D moved her chair back to sit next to Resident #35, again without sanitizing her hands to finish feeding her the remainder of her meal. <p>Interview on 03/18/2025 at 12:14 p.m. with CNA-D revealed she was agency staff and this was her first day working at the facility. CNA-D stated she had received training in infection control both when she was studying to become a CNA and when she started working for the agency. CNA-D stated she knew she was supposed to sanitize her hands in between working with each resident, but did not have any sanitizer readily available, and stated she should probably carry a bottle of sanitizer with her in her pocket. CNA-D stated that by not sanitizing her hands in between working with each resident, she could spread germs from one resident to the next.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the DON on 3/20/2025 at 2:40 p.m. the DON stated all staff should be washing or sanitizing their hands in between feeding or assisting each resident, and not doing this could spread infection. The DON stated she had already been made aware of this incident and had already started on in-servicing CNA-D and the rest of the staff on hand hygiene and infection control.</p> <p>2. Record review of Resident #190's face sheet revealed a [AGE] year old man admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included: Malignant neoplasm of colon (colon cancer), gastrostomy status (presence of a Gastrostomy tube or G-tube which is a tube inserted through the abdominal wall into the stomach used to provide nutrition and hydration), colostomy status (presence of a colostomy, which is an opening in abdominal wall to divert stool from colon), pressure ulcer of sacral region Stage 4 (full-thickness skin loss exposing underlying tissue- also known as a bedsore- on the bony area of the lower back) and pressure ulcer of left heel.</p> <p>Record review of Resident #190's admission MDS assessment dated [DATE] revealed the resident was moderately impaired for daily decision-making skills and was dependent (helper does all the effort) for transfers and hygiene.</p> <p>Record review of Resident #190's Order Summary Report dated 03/19/2025 revealed the following:</p> <p>- Glucerna 1.5 at 70cc/HR x 22 hours daily via G-Tube every shift for Nutrition related to GASTROSTOMY STATUS.</p> <p>Record review of Resident #190's care plan revealed focus areas which included: resident requires tube feeding.</p> <p>Observation on 03/19/2025 at 03:20p.m. of Resident #190's medication administration via G-tube by RN - E, revealed RN-E did not wear a gown, only gloves when administering Resident #190's medication via his G-tube. Further observation revealed there was no EBP sign or PPE available outside Resident #190's door.</p> <p>During an interview with RN -E on 03/19/2025 at 03:35p.m., RN-E stated she though Enhanced Barrier Precautions was only needed when working with wounds or foley catheters. RN-E stated she thought EBP did not apply for G-tubes. RN-E further stated that the purpose of EBP was to prevent spread of infection when working with in-dwelling devices. RN-E said she has received training in infection control and Enhanced Barrier Precautions.</p> <p>3. Record review of Resident #80's face sheet dated 03/20/2025 revealed an admitted [DATE] with re-admit on 02/07/2025 and with diagnoses which included: Essential hypertension (condition characterized by persistently high blood pressure without an identifiable underlying cause)</p> <p>Record review of Resident #80's Order Summary dated 03/20/2025 revealed an order for Losartan Potassium Oral Tablet 25MG Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #12's face sheet revealed an admitted [DATE] with re-admit on 07/31/2022, with diagnoses which included: Essential hypertension (condition characterized by persistently high blood pressure without an identifiable underlying cause)</p> <p>Record review of Resident #12's Order Summary dated 03/20/2022 revealed an order for Carvedilol Tablet 25mg Give 1 tablet by mouth two times a day related to ESSENTIAL (PRIMARY) HYPERTENSION hold for SBP <110 and pulse <50.</p> <p>Observation of medication pass on 03/20/2025 from 07:53 a.m. through 08: 25 a.m. revealed CMA-F checked Resident #80's blood pressure prior to administering her oral medications, and then proceeded to Resident #12's room, where she sanitized her hands, but did not sanitize the blood pressure cuff before checking Resident #12's blood pressure with the same cuff she had checked Resident #80's blood pressure with.</p> <p>During an interview with MA-F on 03/20/2025 at 08:31 a.m., MA-F stated she knew she was supposed to sanitize the blood pressure cuff in between uses with different residents, but just forgot. She stated that by not sanitizing equipment in between uses with different residents it could spread infection. MA-F stated she had received training in infection control.</p> <p>Interview with the DON on 03/20/2025 at 2:40pm revealed all blood pressure cuffs need to be sanitized in between uses with each resident to prevent the spread of infection. The DON further stated that Enhanced Barrier Precautions needed to be used when working directly with any resident who had an indwelling device, and this included G-tubes. The DON stated she will work to ensure each resident who has indwelling devices has an EBP sign placed on their door, and PPE supply outside the door.</p> <p>Record review of the facility policy titled Infection Control Program (undated) revealed In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub for all the following situations: a. Before and after direct contact with residents; .i. After contact with objects (e.g. medical equipment) in the immediate vicinity of the resident.</p> <p>34788</p> <p>4. Record review of Resident #198's face sheet, dated 03/20/2025, revealed an admitted [DATE], with diagnoses which included: Pneumonia (infection of the lungs), Hypertension (High blood pressure), Urinary tract infection (an infection in any part of the urinary system) and Gastrostomy status (tube inserted in the stomach for feeding).</p> <p>Record review of Resident #198's 5 days MDS assessment, dated 03/03/2025 revealed Resident #198 had a BIMS score of 15, indicating no cognitive impairment. Resident #198 was coded as always incontinent of bowel and had an indwelling catheter. Resident #198 required total care with his ADLs (Resident was completely dependent of the staff for his ADLs).</p> <p>Review of Resident #198's care plan, dated 2/14/2025, revealed a problem of The resident has an indwelling Catheter: Neurogenic bladder(Lack of bladder control due to brain, spinal cord, or nerve problems), with a goal of The resident will be/remain free from catheter-related trauma through review date.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>a. Observation on 03/20/2025 at 2:22 p.m. revealed while providing incontinent care for Resident #198, CNA A removed the soiled brief from Resident #198 and, without washing or sanitizing her hands, placed and fasten the new clean brief on Resident #198.</p> <p>During an interview with CNA A on 03/20/2025 at 2:37 p.m., CNA A verbally confirmed she did not wash or sanitize her hands, before touching the clean brief and fastening the brief to the resident. CNA A stated she should have washed or sanitized her hands prior to putting new gloves on and placing the new brief on Resident #198. She stated the staff received infection control training regularly.</p> <p>During an interview with the DON on 03/20/2025 at 3:56 p.m., the DON confirmed the CNA should have washed or sanitized her hands between changing her gloves, prior to placing the clean brief under the resident to prevent risk of cross contamination and prevent infection for the resident. She stated the staff received infection control training frequently and their skills were checked yearly. The DON revealed she and her ADONs were doing spot checks to check the skills of the staff.</p> <p>Review of facility's policy, titled Protecting Residents, employees and Visitors from Infectious Diseases, undated, revealed Use an alcohol-based hand rub [] before moving from a contaminated body site to a clean body site during resident care.</p> <p>b. Observation on 03/20/2025 at 02:22 p.m. of Resident #198's catheter care provided by CNA A and CNA B, revealed CNA A and CNA B did not wear a gown, only gloves when providing catheter care for Resident #198. Further observation revealed there was no EBP sign or PPE available outside Resident #198's door.</p> <p>During an interview with CNA B on 03/20/2025 at 03:51 p.m., CNA B revealed she was not aware Enhanced Barrier Precautions was needed when working with indwelling catheters. She was not sure she had received training regarding Enhanced Barrier Protection.</p> <p>During an interview with the DON on 03/20/2025 at 3:56 p.m., the DON confirmed EBP should be used for Resident #198 due to his indwelling catheter and Enteral feeding tube. DON further stated that the purpose of EBP was to prevent spread of infection when working with in-dwelling devices. The DON revealed training on EBP was provided to the staff.</p> <p>Record review of the facility policy titled Enhanced Barrier Precautions (undated) revealed EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO's to staff hands and clothing. Further review revealed EBP are indicated for residents with any of the following: .Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO.</p>		

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<p>F 0921</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>41651</p> <p>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 beauty shop reviewed, in that:</p> <p>The beauty shop was unlocked and contained potentially dangerous materials.</p> <p>This deficient practice could result in residents, staff, and visitors living, working, and visiting in a potentially dangerous environment.</p> <p>The findings were:</p> <p>Observation on 03/21/2025 at 11:28 a.m. revealed the facility beauty shop was unlocked. Further observation revealed a container of liquid labeled [Brand] Disinfectant, Fungicide, Virucide - Danger Keep Out of Reach of Children and an open tube of hair dye labeled Danger Combustible Liquid. Causes severe skin burns and eye damage. Causes serious eye damage on top of a counter in the beautician shop.</p> <p>During an interview with MA C on 03/21/2025 at 11:29 a.m., MA A confirmed the presence of the disinfectant liquid and hair dye and confirmed that materials with warning labels should not be accessible, so that residents, staff, and the public do not come into contact with potentially dangerous materials.</p> <p>During an interview with the Administrator on 03/21/2025 at 2:50 p.m., the Administrator stated it was the responsibility of all staff to ensure the beauty shop was locked and confirmed that materials with warning labels should not be accessible, so that residents, staff, and the public do not come into contact with potentially dangerous materials.</p> <p>During an interview with the Administrator on 03/21/2025 at 2:50 p.m., the Administrator stated the facility did not have a policy regarding Physical Environment.</p>