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	09/29/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675595	A. Building B. Wing	09/29/2025

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 0584 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 observations, interviews, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for the residents in rooms #203, #215, and #220 (three of ten resident rooms) that were observed for physical environment. 1. The facility failed to ensure the rooms and bathrooms for rooms #203, #215, and #220 were clean and free of dead bug carcasses and dead cock roaches on 09/22/2025 and 09/23/2025.2. The facility failed to ensure the bathroom vanity for room [ROOM NUMBER] was in good repair. Two of two doors for the bathroom vanity were missing on 09/23/25. 3. The facility failed to ensure the broken and missing tile was repaired and replaced in the bathroom for room [ROOM NUMBER] and caulk and flooring around the toilet were stain free on 09/23/25. These failures could place the residents at risk for diminished quality of life.Findings included:During an observation and interview on 09/22/25 at 11:07 a.m. in the bathroom for room [ROOM NUMBER], there were numerous dead bug carcasses and dead cockroaches on the bathroom floor next to the vanity and in the vanity. There were missing baseboards in the room. Resident #7 nodded yes when asked if the housekeeping staff cleaned her room. She shook her head no when asked if the housekeeping staff cleaned the dead cockroaches from her bathroom. She nodded yes when asked if the facility sprayed for bugs, cock roaches, and other pests. During an observation and interview 09/22/25 at 11:14 a.m. in the bathroom for room [ROOM NUMBER] the caulk and floor around the toilet were stained brown and black. There were numerous missing, cracked and falling tiles from the bathroom. The vanity counter was not properly centered and did not cover the particle board vanity. There were dead bug carcasses and dead cockroaches under the vanity sink. Resident #17 said housekeeping staff cleaned his room, but the bathroom was not usually cleaned properly. He said the tiles had been falling off the walls for quite a while. During an observation and interview on 09/22/25 at 11:29 am., in the bathroom for room [ROOM NUMBER], the bathroom vanity was missing two of two doors. There were dead cockroaches on the floor next to the toilet and under the vanity sink. Resident in this room said she was aware the doors were missing on the vanity but could not recall how long they were broken. During an interview on 09/23/25 at 8:20 a.m., the Administrator said she was not aware of any physical plant issues with the facility. She said the facility had one Maintenance Director. She said the facility had one Housekeeping Supervisor and two housekeeping staff. The Administrator said it was her expectation the facility would be clean and in good repair. During an observation and interview on 09/23/25 at 8:34 a.m. in the bathroom for room [ROOM NUMBER], with the Administrator and the Maintenance Director, they acknowledged there were numerous dead cockroaches on the bathroom floor next to the vanity and in the vanity. There were missing baseboards in room [ROOM NUMBER]. The Maintenance Director said he was not aware of the missing baseboards. He said he was not aware of any requests to repair or replace the baseboards. The administrator said she was not aware of the missing baseboards or the dead cockroaches. During an observation and interview on 09/23/25 at 8:40 a.m. in the bathroom for room [ROOM NUMBER] with the Administrator and the Maintenance Director, they acknowledged the caulk and floor around the toilet were stained brown and black. There were numerous missing, cracked and falling tiles from the bathroom walls. The vanity counter was not properly centered and did not cover the particle board vanity. There were dead roaches under the vanity sink. The Maintenance Director said whoever set the vanity top did not set it up correctly and it would have to be taken off and replaced in the correct position. He said the tiles required replacement and/or repair. He said he was not made aware of the required repairs. The Administrator said she was not aware of the condition of the bathroom. During an observation and interview on 09/23/25 at 8:45 a.m. in the bathroom for room [ROOM NUMBER], with the Administrator and the Maintenance Director, they both acknowledged the bathroom vanity was missing two of two doors. There were dead cockroaches on the floor next to the toilet and under the vanity sink. He said he was not aware of the missing vanity doors. He said staff should place maintenance requests on a log at the nurse station. The Maintenance Director said he would look at each room at least once every other week for repairs needed. He said he was not aware of the observed needed repairs. He said there were no requests filed out for repairs. He stated it could affect the residents' quality of life, and it could irritate them if repairs were not completed. He stated he tried to get on maintenance issues as quickly as he could. The Administrator said it was her expectation the facility would be clean and in good repair. During an interview on 09/23/25 at 10:00 a.m. CNA W said housekeeping cleaned resident rooms and bathrooms daily. She said she was not aware of dead bugs or dead cock

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	09/29/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents had the right to be free from abuse and neglect for 10 of 25 residents (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #9, Resident #11, Resident #14, and Resident #216) reviewed for abuse. 1. The facility failed to ensure Resident #6 was free from sexual abuse when Resident #25 came into Resident #6's room and rubbed her right leg under the covers on 08/21/2025.2. The facility failed to ensure Resident #5 was free from physical and verbal abuse by CNA F when CNA F called Resident #5 retarded, pushed and held him down on the bed during incontinent care, pulled him off the low bed, landing on the floor and held him down by his shoulder trying to put his shirt on and pinned him against the wall and stomped on his feet on 7/01/2025. 3. The facility failed to ensure Resident #5 was free from physical and verbal abuse by CNA M when CNA M told Resident #5 to sit your ass down multiple times and then forcefully push Resident #5 into a chair sometime in June 2025. 4. The facility failed to ensure Resident #5 was free from physical abuse when Resident #12 had a physical altercation with Resident #5 when Resident #5 wandered into his room causing Resident #5 to receive a scratch on his chest and a scratch on his back on 07/03/25.5. The facility failed to ensure Resident #5 was free from physical abuse when Resident #13 hit Resident #5 on his chest on 05/26/2025 with no injury.6. The facility failed to ensure Resident #2 & #3 was free from physical abuse when Resident #1 spit on and scratched Resident #2 and scratched Resident #3 on 3/19/2025. 7. The facility failed to ensure Resident #2 was free from physical abuse when Resident #1 pinched Resident #2 on 9/04/2025.8. The facility failed to ensure Resident #3 was free from physical abuse when Resident #1 grabbed her hand and would not let go resulting in Resident #3 hitting Resident #1 on 7/24/2025.9. The facility failed to ensure Resident #1 & #3 was free from physical abuse when Resident #1 and Resident #3 were hitting each other on 8/13/2025.10. The facility failed to ensure Resident #9 was free from physical abuse when Resident #1 ran over Resident #9's foot with her wheelchair and he responded by punching Resident #1 in the face on 7/11/2025.11. The facility failed to ensure Resident #4 was free from physical abuse when Resident #1 hit Resident #4 on her arm on 9/5/2025. 12. The facility failed to ensure Resident #2 was free from physical abuse when Resident #3 scratched Resident #2 who was trying to prevent her from getting coffee on 5/18/2025. 13. The facility failed to ensure Resident #2 was free from physical abuse when Resident #4 hit Resident #2 when Resident #2 took Resident #4's bingo tokens on 6/11/2025. 14. The facility failed to ensure Resident #2 was free from physical abuse when Resident #15 hit Resident #2 in the face and knocked off her glasses on 7/4/2025.15. The facility failed to ensure Resident #14 was free from physical abuse when Resident #4 hit Resident #14 in the chest and pushed her walker on 6/19/2025. 16. The facility failed to ensure Resident #11 was free from physical abuse when Resident #10 hit Resident #11 on the back of the head on 06/19/2025. 17. The facility failed to ensure Resident #216 was free from physical abuse when Resident #215 slapped Resident #216 on 5/12/2025. An Immediate Jeopardy (IJ) was identified on 09/24/2025 at 9:45 a.m. The IJ template was provided to the facility on [DATE] at 11:05 a.m. While the IJ was removed on 09/25/2025, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. These failures could place residents at risk of emotional distress, fear, decreased quality of life and further abuse. Findings included: Resident #6 (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	09/29/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #6's face sheet, dated 09/24/2025, indicated a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted [DATE]. Resident #6 had diagnoses which included cerebral infarction (occurs when blood flow to part of the brain is blacked leading to tissue death), schizophrenia (a chronic mental disorder characterized by symptoms such as hallucinations, delusions, and cognitive challenges) conversion disorder with seizures or convulsions (mental health condition in which individuals experience neurological symptoms without any detectable neurological or medical cause), acquired absence of left leg below the knee (loss of leg below the knee) and hemiplegia (total paralysis or severe loss of muscle function on one side of the body) following cerebral infarction. Record review of Resident #6's quarterly MDS Assessment, dated 06/10/2025, indicated she had a BIMS score of 14 and diagnoses of hemiplegia, cerebral infarct, schizophrenia and seizure disorder. The assessment indicated Resident #6 was dependent for transfer and needed supervision for locomotion in manual wheelchair for 50 feet. Record review of Progress Notes dated 08/22/2025 indicated Resident #6 received 72-hour trauma monitoring by the SW related being touched inappropriately and without consent by Resident #25, no emotional distress indicated. Record review of Progress Notes dated 08/25/2025 indicated Resident #6 received 72-hour trauma monitoring by the SW related being touched inappropriately and without consent by Resident #25, no emotional distress indicated. Record review of Progress Notes dated 08/26/2025 indicated Resident #6 received 72-hour trauma monitoring by the SW related to being touched inappropriately and without consent by Resident #25, no emotional distress indicated. Record review of Resident #6's quarterly MDS Assessment, dated 09/10/2025, indicated she had a BIMS score of 12 and diagnoses of hemiplegia, cerebral infarct, schizophrenia and seizure disorder. The assessment indicated Resident #6 was dependent for assistance of 1 to 2 persons for transfer and dependent for locomotion in manual wheelchair for 50 feet. Record review of Resident #6's care plan with a target date of 11/18/2025 indicated Resident #6 had a diagnosis of schizophrenia and is at risk of increased behaviors. Interventions included intervene and monitor resident for increased agitation, anger, verbal and physical aggression, and document episodes of behavior. Record review of Resident #6 police report dated 08/21/202025 indicated a crime incident of assault, the victim was Resident #6, and she notified the officer that Resident #25 entered her room put his hand under her leg and rubbed his hand on her leg. She said Resident #25 stated, “I'm sorry it just feels so good to feel skin so soft.” Resident #6 indicated she felt it was a sexual nature, and she wished to file a report. The report indicated a non-consent form was signed. Resident #25 (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	09/29/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #25's face sheet, dated 09/24/2025, indicated a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted [DATE]. Resident #6 had diagnoses which included hemiplegia following cerebral infarction, morbid obesity (having too much body fat which increases the risk of health problems), cerebral infarction, post- traumatic stress disorder (disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event) and convulsions. Record review of Resident #25's quarterly MDS Assessment, dated 09/19/2025, indicated he was cognitively independent and had no long-term or short-term memory problem. The assessment indicated Resident #25 required dependence of 1 or 2 persons to transfer from bed to chair and independent of locomotion in a motorized scooter. Record review of Resident #25's Change in Condition Evaluation on 08/21/2025 indicated he had behavior symptoms of sexual behaviors with Resident #25 redirected to his room and sent to a behavioral hospital for monitoring. Record review of Resident #25's care plan with a revision date of 08/22/2025 indicated Resident #25 had inappropriate sexual behaviors and was at risk of further episodes and injury. The Care plan indicated Resident #25 had a history of allowing an intellectually challenged resident perform oral sex on him in the dining room and on 08/21/25 was witnessed rubbing on the leg of another resident that was unwanted. Interventions included to redirect during episodes of inappropriate sexual behavior and document in the clinical record, firmly approach the resident that behaviors are not acceptable. The care plan indicated on 08/21/25 Resident #25 was sent out for a psychiatric evaluation, was on 1 on 1 monitoring and psychiatric referral made in house by the nurse practitioner and discharge planning. During an observation and interview on 09/22/2025 at 10:00 a.m., Resident #25 named in the allegation was lying in bed, he denied sexual abuse of Resident #6. He said he brought his friend Resident #6 a cup of coffee and she was on the verge of tears. Resident #25 said Resident #6 told him no one liked her, and he said everyone here likes you and rubbed her lower leg on top of the covers. Resident #25 said he did not sexually touch anyone inappropriately. He said he was comforting his friend. Resident #25 said a nurse came into the room, did not ask any questions and made a mountain out of a mole hill. Resident #25 said he was sent to the hospital to be evaluated and had not been to Resident #6's room since the incident. During an observation and interview on 09/22/2025 at 10:20 a.m., Resident #6 named in the allegation, was up in her scooter with a left below the knee amputee, she said she was treated well, received needed care, call lights answered timely, and she denied abuse/ neglect. Resident #6 said she felt safe in the facility and was comfortable reporting concerns to the nurse. She said Resident #25 was not allowed in her room. Resident #6 said the day of the incident (08/21/2025) Resident #25 brought her coffee and that it was fine, but she said he started rubbing her right lower leg under the covers. She said she told him, ”I don't like that, she said she did not say stop.” Resident #6 said a nurse came into the room and Resident #25 stopped and left the room. She said I was very upset when it happened but now felt safe in the facility. During an interview on 09/23/2025 at 4:30 a.m., Resident #6 said Resident #25 said her skin was so soft he could not help himself when he rubbed her leg the day of the incident (08/21/2025). (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	09/29/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a phone interview on 9/23/2025 at 4:00 p.m., Hospice RN said on 08/21/2025 she was in Resident #6's room visiting her roommate and heard Resident #25 say “I want to feel your soft skin”, she said Resident #25 had his hand under Resident #6's covers. Hospice RN said Resident #25 saw her, stopped touching Resident #6 and left the room. She immediately reported the incident to LVN X and then wrote her statement. She said she did not say anything to Resident #25. The Hospice RN said she heard LVN X ask Resident #6 if she asked Resident #25 to do that and she said no and cried. During an interview on 09/23/2025 at 12:00 p.m., LVN X said she did not witness the incident on 08/21/2025 with Resident #6 and Resident #25. She said the Hospice RN notified her she witnessed Resident #25 rubbing Resident #6's leg under the covers of her bed. LVN X said Resident #25 said Resident #6 asked me to come into her room. LVN X said Resident #25 said Resident #6 said no one loved her and he touched her leg. LVN X said Resident #25 normally gets up early, goes outside for the morning then back to bed but not normally into other resident rooms. She said there was no reason for him to visit down Resident #6's hall. LVN X said Resident #6 said she did not give Resident #25 consent to touch her. She immediately notified the DON, ADON and Administrator. LVN X placed Resident #25 on 1 on 1 monitoring after the incident. She said that meant constant monitoring, eyes and ears on Resident #25, a CNA sat outside his room and stared at him in his room alone. She completed an assessment on both residents with no injury noted. LVN X said Resident #25 was sent out to the hospital later that night. She said Resident #25 required 2 CNAs to get Resident #25 out of bed and transferred to his scooter. LVN X said Resident #25 was not allowed to go to Resident #6's room. She was in-serviced prior to the incident on abuse/ neglect and sexual abuse prevention. She said after the incident she was in-serviced on abuse/ neglect and sexual abuse prevention. Resident #12 Record review of Resident #12's face sheet, dated 09/24/2025, indicated a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted [DATE]. Resident #12 had diagnoses which included dementia, seizures, bipolar disorder (chronic mental health condition characterized by extreme mood swings between periods of mania {elevated mood} and depression) and abnormalities of gait and mobility (deviations from the normal pattern of walking and movement). Record review of Resident #12's admission MDS Assessment, dated 06/05/2025, indicated he had long and short-term memory loss and was severely impaired of cognition, rarely/ never understood and rarely/never understood understands. The assessment indicated Resident #12 had inattention and disorganized thinking behaviors continuously present. Record review of Resident #12's quarterly MDS Assessment, dated 09/01/2025, indicated he had long and short-term memory loss and was severely impaired of cognition, rarely/ never understood and sometimes understands. He had wandering behaviors that occurred 1 to 3 days within the 7 days look back period. Resident #5 had physical behaviors, verbal behaviors and other behavioral symptoms 1 to 3 days within the 7 days look back period. Record review of Resident #12's care plan dated 07/08/2025 indicated Resident #12 scratched another resident when the other resident wandered into his room. Interventions included intervene as necessary to protect the rights and safety of others, approach/ Speak in a calm manner, divert attention and remove from situation and take to alternate location as needed. (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	09/29/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of an incident report for physical aggression, dated 07/04/2025, indicated an incident was reported that included Resident #5 and Resident #12 with the allegation of abuse. Record review of the facility's PIR, dated 07/11/2025, incident category as other and other specified as a resident-to-resident incident signed by the Administrator on 07/11/2025. The PIR indicated the incident occurred on 07/03/2025 at 7:05 a.m., on the secure unit. The PIR indicated Resident #5 went into Resident #12's room and rummaged, Resident #12 became physically aggressive in an attempt to remove Resident #5 from his room and Resident #5 received scratches to back and chest. Residents were separated immediately, LVN S performed a head-to-toe assessment on both residents, Resident #12 received no injury. Resident #5 was placed on 1:1 supervision and scratches treated. The physician was contacted and gave orders for Resident #5 to have an emergency room psych evaluation with medication changes. Reeducated staff on abuse and neglect, with no concerns, Social Worker conducted resident safe survey interviews with no concerns and IDT team met and discussed incident and updated care plans. Investigation findings: Confirmed that residents did have a person-to-person interaction with no major injury, Resident #5 received a scratch to his back and chest. Record review of Resident #12's physician orders dated 09/24/2025 indicated he was prescribed sertraline (antidepressant medication) 100 mg daily for major depressive disorder (a mental health condition characterized by persistent feelings of deadness, hopelessness and loss of interest or pleasure in activities) with a start date of 07/09/2025 and Aripiprazole (antipsychotic medication) 15 mg daily for bipolar disorder. During an observation and interview on 09/24/2025 at 1:44 p.m., Resident #12 was sitting in recliner, he denied abuse/ neglect and said he felt safe in the facility. Resident #12 denied anyone came into his room and messed with his stuff and denied allegations of scratching or hitting Resident #5. During an Interview on 09/24/2025 at 1:55 p.m. LVN S said Resident #5 was found on the floor in Resident #12's doorway with Resident #12 yelling to get out and trying to shut his door. She said she separated residents and assessed both residents. LVN S said Resident #5 had a scratch on his back and chest and was placed on 1 on 1 monitoring. She said Resident #12 had no injuries. She said she Notified psychiatric services the ADON, DON, Administrators, responsible parties and physicians. Resident #13 Record review of Resident #13's face sheet, dated 09/24/2025, indicated a [AGE] year-old female who was admitted to the facility on [DATE] and discharged to the hospital on [DATE]. Resident #13 had diagnoses which included cerebral infarction (a condition where blood flow to the brain was interrupted leading to brain cell damage), abnormalities of gait and mobility, compression of brain (increased pressure within the skull that compresses the brain tissue), muscle weakness, lack of coordination and cognitive communication deficit. Record review of Resident #13's admission MDS Assessment, dated 03/19/2025, indicated she had a BIMS score of 9 and was moderately impaired of cognition. The assessment indicated Resident #13 had inattention and disorganized thinking behaviors present that fluctuated (comes and goes and changes in severity). Resident #13's assessment indicated delusions (misconceptions or beliefs that are firmly held, contrary to reality) and verbal behavioral symptoms directed toward others and other behavioral symptoms not directed toward others occurred 1 to 3 days of the 7day look back period. (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	09/29/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #13's care plan dated 05/27/2025 indicated Resident #13 was at risk of manic episodes and increased behaviors with interventions of monitor for increased agitation and removed from increased stimuli. Record review of an incident report for physical aggression, dated 05/26/2025, indicated an incident was reported that included Resident #5 and Resident #13 with the allegation of abuse. Resident #13 was sent to the emergency room for a psychological evaluation and neither resident had injuries. Record review of the facility's Provider Investigation Report, dated 06/02/2025, incident category as other and other specified as a resident-to-resident incident signed by the Administrator on 06/02/2025. The PIR indicated the incident occurred on 05/26/2025 at 4:30 p.m. on the secure unit. The PIR indicated Resident #13 hit Resident #5 with a mop handle. LVN S witnessed the incident and separated the two residents and placed Resident #13 on 1 on 1 until she was transferred to the emergency room and did not return to the facility. Investigation Findings: Confirmed that residents did have a person-to-person interaction with no injury, all metal objects and possible safety hazards removed from the unit. Staff in-serviced on abuse/ neglect and safe surveys indicated no patterns of abuse/ neglect on the secured unit. Record review of Resident #13's physician orders dated 09/24/2025 indicated she was prescribed divalproex 125 mg daily for mood disorder (a mental and behavioral disorder) with a start date of 05/09/2025. During an observation and interview on 09/24/2025 at 1:40 p.m., Resident #5 was sitting in a chair, he denied anyone hit him or hurt him and he denied hitting anyone. Resident #5 was confused and unable to answer more than a few questions. During an interview on 09/24/2025 at 1:55 p.m., LVN S said she witnessed the Resident #13 and Resident #5 incident on 05/26/2025. LVN S said Resident #13 barely bumped Resident #5 in the chest with a broom. She said there was no redness or injury on either resident nor were they upset. She separated the residents, put Resident #13 on 1 on 1 monitoring and sent her to the emergency room. LVN S said she notified the responsible parties for both residents, physicians, DON and Administrator. Resident #5 Record review of Resident #5's face sheet, dated 09/23/2025, indicated a [AGE] year-old male who was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident #5 had diagnoses which included diffuse traumatic brain injury (widespread damage across multiple areas of the brain), hypertension (a condition in which the force of the blood against the artery walls is too high), encephalopathy (group of conditions that cause brain dysfunction, which can manifest as confusion, memory loss, personality changes), dementia (loss of cognitive functioning), lack of coordination, cognitive communication deficit, and major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). Record review of Resident #5's quarterly MDS Assessment, dated 5/04/2025, indicated he rarely/never made himself understood and sometimes understood others. He was not assessed for the brief interview for mental status because he is rarely/never understood. He had no behaviors identified within the 7-day look back period. (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	09/29/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #5's quarterly MDS Assessment, dated 08/04/2025, indicated he had long and short-term memory loss and was severely impaired of cognition, rarely/ never understood and sometimes understands. He had wandering behaviors that occurred 1 to 3 days within the 7 days look back period. Resident #5 had physical behaviors, verbal behaviors and other behavioral symptoms 1 to 3 days within the 7 days look back period. Record review of Resident #5's care plan revision dated 7/03/2025 indicated Resident #5 had an incident of confabulation and had a potential for further episodes of confabulation and confabulation triggered behaviors. Interventions included allow residents to verbalize feelings during episodes of confabulation - gently reorient and maintain safety, orient/re-orient resident daily and PRN, encourage to attend activities of choice, and report to MD/RP as needed and document episodes of confabulation in the clinical record. Record review of Resident #5's care plan dated 08/22/2025 indicated Resident #5 had inappropriate behaviors. Interventions included monitor and chart behaviors every shift and report progress to the physician, observe for early warning signs of behavior, approach in a calm manner, call Resident #5 by name and remove from unwanted stimuli. Record review of the facility's Provider Investigation Report (PIR) dated 7/01/2025, incident category as abuse signed by the Administrator on 7/11/2025. PIR indicated the incident occurred 7/01/2025 at 7:00 p.m. on the secure unit. PIR indicated CNA D witnessed CNA F be verbally and physical aggressive with Resident #5. On 7/01/2025, CNA D witnessed CNA F hit Resident #5's head against the wall and pinch him. CNA F was heard calling Resident #5 retarded” and making statements “if these cameras were not here, I would do what I really wanted to do.” LVN X provided head to toe assessment to Resident #5 with no injuries noted. Provider response after the incident included, employee suspended immediately, head to toe assessments on all residents in the secure unit, safe surveys conducted, employee statements collected, abuse and neglect in-services initiated, care plan updated, psych NP notified, MD notified, no family to notify, and local police contacted. Resident abuse confirmed. Employee terminated. During an observation on 9/23/2025 at 11:00 a.m., Resident #5 was well groomed, and appropriately dressed. Resident #5 was ambulating independently in the secure unit hallways and in the outdoor secure area. Resident #5 with no signs of abuse or fear of staff identified. During an interview on 9/23/2025 at 12:53 p.m., CNA D said on 7/01/2025 CNA F had asked her to assist with incontinent care on Resident #5, she said during assisting with care she witnessed CNA F push and held Resident #5 down on the bed during incontinent care. CNA D said CNA F held Resident #5's arm down with her knee when Resident #5 slapped her on the arm. CNA D said CNA F told Resident #5 she would sit on him if he hit her again and then she pinched him. CNA D said CNA F roughly pull Resident #5 off the low bed, landing on the floor and holding him down by his shoulder trying to put his shirt on. CNA D said CNA F pin Resident #5 against the wall and stomped on his feet in the attempt to get him dressed. CNA D said she was a new employee at the time of the incident and was shocked at what she witnessed, she said she reported the incident to the administrator. CNA D said she should have stopped the abuse at the time of the incident but was so shocked by the event she was reluctant to say anything to the seasoned staff member. An attempted telephone interview on 09/23/2025 at 1:15 p.m. with CNA F, the alleged perpetrator was unsuccessful. (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	09/29/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CNA F employee statement dated 07/01/2025 indicated “changing patient on bed, laid him down to change him, he was kicking, told him to stop put diaper on him had to use a little force because he was scratch and kicking me.” Record review of CNA F employee termination form dated 07/07/2025 indicated CNA F was terminated for violation of company policy and a substantiated abuse allegation. During an interview on 9/23/2025 at 1:30 p.m., LVN X said she recalled she assessed Resident #5 after the incident and did not identify any injuries but does not recall how she became aware of the incident. She said if she was notified of an abuse allegation, she would make sure the resident was safe and then immediately report to the Administrator/Abuse Coordinator. She said if she witnessed a resident being abused that she would intervene and remove the abuser and keep the resident safe, notify the AC and/or send the staff member home and if resident to resident keep separated for safety. Record review of the facility's PIR dated 7/01/2025, incident category as abuse signed by the Administrator on 7/11/2025. PIR indicated the incident occurred 7/01/2025 at 7:00 p.m. on the secure unit. PIR indicated during staff interviews ST R said she witnessed CNA M be verbally and physical aggressive with Resident #5 approximately 1.5 weeks ago. CNA M was heard telling Resident #5 to “sit you ass down” and witnessed forcefully pushing him into the chair and pushing his chair forcefully under the table. LVN X provided head to toe assessment to Resident #5 with no injuries noted. Provider response after the incident included, employee suspended immediately, head to toe assessments on all residents in the secure unit, safe surveys conducted, employee statements collected, abuse and neglect in-services initiated, care plan updated, psych NP notified, MD notified, no family to notify, and local police contacted. Resident abuse confirmed. Employee terminated. During an interview on 09/24/2025 at 2:00 p.m., ST R said she had witnessed CNA M physically and verbally abuse Resident #5 sometime in late June 2025 when she heard CNA M tell Resident #5 to sit you ass down multiple times and then forcefully push Resident #5 into a chair and push him up to the table. ST R said she reported this incident late, when she was being interviewed regarding another incident with Resident #5. She said at the time it happened she felt uneasy about the incident and would not want her family treated that way. She said she reported the incident to clear her consciousness and knew it should have been reported when she first witnessed the incident. She said she was suspended and received disciplinary actions regarding not reporting the abuse allegation immediately and re-educated prior to returning to work. She said moving forward that any abuse allegations witnessed or reported to her she would report it immediately to the administrator. An attempted telephone interview on 09/23/2025 at 1:17 p.m. with CNA M, the alleged perpetrator was unsuccessful. Record review of CNA M employee statement dated 07/03/2025 indicated “Resident #5 was ambulated to chair, sat him down and scooted his chair up to the table, so he would be able to eat his lunch tray. If this happened a week ago why it just now being reported on 07/03/2025, the abuse coordinator number is all over the building.” Record review of CNA M employee termination form dated 07/07/2025 indicated CNA M was terminated for violation of company policy and a substantiated abuse allegation. (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	09/29/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 9/23/2025 at 1:30 p.m., LVN X said she recalled assessing Resident #5 after the incident and did not identify any injuries but does not recall how she became aware of the incident. She said if she was notified of an abuse allegation, she would make sure the resident was safe and then immediately report to the Administrator/Abuse Coordinator. She said if she witnessed a resident being abused that she would intervene and remove the abuser and keep the resident safe, notify the AC and/or send the staff member home and if resident to resident keep separated for safety. Resident #1 Record review of Resident #1's face sheet, dated 09/23/2025, indicated a [AGE] year-old female who was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses which included cerebral palsy (congenital disorder of movement, muscle tone, or posture due to abnormal brain development), aphasia (disorder that affects language after a stroke), dysphagia (difficulty swallowing after a stroke), and major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). Record review of Resident #1's quarterly MDS Assessment, dated 8/08/2025, indicated she was sometimes able to make herself understood and usually understood others. She had severe cognitive impairment, identified with a BIMS score of 3. She had an active diagnosis of psychotic disorder and depression in the last 7 days. She had no behaviors identified within the 7 days look back period. Record review of Resident #1's care plan revision dated 11/11/2024 indicated Resident #1 had physical aggression. Interventions included to Intervene before agitation escalates; guide away from source of distress; Engage calmly in conversation; if response is aggressive, staff to walk calmly away, and approach later, administer medications as order and document side effects and effectiveness, assess and address for contributing sensory deficits and monitor/document/report as needed any s/s of resident posing danger to self and others, and consult psychiatric/psychogeriatric as indicated. Record review of Resident #1's care plan dated 7/12/2025 indicated Resident #1 had impulse control. Interventions included assessing coping skills and support system, analyzing key times, places, circumstances, triggers, and what de-escalates, and assessing and anticipating resident's needs: food, thirst. toileting needs, comfort level, body positioning, pain etc. Record review of Resident #1's care plan revision dated 8/13/2025 indicated Resident #1 had physical aggression. Interventions included to place on 1:1 monitoring for 2 hours and separate from another resident, intervene before agitation escalates; guide away from source of distress; Engage calmly in conversation; if response is aggressive, staff to walk calmly away, and approach later, administer medications as order and document side effects and effectiveness, assess and address for contributing sensory deficits and monitor/document/report as needed any s/s of resident posing danger to self and others, and consult psychiatric/psychog

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	09/29/2025

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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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	09/29/2025

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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that all alleged violations involving abuse were reported immediately to the abuse coordinator for immediate intervention and all alleged violations involving abuse were reported no later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or bodily injury, to the administrator of the facility and to other officials, including the State Survey Agency in accordance with State law through established procedures for 3 of 25 residents (Resident #5, #7 and #8) reviewed for abuse. 1. The facility failed ensure ST R reported a witnessed allegation of physical and verbal abuse immediately to the Abuse Coordinator approx. 1.5 weeks prior to 7/1/2025. ST R witnessed CNA M tell Resident #5 to sit you ass down multiple times and then forcefully push Resident #5 into a chair approx. 1.5 weeks prior to 7/1/2025. The Abuse Coordinator became aware of the incident on 7/3/2025 during a facility investigation and staff interviews regarding another abuse allegation of Resident #5. 2. The facility failed to ensure LVN Z reported an allegation of abuse immediately to the Abuse Coordinator on 12/29/24. LVN Z documented on 12/29/24 at 8:16 p.m. that CNA Y observed Resident #7 hit Resident #8. The DON became aware of the incident on 12/30/25 upon review of progress notes and subsequently reported the allegation to the abuse coordinator. 3. The facility failed to ensure LVN XX reported an allegation of abuse immediately to the Abuse Coordinator on 05/18/2025. An Immediate Jeopardy (IJ) was identified on 09/24/2025 at 9:45 a.m. The IJ template was provided to the facility on [DATE] at 11:05 a.m. While the IJ was removed on 09/25/2025, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. The failures could place residents at risk of abuse, physical harm, mental anguish, and emotional distress.Findings included: 1. Record review of Resident #5's face sheet, dated 09/23/2025, indicated a [AGE] year-old male who was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident #5 had diagnoses which included diffuse traumatic brain injury (widespread damage across multiple areas of the brain), hypertension (a condition in which the force of the blood against the artery walls is too high), encephalopathy (group of conditions that cause brain dysfunction, which can manifest as confusion, memory loss, personality changes), dementia (loss of cognitive functioning), lack of coordination, cognitive communication deficit, and major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). Record review of Resident #5's quarterly MDS Assessment, dated 5/04/2025, indicated he rarely/never made himself understood and sometimes understood others. He was not assessed for the brief interview for mental status because he is rarely/never understood. He had no behaviors identified within the 7-day look back period. Record review of Resident #5's care plan revision dated 7/03/2025 indicated Resident #5 had an incident of confabulation and had a potential for further episodes of confabulation and confabulation triggered behaviors. Interventions included allow residents to verbalize feelings during episodes of confabulation - gently reorient and maintain safety, orient/re-orient resident daily and PRN, encourage to attend activities of choice, and report to MD/RP as needed and document episodes of confabulation in the clinical record. Record review of the facility's Provider Investigation Report dated 7/01/2025, incident category as abuse signed by the Administrator on 7/11/2025. PIR indicated the incident occurred 7/01/2025 at 7:00 p.m. on the secure unit. PIR indicated during staff interviews ST R said she witnessed CNA M be verbally and physical aggressive with Resident #5 approximately 1.5 weeks ago. CNA M was heard telling Resident #5 to sit you ass down and witnessed forcefully pushing him into the chair and pushing his chair forcefully under the table. LVN X provided head to toe assessment to Resident #5 with no injuries noted. Provider response after the incident included, employee suspended immediately, head to toe assessments on all residents in the secure unit, safe surveys conducted, employee statements collected, abuse and neglect in-services initiated, care plan updated, psych NP notified, MD notified, no family to notify, and local police contacted. Resident abuse confirmed. Employee terminated. During an interview on 09/24/2025 at 2:00 p.m., ST R said she had witnessed CNA M physically and verbally abuse Resident #5 sometime in late June 2025 when she heard CNA M tell Resident #5 to sit you ass down multiple times and then forcefully push Resident #5 into a chair and push him up to the table. ST R said she reported this incident late, when she was being interviewed regarding another incident with Resident #5. She said at the

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	09/29/2025

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** Based on observation, 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 included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 7 of 25 residents (Resident's #1,2,3,4,5, 6, 25) reviewed for care plans. 1. The facility failed to develop and implement interventions in Resident #25's the care plan revised 08/22/2025 to prevent Resident #25's inappropriate and unwanted touching of Resident #6 on 08/21/25. 2. The facility failed to ensure Resident #1's care plan was updated to indicate Resident #1 had an incident of resident-to-resident aggression on 03/19/2025, 07/24/2025 and 09/05/2025. 3. The facility failed to ensure Resident #2's care plan was updated to indicate Resident #2 had received aggression during a resident-to-resident incident on 03/19/2025. 4. The facility failed to ensure Resident #3's care plan was updated to indicate Resident #3 had received aggression during a resident-to-resident incident on 03/19/2025 and 07/24/2025. 5. The facility failed to ensure Resident #4's care plan was updated to indicate Resident #4 had received aggression during a resident-to-resident incident on 09/05/2025. An Immediate Jeopardy (IJ) was identified on 09/24/2025 at 9:45 a.m. The IJ template was provided to the facility on [DATE] at 11:05 a.m. While the IJ was removed on 09/25/2025 at 5:33 p.m., the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that was not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure could place residents at risk of accidents, injuries, and death due to lack of appropriate interventions in place.Findings included: 1. Record review of Resident #6's face sheet, dated 09/24/2025, indicated a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted [DATE]. Resident #6 had diagnoses which included cerebral infarction (occurs when blood flow to part of the brain is blacked leading to tissue death), schizophrenia (a chronic mental disorder characterized by symptoms such as hallucinations, delusions, and cognitive challenges) conversion disorder with seizures or convulsions (mental health condition in which individuals experience neurological symptoms without any detectable neurological or medical cause), acquired absence of left leg below the knee (loss of leg below the knee) and hemiplegia (total paralysis or severe loss of muscle function on one side of the body) following cerebral infarction . Record review of Resident #6's quarterly MDS Assessment, dated 06/10/2025, indicated she had a BIMS score of 14 and diagnoses of hemiplegia, cerebral infarct, schizophrenia and seizure disorder. The assessment indicated Resident #6 was dependent for transfer and needed supervision for locomotion in manual wheelchair for 50 feet. Record review of Resident #6's quarterly MDS Assessment, dated 09/10/2025, indicated she had a BIMS score of 12 and diagnoses of hemiplegia, cerebral infarct, schizophrenia and seizure disorder. The assessment indicated Resident #6 was dependent for assistance of 1 to 2 people for transfer and dependent locomotion in manual wheelchair for 50 feet. (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	09/29/2025

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #6's care plan with a target date of 11/18/2025 indicated Resident #6 had a diagnosis of schizophrenia and was at risk of increased behaviors. Interventions included intervene and monitor resident for increased agitation, anger, verbal and physical aggression, and document episodes of behavior. Record review of Resident #6 police report dated 08/21/25 indicated a crime incident of assault, the victim was Resident #6, and she notified the officer that Resident #25 entered her room put his hand under her leg and rubbed his hand on her leg. She said Resident #25 stated, “I'm sorry it just feels so good to feel skin so soft.” Resident #6 indicated she felt it was a sexual nature, and she wished to file a report. The report indicated a non-consent form was signed. Record review of Resident #25's face sheet, dated 09/24/2025, indicated a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted [DATE]. Resident #6 had diagnoses which included hemiplegia following cerebral infarction, morbid obesity (having too much body fat which increases the risk of health problems), cerebral infarction, post- traumatic stress disorder (disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event) and convulsions. Record review of Resident #25's quarterly MDS Assessment, dated 02/13/2025, indicated he had a BIMS score of 15 indicating cognitively intact. The assessment indicated Resident #25 required dependence (helper does all the effort) of 1 or 2 persons to transfer from bed to chair and independent of locomotion in a motorized scooter. Record review of Resident #25's quarterly MDS Assessment, dated 09/19/2025, indicated he was cognitively independent and had no long-term or short-term memory problem. The assessment indicated Resident #25 required dependence of 1 or 2 persons to transfer from bed to chair and independent of locomotion in a motorized scooter. Record review of Resident #25's care plan with a revision date of 08/22/2025 indicated Resident #25 had inappropriate sexual behaviors and was at risk of further episodes and injury. The Care plan indicated Resident #25 had a history of allowing an intellectually challenged resident perform oral sex on him in the dining room and on 08/21/25 was witnessed rubbing on the leg of another resident that was unwanted. Interventions included to redirect during episodes of inappropriate sexual behavior and document in the clinical record, firmly approach the resident that behaviors are not acceptable. The care plan indicated on 08/21/25 Resident #25 was sent out for a psychiatric evaluation, was on 1 on 1 monitoring and psychiatric referral made in house by the nurse practitioner and discharge planning. Resident #25's care plan did not include interventions to prevent further sexual abuse episodes on other residents by Resident #25. Record review of a Resident-to-Resident incident report, dated 08/21/2025 indicated an incident was reported that included Resident #25 and Resident #6 with the allegation of abuse and the police were notified. (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	09/29/2025

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility's Provider Investigation Report, dated 08/28/2025, incident category as other and other specified as a resident-to-resident incident signed by the Administrator on 08/28/2025. The PIR indicated the incident occurred on 08/21/2025 at 10:00 a.m. PIR indicated Resident #6 stated Resident #25 rubbed on her leg and she did not want the touching on her leg. The incident was witnessed by Hospice RN, Residents were separated immediately, and Resident #25 was placed on 1:1 supervision. The physician was contacted and gave orders for Resident #25 to be transferred to the emergency room. Psychiatric service was contacted and performed an evaluation on Resident #25. Reeducated staff on abuse and neglect and increased rounding. The SW conducted psychosocial evaluations with no concerns, social worker conducted safe surveys with no concerns and the IDT team met and discussed the incident and updated care plans. Investigation findings were confirmed. Record review of an email from the Administrator on 08/22/25 to the MDS Contractor indicated,” Please update the following Care Plans: Resident #6 made sexual abuse allegations on 08/21/25, against Resident #25. Resident #25 was witnessed rubbing on the leg of patient and was unwanted. Resident #25 was sent out for psych eval and on 1on 1 monitoring. Psych Referral made in-house to NP. …” During an observation and interview on 09/22/25 at 10:00 a.m., Resident #25 named in the allegation was lying in bed, he denied sexual abuse of Resident #6. He said he brought his friend Resident #6 a cup of coffee and she was on the verge of tears. Resident #25 said Resident #6 told him no one liked her and he said everyone here likes you and rubbed her lower leg on top of the covers. Resident #25 said he did not sexually touch anyone inappropriately. He said he was comforting his friend. Resident #25 said a nurse came into the room, did not ask any questions and made a mountain out of a mole hill. Resident #25 said he was sent to the hospital to be evaluated and had not been to Resident #6's room since the incident. During an observation and interview on 09/22/25 at 10:20 a.m., Resident #6 named in the allegation, was up in her scooter with a left, below knee amputee, she said she was treated well, received needed care, call lights answered timely, and she denied abuse/ neglect. Resident #6 said she felt safe in the facility and was comfortable reporting concerns to the nurse. She said Resident #25 was not allowed in her room. Resident #6 said the day of the incident (08/21/25) Resident #25 brought her coffee and that it was fine, but she said he started rubbing her right lower leg under the covers. She said she told him, ”I don't like that, she said she did not say stop.” Resident #6 said a nurse came into the room and Resident #25 stopped and left the room. She said I was very upset when it happened but now felt safe in the facility. During an interview on 09/23/25 at 4:30 a.m., Resident #6 said Resident #25 said her skin was so soft he could not help himself when he rubbed her leg the day of the incident (08/21/25). (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	09/29/2025

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 09/23/25 at 12:00 p.m., LVN X said she did not witness the incident on 08/21/25 with Resident #6 and Resident #25. She said the Hospice RN notified her she witnessed Resident #25 rubbing Resident #6's leg under the covers of her bed. LVN X said Resident #25 said Resident #6 asked me to come into her room. LVN X said Resident #25 said Resident #6 said no one loved her and he touched her leg. LVN X said Resident #25 normally gets up early, goes outside for the morning then back to bed but not normally into other resident rooms. She said there was no reason for him to visit down Resident #6's hall. LVN X said Resident #6 said she did not give Resident #25 consent to touch her. She immediately notified the DON, ADON and Administrator. LVN X placed Resident #25 on 1 on 1 monitoring after the incident. She said that meant constant monitoring, eyes and ears on Resident #25, a CNA sat outside his room and stared at him in his room alone. She completed an assessment on both residents with no injury noted. LVN X said Resident #25 was sent out to the hospital later that night. She said Resident #25 required 2 CNAs to get Resident #25 out of bed and transferred to his scooter. LVN X said Resident #25 was not allowed to go to Resident #6's room. She was in-serviced prior to the incident on abuse/ neglect and sexual abuse prevention. She said after the incident she was in-serviced on abuse/ neglect and sexual abuse prevention. During a phone interview on 9/23/25 at 4:00 p.m., the Hospice RN said on 08/21/25 she was in Resident #6's room visiting her roommate and heard Resident #25 say “I want to feel your soft skin”, she said Resident #25 had his hand under Resident #6's covers. The Hospice RN said Resident #25 saw her, stopped touching Resident #6 and left the room. She immediately reported the incident to LVN X and then wrote her statement. She said she did not say anything to Resident #25. The Hospice RN said she heard LVN X ask Resident #6 if she asked Resident #25 to do that and she said no and cried. 2. Record review of Resident #1's face sheet, dated 09/23/2025, indicated a [AGE] year-old female who was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses which included cerebral palsy (congenital disorder of movement, muscle tone, or posture due to abnormal brain development), aphasia (disorder that affects language after a stroke), dysphagia (difficulty swallowing after a stroke), diabetes (a chronic condition that affects the way the body processes blood sugar), developmental disorder, and major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). Record review of Resident #1's quarterly MDS Assessment, dated 2/09/2025, indicated she was sometimes able to make herself understood and usually understood others. She was not assessed for the brief interview for mental status because she is rarely/never understood. She had an active diagnosis of psychotic disorder and depression in the last 7 days. She had no behaviors identified within the 7 days look back period. Record review of Resident #1's quarterly MDS Assessment, dated 5/08/2025, indicated she was sometimes able to make herself understood and usually understood others. She was unable to complete the brief interview for mental status. She had an active diagnosis of psychotic disorder and depression in the last 7 days. She had no behaviors identified within the 7 days look back period. Record review of Resident #1's quarterly MDS Assessment, dated 8/08/2025, indicated she was sometimes able to make herself understood and usually understood others. She had severe cognitive impairment, identified with a BIMS score of 3. She had an active diagnosis of psychotic disorder and depression in the last 7 days. She had no behaviors identified within the 7 days look back period. (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	09/29/2025

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's care plan revision dated 11/11/2024 indicated Resident #1 had physical aggression. Interventions included to Intervene before agitation escalates; guide away from source of distress; Engage calmly in conversation; if response is aggressive, staff to walk calmly away, and approach later, administer medications as order and document side effects and effectiveness, assess and address for contributing sensory deficits and monitor/document/report as needed any s/s of resident posing danger to self and others, and consult psychiatric/psychogeriatric as indicated. The care plan did not indicate Resident #1 had an updated or revised care plan for aggressive behaviors during a resident-to-resident aggression with two other residents (Resident #2 and #3) on 03/19/2025. Record review of Resident #1's care plan revision dated 8/13/2025 indicated Resident #1 had physical aggression. Interventions included to place on 1:1 monitoring for 2 hours and separate from another resident, intervene before agitation escalates; guide away from source of distress; Engage calmly in conversation; if response was aggressive, staff to walk calmly away, and approach later, administer medications as order and document side effects and effectiveness, assess and address for contributing sensory deficits and monitor/document/report as needed any s/s of resident posing danger to self and others, and consult psychiatric/psychogeriatric as indicated. The care plan did not indicate Resident #1 had an updated or revised care plan for aggressive behaviors during a resident-to-resident aggression with Resident #2 on 07/24/2025. Record review of Resident #1's care plan dated 9/04/2025 indicated Resident #1 had inappropriate behaviors. Interventions included monitoring and charting behaviors every shift and report progress to MD, observing for early warning signs of behavior - approach in a calm manner, call by name, remove from unwanted stimuli and provide psych consult per order. The care plan did not indicate Resident #1 had an updated or revised care plan for aggressive behaviors during a resident-to-resident aggression with Resident #4 on 09/05/2025. Record review of a progress notes/incident report for physical aggression, dated 03/19/2025, indicated an incident was reported that included Resident #1 had fallen and scratched Resident #2 on the leg during the fall. Resident #1 got herself back in her wheelchair and then she spit on Resident #2 and scratched Resident #3. Resident #1 was placed on 1:1 monitoring immediately and was later released. Resident #2 had a scratch on her right forearm. Resident #3 had a scratch on her left leg and 0.5cm x 0.5cm skin tear to left index finger knuckle area. Psych NP of Resident #1 notified of incident and new medication ordered for agitation and anxiety. Record review of the facility's Provider Investigation Report dated 3/19/2025, incident category as resident-to-resident abuse signed by the Administrator on 03/25/2025. PIR indicated the incident occurred 03/19/2025 at 11:13 a.m. PIR indicated Resident #1 scratched Resident #2 and Resident #3. ADON provided head to toe assessment to Resident #2 and #3 injuries of Resident #2 sustained scratch to forearm and Resident #3 sustained scratch to left leg and hand. Provider response after the incident included, residents separated, Resident #1 placed on 1:1 monitoring, Resident #1 referred to psych, head to toe assessments on all involved residents, incident/accident report completed, safe surveys conducted, Resident #2 and #3 treated in house, behavioral monitoring initiate on Resident #1, abuse and neglect in-services initiated, MD/family notified, ordered labs drawn on Resident #1. Resident abuse confirmed. Record review of Resident #2 skin assessment dated [DATE] indicated Resident #2 had a 17 cm x 1cm skin tear to right forearm. No active bleeding but red in color, no swelling, and no bruising. (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	09/29/2025

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #3 skin assessment dated [DATE] indicated Resident #3 had a scratch on her left leg and 0.5cm x 0.5cm skin tear to left index finger knuckle area and bilateral legs had multiple old scarring and multiple scattered areas of discoloration to bilateral arms. During an observation and interview on 09/23/2025 at 1:40 p.m., Resident #2 was sitting in a wheelchair in the dining area, she said that she and Resident #1 had several incidents, she pointed to 2 bruises to left forearm, consistent with being pinched, and said Resident #1 had pinched her causing the bruises. She said that she tries to stay away from Resident #1, so she does not scratch or pinch her. During an observation and interview on 09/23/2025 at 1:45 p.m., Resident #3 was sitting in a wheelchair in the dining area, she denied anyone scratching or hitting her and she denied hitting anyone. Resident #3 was confused and unable to answer more than a few questions. During an interview on 09/24/2025 at 1:50 p.m., LVN A said that Resident #1 and Resident #2, and Resident #3 have a love hate relationship. She said some days they request to sit together and communicate and other days they are mad at each other. LVN A said on the days they are mad or upset that staff try to intervene and separate them to keep residents safe but sometimes the behaviors onset quickly and staff are unable to intervene to prevent incidents. LVN A said that if resident to resident altercations occur that the staff separate the residents, and the aggressor is placed on 1:1 monitoring for 2 hours or until released by psych or transferred to hospital. LVN A said she would assess the involved residents and notify the NP/MD and follow the orders provided. Record review of a progress notes/incident report for physical aggression, dated 07/24/2025, indicated the nurse heard Resident #1 yelling very loudly. Nurses responded to the incident in the dining room. Nurse could see down the hall into the dining room, Resident #1 and Resident #3 were both swing arms at each other. Upon nurses' arrival at the dining room, residents were no longer hitting each other but Resident #3 was holding Resident #1's left hand and would not let go. This resident continued to yell. Resident #3 refused to let go of Resident #1's hand. The nurse was eventually able to ungrasp the other resident's hand and then separate residents. Both residents were evaluated, finding no injuries. Resident #3 placed on 1:1 behavior monitoring for 2 hours. Record review of the facility's Provider Investigation Report, dated 07/24/2025, incident category as resident-to-resident abuse signed by the Administrator on 07/25/2025. The PIR indicated the incident occurred on 07/24/2025 at 7:00 a.m. The PIR indicated Resident #3, and Resident #1 were hitting each other and then Resident #3 grabbed Resident #1's hand and would not let go. LVN A performed a head-to-toe assessment on both residents, no injuries indicated. Provider response after the incident included, residents separated, Resident #3 placed on 1:1 monitoring for 2 hours, head-to-toe assessments on all involved residents, incident/accident report completed, safe surveys conducted, abuse and neglect in-services initiated, Psych NP notified, MD/family/hospice notified. Resident abuse confirmed. (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	09/29/2025

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a progress notes/incident report for physical aggression, dated 09/05/2025, indicated LVN A witnessed Resident #1 hit Resident #4 twice in her right arm with closed fist, unprovoked as she was passing by her. Resident #4 did not hit the other resident back. Resident #1 was removed from area and placed on 1:1 monitoring. Resident #4 was able to verbalize that she did not do anything to Resident #1 to provoke her to hit her. Resident #4 denied any pain in her arm at this time. DON, Administrator, NP and Psych NP notified of incident. Resident #1 continued with behaviors during 1:1 monitoring and Psych NP ordered Resident #1 Hydroxyzine 25mg 1 tablet by mouth every 6 hours as needed x 14 days. Record review of the facility's Provider Investigation Report, dated 09/05/2025, incident category as resident-to-resident abuse signed by the Administrator on 09/10/2025. The PIR indicated the incident occurred on 09/05/2025 at 4:00 p.m. The PIR indicated LVN A witnessed Resident #1 hit Resident #4 on the arm. LVN A performed a head-to-toe assessment on both residents, no injuries identified. Provider response after the incident included, residents separated immediately, Resident #1 placed on 1:1 monitoring for 2 hours, head-to-toe assessments on all involved residents, incident/accident report completed, safe surveys conducted, care plans updated, abuse and neglect in-services initiated, Psych NP and MD/family notified. Resident abuse confirmed. During an interview on 09/24/2025 at 12:45 p.m., Resident #4 said that she was hit by Resident #1 on the arm when she was coming down the hall. She said that she was not hurt and did not hit her back. She said that she knows not to hit other residents and to notify nurse if someone hits her. During an interview on 09/24/2025 at 2:10 p.m., LVN A said that Resident #1 and Resident #4 were in the hallway, and she witnessed Resident #1 hit Resident #4 on the arm. She said that Resident #4 did not provoke the incident and did not hit Resident #1 back. She said Resident #1 gets upset when she cannot talk to her sister on the phone or in person, and this day her family member was out of town and unable to be reached and Resident #1 started having behaviors after not being able to talk to her family member. She said that she goes out with her family member and stays with her family member overnight and when those visits are unable to be arranged Resident #1 gets upset and acts out. She said that Resident #1 was monitored 1:1 after the incident. 3. Record review of Resident #2's face sheet, dated 09/23/2025, indicated a [AGE] year-old female who was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident #2 had diagnoses which included schizophrenia (a chronic mental disorder characterized by symptoms such as hallucinations, delusions, and cognitive challenges), Alzheimer's Disease (progressive disease that destroys memory and other important mental functions), manic episodes, intellectual disabilities, diabetes type 1 (chronic condition in which the pancreas produces little or no insulin), dementia (loss of cognitive functioning), and major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). Record review of Resident #2's annual MDS Assessment, dated 1/17/2025, indicated she was able to make herself understood and understood others. She was intact cognitively, identified with a BIMS score of 14. She had an active diagnosis of anxiety disorder, depression, bipolar disorder, and schizophrenia in the last 7 days. She had no behaviors identified within the 7 days look back period. (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	09/29/2025

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #2's care plan revision dated 1/16/2024 indicated Resident #2 had inappropriate behaviors. Interventions included to activities, explain procedures using terms gestures residents can understand, monitor and chart behaviors every shift and report progress to MD, observe for early warning signs of behavior - approach in a calm manner, call by name, remove from unwanted stimuli, give medications per order - monitor labs - report results to MD, and consult psychiatric/ psychogeriatric as indicated. Record review of Resident #2's care plan dated 5/19/2025 indicated Resident #2 had physical aggression from another resident. Interventions included analyzing times of day, places, circumstances, triggers, and what de-escalates behavior and document, assessing and addressing for contributing sensory deficits, monitor/document/report as needed any s/s of resident posing danger to self and others, when the resident becomes agitated: intervene before agitation escalates; guide away from source of distress; engage calmly in conversation; if response is aggressive, staff to walk calmly away, and approach later and administer medications as ordered, monitor/document for side effects and effectiveness, and psychiatric/psychogeriatric consult as indicated. The care plan did not indicate Resident #2 had an updated or revised care plan for receiving aggressive behavior from another resident during a resident-to-resident aggression on 03/19/2025. 4. Record review of Resident #3's face sheet, dated 09/23/2025, indicated a [AGE] year-old female who was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident #3 had diagnoses which included vascular dementia (changes in thinking and memory that occur when there isn't enough blood flow to part of the brain), diabetes (a chronic condition that affects the way the body processes blood sugar), stroke, dementia (loss of cognitive functioning), and major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). Record review of Resident #3's quarterly MDS Assessment, dated 3/14/2025, indicated she was sometimes able to make herself understood and sometimes understood others. She was moderately impaired cognitively, identified with a BIMS score of 11. She had an active diagnosis of depression in the last 7 days. She had no behaviors identified within the 7 days look back period. Record review of Resident #3's quarterly MDS Assessment, dated 6/12/2025, indicated she was sometimes able to make herself understood and sometimes understood others. She was severely impaired cognitively, identified with a BIMS score of 6. She had an active diagnosis of depression in the last 7 days. She had behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) which occurred 1 to 3 days within the 7-day look back period. The care plan did not indicate Resident #3 had an updated or revised care plan for receiving aggressive behavior from another resident during a resident-to-resident aggression on 03/19/2025 and 07/24/2025. (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	09/29/2025

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	5. Record review of Resident #4's face sheet, dated 09/23/2025, indicated a [AGE] year-old female who was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident #4 had diagnoses which included psychosis (severe mental condition in which thoughts and emotions are so affected that contact is lost with external reality), diabetes (a chronic condition that affects the way the body processes blood sugar), delirium (confusion that happens when illness, changes in your environment or other factors put too much stress on your brain), and major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). Record review of Resident #4's quarterly MDS Assessment, dated 8/30/2025, indicated she was able to make herself understood and understood others. She was moderately impaired cognitively, identified with a BIMS score of 8. She had an active diagnosis of depression and psychotic disorder in the last 7 days. She had no behaviors identified within the 7-day look back period. Record review of Resident #4's care plan revision dated 5/30/2025 indicated Resident #4 has potential to be physically aggressive related to anger, and poor impulse control. Interventions included behavior de-escalation by removing her from the issue as it is happening, analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document, assessing and addressing for contributing sensory deficits, assessing and anticipating resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain etc., give the resident as many choices as possible about care and activities and psychiatric/psychogeriatric consult as indicated. The care plan did not indicate Resident #4 had an updated or revised care plan for receiving aggressive behavior from another resident during a resident-to-resident aggression on 09/05/2025. During an interview on 09/24/2025 at 8:55 a.m., the Administrator said that all incidents and allegations are discussed during morning meetings (including herself, administrator, department heads) and if care plans need to be updated that she emailed the VP of Clinical Reimbursement, a MDS Contractor and the care plans and interventions were updated remotely. She said that it appears that no one was verifying that the emails were received, and the tasks were completed. She said she is unsure why the care plans were not updated as requested and if the care plans were not updated or revised, the care plan would not reflect the current resident's needs. She stated new interventions should be added to the care plan regarding recurrent resident-to-resident altercations. She said the DON should have been assigned the responsibilities of ensuring the care plan was updated when the in-house MDS coordinator left. Record review of an undated facility policy titled, “Policy: Comprehensive Care Planning & IDT Participation” indicated, “…. To ensure that every resident at … has an individualized, comprehensive care plan developed and implemented by the Interdisciplinary Team (IDT) in compliance with federal and Texas state regulations. … 3. Behavioral Care Plans must be initiated and completed by the next business day following identification of behaviors. … Social services and Nursing Department are responsible for updating acute or new care plans identified between quarterly Care Plan Review …” An Immediate Jeopardy (IJ) was identified on 09/24/2025 at 9:45 a.m. The IJ template was provided to the facility on [DATE] at 11:00 a.m. The facility was asked to provide a Plan of Removal to address the Immediate Jeopardy. (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	09/29/2025

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The following Plan of Removal (POR) submitted by the facility was accepted on 9/25/25 at 10:45 a.m.: Resident-Specific Interventions - 09/24/2025 - Completed by VP of Clinical Reimbursement Resident #1's care plan was updated 09/24/25 psych NP discontinued Buspirone 5 mg with new order for Buspirone 20 mg every evening. Resident #2, #3 and #5 care plans updated 09/24/2025 regarding receiving abuse

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	09/29/2025

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 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)

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	09/29/2025

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 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 observations, interviews, and record review, the facility failed to 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 disease and infection for 1 of 5 residents (Resident #16) reviewed for infection control. CNA W and CNA CD did not complete hand hygiene after changing gloves and when going from dirty to clean, while providing incontinent care for Resident #16. This deficient practice could place residents at-risk for infection due to improper care practices. The findings included: Record review of Resident #16's face sheet, dated 09/24/2025, revealed a [AGE] year-old female with an admission date of 11/09/2020 with diagnoses which included: diabetes mellitus type 2, severe obesity, difficulty in walking, and lack of coordination. Record review of Resident #16's quarterly MDS assessment, dated 09/19/2025, revealed Resident #16 had a BIMS score of 12, which indicated moderate cognitive impairment. Resident #16 was indicated to frequently be incontinent of bowel and bladder. Record review of Resident #16's care plan, initiated 5/02/2022, revealed a focus of, The resident has an ADL self-care performance deficit r/t obesity, poor vision, and low endurance d/t respiratory complications and The resident has bladder incontinence and at risk for complications r/t overactive bladder, Type II DM. Observation and interview on 09/23/2025 starting at 10:42 AM revealed CNA W provided incontinent care to Resident #16. Resident #16 was in bed. CNA W and CNA CD were both wearing gowns and informed the resident they were going to provide her with incontinent care and gathered the supplies. CNA W and CNA CD completed hand hygiene, put on gloves, and then started incontinent care. CNA W cleaned the resident with wipes; the resident was soiled with bowel movement. After cleaning the resident, CNA W had bowel movement on her glove and did not complete hand hygiene after changing her gloves or going from dirty to clean supplies. During the care, CNA W apologized for not having her hand sanitizer. CNA CD removed the dirty brief and cleaned bowel movement off Resident #16's bottom. While leaving the same dirty gloves on and without doing hand hygiene, CNA CD touched the clean sheet and adjusted the clean brief. Once incontinent care was completed, CNA W and CNA CD removed their gloves and completed hand hygiene. In an interview on 09/23/2025 at 11:03 AM with CNA W, she stated hand hygiene should be done before and after patient care. She stated she was to wash her hands, dry them, and apologized for not having her hand sanitizer on her while providing care. She stated she was supposed to use hand sanitizer if she could not get to water. She stated she was trained by the facility to complete hand hygiene after glove changes and when moving from dirty to clean. She stated hand hygiene was done to prevent contamination. In an interview on 09/23/2025 at 11:09 AM with CNA CD, she stated she was trained when she became a CNA. She stated hand hygiene was to be done before and after patient care. She stated she was trained a long time ago and was trying to remember when else she should complete hand hygiene. She stated she should change gloves and complete hand hygiene if she was contaminated, if she sees something. She stated she was not trained to complete hand hygiene after glove changes or when moving from dirty to clean. She stated hand hygiene was important so you don't contaminate yourself or others. In an interview on 09/24/25 at 02:15 PM with the DON, she stated infection control in-services were completed approximately every two weeks. The DON stated, I do the trainings, the ADON, or the wound care nurse. The DON stated herself and the ADON were the infection preventionists and the wound care nurse was working through the process to become an infection preventionist. The DON stated she expected staff to follow the hand hygiene policy and procedure. The DON stated hand hygiene should be done before and after patient care, between glove changes, and after soiled hands. She stated this prevents infection. Review of Hand Washing in-service dated 09/23/2025 reflected CNA CCD's signature was on the in-service, but CNA CCC's was not. The summary stated in part . It is imperative that you wash your hands in between dirty and clean hands. Review of the facility policy dated September 2022 and titled Standard Precautions reflected, . 1. Hand hygiene is performed with ABHR or soap and water.before and after contact with the resident.before moving from work on a soiled body site to a clean body site on the same resident.after removing gloves.2. Gloves.After gloves are removed, hands are washed immediately to avoid transfer of microorganisms to other residents or environments.