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	03/28/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39269 Based on interviews, and record review, the facility failed to establish and 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 infection for 2 of 5 residents (Residents #1 and #2) reviewed for infection control. The facility failed to ensure Resident #1 was placed on Isolation after she tested COVID-19 (Coronavirus 2019) positive in the hospital on [DATE]. The facility failed to have signage on Resident #1's door that reflected PPE was required for infection control. The facility failed to removed Resident #2 from a COVID-19 positive room even though she tested negative for COVID. These failures could place residents at risk for infection, or hospitalization . Findings included: According to the intakes received by HHSC, The facility is not practicing infection control. They are not quarantining the covid positive Residents. [Resident #3] is next door to [Resident #1], and she is Covid Positive. The staff are not wearing PPEs, gloves or gowns. The staff are saying the Resident's covid test results are negative. This is false. The Complainant is concerned Covid will spread to other Residents due to the facility lack of infection Control, and on [DATE], [Resident #1] was sent to the local hospital due to loss of appetite, body aches and cough .The Resident came back from the hospital a couple of hours later. The Complainant assisted EMS with getting the Resident back into the facility and overheard an EMT tell [LVN A] that [Resident #1] had COVID. [Resident #1] is not receiving treatment, and there is not even isolation sign on her door. The complainant fears the illness will spread to other Residents. There Complainant is not aware of other active COVID-19 cases in the facility, but there are several Residents with similar symptom. [sic] (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's face sheet, dated [DATE], reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included Systemic Lupus Erythematosus unspecified (a chronic autoimmune disease in which the body's immune system mistakenly attacks healthy tissues in many parts of the body), nontraumatic intracranial hemorrhage (bleeding within the intracranial vault including the brain), Cognitive communication deficit, Acute respiratory failure with hypoxia (Hypoxia is low level of oxygen in the body tissue). Review of Resident #1's Quarterly MDS Assessment, dated [DATE], reflected Resident #1 had a BIMS score of 10, which indicated she had moderate cognitive impairment. Review of Resident #1's Comprehensive Care Plan dated [DATE] reflected Resident #1 had an ADL self-care. performance deficit, had impaired cognitive function/dementia or impaired thought processes, had altered respiratory status/difficulty breathing. Review of Resident #1's progress noted dated [DATE] at 9:51 am written by LVN A reflected, minimally responding to verbal and tactile stimulation, very clammy and diaphoretic. New order received: IV 1L 100ml/hr. CBC, CMP, UA, chest Xray. Review of Resident #1's progress noted dated [DATE] at 1:36 pm written by LVN A reflected, doc notified of COC, resident appears to be lethargic, clammy, and diaphoretic. to receive from doc: CBC, CMP, UA, chest Xray, IV NS 1000mL at 100mL/h. Review of Resident #1's progress notes dated [DATE] at 9:00am written by the DON reflected, LATE ENTRY Note Text: Spoke with nurse at hospital notified at this time that resident was given test for Covid which was NEGATIVE. Also notified that MD seen no need for IV placement. Resident is not dehydrated. Resident sent back to facility with no medications ordered. Review of Resident #1's clinical records from [DATE] through [DATE] did not reflected Resident #1 was COVID positive. It did not reflect Resident #1 was isolated due to COVID and was being monitor. It did not reflect Resident #1 was being treated for COVID 19. Review of Resident #2's face sheet, dated [DATE], reflected a [AGE] year-old female who was admitted to the facility on [DATE] with readmitted [DATE]. Resident #2 had diagnoses which included Metabolic Encephalopathy (a condition characterized by brain dysfunction caused by systemic metabolic disturbances. Symptoms make include confusion, memory loss, loss of consciousness), Urinary tract infection, Dysphagia (difficulty swallowing) following unspecified cerebrovascular disease (group of conditions that affect blood flow and blood vessels in the brain). Review of Resident #2's Admission MDS Assessment, dated [DATE], reflected Resident #2 had a BIMS score of 1, which indicated she had severe cognitive impairment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's Comprehensive Care Plan initiated [DATE] reflected Resident #2 required staff assistance for meeting emotional, intellectual, physical, and social needs related to diagnosis of Dementia, Resident is at risk for infection related to risk of COVID-19, and also at risk for social isolation r/t infection control practices implemented by CDC and CMS guidelines to limit visitation, communal dining, and group activities. Community transmission of COVID-19. Review of Resident #2's progress notes dated [DATE] written by the DON reflected: Late Entry: created [DATE] @1:43 pm Note Text: tested for covid NEGATIVE. Review of Resident #2's clinical records did not indicate Resident #2 was moved to another room due to roommate being tested positive for COVID-19 Review of facility's infection control logs for the months of January, February and March of 2025 did not reflected Resident #1 or any other Resident had COVID-19. During an interview on [DATE] at 12:10 pm, LVN A stated she was not in the facility when Resident #1 was transferred to the local HospitalER on [DATE] and assumed Resident #1 had a changed of condition that is why she was sent to the hospital. LVN A stated she was the assigned nurse when Resident #1 returned from theER on [DATE] and Resident #1 was not in any Respiratory distress, Resident #1 was at baseline. LVN A stated EMT to her Resident #1 was COVID positive and she told the EMS staff that was not true, Resident #1 was not COVID positive because nurse to nurse report from the hospital and was told Resident #1 was COVID negative. LVN A stated EMS gave her Resident #1's hospital papers and it indicated Resident #1 was COVID negative. LVN A stated she told the DON what the EMS staff had said about Resident #1 being COVID positive and put Resident #1's hospital records in the medical records box. LVN A stated since she had been at the facility from ,d+[DATE] to [DATE], no Resident had tested positive for COVID-19 so there was no need to isolate a Resident. During an interview on [DATE] at 12:36 am LVN B stated she was not the nurse on duty who sent Resident #1 to theER on [DATE]. LVN B stated she had not seen Resident #1 with change of condition, no coughing, no running nose. LVN B stated as far as she can recall, there has been no resident with s/s of covid or tested positive for covid. If someone test positive for covid we have to put them on isolation, let the DON and the Administrator know, they will take it from there and notified whoever. During an interview on [DATE] at 12:47pm, Resident #1's family stated, she was told by facility's staff that Resident #1 was sent to the ER to get IV started because they were having trouble starting an IV. Resident #1's family also stated facility staff told her Resident #1 was COVID negative. Family also stated if Resident #1 had COVID, the nurses and the DON did not tell her. During an interview on [DATE] at 1:04 pm, CNA C stated he had worked with Resident #1 and was never told she was COVID-19 positive. CNA C stated since he had worked in the facility from ,d+[DATE], no resident had tested positive for COVID-19; No Resident had been put on isolation due to COVID-19. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 1:37 pm, the Medical Record staff stated when a resident comes from the hospital, the nurses give him the resident's hospital records, and it is scanned into PCC. The Medical Record staff stated he did not get hospital records for Resident #1's hospital visit on [DATE]. He stated he was aware that Resident #1 went to the hospital on [DATE] but there were no records. During an interview on [DATE] at 1:45 pm, CNA D stated she was usually assigned with Resident #1. CNA stated she could not recall if Resident #1 had signs and symptoms of COVID 19. CNA D stated Resident #1 told her she was COVID positive around the time the resident was sent to the ER. CNA D stated there was a rumor in the facility that Resident #1 was COVID positive but there was nothing done to treat Resident #1. CNA D stated Resident #1 had a roommate, the roommate was never removed from the room and Resident #1 was never isolated. During an interview on [DATE] at 2:38 pm, the DON stated she was in the facility when Resident #1 was being sent to theER on [DATE] due to IV placement. She stated she got nurse-to-nurse report from the hospital on [DATE] regarding Resident #1 was being transfer back to the facility. The DON stated she was also told Resident #1 was COVID negative and Resident #1 did not need IV fluids based on labs done at the hospital. The DON stated she was in the facility when Resident #1 got back, and EMS did not provide hospital papers. The DON said she did not hear EMS say Resident #1 was covid positive. The DON stated, Resident #1's family stated Resident #1 was COVID negative. The DON stated she heard the staff say Resident #1 was positive for COVID, but they did not re-test Resident #1 to confirm because there were no covid test in the facility. The DON stated the COVID test in the facility were all expired. The DON stated, if a Resident was COVID positive, they had to isolate the resident, notify family and the Doctor, test roommate and or remove from the room depending on the test result. During an interview with on [DATE] at 2:00 pm, Resident #1 stated she recalled going to the ER for IV meds. Resident #1 stated while in the hospital, they swapped her nose for COVID, and they try to say she had COVID. Resident #1 stated she did not think she had COVID because she did not feel the same as when she had COVID before and was surprised. Requested Hospital records for Resident #1's hospital stay on [DATE] from the Administrator and the Hospital. Received Resident #1's hospital records on [DATE]. Reviewed of Resident #1's hospital records dated [DATE] reflected the following: COVID-19 confirmed, Cough unspecified-confirmed, fever unspecified-confirmed. Chief Complaint-Nausea-Patient is a [AGE] year-old female who comes to the emergency department by EMS from [Nursing Home] complaining of flulike symptoms, of cough, congestions fever, running nose for 2 days. The Nursing home staff was concerned she might be dehydrated and called EMS to have her evaluated. She is speaking in full sentences, alert and oriented without distress.Vital signs stable. Denies any other symptoms. Lab results-2019 Coronavirus SARS-CoV-2Ra positive on [DATE] at 11:42 am (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ED Course: Patient is a [AGE] year-old female who comes to the emergency department complaining of generalized flulike symptoms and cough for the past few days. Denies any Nausea or vomiting to me. No clinical evidence of dehydration. Vital signs are stable. Patient is COVID positive, and symptoms have been going on for the past few days. Unable to get a list of her medications and without this I do not feel comfortable prescribing Paxlovid at this time due to possible interactions with her other medications. Patient is asymptomatic and hemodynamically stable at this time. Recommended continued supportive care, fluid hydration orally and close outpatient follow-up with PCP with droplet precaution at the nursing home to avoid spread of the virus to other residents. During an interview on [DATE], LVN A stated she and the DON sent Resident #1 out to the hospital on [DATE] for IV placement. LVN A stated Resident #1 had a change of condition, the MD and Resident #1's family were notified. LVN A stated she called EMS and explained why Resident #1 was being sent to the ER. LVN A stated she was still at work on [DATE] when Resident #1 returned from the ER. LVN A stated she did not get report for the hospital regarding Resident #1, the DON got report. LVN A stated the EMS staff told her Resident #1 was COVID positive and she did not take them seriously because the 2 EMS personnels did not want to be there and was just doing the job to get pay. LVN A looked at Resident #1's printed hospital records and stated those were the same records Resident #1 came back from the hospital with on [DATE]. LVN A stated if the hospital records indicated Resident #1 was COVID positive, then she was COVID positive. LVN A stated Resident #1 was sent to the ER for IV placement due to dehydration, not COVID test and was tested by the hospital due to protocol. LVN A stated she came back to the facility at the end of my shift I was ready to go home. I have life outside of work, I come and do my job and leave. I passed report on to the incoming shift that Resident #1 was COVID positive, I don't recall speaking with the DON that Resident #1 was COVID positive, I did not notify the MD, I passed it on in report and went to my Kids. LVN A stated, I am assuming we isolate if a Resident was COVID positive, roommate has to be tested and removed from the room, staff wear full PPEs. LVN A stated she did not test Resident #1's roommate for COVID, she did not know what happened to Resident #1's roommate. LVN A stated she left, went home, not sure if she worked the days following because she had taken some days off. LVN A stated isolation is to prevent them from passing on to somebody else. PPEs included gowns, N95 mask/face shield and gloves. During an interview on [DATE] at 09:38 am the DON stated Resident #1 was sent to theER on [DATE] due to showing signs and symptoms of dehydration such as low blood pressure and dry lips. The DON stated the facility tried to start an IV but was unsuccessful, MD was notified, and Resident was transferred to the hospital. The DON stated LVN A said Resident #1 was sent back without hospital papers. The DON stated Resident #1 should have had hospital records and the admitting nurse is responsible to review the hospital records and give to medical record personnel to enable all staff working with the resident to have access to the records. DON stated she did not see Resident #1's hospital records until [DATE]. The DON stated COVID POSITIVE precautions were isolation, verify the test by retesting, notify families and all parties, test the roommate, if negative they are to be removed from the room, don PPEs such as gowns, gloves, face shield, N95 mask, the sign on the door. The DON stated Resident #1 was not COVID positive, but the roommate was tested negative and moved to another room. During an interview on [DATE] at 10:36 am, Resident #1 stated her roommate had been in the room the entire time and had not been moved to another room. Resident #1 stated staff had not been wearing gowns and mask to care for her when she came back from the hospital. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] from 10:42 am through 1:09 pm CNA D, CNA F, CMA G, CNA H, CNA I, Housekeeper J and Housekeeper K all stated Resident #1 was never isolated when she returned from the hospital. They stated there had not been any communication of COVID positive resident in the facility around the time Resident#1 went to the hospital. They all stated it was never passed in report that Resident #1 had COVID. They all stated Resident #1's roommate was never moved to another room. They stated they were never in-serviced on COVID positive in the last 60 days. During an interview on [DATE] at 11:55 am, the Administrator said he first heard Resident #1 went out to theER on [DATE] during their regular morning meeting due to him being off work. The Administrator stated he was not made aware by the DON that Resident #1 tested positive for COVID 19. The Administrator stated if a resident was COVID positive, the expectation was to isolate the resident and monitor, do not have to put them on another hall, follow infection control precautions. The Administrator stated, if the positive resident had a roommate, the roommate should be tested and quarantine when negative. The Administrator stated the DON have details on the facility's policy on COVID, he did not know. The Administrator stated COVID positive should be communicated with other staff caring for the residents for precautions. The Administrator stated he never saw Resident #1's hospital records until [DATE]. The Administrator stated, when a resident was transferred from the hospital, their hospital records are scanned into the system by the Medical Record staff. The Administrator stated the nurses were supposed to review the records for updates, changes and update the Resident's medical records. The Administrator stated he expected the nurses to take into serious consideration what EMS tells them to familiarize themself with the resident, if not done, they will not know how to properly care for the Residents. The Administrator stated they have not isolated any resident for COVID since he had been at the facility due to not having covid positive resident. The Administrator stated it was the expectation for the staff to call the hospital to get paperwork/records, to follow up from the hospital, for continuity of care. He stated, not following the steps for taking precautions could have caused an outbreak, bigger problems, potential to affect other Residents and staff. He stated the DON was supposed to ensure that there were covid tests in facility. During an interview on [DATE] at 2:57 pm, LVN L stated he usually got report from LVN A due to them being on the same rotation. LVN L stated he had never gotten report from LVN A indicating Resident #1 was COVID positive. LVN L stated Resident #1 has never been isolated due to COVID-19 and her roommate had been in the room the entire time. LVN L stated if a Resident tested positive for COVID-19, they are to be isolated in a room by themselves or with another covid positive Resident. Staff would wear full PPE such as N95 mask, gown, gloves, face shield, sign place on the door. LVN L stated if Resident #1 tested positive, it would have been good communicating it to staff that provide care for the resident to prevent the spread of the virus. Review of facility's policy titled Infection Prevent and Control Program updated ,d+[DATE] reflected: 1. The infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program. 2. The elements of the infection prevention and control program consist of coordination/oversight, policies/ (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety. Policies and Procedures Policies and procedures are utilized as the standards of the infection prevention and control program. The infection prevention and control committee, Medical Director, Director of Nursing Services, and other key clinical and administrative staff review the infection control policies at least annually. The review will include: (1) Updating or supplementing policies and procedures as needed; (2) Assessment of staff compliance with existing policies and regulations; and (3) Any trends or significant problems since the previous review. Prevention of Infection a. Important facets of infection prevention include: (1) identifying possible infections or potential complications of existing infections; (2) instituting measures to avoid complications or dissemination; (3) educating staff and ensuring that they adhere to proper techniques and procedures; (4) enhancing screening for possible significant pathogens; (5) immunizing residents and staff to try to prevent illness; (6) implementing appropriate isolation precautions when necessary; and (7) following established general and disease-specific guidelines such as those of the Centers for Disease Control (CDC). Requested facility's COVID policy on [DATE] and [DATE] from the Administrator and policy was never given.