

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675564	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2025
NAME OF PROVIDER OR SUPPLIER Harmony Care at Giddings		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the resident had the right to be treated with respect and dignity for one of five residents (Resident #14) reviewed for dignity. The facility failed to speak to Resident #14 in a way that promoted her dignity and self-worth. This failure could place residents at risk of a decline in their sense of dignity, level of satisfaction with life, and feeling of self-worth. Findings include: Record review of Resident #14's face sheet, dated 07/17/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #14 had diagnoses which included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a condition where a person exhibits symptoms of dementia, but the specific type of dementia was not identified, and the severity had not been specified. Dementia- a loss of thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities) , senile degeneration of the brain, not elsewhere classified (a decline in mental abilities like memory, reasoning, and judgement), and anxiety disorder (excessive, persistent, and uncontrollable feelings of worry, fear, and unease), and Wernicke's encephalopathy (caused by vitamin B1 deficiency, primarily affecting the brain and nervous system). Record review of Resident #14's admission MDS, dated [DATE], reflected the resident had a BIMS score of 9, which indicated her cognition was moderately impaired. Resident #9 did not have any physical or verbal behavior symptoms directed toward others. She had senile degeneration of the brain, Wernicke's encephalopathy, anxiety disorder and non-Alzheimer's dementia (is various types of dementia that are not caused by Alzheimer's disease [(a progressive brain disorder that slowly destroys memory and thinking skills, ultimately interfering with daily life)]. Record review of Resident #14's Comprehensive Care Plan, with a revision date of 06/30/2025, reflected Resident #9 had signs and symptoms of anxiety. Interventions: Allow Resident #14 to voice thoughts and feelings. Explore with resident the reason of anxiety. Psych services as ordered. Resident #14 resides in the secure unit. She was at risk for elopement and needed reduced stimuli and a controlled environment. Resident #14's dignity will be maintained and will be safe in the secured unit. Interventions: Monitor frequently to assure residents safety. Explain all procedures, suing terms/ gestures resident can understand. Call by name when given care. Record review of Resident #14's skin assessment and safe survey, on 07/17/2025 at 4:00 PM, dated 07/17/2025, there were no concerns with skin assessments and the resident did not have any psychosocial negative outcomes. She was calm and did not recall the incident. Observation on 07/17/2025 at 12:15 PM, the state surveyor was entering the secured unit and heard someone in a loud tone state you need to sit in your chair. The hallway revealed staff and residents in the dining room. The State Surveyor was approximately 200 feet from the dining room. Upon entering the dining room CNA G and CNA H were passing out trays. Observation on 07/17/2025 at 12: 30 PM to 12:40 PM revealed CNA G remained in the hall when the State Surveyor exited the secure unit and within 3 minutes found the Corporate Nurse and explained what occurred on the secure unit with CNA G. Another DON from a sister facility immediately went to the unit and walked with CNA G to the front office. CNA G wrote a statement, and she was immediately terminated upon further investigation. Interview on 07/17/2025 at 12:20 PM, CNA H stated CNA G did speak in a loud tone when speaking to Resident #14 in the dining room approximately 12:15 PM on 07/17/2025. She stated CNA G stated, you need to sit in your chair. She stated Resident #14 did not respond to CNA G. CNA H stated Resident #14 did not become upset after CNA H spoke to her in a loud tone. Interview on 07/17/2025 at 12:25 PM, CNA G stated she did speak in a loud tone when she stated sit in your chair when she spoke to Resident #14. CNA G stated, I did use a loud tone and was expected to use a softer tone when speaking to a resident. She stated, I can understand this was not the correct tone of voice to use when speaking to residents. CNA G stated she was in-service on abuse and neglect. She did not remember the date. Interview on 07/17/2025 at 2:05 PM, the Corporate Nurse stated CNA G was immediately terminated. She stated anyone using a loud tone when speaking to a resident was not tolerated in the facility. She stated there was a potential a resident may become more anxious and effect a resident's dignity if a staff used a loud tone when speaking to a resident. The Corporate Nurse stated to prevent this from happening again she felt terminating CNA G was in the best interest of the residents in the facility. She stated they wanted to ensure extra precautions were taken to prevent potential neglect or abuse. She stated the physician, ombudsman, family and HHSC were immediately contacted about the incident with Resident #14. The Corporate Nurse stated safety checks and skin assessments were</p>		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for two of eight residents (Resident# 12 and Resident #16) reviewed for ADL care. The facility failed to ensure Resident #12, and Resident # 16's nails were cleaned, and did not have rough edges. This failure could place residents at risk of not receiving services or care, diminished quality of life, and decreased self-esteem. Findings include: 1. Record review of Resident #12's face sheet, dated 07/17/2025, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #17 had diagnoses which included Type 2 diabetes mellitus without complications (a disorder where the body either does not produce enough insulin or cannot properly use the insulin it produces, leading to high blood sugar levels), lack of coordination (the inability to smoothly and efficiently combine movements of different body parts. It can manifest as clumsiness, unsteadiness, or difficulty with tasks such as buttoning a shirt), and anxiety disorder (conditions characterized by excessive fear, worry, and apprehension that can interfere with daily activities). Record review of Resident #12's Annual MDS, dated [DATE], reflected the resident had a BIMS score of 15, which indicated his cognition was intact. Resident #12 required partial/moderate assistance (helper does less than half the effort) with personal hygiene, and showers. He required supervision/or touching assistance (helper provides verbal cues and/or touching as resident completes activity) with the following: dressing, toileting, and oral hygiene. Record review of Resident #12's Comprehensive Care Plan, with completion date of 06/30/2025, reflected Resident # 12 required one staff assistance with bathing, dressing, grooming and hygiene. Observation and interview on 07/15/2025 at 11:01 AM, revealed Resident #12 was in his room sitting in his wheelchair. He had a blackish/ brownish substance underneath the middle and ring fingernails on his right hand. Resident #12's middle fingernail on his right hand was uneven around the edges. Resident #12 stated he requested for his nails to be cleaned and filed a few days ago. He did not recall the date or who he asked to clean his nails. Resident #12 stated the person explained he would receive nail care on Sunday (07/20/2025). He stated he did not recall the ladies name when he requested his nails to be cleaned and filed. 2. Record review of Resident # 16's face sheet, dated 07/17/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #16 had diagnoses which included paraplegia, unspecified (partial or complete paralysis of both legs and often the lower trunk, with the specific cause or extent of the impairment not being clearly defined), lack of coordination (the inability to smoothly and efficiently combine movements of different body parts. It can manifest as clumsiness, unsteadiness, or difficulty with tasks such as buttoning a shirt), and contracture of left hand (a condition where the tissue under the skin of the palm thickens and tightens, causing one or more fingers to bend towards the palm and making it difficult to straighten them). Record review of Resident #16's Quarterly MDS Assessment, dated 06/09/2025, reflected Resident #16 had a BIMS score of 11, which indicated her cognitive status was moderately impaired. Resident #16 required set up assistance with personal hygiene, oral hygiene, and upper body dressing. She required partial/moderate assistance with showers (helper does less than half the effort). Record review of Resident #16's Comprehensive Care Plan, with completion date of 06/30/2025, reflected Resident #16 had an ADL self-care performance deficit related to disease process and impaired balance. Intervention: Bathing/Showering- check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Observation and interview on 07/15/2025 at 11:15 AM, revealed Resident #16 was in her room sitting in her wheelchair. She had a blackish/ brownish substance underneath the middle ring and fore fingernails on her right hand. Resident #16's ring and middle fingernail on her right hand were uneven around the edges. She stated on Saturday (07/12/2025) she asked a nurse if she would clean her nails. Resident #16 did not recall the nurse's name, and the nurse stated her nails would be cleaned and trimmed on Sunday (07/13/2025). She stated no one cleaned her nails on Sunday (07/13/2025). In an interview on 07/15/2025 at 2:00 PM, LVN F stated the nurses were responsible for residents with diagnosis of diabetes with nail care such as trimming, cleaning, filing. He stated the CNAs were responsible for all other residents' nail care. LVN F stated if a resident had brownish/blackish substance underneath their nails and if a resident swallowed the substance there was a possibility a resident may become ill, such as stomach problems nausea and vomiting. LVN F stated if a resident refused any type of care, the nurse would document the refusal in the nurse's notes. He stated</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>(continued on next page)</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review, the facility failed, to provide an ongoing activities program to support residents in their choice of activities, both facility sponsored group and individual activities, and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for two of five residents (Resident # 15 and Resident #25) reviewed for activities. The facility failed to provide Resident #15 and Resident #25 in room activities on the dates of 07/01/2025 thru 7/17/2025. This failure could place residents at risk for boredom, depression, and diminished quality of life. Based on interview, observation and record review, the facility failed, to provide an ongoing activities program to support residents in their choice of activities, both facility sponsored group and individual activities, and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for two of five residents (Resident # 15 and Resident #25) reviewed for activities. The facility failed to provide Resident #15 and Resident #25 in room activities on the dates of 07/01/2025 thru 7/17/2025. This failure could place residents at risk for boredom, depression, and diminished quality of life. Findings included:Review of Resident #15's Face Sheet, dated 07/17/2025, reflected an [AGE] year-old female admitted on [DATE] with a diagnosis of Parkinson's disease without dyskinesia, without mention of fluctuations (motor symptoms like tremors, rigidity and slowness of movement. Dyskinesia- disease symptoms where involuntary movements are absent, and there are no significant variations in symptom throughout the day), muscle wasting and atrophy, not elsewhere classified, unspecified site (muscles that lose their nerve supply and waste away), and unspecified asthma (a respiratory condition marked by spasms in the lungs, causing difficulty in breathing).Review of Resident #15's admission MDS Assessment, dated 09/21/2024, reflected Resident #15 had a BIMS score of 15 which indicated her cognition was intact. Resident #15's activity preference was the following:1. Reading books or newspaper.2. Listening to music.3. Being around animals.4. Keeping up with the news.5. Do favorite activities.6. Go outside to get fresh air when the weather is good.7. Do things in groups of people.8. Participating in religious services or practices. Review of Resident #15's Quarterly MDS Assessment, dated 06/10/2025, reflected Resident #15 had a BIMS score of 15 which indicated Resident #15's cognition was intact. Review of Resident #15's Comprehensive Care Plan, dated 06/30/2025, reflected Resident #15 required in rom activity related to resident not participating in activities. Intervention: Activity Director will assess the resident's interest and create the activity plan. Review of Resident #15's Activity Initial Assessment, dated 09/16/2024, reflected Resident #15 preferred activities in her room. Review of Resident #15's Activity In room Participation Record, dated July 2025, reflected Resident #15 did not receive any in room activities from 07/01/2025 thru 07/17/2025. Observation and interview on 07/16/2025 at 2:20 PM, revealed Resident # 15 was in her room watching television. She stated she was tired of watching television every day. Resident #15 stated she did want activities in her room and wanted activity director to visit her and assist her with doing activities. Resident #15 stated she was receiving activities from the Activity Director at one time; however, she had not been getting activities in her room from the Activity Director over the past several weeks. Resident #15 stated she did get bored sometimes. She stated she did not want to attend group activities. Review of Resident #25's Face Sheet, dated 07/17/2025, reflected a 68- year-old male was admitted on [DATE] and readmitted on [DATE] with a diagnoses of unspecified dementia, unspecified severity, with other behavioral disturbance (a condition where a person exhibits symptoms of dementia, but the specific type of dementia was not identified, and the severity had not been specified. Dementia- a loss of thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities with behaviors such as agitation - characterized by restlessness, and anxiety - feelings of fear worry, unease , and apprehension), cognitive communication deficit (difficulties in communication that arise from impairments in cognitive functions like attention, memory reasoning, and problem-solving), and lack of coordination (the inability to smoothly and efficiently control movements). Review of Resident #25's Annual MDS, dated [DATE], reflected Resident #25 had a BIMS score of 7 which indicated his cognition was moderately impaired. Resident #25's activity preference was participating in religious services or practices. Review of Resident #25's Quarterly MDS, dated [DATE], reflected Resident #25 had a BIMS score of 8 which indicated his cognition was moderately impaired. Review of Resident #25's Comprehensive Care Plan</p>		

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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. (continued on next page)		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to properly store, prepare, distribute food under sanitary conditions in accordance with professional standards for food service safety for 1 of 1 kitchen. 1. The facility failed to label and date all food items located in the walk-in refrigerator, freezers and in the dry food pantry area on 7/15/2025, and 7/16/2025. 2. The facility failed to clean and sanitize its food storage areas, to include the shelves and 1 freezer in storage room. on 7/15/2025, and 7/16/2025.3. The facility failed to clean and sanitize its dining area on 7/15/2025, 7/16/2025, and 7/17/2025. These failures could place residents who receive meals from the kitchen and dine in the facility's dining room at risk for foodborne illnesses.Observation during the initial tour of the kitchen on 7/15/2025 beginning at 09:30 AM, the following was observed: Dry Food Pantry area: 18 cans of diced red peppers, not labeled and dated 6 cans of Thick it, not labeled and dated 2 gallons of Coleslaw Dressings, not labeled and dated 6 cans of chicken noodles, not labeled and dated 4 boxes of Cream of Wheat, not labeled and dated Walk in refrigerator: Ziploc bag of thawed meat, not labeled and dated 3 pitchers of unmarked liquids or drinks, not labeled and dated A plastic pitcher filled about 2/3 full of peaches, not labeled and dated 6 gallons of milk, not labeled and dated Upright Freezer: 4 frozen jugs of orange juice and 4 frozen jugs of cranberry juice, not labeled and dated. Observed the shelf in the [NAME] freezer to be unclean, the shelf noted with sticky brown residue and an unknown dead insect resembling a beetle. The pantry shelves were observed to be unclean. There were mice droppings noted on the bottom shelf of the pantry room.07/15/2025, 12: 30 PM, the dining area was observed with: 5 dirty windowsills with dead bugs and cobwebs Cobwebs on beams Ceiling fans with significant dust and cobwebs07/16/2025 at 9:11AM, kitchen policy and procedure were requested from facility staff. During a follow up tour of kitchen on 7/16/2025 beginning at 11:00 AM, the following was observed: Unlabeled and not dated items remained: 18 cans of diced red peppers, 6 cans of Thick it, 2 gallons of Coleslaw Dressings,6 cans of chicken noodles, and 4 boxes of Cream of WheatNew items noted to be unlabeled and dated: opened frozen omelets and steak friesThe unclean shelves remained with the mouse droppings.The dining area remained with unclean windowsills.In an interview on 07/16/2025 at 3:15 PM Dietary Supervisor, stated the facility's practice is to keep open food for three days and then dispose of it. She also stated that all food products were expected to be labeled and dated upon arrival. She confirmed that her expectation was for all staff to follow this procedure.When asked about cleaning procedures, she stated that she personally trained staff on the cleaning schedule, which included daily cleaning of shelves and sweeping/mopping the storage room. However, when the surveyor asked to review the cleaning schedule book for the week of July 13-19, 2025, it was observed to have no entries. The Dietary Supervisor acknowledged that although staff had cleaned, no one had recorded their work in the log.The surveyor escorted the Dietary Supervisor to the food storage room and pointed out the mouse droppings and visibly soiled shelves. The Dietary Supervisor acknowledged the issue and stated the area would be cleaned that day. She was also shown the unlabeled food items in dry storage, the refrigerator, and freezer, and stated that they would all be marked immediately. She further admitted that she had previously noted a blue bag of food that was not labeled or dated.When asked what potential harm could result from food items not being labeled and dated properly, the Dietary Supervisor stated that items could expire and become contaminated, which could cause residents to become ill. The surveyor escorted the Dietary Supervisor to the windowsills; she stated housekeeping was responsible for cleaning the windowsills in the dining area.In an interview 07/17/2025 at 9:25 AM, Housekeeping Supervisor stated that she was responsible for overseeing the cleaning of the dining room. She reported that housekeeping staff sweep and mop the floors, sanitize all tables, and wipe down countertops. She stated that windows were cleaned once a week, and that dusting, spraying, and wiping of surfaces are part of the routine duties.When asked about who provides training on the cleaning schedule, the Housekeeping Supervisor stated that she was responsible for training staff. She noted that she has not been in her position long and has not yet had time to complete a formal cleaning schedule. She explained that the department has been short-staffed, and she has been assisting in other areas of the facility.She stated that cleaning the ceiling fans was the responsibility of the maintenance department, as housekeeping staff do not have access to ladders. When informed that several dead bugs were observed in the windowsills, the Housekeeping Supervisor stated that they would address the issue that day. She also stated that the three housekeepers currently working have been employed at the facility</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Dispose of garbage and refuse properly.</p> <p>Based on observation, interview and record review, the facility failed to dispose of garbage properly in 1 of 1 kitchen. On 07/15/2025 at 9:30 AM, 1 of 2 facility garbage containers were observed with no lids attached or on them and they had waste inside. This failure has the potential to affect residents in the facility, staff, and visitors by placing them at risk of infection for exposure to germs and diseases carried by pests and rodents. In an interview with Dietary Supervisor on 07/16/2025 at 3:15 PM, Dietary Supervisor stated that trash cans should always have lids and should remain closed when not in use. Dietary Supervisor stated not keeping the lids closed could lead to cross contamination, placing residents at risk of illness. In an interview 07/17/2025 at 9:51 AM with Dietary Aide D, she stated that she has been employed at the facility for six years and has worked in the kitchen for the past four years. She reported that she has been trained on all kitchen policies. Dietary Aide D stated that trash cans should be kept always closed with a lid. She explained that if a trash can is left open, it can allow germs to accumulate, potentially contaminating the food and causing residents to become ill. Record review of the Dietary Services Policies and Procedures for Waste Control and Disposal, stated that Trash cans must be covered at all times except during use.</p>

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<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>Based on interview and record review the facility failed to electronically submit to CMS complete and accurate direct care staffing information, including the category of work for each person on direct care, including, but not limited to, whether the individual was a registered, nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS for one of one facility reviewed for administration. The facility failed to submit PBJ (Payroll Based Journal) staffing information to CMS for October 1, 2024, to December 31, 2024. This failure could place residents at risk for personal needs not being identified and met, decreased quality of care, decline in health status, and decreased feelings of well-being within their living environment. Record review of the CMS PBJ report for CMS FY Quarter 1 2025 (October 1, 2024 - December 31, 2024) indicated the facility failed to submit data for the quarter. Interview on 07/17/2025 at 7:45 AM the Corporate Nurse stated that she was aware the Payroll Based Journal had not been submitted for the quarter of October 1, 2024 - December 31, 2024, to CMS. She stated she was unsure as to why the data had not been reported and she would reach out to her corporate level staff and attempt to get an answer. She stated she was aware the Payroll Based Journal was required to be submitted. The Corporate Nurse stated the Administrator did quit on 07/01/2025 and she could not answer why he did not ensure the Payroll Based Journal was not submitted. Review of the facility's Reporting Direct Care Staffing Information (Payroll- Based Journal), dated 2001, reflected the following Reporting Direct Care Staffing Information (Payroll-Based Journal)Policy StatementDirect care staffing information is reported electronically to CMS through the Payroll-Based Journal system.Policy Interpretation and Implementation1. Complete and accurate direct care staffing information is reported electronically to CMS through the Payroll-Based Journal (PBJ) system in a uniform format specified by CMS. 2. Direct care staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain their highest practicable physical, mental, and psychosocial well-being.3. Direct care staffing information includes staff hired directly by the facility, those hired through an agency, and contract employees.4. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the facility (for example, housekeeping).5. Providers who are employed by the facility (including physicians) are included in direct care staffing information; providers who bill Medicare directly are not included.6. For auditing purposes, reported staffing information is based on payroll records, invoices, tied back to a contract, or other verifiable information.7. Data is submitted only by designated personnel with training on the PBJ user interface. 8. Technical specifications for uploading data directly from a payroll or time and attendance system will be accessed through: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Staffing-Data-Submission-PBJ.html.9. Direct care staffing information is submitted on the schedule specified by CMS, but no less frequently than quarterly.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675564	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2025
NAME OF PROVIDER OR SUPPLIER Harmony Care at Giddings		STREET ADDRESS, CITY, STATE, ZIP CODE 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.

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675564	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2025
NAME OF PROVIDER OR SUPPLIER Harmony Care at Giddings		STREET ADDRESS, CITY, STATE, ZIP CODE 1181 N Williamson Giddings, TX 78942	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program, including hand hygiene, designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections for 7 (Resident #5, Resident #8, Resident #22, Resident #27, Resident #15, Resident #39, and Resident #42 of 11 residents reviewed for infection control practices, in that: The facility failed to:1. Ensure CNA B and Medication Aide A practiced proper hand hygiene while serving and assisting residents #22, #27, and #42 during the lunch meal on [DATE].2. Ensure CNA C changed dirty gloves when handling clean items while providing peri care to Resident #8.3. Ensure Medication Aide A sanitized blood pressure monitors in between Resident #15 and Resident #39 while obtaining blood pressures. 4. Ensure LVN F washed his hands before and after the wound care on Resident #5 and changed dirty gloves when handling clean items while providing wound care. These failures could place residents at risk for healthcare associated cross-contamination and infections. An observation of the lunch meal on [DATE] between 12:08PM and 12:50PM revealed CNA B, and Medication Aide A assisted in the dining room.CNA B, and Medication Aide A were observed passing out trays to 12 residents at 6 tables.CNA B was observed sitting down to provide feeding assistance to Resident #42 immediately after passing lunch trays, without performing hand hygiene (washing or sanitizing hands). Medication Aide A was also observed sitting down to assist Resident #27 with feeding immediately after passing lunch trays, without performing hand hygiene. CNA B was observed later leaving Resident #42 after providing feeding assistance without performing hand hygiene. CNA B then proceeded to Resident #22 to help with her meal, again without washing or sanitizing his hands. Review of Resident #8's face sheet dated [DATE] reflected a [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including morbid (severe) obesity due to excess calories, depression, muscle weakness, abnormalities of gait, type 2 diabetes, anxiety disorder and infection following a procedure. Review of Resident #8's quarterly MDS assessment, dated [DATE] reflected a BIMS score of 12, indicating she had moderately impaired cognition.Review of Resident #8's care plan dated [DATE] had not indicated peri care.During an observation on [DATE] at 11:45am CNA C was providing peri care for Resident #8. CNA C put on gloves after washing his hands. After that he opened the brief and cleaned Resident #8's front and back with wet wipes dispensed directly from the wipe's packet. In that process he handled the whole wipe packet with the soiled gloves. He had not changed his gloves in the entire process and touched clean items that included a new brief and Resident #8's clothes and blanket. After the completion of peri care he placed the contaminated wipe packet containing wet wipes in a drawer containing Resident #8's personal belongings.During an interview on [DATE] at 11:55am CNA C stated he received training on peri care when he started working at the facility about 5 months ago. When the investigator walked through the peri care that he had done on Resident #8, CNA C stated he understood he should not have contaminated the wet wipe packet by handling it with soiled gloves, due to the danger of spreading germs. He said, by storing the contaminated packet in the drawer he had contaminated the items inside the drawer as well. He stated he also forgot to change the gloves before picking up the clean items after the completion of the cleaning. Review of Resident #5's face sheet dated [DATE] reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including traumatic brain injury without loss of consciousness, injury to L5 level of lumbar spinal cord (5th segment of the lower part of the spinal cord) , severe protein-calorie malnutrition, pressure ulcer of sacral (pelvis) region, stage 4, spinal stenosis of lumbosacral region (narrowing of the spaces within the spine of the lower back region).Review of Resident #5's initial MDS assessment, dated [DATE] reflected a BIMS score of 0 indicated he had severe impairment with cognition. Review of Resident #5's care plan, dated [DATE], reflected Resident #5 had pressure ulcer at the sacrum (pelvis) area r/t Immobility. The relevant intervention was administering treatments as ordered and monitor for effectiveness.Record review of Resident #5's Physician's order revealed : Sacrum: Cleanse with Wash Cloth, Pat dry, Pack with Silver alginate, Cover with Dry dressing, Change QD/PRN one time a day. Start Date-[DATE].During an observation on [DATE] at 3:00pm LVN F was performing wound care on Resident #5. He put on gown and mask and then went to resident for wound care. LVN F started wound care with putting on gloves, without washing or sanitizing his hands. He opened the brief and cleaned the wound on Resident #5's sacral area. LVN F then applied medication and closed the brief. After the completion of the</p>		

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NAME OF PROVIDER OR SUPPLIER Harmony Care at Giddings		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>Based on observations, interviews, and record review, the facility failed to maintain an effective pest control program so that the facility was free of pests for one of one kitchen reviewed for effective pest control. The facility had presence of mouse droppings on a shelf in the food storage room. This failure could place residents at risk for spread of infection, cross-contamination, and decreased quality of life. Observation on 07/15/2025 at 9:22 AM, in the facility's kitchen food storage room revealed several mouse droppings on the bottom shelf. In an interview with Dietary Supervisor on 07/16/2025 at 3:15 PM, she stated it looked like mouse droppings to her as well on the shelf. Dietary Supervisor stated the maintenance department was responsible for pest control. She stated the shelf would be cleaned that day. In an interview with the Maintenance Supervisor on 7/17/2025 at 9:44 AM, he stated that he began working at the facility on June 2, 2025. He reported that he has not personally seen any pests in the facility; however, some staff members have informed him that they have seen mice. The Maintenance Supervisor stated that pest control visited the facility twice last month and performed extermination services. He indicated he could provide the surveyor with copies of the pest control visit documentation. He also stated that the facility was surrounded by wooded areas and that he has contacted the city to request assistance with pest concerns related to the woods located behind the facility. Record Review of the facility's food storage policy, undated, stated: Procedure: 1. Storage areas will be free from rodent and insect infestation; and will be treated for pests and vermin on a regular schedule. Record Review of the facility's pest control service inspection report dated 07/14/2025 revealed, the facility was last treated for rodents. The facility's inspection report dated 06/27/2025 revealed, the facility was treated for roaches, spiders, and ants. Record Review of the facility's pest control policy, not dated revealed, Policy statement: Our facility shall maintain an effective pest control program. Policy Interpretation and Implementation: 1. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents</p>		