STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675564	A. Building B. Wing	02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Care at Giddings	1181 N Williamson Giddings, TX 78942

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17141 Based on observation, interview, and record review, the facility failed to ensure each resident was treated with respect and care in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life for 1 (Resident #5) of 7 residents reviewed for resident rights. The facility failed to honor Resident #5's request of being assisted out of bed on 02/09/25. This failure could place resident at risk for depression, diminished quality of life and isolation. Findings included: Review of Resident #5's face sheet, dated 02/09/2025, reflected a [AGE] year-old female admitted to the facility on [DATE] with a diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (a condition that occurs when the right side of the brain is damaged, resulting in physical disabilities on the left side of the body), depression, unspecified (disorder than can impact your mood, thoughts and feelings, weight, sleeping habits, etc.) and pain. Review of Resident #5's MDS Admission Assessment, dated 07/22/2024, reflected Resident #5 had a BIMS score of a 10, which indicated her cognition was moderately impaired. Resident #5 required a mechanical lift with transfers. Review of Resident #5's Comprehensive Care Plan , revised on 07/29/2024, reflected Resident #5 had a focused area of depression. The interventions included encourage Resident #5 to be an active participant in decision making. Encourage Resident #5 to be involved in activities of choice and preferences. During an observation on 2/9/25 from 8:15 am until 9:10 am revealed Resident #5 remained in her bed. Resident #5 was eating breakfast while in her room alone. (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
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/9/25 at 8:58 am with Resident #5 revealed that she had wanted to get up this morning prior to breakfast time. Resident #5 stated she was told by staff that they could not get her up. Resident #5 stated she liked to get up and eat in the dining room with other people. She stated it makes her mad and sad to be told she cannot get up out of bed. Resident #5 stated it happens all the time that they tell her she cannot get up. During an interview on 2/9/25 at 9:00 am with CNA A revealed she was unable to get Resident #1 out of bed because they did not have a clean sling to use for her. They are waiting for the laundry to get finished washing and drying the sling. In a follow-up interview on 2/10/25 at 9:20 am with CNA A, she stated on average she would guess it happened about one time a week that a sling is not available for Resident #5 to get up. During an interview on 2/9/25 at 9:10 am with Laundry Aide B revealed the sling needed to get Resident #5 out of bed had not been put in the washing machine yet. She stated that the current load had 16 more minutes than she would wash the sling and set it outside to air dry. The amount of time it would take depended on how fast it dried outside and the weather. During an interview on 2/10/25 at 9:50 am with the Adm revealed he was not aware that Resident #5 was not being assisted to get out of bed because of the lack of a sling. He stated soon after the observation yesterday another sling was found. He also had talked to the laundry person and told her if a sling were needed, she could dry it in the dryer. The Adm stated it should not be happening that Resident #5 was told a sling was not available to get her up. He stated all residents have the right to get out of bed when they asked. Review of a facility In-service Training Report dated 11/11/24, with the topics to be covered including resident rights. The in-service contents covered included a document titled Resident Rights which included The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17141 Based on interview and record review, the facility failed to immediately notify the resident's representative(s) when there was a significant change in the resident's physical and psychosocial status for one (Resident #4) of seven residents reviewed for changes in condition. 1. The facility failed to notify Resident #4's RP of Resident #4 being hit by a peer on 2/3/25. 2. The facility failed to notify Resident #4's RP of a visit to the ER after Resident #4 had a fall on 2/7/25 with an onset of increased confusion. These failures could put residents at risk of not having their care needs and health changes communicated and addressed with their responsible party. Findings included: Review of Resident #4's undated face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease with early onset (a progressive disease that destroys memory, thinking and behavior, interfering with daily functioning), cognitive communication deficit (reduced ability to communicate needs), and dementia (brain impairment of at least two brain functions). Responsible Parties are listed as Resident #4 and RP E. Review of Resident #4's payment MDS assessment, dated 1/25/25, reflected a BIMS score of 9, indicating moderate cognitive impairment. Review of Resident #4's quarterly care plan, initiated 1/28/25, reflected focus areas of diet and falls. Review of Resident #4's Progress Notes from 1/13/25 through 2/8/25, revealed there were no entry on the notes for 2/3/25. Continued review revealed on 2/7/25 RN D documented at 11:20 pm that a weekly skin assessment was completed. At 11:32 pm Pt sent to hospital for evaluation post unwitnessed fall, skin tear and new onset of confusion. On 2/8/25 at 10:09am Resident #4 was noted to have returned from the ED with orders for an antibiotic for seven days. No diagnoses or other orders were noted. Review of an IR dated 2/7/25 included Pt found laying down on the floor in room next to wheelchair with blood from the right wrist due to skin tear. The predisposing physiological factors included check marks indicating confusion and impaired memory. People notified were listed as the physician, DON, and Resident #4 herself. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/9/25 at 9:54 am, Resident #4's RP E revealed they did not know that Resident #4 had been hit by another resident or that she had been sent to the ER after a fall. RP E stated although they had not been able to be as involved in Resident #4's care, they still would like to be notified of those types of events. RP E stated the frequency of events like this would indicate whether Resident #4 was in a safe place and that would be something they are interested. RP E stated they had been notified of Resident #4's admission into the facility but had not been notified since that time. RP E stated Resident #4 was not able to make decisions on her own which was why she was on a secure unit, she no longer had safety awareness. During an interview on 2/8/25 at 12:48 pm, CNA F stated he normally worked alone on the secure unit. He stated he can usually handle it but will request help occasionally. CNA F stated on 2/3/25 there was an incident in which Resident #4 was hit by Resident #7. He stated he asked a physical therapist who was in the unit working with another resident to notify the nurse and administration. CNA F stated he separated the two residents into different areas and LVN C came to assess the residents. CNA F stated he assumed someone in administration had also been notified. CNA F stated Resident #4 had redness to the side of her face but no other injuries. During an interview on 2/8/25 at 4:21pm, LVN C stated she had been aware of the incident during which Resident #4 was hit but had not documented or notified the RP as she had been told the DON was involved and she assumed everything needed would be done by the DON. During an interview on 2/8/25 at 11:05 pm with RN D revealed he was not aware that a peer had hit Resident #4. He was working on 2/7/25 when Resident #4 fell . RN D stated she had been sent to the ED due to a possible change in the level of confusion. RN D explained Resident #4 had a history of confusion, but seemed at the time more so than usual and they were not able to determine the cause of the fall. He did not notify the RP; the resident was her own RP. During an interview on 2/10/25 at 8:45 am, the facility DOR stated on 2/3/25 one of the PT staff had come to her while she was in a meeting with the administration, and reported she needed to tell the Administrator about an incident involving two residents on the secure unit. The DOR stated the Administrator was in the meeting so she directed her staff to him. During an interview on 2/10/25 at 9:50 am, the Adm stated he was notified by a PT staff on 2/3/25 that the staff on the secure unit wanted to see him. The Adm stated he assumed the staff wanted to see him regarding an issue they had been discussing previously he had not realized there was an incident of aggression between two residents. He stated had he known about the incident he would have sent a nurse to assess the resident, notify the physician if needed, write an IR, and notify the RP. During an interview on 2/10/25 at 9:30 am, the DON stated she was not notified of Resident #4 being hit by another resident. The DON stated she had been notified of Resident #4's fall and was aware that Resident #4 was being sent to the ED. The DON stated she had instructed RN D to notify Resident #4's RP. She stated that the RP should have been notified of both events. Review of the facility's Charting and Documentation policy, revised April 2008, reflected the policy included the following: All incidents, accidents, or changes in the resident's condition must be recorded. Documentation of procedures and treatments shall include care-specific details and include at a minimum: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f. Notification of family, physician, or other staff, if indicated.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17141 Based on interview and record review, the facility failed to, in response to allegations of abuse, neglect or mistreatment, have evidence that all alleged violations were thoroughly investigated for two (Residents #4 and #7) of seven residents reviewed for abuse and neglect. The facility failed to investigate an allegation of abuse when Resident #7 hit Resident #4 on her face on 2/3/25. This failure placed residents at risk of further abuse, trauma, and psychosocial harm. Findings included: Review of Resident #4's undated face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease with early onset (a progressive disease that destroys memory, thinking and behavior, interfering with daily functioning), cognitive communication deficit (reduced ability to communicate needs), and dementia (brain impairment of at least two brain functions). Responsible Parties are listed as Resident #4 and RP E. Review of Resident #4's MDS assessment, dated 1/25/25, reflected a BIMS score of 9, indicating moderate cognitive impairment. Review of Resident #4's quarterly care plan, initiated 1/28/25, reflected focused areas of diet and falls. Review of Resident #4's Progress Notes from 1/13/25 through 2/8/25, revealed there were no entry on the notes for 2/3/25. Review of Resident #7's face sheet, dated 2/9/25, reflected a [AGE] year-old male admitted to the facility on [DATE] with a diagnosis of dementia severe with agitation (brain impairment of at least two brain functions with worry and anxiety) and schizoaffective disorder (a combination of schizophrenia, a mental health condition with symptoms of hallucinations or delusions mixed with mood disorder such as mania and depression) Review of Resident #7's MDS Assessment, dated 1/31/25, reflected Resident #7 had a BIMS score of a 3, which indicated severe cognitive impairment. Record review of Resident #7's Comprehensive Care Plan, initiated, 1/28/25 reflected a focus area of a regular/mechanical soft diet. No other focused areas were included. Review of Resident #7's Progress Notes from 1/15/25 through 2/8/25, revealed there were no entry on the notes for 2/3/25. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/8/25 at 12:48pm, CNA F stated on 2/3/25 there was an incident in which Resident #4 was hit by Resident #7. He stated he asked a physical therapist who was in the unit working with another resident to notify the nurse and administration. CNA F stated he separated the two residents into different areas and LVN C came to assess the residents. CNA F stated he assumed someone in administration had also been notified. CNA F stated Resident #4 had redness to the side of her face but no other injuries. During an interview on 2/8/25 at 4:21pm, LVN C stated she had been aware of the incident during which Resident #4 was hit but she had not documented or notified the RP as she had been told the DON was involved, and she assumed everything needed would be done by the DON. During an interview on 2/10/25 at 8:45 am, the DOR stated, on 2/3/25, one of the PT staff had come to her while she was in a meeting with the administration, and reported she needed to tell the Administrator about an incident involving two residents on the secure unit. The DOR stated the Administrator was in the meeting so she directed her staff to him. During an interview on 2/10/25 at 9:30 am, the DON stated she was not notified of Resident #4 being hit by another resident. She stated had she been notified, she would have reported the incident as abuse. During an interview on 2/10/25 at 9:50 am, the Adm stated he was notified by a PT staff on 2/3/25 that the staff on the secure unit wanted to see him. The Adm stated he assumed the staff wanted to see him regarding an issue they had been discussing previously he had not realized there was an incident of aggression between two residents. He stated had he known about the incident he would have sent a nurse to assess the resident, notify the physician if needed, write an IR, and notify the RP. The Adm stated if he had been told, he would have investigated the incident to make sure the residents were safe and determine whether or not the incident was reportable. Review of the facility policy abuse/ neglect, undated, reflected the policy included the following: It is the policy of this facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, involuntary seclusion, misappropriation of property, exploitation, neglect, or mistreatment. The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations. These guidelines include compliance with the seven (7) federal components of prevention and investigation .The Administrator is the Abuse Coordinator in this facility and is responsible for developing and implementing the abuse prevention training curriculum and conducting the investigation in situations of alleged abuse/neglect.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17141 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 of 7 residents (Residents #5 and #7) reviewed for care plans. 1. The facility failed to ensure the comprehensive care plan for Resident #5 included the need for a mechanical lift transfer with the assistance of 2 staff. 2. The facility failed to ensure Resident #7's comprehensive care plan included aggressive behaviors. These failures could affect residents by placing them at risk of not receiving appropriate physical and psychosocial care. Findings included: Review of Resident #5's face sheet, dated 2/9/2025, reflected a [AGE] year-old female admitted to the facility on [DATE] with a diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (a condition that occurs when the right side of the brain was damaged, resulting in physical disabilities on the left side of the body), depression, unspecified (disorder than can impact your mood, thoughts and feelings, weight, sleeping habits, etc.) and pain. Review of Resident #5's MDS Admission Assessment, dated 07/22/24, reflected Resident #5 had a BIMS score of 10, which indicated her cognition was moderately impaired. Resident #5 required a mechanical lift with transfers. Record review of Resident #5's Comprehensive Care Plan, revised, 09/12/24 reflected a focus area of ADL self-care performance the interventions listed included TRANSFER: the resident is able to: Requires total assist x1. Review of Resident #7's face sheet, dated 2/9/25, reflected a [AGE] year-old male admitted to the facility on [DATE] with a diagnosis of dementia severe with agitation (brain impairment of at least two brain functions with worry and anxiety) and schizoaffective disorder (a combination of schizophrenia, a mental health condition with symptoms of hallucinations or delusions mixed with mood disorder such as mania and depression) Review of Resident #7's MDS Assessment, dated 1/31/25, reflected Resident #7 had a BIMS score of a 3, which indicated severe cognitive impairment. Review of Resident #7's Comprehensive Care Plan, initiated, 1/28/25 reflected a focus area of a regular/mechanical soft diet. No other focused areas were included. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of progress Notes from previous facility included with admission paperwork, dated 1/13/25, revealed recent documentation of aggressive history for Resident #7 on 1/23/25 it was noted he had the behavior of grabbing and spitting on nurses. During an interview on 2/8/25 at 12:48 pm, CNA F stated Resident #7 had been frequently aggressive with staff when they were providing care. He stated he knew of one incident in which Resident #7 was also aggressive with a peer. CNA F stated he did the best he could do to deal with the aggression and protect the other residents. During an interview on 2/8/25 at 4:49 pm, CNA G stated she experienced Resident #7 being aggressive toward staff. CNA G stated she would, in the past, just back off from assisting him and try again later. During an interview on 2/9/25 at 11:30 am the Adm stated the person responsible for care plans was a corporate nurse, and the DON added some of the nursing needs. He stated aggressive behaviors and transfer needs should be included in a resident's care plan. During an interview on 2/10/25 at 9:30 am with the DON revealed that she was only able to add antibiotic treatments and falls to a care plan. She stated Resident #4's transfer needs with the mechanical lift and 2 staff should be on the care plan. Resident #7's aggression should also be addressed on the care plan. During an interview on 2/10/25 at 9:10 am with Corporate LVN/DOR stated that day she was notified that the MDS nurse was out sick. It was her job to oversee all care plans at that facility, and others owned by the same corporation. The LVN/DOR stated she was not aware that Resident #4's care plan did not include her transfer requirements. She stated a mechanical lift always required the use of two staff members and should be included in the care plan. The LVN/DOR stated she was not familiar with Resident #7 but looking at his records they were close to being within the time, 21 days, that a comprehensive care plan was required. She stated the of the care plans was so they can provide the best care possible for the residents. Review of the facility policy titled Lifting Machine, Using a Mechanical, revised 7/2017, reflected the following: At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift. Review of the facility's Care Plans, Comprehensive Person-Centered policy, revised March 2022, reflected the following: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Statement: The interdisciplinary team is responsible for the development of resident care plans. Policy Interpretation and Implementation: 1. Resident care plans are developed according to the timeframes and criteria established by S483.21.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 17141 Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for one (secure hall) of three halls reviewed for physical environment. The facility failed to ensure an exit door on the secured unit contained an alarm to alert staff if a resident exited the door. This deficient practice could place residents at risk of injury or harm. Findings included: Review of the facility Midnight Census report dated 2/9/25 revealed there were 7 residents listed as residing on the secure unit. Review of the facility IRs from 10/1/2025 through 2/9/25 revealed there were none related to unauthorized departure. During an observation and interview on 2/8/25 at 12:48 pm with CNA F revealed he believed that the exit door contained an alarm that went off when it was opened. CNA F was not certain how to turn the alarm off. He stated he would normally ask the Administrator, who was not at the facility on that day. CNA F stated he had not observed any residents trying to go out the door. Observation of the exit door revealed there was a small box to the right of the door on the wall. There was no indication of the box being connected to the door. During an observation and interview on 2/9/25 at 9:30 am with the Adm revealed there was a problem with one of the secure unit exit doors. He stated they were aware and had ordered an alarm for the door. He stated there was no functioning alarm at that time. Observation of the exit door revealed when opened, it opened to an outside fenced area. No alarm was detected or heard. The Adm confirmed the seven residents housed on the secure unit were there for their safety has they had a history of UDs or attempts . He stated he was not aware of any attempts of UD since those residents were admitted to the newly opened secure unit a little over a month ago. The Adm stated there was always a staff member on the unit, making sure the residents were safe. When asked what happened if a resident went out the door while staff was providing personal care to another resident unaware that someone went out, he stated they would be in a fenced in area that contained a tall fence. During an interview on 2/9/25 at 4:09 pm with the Maintenance Technician revealed he was notified on 2/3/25 that someone had pulled the wires from the door alarm. He stated he did not know why anyone would do that, but it was not repairable. He stated, on 2/4/25, he ordered a new alarm. He stated, on 2/6/25, he put a temporary alarm up so the staff would know if someone went out. The Maintenance Technician stated he did not know what had happened to make that alarm nonfunctioning, but tomorrow morning, he would make sure there was a functioning alarm. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an additional observation and interview on 2/10/25 at 8:15 am with the facility Maintenance Technicia, n he stated the Adm had bought another temporary alarm at a local retail and applied it to the door yesterday. Observation of the door revealed there was a new box to the side of the door. When the door was opened a loud alarm went off.