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	05/22/2026

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

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 of 1 facility reviewed for freedom from abuse, neglect, and exploitation. The facility failed to report allegations that the Administrator, who was living at the facility, was drinking alcohol and intoxicated while at the facility.The facility failed to report concerns that the Administrator was entering Resident #2's room in the early morning hours with no valid explanation for entering her room. These findings could result in a lack of oversight of residents, abuse, and harm. Findings included: Record review of Resident #2's face sheet dated 05/20/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with a diagnoses that included Hemiplegia and Hemiparesis following cerebral infarction affecting left dominant side (Hemiplegia (complete paralysis) and hemiparesis (partial weakness) on the left side of the body commonly result from a stroke (cerebral infarction) on the right side of the brain), Injury at c2 level of cervical spinal cord, sequela (a severe, often life-altering, or fatal injury at the top of the neck, affecting vital functions like breathing, movement, and communication), and cognitive communication deficit (struggle with language expression, comprehension, or social interaction because of underlying impairments in cognitive processes). Record review of Resident #2's MDS (clinical assessment to determine resident's strength and needs) dated 03/30/2026 revealed a BIMS score of 10 indicating moderate cognitive impairment. Record review of Resident #2's care plan reflected a focus dated 02/09/2026 that Resident #2 exhibited impulsive behavior such as for asking for cigarettes and sodas, and was at risk for further episodes of impulsive behavior and injury. There was another care plan focus dated 01/03/2026 that Resident #2 had impaired cognition due to poor judgment and poor insight. Record review of an undated anonymous statement reflected, I would like to report what I have seen, but cannot confirm or deny that any sexual Things have happened between [the Administrator] and [Resident #2]. First instance was at 2 o'clock in the morning, [Administrator] came out of [Resident #2's] room and her lights were off. I was not sure what he was doing in there. But I did say, oh, I thought it was [name of person alleged to be Resident #2's boyfriend] because [name of person alleged to be Resident #2's boyfriend] is her boyfriend and she usually goes to his room. So I asked [the administrator] what are you doing in [Resident #2's] room [the Administrator] stated well I came to ask her if knew the number to the [NAME] Club' and I then said at 2:00 AM in the morning? but I did not question it because he is the administrator. The next night that I saw the administrator it was between two and three in the morning and I heard someone talking in [Resident #2's] room and I thought it might be [name of person alleged to be Resident #2's boyfriend] and so as I was about to (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	open the door, when the [Administrator] opened the door and he came out of her room with lights off and [Resident #2] in the bed. I did not assume anything because he is the administrator and the abuse coordinator. Then the next situation is he and [Resident 2] go and smoke outside in front of the building sometimes between three and four or four and five, they meet outside and they both smoke and the administrator buys her the cigarettes and he bought her Dr. Pepper's. This began to look suspicious to me because I did not understand what he was doing going into her room between the hours of two and three also I did not think it was right for him and [Resident #2] to smoke together every morning between four and five and sometimes two and three in the morning. Record review of TULIP facility complaint dated 05/20/2026 reflected the facility first learned of the incident on 2:17 PM 05/20/2026 from the facility's PM who indicates that there are allegations against the administrator [Administer name] for coming out of a female resident's room (unknown) undressed or disheveled. There are also allegations that [Administrator] was intoxicated during work hours. Record review of notepad kept by the former HR director reflected: *03/14/2026 - 5am both [Administrator] & [Resident #2] smoke in the front, Pee on the floor/outside by dumpster Dranks by bus *03/15/2026 no time indicated- seen [Administrator] going to [Resident #2] room *04/15/2026 no time indicted - seen [the Administrator] he was drunk *Undated - 2:00 AM [Administrator] was in [Resident#1's] room and when asked why he was in Resident #2's room he said he was asking for the lion club number *Undated no time indicated - Drunk - Sunday night *Undated no time indicated - Drunk - Monday night *Undated no time indicated - seen [Administrator] he was Drunk- throwing beer in the dumpster Record review of an email dated 05/08/2026 from the DON to the Area Admin with the subject line complaint reflected [Administrator] goes out of the facility and comes back intoxicated at night. Record review of an email date 05/19/2026 from the VPHR to the facility Administrator, RNC, and the FO stated she was updating the team on recent developments and wrote, As I was leaving, an employee asked to speak with me in the DON's office. She reported that on 5/15/26, while in the smoking area, the same housekeeper mentioned that the Maintenance Director, allegedly her husband or boyfriend, was called to pick [the Administrator] up from a bar where he was reportedly allegedly [sic] intoxicated and brought him back to the building. I asked the employee to provide a written statement and updated [Area Admin] with this new information. [Area Admin] recommended proceeding with the search for an interim administrator to serve until the new administrator starts next month. He asked me to meet with him on 5/21/26 to discuss moving forward with the termination. During an interview on 05/20/2026 at 4:15 PM with the Area Admin, he said the Administrator was no longer working at the facility. During an interview on 05/21/2026 at 2:46 PM with Resident #2 she said there was no inappropriate relationship between herself and the Administrator. During an interview on 05/21/2026 at 2:58 PM, by phone with the former HR director, she said she had concerns about the former Administrator being drunk when he was at the facility. The former HR Director said she did not see the former Administrator drunk, but she said she smelled alcohol on him. The Former HR director said she asked him if he had been drinking, and he said he had been drinking the night before and that was why he smelled of alcohol. The former HR director said she received an anonymous statement about the former Administrator being in a resident's room. The former HR director tried to do an investigation, but the staff would not speak up. The former HR director said she informed the Area Admin, but did not give the date she informed the Area Admin. The former HR director said the Area Admin told her there was nothing to report. The former HR director said it was swept under the rug. The former HR director said she felt uneasy about the situation, and she knew the former Administrator and the Area Admin were friends. During an interview on 05/21/2026 at 3:24 pm with the ADON, she said she saw the Administrator drunk at the facility and she believed he was drunk because he was walking sideways and his skin looked pink and he hit the wall every now and then. She said this was around 05/05/2026 or 05/06/2026. The ADON said the Administrator did not interact with any residents, she said he went to his room. During an interview on 05/21/2026 at 3:35 PM, the Administrator said he had been living at the facility and stayed there five (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nights a week because the facility needed him. He stated he ended up living at the facility longer than he had expected. The Administrator stated he helped out his friend, Area Admin, by taking over the facility. When the Administrator was asked about being drunk in the building, he stated that the building had so many rumors. The Administrator said Resident #2 got up early in the morning and wanted to smoke, and he stated because he also smoked, to make sure Resident #2 smoked safely, he smoked with her. The Administrator said he had never been in Resident #2's room late at night. The Administrator said if he saw Resident #2 in the hallway, Resident #2 would ask him about smoking. The Administrator said that he would not try anything inappropriate with Resident #2 and stated, that's not a pleasant assignment. The Administrator said he had never been inappropriate with Resident #2 at any time, and he said that he had never seen Resident #2 dressed inappropriately. The Administrator stated he was terminated from his job as facility administrator on 05/20/2026. The Administrator stated the facility said the reason for his employment termination was inability to control his staff. During an interview on 05/21/2026 at 3:52 PM with the DON, she said she had not heard any discussions of the Administrator while he was at work, and no one had reported this to her. The DON said there was no discussion of the Administrator having an inappropriate relationship or behavior with any resident. During an interview on 05/22/2026 at 1:42 PM with the VPHR, she said the concerns about the Administrator drinking at the facility and going into [Resident 2's] room were reported to the Area Admin in March of 2026. The VPHR said the DON told her she found a notebook being kept by the former HR director that indicated that the former HR director had begun an investigation into the Administrator drinking alcohol, being drunk at the facility, and entering a resident's room at night. The VPHR said the folder had a note dated 03/14/2026 Dranks by the bus that referred to the Administrator and a note that said 5 AM both Administrator and Resident #2 smoke in the front. The VPHR said because the DON found this folder that indicated the former HR director had collected this information, it showed that the DON knew about the concerns about the Administrator and she should have reported it to the Area Admin. The VPHR said that if the Area Admin did not do anything about the concerns the DON should have reported it to HHSC. The VPHR said the only reason an Administrator would stay at a facility overnight was because of an emergency situation. The VPHR said the facility had a drug free policy. The VPRH said the allegations of the Administrator drinking at work and going into a resident's room at night should have been reported to Area Admin immediately. The VPHR said if Area Admin did not report the incidents to the State of Texas or take any action, the DON should have reported the alleged incidents to the State of Texas. The VPHR said the former HR director was a mandatory reporter, and the HR director should have reported to HHSC any allegations of abuse, neglect, or exploitation. The VPHR said if an employee saw anything unsafe, it should have been reported to the facility's team and the State of Texas. The VPHR said that after the incident was reported to the State of Texas, the Administrator should have been removed from the facility and facility leadership should have investigated. The VPHR said there would be a concern for the residents in the facility if the Administrator was drinking or was drunk when he was at the facility. The VPHR said the situation should have been reported to the State of Texas in March of 2026 when the former HR director first reported it to DON. During an interview on 05/22/2026 at 2:31 PM with the DON, she said on about 05/20/2026 or 05/21/2026 she looked at the notepad from the former HR director about the allegations of the Administrator drinking alcohol and going into Resident #2's room. The DON said when anyone reported any allegation of abuse, neglect, and exploitation or possible safety of the residents it was a reportable incident and she should have reported it to HHSC. The DON said after allegations of abuse, neglect, or exploitation were reported, an investigation was started. The DON said she did not think the Administrator was drinking alcohol on the property. The DON said she knew the Administrator lived at the facility and she did not know if the Administrator was on duty twenty-four hours a day, seven days a week. The DON said she was trained in abuse, neglect, and exploitation by the facility. The DON said it affected the residents if the person who was in charge of the building was drinking when they were in the building. The DON (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated if the Administrator was drinking at the facility, he could fall down or maybe share alcohol with other residents. The DON said this was speculation. During an interview on 05/22/2026 at 4:05 PM, the LMH said she thought that the Administrator was under the influence of alcohol about three weeks ago. She said she thought he was under the influence because he was wobbling. He told her he was having trouble walking because he had hip surgery. She said she thought he was under the influence because his attitude was different and the Administrator was real sharp when he spoke. The LMH said the Administrator lived at the facility. The LMH said she spoke with the former HR Director, and the former HR said she would check into it. During an interview on 05/22/2026 at 04:23 pm with the Area Admin, he said his job was to support the facility. The Area Admin said it was reported to him that the Administrator might have been intoxicated at night or on the weekends when he was at the facility. The Area Admin said he thought this was reported to him about a month ago, but he was unsure and could not confirm the date. The Area Admin said he was not concerned about the Administrator drinking alcohol at the facility because the Administrator lived at the facility. The Area Admin said it was part of the Administrator's employment agreement that the Administrator lived at the facility. The Area Admin said there was no indication that the Administrator was drunk during his normal working business hours and no evidence that he was drunk during non-working hours. The Area Admin said if someone was in the building, he expected them to follow the policies and procedures in the building. The Area Admin said he had no information that the Administrator had been drinking alcohol in the building except for the evenings and weekends. The Area Admin said these were allegations and there was no evidence that the Administrator was drunk. The Area Admin said he asked the Administrator if he was drunk while at the facility and the Administrator denied it. The Area Admin said he did not do any kind of investigation. The Area Admin said there was no alcohol substance seen to indicate the Administrator was drinking while at the facility. The Area Admin said if the Administrator was drinking when he was at the facility the Administrator was drinking when the Administrator was not on duty and not during normal working business hours. The Area Admin said that the Administrator was exempt from the policies and procedures of the facility during non-working hours, evenings and weekends, because the Administrator was living at the facility. The Area Admin said his number one concern was for the safety of the residents and it was not brought to his attention that the residents were not safe. He said the facility did not have a policy for administrators living at the facility and agreements for administrators to live at the facility were on a case-by-case basis. During an interview on 05/22/2026 at 5:25 PM with the VPHR, she said the facility management team, with the exception of the Area Admin, were unaware that Administrator was living in the building. The VPHR said the Area Admin said it was an agreement between him and the Administrator and was only supposed to be for a couple of months. The VPHR said it was not alright for the Administrator to be living at the facility. The VPHR said CMS rules applied to the facility regardless. The VPHR said the Administrator should not have been at the building when he was intoxicated because it was a drug free workplace. The VPHR said the facility policy of a drug free workplace should have been followed by the Administrator whether it was an evening or a weekend. She said if someone at the facility was under the influence of alcohol, it could potentially be a safety issue to the residents. Record review of the facility's policy Drug Free Workplace Policy and Guidelines for Implementation Reasonable Suspicion Testing dated O4/01/2025 reflected with this policy at the facility affirms A commitment to maintaining a drug free workplace and establishes conditions under which the facility will conduct a testing of employees based on reasonable suspicion that the employee has violated this policy and is under the influence of alcohol, intoxicants, illegal or misused prescription or over the counter medications while on duty. This policy outlines the practices and procedures designed to correct instances of identified alcohol and drug use in the workplace. This policy applies to all employees and applicants for employment with the facility. Observation of behavior - when a supervisor is notified or suspects an individual may be in violation of the drug free workplace policy the supervisor must observe the behavior of the individual and immediately complete (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reasonable suspicion testing checklist. Record review of the facility's Abuse, Neglect, Exploitation, and Misappropriation Prevention, Reporting, and Investigation Policy dated January 2026 revealed the Nursing Facility (NF) ensures that all residents are free from abuse, neglect, exploitation, misappropriation of resident property, mistreatment, and involuntary seclusion, in accordance with Texas law and federal CMS regulations. The Facility maintains a zero-tolerance policy and will immediately protect residents, initiate investigations, and report all alleged or suspected incidents as required by the Texas Health and Human Services Commission (HHSC) and Centers for Medicare & Medicaid Services (CMS). Staff Training RequirementsStaff shall receive:Abuse prevention training prior to resident contactAnnual education on:Abuse PreventionAbuse identification and reportingHandling verbally or physically aggressive resident behaviorsProhibition of retaliationRetraining following incidents or identified trends5. Mandatory ReportingImmediate Resident Protection Upon discovery of an allegation or suspicion:Ensure resident safetyProvide medical and psychosocial careSeparate alleged perpetrator from resident contact when appropriatePreserve evidenceReport Within 2 HoursAbuse (with or without serious bodily injury)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that each resident received adequate supervision to prevent accidents for one of three residents (Resident #1) reviewed for quality of care.The facility failed to ensure Resident #1 was transported back to the facility utilizing contracted transportation services after an appointment on [DATE]. Resident #1 was transported back to facility by the MTD in the MTD's personal car rather than by the arranged contracted transportation. During the transport, the personal vehicle was involved in a motor vehicle accident.This failure could place residents at risk of mental distress, serious injuries, and hospitalization.Findings included:Record review of Resident #1's face sheet, dated [DATE] reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left dominant side (paralysis and partial weakness, resulting from stroke), muscle wasting and atrophy (loss of muscle mass and strength), and hypertension (elevated blood pressure).Record Review of Resident #1's MDS assessment dated [DATE] reflected Resident #1 was assessed to have a BIMS score of 07 which indicated severe cognitive impairment. MDS also reflected Resident #1 utilized a manual wheelchair for mobility.In an observation/interview conducted on [DATE] at 11:20 AM, Resident #1 was observed to be in a manual wheelchair, he rolled it independently. Resident #1 stated he was hospitalized the previous day following a motor vehicle accident, but reported he was doing alright. Resident #1 stated he attended an out -of -town appointment at a bank, and that the facility provided transportation to the appointment through a bus company and he was accompanied by MT Tech A. Resident #1 stated that the contracted transportation was to pick him up following his appointment. However, the MT Tech A called her husband, the MTD, to transport them back to the facility instead. Resident #1 stated while they traveled back to the facility in the MTD's personal vehicle, the vehicle was involved in a wreck. Resident #1 stated that emergency medical services responded to the scene, and transported him to the hospital for evaluation. Resident #1 stated that he had X-rays and was informed that he was okay. Resident #1 stated that he was transported back to the facility by ambulance later that evening.In an interview conducted on [DATE] at 11:40 AM, MT Tech A stated she worked at the facility since [DATE]. She stated she was asked to escort Resident #1 to an appointment at the bank. MT Tech A stated the appointment was out of town and they rode a bus. MT Tech A stated the appointment lasted only five minutes due to Resident #1 not having an identification card. She stated the transportation was scheduled to pick them back up at 2:00 PM. MT Tech A stated Resident #1 started to give her a hard time, so she contacted the facility and spoke to a nurse advising they needed to come pick them up. MT Tech A stated the MTD picked them up in his personal vehicle. She stated on the way back to the facility, they were involved in a wreck in which another vehicle hit them even after the MTD swerved. MT Tech A stated paramedics transported all three of them to the hospital. She stated the MTD's vehicle was totaled. MT Tech A stated she was not aware of a facility transportation policy on transporting residents.In an interview conducted on [DATE] at12:23 PM, the MTD stated he worked for the facility since [DATE]. He stated he went to pick Resident #1 up in his personal vehicle from out of town. He stated the facility did not have a vehicle for transportation. He stated he was instructed by the DON to go pick up Resident #1 and the SW sent him the address. The MTD stated he thought Resident #1 was to be transported back by the transportation that took him to the appointment. He stated he didn't think anything was wrong with the situation. The MTD stated another vehicle was speeding across the road and he tried to [NAME] to lessen the impact of the hit. He further stated he notified the facility right away of the accident, and they all were transported to the hospital. The MTD stated that he didn't think there was anything inappropriate about transporting Resident #1 in his personal vehicle. The MTD stated he was just following the directions of the DON (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when he transported Resident #1. The MTD stated he has not read any facility policy regarding resident transportation. The MTD further stated he worked as a CNA more than 10 years ago and he was knowledgeable in CPR.In an interview conducted on [DATE] at 2:05 PM, the DON stated the facility had contracted transportation for resident's appointments. The DON stated she did not give a directive to the MTD to transport Resident #1. She stated staff were not to use personal vehicles to transport residents. She further stated she was not the MTD's supervisor. The DON stated she was in a payroll meeting on that day, and the administrator received a call and she could hear something about an accident; and that was the first time she heard of the MTD picking up the resident in his personal car. The DON stated at 7:00 AM, that same morning, the SW told her she would not be escorting Resident #1 to the appointment and that the administrator said the MTD would escort him on the bus, since it was not a medical appointment. The DON stated she found out later the MTD did not escort Resident #1 to appointment, but instead the MT Tech A.In an interview conducted on [DATE] at 2:37 PM, the SW stated transportation was arranged for Resident #1 to be transported to and from the bank by the contracted transportation. The SW stated MT Tech A called the facility in a panicky tone saying she thought Resident #1 wanted to escape. The SW stated she had not known Resident #1 to behave in that manner. The SW stated the MT Tech repeatedly said her husband the MTD needed to pick them up. The SW stated she went to the conference room to tell the administrator that the MTD was leaving to pick up Resident #1 and the MT Tech A, and the administrator responded roughly that they were busy in a meeting and shut the door on her.In a phone interview conducted on [DATE] at 3:35 PM, the Administrator stated the MTD told him the DON gave him permission to pick up Resident #1 that day, because he was in a payroll meeting. The Administrator stated he told everyone that they were not supposed to pick up anyone in their personal cars. However, he stated the facility did not have a transportation policy on transporting residents, but that was what he personally told staff. He stated he was just shown a policy yesterday regarding driving a personal car for company business. The Administrator stated the MTD had insurance on his car, and he felt it was okay since Resident #1 was not going to a doctor's appointment. The Administrator stated his self was terminated from the facility on the previous day.In an interview conducted on [DATE] at 3:05 PM, the Interim ADMIN stated staff should never drive a resident in their personal vehicle. She stated it was not acceptable. The Interim ADMIN stated potential accidents could occur that could harm residents.Record review of the facility policy provided by the Interim Administrator, undated, titled: [Facility] Resident Transportation Policy Non-Emergency Transport 1.Staff are not allowed to transport residents in their personal vehicles, unless there is a disaster. 2.If there is a predicted disaster, such as a hurricane, families and/or responsible parties will be contacted by the Social Worker and Administrator to check if they would be available to come pick up their loved ones to reside with them until the predicted disaster has subsided. For the remaining ambulatory residents, staff will be asked by the Administrator/designee to assist with transporting ambulatory residents to a safe location. 3.Residents will be transported by an approved transportation vendor for scheduled medical appointments, outside of the facility treatment center appointments, or personal appointments, if the family or responsible party is unavailable to assist with transportation needs. 4.Upon admission, transportation for the resident is coordinated with the resident and, if available, their family to determine any transportation needs and to assist with scheduling as needed.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observations, interviews, and record review, the facility failed to employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required for two(2) of four(4) kitchen staff (DTA C, [NAME] B) reviewed for food and nutrition services. 1. The facility failed to ensure DTA C met the requirements for food handling by maintaining a valid Food Handler's Certificate. 2. The facility failed to ensure [NAME] B met the requirements for food handling by obtaining a current and valid Food Handler's Certificate before preparing and serving meals out of the facility kitchen. These failures could place residents at risk of not having their nutritional needs met and foodborne illnesses.Findings included: Record Review of the dietary food handler certificates provided on 05/21/2026 at 4:35 PM revealed DTA C's food handler certificate had expired on 08/25/2024. There was no certificate for [NAME] B.Observation conducted on 05/20/2026 beginning at 12:05pm revealed [NAME] B and DTA C preparing lunch meals in the facility kitchen. The MTD was also present in the kitchen putting away food items. Interview conducted on 05/20/2026, at 12:15 PM, the MTD revealed he was assisting with the kitchen since the termination of the previous dietary manager. He stated he had a food handlers' certificate and showed a current copy from his cell phone with an issue date of 02/09/2026. He stated he also had a dietary manager certification but didn't have a copy with him. The MTD stated everyone's food handlers' certificates were in a folder, but he didn't know where the previous dietary manager left them.Interview conducted with the DON on 5/20/2026, at 12:20 PM, the food handler certificates were requested for all dietary staff and certified dietary management certificate for the MTD. Interview conducted on 5/21/2025 at 11:01 AM, [NAME] B stated she had worked for the facility 5 years previously but returned approximately one year ago. [NAME] B stated she did not possess a current food handler's certificate. She stated she previously obtained a food handler's certificate; however, she estimated that it had expired approximately 10 years ago. [NAME] B stated the previous dietary manager did not inform her that a current certificate was required. She stated she had over 30 years of experience working in restaurant kitchen settings, and she was familiar with general kitchen operations.Interview conducted on 5/21/2025 at 11:09 AM, DTA C stated that she had been employed at the facility for six years and worked in the kitchen for the past four years. She stated she possessed her food handler's certificate.Interview conducted on 5/22/2025 at 1:18 PM, DTA C revealed she was made aware yesterday evening her certificate was expired. She stated the previous dietary manager did not tell her it was expired. She stated she thought once you had one, it did not expire. DTA C stated she completed her training update that morning and she was current. She stated she understood it was important to maintain proper training requirements. DTA C stated if staff were not properly trained, it could lead to residents getting sick if diets are not followed.Interview conducted on 5/22/2025 at 1:24 PM, the DON stated there should be qualified dietary staff in the kitchen, and they should be familiar with all the regulations to carry out the policies in the kitchen. The DON stated they had a dietician that consults remotely with dietary.In an interview conducted on 05/22/2026 at 3:05 PM, the Interim ADMIN stated she would be checking the dietary staff for compliance. She stated that it was her second day at the facility and she was familiarizing herself with the facility's kitchen process. She stated DTA C updated her certificate earlier in the day and [NAME] B was going to complete her training. The Interim ADMIN stated everyone in the kitchen should follow the regulations.Review of the facility's undated policy titled Food Safety and Sanitation reflected: Policy:All local, state, and federal standards and regulations will be followed to assure a safe and sanitary food and nutrition services department.Procedure:1. Food and Nutrition Services Departmenta. The department will be routinely inspected by the environmental health services of the local public health department, (continued on next page)

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	675564	A. Building B. Wing	05/22/2026

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

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following their accepted standards and regulations. The director of food and nutrition services will have a copy of the applicable regulations on file and should be familiar enough with this information to implement policies and procedures to meet the regulations. Note: Not all states require local health department inspections.b. The state and/or federal survey team as part of the annual survey process will inspect the department.c. The food and nutrition services department will follow regulations as outlined by other official health agencies and organizations with jurisdiction over the facility.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record reviews, the facility failed to properly store, prepare, and distribute food under sanitary conditions in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for food and nutrition services.1.The facility failed to label and date all food items located in the kitchen prep area, walk-in refrigerator and freezers observed on 5/20/2026, and 5/21/2026. 2.The facility failed to have closed fitting lids on the trash containers on observed on 5/20/2026, and 5/21/2026. These failures could place residents who receive meals from the kitchen and dine in the facility's dining room at risk for foodborne illnesses.The findings included:An observation conducted in the kitchen on 05/20/2026 beginning at 12:05 PM, revealed the following:Kitchen prep area: 1 large gray trash container with no lid that contained trash inside 1 large clear container, labeled white sugar 12/11 with no year or expiration date on top. Walk in refrigerator: 2 large storage bags of macaroni and cheese labeled 5/17/26, no discard date. 1 open package of ham, labeled 5/17/26, no discard date. A plastic rectangular container full with what appeared to be peaches, not labeled nor datedAn observation conducted in the kitchen on 05/21/2026 beginning at 10:5 AM, revealed the following:Kitchen prep area: 1 large gray trash container with no lid that contained trash inside about three fourths full A plastic rectangular container full with what appeared to be peaches, not labeled nor datedWalk in refrigerator: 2 large storage bags of macaroni and cheese labeled 5/17/26, no discard date. 1 storage bag with unidentified meat, resembled cooked chicken breast patty dated 5/16/26, no name, no discard dateFreezer: A box of mixed vegetables opened to air, no open date. A box of cheese omelets, package opened to air, no open date. In an interview conducted on 5/21/2025 at 11:01 AM, [NAME] B stated she had worked for the facility 5 years previously, but returned approximately one year ago. [NAME] B stated the kitchen labeling and dating process included placing the name of the food item, the date, and the year on the stored food items; however, the discard dates were not included. She stated, no one does that. [NAME] B acknowledged that old food could potentially lead to illnesses. She stated she did not typically cook an overflow. [NAME] B stated trash cans in the kitchen were expected to always remain covered with lids to help prevent flies and reduce the risk of food contamination from exposed trash. In an interview conducted on 5/21/2025 at 11:09 AM, DTA C stated that she had been employed at the facility for six years, and worked in the kitchen for the past four years. She reported that she had been trained on all kitchen policies. DTA C stated they were to label and date all items received in the kitchen. She stated that opened food products were labeled with the name, date opened, and discard date for cooked foods. DTA C stated all cooked foods were discarded after three days. DTA C stated the trash must have closed lids at all times. She stated not following any of the kitchen procedures could lead to cross contamination and residents could become sick.In an interview 05/22/2025 at 1:24 PM, the DON stated that she is not familiar with the dietary policy on labeling and dating food, she stated she knows the food should be labeled with the date opened but was unsure of the discard date. The DON also stated she was not familiar with the trash can policy in the kitchen. The DON stated her role with the kitchen was to ensure that orders were entered into the computer for the residents' diets. In an interview conducted on 05/22/2026 at 3:05 PM, the Interim ADMIN stated that was her second day at the facility and she was familiarizing herself with the facility's kitchen process. She stated she would be making sure the Dietary Manager position was posted immediately. She stated she was not yet aware of the labeling and dating process for the kitchen, but she would be checking for compliance. The Interim ADMIN stated she knew the trash cans should always have lids. She stated not having lids could lead to cross contamination and infection control issues.Record Review of facility's Food Safety and Sanitation Policy not dated revealed: 4. Food Storage (see Chapter 3: Food Production and Food Safety for Food Storage)a. Stored food is handled to prevent contamination and growth of pathogenic organisms. Leftovers are used within 72 hours (or discarded). Note: 2022 Federal Food (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Code guidelines allow 7 days for food safety with the day of preparation counted as day 1 of the 7 days and then food is discarded. Check local and state regulations and if differentfrom the Federal Food Code, determine which regulation should be followed. Perishable foods with expiration dates should be used prior to the use by date on the package. All time and temperature control for safety (TCS) foods (including leftovers) should be labeled, covered and dated when stored. Refrigerated food should be stored at or below 41 F. Frozen food should be stored at a temperature that keeps it frozen solid. Food should be protected from contamination (dust, flies, rodents, and other vermin). When a food package is opened, the food item should be marked to indicate the opendate. This date is used to determine when to discard the food. 11. Proper waste disposal methods will be used.Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of Health and Human Services revealed, 5-501.113 Covering Receptacles. Receptacles and waste handling units for refuse, recyclables, and returnable shall be kept covered: (B) With tight-fitting lids or covers when not in use. Must not be placed in a way that contaminates food, equipment and utensils.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to be administered in a manner that enabled 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 a safe, clean, comfortable, and homelike environment for reviewed for administration in that:1. The facility failed to ensure the Administrator followed the internal drug and alcohol policy.2. The facility failed to ensure the Administrator had his own residence and did not reside in the facility.3. The facility failed to ensure Area ADMIN followed up on reported concerns of the Administrator being drunk, drinking alcohol at the facility, and smoking in areas that were not designated for smoking.These failures placed residents at risk of inadequate supervision, physical, verbal, and/or psychosocial harm.Findings included: Observation on 5/20/2026 at 9:19 AM, outside the facility revealed a man in a blue hairnet, with a walker smoking in front of the facility. He was identified as the Administrator. Observation on 5/20/2026 at 10:27 AM, revealed room [ROOM NUMBER] appeared to be occupied, no resident's name was on the door. Noted in the room was a suitcase, clothing on the floor, clothing in a fallen over laundry basket, and clothing hanging up in the closet resembled men clothing.In an interview conducted on 05/20/2026 at 2:15 PM, the DON stated information was brought to her attention on the previous day that the Administrator had been seen drunk and that corporate was at the facility to investigate. The DON stated the Administrator was residing in room [ROOM NUMBER]. She stated the Administrator had been living at the facility since a week before her arrival on January 19, 2026. She stated the company paid for her a hotel a few weeks, but she did not know the arrangement for the Administrator. In an interview conducted on 05/20/2026 at 2:37 PM, the SW stated she heard a rumor the previous week that the Administrator had been drunk at the facility, but she had not personally witnessed him drinking alcohol. She stated a nurse came in this morning and reported that the Administrator's car was parked on the grass in front of the facility, and the nurse sent a picture to the DON. The SW started with the facility around March 23, 2026 or March 24, 2026, and she noticed a box of alcoholic beverage in the Administrators office. The SW stated she has noticed the Administrator smoking wherever he wanted, including areas that were not designated smoke areas. She stated corporate is at the facility investigating the Administrator.In an interview on 05/20/2026 at 4:15 PM with the Area Admin, he stated the Administrator was no longer employed at the facility and provided a phone number to reach the former Administrator. In an interview conducted on 05/21/2026 at 11:14 AM, the DTA C stated she smelled alcohol on the Administrators breath on one occasion but did not remember the date. She stated she had not observed him drunk while at work. DTA C stated she had seen the Administrator parked at the local liquor store on occasions. In an interview conducted on 05/21/2026 at 3:24 PM, the ADON stated around May 4, 2026, she noted a person sitting outside for a while by the dumpster in a red car. She stated she was told the person in the red car was the Administrator. The ADON stated when he walked into the building, he appeared impaired in her opinion. She stated her assessment was based on her previous work experience with alcohol and drug -affected patients at the State Hospital. She stated she observed him to look pinkish in color and he walked sideways down the hall.In a phone interview conducted on 05/21/2026 at 3:35 PM, the Administrator stated he lived at the facility five nights a week. He stated he stayed at the facility because the facility needed him. He stated he stayed at the facility longer than expected. The Administrator stated he came to help out his friend, the Area Admin, by taking over the facility. When the Administrator was asked about being drunk in the building, he stated, the building had so many rumors.In an interview conducted on 05/22/2026 at 1:42 PM, the VPHR she said the concerns about the Administrator drinking at the facility. The VPHR said the DON told her she found a notebook being kept by the former HR director that indicated that the former HR director had begun an investigation into the Administrator drinking alcohol, being drunk at the facility. The VPHR said the folder had a (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	note dated 03/14/2026 Dranks by the bus that referred to the Administrator and a note that that said 5 AM both Administrator and [Resident #2] smoke in the front. The VPHR said because the DON found this folder that indicated the former HR director had collected this information it showed that the DON knew about the concerns about the Administrator and she should have reported it to the Area Admin. The VPHR said the only reason a Administrator would stay at a facility overnight was because of an emergency situation. The VPHR said the facility had a drug free policy. The VPRH said the allegations of the Administrator drinking at work should have been reported to Area Admin immediately. The VPHR said if Area Admin did not report the incidents to the State of Texas or take any action the DON should have reported the alleged incidents to the State of Texas. The VPHR said the former HR director was a mandatory reporter and the HR director should have reported to HHSC any allegations of abuse, neglect, or exploitation. The VPHR said if an employee saw anything unsafe it should have been reported to the facility team and the State of Texas. The VPHR said that after the incident was reported to the State of Texas, the Administrator should have been removed from the facility and facility leadership should have investigated. The VPHR said there would be a concern for the residents in the facility if the Administrator was drinking or was drunk when he was at the facility. The VPHR said the situation should have been reported to the State of Texas in March of 2026 when the former HR director first reported it to DON.In an interview conducted on 05/22/2026 at 04:23 pm with the Area Admin he stated his job was to support the facility. The Area Admin said it was reported to him that the Administrator might have been intoxicated at night or on the weekends when he was at the facility. The Area Admin said he thought this was reported to him about a month ago, but he was unsure and could not confirm the date. The Area Admin said he was not concerned about the Administrator drinking alcohol at the facility because the Administrator lived at the facility. The Area Admin said it was part of the Administrator's employment agreement that the Administrator lived at the facility. The Area Admin said there was no indication that the Administrator was drunk during his normal working business hours and no evidence that he was drunk during non-working hours. The Area Admin said if someone was in the building he expected them to follow the policies and procedures in the building. The Area Admin said he had no information that the Administrator had been drinking alcohol in the building except for the evenings and weekends. The Area Admin said those were allegations and there was no evidence that the Administrator was drunk. The Area Admin said he asked the Administrator if he was drunk while at the facility and the Administrator denied it. The Area Admin said he did not do any kind of investigation. The Area Admin said there was no alcohol substance seen to indicate the Administrator was drinking while at the facility. The Area Admin said if the Administrator was drinking when he was at the facility the Administrator was drinking when the Administrator was not on duty and not during normal working business hours. The Area Admin said that the Administrator was exempt from the policies and procedures of the facility during non-working hours, evenings and weekends, because the Administrator was living at the facility. The Area Admin said his number one concern was for the safety of the residents and it was not brought to his attention that the residents were not safe. He said the facility did not have a policy for administrators living at the facility and agreements for administrators to live at the facility were on a case-by-case basis.In an additional interview conducted on 05/22/2026 at 5:25 PM, the VPHR stated she and the facility management team, with the exception of the Area Admin, were unaware that the Administrator was living in the building. The VPHR said the Area Admin said it was an agreement between him and the Administrator and was only supposed to be for a couple of months. The VPHR said it was not alright for the Administrator to be living at the facility. The VPHR said CMS rules applied to the facility regardless. The VPHR said the Administrator should not have been at the building when he was intoxicated because it was a drug free workplace. The VPHR said the facility policy of a drug free workplace should have been followed by the Administrator whether it was an evening or a weekend. She said if someone at the facility was under the influence of alcohol, it could potentially be a safety issue to the residents.Record review of the facility's policy titled : Drug Free (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Workplace Policy and Guidelines for Implementation Reasonable Suspicion testing dated April 1, 2025 reflected: With this policy [facility] affirms a commitment to maintaining a Drug-Free Workplace and establishes conditions under which the facility will conduct testing of employees based on reasonable suspicion that the employee has violated this policy and is under the influence of alcohol, intoxicants, illegal or misused prescription or over-the-counter medications while on duty. This policy outlines the practices and procedures designed to correct instances of identified alcohol and drug use in the workplace. This policy applies to all employees and applicants for employment with the facility. Observation of behavior - when a supervisor is notified or suspects an individual may be in violation of the drug free workplace policy the supervisor must observe the behavior of the individual and immediately complete reasonable suspicion testing checklist.