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	12/17/2025

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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of property of resident property, establish policies and procedures to investigate any such allegations, and ensure reporting of crimes for 2 of 6 residents (R#1 and R#2).1. The facility failed to ensure R#1 was safe after alleging the ADM harassed, bullied, and picked on him on 12/06/25.2. The facility failed to ensure R#2 was safe after alleging R#1 threatened to choke her with his genitals on 12/06/25.3. The facility failed to ensure an AP was removed upon being notified of abuse and neglect allegations on 12/06/25. 4. The facility failed to report and investigate R#1's and R#2's allegations on 12/06/25. An IJ was identified on 12/15/25. The IJ template was provided to the facility on [DATE] at 5:41 p.m. While the IJ was removed on 12/17/25 at 5:30 p.m., the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy because of the facility's need to evaluate the effectiveness of their corrective systems.This failure could place residents at risk of further abuse, neglect, harm, injury, or death. R#1Review of R#1's admission record, dated 12/10/25, showed he was initially admitted to the facility on [DATE]. He had medical diagnoses that included vertebra osteomyelitis (a serious infection and inflammation of the spinal bones), a stage 4 pressure ulcer in his sacral region (a severe, full-thickness wound extending to muscle, bone, or supporting structures, involving tissue loss with potential for dead tissue, deep tunneling, and serious infection risk), neuromuscular bladder dysfunction (nerve damage disrupts signals between the brain and bladder, causing it to not fill or empty properly), paraplegia (paralysis affecting the lower half of the body, including the legs and sometimes the trunk), protein-calorie malnutrition (a serious nutritional disorder from not getting enough protein and/or energy), left lower limb cellulitis (a common bacterial skin infection affecting the skin and tissue of your left leg), and sepsis (life-threatening medical emergency where the body's extreme response to an infection damages its own tissues). He was discharged on 12/10/25 at 3:02 p.m. to other. Review of R#1's annual MDS, dated [DATE], showed he had a 15/15 BIMS, which indicated he was cognitively intact. He required partial/moderate assistance with upper body dressing and bed mobility, substantial/maximal assistance with toileting and showering and dependent on staff for lower body dressing and transfers. He also had one stage 3 pressure ulcer and one stage 4 pressure ulcer. He also had verbal behaviors that occurred 4-6 days but less than daily that did not impact him and others. Review of R#1's care plan report, initiated on 09/25/25, showed he had a stage 3 pressure ulcer on his left heel, stage 4 pressure ulcer to his sacral, right leg amputation and had a suprapubic catheter. He was also at risk for ADL decline and staff were required to provide extensive assistance for bed mobility and upper/lower body dressing, and total assistance with transfers. He also had episodes of exhibiting verbal/physical aggression towards staff and residents who reside in the facility and had a history of manipulative behavior. Nursing staff (CNA, LVN and RN) were required to provide safety, offer alternative time for care, back away, seek assistance if needed, notify the nurse of behaviors, provide medications as ordered, assess reports of behaviors and notify the MD if interventions are not effective if he becomes combative or aggressive. Staff were also required to be direct and firm when approaching him about behavior, clarify from him what he actually was saying or doing, document behavior in clinical record, inform staff on redirect methods for his behaviors when providing care, monitor for mental status changes, and psych services as needed. There were no notes related to R#1 and R#2's allegations. Review of R#1's progress notes between 12/06/25 and 12/09/25 reflected there were no notes related to R#1's and R#2's allegations. Review of R#1's POC response history for December 2025 showed staff documented there were no behaviors observed on 12/06/25, 12/07/25 and 12/09/25. There were also no documented entries on 12/08/25. Review of R#1's assessments from 12/06/25 through 12/10/25 reflected there were none related to R#1's and R#2's allegations. R#2Review of R#2's admission record, dated 12/12/25, showed she was admitted to the facility on [DATE]. She had medical diagnoses including cerebral palsy (a permanent group of neurological disorders affecting movement, posture, and coordination), bipolar disorder, schizophrenia, and generalized muscle weakness. Review of R#2's comprehensive MDS, dated [DATE], showed she had a 15/15 BIMS, which indicated she was cognitively intact. She also took antipsychotic, antianxiety, and antidepressant high risk medications. She required substantial/maximal assistance with dressing, toileting, bed mobility and dressing and was dependent on staff assistance for personal hygiene and transfers. Review

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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 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

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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 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to permit each resident to remain in the facility and not discharge the resident when the resident exercises his or her right to appeal a discharge notice for 1 of 6 residents (R#1). 1. The facility failed to discharge R#1 to a safe environment on [DATE]. R#1 had nowhere to go from [DATE] through [DATE] and was hospitalized on [DATE]. 2. The facility failed to allow R#1 to remain in the facility when he exercised his right to appeal the discharge notice staff served him on [DATE]. An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 5:17 p.m. While the IJ was removed on [DATE] at 5:30 p.m., the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy because of the facility's need to evaluate the effectiveness of their corrective systems.This failure could place residents at risk of worsening medical conditions, injury, hospitalization or death. Review of R#1's admission record, dated [DATE], revealed he was initially admitted to the facility on [DATE]. He had medical diagnoses that included vertebra osteomyelitis (a serious infection and inflammation of the spinal bones), a stage 4 pressure ulcer in his sacral region (a severe, full-thickness wound extending to muscle, bone, or supporting structures, involving tissue loss with potential for dead tissue, deep tunneling, and serious infection risk), neuromuscular bladder dysfunction (nerve damage disrupts signals between the brain and bladder, causing it to not fill or empty properly), paraplegia (paralysis affecting the lower half of the body, including the legs and sometimes the trunk), protein-calorie malnutrition (a serious nutritional disorder from not getting enough protein and/or energy), left lower limb cellulitis (a common bacterial skin infection affecting the skin and tissue of your left leg), and sepsis (life-threatening medical emergency where the body's extreme response to an infection damages its own tissues). He was discharged on [DATE] at 3:02 p.m. to other. Review of R#1's annual MDS, dated [DATE], revealed he had a 15/15 BIMS score, which indicated he was cognitively intact. He required partial/moderate assistance with upper body dressing and bed mobility, substantial/maximal assistance with toileting and showering and dependent on staff for lower body dressing and transfers. He also had one stage 3 pressure ulcer and one stage 4 pressure ulcer. He also had verbal behaviors that occurred 4-6 days but less than daily that did not impact him and others .Review of R#1's care plan report, initiated on [DATE], revealed he had a stage 3 pressure ulcer on his left heel, stage 4 pressure ulcer to his sacral region, right leg amputation and had a suprapubic catheter. He was also at risk for ADL decline and staff were required to provide extensive assistance for bed mobility and upper/lower body dressing, and total assistance with transfers. He also had episodes of exhibiting verbal/physical aggression towards staff and residents who reside in the facility and had a history of manipulative behavior. Nursing staff (CNA, LVN and RN) were required to provide safety, offer alternative time for care, back away, seek assistance if needed, notify the nurse of behaviors, provide medications as ordered, assess reports of behaviors and notify the MD if interventions are not effective if he becomes combative or aggressive. Staff were also required to be direct and firm when approaching him about behavior, clarify from him what he actually was saying or doing, document behavior in clinical record, inform staff on redirect methods for his behaviors when providing care, monitor for mental status changes, and psych services as needed. Review of R#1's order summary report, dated [DATE], showed he required hospice care every shift, a catheter change every shift if it was dislodged, his foley catheter bag drained empty every shift, pain assessed every shift, and left heel pressure ulcer cleaned every night shift. Review of R#1's discharge planning review initiated by the CNO on [DATE] showed it was incomplete . Review of the OMB's email correspondence showed the OMB emailed the ADM on [DATE] and asked if he could let R#1 give him a call to discuss his discharge and attached a copy of the discharge and provider letter. There was no email response to the OMB's request. Review of R#1's notice of immediate discharge, dated [DATE], showed staff served a formal written notice of his immediate transfer and discharge from the facility on [DATE]. The was no address included that R#1 would discharge to. The reasons for this action reflected, On [DATE], you made a direct and credible threat to shoot the ADM, as reported by staff member. You have stated to staff that you have previously served time in prison and ‘would go back,' increasing concern for the seriousness of the threat.You routinely leave the community for extended periods and have access to financial resources, creating a credible risk that you could obtain a weapon and return to the facility. Texas Penal Code - Terroristic Threat (threat of violence causing fear and disrupting a licensed healthcare facility) The right to appeal section reflected, You have the

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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 0628 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (continued on next page)

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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 0628 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide notice as soon as practicable before discharge and include the location to which the resident is discharged for 1 of 6 residents (R#1). 1. The facility failed to notify R#1 of his discharge before [DATE].2. The facility failed to include the address where R#1 would be discharged to on the discharge notice he was served on [DATE]. R#1 had nowhere to go from [DATE] through [DATE] and was hospitalized on [DATE]. An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 5:41 p.m. While the IJ was removed on [DATE] at 5:30 p.m., the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy because of the facility's need to evaluate the effectiveness of their corrective systems.This failure could place residents at risk of worsening medical conditions, injury, hospitalization or death. Review of R#1's admission record, dated [DATE], showed he was initially admitted to the facility on [DATE]. He had medical diagnoses that included vertebra osteomyelitis (a serious infection and inflammation of the spinal bones), a stage 4 pressure ulcer in his sacral region (a severe, full-thickness wound extending to muscle, bone, or supporting structures, involving tissue loss with potential for dead tissue, deep tunneling, and serious infection risk), neuromuscular bladder dysfunction (nerve damage disrupts signals between the brain and bladder, causing it to not fill or empty properly), paraplegia (paralysis affecting the lower half of the body, including the legs and sometimes the trunk), protein-calorie malnutrition (a serious nutritional disorder from not getting enough protein and/or energy), left lower limb cellulitis (a common bacterial skin infection affecting the skin and tissue of your left leg), and sepsis (life-threatening medical emergency where the body's extreme response to an infection damages its own tissues). He was discharged on [DATE] at 3:02 p.m. to other.Review of R#1's annual MDS, dated [DATE], showed he had a 15/15 BIMS, which indicated he was cognitively intact. He required partial/moderate assistance with upper body dressing and bed mobility, substantial/maximal assistance with toileting and showering and dependent on staff for lower body dressing and transfers. He also had one stage 3 pressure ulcer and one stage 4 pressure ulcer. He also had verbal behaviors that occurred 4-6 days but less than daily that not impact him and othersReview of R#1's care plan report, initiated on [DATE], showed he had a stage 3 pressure ulcer on his left heel, stage 4 pressure ulcer to his sacral, right leg amputation and had a suprapubic catheter. He was also at risk for ADL decline and staff were required to provide extensive assistance for bed mobility and upper/lower body dressing, and total assistance with transfers. He also had episodes of exhibiting verbal/physical aggression towards staff and residents who reside in the facility and had a history of manipulative behavior. Nursing staff (CNA, LVN and RN) were required to provide safety, offer alternative time for care, back away, seek assistance if needed, notify the nurse of behaviors, provide medications as ordered, assess reports of behaviors and notify the MD if interventions are not effective if he becomes combative or aggressive. Staff were also required to be direct and firm when approaching him about behavior, clarify from him what he actually was saying or doing, document behavior in clinical record, inform staff on redirect methods for his behaviors when providing care, monitor for mental status changes, and psych services as needed. Review of R#1's order summary report, dated [DATE], showed he required hospice care every shift, a catheter change every shift if it was dislodged, his foley catheter bag drained empty every shift, pain assessed every shift, and left heel pressure ulcer cleaned every night shift. Review of R#1's discharge planning review initiated by the CNO on [DATE] showed it was incomplete. Review of the OMB's email correspondence showed the OMB emailed the ADM on [DATE] and asked if he could let R#1 give him a call to discuss his discharge and attached a copy of the inappropriate discharge and provider letter. There was no email response to the OMB's request. Review of R#1's notice of immediate discharge, dated [DATE], showed staff served a formal written notice of his immediate transfer and discharge from the facility on [DATE]. There was no address included that R#1 would discharge to. The reasons for this action reflected, On [DATE], you made a direct and credible threat to shoot the ADM, as reported by staff member. You have stated to staff that you have previously served time in prison and 'would go back,' increasing concern for the seriousness of the threat.You routinely leave the community for extended periods and have access to financial resources, creating a credible risk that you could obtain a weapon and return to the facility. Texas Penal Code - Terroristic Threat (threat of violence causing fear and disrupting a licensed healthcare facility)The right to appeal section reflected, You have the right to appeal this discharge to HHSC

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for 1 of 6 residents (R#1). 1. The facility failed to ensure a thorough investigation was completed in regard to the validity of witness statements alleged against R#1 on [DATE]. R#1 was discharged from the facility on [DATE] had nowhere to go from [DATE] through [DATE] and was hospitalized on [DATE].2. The facility failed to take immediate action to ensure the safety of all residents when there is a credible threat to the health and safety of residents alleged against R#1 on [DATE]. An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 5:41 p.m. While the IJ was removed on [DATE] at 5:30 p.m., the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy because of the facility's need to evaluate the effectiveness of their corrective systems.This failure could place residents at risk of improper discharge, worsening medical conditions, injury, hospitalization or death. Review of R#1's admission record, dated [DATE], showed he was initially admitted to the facility on [DATE]. He had medical diagnoses that included vertebra osteomyelitis (a serious infection and inflammation of the spinal bones), a stage 4 pressure ulcer in his sacral region (a severe, full-thickness wound extending to muscle, bone, or supporting structures, involving tissue loss with potential for dead tissue, deep tunneling, and serious infection risk), neuromuscular bladder dysfunction (nerve damage disrupts signals between the brain and bladder, causing it to not fill or empty properly), paraplegia (paralysis affecting the lower half of the body, including the legs and sometimes the trunk), protein-calorie malnutrition (a serious nutritional disorder from not getting enough protein and/or energy), left lower limb cellulitis (a common bacterial skin infection affecting the skin and tissue of your left leg), and sepsis (life-threatening medical emergency where the body's extreme response to an infection damages its own tissues). He was discharged on [DATE] at 3:02 p. m. to other.Review of R#1's annual MDS, dated [DATE], showed he had a 15/15 BIMS, which indicated he was cognitively intact. He required partial/moderate assistance with upper body dressing and bed mobility, substantial/maximal assistance with toileting and showering and dependent on staff for lower body dressing and transfers. He also had one stage 3 pressure ulcer and one stage 4 pressure ulcer. He also had verbal behaviors that occurred 4-6 days but less than daily that did not impact him and othersReview of R#1's care plan report, initiated on [DATE], showed he had a stage 3 pressure ulcer on his left heel, stage 4 pressure ulcer to his sacral, right leg amputation and had a suprapubic catheter. He was also at risk for ADL decline and staff were required to provide extensive assistance for bed mobility and upper/lower body dressing, and total assistance with transfers. 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Review of R#1's order summary report, dated [DATE], showed he required hospice care every shift, a catheter change every shift if it was dislodged, his foley catheter bag drained empty every shift, pain assessed every shift, and left heel pressure ulcer cleaned every night shift. Review of R#1's discharge planning review initiated by the CNO on [DATE] showed it was incomplete. Review of the OMB's email correspondence showed the OMB emailed the ADM on [DATE] and asked if he could let R#1 give him a call to discuss his discharge and attached a copy of the inappropriate discharge and provider letter. There was no email response to the OMB's request. Review of R#1's notice of immediate discharge, dated [DATE], showed staff served a formal written notice of his immediate transfer and discharge from the facility on [DATE]. The was no address included that R#1 would discharge to. The reasons for this action reflected, On [DATE], you made a direct and credible threat to shoot the ADM, as reported by staff member. You have stated to staff that you have previously served time in prison and 'would go back,' increasing concern for the seriousness of the threat.You routinely leave the community for extended periods and have access to financial resources, creating a credible risk that you