

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/03/2025
NAME OF PROVIDER OR SUPPLIER Harmony Care at Beaumont		STREET ADDRESS, CITY, STATE, ZIP CODE 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 observation, interview, and record review, the facility failed to protect the residents' right to be free from physical abuse for 1 of 19 residents reviewed for abuse. (Resident #39)The facility failed to ensure Resident #39 was free from physical abuse when on 11/30/25 CNA A slapped Resident #39 in the face. The noncompliance was identified as PNC. The IJ began on 11/30/25 and ended on 11/30/25. The facility corrected the noncompliance before the survey began. This failure could place residents at risk for emotional distress, fear, decreased quality of life, and further abuse. Findings included: Record review of a face sheet dated 12/01/25 indicated Resident #39 was an [AGE] year-old male admitted on [DATE]. His diagnoses included dementia (loss of cognitive functioning) and cerebral infarction (lack of adequate blood supply to brain cells that deprives them of oxygen and vital nutrients which can cause parts of the brain to die off). Record review of the quarterly MDS dated [DATE] indicated Resident #39 had adequate hearing, clear speech, usually understood others, usually made himself understood, had severely impaired cognition with a BIMS of 03 out of 15, and he had no behaviors. Record review of an Incident/Accident Report dated 11/30/25 indicated on 11/30/25 Resident #39 was sitting in bed yelling out and cursing. CNA A was in the room, extended her right hand out, and smacked the left side of Resident #39's face with her open hand. She then stepped back. Resident #39 stated you dirty m@\$%& f@\$%&! CNA A picked up the meal tray and stated, Don't talk to me like that, I am taking care of you! and exited the room. This was witnessed by LVN B. During an observation and interview on 12/01/25 at 08:40 a.m. Resident #39 was in bed. He was clean, neat, and had no lingering odors. There was no visible redness to the left side of his face. He asked surveyor What the f@\$% do you want? Surveyor explained who they were and purpose of visit. Resident #39 said Okay, now get the f@\$% out! During a phone interview on 12/01/25 at 02:42 p.m. LVN B said she was walking the hall when she saw into Resident #39's room. She said he had his arms up and CNA A put her right hand between his arms and slapped Resident #39 on the left side of his face with her open hand. LVN B said CNA A and Resident #39 exchanged words then CNA A picked up his dinner tray and left the room. She said CNA A then went to fill up the ice chest. She said while CNA A was filling up the ice chest, she contacted the DON and informed her of what she witnessed. She said the DON told her to tell CNA A to clock out, go home, and she would contact her. She said CNA A was a good staff member and she had no issues with her. She said she was shocked by CNA A's action towards Resident #39. During an interview on 12/01/25 at 02:58 p.m. the DON indicated she was contacted on 11/30/25 by LVN B regarding incident involving Resident #39 and CNA A. She said LVN B said she was watching CNA A while on the phone with her so CNA A was not entering resident rooms. She said she told LVN B to have CNA A clock out, go home, and she would contact her later. She said she arrived at the facility, assessments were conducted on residents assigned to CNA A. She said safe survey interviews were also conducted. She said ANE in-service was started. She said there had not been any conflicts reported between LVN B and CNA A. During an interview on 12/01/25 at 03:00 p.m. the Administrator said it was his first day at the facility. He said if a staff member was accused of abusing a resident they were to be removed from the situation and (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	ensure the resident was safe. He said the staff member would be sent home and there would be a report made to HHSC. He said an investigation would then be conducted with a written report completed and submitted to HHSC within 5 days. Several attempts were made to contact CNA A on 12/01/25 and 12/02/25 with no success and not able to leave a message. Record review of the Abuse and Neglect policy dated June 2023 indicated the following: Policy Statement: It is the policy of the facility to administer care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment. The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations. These guidelines include compliance with the seven (7) federal components of prevention and investigation. The administrator was notified of the IJ on 12/02/25 at 03:40 p.m. due to the above failures. The administrator was provided with the IJ template on 12/02/25 at 03:46 p.m. The surveyor confirmed the facility implemented sufficient interventions to remove the Immediate Jeopardy on (11/30/25) by:- Record review of an Employee Change of Status form dated 11/30/25 indicated CNA A was suspended on 11/30/25 pending investigation. - Record review of Skin Assessments indicated Resident #39 and other residents assigned to CNA A were assessed on 11/30/25.- Record review of safe survey questionnaires indicated residents assigned to CNA A were questioned on 11/30/25.- Record review of a facility conducted in-service, Abuse and neglect dated 11/30/25, indicated 21 of 74 facility staff were provided education on the topic.- Interviews with LVN B and LVN H (6a-2p and 2p-10p shifts); CNA D (central supply); CNA K and CNA M (2p-10p shift), CNA L (10p-6a and 6a-2p shifts), and MA J (7a-7p shift) indicated they had received an in-service on ANE on 11/30/25. The noncompliance was identified as PNC. The IJ began on 11/30/25 and ended on 11/30/25. The facility corrected the noncompliance before the survey began.		

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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. Based on interview and record review the facility failed to ensure they had an RN for 8 consecutive hours 7 days a week for 8 of 8 months reviewed for RN coverage. * The facility did not have RN coverage every day in April 2025, May 2025, June 2025, August 2025, September 2025, October 2025, and November 2025.* The facility did not have an RN for 8 consecutive hours every day in April 2025, May 2025, June 2025, July 2025, and August 2025. These failures could place residents at risk by leaving staff without supervisory coverage for RN specific nursing activities and for coordination of events such as emergency care and disasters. Findings included: During an interview on 12/02/25 at 10:16 a.m. the Administrator said on the Exel form of the RN hours the Raw Hours were potential hours to work and the Work Hours were the actual hours worked. He said he clarified if there were no hours under the Work Hours then the nurse did not work. During an interview on 12/03/25 at 01:56 p.m. HR said there were only 2 RNs employed at the facility-the DON and RN R. Record review of the RN time sheets for April 2025 indicated:* there was no RN coverage for 04/04 (FR), 04/11 (FR), 04/18 (FR), and 04/25 (FR); * RN R worked:-04/05 (SA) from 09:25 p.m. to 12 a.m.-2.5 hours-04/19 (SA) from 01:14 p.m. to 06:32 p.m.-4.75 hours-04/26 (SA) from 09:31 p.m. to 12 a.m.-2.5 hours The DON and no other RN worked on these days. Record review of the RN time sheets for May 2025 indicated:* there was no RN coverage for 05/02 (FR), 05/09 (FR), 05/10 (SA), 05/16 (FR), 05/23 (FR)* RN R worked:-05/03 (SA) from 08:42 a.m. to 02:32 p.m.-5.25 hours-05/03 (SA) from 09:31 p.m. to 12 a.m.-2.5 hours (not consecutive)-05/24 (SA) from 08:08 a.m. to 03:14 p.m.-6.5 hours-05/30 (FR) from 01:03 p.m. to 03:27 p.m.-2.5 hours-05/31 (SA) from 07:43 a.m. to 02:49 p.m.-6.5 hours* The DON worked:-05/30 (FR) for 3 hoursThe DON and no other RN worked on these days. Record review of the RN time sheets for June 2025 indicated:* there was no RN coverage for 06/14 (SA), 06/21 (SA), 06/27 (FR), and 06/28 (SA)* RN R worked:-06/06 (FR) from 07:26 a.m. to 12:23 p.m.-4.75hours-06/13 (FR) from 08:00 a.m. to 12:24 p.m.-4.5 hours -06/20 (FR) from 07:12 a.m. to 12:29 p.m.-4.75 hoursThe DON and no other RN worked on these days. Record review of the RN time sheets for July 2025 indicated:* there was no RN coverage for 07/03 (TH), 07/04 (FR), 07/05 (SA), 07/11 (FR), 07/19 (SA), and 07/25 (FR)* RN R worked:-07/12 (SA) from 08:15 p.m. to 02:41 p.m.-5.75 hours-07/18 (FR) from 09:43 p.m. to 12 a.m.-2.25 hours-07/19 (SA) from 12:01 a.m. to 06:01 a.m.-6 hoursThe DON and no other RN worked on these days. Record review of the RN time sheets for August 2025 indicated:* there was no RN coverage for 08/01 (FR), 08/08 (FR), 08/15 (FR), 08/17 (SA), 08/23 (SA), and 08/24 (SU)* RN R worked on -08/16 from 11:29 p.m. to 12 a.m.-0.5 hours-08/17 from 12:01 a.m. to 06:55 a.m.-7 hoursThe DON and no other RN worked on these days. Record review of the RN time sheets for September 2025 indicated there was no RN coverage for 09/01 (MO), 09/06 (SA), 09/07 (SU), 09/13 (SA), 09/14 (SU), 09/20 (SA), 09/21 (SU), 09/27 (SA), and 09/28 (SU).The DON, RN R, and no other RN worked on these days. Record review of the RN time sheets for October 2025 indicated there was no RN coverage for 10/04 (SA), 10/05 (SU), 10/11 (SA), 10/12 (SU), 10/18 (SA), and 10/19 (SU).The DON, RN R, and no other RN worked on these days. Record review of the RN time sheets for November 2025 indicated there was no RN coverage for 11/01 (SA), 11/02 (SU), 11/08 (SA), 11/09 (SU), 11/16 (SU), 11/22 (SA), 11/23 (SU) and 11/27 (TH).The DON, RN R, and no other RN worked on these days. During an interview on 12/03/25 at 02:05 p.m. the DON said there was only her and RN R as the RNs in the facility. She said she tried to cover as much of the RN hours as possible but just could not do it all. During an interview on 12/03/25 at 02:52 p.m. the Administrator said he noticed when he was provided the information on the RN coverage he saw there was an issue with the RN coverage. He said there should be an RN on duty 8 hours a day every day. Record review of a Departmental Supervision, Nursing policy revised August 2022 indicated: Policy Statement: The nursing services department shall be under the direct supervision of a registered or licensed practical/vocational nurse at all times.Policy Interpretation and Implementation:. 2. A registered nurse provides services at least (continued on next page)		

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	eight (8) consecutive hours every 24 hours, seven (7) days a week. RNs may be scheduled more than eight (8) hours depending on the acuity needs of the resident.		

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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. Based on interview and record review the facility failed to follow guidelines for mandatory submission of staffing information based on payroll data in a uniform format. The facility failed to submit direct care staffing information on the schedule specified by CMS (Centers for Medicare and Medicaid Services), but no less frequently than quarterly for 1 of 4 quarters reviewed for payroll data information. (Quarter 3 2025) *The facility failed to submit staffing information to CMS for the 3rd quarter of the fiscal year 2025. 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) dated 12/03/25 indicated the following:2 RNs 9 LVNs 20 Direct Care Staff9 Dietary8 Housekeeping & Laundry 6 All OthersRecord review of the CMS PBJ Staffing Data Report (payroll-based staffing), CASPER Report (Certification and Survey Provider Enhanced Report) 1705D FY Quarter 3 2025 (April 1- June 30), dated 11/25/2025, indicated the following entry: Failed to Submit Data for the Quarter Triggered .Triggered=No Data Submitted for the Quarter. During an interview on 12/02/25 at 09:22 a.m., HR said the corporate HR department was responsible for submission of the staffing data to CMS every quarter (every three months). A policy regarding the PBJ reporting was requested. During an interview on 12/03/25 at 01:50 p.m. the Administrator indicated he understood corporate handled the PBJ reports. The facility did not have a PBJ reporting policy.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 1 of 2 units (secure unit) and room [ROOM NUMBER] and room [ROOM NUMBER] reviewed for homelike environment. 1.The facility failed to provide home-like furniture in TV room and dining room area just with a table. 2.The facility failed to ensure the walls of room [ROOM NUMBER] and room [ROOM NUMBER] did not have scratches and areas of missing paint. 3.The facility failed to provide a clean and sanitary bathroom for room [ROOM NUMBER]. These failures placed the staff and visitors at risk of living and working in conditions of institution which can lead to decline of mental, social skills and increase of behaviors. Findings included: During an observation on 12/03/25 at 11:30 a.m. revealed a plain table with no placements or tablecloths. The table had no decorations. The dining room area / TV room had bare walls and was not homelike. The TV area had no furniture like chairs, end tables or couches. During observations on 12/03/25 at 11:45 a.m. revealed Resident room [ROOM NUMBER] and Resident room [ROOM NUMBER] had areas of missing paint by the beds and scratches on the sheet rock. During observations on 12/03/25 at 11:50 a.m., Resident room [ROOM NUMBER]'s shower had a missing grate over the shower drain leaving a 3-inch hole and both corners of the shower areas had spider's webs. The grout in the shower was discolored and was 2 inches thick and 3-4 inches wide along the base of the walls of the shower. During an interview on 12/03/25 at 2:00 p.m., CNA N said the secure unit needed some homelike furniture in the TV/ dining room. CNA N and CNA P both said the resident rooms need to be painted. CNA N said the unit needed to be homelike for the resident's mental happiness. They said they had not reported the secure unit for not being homelike because this was the way it had been. During an interview on 12/03/25 at 2:10 p.m., the maintenance supervisor said the walls needed repairs and paint. He said the grout would have to be removed and he would remove spider web. He said he was responsible for repairs and removing spiders. He said the residents needed homelike environment for comfort. During an interview on 12/03/25 at 2:15 p.m., the Administrator said the secure unit needed to be updated with paint and furniture. He said the residents deserved homelike environment with decorations and personal items. He said the facility had started with some painting and remodeling in the front of the building. Record review of the facility's Homelike Environment policy dated May 2017 indicated Residents are provided with a safe , clean, comfortable and homelike environment . The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include a. Clean, sanitary and orderly environment.Inviting colors and decor.		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review the facility failed to implement the written abuse policy that prohibit mistreatment, neglect, and abuse of residents, for 7 of 7 staff reviewed for abuse. (LVN A, LVN F, Former SW, CNA B, CNA G, CNA M, and CNA Q)The facility did not screen potential employees LVN A, LVN F, Former SW, CNA B, CNA G, CNA M, and CNA Q to include attempting to obtain information from previous employers and/or current employers.This failure could place residents at risk of abuse, physical harm, mental anguish, and emotional distress.Findings included:Record review of the Abuse and Neglect policy dated June 2023 indicated the following: Policy Statement: It is the policy of the facility to administer care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment. The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations. These guidelines include compliance with the seven (7) federal components of prevention and investigation.I. Screening (483.13 (c)(l)(ii)(A) & (B): Have procedures to: Screen potential employees for a history of abuse, neglect, exploitation, misappropriation of property, or mistreating residents This includes attempting to obtain information from previous employers and/or current employers and checking with the appropriate licensing boards and registries.Record review of employee files indicated the following had no documentation of information from previous employers and/or current employers:* LVN A, hire date 06/26/25;* LVN F, hire date 09/18/25;* Former SW, hire date, 07/10/25;* CNA B, hire date 06/11/25;* CNA G, hire date 11/12/25;* CNA M, hire date 09/11/25; and * CNA Q, hire date 10/16/25.During an interview on 12/02/25 at 10:25 a.m. HR said there was no documentation in the employee files where the previous/current employers were contacted. During an interview on 12/03/25 at 11:20 a.m. the Administrator said if there was no documentation in the employee files then there was no way to show the checks were done.		

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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. Based on observations, interviews, and record reviews, the facility failed to properly store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed. The facility failed to ensure food items in the dry pantry were labeled, dated, and sealed. This failure could place residents that eat out of the kitchen at risk for foodborne illnesses. Findings include: An observation of dry storage on 12/01/2025 at 8:10 AM indicated the following: *2 large plastic gallon zipper top bags each with an 5-pound, opened and used original container bag labeled cornbread and muffin mix with no use by date or open date, *1, 11-ounce box of vanilla wafers with bag ripped open in the original yellow Nilla wafer box. The tabs were opened, and the bag was not sealed, exposing the wafers to the elements, with no use by date or open date, *1, opened and used 12-ounce bag of Best Choice ribbon pasta not sealed and with no use by date or open date. During an interview on 12/01/2025 at 8:20 AM, the DM said she did not know when or who opened the muffin mix, wafers, or pasta and would discard them. The DM said all products should have a received date or used by date and should be sealed. She said packages of food items should be sealed so as not to expose food to the elements. The DM said it was the responsibility of all the dietary staff to ensure products were labeled and stored correctly. The DM said she was the person responsible for monitoring kitchen staff and ensuring products are labeled, sealed, and dated. She said she usually checked every Monday, but had not had a chance that day because of the survey. The DM said all kitchen staff completed the required food preparation and food storage training. The DM said the potential harm to residents would be food poisoning, rodents getting into stored food if not properly sealed, sickness, and bacteria on food. The DM said the failure occurred due to staff not paying attention. During an interview on 12/03/2025 at 3:20 PM, the Administrator said his expectation was for kitchen staff to follow policies on food storage, preparation, and that everything was dated. He said the DM was responsible for monitoring that kitchen staff were following the facility's policy. The Administrator said not storing and preparing food appropriately could cause residents to be given food beyond the expiration date and not the correct time frame. The Administrator said it could also affect the freshness and quality of residents' food. Record review of the facility's policy revised dated November 2022 titled, Food Receiving and Storage: .Dry Food Storage reflected .3. Dry foods and goods are handled and stored in a manner that maintains the integrity of the packaging until they are ready to use. 4. Dry foods that are stored in bins will be removed from original packing, labeled and dated (use by date). Record review of the Food and Drug Administration Food Code, dated 2022, reflected, . 3-201.11 Safe, Unadulterated, and Honestly Presented. Compliance with Food Law. FDA considers food in hermetically sealed containers that are swelled or leaking to be adulterated and actionable under the Federal Food, Drug, and Cosmetic Act .3-302.12 Food Storage Containers, Identified with Common Name of Food. Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food, or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food 3-305.11 Food Storage.(B) .refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety		

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. Based on interview and record review, the facility's governing body failed to operate and provide services in compliance with all applicable Federal, State and local laws, regulations, and codes for 1 of 1 facility reviewed for Social Worker (SW).The facility did not employ or contract a SW as required by state regulations. This failure could place residents at risk of administrative duties not being carried out attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Findings included:Record review of a employee list provided by the DON on 12/01/25 indicated there was no SW listed. During an interview on 12/01/25 at 01:15 p.m., the VPO said they did not have a SW working for the facility either contract or part-time. He said they had not had one for a couple of weeks. He said they were advertising for a SW but had no responses yet. During an interview on 12/01/25 at 01:21 p.m. HR said they did not have a SW currently. She said the previous one was terminated a couple of weeks ago. Record review of the employee file for the former SW indicated she was hired on 07/10/25. An Employee Change of Status form dated 11/18/25 indicated the former SW was terminated on 11/18/25.Record review of the Texas Administrative Code 554.703 (a)(2) indicated (2) A facility of 120 beds or less must employ or contract with a qualified social worker (or in lieu thereof, a social worker who is licensed by the Texas State Board of Social Worker Examiners, and who meets the requirements of subsection (b)(2) of this section) to provide social services a sufficient amount of time to meet the needs of the residents.		

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 12/03/2025
NAME OF PROVIDER OR SUPPLIER Harmony Care at Beaumont		STREET ADDRESS, CITY, STATE, ZIP CODE 2660 Brickyard Rd Beaumont, TX 77703	
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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to maintain essential equipment in safe operating condition for 1 or 1 facility kitchen. The walk-in freezer had excessive accumulation of ice build-up. This failure had the potential to affect residents by placing them at risk for food borne illness. Findings were: An observation of the walk-in freezer and interview on 12/01/25 at 9:00 a.m. revealed the temperature was -19. The walk-in freezer had excessive amounts of ice build-up on the top shelf, and around the electrical cord of the freezer fan was a large block of ice build-up appearing to be so heavy, the electrical cord was drooping. There was also ice accumulation on left side of the doorway wall entering the walk-in freezer. There were 30, 1-inch thick, 6-inches long icicles covering the upper left area of the wall. On the ceiling of the walk-in freezer were multiple frozen water drops. The DM said she had talked to the maintenance department about the freezer, but did not have any evidence that a requisition had been made for the repairs needed. During an interview with the DM on 12/01/25 at 9:20 a.m., she said she had been in the facility for 6 months, and was trying to get things done. She confirmed the condition of the freezer and the door of the freezer not properly closing causing icicles to form on the wall and ceiling. She said a couple of weeks ago, the freezer door would not seal and the MS had serviced the walk-in freezer by replacing the rubber seal along the bottom of the freezer. The DM said she did not have any evidence that a repair requisition was made for the freezer. The DM said the dietary department did not have their own log. The DM said she would notify the MS in the morning meeting of things that needed to be fixed. The DM said the risk to walk-in freezer having excess ice accumulation was it placed food at risk for contamination, freezer burn, and deterioration. During an interview on 12/03/25 at 2:00 p.m., the MS said he had been working for the facility for 6 months and the temperatures in the walk-in freezer were ok. The MS said he was not aware of the extent of repairs the kitchen needed. The MS said the DM had not made him aware of the condition of the walk-in freezer. He stated the walk-in freezer needed to be replaced, because it was old and he couldn't find or buy the part needed to fix the freezer. The MS said the only problem with the freezer was the staff did not close the door correctly, allowing ice to accumulate. The MS said he replaced the door seal himself recently about 1-2 weeks ago. He said he thought it was working properly until the beginning of today. The MS said ice accumulation in the walk-in freezer could cause collapse of the ceiling or wall from the ice build-up. During an interview on 12/03/25 at 3:22 p.m., the Administrator was made aware of walk-in freezer having excess ice accumulation. The Administrator said he had been working at the facility for one day. The Administrator said he expected the MS and DM to do spot checks periodically in kitchen to be sure everything was working in kitchen. The Administrator said ice build-up in the freezer could make the food become freezer burn. The Administrator said he would look into it and look for a policy regarding essential equipment. Record review of the maintenance log reflected no entry to service the walk-in freezer or replace the floor tiles under the stove. Review of the facility's policy Kitchen Maintenance dated 12/2009 indicated: Policy Statement: Kitchen equipment and storage areas must be kept clean, safe and in proper working condition to prevent accidents, contamination and fire hazards. 4. Equipment Care: staff must report any damaged, malfunctioning or unsafe kitchen equipment to maintenance. Equipment should be cleaned and serviced routinely as recommended by the manufacturer.		

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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. Based on observations, interviews, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for staff for 1 of 1 facility kitchen floor reviewed for environmental concerns. The floor under the back of the stove was missing 8-10 tiles. These failures could place staff at risk for exposure to an unclean, unsanitary environment, risk of falls and other injuries due to an unsafe environment. Findings were: An observation on 12/01/25 at 9:15 a.m. of the kitchen floor revealed the flooring under the back of the kitchen stove, had 8-10 floor tiles were missing. Around the edges, there was a build up of dirt and brown grime. During an interview with the DM on 12/01/25 at 9:20 a.m., she said she had been in the facility for 6 months, and was trying to get things done. She confirmed the condition of the floor missing tiles. The DM said the floor in the kitchen had been like that for several months. The DM said she did not have any evidence that a repair requisition was made for the floor. The DM said the dietary department did not have their own log. The DM said she would notify the MS in the morning meeting of things that needed to be fixed. During an interview on 12/03/25 at 2:00 p.m., the MS said he had been working for the facility for 6 months. The MS said he was not aware of the extent of repairs the kitchen needed. The MS said he was not aware the floor under the stove needed repairing and would replace the missing tiles. The MS said not having the tile on the floor could cause the stove to be uneven and cause an accident. During an interview on 12/03/25 at 3:22 p.m., the Administrator was made aware of missing tiles under the stove. The Administrator said he had been working at the facility for one day. The Administrator said he expected the MS and DM to do spot checks periodically in kitchen to be sure everything was working in kitchen. The Administrator said tiles missing on the floor was a safety hazard for the staff. The Administrator said he would look into it and look for a policy regarding essential equipment. Record review of the maintenance log reflected no entry to replace the floor tiles under the stove. Review of the facility's policy Kitchen Maintenance dated 12/2009 indicated: Policy Statement: Kitchen equipment and storage areas must be kept clean, safe and in proper working condition to prevent accidents, contamination and fire hazards. 4. Equipment Care: staff must report any damaged, malfunctioning or unsafe kitchen equipment to maintenance. Equipment should be cleaned and serviced routinely as recommended by the manufacturer.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all residents had the right to formulate an advance directive for 1 of 10 residents (Resident #9) reviewed for advanced directives. The facility failed to ensure Resident #9 who was listed as a DNR (Do Not Resuscitate) had valid Out-of-Hospital Do Not Resuscitate (OOH-DNR) form that was not missing required information. This failure could place residents at risk of not having their end-of-life wishes honored and incomplete records. Findings included: Record Review of Resident #9's face sheet, dated [DATE], indicated a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses that included: Major Depressive Disorder (a mental disorder characterized by pervasive low mood, low self-esteem, and loss of interest or pleasure in activities), and Schizoaffective disorder bipolar type [a serious mental illness combining symptoms of schizophrenia (hallucinations, delusions, disorganized thinking) with mood swings from bipolar disorder, specifically involving manic episodes (high energy, euphoria) and depressive episodes (low mood, hopelessness)], legal blindness and under the advance directive section was listed DNR-NO CPR. Record review of a quarterly MDS dated [DATE] indicated Resident #9 had minimal difficulty hearing, he had clear speech, he was able to make himself understood, he was able to understand others and he had severely impaired cognition with a BIMS score of 6 out of 15. Record Review of Resident #9's Care Plan dated [DATE] indicated: The resident request code status of: DNR., and interventions Make sure code status is signed and placed in clinical record. Record Review of Resident #9's physician order dated [DATE] indicated: communication method verbal, order status Active, orders placed for DNR - NO CPR. Record Review of Resident #9's OOH-DNR records dated [DATE] indicated: Under the section labeled, Directive by two physicians, next to each Physician's signature/printed name, a physician's license number was not listed and there was no date of when each Physician completed the DNR form. During an observation and interview on [DATE] at 10:28 a.m. Resident #9 was sitting up in his wheelchair in his room. He said he was doing fine. He said he did not want anyone to do CPR on him, he just wanted to pass-on peacefully. During an interview on [DATE] at 11:10 AM the ADON said Advance Directives were reviewed by the admitting nurse and social worker to ensure accuracy. The ADON said Advance Directives should be completed thoroughly. The ADON verified there were no additional advance directives for Resident #9. The ADON verified the current Advance Directives for Resident #9 was not completed, as it was missing both Physician's license number and missing the date the Physicians had signed the DNR Advance Directive. The ADON said it was important for Advance Directives to be completed thoroughly to ensure the documents were legally binding. The ADON said if an advance directive was not completed, the resident's wishes may not be honored. The ADON said she would ensure the advance directives for Resident #9 was updated as soon as possible. The ADON said that she had checked the other Residents with DNR Advance Directives, and they were complete. During an interview on [DATE] at 2:10 p.m. the DON said if a DNR form was not completed correctly with accurate dates and signatures, the DNR would be invalid. She said that in such a case, staff would be required to initiate CPR, which would go against the resident's expressed wishes. The DON said she believed it was the social worker's responsibility to ensure DNR forms were completed accurately and in accordance with requirements, and the social worker responsible at the time of Resident #9's admittance was no longer working for the facility. The DON said currently the facility did not have a social worker and that she would be responsible for making sure Advanced Directives were complete. The DON said hospice services obtained the DNR on Resident #9 and should have ensured it was complete but ultimately it was the facility's responsibility. The DON said the negative outcome would be the resident could have CPR performed on them against their wishes and she would check the other Residents with DNRs for completeness. During an interview on [DATE] at 3:00 PM, the Administrator (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said if a DNR form was not completed correctly with accurate dates and signatures, the DNR would be invalid. The Administrator said it was the social worker's responsibility to ensure DNR forms were completed accurately to include signatures and dates. The Administrator said the facility did not have a social worker. The Administrator said he had only worked for the facility one day before surveyors entered for survey. The Administrator said it was his expectation that advance directives would be completed properly and reviewed regularly. The Administrator said a resident's wishes may not have been followed if their advance directive was not completed. Record review of a Do Not Resuscitate Order policy revised [DATE] indicated: .2. A Do Not Resuscitate (DNR) order form must be completed and signed by the attending physician and resident (or resident's legal surrogate, as permitted by state law) and placed in the front of the resident's medical record.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure each resident drug regimen was free from unnecessary medications for 1 of 5 residents reviewed for unnecessary medications. (Resident #4)* The facility did not have appropriate diagnoses for Resident #4's Abilify (antipsychotic). * The facility did not have behavior monitoring for Resident#4's Lexapro (antidepressant). These failures could place residents at risk for unintended, harmful events attributed to the use of a medication without the appropriate monitoring or indication for use. Findings included: Record review of a face sheet dated 12/03/25 indicated Resident #4 was a [AGE] year-old male admitted on [DATE]. His diagnoses included paranoid schizophrenia (a mental disorder characterized variously by hallucinations, delusions, disorganized thinking and behavior, and flat or inappropriate affect with a strong belief that they are being persecuted, spied on, or conspired against by others), schizoaffective disorder (mental health condition with a combination of symptoms of schizophrenia and mood disorder), psychosis (a severe mental condition in which thoughts and emotions are so affected that contact is lost with external reality), hypertension (a condition in which the force of the blood against the artery walls is too high), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), and cirrhosis of the liver (a condition in which healthy tissue is replaced with scar tissue). Record review of a psychiatric hospital Discharge summary dated [DATE] had no indication of a diagnosis of depression or major depressive disorder. Resident was seen at the hospital for because he was had not taken his medications for 16 years and had been having increased hallucinations and paranoia. He was having bad thoughts about hurting himself and people were messing with him. Record review of the admission MDS dated [DATE] indicated Resident #4 was cognitively intact with a BIMS of 13 out of 15 and he had diagnoses psychotic disorder and schizophrenia. The diagnosis of depression was not checked. Record review of physician orders for December 2025 indicated Resident #4 had the following orders: * Abilify (aripiprazole) 5mg daily for depression; and * Lexapro (escitalopram) 10mg daily for major depressive disorder. There was no indication of an order for behavior monitoring for the Lexapro (escitalopram) or diagnoses of depression or major depressive disorder. During an observation and interview on 12/01/25 at 10:48 a.m. Resident #4 was in his room. He awake and alert. He said he was doing just fine and had no issues at the facility. He said he had not been taking his medications for years for his paranoid schizophrenia or psychosis and was having issues with hearing people and wanting to hurt himself. He said the hospital put him back on medication and he was doing better now. During an interview on 12/03/25 at 01:10 p.m. LVN E said there was no behavior monitoring for Resident #4's Lexapro. She said they should monitor for behaviors to determine if the medication was working properly or if an increase/decrease in dosage was needed. She said she was not aware of Resident #4 not having a diagnosis of depression or major depressive disorder. She said if psychotropic medications do not have the monitoring then they would not know which behaviors to watch for and document. During an interview on 12/03/25 at 01:30 p.m. the DON said she did not realize behavior monitoring was not ordered for Resident #4's Lexapro. She said all psychotropic medications should have monitoring for behaviors and side effects. She said she thought he had a diagnosis of depression. She acknowledged the psychiatric hospital discharge with no diagnosis of depression. She said if a resident received a medication and the wrong diagnosis was associated with it the adverse effect could be a GDR on a medication for a psychiatric condition that should not have a GDR done resulting in increased behaviors, hallucinations, and different types of aggression. During an interview on 12/03/25 at 01:35 p.m. the Administrator said he expected staff to review all records that come from the hospital with a resident for diagnoses. Record review of an Antipsychotic Medication Use revised June 2022 indicated the following: Policy Statement: Antipsychotic/psychotropic medications may be considered (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed. Policy Interpretation and Implementation: 1. Residents will only receive antipsychotic/psychotropic medications when necessary to treat specific conditions for which they are indicated and effective. 2. The attending physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received an accurate assessment, reflective of the resident's status for 1 of 16 residents reviewed for accuracy of assessments. (Resident #16) The facility did not accurately complete the MDS assessment to indicate Resident #16 used tobacco. This failure could place the residents at risk of not receiving the appropriate care and services to maintain their highest level of well-being. Findings included: Record review of a face sheet dated 12/03/25 indicated Resident #16 was a [AGE] year-old male admitted on [DATE]. His diagnoses included hypertension (a condition in which the force of the blood against the artery walls is too high), major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), cerebral infarction (lack of adequate blood supply to brain cells deprives them of oxygen and vital nutrients which can cause parts of the brain to die off), and myocardial infarction (blood flow decreases or stops in one of the blood vessels of the heart causing tissue death). Record review of a Smoker List provided by the DON on 12/01/25 indicated Resident #16 was listed as a smoker. Record review of a Safe Smoking Evaluation dated 11/19/25 indicated Resident #16 used tobacco. Record review of a Smoking assessment dated [DATE] indicated Resident #16 smoked 2-5 times a day, he smoked in the afternoon, he could light his own cigarette, and he required supervision while smoking. Form was signed by the AD. Record review of the admission MDS dated [DATE] indicated Resident #16 had minimal difficulty hearing, he wore a hearing aide, his speech was clear, he could make himself understood, he understood others, he was cognitively intact with a BIMS of 15 out of 15, and current tobacco use was marked no. During an observation and interview on 12/01/25 at 10:46 a.m. Resident #16 was in his room. He was sitting up in his wheelchair. He said he had smoked for many years. He said he was told the smoking times and where he could go smoke. During an interview on 12/03/25 at 11:15 a.m. the AD said she would do some of the smoking assessments. She said Resident #16 was a smoker. During a phone interview on 12/03/25 at 01:02 p.m. the MDS Nurse indicated she reviewed a resident's chart to obtain information as well as speak with staff members to obtain information. She said she must have missed the Smoking Assessment and Safe Smoking Evaluation on Resident #16 showing he was a smoker. She said inaccuracy of the MDS could leave residents not provided the care they need. She said she followed the MDS RAI manual for the MDS. During an interview on 12/03/25 at 01:30 p.m. the DON said she would only check the MDS for completion because she expected staff responsible for them would ensure the information was correct when they put it on the MDS. During an interview on 12/03/25 at 01:35 p.m. the Administrator said he expected staff to be professional and complete information for the clinical record to accurately reflect the residents' needs. Surveyor requested from the Administrator an MDS policy. An MDS Assessment Coordinator job description was received on 12/03/25 instead of an MDS policy.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **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 baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality of care for 1 of 3 residents (Resident #16) reviewed for new admissions. The facility did not accurately complete a baseline care plan within 48 hours of admission for Resident #16 to address his smoking. This failure could lead to residents not receiving necessary care and decreased quality of life. Findings included: Record review of a face sheet dated 12/03/25 indicated Resident #16 was a [AGE] year-old male admitted on [DATE]. His diagnoses included hypertension (a condition in which the force of the blood against the artery walls is too high), major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), cerebral infarction (lack of adequate blood supply to brain cells deprives them of oxygen and vital nutrients which can cause parts of the brain to die off), and myocardial infarction (blood flow decreases or stops in one of the blood vessels of the heart causing tissue death). Record review of a Smoker List provided by the DON on 12/01/25 indicated Resident #16 was listed as a smoker. Record review of a Safe Smoking Evaluation dated 11/19/25 indicated Resident #16 used tobacco. Record review of a Smoking assessment dated [DATE] indicated Resident #16 smoked 2-5 times a day, he smoked in the afternoon, he could light his own cigarette, and he required supervision while smoking. Form was signed by the AD. Record review of the admission MDS dated [DATE] indicated Resident #16 had minimal difficulty hearing, he wore a hearing aide, his speech was clear, he could make himself understood, he understood others, he was cognitively intact with a BIMS score of 15 out of 15, and current tobacco use was marked no. Record review of a Baseline Care Plan dated 11/19/25 indicated Resident #16 was marked no for smoker. The form was completed by LVN E. During an observation and interview on 12/01/25 at 10:46 a.m. Resident #16 was in his room. He said he had smoked for many years. He said he was told the smoking times and where he could go smoke. During an interview on 12/03/25 at 11:05 a.m. the AD said she would do some of the smoking assessments. She said Resident #16 was a smoker. During an interview on 12/03/25 at 11:15 a.m. LVN E said she did not realize she had marked no on Resident #16's BCLP. She said he might not have answered he was a smoker on admission. During an interview on 12/03/25 at 01:30 p.m. the DON said she was responsible for all the care plans. She said the admission nurse usually filled out the BCLP when the residents were admitted. She said Resident #16 was a smoker. During an interview on 12/03/25 at 01:35 p.m. the Administrator said he expected staff to be professional and complete information for the clinical record to accurately reflect the residents' needs. Record review of a Care Plans-Baseline policy revised March 2022 indicated: Policy Statement A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission. Policy Interpretation and Implementation 1. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to the following: a. Initial goals based on admission orders and discussion with the resident/representative; b. Physician orders; c. Dietary orders; d. Therapy services; e. Social services; and f. PASARR recommendation, if applicable. 2. The baseline care plan is used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered comprehensive care plan (no later than 21 days after admission). The baseline care plan is updated as needed to meet the resident's needs until the comprehensive care plan is developed.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 16 residents (Resident #4) reviewed for care plans. The facility failed to ensure that Resident #4's care plan addressed his psychiatric diagnoses or his psychotropic medications. This failure could place residents at risk of not receiving appropriate interventions to meet their current needs. Findings included: Record review of a face sheet dated 12/03/25 indicated Resident #4 was a [AGE] year-old male admitted on [DATE]. His diagnoses included paranoid schizophrenia (a mental disorder characterized variously by hallucinations, delusions, disorganized thinking and behavior, and flat or inappropriate affect with a strong belief that they are being persecuted, spied on, or conspired against by others), schizoaffective disorder (mental health condition with a combination of symptoms of schizophrenia and mood disorder), psychosis (a severe mental condition in which thoughts and emotions are so affected that contact is lost with external reality), hypertension (a condition in which the force of the blood against the artery walls is too high), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), and cirrhosis of the liver (a condition in which healthy tissue is replaced with scar tissue). Record review of a psychiatric hospital Discharge summary dated [DATE] indicated Resident #4 had psychiatric diagnoses of paranoid schizophrenia, schizoaffective disorder, and psychosis. Record review of physician orders for December 2025 indicated Resident #4 had the following: * Diagnoses-paranoid schizophrenia, schizoaffective disorder, and psychosis. * Medications-Abilify (aripiprazole) antipsychotic 5mg daily and Lexapro (escitalopram) antidepressant 10mg daily. Record review of the admission MDS dated [DATE] indicated Resident #4 had diagnoses of psychotic disorder and schizophrenia. He also received antipsychotic and antidepressant medications. Record review of the care plan dated 11/17/25 for Resident #16 had no indication the following were addressed: * Diagnoses-paranoid schizophrenia, schizoaffective disorder, and psychosis. * Medications-Abilify (aripiprazole) antipsychotic 5mg daily and Lexapro (escitalopram) antidepressant 10mg daily. During an observation and interview on 12/01/25 at 10:48 a.m. Resident #4 was in his room. He awake and alert. He said he was doing just fine and had no issues at the facility. He said he had not been taking his medications for years for his paranoid schizophrenia or psychosis and was having issues with hearing people and wanting to hurt himself. He said the hospital put him back on medication and he was doing better now. During an interview on 12/03/25 at 01:30 p.m. the DON said she was responsible for all the care plans. She said Resident #4's diagnoses and medications were missed. During an interview on 12/03/25 at 01:35 p.m. the Administrator said he expected staff to be professional and complete information for the clinical record to accurately reflect the residents' needs. Record review of a Care Plan-Comprehensive Person-Centered policy revised March 2022 indicated the following: Policy Statement A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation: 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: (1) services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; (2) any specialized services to be provided as a result of PASARR recommendations; and (3) which professional services are responsible for each element of (continued on next page)		

Department of Health & Human Services
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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 12/03/2025
NAME OF PROVIDER OR SUPPLIER Harmony Care at Beaumont		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care;c. includes the resident's stated goals upon admission and desired outcomes;d. builds on the resident's strengths; ande. reflects currently recognized standards of practice for problem areas and conditions.		

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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. Based on observation, interview, and record review, the facility failed to ensure in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for 1 of 1 treatment carts (treatment cart) of 1 of 3 medication carts (200 Hall cart) reviewed for medication storage. - The facility failed to ensure the medication treatment cart was locked when left unsecured and unsupervised at the main nurse station. - The facility failed to ensure Hall 200 Nurse Cart was locked when left unsecured and unsupervised at the main nurse station. These failures could place residents at risk of adverse reactions to medications, misappropriation of medications and not receiving therapeutic effects of medication. Findings include: During an observation and interview on 12/01/25 at 09:15 a.m., the treatment cart was noted to be unsecured and unsupervised at the main nurse station. Located inside the unlocked medication treatment cart was the following items labeled as keep out of reach of children: -AmLactin cream -a cream applied to the skin to remove dead skin. -Ketoconazole shampoo 2% for prescription use as antifungal medicated shampoo.-Nystatin Cream - a prescription used to treat skin infections.-Container of bleach wipes used to sanitize tables and carts. During an interview on 12/01/25 at 9:30 a.m., LVN E said the open cart was the treatment cart and the treatment nurse was not on duty. LVN E stated I guess all of the nurses should had ensured the treatment cart was kept locked. She said she had been trained in keeping carts locked to prevent residents and visitors from being able to assess treatment not prescribed for them, and safety concerns. During an observation on 12/02/25 at 2:00 p.m., an unlocked medication cart was near the nurse's station and contained cards of prescription medications for high blood pressure, seizures, and heart medications. The cart contained bottles of over-the-counter medications vitamins, stool softeners and natural tears. During an interview on 12/02/25 at 2:15 p.m., LVN C said the medication cart belonged to her and should have been locked. She said to prevent residents and visitors from taking medications which do not belong to them. During an interview on 12/03/25 at 8:24 a.m., the Administrator said his expectation was for medication carts and the treatment cart to be locked when not in use or within eyesight of the nurse responsible for the cart. He said locking carts was the policy and to prevent accidents. During an interview on 12/03/25 at 11:30 a.m., the DON said licensed nursing staff performed the treatments to the residents they oversaw, when the treatment nurse was not at the facility. She said medication and treatment carts should be kept locked and always secured when not in use, for safety purposes. The DON said the risk of treatment cart being left unlocked and unsupervised would be that any resident, staff, or visitor could open the drawers while passing by and retrieve harmful items including any treatment medications. Record review of the facility's Pharmacy policy dated August 2021 indicated . 15. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide.		

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NAME OF PROVIDER OR SUPPLIER Harmony Care at Beaumont		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, interviews, and record reviews the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections during medication pass for 1 of 4 medication carts (Hall 200 medication cart) reviewed for infection control. The facility failed to ensure the Hall 200 medication cart was clean and free of spills and buildup of grime. This failure could place residents at risk for medications being stored in unsanitary cart and infections. Findings included: During an observation and interview on 12/02/25 at 10:20 a.m., medication cart for the long Hall 200 had a buildup of black substance on inside of the second drawer where medications were kept in the drawer. The lower drawer contained bottles of liquid medications that had spills of liquid medications on the bottles and labels. The bottom of the drawer had a sticky substance. LVN C said the cart needed to be cleaned and spills could make labels unreadable. During an interview on 12/03/25 at 1:10 p.m., the DON said the medication carts should be kept clean and if medication was spilled the nurses were to clean up spills immediately. She said all nurses are responsible to keep the medication cart sanitary and prevent infections. Record review of the Pharmacy Services for Nursing Facilities indicated .Medication storage areas are kept clean, well-lit, and free of clutter and extreme temperatures and humidity.		

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to follow their own established smoking policy for 1 (Residents #30) of 2 residents reviewed for smoking. The facility failed, on 12/03/25, to ensure that Resident #30 did not keep his personal cigarettes and lighter in his possession and was attempting to smoke unsupervised. This failure could place residents at risk of an unsafe smoking environment and injury. Findings included: Record review of Resident #30's comprehensive MDS assessment dated [DATE] indicated a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses that included high blood pressure, and seizure disorder. Resident #30's BIMS score was 05, indicating his cognition was severely impaired. Record review of Resident #30's care plan dated 05/09/25 indicated he was a tobacco smoker and was at risk for injury. The interventions included to keep his smoking material at the nurses' station and observe, as needed, when smoking to assure resident's safety. Record review of Resident #30's safe smoking assessment dated [DATE] indicated he was to smoke with supervision, and the facility would keep his cigarettes and lighters, so he would be safe. Record review of the facility's Smoking Residents list dated 11/25/25, identified Resident #30 as a smoker. During an interview and observation on 12/03/25 at 12:30 p.m., Resident #30 was walking down the sidewalk towards the smoking area. He said he was going to smoke as he walked by this surveyor, and he had a lighter in his right hand, and his cigarette was hanging in his lips. He lifted the lighter towards the cigarette. There were no staff outside to supervise Resident #30. During an interview on 12/03/25 at 12:35 p.m., CNA D said the residents only smoked at certain times with supervision at the facility. She said the policy indicated smoking with supervision only, and all cigarettes and lighters were kept locked up. She was unaware Resident #30 was outside and was smoking and she immediately went to supervise Resident #30. She said she would report his unsupervised smoking to the DON and the Administrator. During an interview on 12/03/25 at 1:00 p.m., the DON said residents' smoking materials (lighters and cigarettes) were to be kept at nurse's stations. She stated that residents should not keep cigarettes and lighters when not supervised. A negative outcome of residents keeping their smoking materials could have been residents smoking when they were not supposed to and for safety reasons. The DON said the residents needed to follow the smoking policy. She said CNA D had reported Resident #30 smoked unsupervised. Review of the facility's policy Smoking Policy-Residents dated August 2025 indicated, This facility shall establish and maintain safe resident smoking practices. This facility has established and maintains safe resident smoking practices. Prior to, and upon admission, residents are informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences. Resident smoking status is evaluated upon admission. and ability to smoke safely with or without supervision (per a complete Safe Smoking Evaluation). The staff consults with the attending physician and the director of nursing services (DNS) to determine if safety restrictions need to be placed on a resident's smoking privileges based on the Safe Smoking Evaluation.		