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	08/29/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents received an accurate assessment, reflective of the resident's status for 1 of 5 residents (Resident #2) reviewed for accuracy of assessments. The facility did not accurately complete the MDS assessment to indicate Resident #2's active diagnoses. This failure could place the residents at risk of not receiving the appropriate care and services to maintain their highest level of well-being. Findings included: Record review of Resident #2's face sheet dated 08/28/25 indicated he was a [AGE] year old male, admitted to the facility on [DATE], and his diagnoses included C1-C4 complete quadriplegia (paralysis that affects all four limbs), diabetes (high blood sugar), hyperlipemia (high levels of fats in the blood), chronic embolism and deep vein thrombosis of bilateral lower extremities (presence of a blood clot), neuromuscular dysfunction of bladder (problem with brain , nerves or spinal cord causes loss of bladder control), hypertension (high blood pressure), neurogenic bladder (condition affects bladder function due to nervous system problems), chronic kidney disease (gradual loss of kidney function), obesity (excessive fat), atherosclerotic heart disease with unstable angina (heart muscle does not receive enough oxygen due to narrowed or blocked arteries caused by plaque buildup), spinal stenosis of cervical region (narrowed space in the spine), complete lesion at C6 of spinal cord (total loss of motor control and function below level of injury), generalized muscle weakness lack of energy and strength, and major depressive disorder (persistent feeling of sadness or loss of interest). Record review of Resident #2's admission MDS dated [DATE] indicated he was able to make himself understood, was able to understand others, was cognitively intact (BIMS-15), used a wheelchair for mobility, and was dependent for most ADLS. The MDS did not include the active diagnoses of coronary artery disease, neurogenic bladder, quadriplegia, or depression. During an interview on 08/29/25 at 9:00 a.m., the DON said the accuracy of MDS was the responsibility of the Administrator. She said Resident #2's MDS dated [DATE] had her signature but she could not verify it was her electronic signature. She said if the MDS did not include the required information, it was probably missed. She said the MDS Coordinator was directly under the supervision of the administrator and the Administrator was supposed to review to ensure the MDS was initiated and competed as required. She said she was never informed that she should review the MDS for accuracy and completion. During an interview on 08/29/25 at 10:26 a.m., the Administrator said the Regional MDS Coordinator was supposed to review the MDS completed by the facility MDS Coordinator for accuracy and timeliness of completion. She said the facility did not have an MDS Coordinator as of 07/23/25. She said it was her expectation was the DON would ensure the MDS was completed as required. The Administrator said the facility did not have an MDS policy and they followed the RAI. She said residents were at risks of not receiving care and services and required if the MDS was not completed as required. During an interview on 08/29/25 at 10:50 a.m., the VPO said the facility did not have a current MDS Coordinator. He said the Regional MDS Coordinator was supposed to fill in and ensure the residents' MDS assessments were completed as required. He said the Regional MDS Coordinator was terminated and a new one was recently hired. He said the leadership of the facility (the Administrator and the DON) were supposed to ensure the MDS was completed on time and accurate. He said residents were at risks of not receiving care and services and required if the MDS was not completed as required. Record review of Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated October 2024 indicated .SECTION I: ACTIVE DIAGNOSES Intent: The items in this section are intended to code diseases that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health status. 0100-I8000: Active Diagnoses in the Last 7 Days Item Rationale Health-related Quality of Life Disease processes can have a significant adverse effect on an individual's health status and quality of life. Planning for Care This section identifies active diseases and infections that drive the current plan of care. Check the following information sources in the medical record for the last 7 days to identify active diagnoses: transfer documents, physician progress notes, recent history and physical, recent discharge summaries, nursing assessments, nursing care plans, medication sheets, doctor's orders, consults and official diagnostic reports, and other sources as available.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the comprehensive plan of care was developed within 7 days after completion of the comprehensive assessment and revised to reflect the current status for 3 of 5 residents (Resident #2, Resident #3, and Resident #4) reviewed for care plan timing The facility did not develop a comprehensive care plan within 7 days of the completion of the comprehensive assessment for Residents #2, #3, and #4. This failure could place residents at risk of not receiving appropriate care and services timely.Findings included: Record review of Resident #2's face sheet dated 08/28/25 indicated he was a [AGE] year old male, admitted to the facility on [DATE], and his diagnoses included C1-C4 complete quadriplegia (paralysis that affects all four limbs), diabetes (high blood sugar), hyperlipemia (high levels of fats in the blood), chronic embolism and deep vein thrombosis of bilateral lower extremities (presence of a blood clot), neuromuscular dysfunction of bladder (problem with brain , nerves or spinal cord causes loss of bladder control), hypertension (high blood pressure), neurogenic bladder (condition affects bladder function due to nervous system problems), chronic kidney disease (gradual loss of kidney function), obesity (excessive fat), atherosclerotic heart disease with unstable angina (heart muscle does not receive enough oxygen due to narrowed or blocked arteries caused by plaque buildup), spinal stenosis of cervical region (narrowed space in the spine), complete lesion at C6 of spinal cord (total loss of motor control and function below level of injury), generalized muscle weakness lack of energy and strength, and major depressive disorder (persistent feeling of sadness or loss of interest). Record review of Resident #2's admission MDS dated [DATE], signed by the DON as completed on 07/07/25, indicated he was able to make himself understood, was able to understand others, was cognitively intact (BIMS-15), used a wheelchair for mobility, and was dependent for most ADLS. Record review of Resident #2's clinical record indicated his care plan was not completed until 08/14/25, 38 days after the MDS was signed by the DON as completed on 07/07/25. Record review of Resident #3's face sheet dated 08/29/25 indicated he was a [AGE] year old male, admitted on [DATE], and his diagnoses included rhabdomyolysis (breakdown of skeletal muscle tissue), unspecified altered mental status (symptoms of mental distress), metabolic encephalopathy (brain dysfunction), hypertension (high blood pressure), and hyperosmolality (high concentration of dissolved particles) and hypernatremia (too much sodium in blood). Record review of Resident #3's admission MDS dated [DATE], signed as completed by MDS Coordinator B on 07/15/25 indicated he was usually able to make himself understood, usually understood others, had sever cognitive impairment (BIMS -6), signs and symptoms of delirium included fluctuating inattention, disorganized thinking, and altered level of consciousness, and was dependent for most ADLS. Record review of Resident #3's clinical record indicated the care plan for pain, the care plan for skin concerns, and the care plan for ADL functional deficits were completed on 08/06/25, 22 days after the MDS was signed as completed by MDS Coordinator B on 07/15/25. Record review of Resident #3's clinical record indicated the care plans for psychosocial well-being, cognitive impairment, delirium, visual impairment, physical aggression, oral/dental problems, falls, rhabdomyolysis, and bladder incontinence were not completed until 08/18/25, 34 days after the MDS was signed as completed by MDS Coordinator B on 07/15/25. Record review of Resident #4's face sheet dated 08/29/25 indicated he was a [AGE] year old male, admitted on [DATE], and his diagnoses included unspecified dementia (decline of cognitive function) with unspecified severity and other behavioral disturbance, Alzheimer's (progressive decline in memory, thinking, and behavior), anxiety (excessive, persistent, and uncontrollable worry and fear about everyday situations), benign prostatic hyperplasia with lower urinary tract symptom (enlarged prostate), unspecified lack of coordination (difficulty in executing controlled, purposeful movements), repeated falls, and cognitive communication deficit (difficulties in communication0. Record review of Resident #4's admission MDS dated [DATE] and signed as completed by MDS Coordinator B on 07/10/25 indicated he was usually able to make himself understood, usually understood others, had severe cognitive impairment (BIMS-3), signs and symptoms of delirium included fluctuating inattention and disorganized thinking, Record review of Resident #4's care plan dated 08/25/25 indicated he was at risk for malnutrition, was completed 46 days after the MDS was signed as completed by MDS Coordinator B on 07/10/25. There were no other care plans available for review in Resident #4's clinical record. During an interview on 08/28/25 at 4:40 p.m., the DON said the MDS Coordinator was responsible for completion of the resident care plans within the required 7 days. She said the Regional MDS Coordinator, DON, and the Administrator were responsible to ensure the care plans were

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 4 residents (Residents #1) reviewed for infection control. The facility failed to ensure LVN A utilized enhanced barrier precautions with wearing a gown while providing wound care to Resident #1. These failures could place residents at risk for cross contamination and the spread of infection.Findings included: Record review of a face sheet dated 08/28/25 indicated Resident #1 was a [AGE] year-old male admitted on [DATE]. His diagnoses included traumatic subdural hemorrhage (a type of bleeding near your brain that can happen after a head injury) without loss of consciousness, abnormalities of gait and mobility, lack of coordination, cognitive communication deficit (problem with communication that results from impaired cognition, as opposed to a problem affecting language and/or speech), human immunodeficiency virus [HIV] disease (a virus that attacks cells that help the body fight infection, making a person more vulnerable to other infections and diseases), and moderate protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function). Record review of an incomplete MDS dated [DATE] indicated Resident #1 had cognitive communication deficit, 1 or more pressure ulcer/injuries, and had 1 unstageable pressure injuries due to coverage of wound bed by slough (type of dead tissue that accumulates on the surface of a wound) and/or eschar (dead tissue). Record review of a care plan dated 08/28/25 indicated Resident #1 had a care plan initiated on 08/21/25 for a current skin concern and is at risk for further skin break down, infection and pressure ulcer formation r/t necrotic wound to upper thigh, upper hip, lower legs, bilateral clavicle with interventions of perform treatments as ordered, if no improvement report to MD. Resident is at risk for increased infections and multiple complications r/t HIV with interventions of encourage fluid intake, give medication per orders, monitor labs, observe for increase pain, discomfort and give medications as ordered, and provide for infection control and standard precautions. Record review of Physician Orders for August 2025 indicated Resident #1 had an order dated 08/20/25 cleanse left anterior shoulder with wound cleanser, apply medical grade honey, cover with bordered gauze every day shift every Mon, Wed, Fri and as needed; cleanse left forearm with wound cleanser, apply skin prep, LOTA every day shift and as needed; cleanse left hip with wound cleanser, apply medical grade honey, calcium alginate, cover with bordered gauze every day shift every Mon, Wed, Fri and as needed; cleanse left lateral knee with wound cleanser, apply collagen, cover with bordered gauze every day shift and as needed; cleanse left lateral thigh with wound cleanser, apply collagen, cover with bordered gauze every day shift and as needed; cleanse right anterior shoulder with wound cleanser, apply medical grade honey, cover with bordered gauze every day shift every Mon, Wed, Fri and as needed; and cleanse right chest wall with wound cleanser, apply collagen, cover with bordered gauze. every day shift every Mon, Wed, Fri and as needed. Record review of an admission/readmission assessment dated [DATE] indicated skin integrity assessment identified skin concerns noted and wound care to assess areas. Record review of a Weekly Skin assessment dated [DATE] indicated Resident #1 had a laceration to left lateral thigh, abrasion to left lateral knee, abrasion to right chest wall, laceration to right anterior shoulder, abrasion to left anterior shoulder, pressure ulcer to left hip and skin tear to the left forearm. During an observation on 08/28/25 at 9:49 a.m. indicated Resident #1 had EBP signage on the door and set up for PPE at doorway. LVN A prepared for Resident #1's wound care, sanitized Resident #1's bedside table, returned to wound care cart, sanitized hands, applied gloves and prepped needed supplies on barrier sheet. LVN A knocked on Resident #1's door, notified she would be providing wound care and Resident #1 consented for surveyor to observe. LVN A applied prepared supplies on sanitized bedside table, washed hands in resident's bathroom, and applied gloves, and removed old dressings and disposed properly. LVN A hand sanitized and applied new gloves. LVN A provided wound care to left forearm, left outer knee, and left upper thigh as prescribed. During wound care LVN A did not have on a PPE gown and her uniform touched the resident's bed and his left side while she leaned to provide wound care to left outer knee. During an observation and interview on 08/28/25 at 10:00 a.m. Resident #1 was lying in his bed with bandages to left outer knee, left upper thigh, left hip, left shoulder, right upper arm and right shoulder. He said he had been at the nursing facility for about 2 weeks, and he had fallen in his home and sustained head injury and multiple wounds. He said he was not found in his home for