STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675769	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Care at Stamford	1003 Columbia Stamford, TX 79553

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44558 45216 Based on interview and record review, the facility failed to develop and implement a person-centered, comprehensive care plan for each resident, consistent with resident rights, that included measurable objectives and timeframes to meet residents medical, nursing, mental and psychosocial needs that were identified in the comprehensive assessment for 5 (Resident #1, Resident #4, Resident #8, Resident #14, and Resident #24) of 5 residents reviewed for care plans. The facility failed to ensure care plans specified measurable objectives that could be evaluated or quantified for Resident #1, Resident #4, Resident #8, Resident #14, and Resident #24. This failure could place residents at risk for not receiving care and services individualized to meet their specific physical, mental, and/or emotional needs. Findings included: Review of Resident #1's face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with medical diagnoses of malnutrition (lack of proper nutrition), traumatic brain injury, major depression, high blood pressure, osteoarthritis, schizoaffective disorder (mental health disorder that is a combination of schizophrenia symptoms like hallucinations, and mood disorder symptoms like depression or mania), weakness, psychotic disorder (collection of symptoms that affect the mind, where there has been some loss of contact with reality), and anxiety. Review of Resident #1's Medicare 5-day MDS dated [DATE], revealed in Section C - Cognitive Patterns C0500. BIMS Summary Score, Resident #1 scored 6 out of 15 indicating severe cognitive impairment. (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: 675769	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2024
NAME OF PROVIDER OR SUPPLIER Harmony Care at Stamford		STREET ADDRESS, CITY, STATE, ZIP CODE 1003 Columbia Stamford, TX 79553	

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's Comprehensive Care Plan review start date of 09/20/2023 revealed the following focus care areas with objectives that were not measurable: Focus: [Resident] has impaired cognitive thought processes r/t Head Injury (HX of TBI), Impaired decision making; Dementia with an objective of The resident will maintain current level of cognitive function ., Focus: [Resident] has potential to be physically aggressive (SPECIFY: hitting/swinging at/attempting to stab, staff/residents) r/t Dementia, history of harm to others, Poor impulse control with an objective of The resident will demonstrate effective coping skills ., Focus: [Resident] has an ADL self-care performance deficit r/t Alzheimer's, Confusion, Dementia with an objective of She will maintain current level of function in ADLs ., Focus: [Resident] express desire to return to community but due to inability to manage medications, prepare meals, provide ADLs without assistance, identify change in medical condition, manage appointments/test or fiances they require long term care with an objective of 'Resident will adjust to facility and need for placement ., and Focus: [Resident] does wander around facility with/without purpose. Has no history of attempting to leave facility. She wanders in and out of other resident's rooms into bathrooms with an objective of Resident will be redirected from other residents rooms, out of unauthorized area with out injury to self or others . Review of Resident #4's face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with medical diagnoses of arthritis in both knees, dementia, overactive bladder, high blood pressure, and weakness. Review of Resident #4's Annual MDS dated [DATE], revealed in Section C - Cognitive Patterns C0500. BIMS Summary Score, Resident #4 scored 12 out of 15 indicating moderate cognitive impairment. Review of Resident #4's Comprehensive Care Plan review start date 10/04/2023 revealed the following focus care areas with objectives that were not measurable: Focus: [Resident] attends Activities of interest. Attends (specify Activity). Resident requires (specify) assistance to attend. [Resident] refuses to come out of room to any activity or meal, offer activity in room she declines states she just wants the quiet and to watch TV undisturbed. with an objective of Resident will continue to attend activities daily ., Focus: [Resident] is at risk for weight loss due to: her diagnosis with an objective of {Resident] nutritional status will remain stable AEB no reports of significant weight change ., Focus: [Resident] is incontinent-by choice, will request to be laid in the bed to have BM in brief, refuses to sit on BSC or bed pan with an objective of Episodes of incontinence will decrease ., Focus: [Resident] has an ADL self-care performance deficit r/t Activity Intolerance. Fatigue, Impaired balance with an objective of The resident will maintain current level of function . , and Focus: [Resident] is at risk for chest pin r/t a dx A-FIB (irregular heart rhythm); is at risk for side effects of medications-ASA; Apixaban with an objective of The resident will demonstrate an understanding of the disease process (SPECIFY: A-FIB) and the importance of compliance with treatment . Review of Resident #8's face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with medical diagnoses of osteomyelitis (inflammation of bone or bone marrow), suicidal ideations, pseudobulbar affect (condition characterized by episodes of sudden uncontrollable and inappropriate laughing or crying), high blood pressure, Type 2 diabetes, anxiety, cataracts (cloudy area in the lens of the eye), weakness, and major depression. Review of Resident #8's Quarterly MDS dated [DATE], revealed in Section C - Cognitive Patterns C0500. BIMS Summary Score, Resident #8 scored 11 out of 15 indicating moderate cognition impairment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675769	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2024
NAME OF PROVIDER OR SUPPLIER Harmony Care at Stamford		STREET ADDRESS, CITY, STATE, ZIP CODE 1003 Columbia Stamford, TX 79553	

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #8's Comprehensive Care Plan dated 09/27/2023 revealed the following focus care areas with objectives that were not measurable: Focus: [resident] has a DX of Diabetes. Is at risk for Hypo/hyperglycemic (low/high blood sugar) episodes and complications related to disease process and is risk for side effect to medication-actos/metformin/Levemir/Humulin R per sliding scale with an objective of Resident will be compliant with dietary restrictions., Focus: [Resident] has DX of Depression. Is at risk for side effects to medication . with an objective of Resident will have no S/S or reports of side effects to medication. , Focus: [Resident] has Edema (swelling) +2 to both lower extremity, with an objective of Resident will have no complication related to edmea . , Focus: [Resident] is at risk for weight loss due to: dementia with an objective of [Resident's] nutritional status will remain stable with no reports of significant weight change ., Focus: [Resident] express desire to return to community but due to inability to manage medication, prepare meals, provide ADLs without assistance, identify change in medication condition, manage appointment/test or finances they require long term care. Family/resident request that they be asked about discharge goal only on comprehensive assessments with an objective of [Resident} will adjust to facility and need for placement ., Focus: [Resident] has (SPECIFY: Impaired visual function/unable to determine visual function) R/T Bilateral (both sides) cataract with an objective of Will have no indications of acute eye problems . , Focus: [Resident] has long and short term memory problems. Needs verbal cue, redirection. Needs supervision for decisions with an objective of Resident right to refuse will be respected . , Focus: [Resident] has an ADL self-care performance deficit r/t Disease Process ID; activity intolerance; weakness with an objective of The resident will maintain current level of function in all ADL's. , Focus: [Resident] has had an actual fall on 7/2/18 during transfer . with an objective of The resident will resume usual activities without further incident. Review of Resident #14's face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with medical diagnoses of malnutrition, down's syndrome (a condition which a person has an extra chromosome that causes intellectual disability, developmental delays and a distinct facial appearance), convulsions, hearing loss, heart burn, osteoporosis (a condition in which the bones become brittle and fragile), high level of fat in the blood, high blood pressure, and overactive bladder. Review of Resident #14's Quarterly MDS dated [DATE], revealed in Section C - Cognitive Patterns C0500. BIMS Summary Score, Resident #14 scored 99 indicating the resident was unable to complete the interview. Review of Resident #14's Comprehensive Care Plan dated 08/09/2023 revealed the following focus care areas with objectives that were not measurable: Focus: [Resident] is at risk for weight loss and dehydration due to her diagnosis . with an objective of [Resident] nutritional status will remain stable no reports of significant weight change ., Focus: [Resident] is at risk for skin breakdown r/t (specify decreased mobility, incontinence nutritional status) with an objective of Resident will have not reports of skin breakdown ., Focus: [Resident] has an ADL self-care performance deficit r/t Activity Intolerance. Limited Mobility. Limited ROM with an objective of The resident will maintain current level of function in ADLs ., and Focus [Resident] has impaired cognitive function/dementia or impaired thought processes r/t Developmentally delayed, Disease Process (SPECIFY: down's syndrome) with an objective of The resident will maintain current level of cognitive function . Review of Resident #24's face sheet revealed a [AGE] year-old male admitted to the facility on [DATE] with medical diagnoses of Alzheimer's, high blood pressure, gout (a type of arthritis affecting smaller bones such as in the feet), benign prostatic hyperplasia (an enlarged prostate), major depression, and diverticulitis (bulging pouches in the digestive tract). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #24's Quarterly MDS dated [DATE] revealed in Section C - Cognitive Patterns C0500. BIMS Summary Score, Resident #24 scored 01 out of 15 indicating severe cognitive impairment. Review of Resident #24's Comprehensive Care Plan dated 08/09/2023 revealed the following focus care areas with objectives that were not measurable: Focus: [Resident] is at risk for weight loss and dehydration due to his diagnosis of alzheimer's with an objective of [Resident] nutritional status will remain stable with no reports of significant weight change . , Focus: [Resident] is at risk for pain due to (specify: dx of gout, general aches/pains) with an objective of Resident will show signs/symptoms of pain control ., Focus: [Resident] has DX of BPH. AT risk for difficulty starting/stopping urinary flow, urinary retention, UTI, urinary obstruction and adverse reaction to medications . with an objective of Resident will have no S/S of complications due to BPH ., Focus: FALLS: [Resident] is at risk for falls and injuries AEB multiple falls, poor safety awareness, think fragile skin with an objective of [Resident's] dignity will be maintained ., Focus: ANTIBIOTICS: (resident name) is on antibiotics and is at risk for adverse reactions/side effects AEB - Antibiotic: Levaquin - Dx: UTI no objective was documented for this focus care area, Focus: [Resident] has an ADL self-care performance deficit r/t Activity Intolerance, Confusion, Dementia with an objective of He will maintain current level of function ., Focus: [Resident] is an elopement risk/wanderer r/t History of attempts to leave facility unattended, Impaired safety awareness, Resident wanders aimlessly with an objective of The resident's safety will be maintained . , and Focus: [Resident] has impaired cognitive function/dementia or impaired thought processes r/t Alzheimer's, Dementia, Impaired decision making with an objective of The resident will maintain current level of cognitive function . During an interview on 03/13/24 at 11:34 AM, the DON stated she and the MDS coordinator were responsible for developing and updating the care plans. The DON stated she started working at the facility in November 2023 and the MDS coordinator started working at the facility on 03/09/2024. She stated objectives on care plans need to be measurable so the facility could determine if the care plan interventions were effective, and she was not able to provide an explanation of why the failure do document measurable objectives occurred other than the recent turnover in nursing leadership. The DON stated changes in the plan of care for residents was communicated to staff via in-services, nurse meetings, shift change reports, and CNA room to room reports. She explained the effect on residents of failing to have measurable objectives on the care plans was that the care plans should coincide with the care needed and the care provided. The DON acknowledged the examples of objectives given such as nutritional status will remain stable with no reports of significant weight change . and She will maintain current level of function in ADLs . were not measurable and needed to be written in a way that was individualized to each resident. The DON stated the reason care area needs identified in resident records but were not addressed on the care plan was because revising the care plan had been overlooked. She stated the same was true for care needs listed on care plan that were no longer needed. The DON explained certain tasks for the nursing staff to complete were triggered on the care plans. She stated training for developing care plans was received in nursing school and during her more than [AGE] years working as a nurse. During an interview on 03/13/24 at 11:46 AM, LVN A stated she did not look at the care plans, she did not know what was on a care plan. LVN A stated the DON was responsible for the care plans. Review of the facility policy titled Care Plans, Comprehensive Person-Centered, no date, revealed A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed for each resident.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44558 Based on observation, interview and record review, the facility failed to review and revise resident-centered comprehensive care plans within 7 days of a comprehensive assessment for 4 (Resident #1, Resident #4, Resident #8, and Resident #14) of 5 residents reviewed for care plans. The facility failed to review and revise Resident #1, Resident #4, Resident #8, and Resident #14's, Comprehensive Patient-Centered Care Plan within 7 days following the completion of a comprehensive assessment. The facility failed to review and revise Resident #8's Comprehensive Patient-Centered Care Plan to reflect a change in condition regarding the bed and chair alarms no longer necessary for the resident's safety. These failures could put residents at risk for not receiving the care and services needed to maintain or improve physical, mental, emotional, psychological well-being. Findings included: Review of Resident #1's face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with medical diagnoses of malnutrition (lack of proper nutrition), traumatic brain injury, major depression, high blood pressure, osteoarthritis, schizoaffective disorder (mental health disorder that is a combination of schizophrenia symptoms like hallucinations, and mood disorder symptoms like depression or mania), weakness, psychotic disorder (collection of symptoms that affect the mind, where there has been some loss of contact with reality), and anxiety. Review of Resident #1's Medicare 5-day MDS dated [DATE], revealed in Section C - Cognitive Patterns C0500. BIMS Summary Score, Resident #1 scored 6 out of 15 indicating severe cognitive impairment. Review of Resident #1's Medicare 5-day MDS revealed a comprehensive assessment was completed on 01/29/2024. The most recent comprehensive care plan revealed a review start date of 09/20/2023. Review of Resident #4's face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with medical diagnoses of arthritis in both knees, dementia, overactive bladder, high blood pressure, and weakness. Review of Resident #4's Annual MDS dated [DATE], revealed in Section C - Cognitive Patterns C0500. BIMS Summary Score, Resident #4 scored 12 out of 15 indicating moderate cognitive impairment. Review of Resident #4's Annual MDS revealed a comprehensive assessment was completed on 12/31/2023. The most recent comprehensive care plan revealed a review start date of 10/04/2023. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #8's face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with medical diagnoses of osteomyelitis (inflammation of bone or bone marrow), suicidal ideations, pseudobulbar affect (condition characterized by episodes of sudden uncontrollable and inappropriate laughing or crying), high blood pressure, Type 2 diabetes, anxiety, cataracts (cloudy area in the lens of the eye), weakness, and major depression. Review of Resident #8's Quarterly MDS dated [DATE], revealed in Section C - Cognitive Patterns C0500. BIMS Summary Score, Resident #8 scored 11 out of 15 indicating moderate cognition impairment. Review of Resident #8's Annual MDS revealed a comprehensive assessment was completed on 03/02/2024. The most recent comprehensive care plan revealed a review start date of 09/27/2023. Review of Resident #8's Comprehensive Care Plan dated 08/09/2023 revealed a fall prevention intervention Clip alarm to bed and chair when out of bed. Check position and functioning every shift and after transfers. with a revised date of 06/15/2021. Review of Resident #8's Annual MDS dated [DATE], revealed in Section P0200. Alarms A. Bed alarm - 0. Not used; B Chair alarm - 0. Not used. During an observation on 03/12/2024 at 1:18 PM Resident #8's wheelchair and bed revealed no alarms were in place. Review of Resident #14's face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with medical diagnoses of malnutrition, down's syndrome (a condition which a person has an extra chromosome that causes intellectual disability, developmental delays and a distinct facial appearance), convulsions, hearing loss, heart burn, osteoporosis (a condition in which the bones become brittle and fragile), high level of fat in the blood, high blood pressure, and overactive bladder. Review of Resident #14's Quarterly MDS dated [DATE], revealed in Section C - Cognitive Patterns C0500. BIMS Summary Score, Resident #14 scored 99 indicating the resident was unable to complete the interview. Review of Resident #14's Quarterly MDS revealed a comprehensive assessment was completed on 01/30/2024. The most recent comprehensive care plan revealed a review start date of 08/09/2023. During an interview on 03/13/24 at 11:34 AM, the DON stated she and the MDS coordinator were responsible for developing and updating the care plans. The DON stated she started working at the facility in November 2023 and the MDS coordinator started working at the facility on 03/09/2024. The DON stated the reason interventions listed on care plan that were no longer needed was because revising the care plans had been overlooked. The DON stated Resident #8 no longer needed a bed and/or chair alarm. She stated training for developing care plans was received in nursing school and during her more than [AGE] years working as a nurse. During an interview on 03/13/24 at 01:32 PM, the DON stated the timeframe to review/revise care plans after comprehensive assessment was 14 days. She stated she was responsible for reviewing and/or revising care plans. The DON did not have an explanation as to why care plans were not updated and but stated she and the MDS Coordinator had identified that the comprehensive care plans had not been updated and was working on resolving the problem. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled Care Plans, Comprehensive Person-Centered, no date, revealed in item 12. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS)., item 13. Assessments of residents are ongoing, and care plans ae revised as information about the residents and the residents' conditions change., and item 14. The Interdisciplinary Team must review and update the care plan: a. When there has been a significant change in the resident's condition. Review of the facility policy titled Resident Assessment Instrument, no date, revealed in item 6. Within seven (7) days of the completion of the resident assessment, a comprehensive care plan will be developed. 45216

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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. 44558 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 1 of 4 FY quarters reviewed (FY Quarter 1 2024 (October1-December 31) reviewed for administration. The facility failed to submit data to CMS for FY Quarter 1 2024 (October1-December 31). 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 03/11/2024 provided by the Administrator indicated a total of 27 residents and 47 staff that included: 5-Registered Nurses 6-Licensed Vocational Nurses 12-Direct Care Staff 6-Dietary Staff 4-Housekeeping and Laundry 14-All others Record Review of the CMS PBJ report for CMS for FY Quarter 1 2024 (October1-December 31) indicated the facility had failed to submit data for the quarter triggered. During an interview on 03/13/2024 at 11:54 AM, the Administrator stated there was no submission for last quarter. She stated the management office verified with IQIES and tried to pull a report, but it was blank. She stated the former accountant who was responsible to submit failed to do so. The Administrator stated hours were submitted from facility to managing accountant for PBJ reporting. She stated the facility's nurse consultant now had access for the facility and was in the process of submitting for this quarter. (continued on next page)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of a facility policy titled Reporting Direct-Care Staffing Information (Payroll-Based Journal) undated indicated, Policy Statement: 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. Interpretation and Implementation: l. Beginning with the fiscal quarter of 2016 (beginning July 1, 2016), direct-care staffing and census information will be reported electronically to CMS through the Payroll-Based Journal (PBJ) system. 2. Direct-care staffing information will include staff hired directly by the facility, those hired through an agency, and contract employees .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 . 45732