STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675595	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Care at Beaumont	2660 Brickyard Rd Beaumont, TX 77703

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36214 Based on observation, interview and record review, the facility failed to immediately consult with the resident's physician, and notify, consistent with his or her authority, the resident representative when there was a significant change in the resident's physical, mental or psychosocial status for 2 of 7 residents (Resident #1 & #2) reviewed for resident rights. The facility failed to ensure Resident #1's physician and responsible party were immediately notified on 04/19/24 after Resident #1 placed a pillow over Resident #2's face and said she tried to kill her. The facility failed to ensure Resident #2's physician was immediately notified on 04/19/24 after she reported Resident #1 had put a pillow over her face while she was sleeping and tried to kill her. On 04/22/24 at 11:03 a.m., an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 04/23/24, the facility remained out of compliance at a severity level with potential for more than minimal harm and a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. These failures could place residents at risk of a delay in medical intervention and decline in health or possible worsening of symptoms. Findings included: 1. Record review of Resident #1's face sheet, dated 04/20/24, indicated she was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included schizophrenia (a serious mental condition involving breakdown in the relation between thought, emotion, and behavior, leading to faulty perception, inappropriate actions and feelings, withdrawal from reality and personal relationships into fantasy and delusion), persistent mood [affective] disorder (marked disruptions in emotions {severe lows called depression or highs called hypomania or mania]), and anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations). (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675595	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's care plan, dated 10/25/23, indicated Resident #1 had a diagnosis of schizophrenia and was at risk for manic episodes and increased behaviors. Interventions included monitor for delusions and hallucinations and monitor for increased agitation, anger, verbal, and physical aggression and document in clinical record. Resident #1 was taking psychotropic medication and was at risk for adverse reactions and depression, anxiety, and/or psychosis driven behaviors. Interventions included monitor for anxiety driven behaviors and report any noted behaviors to MD for further orders. Record review of Resident #1's quarterly MDS assessment, dated 04/08/24, indicated Resident #1 was able to make herself understood and usually understood others, and had moderate cognitive impairment indicated by a BIMS score of 11. She had had no hallucinations, delusions, or physical or verbal behaviors. She required partial to moderate assistance with most ADLs. Record review of Resident #1's clinical file revealed there were no care plans available for review related to homicidal ideations. Record review of a clinical note dated 04/20/24 at 09:59 a.m., and completed by the DON, indicated she spoke with behavioral hospital to initiate referral process due to Resident #1's aggressive behaviors towards other residents. Spoke over the phone with Resident #1's POA to inform of behaviors and sending resident to a behavioral hospital. Verbal consent given by POA. NP for physician also in agreement. Record review of a late entry clinical note dated 04/20/24, at 10:30 a.m., and completed by LVN A, indicated LVN A was notified by CNA B that Resident #2 was yelling for help as Resident #1 had placed a pillow over Resident #2's face and held it over her face. Resident #2 came out of her room yelling for help. Residents were separated and assessed with no bruising to Resident #2's face or complaints of shortness of breath. Resident #1 stated, don't send me to jail please send me to a mental institution. Resident #2 was moved to another room for her protection and safety. Paged on call physician and awaiting response. 2. Record review of Resident #2's face sheet, dated 04/20/24, indicated she was a [AGE] year-old female who was admitted to the facility 12/05/23. Resident #2 had diagnosis which included dementia (a condition characterized by progressive or persistent loss of intellectual functioning) with agitation, major depressive disorder (a metal health disorder characterized by persistently depressed mood causing significant impairment in daily life), and schizophrenia. Record review of Resident #2's quarterly MDS dated [DATE] indicated Resident #2 was able to make herself understood and understood others, and had severe cognitive impairment indicated by a BIMS score of 6. She had feelings of being down, depressed, and hopeless 2-6 (several) days and had no behaviors. Record review of Resident #2's care plan, dated 07/31/23 indicated Resident #2 had an altered thought process and was at risk for further decline and injury as evidenced by dementia and short- and long-term memory deficit. Interventions included keep resident and others safe and monitor for mental status changes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675595	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 04/20/24 at 08:40 a.m., the Administrator said she received a text from LVN A on 04/19/24 at approximately 06:00 a.m., when she woke up reporting that Resident #1 had placed a pillow over Resident #2's face and Resident #1 was requesting to go to a mental institution. She said her immediate action had been to request an additional CNA from her corporate office and she had just received approval for the CNA this morning but had not hired a new CNA yet. The Administrator said LVN A's text indicated she had called the MD but had not received a response. The Administrator said she was not sure if the MD or Resident #1's RP had been notified about the incident. During an observation and interview on 04/20/24 at 09:10 a.m., Resident #1 was alone in her room on the secure unit resting in bed. She said yesterday (04/19/24) her roommate (Resident #2) was trying to put spells on her, and she had to stop her. She said she tried to hurt Resident #2. Resident #1 would not say how she tried to hurt Resident #2. During an observation and interview on 04/20/24 at 09:15 a.m., Resident #2 was alone in her room on the secure unit lying in bed. She said she had to be moved to a new room because her previous roommate had put a pillow over her face and tried to kill her while she was sleeping. She said she felt as safe as she could in her present surroundings. During an interview on 04/20/24 at 09:35 a.m., the DON said she was not at the facility on 04/19/24 because she had to work the night shift last night. She said she was notified on 04/19/24 that Resident #1 put a pillow over Resident #2's face, but she was now looking back on what was done after the incident. She said LVN A reported the incident, but there was no documentation in the clinical notes that she notified the MD or Resident #1's RP. The DON said Resident #2 was her own RP. The DON said notifications should have been made immediately after the incident, but she was notifying the physician and Resident #1's RP now. During a telephone interview on 04/20/24 at 9:55 a.m., LVN A said on 04/19/24 at 03:30 a.m., CNA B called her and reported that Resident # 1 had placed a pillow over Resident #2's face and tried to smother her. She said CNA B had separated the residents when she arrived on the secure unit. She said she assessed Resident #2 who had no visible injuries, but she kept repeating she tried to kill me. LVN A said Resident #1 admitted she tried to kill Resident #2. LVN A said she did not notify Resident #1's RP about the incident. LVN A said she paged the MD twice but did not receive a response. She said she gave report to LVN C about the incident and that she had not received a return call from the MD. LVN A said she assumed LVN C would notify the MD. LVN A said she had not documented her attempts to notify the MD. During an interview on 04/20/24 at 10:05 a.m., LVN C said he received report from LVN A on 04/19/24 at 06:00 a.m. about the incident between Resident #1 and Resident #2. He said LVN A reported to him she had paged the MD twice and not received a response. He said he did not try to notify the MD or Resident #1's RP about the incident on 04/19/24. During an interview on 04/20/24 at 10:51 a.m., the DON said she notified the NP of the incident that occurred on 04/19/24 to the NP and Resident #1's RP on 04/20/24 at approximately 10:00 a.m. She said she had completed the referral to the behavioral hospital for Resident #1 and was awaiting her transfer. She said the NP gave no new orders for Resident #2. (continued on next page)

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	675595	A. Building B. Wing	04/23/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 04/20/24 at 02:30 p.m., the DON said she expected all resident changes of condition to be reported immediately to the MD and the resident's RP. She said not reporting these changes could result in harm to the resident or a further decline in the resident's physical or emotional health. During a telephone interview on 04/20/24 at 3:25 p.m., the MD said he did not receive any pages on 04/19/24 and the incident of Resident #1 putting a pillow over the face of Resident #2 had not been reported to him. The MD said if the incident had been reported to him, he would have given orders to transfer Resident #1 to a behavioral hospital. During an observation and interview on 04/20/24 at 02:59 p.m., Resident #1 was walking with ambulance attendants and the DON to an awaiting ambulance. The DON said Resident #1 was being transferred to a behavioral hospital. During a telephone interview on 04/22/24 at 11:15 a.m., the NP said she was notified on 04/20/24 at 09:57 a. m. by the DON of the incident that happened on 04/19/24 when Resident #1 had put a pillow over the face of Resident #2 and admitted to trying to kill her. NP said she gave an order to the DON to transfer Resident #1 to a behavioral hospital. During a telephone interview on 04/22/24 at 11:23 a.m., Resident #1's RP said he was notified of Resident #1 putting a pillow over Resident #2's face by the DON the morning of 04/20/24 and gave the DON his permission to send Resident #1 to a behavioral hospital. Record review of the facility's undated Change in Resident's Condition or Status policy, Indicated Our facility shall promptly notify the resident, his or her attending physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (for example, changes in level of care, billing/payments, resident rights, et cetera). This was determined to be an Immediate Jeopardy (IJ) on 04/22/24 at 08:40 a.m. The Administrator was notified. The Administrator was provided with the IJ template on 04/22/24 at 11:03 a.m. The following Plan of Removal submitted by the facility was accepted on 04/23/24 at 08:08 a.m. Immediate Action: -On 4-20-24 Director of Nursing called Responsible party and the Physician to notify him of the incident involving R1 and R2 on 4-19-24. New orders received to send R1 to inpatient psychiatric hospital. -On 4-22-24 ADON re-educated all nurses on notification policy and what steps to take if the incident occurs as outlined in the change of condition policy. 100% compliance was completed. -On 4-22-24 ADON and Administrator reviewed all new physician orders incident reports and progress notes to make sure any changes in conditions physician were notified. 3 residents were identified as having a change in condition and the physician and responsible party was notified immediately, new orders to be sent to Behavior hospital on all. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In-Services All licensed nursing staff were in-serviced on immediate notification of the MD, the RP, the Administrator, and the DON of any mental or physical change in a resident's condition. The ADON completed in-service on the facility's Change in a Resident's Condition or Status policy on 04/22/24. Monitoring On 04/22/24 the Administrator and the ADON reviewed all new physician orders, incident reports, and progress notes to ensure the physician was notified of any change in resident condition. Monitoring of the POR included the following: During interviews on 04/22/24 from 4:00 p.m. through 6:00 p.m. and 04/23/24 from 9:15 a.m. through 10:15 a.m. with LVN A 10 p.m. - 6 a.m., LVN C (6:00 a.m. to 2:00 p.m.), LVN D (6:00 a.m. -2:00 p.m.), LVN E (6:00 a.m. to 2:00 p.m. and 2:00 p.m. to 10:00 p.m.), LVN F (10:00 p.m. to 6:00 a.m.), LVN G (10 p.m. to 10 p.m.), LVN H (2:00 p.m. to 10:00 p.m., LVN I (2:00 a.m. to 10 p.m.), RN J (weekend shifts), and LVN K (6:00 a.m. to 2:00 p.m. and 2:00 p.m. to 10:00 p.m.) and the ADON indicated staff were able to identify the Abuse Coordinator as the administrator. Licensed staff all indicated they were educated on reporting any change of resident condition immediately to the Administrator, DON, MD, and RP. All staff verbalized knowledge of examples of changes in resident condition such as an accident or incident involving the resident, injury of an unknown source, change in the resident's physical/emotional/mental condition, or adverse reactions to medications. The ADON indicated all licensed staff had received in-service training either in person, by email, or be text. During an interview on 04/23/24 at 10:20 a.m., the Administrator said she was in-serviced on 09/22/24 by the Regional Director of Clinical Operations (RCDO). She was able to verbalize the facility change of condition policy and the facility would conduct a thorough investigation of all incidents of resident verbal or physical aggression to others. She said the physician would be notified immediately of any change of condition of any resident. She and the DON would be in-serviced on the change of condition policy upon her return to the facility. She said The DON and ADON would conduct audits daily of any new physician orders, incident reports, progress notes and the 24-hour report to ensure every change in resident condition was reported to the MD and the RP. During an interview on 04/23/24 at 10:25 a.m., the ADON said she was in-serviced on 04/22/24 by the RDCO. She was able to verbalize the facility change of condition policy and the facility would conduct a thorough investigation of all incidents of resident verbal or physical aggression to others. She said the physician would be notified immediately of any change of condition of any resident. She and the DON would be in-serviced on the change of condition policy upon her return to the facility. She said The DON and the ADON would conduct audits daily of any new physician orders, incident reports, progress notes and the 24-hour report to ensure every change in resident condition was reported to the MD and the RP. Record review of all incidents from the previous 90 days indicated there were no additional incidents of resident change of condition not being reported to the MD and the RP. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of training records indicated all Licensed staff were in-serviced on 04/22/24 regarding the facility change in resident condition policy, the procedure for reporting any change in resident condition to the resident RP, and physician notification. The Administrator and the ADON were informed the Immediate Jeopardy was removed on 04/23/24 at 10:35 a.m. The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm and with a scope identified as isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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F 0600

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 36214

Based on observation, interview, and record review, the facility failed to ensure residents the right to be free from abuse for 2 of 7 residents (Residents #2 and #3) reviewed for abuse.

1. On 04/03/24 Resident #3 self-propelled her wheelchair into Resident #1's room and Resident #1 pulled Resident #3 out of her wheelchair onto the floor.

2. On 04/19/24 Resident #1 placed a pillow over the face of Resident #2 and later admitted she was trying to kill Resident #2.

On 04/20/24 at 02:29 p.m. an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 04/21/24, the facility remained out of compliance at a severity level with the potential for more than minimal harm and a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of thei Plan of Removal.

These failures could place residents at risk of abuse, physical harm, mental anguish, and emotional distress.

Findings included:

1. Record review of Resident #1's face sheet, dated 04/20/24, indicated she was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included schizophrenia (a serious mental condition involving breakdown in the relation between thought, emotion, and behavior, leading to faulty perception, inappropriate actions and feelings, withdrawal from reality and personal relationships into fantasy and delusion), persistent mood [affective] disorder (marked disruptions in emotions {severe lows called depression or highs called hypomania or mania]), and anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations).

Record review of Resident #1's care plan, dated 10/25/23, indicated Resident #1 had a diagnosis of schizophrenia and was at risk for manic episodes and increased behaviors. Interventions included monitor for delusions and hallucinations and monitor for increased agitation, anger, verbal, and physical aggression and document in clinical record. Resident #1 was taking psychotropic medication and was at risk for adverse reactions and depression, anxiety, and/or psychosis driven behaviors. Interventions included monitor for anxiety driven behaviors and report any noted behaviors to MD for further orders.

Record review of Resident #1's care plan, dated 10/25/23, indicated Resident #1 was taking psychotropic medication and was at risk for adverse reactions and depression, anxiety, and/or psychosis driven behaviors. Interventions included monitor for anxiety driven behaviors and report any noted behaviors to MD for further orders.

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's quarterly MDS assessment, dated 04/08/24, indicated Resident #1 was able to make herself understood and usually understand others, and had moderate cognitive impairment indicated by a BIMS score of 11. She had had no hallucinations, delusions, or physical or verbal behaviors. She required partial to moderate assistance with most ADLs. Record review of Resident #1's clinical file revealed there were no care plans available for review related to homicidal ideations. Record review of the incident report dated 04/19/24 at 03:40 a.m., completed by LVN A indicated she was notified by CNA B that Resident #2 was yelling for help because Resident #1 (her roommate) had placed a pillow over Resident #2's face and held it over her face. Resident #2 came out of her room yelling for help. The residents were separated, and Resident #2 was assessed with no bruising on her face and no shortness of breath. Resident #1 admitted she did it and stated, Don't send me to jail please send me to a mental institution. Resident #2 was moved to another room for her protection and safety. MD was paged and LVN A was awaiting response. Administrator was notified. 2. Record review of Resident #2's face sheet, dated 04/20/24, indicated she was a [AGE] year-old female who was admitted to the facility 12/05/23. Resident #2 had diagnosis which included dementia (a condition characterized by progressive or persistent loss of intellectual functioning) with agitation, major depressive disorder (a metal health disorder characterized by persistently depressed mood causing significant impairment in daily life), and schizophrenia. Record review of Resident #2's care plan, dated 07/31/23 indicated Resident #2 had an altered thought process and was at risk for further decline and injury as evidenced by dementia and short- and long-term memory deficit. Interventions included keep resident and others safe and monitor for mental status changes. Record review of Resident #2's quarterly MDS dated [DATE] indicated Resident #2 was able to make herself understood and understood others, and had severe cognitive impairment indicated by a BIMS score of 6. She had feelings of being down, depressed, and hopeless 2-6 (several) days and had no behaviors. During a telephone interview on 04/20/24 at 08:40 a.m., the Administrator said she received a text from LVN A on 04/19/24 at approximately 06:00 a.m. when she woke up reporting Resident #1 had placed a pillow over Resident #2's face and Resident #1 was requesting to go to a mental institution. She said her immediate action had been to request an additional CNA for the secure unit from her corporate office and she had just received approval for the CNA this morning but had not hired a new CNA yet. The Administrator said the secure unit had one dedicated CNA and one nurse that floats between the other rooms and the secure unit. She said Resident #2 had been moved into another room on the secure unit. During an observation and interview on 04/20/24 at 09:05 a.m., CNA L said she was assigned the secure unit today with LVN C who was floating between the secure unit and rooms outside the unit. CNA L was sitting in the TV room with 4 residents and said Residents #1 and #2 were in their rooms alone. During an observation and interview on 04/20/24 at 09:10 a.m., Resident #1 was alone in her room on the secure unit and resting in bed. She said yesterday (04/19/24) her roommate (Resident #2) was trying to put spells on her, and she had to stop her. She said she tried to hurt Resident #2. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation and interview on 04/20/24 at 09:15 a.m., Resident #2 was alone in her room on the secure unit lying in bed. She said she had to be moved to a new room because her previous roommate had put a pillow over her face and tried to kill her while she was sleeping. She said she felt as safe as she could in her present surroundings. During an interview on 04/20/24 at 09:35 a.m., the DON said she was not at the facility on 04/19/24 because she had to work the night shift last night. She said was notified on 04/19/24 about Resident #1 putting a pillow over Resident #2's face, but she was now looking back on what was done after the incident. She said LVN A reported the incident, but there was no documentation in the clinical record about the incident or if LVN A notified the police, the physician, or the responsible party. She said notifications should have been made and she was doing the notifications to the MD and RP. She said based on the aggression Resident #1 should have been transferred to a behavioral hospital for evaluation. During a telephone interview on 04/20/24 at 09:55 a.m., LVN A said on 04/19/24 at 03:30 a.m. she received a call from CNA B who reported Resident #1 had placed a pillow over Resident #2's face and tried to smother her. She said CNA B had separated the residents when she arrived on the secure unit. LVN A said she assessed Resident #2 and found no visible injuries, but she kept repeating she tried to kill me. She said Resident #1 admitted she tried to kill Resident #2. LVN A said she paged the MD twice and he did not call by the end of her shift. She said she reported the incident to her Administrator via text and LVN C who was the nurse working the 06:00 a.m. to 02:00 p.m. shift. During an interview on 04/20/24 at 10:05 a.m., LVN C said he received report from LVN A on 04/19/24 at 06:00 a.m. about the incident between Resident #1 and Resident #2. He said LVN A reported to him she had paged the MD twice and not received a response. He said he did not try to notify the MD or Resident #1's RP about the incident on 04/19/24. He said he never noticed if Resident #1 ever came out of her room on his shift and he wasn't sure if Resident #2 was in or out of her room during the day. During a telephone interview on 04/20/24 at 10:21 a.m. CNA B said on 04/19/24 at approximately 03:20 a.m. she was passing by the room Resident #1 and Resident #2 shared when Resident #2 ran out of the room saying Resident #1 put a pillow over her head and tried to kill her. Resident #1 said Resident #2 had been naked during the day and she tried to kill her. Resident #1 then said she wanted to go to a mental hospital in Dallas because that was where her brother sent her whenever she tried to hurt people. CNA B said she separated the residents by bringing Resident #2 into the TV room with her and called LVN A and reported the incident. CNA B said after the incident Resident #1 was pacing up and down the hall talking loudly but not making any sense. She said then Resident #1 went into her room and pulled the mattress off her bed and disrobed and continued pacing around her room. She said Resident #2 said she was afraid to be alone in her room, so CNA B kept Resident #2 with her the rest of the night except when assisting other residents and she took her to sit with LVN A. During an interview on 04/20/24 at 10:51 a.m., the DON said she notified the NP of the incident that occurred on 04/19/24 to the NP and Resident #1's RP on 04/20/24 at approximately 10:00 a.m. She said she had completed the referral to the behavioral hospital for Resident #1 and was awaiting her transfer. She said the NP gave no new orders for Resident #2. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675595	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2024
NAME OF PROVIDER OR SUPPLIER: Harmony Care at Beaumont		STREET ADDRESS, CITY, STATE, ZIP CODE: 2660 Brickyard Rd Beaumont, TX 77703	

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation and interview on 04/20/24 at 11:19 a.m., Police Officer M visited Resident #2 in her room. Resident #2 remained alone in her room made a verbal statement to Police Officer M that Resident #1 had tried to kill her by placing a pillow over her face while she was sleeping. She said she wanted to press charges against Resident #1 so she wouldn't try to kill her again. During an observation on 04/20/24 at 11:26 a.m., Resident #1 was sleeping alone in her room. During an interview on 04/20/24 at 03:59 p.m., the DON said she sat with Resident #1 until she was transported by ambulance to a behavioral hospital at approximately 03:30 p.m. 3. Record review of Resident #3's face sheet dated 04/20/24 indicated she was a [AGE] year old female, admitted on [DATE], and her diagnoses included cerebral infarction (stroke), spastic hemiplegia (a common post-stroke condition that causes stiff or rigid muscles) affecting right dominant side, vascular dementia (dementia [a condition characterized by progressive or persistent loss of intellectual functioning] caused by an impaired supply of blood to the brain), mood disorder (marked disruptions in emotions [severe lows called depression or highs called hypomania or mania]), and depression Record review of Resident #3's care plan revised on 06/21/23 indicated Resident #3 was deemed at risk for wandering related to being ambulatory with her wheelchair, diagnosis of dementia, and history of exit seeking. Goals included Resident #3 would be able to wander in a safe environment (secure unit) with no occurrence of injury and dignity would be maintained. Record review of Resident #3's annual MDS dated [DATE] indicated Resident #3 was sometimes able to make herself understood and usually understood others, and had severe cognitive impairment indicated by a staff assessment. She had mood of little interest or pleasure in doing things several (2-6 days) and behaviors directed toward others 1 to 3 days and no wandering behaviors. Record review of Resident #1's clinical note (related to the incident with Resident #3) dated 04/03/24 at 11:30 a.m. and signed by LVN N indicated a CNA B came and informed LVN N that Resident #1 pulled Resident #3 out of her wheelchair onto the floor of Resident #1's room. Resident #1 said I'm not a fucking babysitter, I need help my motherfucking self she needs to keep her ass out of my motherfucking room. On arrival to the secure unit residents were already separated and in different rooms. LVN N educated and redirected Resident #1, she was informed that physical aggression would not be tolerated, and it was not her right to put hands on anyone. LVN A indicated that Resident #1 did not verbalize understanding. During an observation and interview on 04/20/24 at 09:05 a.m., Resident #3 was sitting in the TV room of the secure unit. She was unable to answer question about the incident. She was holding her right arm against her, and it appeared to have contractures at her elbow and wrist. Resident #3 said her arm was not painful. CNA L said Resident #3's arm was paralyzed from a stroke. CNA L said staff tried to keep Resident #3 busy because she wandered into other resident's rooms. She said she was not working the day Resident #3 wandered into Resident #1's room and Resident #1 pulled her out of her wheelchair to the floor, but it had been reported to her by another CNA. During an interview on 04/20/24 at 09:35 a.m. the DON said the only reason Resident #1 had pulled Resident #3 out of her wheelchair on 04/03/24 was because she went into Resident #1's room. She said she had instructed all staff on the secure unit to keep Resident #3 from wandering into other resident's rooms. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 04/22/24 at 11:35 a.m., LVN N said on 04/03/24 at approximately 11:30 a.m. , a CNA reported to her that Resident #3 had self-propelled her wheelchair into Resident #1's room and Resident #1 pulled her out of her wheelchair and onto the floor. LVN N said she assessed Resident #3 who was sitting in the floor of Resident #1's room at the foot of her bed. She had no visible injuries, and she was assisted back into her wheelchair and out of the room. Resident #3 was unable to say how she got onto the floor. LVN N said she notified the ADON, the Administrator, the MD, and the RP of the incident. During a telephone interview on 04/22/24 at 12:16 p.m., Resident #3's RP said she was notified on 04/03/24 by the nurse that Resident #3 had wheeled herself into another resident's room and the other resident had pulled Resident #3 out of her wheelchair and onto the floor. She said Resident #3's right arm had paralysis since her stroke. She said Resident #3 had no bruising or pain after she was pulled from her wheelchair. RP said she visited Resident #3 every day and she had witnessed residents on the secure unit being aggressive to staff and other residents. RP said she could not name the Residents she had seen be aggressive, but she had seen Resident #1 yell and cuss at other residents. She said she had not told the Administration about resident aggression. Record review of the facility's Abuse and Neglect Policy dated June 2023 indicated It is the policy of the facility to administer care and services in an environment that is free of any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment .The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations. These guidelines include compliance with the seven (7) federal guidelines of prevention and investigation . VI. Protect residents from physical and psychosocial harm during investigations. This was determined to be an Immediate Jeopardy (IJ) on 04/20/24 at 02:25 p.m. The Administrator was notified. The Administrator was provided the IJ template on 04/20/24 at 2:29 p.m. The Facility's Plan of Removal for Immediate Jeopardy was accepted on 04/21/24 at 10:37 a.m. and reflected the following: Immediate action: On 4/20/24 Resident #1 was immediately placed on 1 on 1 monitoring until the facility could transfer Resident #1 to psychiatric hospital, waiting on approval from the behavioral hospital to transport. *Charge nurse/ nurse managers Immediately assessed Resident #2 & Resident #3 and the rest of the residents in the secure unit for possible mental or physical abuse, no additional mental health needs were identified, nor any suspected physical abuse found at this time. oAdministrator/abuse coordinator Immediately in-serviced all staff 100% completion on Abuse & Neglect policy. o on 4/20/24 the Director of Nursing, Inservice all 100% of staff on behavioral management policy which included resident to resident abuse regarding residents exhibiting aggressive behaviors towards others, and steps to do, and how to approach the situation. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Care at Beaumont	2660 Brickyard Rd Beaumont, TX 77703

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/21/24 the MDS nurse reviewed all residents who have had aggressive behaviors, to make sure interventions were in place, for the floor staff to be able to see in electronic health record (EHR). The facility reviewed the system for abuse identification and reporting. The facility created a plan of improvement to assure residents were free from abuse to address changes including education, daily chart reviews and IDT discussions. The DON and/or Designee will review incident reports and progress notes 5 days weekly to assure that there were no incidents that could meet the qualifications of abuse and discuss any concerns with the abuse coordinator immediately. Resident #1 was placed on one-on-one monitoring until her transfer to a behavioral on 04/20/24. The charge nurses and the nurse managers reviewed all residents on the secure unit on 04/20/24 that were involved in incidents within the last 30 days to ensure all residents had the correct supervision. No additional mental or physical abuse was identified. On 04/20/24 the Administrator completed in-service with all facility staff regarding the behavioral management policy which included resident to resident abuse, residents exhibiting aggressive behaviors, and steps to approach a resident-to-resident situation. On 04/21/23 at 11:48 a.m., the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by: During interviews conducted on 04/20/24 from 03:30 p.m. though 06:00 p.m. and 04/21/24 from 08:15 a.m. 11:48 a.m. included LVN A 10 p.m. - 6 a.m., LVN C (6:00 a.m. to 2:00 p.m.), LVN D (6:00 a.m. -2:00 p.m.), LVN E (6:00 a.m. to 2:00 p.m. and 2:00 p.m. to 10:00 p.m.), LVN F (10:00 p.m. to 6:00 a.m.), LVN G (10 p.m. to 10 p.m.), LVN H (2:00 p.m. to 10:00 p.m., LVN I (2:00 a.m. to 10 p.m.),RN j (weekend shifts), and LVN K (6:00 a.m. to 2:00 p.m. and 2:00 p.m. to 10:00 p.m.), CNA B (10:00 p.m. to 6:00 a.m.), CNA L (6:00 a.m. to 2:00 p.m.), CNA O (6:00 a.m. to 2:00 p.m.), CNA P (2:00 p.m. to 10:00 p.m.), CNA Q (2:00 p.m. to 10:00 p.m.), CNA R (10:00 p.m. to 6:00 a.m.), and CNA S (6:00 a.m. to 2:00 p.m.), the Dietary Manager, Dietary Aide T, Dietary Aide U, Housekeeper V, Housekeeper W, MDS Nurse and 1 ADON who worked all shifts. Staff were able to identify the Abuse Coordinator as the administrator. Staff indicated they were to report allegations of abuse and neglect immediately to the charge nurse or administrator and were able to give example of physical, verbal, sexual abuse and immediate intervention procedures. They were able to state immediate actions to take when an allegation was made and/or identified, such as immediately removing the alleged perpetrators from providing care to residents and separating residents. Staff were educated on facility posting related to reporting abuse were able to locate numbers for reporting and alternate methods of reporting abuse such as department supervisors and/ or charge nurses. During an interview on 04/21/24 at 10:20. a.m., the Administrator and the DON indicated the facility 24 Hour Report and Incident Reports would be reviewed in the morning clinical meetings attended by the Administrator and the Director of Nursing to review for any allegations or instances of abuse and/ or neglect. The weekend manager on duty and weekend RN Supervisor would report any incidents or allegations to the DON and administrator immediately. The Administrator was informed the IJ was removed on 04/21/24 at 12:39 a.m. The facility remained out of compliance at potential for more than minimal harm with a scope identified as isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put in place.

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F 0657

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 36214

Based on interview and record review, the facility failed to ensure that a comprehensive person-centered care plan was reviewed and revised by the interdisciplinary team after each assessment for 3 of 7 residents (Residents #1, #2, and #3) reviewed for comprehensive person-centered care plans.

1. Resident #1's comprehensive person-centered care plan was not updated to reflect behavior of physical aggression toward another resident.

2. Resident #2's comprehensive person-centered care plan was not updated to reflect an altercation when another resident had been physically aggressive with her.

3. Resident #3's comprehensive person-centered care plan was not updated to reflect when another resident had been physically aggressive with her.

These failures could place residents at risk for not receiving the necessary care and services they required.

The findings were:

1. Record review of Resident #1's face sheet, dated 04/20/24, indicated she was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included schizophrenia (a serious mental condition involving breakdown in the relation between thought, emotion, and behavior, leading to faulty perception, inappropriate actions and feelings, withdrawal from reality and personal relationships into fantasy and delusion), persistent mood [affective] disorder (marked disruptions in emotions {severe lows called depression or highs called hypomania or mania]), and anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations).

Record review of Resident #1's care plan, dated 10/25/23, indicated Resident #1 had a diagnosis of schizophrenia and was at risk for manic episodes and increased behaviors. Interventions included monitor for delusions and hallucinations and monitor for increased agitation, anger, verbal, physical aggression and document in the clinical record. The care plan was not updated with Resident #1's physical aggression toward other residents on 04/03/24 when she pulled Resident #3 out of her wheelchair or on 04/19/24 when she attempted to smother her roommate (Resident #2) with a pillow.

Record review of Resident #1's quarterly MDS assessment, dated 04/08/24, indicated Resident #1 was able to make herself understood and usually understand others, and had moderate cognitive impairment indicated by a BIMS score of 11. She had had no hallucinations, delusions, or physical or verbal behaviors. She required partial to moderate assistance with most ADLs.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675595	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2024
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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's clinical note (related to the incident with Resident #3) dated 04/03/24 at 11:30 a.m. and signed by LVN N indicated CNA came and informed LVN N that Resident #1 pulled Resident #3 out of her wheelchair onto the floor of Resident #1's room. Resident #1 said I'm not a fucking babysitter, I need help my motherfucking self she needs to keep her ass out of my motherfucking room. On arrival to the secure unit residents were already separated and in different rooms. LVN N educated and redirected Resident #1, she was informed that physical aggression would not be tolerated, and it was not her right to put hands on anyone. LVN A indicated that Resident #1 did not verbalize understanding. Record review of the incident report dated 04/19/24 at 03:40 a.m., Completed by LVN A indicated she was notified by CNA that Resident #2 was yelling for help because Resident #1 (her roommate) had placed a pillow over Resident #2's face and held it over her face. Resident #2 came out of her room yelling for help. The residents were separated, and Resident #2 was assessed with no bruising on her face and no shortness of breath. Resident #1 admitted she did it and stated, Don't send me to jail please send me to a mental institution. Resident #2 was moved to another room for her protection and safety. MD was paged and LVN A was awaiting response. Administrator was notified. During an interview on 04/22/24 at 01:05 p.m., the MDS nurse said she was responsible for updating resident care plans with the DON's supervision. She said she had not been aware of Resident #1's aggression toward other residents. She said she received updates concerning residents during the facility morning care meetings, through review of new orders, and reviewing the facility 24-hour updates. She said not updating care plans with changes in resident status or behaviors could result in staff being unaware of the changes. During an interview on 04/22/22 at 01:26 p.m., the ADON stated Resident #1 was transferred to a behavioral hospital on 04/20/24 after her attempt to hurt Resident #2. The ADON stated he was not sure why Resident #1's comprehensive person-centered care plan was not updated and should have been because it would ensure the resident received consistent care. 2. Record review of Resident #2's face sheet, dated 04/20/24, indicated she was a [AGE] year-old female who was admitted to the facility 12/05/23. Resident #2 had diagnosis which included dementia (a condition characterized by progressive or persistent loss of intellectual functioning) with agitation, major depressive disorder (a metal health disorder characterized by persistently depressed mood causing significant impairment in daily life), and schizophrenia. Record review of Resident #2's care plan, dated 07/31/23 indicated Resident #2 had an altered thought process and was at risk for further decline and injury as evidenced by dementia and short- and long-term memory deficit. Interventions included keep resident and others safe and monitor for mental status changes. The care plan was not updated with the altercation 0n 04/19/24 when Resident #1 attempted to smother her with a pillow. Record review of Resident #2's quarterly MDS dated [DATE] indicated Resident #2 was able to make herself understood and understood others, and had severe cognitive impairment indicated by a BIMS score of 6. She had feelings of being down, depressed, and hopeless 2-6 (several) days and had no behaviors. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Harmony Care at Beaumont		STREET ADDRESS, CITY, STATE, ZIP CODE 2660 Brickyard Rd Beaumont, TX 77703	

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's clinical note dated 04/19/24 at 03:54 a.m. and signed by LVN A indicated she was notified by CNA B that Resident #2 came running out of her room yelling for help and saying her roommate (Resident #1) placed a pillow over her face and held it over her face. The residents were separated, and Resident #2 was assessed with no bruising on her face and no shortness of breath. Resident #2 was moved to another room for her protection and safety. During an interview on 04/21/24 at 02:44 p.m., the DON said the MDS nurse was responsible for updating care plans with changes in resident status/behavior with her supervision. She said Residents #1, #2, and #3's care plans should have been updated that the physical altercations had happened and goals and interventions for those focuses. She said if care plans were not updated it put residents at risk for not receiving the care and services they needed. During an interview on 04/22/24 at 01:05 p.m., the MDS nurse said she had not been aware that Resident #2 had been involved in an altercation with Resident #1 on 04/03/24 so she didn't update the care plan. 3. Record review of Resident #3's face sheet dated 04/20/24 indicated she was a [AGE] year old female, admitted on [DATE], and her diagnoses included cerebral infarction (stroke), spastic hemiplegia (a common post-stroke condition that causes stiff or rigid muscles) affecting right dominant side, vascular dementia (dementia [a condition characterized by progressive or persistent loss of intellectual functioning] caused by an impaired supply of blood to the brain), mood disorder (marked disruptions in emotions [severe lows called depression or highs called hypomania or mania]), and depression. Record review of Resident #3's care plan revised on 06/21/23 indicated Resident #3 was deemed at risk for wandering related to being ambulatory with her wheelchair, diagnosis of dementia, and history of exit seeking. Goals included Resident #3 would be able to wander in a safe environment (secure unit) with no occurrence of injury and dignity would be maintained. The care plan was not updated with the incident from 04/03/24 when Resident #3 wandered into Resident #1's room and Resident #1 pulled her out of her wheelchair onto the floor. Record review of Resident #3's annual MDS dated [DATE] indicated Resident #3 was sometimes able to make herself understood and usually understood others, and had severe cognitive impairment indicated by a staff assessment. She had mood of little interest or pleasure in doing things several (2-6 days) and behaviors directed toward others 1 to 3 days and no wandering behaviors. During an interview on 04/22/24 at 01:05 p.m., the MDS nurse said she had not been aware Resident #3 was pulled out of her wheelchair onto the floor by Resident #1 on 04/03/24 so she had not updated the care plan with the altercation. Record review of facility policy Care Plans, Comprehensive Person-Centered revised October 2018, indicated A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675595	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Care at Beaumont	2660 Brickyard Rd Beaumont, TX 77703

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 36214 Based on observation, interview and record review the facility failed to ensure each resident received adequate supervision to prevent accidents for 1 of 7 residents (Resident #1) reviewed for accidents and supervision. The facility failed to place Resident #1 on one-on-one supervision or move her to a private room after she pulled Resident #3 out of her wheelchair after Resident #3 self-propelled her wheelchair into Resident #1's room. The facility failed to place Resident #1 on one-on-one supervision after Resident #1 tried to kill Resident #2 (her roommate) by placing a pillow over her face. On 04/20/24 at 02:29 p.m. an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 04/21/24, the facility remained out of compliance at a severity level with the potential for more than minimal harm and a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. These failures could place residents at risk of abuse, physical harm, mental anguish, emotional distress, and death. Findings included: 1. Record review of Resident #1's face sheet, dated 04/20/24, indicated she was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included schizophrenia (a serious mental condition involving breakdown in the relation between thought, emotion, and behavior, leading to faulty perception, inappropriate actions and feelings, withdrawal from reality and personal relationships into fantasy and delusion), persistent mood [affective] disorder (marked disruptions in emotions {severe lows called depression or highs called hypomania or mania]), and anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations). Record review of Resident #1's care plan, dated 10/25/23, indicated Resident #1 had a diagnosis of schizophrenia and was at risk for manic episodes and increased behaviors. Interventions included monitor for delusions and hallucinations and monitor for increased agitation, anger, verbal, and physical aggression and document in clinical record. Resident #1 was taking psychotropic medication and was at risk for adverse reactions and depression, anxiety, and/or psychosis driven behaviors. Interventions included monitor for anxiety driven behaviors and report any noted behaviors to MD for further orders. Record review of Resident #1's quarterly MDS assessment, dated 04/08/24, indicated Resident #1 was able to make herself understood and usually understand others, and had moderate cognitive impairment indicated by a BIMS score of 11. She had had no hallucinations, delusions, or physical or verbal behaviors. She required partial to moderate assistance with most ADLs. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's clinical file revealed there were no care plans available for review related to homicidal ideations. Record review of Resident #1's clinical note (related to the incident with Resident #3) dated 04/03/24 at 11:30 a.m. and signed by LVN N indicated CNA came and informed LVN N that Resident #1 pulled Resident #3 out of her wheelchair onto the floor of Resident #1's room. Resident #1 said I'm not a fucking babysitter, I need help my motherfucking self she needs to keep her ass out of my motherfucking room. On arrival to the secure unit residents were already separated and in different rooms. LVN N educated and redirected Resident #1, she was informed that physical aggression would not be tolerated, and it was not her right to put hands on anyone. LVN A indicated that Resident #1 did not verbalize understanding. Record review of a psychiatric services visit note completed on 04/17/24 at 11:01 a.m. and signed by the NP indicated Resident #1 was being seen for schizophrenia and anxiety. Goals for treatment included compliance with treatment plan, reduced risk of assaultive or inappropriate behaviors, reduction of psychotic thinking, stabilization of anxious/irritable mood, stabilization of cognitive problems, stabilization of depressed mood, increased interpersonal interactions and reduced withdrawal. Resident #1 had shown mild improvement in response to treatment. Record review of the incident report dated 04/19/24 at 03:40 a.m., Completed by LVN A indicated she was notified by CNA B that Resident #2 was yelling for help because Resident #1 (her roommate) had placed a pillow over Resident #2's face and held it over her face. Resident #2 came out of her room yelling for help. The residents were separated, and Resident #2 was assessed with no bruising on her face and no shortness of breath. Resident #1 admitted she did it and stated, Don't send me to jail please send me to a mental institution. Resident #2 was moved to another room for her protection and safety. MD was paged and LVN A was awaiting response. Administrator was notified. During a telephone interview on 04/20/24 at 08:40 a.m., the Administrator said she received a text from LVN A on 04/19/24 at approximately 06:00 a.m. when she woke up reporting Resident #1 had placed a pillow over Resident #2's face and Resident #1 was requesting to go to a mental institution. She said her immediate action had been to request an additional CNA for the secure unit from her corporate office and she had just received approval for the CNA this morning but had not hired a new CNA yet. The Administrator said the secure unit had one dedicated CNA and one nurse that floats between the other rooms and the secure unit. She said Resident #2 had been moved into another room on the secure unit. She said no other safety measures had been put in place on the secure unit. During an observation and interview on 04/20/24 at 09:05 a.m., CNA L said she was assigned the secure unit today with LVN C who was floating between the secure unit and rooms outside the unit. CNA L was sitting in the TV room with 4 residents and said Residents #1 and #2 were in their rooms alone. During an observation and interview on 04/20/24 at 09:10 a.m., Resident #1 was alone in her room on the secure unit and resting in bed. She said yesterday (04/19/24) her roommate (Resident #2) was trying to put spells on her, and she had to stop her. She said she tried to hurt Resident #2. Resident #1 could not recall trying to hurt any other residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675595	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Care at Beaumont	2660 Brickyard Rd Beaumont, TX 77703

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 04/20/24 at 09:35 a.m., the DON said she was not at the facility on 04/19/24 because she had to work the night shift last night. She said was notified on 04/19/24 about Resident #1 putting a pillow over Resident #2's face, but she was now looking back on what was done after the incident. She said LVN A reported the incident, but there was no documentation in the clinical record about the incident or if LVN A notified the police, the physician or the responsible party. She said notifications should have been made and she was doing the notifications to the MD and RP. She said based on the aggression Resident #1 should have been transferred to a behavioral hospital for evaluation. The DON said the only reason Resident #1 had pulled Resident #3 out of her wheelchair on 04/03/24 was because she went into Resident #1's room. She said she had instructed all staff on the secure unit to keep Resident #3 from wandering into other resident's rooms, but no additional safety measures had been put in place. During an interview on 04/20/24 at 10:05 a.m., LVN C said he received report from LVN A on 04/19/24 at 06:00 a.m. about the incident between Resident #1 and Resident #2. He said he was assigned to the secure unit and other rooms outside the secure unit on the 06:00 a.m. to 02:00 p.m. shift on 04/19/24. He said he never noticed if Resident #1 ever came out of her room on his shift and he wasn't sure if Resident #2 was in or out of her room during the day. During an interview on 04/20/24 at 10:51 a.m., the DON said she notified the NP of the incident that occurred on 04/19/24 to the NP and Resident #1's RP on 04/20/24 at approximately 10:00 a.m. She said she had completed the referral to the behavioral hospital for Resident #1 and was awaiting her transfer. She said the NP gave no new orders for Resident #2. During an observation on 04/20/24 at 11:26 a.m., Resident #1 was sleeping alone in her room. Staff were assisting other residents on the secure unit with ADLs. There was no one-on-one monitoring with Resident #1. During an interview on 04/20/24 at 02:30 p.m., the DON said the facility only placed residents on one-on-one monitoring if they were homicidal or suicidal. She said Resident #1 was not placed on one-on one monitoring, but she should have been. The DON said was going to sit with Resident #1 (after surveyor intervention) until she was transported to the behavioral hospital. She said not having her under increased monitoring could result in harm to other residents on the secure unit. During a telephone interview on 04/20/24 at 3:25 p.m., the MD said he did not receive any pages on 04/19/24 and the incident of Resident #1 putting a pillow over the face of Resident #2 had not been reported to him. The MD said if the incident had been reported to him, he would have given orders to transfer Resident #1 to a behavioral hospital. During an interview on 04/20/24 at 03:59 p.m., the DON said she sat with Resident #1 until she was transported by ambulance to a behavioral hospital at approximately 03:30 p.m. 2. Record review of Resident #2's face sheet, dated 04/20/24, indicated she was a [AGE] year-old female who was admitted to the facility 12/05/23. Resident #2 had diagnosis which included dementia (a condition characterized by progressive or persistent loss of intellectual functioning) with agitation, major depressive disorder (a metal health disorder characterized by persistently depressed mood causing significant impairment in daily life), and schizophrenia. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #2's care plan, dated 07/31/23 indicated Resident #2 had an altered thought process and was at risk for further decline and injury as evidenced by dementia and short- and long-term memory deficit. Interventions included keep resident and others safe and monitor for mental status changes. Record review of Resident #2's quarterly MDS dated [DATE] indicated Resident #2 was able to make herself understood and understood others, and had severe cognitive impairment indicated by a BIMS score of 6. She had feelings of being down, depressed, and hopeless 2-6 (several) days and had no behaviors. Record review of a psychiatric visit note completed on 04/17/24 at 11:01 a.m. and signed by the NP indicated Resident #2 was being seen for anxiety, dementia, depression/sadness, schizophrenia, bipolar, and insomnia. Resident #2 was oriented to person, place, month, and situation. Resident #2 exhibited a logical thought process with fair insight and judgement. She had little to no risk of aggression. Record review of Resident #2's clinical note dated 04/19/24 at 03:54 a.m. and signed by LVN A indicated she was notified by CNA that Resident #2 came running out of her room yelling for help and saying her roommate (Resident #1) placed a pillow over her face and held it over her face. The residents were separated, and Resident #2 was assessed with no bruising on her face and no shortness of breath. Resident #2 was moved to another room for her protection and safety. During an observation and interview on 04/20/24 at 09:15 a.m., Resident #2 was alone in her room on the secure unit lying in bed. She said she had to be moved to a new room because her previous roommate had put a pillow over her face and tried to kill her while she was sleeping. She said she felt as safe as she could in her present surroundings. During an observation and interview on 04/20/24 at 11:19 a.m., Police Officer M visited Resident #2 in her room. Resident #2 remained alone in her room and made a verbal statement to Police Officer M that Resident #1 had tried to kill her by placing a pillow over her face while she was sleeping. She said she wanted to press charges against Resident #1 so she wouldn't try to kill her again. During an interview on 04/22/24 at 01:45 p.m., CNA O said she worked the 06:00 a.m. to 02:00 p.m. on 04/19/24 and the incident of Resident #1 putting a pillow over Resident #2's face was reported to her by CNA B. She said Resident #1 was in a happy mood all day going into and out of the TV room listening to the music that was playing in the room. CNA O said Resident #2 said she was afraid to be in her room and stayed close to her or other residents in the TV room. She said Resident #2 kept saying, why is she still here-she tried to kill me. 3. Record review of Resident #3's face sheet dated 04/20/24 indicated she was a [AGE] year old female, admitted on [DATE], and her diagnoses included cerebral infarction (stroke), spastic hemiplegia (a common post-stroke condition that causes stiff or rigid muscles) affecting right dominant side, vascular dementia (dementia [a condition characterized by progressive or persistent loss of intellectual functioning] caused by an impaired supply of blood to the brain), mood disorder (marked disruptions in emotions [severe lows called depression or highs called hypomania or mania]), depression (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Harmony Care at Beaumont		STREET ADDRESS, CITY, STATE, ZIP CODE 2660 Brickyard Rd Beaumont, TX 77703	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #3's care plan revised on 06/21/23 indicated Resident #3 was deemed at risk for wandering related to being ambulatory with her wheelchair, diagnosis of dementia, and history of exit seeking. Goals included Resident #3 would be able to wander in a safe environment (secure unit) with no occurrence of injury and dignity would be maintained. Record review of Resident #3's annual MDS dated [DATE] indicated Resident #3 was sometimes able to make herself understood and usually understood others, and had severe cognitive impairment indicated by a staff assessment. She had mood of little interest or pleasure in doing things several (2-6 days) and behaviors directed toward others 1 to 3 days and no wandering behaviors. Record review of a psychiatric services visit note completed 04/10/24 at 11:06 a.m. and signed by the NP indicated Resident #3 was being seen for anxiety, dementia, and depression/sadness. Resident #3 was aphasic (unable to speak, write, or understand speech or writing because of damage to the brain) with no behavioral problems. Goals for treatment included adjustment to need for placement in facility, increased compliance with treatment plan, stabilization of anxious/irritable mood, stabilization of cognitive problems, stabilization of depressed mood, increased interpersonal interactions and reduced withdrawal. Resident had shown mild decline in response to treatment. During an observation and interview on 04/20/24 at 09:05 a.m., Resident #3 was sitting in the TV room of the secure unit. She was unable to answer question about the incident. She was holding her right arm against her, and it appeared to have contractures at her elbow and wrist. CNA L said staff tried to keep Resident #3 busy because she wandered into other resident's rooms. She said she was not working the day Resident #3 wandered into Resident #1's room and Resident #1 pulled her out of her wheelchair to the floor, but it had been reported to her by another CNA. During an interview on 04/20/24 at 09:35 a.m. the DON said the only reason Resident #1 had pulled Resident #3 out of her wheelchair on 04/03/24 was because she went into Resident #1's room. She said she had instructed all staff on the secure unit to keep Resident #3 from wandering into other resident's rooms. During an interview on 04/20/24 at 10:51 a.m., the NP said the facility notified her on 04/03/24 of the incident of Resident #1 pulling Resident #3 out of her wheelchair and onto the floor. During a telephone interview on 04/22/24 at 11:35 a.m., LVN N said on 04/03/34 at approximately 11:30 a.m. , a CNA reported to her that Resident #3 had self-propelled her wheelchair into Resident #1's room and Resident #1 pulled her out of her wheelchair and onto the floor. Resident #3 was on the floor in Resident #3's room. LVN N said she assessed Resident #3 who was sitting in the floor of Resident #1's room at the foot of her bed. She had no visible injuries, and she was assisted back into her wheelchair and out of the room. Resident #3 was unable to say how she got onto the floor. LVN N said she notified the ADON, the Administrator, MD, and the RP of the incident. During a telephone interview on 04/22/24 at 12:16 p.m., Resident #3's RP said she was notified on 04/03/24 by the nurse that Resident #3 had wheeled herself into another resident's room and the other resident had pulled Resident #3 out of her wheelchair and onto the floor. RP said she visited Resident #3 every day and she had witnessed residents on the secure unit being aggressive to staff and other residents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's Abuse and Neglect Policy dated June 2023 indicated VI. Protection: Have procedures to: Protect residents from physical or psychosocial harm during the investigation . 3. Attending physician will be notified. A. This includes but not limited to full assessment of physical and psychosocial well-being; sending resident to hospital if needed; depending on circumstance, keep resident on 1:1, assign a female/male depending on the accusation/allegation. Record review of the facility's undated policy Problematic Behavior Management- Clinical Protocol indicated 2. The staff will identify, document, and inform the Physician about a resident's mental status, behavior, and cognition. This will include details about any problematic behavior such as onset, frequency, and precipitating factors. This was determined to be an Immediate Jeopardy (IJ) on 04/20/24 at 02:25 p.m. The Administrator was notified. The Administrator was provided the IJ template on 04/20/24 at 2:29 p.m. The Facility's Plan of Removal for Immediate Jeopardy was accepted on 04/21/24 at 10:37 a.m. and reflected the following: Action: o On 4/20/24 Resident #1 was immediately placed on 1 on 1 until the facility could transfer Resident #1 to psychiatric hospital, waiting on approval from the behavioral hospital to transport. On 4/20/24 Charge nurse/ nurse managers Immediately reviewed residents in the secure unit that have had recent incidents within the last 30 days involving resident altercation to make sure they had the correct supervision. 0 residents besides Resident #1 were identified. Charge nurse/ nurse managers Immediately assessed Resident #2 & Resident #3 and the rest of the residents in the secure unit for possible mental or physical abuse, no additional mental health needs were identified, nor any suspected physical abuse found at this time. o on 4/20/24 Administrator/ or designee Immediately in-service all staff 100% completion on behavioral management policy which included resident to resident abuse regarding residents exhibiting aggressive behaviors towards others, steps to do and how to approach the situation. o On 4/20/24 the Administrator reviewed schedules and a second CNA was added in the secure unit for extra supervision. If a resident was identified as a repeated aggressor, the facility will immediately add additional support staff in order to keep residents safe. On 4/21/24 Administrator/ DON were Inservice by Regional Director of Clinical Operations if additional staff was needed for immediate safety interventions no approval was needed from corporate to add additional staff for support. After completion of secure unit resident review/assessments on 04/20/24 by charge nurses and nurse mangers, no other residents were found to have additional mental health needs and no other suspected physical abuse was found. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility reviewed the system for problematic behavior management. The facility created a plan of improvement to assure residents behaviors were monitored, documented, and reported to the MD. The Administrator reviewed schedules and a second CNA was added in the secure unit for extra supervision and if a resident was identified as a repeated aggressor, the facility will immediately add additional support staff in order to keep residents safe. All staff were educated on behavioral management policy which included resident to resident abuse regarding residents exhibiting aggressive behaviors towards others. steps to do and how to approach the situation. Until alternative and/or safe living arrangements were made the resident will be placed on one-on-one supervision with facility staff. Resident care plans will also be updated to include any acts of aggression or being to receiver of aggression. Monitoring of the POR included the following: During interviews conducted on 04/20/24 from 03:30 p.m. though 06:00 p.m. and 04/21/24 from 08:15 a.m. 11:48 a.m. included LVN A (10 p.m. - 6 a.m.), LVN C (6:00 a.m. to 2:00 p.m.), LVN D (6:00 a.m. -2:00 p.m.), LVN E (6:00 a.m. to 2:00 p.m. and 2:00 p.m. to 10:00 p.m.), LVN F (10:00 p.m. to 6:00 a.m.), LVN G (10 p.m. to 10 p.m.), LVN H (2:00 p.m. to 10:00 p.m., LVN I (2:00 a.m. to 10 p.m.),RN j (weekend shifts), LVN K (6:00 a.m. to 2:00 p.m. and 2:00 p.m. to 10:00 p.m.), CNA B (10:00 p.m. to 6:00 a.m.), CNA L (6:00 a.m. to 2:00 p. m.), CNA O (6:00 a.m. to 2:00 p.m.), CNA P (2:00 p.m. to 10:00 p.m.), CNA Q (2:00 p.m. to 10:00 p.m.), CNA R (10:00 p.m. to 6:00 a.m.), CNA S (6:00 a.m. to 2:00 p.m.), the Dietary Manager, Dietary Aide T, Dietary Aide U, Housekeeper V, Housekeeper W, MDS Nurse and 1 ADON who worked all shifts. Staff were able to verbalize procedure of separating residents during an act of aggression, reporting the aggression to a charge nurse, the ADON, the DON, and the Administrator. To maintain one-on one monitoring of the aggressor for the protection of other residents. Licensed staff verbalized aggression incidents should also be reported to the MD, police, and both resident's RPs. Interviews conducted with five alert residents on 04/21/24 from 8:00 a.m. to 10:00 a.m. indicated they would report abuse to the administrator or the DON. They were not afraid of any residents. During an interview on 04/21/24 at 10:20. a.m., the Administrator and the DON indicated the facility 24 Hour Report and Incident Reports would be reviewed in the morning clinical meeting attended by the Administrator and Director of Nursing to review for any allegations or instances physical aggression. The weekend manager on duty and weekend RN Supervisor would report any incidents or allegations to the DON and administrator immediately. Record review of all incidents from the previous 90 days indicated there were no additional incidents of acts of physical aggression as of 04/21/24. Record review of training records indicated all staff (nursing and non-nursing) were in-serviced on 04/20/24 and 04/21/24 regarding the facility abuse and neglect policy and the behavioral management policy, the procedure for reporting incidents and acts of aggression, suspected abuse/neglect, recognizing threats of harm (to self and others), and physician notification. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Administrator was informed the Immediate Jeopardy was removed on 04/21/24 at 12:39 p.m. The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm and with a scope identified as isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.