STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675700	A. Building B. Wing	09/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Care at Brookshire	710 Hwy 359 S Brookshire, TX 77423

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. (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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on interviews and record review, the facility failed to ensure effective administration to maintain the highest practicable well-being of each resident. The facility operated without an administrator from 08/20/25 to 09/13/25, in the 1 of 1 facility reviewed for administration.Record review of personnel records revealed the Former Administrator was terminated on 08/19/2025, there was no record of a licensed interim or permanent replacement appointed from the period of 08/20/2025 - 09/13/2025. During an interview on 09/13/2025 @ 10:30am with the nurse supervisor, she stated that the facility had not had a facility administrator, since 08/2025. She stated that DON, who was not a state-licensed nursing home administrator, was informally made responsible for the Administrator's tasks. During interview on 09/13/2025 @ 1:00pm with DON, stated that the prior facility administrator was terminated 08/19/2025. She stated she was not aware if Human Resources staff had documentation of a designated full-time acting Administrator since the prior Administrator was terminated. She stated that she was informed the facility had a thirty-day window period to hire an Administrator; and a new Administrator was expected to start at the facility on 09/ 29/ 2025. She stated that administrative duties were reassigned informally among the facility department heads. She stated the VP of Operations holds a state administrator license and had been in contact with the department heads. Attempted telephone interview on 09/13/2025 @ 1:45pm with Human Resources Staff was unsuccessful; voicemail requested a return follow up call. During telephone interview on 09/13/2025 @ 2:35pm with the facility's VP of Operations, he stated that the Former Administrator was terminated on 08/19/2025. He stated the facility had no full-time, state-licensed nursing home Administrator on staff since the Former Administrator was terminated. He stated that the facility had a thirty-day window to hire an Administrator; and a new licensed administrator was hired and expected to assume Administrator role and duties on 09/ 29/ 2025. He stated the facility department's heads were provided with his contact information. He stated that he holds a state administrator license and had last visited the facility on 08/19/2025. He stated nursing leadership (DON and department heads) had been in regular communication with him via a group text message created. He stated the DON and department heads were not licensed administrators. During interviews on 09/13/2025 at various times, staff (CNA S, CNA O, CNA T, Nurse A, Nurse J, Nurse I) stated that the facility had not had a facility administrator, since 08/2025 and they were not aware of a designated acting Administrator responsible for carrying out administrative duties. Staff interviews confirmed that several administrative duties had been reassigned informally to the facility's DON. The staff stated that the DON was the person they report to for administrative issues that presented since the Former Administrator left the facility.During interviews on 09/13/2025 at various times, residents (1, #2, #3, #4 and #5) stated that they did not know who the Administrator was since the Former Administrator left. Residents reported no immediate safety concerns. All residents interviewed stated they would report any concerns to the facility DON. The signed Administrator's job description was requested from the facility's VP of Operations on 09/13/2025 at various times (2:35pm, 3:30pm, 5:34pm) via telephone call and (5:06pm and 6:00pm) via email request. The facility failed to provide the requested document. The facility provided Policy, titled Administrator, revised March 2021, indicated in part:Policy Statement: A licensed Administrator is responsible for the day-to-day functions of the facility.Policy Interpretation and Implementation: (g). ensuring that an adequate number of personnel are employed to meet resident needs. (i). maintaining his/her license on a status as required by law and maintaining a copy of such license or registration on premises. (d). implementing established resident care policies, personnel policies, safety and security policies, and other operational policies and procedures necessary to remain in compliance with current laws, regulations, and guidelines governing long-term care facilities.

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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 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on observation, interviews, and record review, the facility failed to ensure that all staff were trained in the procedures for reporting abuse, neglect, exploitation, or misappropriation of resident property for 6 of 6 facility employees reviewed for training. The facility failed to provide training on the identity of the Abuse Coordinator and the procedures for reporting abuse. This deficient practice has the potential to affect all residents by placing them at risk for unrecognized or unreported abuse due to staff being unaware of who to report to and how to initiate the facility's abuse reporting process. Observation 09/13/2025 @ 2:40pm, during the onsite visit, revealed the facility had not update the signage and posting of the facility's Abuse Coordinator. The posting reflected the Former Abuse Coordinator, who was terminated on 08/19/2025, contact information.During interview on 09/13/2025 @ 1:00pm with DON, stated that the Former Abuse Coordinator was terminated 08/19/2025. She stated the in - service was usually provided by the administrator. She stated the facility failed to provide training on the identity of the Abuse Coordinator and the procedures for reporting abuse. She stated that signage and posting had not been updated but would be updated following the interview. She stated failure to updated and train staff of the Abuse Coordinator could have potentially affected the residents by placing them at risk for unreported abuse. During telephone interview on 09/13/2025 @ 2:35pm with the facility's VP of Operations, he stated that the prior facility Administrator/ Abuse Coordinator was terminated on 08/19/2025. He stated the facility had no full-time Abuse Coordinator since 08/19/2025. He stated the facility was responsible and had not provided training on the identity of the Abuse Coordinator and the procedures for reporting abuse. He stated he would be the identified facility Abuse Coordinator; staff would be informed and trained regarding the process and who to contact. He stated the signage and posting with updated Abuse Coordinator's contact would be updated following the interview.During staff interviews on 09/13/2025, 6 out of 6 direct care staff members (CNA S, CNA O, CNA T, Nurse A, Nurse J, Nurse I) were unable to identify the facility's designated Abuse Coordinator. Staff stated they had not received recent or updated in-service training on abuse reporting protocols or on the identity of the person responsible for handling abuse allegations.The training records or sign-in sheets showing that Abuse Coordinator training had been conducted within the last 30 days, were requested from the facility's VP of Operations on 09/13/2025 at various times (2:35pm, 3:30pm, 5:34pm). The facility failed to provide the requested documentation.