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	05/23/2024

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115 Based on interview and record review, the facility failed to ensure prompt efforts were made to resolve resident grievances for 1 of 22 residents (Resident #2) reviewed for grievances. There was no grievance available or evidence of resolution when Resident #2 reported to CMA H she did not want CNA M to come in her room or provide her care. This failure could place all residents at risk of unresolved grievances and decreased quality of life. Findings included: Record review of Resident #2's face sheet dated 05/22/24 indicated she was [AGE] years old, was admitted [DATE], and her diagnoses included dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities), and schizophrenia (serious mental health condition that affects how people think, feel and behave). Record review of Resident #2's quarterly MDS assessment dated [DATE] indicated she was able to make herself understood and understood others and she was cognitively intact (BIMS score 15). Record review of Resident #2's care plan dated 08/25/23 indicated she had a history of confabulation (a neuropsychiatric disorder wherein a patient generates a false memory without the intention of deceit) and presents false information that she believed was true related to her care. Interventions included psychiatric consult as ordered and report to MD/RP as needed and document episodes of confabulation. Record review of Resident #2's care plan dated 04/06/21 and revised on 08/05/21 indicated she had a behavior problem of confabulation related to schizophrenia, major depressive disorder, and bipolar disorder. Intervention included anticipate and meet her needs and stop and talk to resident. Record review of facility's grievances from 03/14/24 through 05/14/24 indicated no grievances were documented or resolved for Resident #2. (continued on next page)

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

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/21/24 at 3:24 p.m., Resident #2 said she did not want CNA M in her room or providing care. She said she felt CNA M was not nice. She said CNA M would not let her hold on to her legs when she did incontinent care. She said she felt unsafe and afraid. She said she did not tell the Administrator but she did tell other staff. She did not want to identify the other staff. During an interview on 05/22/24 at 1:38 p.m., CMA H said Resident #2 told her that she did not want CNA M in her room or to provide her care. She said she spoke with CNA M about Resident #2 not wanting her in her room. She said she did not fill out any concern or grievance form or let the Grievance Official (SW A) or the Administrator know of Resident #2's grievance. CMA H said if a resident has a grievance, you should follow through with it, notify the administrator or grievance officer immediately. CMA H said she should have reported Resident #2's grievance to the administrator immediately. CMA H said Resident #2 complained about staff routinely and only wanted certain staff to provide care and was hard to please. CMA H said she tried to keep a good rapport with Resident #2 so that she would take her medications and voice concerns. During an interview on 05/22/24 at 11:10 a.m., CNA M said she was aware Resident #2 did not want her to go in her room or provide care. She said Resident #2 had reported to other aides in the facility that she did not put on her diaper correctly. She said Resident #2 held on her legs during incontinent care so tight that her nails were digging into her. She said Resident #2 said she thought she would fall but she tried to reassure her she would not fall. She said Resident #2 got mad when she moved her hand from her leg. She said it was just this past Monday (05/20/24) when she went into provide care and asked CNA I to assist with care after Resident #2 had complained to CMA H about not wanting her to come in her room or provide care. She said she did not understand why Resident #2 would complain and not want her to provide care. She said if a resident had a grievance, you should follow through with it, notify the administrator or grievance officer immediately. CNA M said she should have reported Resident #2's grievance to the DON and the administrator. During an interview on 05/23/24 at 1:14 p.m., the Administrator said SW A was the Grievance Official. She said SW A was not aware of Resident #2's complaint of CNA M. She said she was not made aware of Resident #2's grievance related to CNA M. She said any staff who is made aware of a complaint or grievance should have reported the grievance to her or SW A. She said she would have re-assigned CNA M if she was made aware of Resident #2's grievance. She said all grievances were reviewed in the morning meeting. She said the facility staff assigned to each resident should check with them and ask for any issues or concerns. She said no staff reported any complaints from Resident #2. She said Resident #2 does not report any concerns when she was asked and only called the state to make complaints. During an interview on 05/22/24 at 5:45 p.m., the DON said she spoke with Resident #2 on 05/13/24 and asked her if she had any concerns. She said Resident #2 had no complaints. She said she had not yet spoke to Resident #2 to address any issues for the current week, as of 05/22/24. Record review of the facility's Complaints/Grievance policy revised 06/19 and 07/23 indicated It is the policy of this facility to adopt a process to support the resident's right to voice complaints/grievances to facility management and have those grievances/complaints investigated and resolved in a reasonable timeframe. 9. Grievances/complaints can be taken by any staff member and documented on a Concern Form. The concern form is then forwarded to the Grievance Official. 47879

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 12 residents (Resident #1) reviewed for comprehensive person-centered care plans. The facility failed to develop and implement a care plan for Resident #1's aggressive behaviors toward others. This failure could place residents at risk of not having individual needs met and a decreased quality of life. Findings included: Record review of Resident #1's face sheet dated 05/14/24 indicated he was [AGE] years old, admitted on [DATE], and his diagnoses included encephalopathy (brain dysfunction), dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities) without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, and cognitive communication deficit. Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated he sometimes was able to make himself understood and understood others, and had severe cognitive impairment (BIMS score 00). His behaviors included physical behaviors directed at others (e.g. hitting, kicking, pushing, scratching, grabbing, abusing others sexually) that occurred 1 to 3 days (out of 7 day look back period) Record review of Resident #1's electronic record indicated there was no care plan related to aggression towards others. Record review of a progress note dated 05/12/24 at 10:23 p.m., completed by LVN L indicated she wheeled Resident #1 to his room for CNA R to provide care. CNA R reported Resident #1 initiated physical aggression and reached up and scratched CNA R's face. CNA N and CNA O entered Resident #1's room to complete Resident #1's care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/14/24 at 5:58 p.m., CNA R said she had been employed at the facility for 2 weeks and had worked at a secure unit as a CNA prior to this facility and had received training on abuse and self-defense tactics. She said that Resident #1 was never aggressive and she did not know what happened that day, but he was fighting all three of them, which included CNA N and CNA O, and her on 05/12/24. She said she was trying to get him dressed and he was so strong and grabbed her face and started scratching, punching, and kicking. She said she never hit him back and that she used the self-defense tactics of raising her arms like an x. She said he was fighting all three of them pretty hard and she did not see anyone ever hit him back. She said she was just trying to make sure he did not fall on the floor and resolve the situation. She said she had not worked with him since the incident and that she had observed his injuries. She said she did not know how he got those injuries other than he was fighting so hard and was not just fighting her that the other two girls were bigger than her. She said the administrator informed her that Resident #1 was never aggressive unless someone was mean to him and that it appeared she was getting the brunt of it. During an interview on 05/22/24 at 12:30 p.m., CNA N said she overhead conversation on 05/12/24 when CNA R reported to LVN L that Resident #1 exhibited aggressive behaviors and had scratched CNA R on the face while she was trying to provide personal care. CNA N said she told CNA R and CNA O that she would try to assist with Resident #1 with care. CNA N said she and CNA O went back into Resident #1's room approximately 10 minutes after the incident of aggression with CNA R to assist resident with care. CNA N said she did not know what happened, but when she went to assist Resident #1, he started spitting and fighting. She said she and CNA O left the room, to allow Resident #1 to calm down. CNA N said Resident #1 had behaviors at times and they leave the room and try to go back later to assist him. During an interview on 05/22/24 at 12:42 p.m., CNA O said she went to Resident #1's room to assist with care. She said CNA N and CNA R were already in the room. CNA O said she observed CNA N attempting to provide care to Resident #1, but Resident #1 was upset and was spitting at CNA N. CNA R was standing in room but not assisting with care because Resident #1 had already scratched her on the face. CNA O said Resident #1 was being aggressive spitting and slapping at CNA N. She left the room to notify LVN L of the incident and LVN L said she was aware of the incident and the behaviors. CNA O returned to Resident #1's room and notified CNA N and CNA R that LVN L was notified of Resident #1's behaviors. During an interview on 05/22/24 at 2:08 p.m., LVN/MDS J said she was responsible for completing resident care plans. She said it was a mistake and she just missed completing a care plan related to Resident #1's aggression towards others. During an interview on 05/22/24 at 1:14 p.m., the Administrator stated the DON and the MDS Coordinator were responsible for completing the care plans. The Administrator stated she expected them to include anything unusual or special for the resident's care. The Administrator stated it was important for Resident #1's aggressive behavior towards others to be included in the care plan so the staff could ensure the resident was receiving appropriate care. During an interview on 05/22/24 at 2:45 p.m., LVN L said CNA R left Resident #1's room and reported Resident #1's aggressive behaviors and that he had scratched her face on 05/12/24. She said CNA N and CNA O went to complete Resident #1's care and he continued with his aggressive behaviors. She said the staff left his room to allow him to calm down. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Comprehensive Person-Centered Care plans policy dated 2001 (revised October 2018) indicated Policy Statement-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. Policy Interpretation and Implementation 1. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 9 Areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan. 10. Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process. 11. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. 12. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS). 13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 47879

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115 Based on interview, and record review, the facility failed to ensure services provided or arranged by the facility as outlined by the comprehensive care plan meets professional standards of quality for 3 of 6 residents (Resident #s 1, 2, and 3) reviewed for skin assessments. The facility failed to ensure Residents #1, #2, and #3 received a weekly skin assessment. This failure could place the resident at increased risk of not having their individual needs met and of not receiving adequate care and medical interventions to maintain their health and prevent worsening health conditions. Findings included: Record review of Resident #1's face sheet dated 05/14/24 indicated he was [AGE] years old, admitted on [DATE], and his diagnoses included encephalopathy (brain dysfunction), dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities) without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, muscle wasting and atrophy (decrease in size and wasting of muscle tissue), heart disease, acute kidney failure, chronic iron deficiency anemia secondary to blood loss, unspecified protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function), and cognitive communication deficit. His assigned room was 216. Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated he sometimes was able to make himself understood and understood others, had severe cognitive impairment (BIMS score 00), was at risk of developing pressure ulcers/injuries, and had application of non-surgical dressing (with ow without topical medications other than to feet. Record review of Resident #1's care plan dated 12/11/23 (revised 12/14/23) indicated Resident #1 was at risk for impaired skin integrity related to chronic fragile skin and self-inflicted skin tears. Interventions included ensure nails are clipped. Record review of Resident #1's care plan dated 05/13/24 indicated Resident #1 is on anticoagulant therapy Plavix and ASA. Interventions included daily skin inspections. Record review of Resident #1's physician orders dated 04/10/24 indicated perform head to toe assessment, assess all areas of skin and skin assessment to be done weekly. Record review of Resident #1's daily skilled nurse assessment dated [DATE] indicated Resident #1 had no skin breakdown. Record review of Resident #1's weekly skin assessment dated [DATE] indicated Resident #1's had a dark purplish bruise to right lower lip area, three scratches to left side of face (cleaned and treatment in place, and left and right arm bruising to numerous sites). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's electronic record indicated there was no weekly skin assessment from 04/10/24 through 05/13/24. Record review of Resident #2's face sheet dated 05/22/24 indicated she was [AGE] years old, was admitted [DATE], and her diagnoses included dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities), heart disease, cellulitis (deep bacterial infection of the skin), and muscle wasting and atrophy, edema (swelling caused by too much fluid trapped in the body's tissues), and phlebitis (inflammation that causes a blood clot to form in a vein, usually in the leg) and thrombophlebitis (an inflammatory process that causes a blood clot to form and block one or more veins, usually in the legs. The affected vein might be near the surface of the skin (superficial thrombophlebitis) or deep within a muscle -deep vein thrombosis, or DVT) of lower extremities. Her assigned room was 217. Record review of Resident #2's quarterly MDS assessment dated [DATE] indicated she was able to make herself understood and understood others, she was cognitively intact (BIMS score 15), was at risk of developing pressure ulcers/injuries, had MASD. Record review of Resident #2's care plan dated 08/25/23 (revised 08/27/23) indicated Resident #2 was at risk for skin breakdown and injury due to not wanting to sleep on her bed. Interventions included assess skin on a weekly basis and as needed. Record review of Resident #2's care plan dated 09/18/23 (revised 09/21/23) indicated Resident #2 had skin concerns and was at risk of further skin breakdown, infection, and pressure ulcer formation related to chronic edema and a history of cellulitis. Interventions included monitor areas of increased skin break down and signs and symptoms of infection. Perform treatments as ordered and if no improvement report to MD. Record review of Resident #2's care plan dated 09/18/23 (revised 09/21/23) indicated Resident #2 had a history of cellulitis of bilateral lower extremities related to fragile skin and was on edema management. Interventions included monitor LE 2 times weekly and report any skin breakdown to MD immediately. Record review of Resident #2's physician orders dated 04/10/24 indicated complete weekly head to toe skin assessment every day shift every Tuesday. Record review of Resident #2's weekly skin monitoring (not weekly skin assessment) dated 04/30/24 and completed by LVN D indicated rear of left lower leg ulcerations was improved. Record review of Resident #2's MAR/TAR dated April 2024 indicated a weekly skin assessment was completed on 04/30/24. Record review of Resident #2's MAR/TAR dated May 2024 indicated there was no weekly skin assessment completed on 05/07/24 or 05/14/24. Record review of Resident #2's electronic record indicated there were no weekly skin assessments from 04/10/24 through 05/14/24. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #3's face sheet dated 05/23/24 indicated he was [AGE] years old, was admitted [DATE], and his diagnoses included hemiplegia (paralysis that affects one side of the body), hemiparesis (weakness or the inability to move on one side of the body, making it hard to perform everyday activities like eating or dressing), morbid obesity, unspecified protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function), cerebral infarction (stroke), and diabetes (a condition that happens when blood sugar is too high). His assigned room was 226. Record review of Resident #3's significant change MDS assessment dated [DATE] indicated he was able to make himself understood and understood others, had moderate impaired cognition (BIMS score of 10), and was at risk of developing pressure ulcers/injuries. Record review of Resident #3's physician orders dated 04/11/24 (start 04/18/24), indicated skin assessment was to be done weekly every day shift every Thursday. Record review of Resident #3's weekly skin assessment completed by LVN G dated 04/09/24 indicated a groin rash was resolved. Record review of Resident #3's electronic record indicated there was no weekly skin assessment for review from 04/18/24 through 05/22/24. Record review of the skin assessment schedule dated 01/02/23 for the Long Hall indicated Skin assessments must be done every 7 days or within 7 days from the last one. Resident #1's (room [ROOM NUMBER]) weekly skin assessment was scheduled for Friday 2:00 p.m. -10:00 p.m. Record review of the skin assessment schedule dated 01/02/23 for the Long Hall indicated Skin assessments must be done every 7 days or within 7 days from the last one. Resident #2's (room [ROOM NUMBER]) weekly skin assessment was scheduled for Tuesday 6:00 a.m.-2:00 p.m. Resident #3's (room [ROOM NUMBER]) weekly skin assessment was scheduled for Thursday 6:00 a.m.-2:00 p.m. During an interview on 05/22/24 at 2:35 p.m., RN C said the previous DON was going to edit the weekly skin reports so the new wound care nurse could schedule how they wanted the weekly skin assessment completed. She said the previous DON then quit working at the facility and the weekly skin assessments were not re-scheduled in the electronic system and were not completed. During an interview on 05/22/24 at 2:40 p.m., the Administrator said she was not aware Resident #1's weekly skin assessments were not completed as ordered by his physician. She said she expected the nurses to complete weekly skin assessments when the facility wound care nurse was not available. She said the facility had hired a new wound care nurse however she had not taken over the weekly skin assessments. She said the residents were at risk of not receiving care as necessary without assessments. During an interview on 05/22/24 at 5:15 p.m., LVN S said she would complete weekly skin assessment if they were assigned or flagged in the resident's electronic record. She said the residents were at risk of not receiving care as necessary without assessments. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/23/24 at 9:44 a.m., LVN E said all residents were assigned on a schedule for skin assessments. She said the resident weekly skin assessment was usually triggered in the electronic record and indicated the assessment is due. She said the residents were at risk of not receiving care as necessary without assessments. During an interview on 05/23/24 at 10:15 a.m., LVN D said she did not complete Resident #1's weekly skin assessment as scheduled. She said there was a schedule for each room/bed of the facility. She said she did not do the assessment because she was busy and did not have enough time. She said she believed she reported to the next shift nurse that she was not able to complete the weekly skin assessment but could not recall the name of the nurse. She said she believed the wound care nurse was supposed to do the weekly skin assessment but did not know when the wound care nurse was available. She said the residents were at risk of not receiving care as necessary without assessments. During an interview on 05/23/24 at 12:30 p.m., the Administrator said that the previous DON had deleted some of the history in the resident electronic record and if she deleted the task or did not re-assign the tasks, the nurse staff would not see the task as a scheduled assignment. During an interview on 05/23/24 at 4:39 p.m., the Administrator said resident skin problems were discussed in the morning meetings. She said she was not aware the weekly skin assessments were not triggered in the electronic system. She said usually the assessments were scheduled and were triggered for the nurses to do and populate with the required information. She said the problem was the previous DON and wound care nurse were auditing the forms and had not put a new start date in the system. She said LVN E and LVN F were experienced nurses and were aware of the weekly forms and schedule and were able to complete their skin assessments as required. She said the newer nurses would have completed the skin assessment had the trigger in the resident's electronic record notified them that a skin assessment was due. She said the facility did not have a skin assessment policy. 47879

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115 Based on observation, interview and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain grooming, and personal and oral hygiene for 1 of 12 residents (Resident #1) reviewed for ADLS. The facility failed to ensure Resident #1's fingernails were trimmed. This failure could place the residents at risk of not receiving the care and services to maintain their highest level of physical, mental and psycho-social well-being. Findings included: Record review of Resident #1's face sheet dated 05/14/24 indicated he was [AGE] years old, admitted on [DATE], and his diagnoses included encephalopathy (brain dysfunction), dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities) without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety and cognitive communication deficit. Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated he sometimes was able to make himself understood and understood others, had severe cognitive impairment (BIMS score 00), required partial/moderate assistance for most ADLS including personal hygiene. Record review of Resident #1's care plan dated 12/11/23 (revised 12/14/23) indicated Resident #1 was at risk for impaired skin integrity related to chronic fragile skin and self-inflicted skin tears. Interventions included to ensure nails were clipped. Record review of Resident #1's care plan dated 05/13/24 indicated Resident #1 is on anticoagulant therapy Plavix and ASA. Interventions included daily skin inspections. Record review of Resident #1's physician orders dated 04/10/24 indicated perform head to toe assessment, assess all areas of skin and skin assessment to be done weekly. Record review of Resident #1's weekly skin assessment dated [DATE] indicated Resident #1's had a dark purplish bruise to right lower lip area, three scratches to left side of face (cleaned and treatment in place, and left and right arm bruising to numerous sites. Resident #1's finger nails were noted as not clean, neat or trimmed. Resident #1 required scheduled nail trimming from staff related to aggression and fighting staff during incontinent care changes. Record review of Resident #1's Kardex (electronic care record) dated 05/23/24 indicated ensure nails are clipped. Record review of Resident #1's electronic record indicated there was no nail trimming documentation available for review for the previous 30 days (04/21/24 through 05/21/24) . (continued on next page)

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	05/23/2024

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 05/21/24 at 3:00 p.m., Resident #1 was sitting in the wheelchair in TV common area. All of Resident #1's finger nails were long and jagged. Resident #1's fingernails were approximately 1/4 inch past the tips of the fingers and thumbs on both hands. Resident #1 did not respond to questions about his nails. He laughed and held out his hand to the surveyor. During an interview on 05/22/24 at 12:30 p.m. CNA N said she did not notice Resident #1's nails being too long. She could not say when Resident #1's nails were last trimmed. She said the aides were responsible for trimming resident nails as needed but the nurses completed nail care for the residents with diabetes. She said the residents who required nail care was usually noted in each resident's Kardex and documented on the task in the electronic record. During an interview on 05/23/24 12:35 p.m., the DON said she was not able to locate Resident #1's care sheets for nail trimming. She said he was not a diabetic and the aides were expected to complete nail care. She said the aides should report any issues or concerns to her (the DON) or the administrator. During an interview on 05/23/24 at 12:40 p.m., the Administrator said her expectations were for the staff to keep the resident's nails trimmed. She said the possible negative outcome would be Resident #1 could scratch himself or get a skin tear. 47879