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	02/27/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview, and record review, the facility failed to determine that drug records were in order and that an account of all controlled drugs was maintained and periodically reconciled for 2 of 4 months of controlled drug count records reviewed. The facility failed to ensure the controlled drug (medication) count record was signed acknowledging that the controlled drugs (medications) were counted by LVN A, LVN B, LVN C, MA D, LVN E and LVN F. The facility failed to ensure LVN A, LVN B, LVN C, MA D, LVN E and LVN F signed the controlled drug count records acknowledging the controlled drugs were counted and correct each time they took possession of the medication cart for the months of January and February. This failure could place the facility at risk for drug diversion.Findings included: Record review of the controlled drug count sheets indicated signing below acknowledges that you have counted the controlled drugs on hand and have found that the quantity of each medication counted is in agreement with the quantity stated on controlled Drug Administration Record. missing nursing and MA's signatures for: Hall: Short (MA and Nurse medication cart) 01/7/2026 for shift 10:00 p.m.- 6:00 a.m. by LVN A01/9/2026 for shift 10:00 p.m.- 6:00 a.m. by LVN B01/31/2026 for shift 10:00 p.m.- 6:00 a.m. by LVN C02/20/2026, 02/21/2026, 02/22/2026 for shift 10:00 p.m.- 6:00 a.m. by LVN B02/24/2026 for shift 7:00 a.m.- 7:00 p.m. by MA D Hall: Long (MA cart) 02/05/2026 for shift 7:00 a.m.- 7:00 p.m. by MA D02/15/2026 for shift 7:00 a.m.- 7:00 p.m. by MA D Hall: 100 (Nurses medication cart) 02/02/2026 for shift 2:00 p.m.- 10:00 p.m. by LVN C02/03/2026 for shift 10:00 p.m.- 6:00 a.m. by LVN F02/04/2026 for shift 2:00 p.m.- 10:00 p.m. and 10:00 p.m.- 6:00 a.m. by LVN F02/05/2026 for shift 7:00 a.m.- 7:00 p.m. by LVN B02/21/2026 for shift 2:00 p.m.- 10:00 p.m. and 10:00 p.m.- 6:00 a.m. by LVN F02/25/2026 for shift 2:00 p.m.- 10:00 p.m. and 10:00 p.m.- 6:00 a.m. by LVN F During an interview on 02/26/2026 at 1:55 p.m., LVN C said she had counted the controlled medications before taking the keys for the dates of 01/31/2026 for shift 10:00 p.m.- 6:00 a.m. and 02/02/2026 for shift 2:00 p.m.- 10:00 p.m. She said she could not recall the reason she did not sign the controlled drug (medication) sheet. She said she was responsible for signing the controlled drug sheet at the beginning of her shift and at the end of her shift. She said she should have signed because it shows she counted before taking responsibility for the controlled medications. She said the potential risk was drug diversion and inaccurate drug count documentation. She said she had been trained to sign the controlled drug (medication) sheets when coming and leaving her shift. During an interview on 02/27/2026 at 9:22 a.m., LVN F said the controlled drug (medication) sheet was for nurses and MAs to acknowledge they counted the controlled drugs and had assumed responsibility for the drugs. She said she was responsible for signing the controlled drug sheet at the beginning of her shift and at the end of her shift. She said she had counted the drugs on the dates and shifts of: 02/04/2026 for shift 2:00 p.m.- 10:00 p.m. and 10:00 p.m.- 6:00 a.m., 02/21/2026 for shift 2:00 p.m.- 10:00 p.m. and 10:00 p.m.- 6:00 a.m., 02/25/2026 for shift 2:00 p.m.- 10:00 p.m. and 10:00 p.m.- 6:00 a.m. LVN F said she was human and forgot to sign the controlled drug count record sheet (continued on next page)

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

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	after working doubles. She said her narcotic drug count had always been correct and never had any issues with the count not being accurate. She said the potential risk was drug diversion if the documentation was not completed. During an interview on 02/27/2026 at 9:35 a.m., LVN B said she was responsible for signing the controlled drug sheet at the beginning of her shift and at the end of her shift. She said she could not recall why she did not sign the controlled drug sheet on 01/09/2026 for shift 10:00 p.m.- 6:00 a.m., 02/20/2026, 02/21/2026, 02/22/2026 for shift 10:00 p.m.- 6:00 a.m., and 02/05/2026 for shift 7:00 a.m.- 7:00 p.m. LVN B said she always counted the controlled medication cart before taking responsibility for the controlled medications and had never had any issues with the count being accurate. She said the potential risk was drug diversion if the documentation was not completed. A phone interview was attempted with MA D on 02/27/2026 at 9:43 a.m., there was no answer, voicemail was left. A interview was attempted with LVN E on 02/27/2026 at 10:12 a.m., there was no answer, voicemail was left. During an interview on 02/27/2026 at 10:20 a.m., the DON said she expected the nurses and MA's to sign in and sign off on the controlled drug (medic ation) sheet to ensure the controlled drugs are being counted and accurate to prevent the potential for drug diversion. She said she and the ADON were responsible for reviewing the controlled drug count sheets every Monday and Fridays. She said the drug count sheets had been overlooked because she was still adjusting to her role as DON. She said the controlled drug count sheets should have been signed by the nursing staff that was responsible for medication and reviewed by her and the ADON to ensure it was completed correctly and accurately. During an interview on 02/27/2026 at 10:40 a.m., the Administrator said all nurses and MA's were responsible for signing in and out on the controlled drug count sheet. He said the potential risk was drug diversion and missing medications. During an interview on 02/27/2026 at 5:00 p.m., LVN A said she was responsible for signing the controlled drug sheet at the beginning of her shift and at the end of her shift. She said she could not recall why she did not sign the controlled drug sheet on the dates of 01/7/2026 for shift 10:00 p.m.- 6:00 a.m. She said the potential risk was drug diversion by staff, visitors, or residents. She said she had no issues with the controlled drug count and always had an accurate count of controlled drugs (medications.) An interview attempt was made, but the ADON was off and unavailable to interview. Record review of the facility policy titled: Controlled Substances revision date November 2022 indicated: Policy StatementThe facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications (listed as Schedule II-V of the Comprehensive Drug Abuse Prevention and Control Act of 1976).Policy Interpretation and ImplementationDispensing and Reconciling Controlled Substances Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up.The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following:Records of personnel access and usage;Medication administration records;Declining inventory records; andDestruction, waste and return to pharmacy records.Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count.The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services.The director of nursing services documents irreconcilable discrepancies in a report to the administrator.If a major discrepancy or a pattern of discrepancies occurs, or if there is apparent criminal activity, the director of nursing notifies the administrator and consultant pharmacist immediately.The administrator, consultant pharmacist, and/or director of nursing services determine whether other action(s) are needed, e.g., notification of police or other enforcement personnel.The medication regimen of residents using (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications that have such discrepancies are reviewed to assure the resident has received all medications ordered and the goal of therapy is met (example: a resident receiving a pain medication complains of unrelieved pain).The director of nursing services consults with the provider pharmacy and the administrator to determine whether any further legal action is indicated.