STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675595	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2024

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 41057 Based on interview and record review, the facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week reviewed for RN coverage for 24 of 45 days reviewed for nursing services. (10/7/24, 10/9/24, 10/10/24, 10/11/24,10/14/24, 10/15/24, 10/21/24, 10/22/24, 10/23/24, 10/24/24, 10/25/24, 10/28/24, 10/29/24, 10/30/24, 10/31/24, 11/1/24, 11/2/24, 11/3/24, 10/19/24, 10/20/24, 11/9/24, 11/10/24, 11/16/24 and 11/17/24) The facility did not have 8 consecutive hours a day for 7 days a week of RN coverage for 24 days. This failure could place residents at risk of lack of nursing oversight and a higher level of care. Findings included: Record review of a Calculated Time by Entry form from 10/6/24 through 11/19/24 indicating RN hours worked indicated no RN hours for 10/7/24, 10/9/24, 10/10/24, 10/11/24,10/14/24, 10/15/24, 10/21/24, 10/22/24, 10/23/24, 10/24/24, 10/25/24, 10/28/24, 10/29/24, 10/30/24, 10/31/24, 11/1/24, 11/2/24, 11/3/24. The report indicated less than 8 hours a day worked on 10/19/24 - 4.90 hours, 10/20/24 - 5.18 hours, 11/9/24 - 4.97 hours, 11/10/24 - 5.43 hours, 11/16/24 - 6.1 hours and 11/17/24 6.35 hours. Record Review of the facility's Civil Rights form (3761) (Texas Health and Human Services form that list the facility staff to ensure the facility is not violating the Civil Rights of staff hired) dated 11/18/24 indicated the following: 4 RNs 22 LVNs 35 Direct Care Staff 12 Dietary 8 Housekeeping & Laundry 20 All Others (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: 675595	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2024

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Harmony Care at Beaumont	2660 Brickyard Rd Beaumont, TX 77703

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/19/24 at 12:00 p.m., the HR said the facility was missing RN hours for some time, and she was unsure exactly how many but would run a report . She said the facility was having trouble hiring a DON and RNs, and some of the RNs hired did not work a full 8 hours as required. The HR said the facility had a DON and a couple of new RNs currently. During an interview on 11/20/24 at 1:23 p.m., the DON said she was responsible for ensuring RN coverage 8 hours a day, and the Administrator was her backup to ensure the facility had 8 hours a day RN coverage. She said there was not enough staff to provide 8 hours of RN coverage before she started. She said the weekend RN was not working 8 consistent hours a day, as required. The DON said she was educated by the Regional Director of Clinical Operations to ensure 8 hours of RN coverage daily. She said the risk was not following the policy and could affect resident care. The DON said her expectation was 8 consecutive hours of RN coverage daily. During an interview on 11/20/24 at 1:35 p.m., the Administrator said she was responsible for RN coverage and the DON was the back up to ensure they had an RN working 8 hours a day. The Administrator said the DON started the first of November. She did not have a DON for a short time. She said the risk for residents of not having RN coverage 8 hours a day may affect resident care. The Administrator said her expectation was RN coverage at a minimum of 8 hours a day. Record review of an undated facility policy titled, Staffing coverage indicated, . A registered nurse (RN) must be onsite 8 consecutive hours a day, 7 days a week.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33460 Based on observation, interview, and record review, the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys for 1 (Resident #28) of 13 residents reviewed for pharmacy services. The facility failed to ensure Resident #28's nystatin powder (prescription powder treats fungus or yeast) was not left on her nightside table and within the eyesight of the nurse This failure could place residents at risk for medication overdose, medication under-dose, ineffective therapeutic outcomes, and drug diversion. Findings included: Record review of Resident #28's face sheet dated 11/20/24 indicated Resident #28 was admitted on [DATE] was [AGE] years old female with diagnoses of severe obesity and diabetes (too much sugar in the blood). Record review of Resident #28's MDS assessment dated [DATE] indicated Resident #28's cognition was intact and had diabetes. Review of Resident #28's physician orders dated November 2024 indicated Resident #28 had an order for Nystatin External Powder, Apply to abdominal folds topically every day and evening shift for yeast. Cleanse area with soap and water, pat dry, then apply Nystatin powder under abdominal folds twice daily, until resolved with start date of 07/16/24. Record review of the MDS dated [DATE] indicated Resident #28 was cognitively intact and had diabetes. During observation on 11/18/24 at 9:45 a.m., there was a 30-cc medicine cup with approximately 20 cc of white powder on the nightside table next to Resident #28's bed. During an interview on 11/18/24 at 9:55 a.m., Resident #28 said the powder was not her medication. She said she did not know who put it there or why it was there. During an interview on 11/18/24 at 10:00 a.m., ADON A said the white powder was nystatin powder and was used under the breast and skin folds. She said no medications/treatments should have been left in Resident #28's room or in any resident's' rooms. She said the nurses were responsible for medication/treatment items and should have been stored in the cart unless when were being used. During an interview on 11/20/24 at 1:30 p.m., the Administrator said her expectation was for the nurses not to leave medications or treatments at bedside. The medications should have been within the eyesight of the nurse. She said all of the staff should have reported medication left in resident rooms.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 30664 Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food under sanitary conditions in 1 of 1 preparation kitchen. The facility did not ensure baking sheets and baking pans did not have dark colored build up on the outside and inside. The facility did not ensure the foods labeled were disposed of after the use by date. The facility did not ensure foods removed from their original package were labeled with the required information of what the food was in the container and the use by date or date it was placed in the container. The facility did not ensure red bucket of sanitizing solution to clean surfaces in the kitchen had the right amount of cleaning solution. These failures could place residents who ate food from the kitchen at risk of foodborne illness. Findings included: During observation and interview on 11/18/24 of the kitchen on initial tour indicated: * at 08:22 a.m. there were -4 large baking sheets with dark colored buildup on the inside corners and all along the outside edges; they were stacked together -3 large baking pan with dark colored buildup on the inside corners and all along the outside edges; they were stacked together. -1 baking pan 9 x 13 with dark colored buildup on the inside corners and all along the outside edges. -2 large skillets dark colored buildup on the inside and outside. -9 half baking sheets with dark colored buildup on the inside corners and all along the outside edges; they were stacked together.The DM said she had been trying to get them replaced meanwhile she would scrub them. * at 08:30 a.m. the right walk-in cooler had a container of pureed food (it was hard to read what item was on the label) dated 11/09/24 and a container of what appeared to be fruit with no label. The DM said the food dated 08/09/24 should have been thrown out after 7 days and the other container should have a label with what was in the container and the date it was placed in the container. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* at 08:40 a.m. a red bucket of sanitizing solution to clean surfaces in the kitchen was checked and registered less than 50 ppm of chlorine indicating it had no solution. The DM noticed the chlorine solution container was not connected to the dispenser in the 3-compartment sink. The DM said the dispenser was used to fill up the red bucket and should be connected at all times. Record review of an undated Food Receiving and Storage policy indicated the following: Policy Interpretation and Implementation: 7. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date) Record review of a Sanitation policy revised 2008 indicated the following: Policy Interpretation and Implementation: 4. Sanitizing of environmental surfaces must be performed with one of the following solutions: a. 50-100 ppm chlorine solution; Record review of the 2022 Food Code dated 01/18/23 indicated the following: 3-602.11 Food Labels. (A) FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified in LAW, including 21 CFR 101 - Food labeling, and 9 CFR 317 Labeling, marking devices, and containers 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 41057 Based on interview and record review, the facility failed to electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS for 2 of 3 quarters reviewed for administration (Quarter 2 2024 (January 1-March 31), Quarter 3 2024 (April 1-June 30), Quarter 4 2023 (July1- September 30) 1. The facility failed to submit staffing information to CMS for FY Quarter 2 2024 (January 1-March 31); and 2. The facility failed to submit staffing information to CMS for FY Quarter 3 2024 (April 1-June 30). This failure could place residents at risk for personal needs not being identified and met, decreased quality of care, decline in health status, and decreased feelings of well-being within their living environment. Findings included: Record Review of the facility's Civil Rights form (3761) (Texas Health and Human Services form that list the facility staff to ensure the facility is not violating the Civil Rights of staff hired) dated 11/18/24 indicated the following: 4 RNs 22 LVNs 35 Direct Care Staff 12 Dietary 8 Housekeeping & Laundry 20 All Others Record Review of the CMS PBJ report for CMS for FY Quarter 2 2024 (January 1-March 31) indicated the facility failed to submit data for the Quarter. Record Review of the CMS PBJ report for CMS for FY Quarter 3 2024 (April 1-June 30) indicated the facility failed to submit data for the Quarter. (continued on next page)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/19/24 at 12:00 p.m., the HR said the Regional Director of Clinical Operations was responsible for submitting the PBJ report and before that another company was responsible for ensuring it was submitted. She said the staff clock in and out and the system automatically logged the times. She said she added the vendors times. The HR said the staff were educated to clock in and out as required. During an interview on 11/19/24 at 4:00 p.m., the Regional Director of Clinical Operations said their company hired a 3rd party company to do their payroll and submit the PBJ reports. She said they found out around last quarter, the company was not sending their PBJ report in and terminated the contract with the third-party company. She said the new Corporate HR was not aware to check and see if the PBJ was submitted at that time. The Director of Clinical Operations said she was the Coporate HR's back up. She said they were both recently educated to check to see if the PBJ report was submitted. The Regional Director of Clinical Operations said when she found out the PBJ reports were not sent in, she called CMS and tried to send in the next group, but it was past the deadline and would not be accepted past the deadline. The Regional Director of Clinical Operations said the risk of not submitting the PBJ report timely was the facility was not taking credit for the staff in the facility and could affect quality of care. During an interview on 11/20/24 at 1:23 p.m., the DON said she started working at the facility on November 4, 2024. She said the Regional Director of Clinical Operations was responsible for submitting the PBJ report with no back up. She said she was unsure why it was not submitted timely. The DON said the risk of not submitting the PBJ Report timely was not following PBJ policy . During an interview on 11/20/24 at 1:35 p.m., the Administrator said HR was responsible for sending the staffing documentation to corporate and the Director of Clinical Operations was responsible for reporting to CMS. She said the PBJ report was previously outsourced and not submitted timely. She said the risk of the PBJ report not submitted timely was not following PBJ policy. She said her expectation was for the PBJ report to be submitted timely. During an interview on 11/20/24 at 3:20 p.m., the Corporate HR said she was new to the position and started less than a year ago, but she was aware that the hours worked by the staff must be reported. She said she was unaware the PBJ report was not submitted timely and unaware she was supposed to check to ensure it was submitted. She said the Regional Director of Clinical Operations was responsible for submitting the PBJ report. She said she did not receive any education on checking to see if it was submitted. The Corporate HR said before the Regional Director of Clinical Operations, a third party was submitting the PBJ report for them. She said it was overlooked. The Corporate HR said the risk was not following PBJ policy . Record review of an undated policy, titled Reporting Direct-Care Staffing Information (Payroll-Based Journal) indicated, . Staffing and census information will be reported electronically to CMS through the Payroll-Based Journal system in compliance with 6106 of the Affordable Care Act. Policy Interpretation and Implementation: 9. Staffing information will be collected daily and reported for each fiscal quarter no later than 45 days after the end of the reporting quarter. Dates are as follows: 1 October 1 - December 31, February 14 (continued on next page)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2 January 1 - March 31, May 15 3 April 1 - June 30, August 14 4 July 1 - September 30, November 14

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30664 Based on observation, interview, and record review, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 1 stove, 1 of 2 walk-in coolers, 1 of 1 milk box in the kitchen; and 1 of 15 resident rooms on 1 of 2 Halls (long part of Hall 200) reviewed for essential equipment. * The facility failed to ensure the gas stove was in safe operating condition. Two burners on the back of the stove and 1 burner on the front of the stove would not ignite when the knobs were turned. The side of the griddle next to the burners had black buildup. * The facility failed to maintain the walk-in freezer. The walk-in freezer had a door gasket that was loose and hanging. * The facility failed to maintain the milk box. The milk box had a loose gasket with mildew on it. * The facility failed to ensure room [ROOM NUMBER]'s electric bed was in safe operating condition. The electrical cord plugged into the wall socket was spliced together. These failures could place the residents at risk of a fire and not having safe operating equipment. Findings included: 1. During observations and interviews on 11/18/24 during initial tour indicated the following: * at 08:15 a.m. the milk box gasket was loose and had mildew on it. The DM said they were supposed to be getting a new gasket. * at 08:18 a.m. of the stove, the rear left and right burners and the front right burner were not lighting when the knobs were turned on. The side of the griddle area next to the burners had a black buildup. The DM said she did not realize the burners were not lighting and the stove had been cleaned recently. * at 08:30 a.m. left walk-in freezer had the door gasket loose and hanging, icy frost on the clear flaps hanging over the door, and frozen liquid on the floor. The DM said she did not realize the gasket was that bad. During an observation and interview on 11/18/24 at 10:53 a.m. the MD was working on the stove burners. He was lighting the rear right burner with a wand type lighter. He said he was not sure why the burners were not lighting with the turning the knobs on. He said staff should not have to use a lighter to light burners as it could cause an explosion. He acknowledged the gaskets needed to be changed on the milk box and the walk-in freezer. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. During an observation on 11/20/24 at 11:45 a.m., room [ROOM NUMBER] was an occupied resident's room. On the floor bedside the electric bed was a black cord plugged into the wall socket and approximately 2 feet towards the bed was a white cord spliced into the black cord. Three wires of the white and black cords were cut and held together with twist type wire connectors. There was no tape or connection box covering the connectors of the wires to prevent access to the live wires. During an interview on 11/20/24 at 11:50 a.m., the Administrator said her expectation was for the electric beds to be in good working condition. She said a new cord should have been ordered. She said her staff had not reported this type of wire connection was in a resident ' s room or the need of a new wire for the electric bed. Record review of an undated Maintenance Service policy indicated .Policy Interpretation and Implementation: 1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times 33460

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33460 Based on observation, interview, and record review, the facility failed to provide a safe and sanitary environment for 1 of 2 Halls (Hall 200 long) and the dining room reviewed for physical environment. The facility failed to maintain the 200 long hall. Door frames of resident's rooms were not intact. Floor tiles were discolored tiles. There was a buildup of glue, paint, and debris behind all the doors to resident's rooms. The facility failed to maintain the exit corridor from the long hall 200 to the smoking area. There were 6 missing floor tiles that each measured 12 inch by 12 inch. The facility failed to maintain the main dining room floor. The tile in the main dining room along the back wall on the floor had a 2-inch-wide buildup of old paint and dried glue. There was one missing tile near the door. The facility failed to maintain an unlocked closet closet on the 200 long hall that was labeled oxygen on the door. The closet was empty and the walls were covered with black fuzzy substance in clusters on all walls and ceiling. The closet smelled like wet dirt. There was white substance in patches on the inside of the door. Spider webs with round sacs made of silk or web along both lower edge of the closet. The facility failed to maintain room [ROOM NUMBER]. room [ROOM NUMBER] had 6-inch base trim detached from the wall and on the floor between the beds for approximately 5 feet. The facility failed to maintain room [ROOM NUMBER]. room [ROOM NUMBER] had splashes of a beige substance measuring 2 feet by 3 feet on the ceiling and rips in the curtains covering the sliding door measuring 8 feet along the bottom of the curtains. These failures could place residents, staff and visitors at risk of being in unsafe, uncomfortable environment and decreased quality of life due to poor conditions of the facility. Findings included: During observations on 11/18/24 from 9:00 a.m. to 10:30 a.m., the following was observed: *The long hall 200 door frames of all resident rooms were missing paint and were not smooth the wood had missing pieces. The tile from the start of the hall to the end of the hall was discolored and had build-up of glue, paint. In the resident rooms had grime and debris behind all of the doors into the resident's rooms. *The exit corridor from the long hall 200 to the smoking area was missing 6 tiles (12 inch by 12 inch tiles) and left the area with discolored concrete in the areas of missing tiles. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*The tile in the main dining room along the back wall on the floor had 2-inch-wide buildup of old paint and dried glue. There was one missing tile near the door and the floor was approximately 2 inches lower. *There was an unlocked closet on the 200 long hall that was labeled oxygen on the door. The closet was empty and the walls were covered with black fuzzy substance in clusters on all walls and ceiling. The closet measured 3 feet by 5 feet and the closet smelled like wet dirt. There was white substance in patches on the inside of the door. There were spider webs with round sacs along both lower edges of the closet extended the full width of the closet. The inside of the door had white substance in patches/clusters covering the door. During an observation on 11/20/24 at 11:00 a.m., room [ROOM NUMBER] had 6-inch base trim that was detached from the wall and on the floor between the beds for approximately 5 feet. room [ROOM NUMBER] had splashes of beige substance on the ceiling in an area of 2 feet by 3 feet. The curtains covering the sliding door were ripped and torn all along the bottom of the approximately 8 feet of the drapes. During an interview on 11/18/24 at 10:45 a.m., the MD said he was responsible for the maintenance of the building. He said he never opened that closet and it would need to be painted and cleaned up. He said the closet should not be like that. He said the floors and door frames needed to be replaced and fixed and had not gotten to fix the other areas. During an interview on 11/20/24 at 11:00 a.m., the Administrator said the floors needed to be replaced and door frames repaired. She said the base trim needed to be reattached in several resident rooms and would be repaired. She denied any documented plans for remodel or repairs. She said the facility had replaced the curtains in most of the rooms. She said in room [ROOM NUMBER], the curtains would be replaced again and raised so the resident's wheelchair would not roll on the drapes and tear them. She said all the staff were responsible for the facility being comfortable and in good repair. She said she was responsible for the facility. Record review of an undated Maintenance Service policy indicated .Policy Interpretation and Implementation: 1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times