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	03/25/2026

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 observations, interviews, and record review the facility failed to ensure the residents had the right to be free from abuse for 1 of 7 (Resident #1) residents reviewed for abuse. The facility failed to ensure Resident #1 was free from physical abuse by CNA B. The non-compliance was identified as PNC. The IJ began on 03/05/26 and ended on 03/13/26. The facility had corrected the non-compliance before the survey began. This failure could place residents at risk for abuse/neglect, humiliation, intimidation, fear, shame, agitation, and decreased quality of life.Findings included: Record review of Resident #1's face sheet revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included dementia (decline in mental ability), anxiety disorder, and Alzheimer's disease (progressive, irreversible neurological disorder that shrinks the brain and kills brain cells). Record review of Resident #1's MDS Resident Assessment and Care Screening form dated 02/04/26 revealed under Cognitive Patterns, Should brief interview of mental status be conducted? .0. No (resident is rarely/never understood) . Record review of Resident #1's care plan, admission date on 02/17/26, indicated Resident #1 has impaired cognition and is at risk for further decline and injury.BIMS score: 3.0 (severely cognitively impaired), dx of Alzheimer's Disease, Dementia, Anxiety Disorder.needs will be met and dignity maintained over the next 90 days. Record review of the Provider Investigation Report, dated 03/05/26, indicated, Investigation revealed that a CNA told a nurse that another CNA abused a resident while providing care. Employee was removed from the facility. Suspended (then terminated) pending investigation. MD, psych NP, and RP were all notified. Police Department notified case # [number]. Safe surveys completed with no adverse findings. Skin sweep completed with no adverse findings. Resident assessed for physical and psychosocial harm. Nothing noted. Conducted interview with resident and resident could not recall any issues with any staff members. Resident appears to be at baseline for cognition. Employee interviewed and denied. Resident remains stable .inservice on abuse/neglect.care plan updated.assessed resident with no adverse findings.psychosocial screening. Resident showed no signs of emotional distress, pain or any delayed injuries. Record review of CNA A's handwritten statement, dated 03/05/26, indicated CNA A 03/05/26.at 9:30 (p.m.) me and CNA B attempted/asked Resident #1 if he would like to be change, he refused, I asked again, he refused again. When I started to grab the belongings and leave, CNA B try to force him [Resident #1] to the bed Resident #1 started to get a little aggressive and CNA B started to get aggressive back, he first started by manhandling him and try to force him to the bed, once he was finally able to force him into the bed, Resident #1 began trying to push CNA B off him that's when CNA B hit Resident #1 on the arms around 3/4 times, then he grabbed both of Resident #1's hand pinned them down and started forcing his shorts down, he ripped Resident #1's brief off and just had him laying on the bed with nothing on his bottom, once he realized Resident #1 wasn't going to let him change him he let Resident #1 get up and walk out the room with nothing on, I tried to stop Resident #1 from leaving out the room with no pants on but he didn't let me. Before all of this happened I told CNA B multiple times to just leave Resident #1 alone and report he refused, he denied. Record review of skin assessments dated 03/05/26, 03/06/26 (during the day), and 03/06/26 (during the evening) (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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	revealed no skin injuries. During an interview on 03/24/26 at 08:10 a.m., the DON stated there was no current administrator. The previous one quit and an interim administrator would be coming the following day. She stated a staff member had reported she witnessed another staff member being aggressive with a resident. She was told the staff member was trying to force him into bed, into clothes and yelling at him. Both staff were suspended due to CNA A not reporting it immediately, and CNA B for the abuse allegation. The staff were all re-in-serviced regarding abuse and timely reporting. During an observation and interview on 03/24/26 at 09:34 a.m., Resident #1 was sitting in his wheelchair in the common area on the Secured Unit. An attempt was made to interview the resident. He was not interview able. During a phone interview on 03/24/26 at 12:45 p.m., CNA B denied the abuse allegations and denied being rough with the resident. He stated he was suspended immediately pending the investigation and then he was terminated. During a phone interview on 03/24/26 at 12:52 p.m., CNA A confirmed she had provided a written statement to the facility regarding the abuse incident. She confirmed CNA B was rough with the resident and manhandled him. She stated she had asked him to leave Resident #1 alone multiple times. She stated CNA B had hit Resident #1 on his arm repeatedly with a closed fist. She stated she was fired due to not reporting promptly. She stated she knew she was supposed to report abuse immediately but did not feel comfortable leaving CNA B alone with the residents on the memory care unit. She reported as soon as she felt comfortable the residents were safe. During a phone interview on 03/25/26 at 11:00 a.m., Resident #1's family member stated she filed charges against CNA B. She stated it would be hard to explain or understand what he thinks of things now.because of how sick he is. I was livid. She stated he never raised a hand to her and never screamed or hollered at her. She stated he didn't deserve that. She stated she was so mad.I want to scrutinize everybody and everything. I don't want anyone to have half the chance of doing that again. She stated it was traumatizing to her. Record review of CNA B's personnel file: Hire date: 02/25/26. Proof of background check and EMR check were provided. Proof of abuse, resident rights, behavioral health, and dementia/cognitive impairment, and abuse report training was completed and signed by CNA B on 02/24/26.Record review of the policy titled Abuse, Neglect, Exploitation, and Misappropriation Prevention, Reporting, and Investigation Policy, revised January 2026, indicated .The Nursing Facility (NF) ensures that all residents are free from abuse, neglect, exploitation, misappropriation of resident property, mistreatment .Definitions . Abuse . the willful infliction of injury, unreasonable confinement, intimidation, punishment .resulting in physical harm, pain, mental anguish, or emotional distress .The interim Administrator was notified on 03/25/2026 at 11:35 a.m. that a past non-compliance was identified due to the above failure. The facility implemented the following interventions before the survey entrance on 03/24/2026.- Staff were suspended during the investigation and then terminated.-Assessment of Resident #1.- Completion of in-services regarding abuse/neglect and timely reporting of incidents (03/05 and 03/06/26).- Staff re-educated as to interventions on handling residents with behaviors, abuse/neglect, and resident rights (related to another incident on 03/13/26). To ensure the trainings were completed, 14 staff (DON, ADON, LVN C, LVN D, CNA E, CNA F, CNA G, CNA H, CNA J, CNA K, Dietary L, Dietary M, and CNA N) were interviewed from all shifts on 03/24/26 and 3/25/26. Staff were able to appropriately define abuse, identify the abuse coordinator, and said they would immediately notify the administrator or the DON of any abuse allegations. They were able to state to intervene appropriately and if they were the only two staff on the floor, to call for help using a phone, or to yell out the door for help at the nearby nursing station. The non-compliance was identified as PNC. The IJ began on 03/05/26 and ended on 03/13/26. The facility had corrected the non-compliance before the survey began.