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	03/04/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 2 (Resident #1 and Resident #2) out of 7 residents observed for resident rights. LVN B failed to sit at eye level when feeding Resident #1 their lunch in the dining room, LVN B stood while feeding Resident #1.CNA A failed to sit at eye level when feeding Resident #2 their lunch in the dining room. CNA A stood while feeding Resident #2. This failure could place residents at risk for choking and compromising their dignity and respect. Findings: Resident #1 Record review of Resident #1's face sheet dated 03/04/26 revealed an [AGE] year-old female admitted to the facility on [DATE] and again on 08/22/24. Resident #1's diagnoses included the following: dementia (a decline in memory, thinking, behavior, and daily functioning), dysphagia (difficulty swallowing) following cerebrovascular (decrease in blood flow to the brain) disease, epilepsy (seizures), Parkinson's disease (impaired movement issues) without dyskinesia (involuntary uncontrollable body movement), and depression.Record review of Resident #1's quarterly MDS dated [DATE] reflected a BIMS score of 5 indicating that Resident #1's cognition was severely impaired. Section GG-Functional Abilities revealed that Resident #1 was dependent on staff for eating.Record review of Resident #1's Physician Order Summary Report for the month of February 2026 included the following order:-Dated 03/07/23 Regular diet mechanical soft texture, thin consistency, double portions with all meals for weight maintenance and wound healing. Record review of Resident #1's Comprehensive Care Plan revised 12/15/25 revealed that resident was being care planned for nutritional problem risk for malnutrition r/t receiving mechanically altered diet with divided plate all meals, requires assist with eating. An intervention included monitor/document /report PRN any s/sx of dysphagia: pocketing food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals. Resident #2 Record review of Resident #2's face sheet dated 03/04/26 revealed a [AGE] year-old male admitted to the facility on [DATE]. Resident #2's diagnoses consisted of the following: cerebral infarction (when blood flow to the brain is blocked or reduced), gastro-esophageal reflux disease without esophagitis (when someone experience heartburn without visible damage to the esophagus {a muscular tube that serves as the route for transporting food and liquids from the throat to the stomach}, epigastric pain (discomfort beneath the ribcage and above the navel), lack of coordination, and dysphagia (difficulty swallowing). Record review of Resident #2's quarterly MDS dated [DATE] reflected a BIMS score of 8 indicating that Resident #2's cognition was moderately impaired. Section GG-Functional Abilities revealed that Resident #2 required setup or clean-up assistance with eating. Record review of Resident #2's Comprehensive Care Plan revised 03/02/26 reflected resident being care planned for ADL self-care performance deficit r/t fatigue, impaired balance. An intervention reflected that Resident #2 was independent with eating. Record review of Resident #2's Physician Order Summary Report for the month of February 2026 included the following order:-Dated 04/04/25 Regular diet pureed texture (food that is blended to a smooth, pudding-like texture), regular/thin liquids consistency. Observation (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on 03/04/26 at 12:36PM of Resident #1 sitting in the dining room in wheelchair at the dining table. Further observation was made of LVN B standing on Resident #1's left side feeding resident their lunch (mechanical soft diet) that consisted of green beans, chopped ground beef, mashed potatoes, and a slice of cake for dessert. Observation on 03/04/26 at 12:40PM of Resident #2 sitting in wheelchair in the dining room at the dining room table with lunch (food was pureed) plate in front of him. CNA A came to the dining room to assist Resident #2 with setting up his food. CNA A began to feed Resident #2 standing on resident right side. At 12:45 PM CNA A left Resident #2's side leaving the dining room. While CNA A was gone, Resident #2 began to open his cup of ice cream and began to feed himself. At 12:47PM CNA A returned to the dining room and began to feed Resident #2 again standing on Resident #2's right side. At 12:48PM CNA C instructed CNA A to get a chair, sit down, and feed Resident #2. CNA A then got a chair and did what CNA C asked him to do. Interview on 03/04/26 at 12:50PM CNA C said she was taught in CNA school to never stand while feeding a resident but to sit at eye level when feeding a resident. CNA C this was done to not make the resident feel threaten and to respect the resident. Interview on 03/04/26 at 12:53PM with LVN B said he had been working at the facility for a little over 2 months on the morning shift. LVN B said he had been a nurse since 2018. LVN B said when feeding a resident one should not stand to feed the resident instead, one should get a chair and sit while feeding the resident. LVN B said it really did not matter if he stood or sat while feeding a resident and that it was a matter of preference. LVN B said he had received in-service on Resident Rights. LVN B said the more he thought about it if someone was standing while feeding him, he would not like it because he would feel disrespected. Interview on 03/04/26 at 1:08PM with CNA A said he had been instructed while feeding a resident, he should always sit instead of standing to make eye contact with the resident and to allow the resident to feel comfortable. CNA A said when he entered the dining room to assist with feeding Resident #2, he saw LVN B standing while feeding Resident #1 therefore he stood. CNA A said he did not want LVN B to look bad. Interview on 03/04/26 at 1:13PM with ADON said he had been working at the facility since 2025 as the ADON. The ADON said when staff were assisting residents with feeding, they were supposed to sit at eye level with the resident. The ADON said this was done to assess if resident was swallowing correctly without signs or symptoms of choking to ensure the resident was tolerating the ordered diet. The ADON said staff should not stand when feeding a resident because it was disrespectful to the resident. The ADON said he would not like it if someone was standing while feeding him. Interview on 03/04/26 at 1:22PM with the DON said she had been working at the facility for a year. The DON said staff should not be standing while feeding a resident but sitting. The DON said this was done to preserve the resident's dignity and also a matter of respect. Interview on 03/04/26 at 1:43PM with Resident #2 in his room. Resident #2 was alert to name and knew that he was residing in a Nursing facility. Resident #2 said he did not like when staff stood when feeding his meal. Resident #2 said it made him feel bad and that he did not want to elaborate on it any further. Attempted interview on 03/04/26 at 1:50PM with Resident #1. Resident #1 was not interview able. Record review of the facility policy on Assistance with Meals revised March of 2022 reflected in part: .Residents shall receive assistance with meals in a manner that meets the individual needs of each resident.Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity, for example: not standing over residents while assisting them with meals. Record review of the facility policy on Resident Rights revised January of 2026 reflected in part: .Employees shall treat all residents with kindness, respect, and dignity recognizing each resident's individuality.