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	07/02/2024

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637 Based on interview and record review the facility failed to develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that met professional standards of quality care and that was developed within 48 hours of a resident's admission for 1 of 7 residents (Resident #6) reviewed for baseline care plans. The facility failed to ensure Resident #6 had a baseline care plan completed within 48 hours of his admission on 6/5/24. This failure could place newly admitted residents at risk of receiving inadequate care and services. Findings included: 1. Record review of the face sheet dated 7/1/24 indicated Resident #6 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including cellulitis (a common and potentially serious bacterial skin infection) of the left lower limb, hypertension (elevated blood pressure), diabetes (high blood sugar), Charcot's joint syndrome (a rare complication of diabetes related neuropathy [nerve damage where feeling in the lower legs and feet are lost]. It can make injuries or infections much more serious). Record review of the MDS dated [DATE] indicated Resident #6 admitted to the facility on [DATE]. The MDS indicated Resident #6 was usually understood by others and usually understood others. The MDS indicated Resident #6 had a BIMS of 08 and was moderately cognitively impaired. The MDS indicated Resident #6 required set-up assistance with eating and was dependent on staff for oral hygiene, showering/bathing, dressing, and transferring. Record review of Resident #6's EHR record indicated there was no baseline care plan for review. (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/28/24 at 12:37 p.m. the MDS Coordinator said there should have been a baseline care plan Resident #6. The MDS Coordinator said the baseline care plan was triggered when a resident was admitted or readmitted to the facility. The MDS Coordinator said if Resident #6 did not have a baseline care plan it either did not trigger or was deleted. The MDS Coordinator said the importance of baseline care plans and comprehensive care plans was to know how to take care of the resident. During an interview on 7/1/24 at 12:36 p.m., DON JJ said a baseline care plan should be completed within 3 days of a resident's admission to the facility. DON JJ said the importance of baseline and comprehensive care plans was, it was the framework that told staff how to care for a resident. During an interview on 7/1/24 at 1:37 p.m., the Administrator said the baseline care plan should be completed upon admission to the facility. The Administrator said the importance of baseline and comprehensive care plans was they were a guideline of care to be performed on a resident to help maintain the resident's quality of life. Record review of the facility's Care Plan-Baseline policy, revised December 2016, indicated, The baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission. To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission .The baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan

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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** 44637 Based on interview and record review the facility failed to ensure comprehensive care plans were reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments for 1 of 7 residents (Resident #9) reviewed for care plans. The facility failed to ensure Resident #9's care plan was not closed on 12/19/23 and was being reviewed and revised quarterly. This failure could place residents at increased risk of not having their individual needs met and a decreased quality of life. Findings included: Record review of the face sheet dated 6/28/24 indicated Resident #9 was an [AGE] year-old female readmitted to the facility on [DATE] with diagnoses including dementia, blindness, heart disease, schizoaffective disorder (a mental condition including schizophrenia and mood disorder symptoms), hypertension (elevated blood pressure), bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), and Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors). Record review of the MDS, dated [DATE], indicated Resident #9 sometimes understood others and was sometimes understood by others. The MDS indicated Resident #9 had a BIMS of 03 and was severely cognitively impaired. The MDS indicated Resident #9 required substantial/maximal assistance with activities of daily living. Record review of the care plan last revised on 12/13/23 for Resident #9 indicated the care plan was closed on 12/19/23 due to resident discharge (resident was not discharged) During an interview on 6/28/24 at 12:37 p.m. the MDS Coordinator said Resident #9's care plan should have been updated or revised. The MDS Coordinator said Resident #9's care plan should have never been closed on 12/19/23. The MDS Coordinator said a previous DON closed Resident #9's care plan. The MDS Coordinator said there should be an active care plan for Resident #9. The MDS Coordinator said the importance of baseline care plans and comprehensive care plans was to know how to take care of the resident. During an interview on 6/28/24 at 12:55 pm., the MDS Coordinator said she reactivated Resident #9's care plan. The MDS Coordinator said Resident #9 should have had a care plan revision in March 2024 and June 2024 but due to the care plan being closed on 12/19/23 the revisions had not been completed. The MDS coordinator said the last care plan revision Resident #9 had, was dated on 12/14/23. During an interview on 7/2/24 at 12:36 p.m., DON JJ said the MDS Coordinator was responsible for completing comprehensive care plans. DON JJ said the comprehensive care plan should be revised quarterly and anytime a resident had a change in condition. DON JJ said the importance of baseline and comprehensive care plans was it was the framework that told staff how to care for a resident. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/2/24 at 1:37 p.m. the Administrator said the MDS Coordinator was responsible for completing the comprehensive care plans. The Administrator said the comprehensive care plan should be completed within 14-21 days of admission and reviewed quarterly. The Administrator said the importance of baseline and comprehensive care plans was they were a guideline of care to be performed on a resident to help maintain the resident's quality of life. Record review of the facility's Care Plans, Comprehensive Person-Centered policy indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional need is developed and implemented for each resident .The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS). Assessments of the residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. The Interdisciplinary Team must review and update the care plan: a. When there had been a significant change in the resident's condition; b. When the desired outcome is met; c. When the resident has been readmitted to the facility from a hospital stay; and d. At least quarterly, in conjunction with the required quarterly MDS assessment

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115 Based observation, interview and record review the facility failed to ensure a resident with limited range of mobility received appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility was demonstrably unavoidable for 1 of 5 residents (Resident #1) reviewed for range of motion. The facility failed to assess and provide hand rolls and/or positioning devices in Resident #1's right hand to prevent future decline in ROM. This failure could place resident at risk of not receiving the appropriate care and services to maintain their highest level of well-being. Findings include: Record review of Resident #1's face sheet, dated 06/20/24, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included epilepsy (seizures), falls, mood disorder (intense shifts in mood), intellectual disabilities, GERD (reflux disease), functional quadriplegia (complete immobility due to severe physical disability or frailty), dysphagia (difficulty swallowing), and psychosis (some loss of contact with reality), contracture of right shoulder, contracture of right wrist and contracture of right hand. Record review of Resident #1's annual assessment, dated 07/27/23, reflected she had serious mental illness and intellectual disability. She had severe cognitive impairment, indicated with a BIMS score of 00. She required supervision and one person assist for eating. ROM was noted as no impairment. Record review of Resident #1's MDS, dated [DATE], reflected she had serious mental illness and intellectual disability. She had severe cognitive impairment indicated with a BIMS score of 00. She was able to make herself understood. She required extensive assist of one staff for eating and extensive assist of two+ staff for bed mobility, transfers and toilet use. ROM was noted as 0 days provided of restorative therapy. Record review of Resident #1's EHR reflected there was no care plan or interventions related to her contractures. Record review of Resident #1's OT assessment, dated 03/05/24, reflected right UE severe flexed contractures, shoulder extension, rotated elbow flexed 115-120 degrees, wrist flexed 120 degrees with thumb abducted across palm, poor sitting balance, abnormal posturing, leaning to left side, increased need of assistance in self-care including feeding, bedfast 24/7, decreased ROM, and muscle weakness of LUE. Resident #1 was discharged from OT services due to no payer source. There was no recommendation for right hand roll or positioning device. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of an undated picture provided by a family member on 06/21/24, Resident #1's right hand was contracted, the fingers and thumb had extremely long nails, and there were excessive debris and unknown substance of various colors between her fingers, thumb and under her nails. There was no roll or brace in Resident #1's right hand. During an observation and interview on 06/24/24 at 12:35 p.m., Resident #1's family member placed a folded wash cloth between Resident #1's fingers and palm of her hand. Resident #1's hand was clean and the nails were trimmed. The family member indicated the facility had not provided any assessment of hand roll or a brace for Resident #1's contacted hand. During an interview on 06/24/24 at 3:56 p.m., DON II said she was new to the position of DON in the facility as of May 2024. DON II said she was not aware Resident #1's contracted right hand was not assessed for a hand roll or brace to prevent further contraction. She said Resident #1 was admitted to the facility on [DATE] and the contracture should have been assessed and addressed. During an interview on 06/27/24 at 4:15 p.m., the Rehabilitation Director said Resident #1 should have been assessed for contractures and ROM upon admission. She said she was just made aware in April 2024 that Resident #1 should have been assessed quarterly. She said she believed a brace was attempted with Resident #1 when she was first admitted to the facility but there was no documentation because the previous owners took all documentation. She said Resident #1 did not receive OT/PT services due to no payer source. She said Resident #1 did receive restorative therapy but a hand roll or brace was not included in the restorative therapy. She said she never received a recommendation or request for a hand brace. She said Resident #1 was added to the list and would be seen by the brace consultant the next week. During an interview on 07/02/24 at 2:36 p.m., DON JJ said she expected residents with contractures to receive contracture management to keep them mobile. DON JJ said it was a team effort and the ultimate responsibility of the restorative program and therapy. DON JJ said she would have to review the facility policy to ensure who the facility deemed responsible for contracture management. DON JJ said the importance of contracture management was to prevent further decline. Record review of the facility's, undated, Joint Mobility/Range of Motion (ROM) Program and Splinting - Initiating the Program policy reflected POLICY: Patients / residents will be assessed for joint mobility limitation upon admission, re-admission, quarterly, annually, and with significant changes through the comprehensive nursing assessment. A restorative program will be implemented through the care plan to increase, maintain, or prevent deterioration of joint mobility and to maximize physical function when referral to therapy is not indicated or upon discharge from skilled therapy. Orthotic, assistive, or prosthetic devices will be provided if indicated . TREATMENT PROTOCOLS: Individual positioning with splinting: Static or dynamic splinting and positioning are utilized to inhibit tone and maintain or prevent abnormal posturing or positioning. Appropriate use of splints to assist with positioning may enhance functional mobility. Record review of the facility's policy, dated 2001 (revised April 2013), reflected Policy Statement Rehabilitative nursing care is provided for each resident admitted . Policy Interpretation and Implementation (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. General rehabilitative nursing care is that which does not require the use of a qualified Professional Therapist to render such care. 2. Nursing personnel are trained in rehabilitative nursing care. Our facility has an active program of rehabilitative nursing which is developed and coordinated through the resident's care plan. 3. The facility's rehabilitative nursing care program is designed to assist each resident to achieve and maintain an optimal level of self-care and independence. 4. Rehabilitative nursing care is performed daily for those residents who require such service. Such program includes , but is not limited to: a. Maintaining good body alignment and proper positioning; b. Encouraging and assisting bedfast residents to change positions at least every two (2) hours (day and night) to stimulate circulation and to prevent decubitus ulcers, contractures, and deformities; c. Making every effort to keep residents active and out of bed for reasonable periods of time, except when contraindicated by physicians' orders, and encouraging residents to achieve independence in activities of daily living by teaching self care and ambulation activities; d. Assisting residents to adjust to their disabilities, to use their prosthetic devices, and to redirect their interests, if necessary; e. Assisting residents to carry out prescribed therapy exercises between visits of the therapists; f. Assisting residents with their routine range of motion exercises; .

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115 Based on interview and record review the facility failed to maintain acceptable parameters, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrated that this was not possible or resident preferences indicated otherwise and the facility failed to offer a therapeutic diet when there was a nutritional problem and the healthcare provider ordered a therapeutic diet for 5 of 5 residents (Resident #s 1, 2, 3, 4, and 5) reviewed for weight loss and nutrition. The facility failed to ensure systems were in place to monitor for weight changes. 1. The facility failed to ensure Resident #1 did not sustain a significant weight loss of 47 lbs./20% weight loss X 1 month, 51 lbs./22% weight loss X 3 months, and 49 lbs./21% weight loss X 6 months. 2. The facility failed to ensure Resident #2 did not sustain significant weight loss of 7.5% change (comparison weight 03/14/24, 117.6 lbs., -15.3%, -18 lbs.) 3. The facility failed to ensure Resident #3 did not sustain a significant weight loss. Weight changes - 10 lbs. 9 lbs. weight loss X 1 month, 10 lbs./8% weight loss X 3 months 4. The facility failed to ensure Resident #4 did not sustain a significant weight loss. Weight changes-7.5% change (Comparison Weight 04/05/24, 129.7 lbs., -13.6%, -17.7 lbs.) -10.0% change (Comparison Weight 12/23/23. 136.6 lbs., -18.0%, -24.6 lbs.) 5. The facility failed to ensure Resident #5 did not sustain a significant weight loss Weight changes-14 lbs. /7% X 1 month (comparison weight 212 lbs.) These failures could place residents at risk of severe weight loss, delayed interventions, hospitalization , worsening health condition and death. Findings include: 1. Record review of Resident #1's face sheet, dated 06/20/24, reflected a [AGE] year old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included epilepsy (seizures), falls, mood disorder (intense shifts in mood), intellectual disabilities, GERD (reflux disease), functional quadriplegia (complete immobility due to severe physical disability or frailty), dysphagia (difficulty swallowing), and psychosis (some loss of contact with reality). Record review of Resident #1's MDS, dated [DATE], reflected she had serious mental illness and intellectual disability. She had severe cognitive impairment, indicated with a BIMS score of 00. She was able to make herself understood. She required extensive assist of one staff for eating and extensive assist of two+ staff for bed mobility, transfers, and toilet use. Weight loss was unknown. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's annual assessment, dated 07/27/23, reflected she had serious mental illness and intellectual disability. She had severe cognitive impairment, indicated with a BIMS score of 00. She required supervision and one person assist for eating. Her weight was noted as 250 lbs. Record review of Resident #1's care plan, dated 08/19/23, reflected she was at risk for increased abdominal distress. Weight loss and GI bleed due to GERD. Intervention included check appetite, weight, and encourage appropriate intake, serve diet per order, and offer snacks within diet. Report to MD if resident complains of increased abdominal distress. Record review of Resident #1's care plan, dated 08/19/23, reflected she was at risk for aspiration and choking related to dysphagia. Intervention included notify MD and RD of changes PRN, offer alternate meals when intake was less than 50%, and sit resident up during meals to decrease risk of choking. Record review of Resident #1's clinical file reflected there were no care plans for weight loss available for review. Record review of Resident #1's physician orders dated 04/11/24 reflected the diet as regular mechanical soft, thin consistency and chopped meat. There was no dietary supplements added as of 06/20/24. Record review of Resident #1's meal intake record from 05/28/24 through 06/25/24 reflected there were 21 meals refused and 26 meals not documented out of 87 possible meals. Resident #1 intake was 0-25% for 2 meals, 26-50% for 2 meals, 51-75% for 5 meals, and 76-100% for 14 meals. Record review of Resident #1's ADL-eating record for 04/01/24 through 04/30/24 reflected there were 38 meal refusals noted. Record review of Resident #1's ADL-eating record for 05/01/24 through 05/31/24 reflected there were 34 meal refusals noted. Record review of Resident #1's ADL-eating record for 06/01/24 through 06/24/24 reflected there were 30 meal refusals noted. Record review of Registered Dietician note, dated 05/14/24, completed by RD DD, reflected Resident #1's weight was 187 lbs. She had 47 lbs./20% weight loss X 1 month, 51 lbs./22% weight loss X 3 months, and 49 lbs./21% weight loss X 6 months. RD DD noted poor intake at most meals, less than 50% intake at meals, and refused most meals. Recommendations included offering a house shake if intake was less than 51% at meals and encourage good intake. Record review of Registered Dietician note, dated 06/14/24 and completed by RD DD, reflected Resident #1's weight was 187 lbs. 5% change (comparison weight 5/6/24 278.4 lbs. (error per RD interview-actual weight was 187 lbs. -33%, -91.9 lbs.) , 7.5 % change (comparison weigh 4/5/24 234.0 lbs., -20.3%, -47.5 lbs.), -10.0% change(comparison weight 01/08/24 236.7 lbs., -21.2%. -50.2 lbs.). Recommendations included: Resident #1 triggered for weight loss, needs some assistance with ADLS. Record review of Resident #1's physician notes from 05/14/24 through 06/20/24 reflected there was no weight loss addressed. There were no physician or NP notes in Resident #1's electronic record related to weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/24/24 at 9:20 a.m., CNA V said Resident #1 was offered her meal but she refused and the nurse was notified. She said she offered Resident #1 an alternate meal choice and it was refused. She said she was not aware of any supplements. During an interview on 06/24/24 at 9:25 a.m., CNA FF said Resident #1 was offered her meal but she refused (06/24/24) and the nurse was notified. She said she offered Resident #1 an alternate meal choice and it was refused. She said she was not aware of any supplements. During an interview on 06/25/24 at 9:30 a.m., LVN F said if Resident #1 refused meals it was documented and the physician was notified. She said she was made aware by DON II that the physician indicated he was not notified. LVN F said Resident #1 would be offered shakes but when Resident #1 said no it was no. She said she was not aware the physician or NP were not informed of Resident #1 refusing meals or her weight loss. 2. Record review of Resident #2's face sheet, dated 06/29/24, reflected a [AGE] year old female who was admitted to the facility on [DATE]. Her diagnoses included hepatic failure (liver failure), dementia (loss of cognitive functioning), dysphagia (difficulty swallowing), and GERD (Gastroesophageal reflux disease). Record review of Resident #2's MDS, dated [DATE], reflected she was usually understood and able to understand others, she had severe cognitive impairment, indicated with a BIMS score of 2. Record review of Resident #2's care plan, dated 04/12/24 (revised 04/30/24), reflected Resident #2 had potential problems related to CCD diet. Interventions included monitor, document and report PRN any signs or symptoms of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, refusing to eat or appears concerned during meals. Record review of Registered Dietician note, dated 06/11/24, completed by RD DD, reflected Resident #2 weighed 99 lbs. Weight changes-7.5% change (comparison weight 03/14/24, 117.6 lbs., -15.3%, -18 lbs.) No supplements noted. Recommendations: Resident #2 triggered for assessment/weight loss. Resident #2 had intermittent confusion and disoriented. She required supervision with meals. Add house shakes TID thickened. Resident met criteria for severe protein-calorie malnutrition related to unintentional weight loss and poor intake. Consider adding diagnoses to list. Record review of Resident #2's physician notes from 05/14/24 through 06/20/24 reflected there was no weight loss addressed. 3. Record review of Resident #3's face sheet, dated 06/27/24, reflected a [AGE] year old female who was admitted to the facility on [DATE]. Her diagnoses included cerebral palsy (conditions that affect movement), dysphagia (difficulty eating) and diabetes (pancreas does not make enough insulin or any at all). Record review of Resident #3's MDS, dated [DATE], reflected she was rarely understood, was usually able to understand others, had severe cognitive impairment, indicated with a BIMS score of 3. She was able to eat with supervision and supervisor may be provided. Record review of Resident #3's care plan did not address diet or weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Registered Dietician note, dated 05/14/24, completed by RD DD, reflected Resident #3 was 108.2 lbs. She was underweight for her age. Weight changes - 10 lbs. 9 lbs. weight loss X 1 month, 10 lbs./8% weight loss X 3 months. There were no supplements recorded. Recommendations included: Resident #1 triggered for quarterly weight loss. Recommend re-weighing Resident #3 using previous weight method from April. Add house shakes BID. Record review of Registered Dietitian note, dated 06/14/24, completed by RD DD, reflected Resident #3's weight was 108.6 lbs. she was underweight for her age. Weight changes- 7.5 % change (comparison weight 04/05/24 118.6 lbs. -8.4%, -10 lbs.) No supplements noted. Recommendations included: Resident #1 triggered for weight loss. Resident required assistance with some ADLS. Predicted inadequate intake related to unintentional weight loss. Add house shake BID. Record review of Resident #3's physician notes from 05/14/24 through 06/20/24 reflected there was no weight loss addressed. Record review of Resident #3's physician order summary, dated 06/27/24, reflected were no current orders for supplements. 4. Record review of Resident #4's face sheet, dated 06/27/24, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #4 had diagnoses which included dementia (loss of cognitive functioning) and cognitive communication deficit (trouble participating in conversations). Record review of Resident #4's MDS, dated [DATE], reflected she had severe cognitive impairment, indicated with a BIMS score-6, was usually understood and usually able to understand others. Her weight was noted as 133 lbs. She required supervision and/or assistance for eating. Record review of Resident #4's care plan, dated 07/21/23, reflected Resident #4 was on a therapeutic diet due to heart disease and HTN. Interventions included: Serve diet as ordered and offer substitutions if less than 75% is eaten. Monitor intake. Resident #4 was on Megace for appetite stimulation. Weight monthly and PRN. Report 5% loss/gain to MD and RP. Record review of the Registered Dietician note, dated 05/14/24, completed by RD DD, reflected Resident #4 weighed 113.2 lbs. She was underweight for her age. Weight changes-17 lbs./13% eight loss X 1 month, 17 lbs./13% weight loss X 3 months, and 18 lbs./14% weight loss X 6 months. No supplements were recorded. Recommendation included: Resident #4 triggered for weight loss/quarterly. Recommend re-weighing Resident #1 using previous weight method from April 2024. Add house shakes BID. Record review of Registered Dietician note, dated 06/14/24, completed by RD DD, reflected Resident #4 weighed 112.5 lbs. She was underweight for her age. Weight changes-7.5% change (Comparison Weight 04/05/24, 129.7 lbs., -13.6%, -17.7 lbs.) -10.0% change (Comparison Weight 12/23/23. 136.6 lbs., -18.0%, -24.6 lbs.) No supplements noted. Recommendations included: Resident #4 triggered for weight loss. Resident #4 needed some assistance with ADLS. Add health shakes BID. Record review of Resident #4's physician order summary reflected from 01/04/23 through 02/03/23, Resident #4 may have house shakes BID for weight loss for 30 days. There were no current orders for supplements. (continued on next page)

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	675595	A. Building B. Wing	07/02/2024

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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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #4's physician notes from 05/14/24 through 06/20/24 reflected there was no weight loss addressed. 5. Record review of Resident #5's face sheet, dated 06/27/24, reflected he was a 67- year-old male who was admitted to the facility on [DATE]. Resident #5 had diagnoses which included dementia (loss of cognitive functioning), complete traumatic amputation of left lower leg, diabetes (pancreas does not make enough insulin or any at all), and unspecified protein-calorie malnutrition (lack of sufficient energy or protein to meet the body's metabolic demands). Record review of Resident #5's MDS, dated [DATE], reflected he was able to be understood and understood others and he was cognitively intact, indicated with a BIMS score of 15. He ate independently. His weight was noted as 209 lbs. Record review of Registered Dietician note, dated 05/14/24, completed by RD DD reflected Resident #5's weight was 197.8 lbs. Weight changes-14 lbs./7% X 1 month (comparison weight 212 lbs.) Recommendations: Resident #5 triggered for weight loss quarterly. Re-weight using same as previous weight. Weight loss was not detrimental at this time. Record review of Resident #5's physician notes from 05/14/24 through 06/20/24 reflected there was no weight loss addressed. Record review of Resident #5's physician order summary, dated 06/27/24, reflected no current orders for supplements. During an interview on 06/25/24 at 9:10 a.m., DM EE said she had not received any supplement dietary recommendations for Residents #1, #2, #3, #4 or #5. She said the recommendations had to be input into the EHR from the physician orders. She said house shakes and additional supplements would be added to the resident meal ticket but she was not made aware of any recommendations. She said the house shakes were not routinely put on the resident's meal trays. She said if a resident refused meals then the CNAs would come to the kitchen and request a shake. During an interview on 06/24/24 at 3:56 p.m., DON II said the physician was not notified of resident weight loss or RD DD's recommendations. She said she made NP aware of Resident #1's weight loss and recommendations from 05/14/24. NP A ordered shakes TID with every meal and Megace to increase her appetite as of 06/24/24. She said she became DON the first part of May 2024 and the facility had also hired a new ADON. She said she was not aware of RD DD's recommendations. She said the restorative aide was responsible for weighing the residents. She said the weights were then put into the EHR by the previous DON . She said the physician should have been made aware of all resident weight loss and dietitian recommendations. She said the residents were at risk of continued weight loss, malnutrition, and health decline if their weight loss and the dietary recommendations were not addressed. During an interview on 06/25/24 at 10:31 a.m., NP GG said she was not made aware of any resident weight loss. She said she was not made aware of any of RD DD's recommendations. She said she would have reviewed the weight loss and the recommendations and given new orders as appropriate for each resident. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/25/24 at 10:44 a.m., MD HH said he was not made aware of any resident weight loss. He said if RD DD's recommendations were sent to him he would have addressed and signed the recommendations. He said he was made aware of Resident #1's meal refusals on 06/20/24 but could not recall previous notifications. He said he would expect DON II or the ADON would notify him of the RD DD's recommendations and all resident weight loss. He said residents were at risk of malnutrition, continued weight loss, and decline of health without adequate nutrition. During an interview on 06/25/24 at 12:25 p.m., CNA J said Resident #1 refused her lunch tray. She said the tray did not include a shake. She said Resident #1 requested a ham sandwich with mustard. During an interview on 06/25/24 at 3:55 p.m., LVN Z said Resident #1 often refused her meals. She said she would make the family aware but did not notify the physician or NP. She said on 06/24/24, Resident #1 refused her tray and threw the tray while in the dining room. Resident #1 was offered a supplement but refused. She said Resident #1 was offered a sandwich, cookies and cracker and it was accepted. During an interview on 06/26/24 at 2:46 p.m., RD DD said she had been going to the facility monthly for the past two months (May 2024 and June 2024). She said when she arrived at the facility, she checked in with DON II/ADON to ask if there was anyone who needed to be seen. She said each visit, she screened for weight loss in the past 180 days. She said she would see new admissions during the visits. If a resident had weight loss they would be seen monthly along with pressure injuries and tube feedings. She said she ran an audit report from the electronic health record system and looked for weight variances and it calculated the percentages of weight loss. She said her last visit at the facility was on 06/14/24. She said during her visits, she conducted an audit of the recommendations from the previous month to ensure they were followed. She said if they were not, she would let DON II know that they were not done and would review the following month. She said during her monthly visits, she did not visit every resident in the facility, only the ones who were screened. RD DD said she sent her dietary reports for May 2024 and June 2024 with all recommendations to the administrator, DON II, and DM EE. She said she reviewed resident charts and weights and the reports were sent at the end of her visit. She said the reports and recommendations would then be reviewed by the physician and the physician would document any comments and sign the reports. She said Resident #1's documented weight for May 2024 was an error and her actual weight was 187 lbs. She said she was not aware any of the recommendations for May 2024 or June 2024 were not addressed. She said the residents were at risk of continued unwanted and unexpected with loss and malnutrition if the recommendations and weight loss were not addressed. She said the failure to obtain orders for the recommendations may have caused residents to lose unnecessary weight due to the recommendations were not acted on. She said resident weight loss was not addressed by the facility as needed. During an interview on 06/26/24 at 3:00 p.m., the Administrator said resident weights and dietary recommendations were reviewed in the morning meeting. She said she was not made aware of any resident weight loss or dietician recommendations. She said she expected The DON or ADON to inform her of any resident weight loss and dietary recommendations. She said the physician should have been made aware of all resident weight loss and dietitian recommendations. She said the residents were at risk of continued weight loss, malnutrition, and health decline if their weight loss and the dietary recommendations were not addressed. Record review of the facility's, undated, Weight Assessment and Intervention policy reflected: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Weight Assessment: 1. The nursing staff will measure resident weights on admission, the next day, and weekly for two weeks thereafter. If no weight concerns are noted at this point, weights will be measured monthly thereafter. 2. Weights will be recorded in each unit's Weight Record chart or notebook and in the individual's medical record. 3. Any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the Dietitian in writing. Verbal notification must be confirmed in writing. 4. The Dietitian will respond within 24 hours of receipt of written notification. 5. The Dietitian will review the unit Weight Record by the 15th of the month to follow individual weight trends over time. Negative trends will be evaluated by the treatment team whether or not the criteria for significant weight change has been met. 6. The threshold for significant unplanned and undesired weight loss will be based on the following criteria [where percentage of body weight loss = (usual weight - actual weight) / (usual weight) x 100]: 1. 1 month - 5% weight loss is significant; greater than 5% is severe. 3 months - 7.5% weight loss is significant; greater than 7.5% is severe. 6 months - 10% weight loss is significant; greater than 10% is severe. 7. If the weight change is desirable, this will be documented and no change in the care plan will be necessary.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637 Based on observation, interview and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 7 residents (Resident #6) reviewed for infection control. 1. The facility failed to ensure Resident #6's central line (a tube that is inserted into a large vein in the neck, chest, groin, or arm to give fluids, blood, medications, or to do medical tests quickly) dressing was changed every seven days per the physician's order. 2. The facility failed to ensure the Treatment Nurse changed gloves and performed hand hygiene between glove changes during wound care, after picking up a packaged mint off the floor, and before and after entering and exiting Resident #6's room. These failures could place residents at risk for infections. Findings included: 1. Record review of the face sheet dated 7/1/24 indicated Resident #6 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including cellulitis (a common and potentially serious bacterial skin infection) of the left lower limb, hypertension (elevated blood pressure), diabetes, Charcot's joint syndrome (a rare complication of diabetes related neuropathy [nerve damage where feeling in the lower legs and feet are lost]. It can make injuries or infections much more serious). Record review of the MDS dated [DATE] indicated Resident #6 admitted to the facility on [DATE]. The MDS indicated Resident #6 was usually understood by others and usually understood others. The MDS indicated Resident #6 had a BIMS of 08 and was moderately cognitively impaired. The MDS indicated Resident #6 required set-up assistance with eating and was dependent on staff for oral hygiene, showering/bathing, dressing, and transferring. Record review of the physician orders dated 6/28/24 indicated Resident #6 had an order starting 6/7/24 to change the dressing to single lumen (one tubing and one cap end) PICC line to the left upper extremity every day shift every 7 days for IV (intravenous) management. During an observation and interview on 6/28/24 at 11:47 a.m. Resident #6's PICC line dressing was dated 6/4/24. Resident #6 said the facility staff had not changed his PICC line dressing since he admitted to the facility. During an interview on 7/1/24 at 11:23 am the Medical Director said he would expect a PICC line dressing to be changed every 7 days as ordered to prevent infection. During an interview on 7/1/24 at 12:01 p.m. the Administrator said Resident #6 was the only resident at the facility with a PICC line. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/2/24 at 10:04 a.m. LVN T said the treatment nurse, or a RN was responsible for changing PICC line dressings. LVN T said if she noticed a PICC line dressing had not been changed as ordered she would notify a supervisor. LVN T said PICC line dressing should be changed weekly. LVN T said she had only administered Resident #6's IV medication once or twice because it was due on the evening shift, and she normally worked day shift. LVN T said she had not assessed Resident #6's PICC line dressing. LVN T said the importance of ensuring PICC line dressings were changed weekly was to prevent bacteria from entering the site and to prevent dressing from rolling up. 2. During an observation on 6/28/24 at 1:22 p.m. the Treatment Nurse performed wound care to Resident #6's ankle. The Treatment Nurse wiped the bedside table with normal saline and did not put a barrier down between the bedside table and the wound care supplies. The Treatment Nurse cleansed the medial incision, lateral incision, and bottom of foot with same piece of gauze with normal saline on it. The Treatment Nurse removed her gloves, did not perform hand hygiene, and went to the treatment cart to retrieve a package of rolled gauze. The Treatment Nurse dropped a packaged mint on the floor, reached down to pick it up, did not perform hand hygiene, and then applied a new pair of gloves. The Treatment Nurse touched Resident #6's foot and incisions with her gloved hands to see if he could feel her touch. The Treatment Nurse went to the treatment cart to obtain a tube of ointment for Resident #6's wound without removing her gloves or performing hand hygiene. The Treatment Nurse returned to the room, applied ointment to the incisions with her gloved hand, removed her gloves, did not perform hand hygiene, and wrapped the foot/ankle with rolled gauze. During an observation and interview on 06/29/24 at 11:50 a.m., the Treatment Nurse removed the kerlix wrap from Resident #6's left foot. The Treatment Nurse said Resident #6 was on isolation for MRSA (methicillin-resistant Staphylococcus aureus) of his surgery sites. The Treatment Nurse removed her gloves washed her hands applied new gloves and cleaned wounds with wound cleanser and 4 by 4 gauze for each site. The Treatment Nurse then applied clindamycin by using fingers on her gloved hand: * applied clindamycin to the inside surgical wound using gloved the first finger applied directly to the wound. *, applied clindamycin to the outside of the surgical wound using gloved the second finger applied directly to the wound; and * applied clindamycin to the great left toe a necrotic area using gloved the ring finger applied directly to the wound. The Treatment Nurse did not change her gloves or perform hand hygiene between treating areas on Resident #6's foot. The Treatment Nurse removed her gloves after she wrapped the left foot with kerlix wrap then walked out of the room down the hall approximately 7 feet to the hand sanitizer with her isolation gown on she wore while she performed wound care. During an interview on 06/29/24 at 12:00 p.m., the Treatment Nurse said she should have removed her gown in the room and said she never told about changing gloves between areas. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/1/24 at 11:23 a.m., the Medical Director said the Treatment Nurse cleaning Resident #6's wounds with the same gauze would not have spread the MRSA as it was systemic. The Medical Director said the treatment nurse not performing appropriate hand hygiene during wound care and leaving the room with gloved hands and without performing hand hygiene should be something staff were in-serviced regarding because the action could lead to the spread of infections. During an interview on 7/2/24 at 12:36 p.m. DON JJ said an RN or trained LVN could change a PICC line dressing. DON JJ said the charge nurses were responsible for changing PICC line dressings. DON JJ said PICC line dressings should be changed weekly. DON JJ said the importance of ensuring PICC line dressings were changed weekly was for infection control. DON JJ said she expected staff to perform hand hygiene before entering a resident room, before patient care, during patient care when warranted, before leaving a resident room, and between glove changes. DON JJ said if a staff member picked an item up out of the floor, she expected them to perform hand hygiene afterwards. DON JJ said the importance of proper hand hygiene was infection control. During an interview on 7/1/24 at 1:37 p.m. the Administrator said an RN was responsible for changing PICC line dressings. The Administrator said PICC line dressing changes were the responsibility of DON JJ or the weekend RN Supervisor. The Administrator said a PICC line dressing should be changed in accordance with the doctor's order. The Administrator said the importance of ensuring PICC line dressings were changed as ordered was infection control. The Administrator said she expected staff to perform hand hygiene when performing care for a resident, during different intervals of wound care including going from one wound site to another, and if they picked something up off the floor. The Administrator said the importance of proper hand hygiene was infection control. Record review of the facility's undated Infections-Clinical Protocol policy indicated, During the initial assessment, the physician will help identify individuals who have had a recent infection or who are at risk for developing an infection . Record review of the facility's undated Central Venous Catheter Dressing Changes policy indicated, The purpose of the procedure is to prevent catheter-related infections associated with contaminated, loosened, soiled, or wet dressings. Check the State's Nursing Practice Act for LPNs (Licensed Practical Nurse) regarding the scope of practice for changing a central venous catheter dressing. A physician's order is not needed for this procedure. Apply and maintain sterile dressing on intravenous access devices .Change dressings if any suspicion of contamination is suspected .Change transparent semi-permeable membrane (TSM) dressings at least every 5-7 days and PRN (when wet, soiled, or not intact) . Record review of the facility's undated Handwashing/Hand Hygiene policy indicated, The facility considers hand hygiene the primary means to prevent the spread of infection .7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water in the following situations .b. Before and after direct contact with residents; c. Before preparing or handling medications; c. Before performing a non-surgical invasive procedure .g. Before handling clean or soiled dressing, gauze pads, etc.; h. Before moving from a contaminated body site to a clean body site during resident care .k. After handling used dressings, contaminated equipment, etc.; l. after contact with objects in the immediate vicinity of the resident; m. After removing gloves; n. Before and after entering isolation precaution settings .9. The use of gloves does not replace hand washing/hand hygiene.