

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  06/08/2024
NAME OF PROVIDER OR SUPPLIER  Harmony Care at Beaumont		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 33460</p> <p>Based on observation, interview, and record review, the facility failed to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the discharge was necessary for the resident's welfare and the resident's needs could not be met in the facility for 1 of 6 residents (Resident #1) reviewed for discharge requirements.</p> <p>The facility failed to ensure Resident #1 was readmitted to the facility, after being treated at a behavior hospital.</p> <p>This failure could place discharged residents and residents residing in the facility at risk of being discharged and not allowed to return to the facility causing a disruption in their care and/or services.</p> <p>Findings included:</p> <p>Record review face sheet dated 6/3/24 indicated Resident #1 was readmitted on [DATE] and her original admitted was 07/01/22. She was [AGE] years old with diagnoses included schizophrenia (a disorder that affects a person ability to think, feel and behave clearly), persistent mood disorder (chronic mental illness), and gastrostomy tube.</p> <p>Record review physician orders dated June 2024 indicated Resident #1 received Haloperidol (treats mental disorder) 10 mg three times a day for schizophrenia, Seroquel (treats schizophrenia) 100 mg one time a day related to psychosis (mental disorder characterized by a disconnection from reality), and valproic acid (treats mental disorder) 250 mg three times a day. The orders included an order to transfer Resident #1 to the behavior hospital on 06/03/24.</p> <p>Record review of a quarterly MDS assessment dated [DATE] indicated Resident #1 had a BIMS score of 11 which indicated impaired cognition and she required assistance with ADLs. She had no behaviors listed on this MDS. Section Q indicated no active discharge planning for Resident #1 to return to the community and did not want to be asked about returning to the community on all assessments.</p> <p>Record review of the care plan dated 04/09/24 indicated Resident #1 had diagnoses of schizophrenia and was at risk of manic episodes and mood swings. Interventions included administering medications as ordered, to monitor the resident, and to notify psychiatric services as needed.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of 30-day discharge notice with the reason of harm to self and others dated 05/10/24 indicated the effective date of discharge for Resident #1 was for 06/10/24. The letter was sent to the ombudsman and the responsible party for Resident #1 on 05/10/24.</p> <p>Record review of nurse's notes dated 04/19/24 indicated Resident #1 was sent to Behavioral Hospital A after she placed a pillow over her roommate's face.</p> <p>Record review of nurse's notes dated 06/03/24 Resident #1 returned to the facility from Behavioral Hospital A and was sent to Behavioral Hospital B on the same day.</p> <p>Record review of the nurse's notes dated 06/07/24 indicated the Behavioral Hospital B sent Resident #1 back to the facility and the administrator told the nurse not to readmit the resident.</p> <p>During an interview on 6/8/24 at 8:30 a.m., the Administrator stated, the facility had discharged Resident #1 before the 30th day of the 30-day discharge notice. She stated, the reason was because the Behavior Hospital B had dumped Resident #1 and if the facility would had accepted the resident on 06/07/24, it would have been an unsafe admission. She said Resident #1's bed had to be given to another resident who required the secure unit. The Administrator said there was no bed on the secure unit for Resident #1. She said on 4/19/24 Resident #1 had placed a pillow over another resident's face and she was sent to the hospital then on to the Behavior Hospital A.</p> <p>During an interview on 06/08/24 at 10:00 a.m., the DON said the Administrator told her Resident #1 was discharged from the facility and the facility was not accepting her back. She said Resident #1 was sent to their facility on 06/07/24 and was not readmitted . She said the van driver said Resident #1 had vomited and he was taking her to the Hospital C. She said the effective date of the 30-day discharge notice was 06/10/24. She said she just did what the Administrator told her not to accept the resident back from Behavioral Hospital B</p> <p>During an interview on 06/08/24 at 9:00 a.m., LVN A said she was the charge nurse on 06/07/24 when the Behavioral Hospital B sent Resident #1 back from the hospital. She said the DON and the Administrator told her Resident #1 was discharged from this facility and not to accept the resident back into the facility.</p> <p>During an interview on 06/08/24 at 10:30 a.m., the ADON said the Administrator told her Resident #1 was discharged the facility. She said the resident had been given a 30-day notice of discharge and the resident was supposed to stay at the Behavior Hospital B until after 06/10/24. She said Resident #1's personal belongings were packed in a box and her room on the secure unit had been given to a new resident last week.</p> <p>During an interview on 06/08/24 at 11:00 a.m., the SW said she had been trying to find placement for Resident #1 at other nursing homes and she was on a waiting list at the state mental hospital because of the diagnosis of harm to herself and others. She said on 06/07/24 during the morning she received a phone call from the discharge planner at the Behavioral Hospital B. She said Resident #1 was discharged and was going to be sent back to the facility. She said she texted the Administrator and called the DON and reported this. She said the plan was for the resident to stay at the Behavioral Hospital B until after 06/10/24, the effective date of the 30-day discharge notice. She said the family was to bring the resident to his home until placement at the state hospital could be completed.</p> <p>(continued on next page)</p>

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/08/24 at 12:15 p.m., the Case Manager at the Hospital C said Resident #1 was discharged however they were not going to send her out of the hospital due to her childlike behaviors and her inability to make decisions. She said no aggressive behaviors had been displayed while she had been at the hospital. She said the facility refused to accept Resident #1, so she would be trying to find placement at other facilities.</p> <p>During an interview and observation on 06/08/24 at 12:30 p.m., Resident #1 was sitting in the bed in minor care at the local hospital. She was smiling and joking with the staff. She said when the facility would not let her back into the facility, she was upset but she said she did not want to be at that place. She said, I think I will just stay here at the hospital or go to a state mental hospital or live with you.</p> <p>During an interview on 06/08/24 at 1:35 p.m., the Responsible Party for Resident #1 said the facility gave them a 30-day notice on 05/10/24. He said the reason the facility was discharging Resident #1 was because she was labeled a harm to herself and others. He said at the beginning of this week the facility blocked his email and was not returning his calls. He said the last he knew was the resident was on a waiting list for the state hospital. He said the Behavioral Hospital B informed him of them attempting to discharge the resident and the facility refused to admit her back. He said the Behavioral Hospital B said she vomited in the van during transport and was taken to Hospital C on 06/07/24.</p> <p>During an interview on 06/08/24 at 2:45 p.m., the Director of the Behavioral Hospital B said Resident #1 was not having behaviors. She said report was called to the nursing home, and we made arrangement for transportation on 06/07/24. She said the report she received Behavioral Hospital B's van driver was that the facility would not accept their resident back into the building. She said the van driver placed Resident #1 back into the van and while at the facility parking lot Resident #1 vomited and her staff directed by Behavioral Hospital to take her to Hospital C. The van driver gave the hospital the nursing home phone number and left the resident at the hospital.</p> <p>During an interview on 06/08/24 at 5:45 p.m., the Ombudsman said she received a 30-day discharge notice for Resident #1 and had spoken to the family and the facility. She said the facility was working to get her a room at the state hospital; however, the family voiced the resident was now at the local hospital and the facility discharged the resident before the 30 days' notice ended.</p> <p>Record review of the policy titled Transfer or Discharge Notice dated 12/20/12 indicated Our facility shall provide a resident and /or resident's representative with a 30-day written notice of an impending discharge notice.</p>		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 33460</p> <p>Based on observation, interview, and record review, the facility failed to establish and follow a written policy on permitting residents to return to the facility after they were hospitalized for 1 of 6 residents (Resident #1) reviewed for discharge requirements.</p> <p>The facility failed to follow the written policy to ensure Resident #1 was readmitted to the facility, after being treated at the Behavior Hospital and after being treated at Hospital C.</p> <p>This failure could affect discharged residents and placed residents residing in the facility at risk of being discharged and not allowed to return to the facility causing a disruption in their care and/or services.</p> <p>Findings included:</p> <p>Record review of the policy titled Transfer or Discharge Notice dated 12/20/12 indicated Our facility shall provide a resident and /or resident's representative with a 30-day written notice of an impending discharge notice .</p> <p>Record review face sheet dated 6/3/24 indicated Resident #1 was readmitted on [DATE] and her original admitted was 07/01/22. She was [AGE] years old with diagnoses included schizophrenia (a disorder that affects a person ability to think, feel and behave clearly), persistent mood disorder (chronic mental illness), and gastrostomy tube.</p> <p>Record review physician orders dated June 2024 indicated Resident #1 received Haloperidol (treats mental disorder) 10 mg three times a day for schizophrenia, Seroquel (treats schizophrenia) 100 mg one time a day related to psychosis (mental disorder characterized by a disconnection from reality), and valproic acid (treats mental disorder) 250 mg three times a day. The orders included an order to transfer Resident #1 to the behavior hospital on 06/03/24.</p> <p>Record review of a quarterly MDS assessment dated [DATE] indicated Resident #1 had a BIMS score of 11 which indicated impaired cognition and she required assistance with ADLs. She had no behaviors listed on this MDS. Section Q indicated no active discharge planning for Resident #1 to return to the community and did not want to be asked about returning to the community on all assessments.</p> <p>Record review of the care plan dated 04/09/24 indicated Resident #1 had diagnoses of schizophrenia and was at risk of manic episodes and mood swings. Interventions included administering medications as ordered, to monitor the resident, and to notify psychiatric services as needed.</p> <p>Record review of 30-day discharge notice with the reason of harm to self and others dated 05/10/24 indicated the effective date of discharge for Resident #1 was for 06/10/24. The letter was sent to the ombudsman and the responsible party for Resident #1 on 05/10/24.</p> <p>Record review of nurse's notes dated 04/19/24 indicated Resident #1 was sent to Behavioral Hospital A after she placed a pillow over her roommate's face.</p> <p>(continued on next page)</p>		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of nurse's notes dated 06/03/24 Resident #1 returned to the facility from Behavioral Hospital A and was sent to Behavioral Hospital B on the same day.</p> <p>Record review of the nurse's notes dated 06/07/24 indicated the Behavioral Hospital B sent resident #1 back to the facility and the administrator told the nurse not to readmit the resident.</p> <p>During an interview on 6/8/24 at 8:30 a.m., the Administrator stated, the facility had discharged Resident #1 before the 30th day of the 30-day discharge notice. She stated, the reason was because the Behavior Hospital B had dumped Resident #1 and if the facility would had accepted the resident on 06/07/24, it would have been an unsafe admission. She said Resident #1's bed had to be given to another resident who required the secure unit. The Administrator said there was no bed on the secure unit for Resident #1. She said on 4/19/24 Resident #1 had placed a pillow over another resident's face and she was sent to the hospital then on to the Behavior Hospital A.</p> <p>During an interview on 06/08/24 at 10:00 a.m., the DON said the Administrator told her Resident #1 was discharged from the facility and the facility was not accepting her back. She said Resident #1 was sent to their facility on 06/07/24 and was not readmitted . She said the van driver said Resident #1 had vomited and he was taking her to the Hospital C. She said the effective date of the 30-day discharge notice was 06/10/24. She said she just did what the Administrator told her not to accept the resident back from Behavioral Hospital B</p> <p>During an interview on 06/08/24 at 9:00 a.m., LVN A said she was the charge nurse on 06/07/24 when the Behavioral Hospital B sent Resident #1 back from the hospital. She said the DON and the Administrator told her Resident #1 was discharged from this facility and not to accept the resident back into the facility.</p> <p>During an interview on 06/08/24 at 10:30 a.m., the ADON said the Administrator told her Resident #1 was discharged the facility. She said the resident had been given a 30-day notice of discharge and the resident was supposed to stay at the Behavior Hospital B until after 06/10/24. She said Resident #1's personal belongings were packed in a box and her room on the secure unit had been given to a new resident last week.</p> <p>During an interview on 06/08/24 at 11:00 a.m., the SW said she had been trying to find placement for Resident #1 at other nursing homes and she was on a waiting list at the state mental hospital because of the diagnosis of harm to herself and others. She said on 06/07/24 during the morning she received a phone call from the discharge planner at the Behavioral Hospital B. She said Resident #1 was discharged and was going to be sent back to the facility. She said she texted the Administrator and called the DON and reported this. She said the plan was for the resident to stay at the Behavioral Hospital B until after 06/10/24, the effective date of the 30-day discharge notice. She said the family was to bring the resident to his home until placement at the state hospital could be completed.</p> <p>During an interview on 06/08/24 at 12:15 p.m., the Case Manager at the Hospital C said Resident #1 was discharged however they were not going to send her out of the hospital due to her childlike behaviors and her inability to make decisions. She said no aggressive behaviors had been displayed while she had been at the hospital. She said the facility refused to accept Resident #1, so she would be trying to find placement at other facilities.</p> <p>(continued on next page)</p>		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview and observation on 06/08/24 at 12:30 p.m., Resident #1 was sitting in the bed in minor care at the local hospital. She was smiling and joking with the staff. She said when the facility would not let her back into the facility, she was upset but she said she did not want to be at that place. She said, I think I will just stay here at the hospital or go to a state mental hospital or live with you.</p> <p>During an interview on 06/08/24 at 1:35 p.m., the Responsible Party for Resident #1 said the facility gave them a 30-day notice on 05/10/24. He said the reason the facility was discharging Resident #1 was because she was labeled a harm to herself and others. He said at the beginning of this week the facility blocked his email and was not returning his calls. He said the last he knew was the resident was on a waiting list for the state hospital. He said the Behavioral Hospital B informed him of them attempting to discharge the resident and the facility refused to admit her back. He said the Behavioral Hospital B said she vomited in the van while in the parking lot of the facility which refused to readmitted her and was taken to Hospital C on 06/07/24. He said the effective date of the 30-day notice was 06/10/24.</p> <p>During an interview on 06/08/24 at 2:45 p.m., the Director of the Behavioral Hospital B said Resident #1 was not having behaviors. She said report was called to the nursing home, and we made arrangement for transportation on 06/07/24. She said the report she received Behavioral Hospital B's van driver was that the facility would not accept their resident back into the building. She said the van driver placed Resident #1 back into the van and while at the facility parking lot Resident #1 vomited and her staff directed by Behavioral Hospital to take her to Hospital C. The van driver gave the hospital the nursing home phone number and left the resident at the hospital.</p> <p>During an interview on 06/08/24 at 5:45 p.m., the ombudsman said she received a 30-day discharge notice for Resident #1 and had spoken to the family and the facility. She said the facility was working to get her a room at the state hospital; however, the family voiced the resident was now at the local hospital and the facility discharged the resident before the 30 days' notice ended.</p>		