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	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Care at Stamford	1003 Columbia St 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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interviews and record review[KA73.1], the facility failed to maintain a quality assessment and assurance committee consisting at a minimum of the required committee members for 4 quarterly meetings reviewed for QAPI[KA74.1]. The facility did not ensure the Medical Director or a representative attended quarterly QAPI meetings. This failure could place residents at risk for quality deficiencies being unidentified, no appropriate plans of action developed and implemented, and no appropriate guidance developed. Findings included: Record review of the Quality Assurance Performance Improvement Attendance Sign-In forms revealed:Sign in sheet for the 3rd Quarter 2025, undated, indicated the Medical Director was not present. Sign in sheet for the 4th Quarter 2025, undated, indicated the Medical Director was not present. Sign in sheet, dated January 2026, indicated the Medical Director was not present. Sign in sheet, dated 03/10/2026, indicated the Medical Director was not present. During an interview on 06/17/2026 at 12:10 PM, the ADMN stated no Medical Director was present for QAPI during the last 4 quarters. He stated the MD either couldn't[KA75.1] , or wouldn't[KA76.1], attend. He stated the MD was making rounds, giving orders and signing orders during QAPI meetings[KA77.1]. He stated the negative outcome of the Medical Director not attending QAPI meetings made it more likely to overlook a potential process or improvement without his expertise. Record review of facility's policy titled, Quality Assurance and Performance Improvement, revised April 2014, revealed: This facility shall develop, implement, and maintain and ongoing facility wide QAPI program that builds on the Quality Assessment and Assurance Program to actively pursue quality of care and quality of life goals.Review[KA78.1] of the facility document titled, QAA[KA79.1] Committee[KA80.1], not dated revealed: Administrator, MD, DON, ADON.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675769	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Care at Stamford	1003 Columbia St 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 that the assessment accurately reflected the resident's status for 4 of 5 (Resident #1, Resident #2, Resident #18, and Resident #30) reviewed for accuracy of assessments. The facility failed to ensure Resident #1, Resident #2, Resident #18, and Resident #30 had tobacco use accurately coded on the admission/annual MDS assessment. This failure could place residents at risk for inadequate care and services to meet their needs.Findings included: During record review of Resident #1's electronic face sheet, dated 06/16/2026, revealed a [AGE] year-old male, admitted on [DATE], with diagnoses of chronic obstructive pulmonary disease (a progressive, chronic lung disease that makes breathing difficult), dementia, major depressive disorder (a serious mental health condition characterized by persistent low mood and loss of interest in activities), anxiety, and high blood pressure. Record review of Resident #1's Annual MDS Assessment, dated 02/16/2026, revealed in Section C - Cognitive Patterns, subsection C0500, a BIMS score of 14 out of 15, indicating intact cognition. Section J - Health Conditions, subsection J1300 Current Tobacco Use, 0 was entered indicating No. During record review of Resident #2's electronic face sheet, dated 06/16/2026, revealed a [AGE] year-old female, admitted on [DATE], with diagnoses of chronic obstructive pulmonary disease, major depressive disorder, anxiety, high blood pressure, and emphysema (a progressive, incurable lung condition characterized by the destruction of the air sacs in the lungs). During record review of Resident #2's Annual MDS Assessment, dated 11/18/2025, revealed in Section C - Cognitive Patterns, subsection C0500, a BIMS score of 15, indicating intact cognition. Section J - Health Conditions, subsection J1300 Current Tobacco Use, 0 was entered indicating No. During review of Resident #18's electronic face sheet, dated 06/16/2026, revealed a [AGE] year-old female, admitted on [DATE], with diagnoses of chronic obstructive pulmonary disease, dementia, and high blood pressure. During record review of Resident #18's admission MDS Assessment, dated 04/30/2026, revealed in Section C - Cognitive Patterns, subsection C0500, a BIMS score of 12, indicating moderate cognitive impairment. Section J - Health Conditions, subsection J1300 Current Tobacco Use, 0 was entered indicating No. During record review of Resident #30's electronic face sheet, dated 06/16/2026, revealed an [AGE] year-old female, admitted on [DATE], with diagnoses of chronic obstructive pulmonary disease, dementia, depression, anxiety, and high blood pressure. Record review of Resident #30's admission MDS Assessment, dated 02/26/2026, revealed in Section C - Cognitive Patterns, subsection C0500, a BIMS score of 15, indicating intact cognition. Section J - Health Conditions, subsection J1300 Current Tobacco Use, 0 was entered indicating No. During an observation on 06/16/2026 at 8:32 a.m., Resident #1, Resident #2, Resident #18, and Resident #30 were sitting outside in the enclosed patio area smoking. Observation indicated dietary staff were present to supervise residents smoking. During an observation on 06/17/2026 at 10:05 a.m., Resident #2, Resident #18, and Resident #30 were assisted to the enclosed patio area to smoke. Observation indicated staff provided one cigarette to each resident and lit each cigarette. Observation further indicated no residents had supplemental oxygen or required clothing protection. During an interview on 06/17/2026 at 10:47 a.m., the DON stated her expectation was for each resident's tobacco use status to be correct on the MDS. Stated the MDS Coordinator was responsible for entering data for the MDSs. The DON was not able to state a consequence to residents if tobacco use on the MDS was not coded correctly. During a telephone interview on 06/17/2026 at 11:15 a.m., the MDS Coordinator stated she received information for the MDS through the RN assessment and correlating with the nursing staff. She stated the reason the tobacco use section may have been coded on the MDS different from the resident's current status was the resident may have started using tobacco products after admission or after the annual assessment. The MDS Coordinator stated a resident's tobacco use status not accurately documented could be unsafe for the resident. She stated the regional nurse randomly audited the MDS's for (continued on next page)

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	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Care at Stamford	1003 Columbia St 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	accuracy but was unable to state how often an audit was conducted. She stated she learned the responsibilities of the MDS Coordinator position through on the job training and by attending a face-to-face workshop. During an interview on 06/17/2026 at 12:38 p.m., Resident #30 stated she had been smoking since age [AGE] or 19. She stated the facility was aware of her tobacco use status when she was admitted . During an interview on 06/17/2026 at 12:41 p.m., Resident #2 stated she smoked for 50 years. She stated the facility was aware of her tobacco use status when she was admitted . During an interview on 06/17/2026 at 1:48 p.m., the ADON stated the reason a resident's tobacco use status was not correct on the admission MDS was the resident may not admit to smoking when admitted . He stated the DON was responsible for accuracy of the MDSs. He did not state how an inaccurate MDS could affect a resident. The ADON stated he randomly reviewed MDSs during the DON's recent 6-week absence. During an interview on 06/16/2026 at 9:14 a.m., the Administrator stated the facility followed the RAI guidelines for completing the MDSs. Record review of the Resident Assessment Instrument Manual v1.19.1, dated October 2024, Section J1300: Current Tobacco Use, Steps for Assessment, revealed, 2. If the resident states that they used tobacco in some form during the 7-day look-back period, code 1, yes.

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	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Care at Stamford	1003 Columbia St 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 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the residents were seen by a physician at least once every 60 days for 3 of 13 Residents (Resident #2, Resident #4, and Resident #16) whose records were reviewed for physician visits.The facility failed to ensure Resident #2's, Resident #4's, and Resident #16's primary care physician met with them as required.This failure could place residents at risk for medical needs not being addressed or met.Based on interview and record review, the facility failed to ensure the residents were seen by a physician at least once every 60 days for 3 of 13 Residents (Resident #2, Resident #4, and Resident #16) whose records were reviewed for physician visits.The facility failed to ensure Resident #2's, Resident #4's, and Resident #16's primary care physician met with them as required.This failure could place residents at risk for medical needs not being addressed or met.Findings included:Resident #2Review of Resident #2's electronic face sheet, dated 6/17/2026 revealed a [AGE] year-old female, admitted [DATE], with diagnoses that included right leg fracture, anxiety, and major depression. Record review of Resident #2's significant change MDS assessment, dated 05/19/2026, revealed a BIMS of 15 which indicated no cognitive impairment.Record review of Resident #2's electronic health record, revealed physician progress notes dated 10/22/2025 through 06/08/2026, revealed no documentation from the primary physician. During an observation and interview on 06/17/2026 at 1:25 PM, Resident #2 was up in the wheelchair. Resident #2 stated she had not seen a physician for as long as she could remember. Resident #4Record review of Resident #4's electronic face sheet dated 06/17/2026 revealed a [AGE] year-old male admitted on [DATE] with diagnoses that included cirrhosis of liver and anxiety. Record review of Resident #4's Annual MDS assessment, dated 05/01/2026, revealed a BIMS of 15 which indicated no cognitive impairment.Record review of Resident #4's electronic health record revealed physician progress notes dated 10/22/2025 through 05/06/2026, revealed no documentation from the primary physician. During an observation and interview on 06/17/2026 at 1:30 PM, Resident #4 was seated in the wheelchair at the end of the hall. Resident #4 stated he saw the new physician in May but, prior to that, he had not seen a physician in months. Resident #16Record review of Resident #16's electronic face sheet dated 6/17/2026, revealed a [AGE] year-old male, admitted [DATE], with diagnoses that included seizures and severe intellectual disabilities. Record review of Resident #16's Annual MDS assessment, dated 05/22/2026, revealed a BIMS of 03 which indicated severe cognitive impairment.Record review of Resident #16's electronic health record, including physician progress notes, revealed no documentation from the primary physician from 10/29/2025 through 06/08/2026.During an interview on 06/16/2026 at 10:15 AM, the ADMN stated the new Medical Director started in May 2026. He stated that there was no lapse between the previous Medical Director and there was never a time when they did not have a physician. He stated the MD was making rounds, giving orders, and signing orders. He stated the MD was not sending the documentation and progress notes. During an interview on 06/17/2026 at 10:01 AM, the DON stated the MD left at the end of April 2026. She stated he made his visits, but he was not sending the progress notes. She stated she asked him to please send them, but he did not. She stated there was no written evidence of the MD making rounds on residents. Record review of the facility policy, Physician Visits, revised April 2013, revealed, The attending physician must make visits in accordance with applicable state and federal regulations. 1. The attending physician will visit residents in a timely fashion, consistent with applicable state and federal requirements, and depending on the individual's medical stability, recent and previous medical history, and the presence of medical conditions or problems that cannot be handled readily by phone. 2. The attending physician must visit his/her patients at least once every thirty (30) days for the first ninety (90) days following the resident's admission, and then at least every sixty (60) days thereafter.

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	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Care at Stamford	1003 Columbia St 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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident had the right to be informed of, and participate in, his or her treatment, including the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she preferred for 1 of 13 residents (Resident #25) reviewed for informed decisions. The facility failed to ensure Resident #25 or their representative signed consent for psychotropic medication trazodone and sertraline prior to administering medication.This failure could place residents at risk of not being informed of their health status, which would allow them to make informed decisions regarding their care. Findings included: ˆ Record review of Resident #25's electronic face sheet, dated 06/17/2026 reflected an [AGE] year-old female, admitted [DATE], with the following diagnosis of depression, anxiety, and dementia. Further review reflected resident was her own responsible party.ˆ Record review of Resident #25's admission MDS Assessment, dated 06/05/2026, reflected a BIMS score of 12, indicating cognitively intact. Further review reflected Resident #25 was taking high risk antidepressant medication. Record review of Resident #25's comprehensive care plan, dated 06/07/2026, reflected Resident #25 used antidepressant medication with interventions including to educate the resident/family/caregivers about risks, benefits and side effects. ˆ Record review of Resident #25's electronic physician orders, dated 06/07/2026 reflected, Trazodone Oral Tablet 50MG Give 1 tablet by mouth in the evening for insomnia, order date 05/29/2026 and Sertraline Oral Tablet 50MG Give 1 tablet by mouth in the morning for depression, order date 05/29/2026.ˆ Record review of Resident #25's MAR, dated June 2026, reflected Resident #25 received 50mg sertraline in the A.M. every day from 06/01/2026-06/16/2026. Record review of Resident #25's MAR, dated June 2026, reflected Resident #25 received 50 mg trazodone in the PM every day from 06/01/2026-06/16/2026. Record review of Resident #25's electronic medical chart, accessed on 06/16/2026, reflected no evidence she or her representative consented to trazodone or sertraline prior to receiving the medication starting on 05/29/2026.ˆDuring an interview on 06/16/2026 at 12:00 pm, Resident #25 stated she did not really know what medications she took. She stated she just took what they brought her. She stated she did not remember being educated or signing any papers for her antidepressants but that she trusted whatever the physician ordered. During an interview on 06/17/2026 at 11:00 A.M., the DON stated consent must be obtained prior to administering psychotropic medications. She stated she made it her priority to review all orders and new admissions for the need for a consent. She stated she was out on maternity leave when Resident #25 was admitted . She stated it was the ADON's and the admitting nurse's responsibility to ensure that a consent was received. She stated the negative outcome would be residents receiving psychotropic medications without knowing the possible side-effects. During an interview on 06/17/2026 at 12:30 PM, the Administrator stated that all psychotropic medications must have written consent prior to administration. He stated the DON was on maternity leave, and it must have just gotten missed. He stated the responsibility began with the charge nurse who entered the order and gave the medication. He stated he was ultimately responsible. He stated the negative outcome would be residents receiving medications without knowing why and what side-effects they could experience. Record review of facility's policy titled, Psychoactive Medication Use, revised July 2023, reflected, Policy Statement: Residents will not receive medications that are not clinically indicated to treat a specific condition. Policy Interpretation and Implementation: 1. A psychotropic medication is any mediation that affects brain activity associated with mental processes and behavior. 2. Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: a. Anti-psychotics; b. Anti-depressants; c. Anti-anxiety medications; and d. Hypnotics. 3. Residents, families and/or the representative are involved in the medication (continued on next page)

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	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Care at Stamford	1003 Columbia St 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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	management process.ˆ Record review of the website drugs.com, accessed on 06/22/2026 at https://www.drugs.com/trazodone.html, revealed: trazodone .Drug class: Antidepressant . Report any new or worsening symptoms to your doctor, such as: mood or behavior changes, anxiety, panic attacks, trouble sleeping, or if you feel impulsive, irritable, agitated, hostile, aggressive, restless, hyperactive (mentally or physically), more depressed, or have thoughts about suicide or hurting yourself.Record review of the website drugs.com, accessed on 06/22/2026 at https://www.drugs.com/sertraline.html, revealed: sertraline .Drug class: Antidepressant . medication used for depression Common sertraline side effects are nausea, diarrhea, indigestion, loss of appetite, increased sweating, shaking or trembling, decreased appetite, inability to ejaculate, and decreased libido. These side effects occurred in 5% or more of patients using this medicine.

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	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Care at Stamford	1003 Columbia St 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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to refer all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability or a related condition for level II resident review upon a significant change in status for 1 of 13 residents (Resident #28) reviewed for PASSR. The facility failed to follow up with the local authority for PASRR level II determination when Resident #28's PASRR level 1 dated 2.17.2024 screening reflected they were positive for Mental Illness. This failure could place residents at risk of not receiving specialized and/or habilitative services as needed to meet their needs. Findings included:Record review for Resident #28's electronic face sheet, dated 06.16.2026, revealed a [AGE] year-old female, admitted 03.01.2024, with diagnoses of bipolar disorder (a mental health condition that causes uncontrollable shifts in mood, energy and activity levels), Type II Diabetes Mellitus (metabolic disorder, high blood glucose levels), Hypertension (high blood Pressure), and Major Depressive Disorder. Record review of Resident #28's Annual MDS Assessment, dated 03.10.2026, revealed Section A-Identification information Resident #28 had level II PASRR Serious Mental Illness; Section C-cognitive status revealed Resident #28 had a BIMS score of 15, indicating cognitively intact, and Section I Active Diagnosis revealed Resident #28 had a diagnosis of Bipolar. Record review of Resident #28's Care Plan, dated 06.17.2026 revealed Resident #28 had a mood problem related to Bipolar Diagnosis. Interventions included behavioral health consults as needed, Record review on 06.16.2026 of Resident #28's PASRR level I screening, dated 2.28.2024, revealed Section C was coded yes indicating Mental Illness. Record review of Resident #28's electronic clinical record revealed no evidence of a Level II PASRR evaluation completed. During an interview on 06.17.2026 at 11:03 a.m., the DON stated any resident with a positive PASRR level I should have a level II PASRR evaluation and plan. She stated the MDS Coordinator was responsible for ensuring the PASSRs were completed and accurate. She stated she did not know why this failure occurred. She stated this failure could affect the residents as they may not get other services that they qualified to have. During a telephone interview on 06/17/2026 at 11:50 a.m., the MDS Coordinator stated Resident #28's primary diagnosis was Dementia for billing purposes and Level II PASSR Evaluation was not done. She stated this failure could affect in that she may not be getting the services she may qualify for. The MDS Coordinator stated this failure occurred due to the billing process. She stated she was responsible for ensuring PASRR level IIs were completed. During an interview on 06.24.2026 at 10:00 ama PASRR policy was requested by ADM the facility did not have a policy for PASRR

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	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Care at Stamford	1003 Columbia St 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 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 interviews and record reviews[KA41.1], 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 residents that meet professional standards of quality care within 48 hours of a resident's admission for 1 (Resident #25) of 13 residents reviewed for care planning.The facility failed to develop a baseline care plan for Resident #25 within 48 hours of her admission.This failure could place residents at risk of not receiving effective, person-centered care.Record review of Resident #25's electronic face sheet dated 06/17/2026 reflected an [AGE] year-old female, admitted [DATE], with the following diagnoses of depression, anxiety, and dementia. Further review reflected resident was he own responsible party. ˆ Record review of Resident #25's admission MDS Assessment, dated 06/05/2026, reflected a BIMS score of 12, indicating cognitively intact.Record review of Resident #25's electronic medical chart, accessed on 06/16/2026 reflected no evidence of a baseline care plan. During an interview on 06/17/2026 at 11:00 A.M., the DON stated a baseline care plan should be initiated within 48 hours of admission. She stated she made it her priority to review all new admissions. She stated she was out on leave when Resident #25 was admitted . She stated it was the ADON and the admitting nurse's responsibility to ensure that a baseline care plan was initiated. She stated the negative outcome would be residents not receiving the care they needed. During an interview on 06/17/2026 at 12:30 PM, the ADMN stated that all new admissions should have a baseline care plan initiated within 48 hours. He stated the DON was on leave and it must have just gotten missed. He stated the responsibility began with the charge nurse and then the ADON. He stated he was ultimately responsible. He stated the negative outcome would be residents not receiving the care they needed. Record review of facility policy titled, Care Plans-Baseline, dated March 2022, revealed the following: . 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.

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	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Care at Stamford	1003 Columbia St 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 - 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 observations, interviews and record reviews, the facility failed to develop and implement a comprehensive, person-centered care plan for each resident that included measurable objectives and time frames to meet, attain, or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 of 5 residents (Residents #1 and Resident #30) reviewed for care plans. The facility failed to ensure Resident #1 had a care plan in place for smoking. The facility failed to ensure Resident #30 had a care plan in place for smoking. This failure could place residents at risk of not receiving individualized care and services to meet their needs.Findings included: Review of Resident #1's electronic face sheet dated 06/16/2026, revealed a [AGE] year-old male admitted on [DATE] with medical diagnoses of chronic obstructive pulmonary disease, dementia, major depressive disorder, anxiety, and high blood pressure. Review of Resident #1's Annual MDS Assessment, dated 02/16/2026, revealed in Section C - Cognitive Patterns, subsection C0500 BIMS Summary Score revealed he had a BIMS score of 14 out of 15, indicating intact cognition. Section J - Health Conditions, subsection J1300 Current Tobacco Use, 0 was entered indicating No. Record review of Resident #1's Comprehensive Care Plan dated 01/19/2022, reviewed/revised 11/02/2025, 02/16/2026, 04/19/2026, 04/20/2026, and 06/15/2026, revealed his current smoking status was not addressed. Record review of Resident #30's electronic face sheet, dated 06/16/2026, revealed an [AGE] year-old female admitted on [DATE] with medical diagnoses of chronic obstructive pulmonary disease, dementia, depression, anxiety, and high blood pressure. Review of Resident #30's admission MDS dated [DATE], revealed in Section C - Cognitive Patterns, subsection C0500 BIMS Summary Score revealed he had a BIMS score of 15 out of 15, indicating intact cognition. Section J - Health Conditions, subsection J1300 Current Tobacco Use, 0 was entered indicating No. Review of Resident #30's Comprehensive Care Plan dated 02/16/2026, reviewed/revised 04/20/2026 and 06/05/2026, revealed his current smoking status was not addressed. During an observation on 06/16/2026 at 8:32 a.m., Resident #1, and Resident #30 were sitting outside in the enclosed patio area smoking. Dietary staff were present to supervise residents smoking. During an observation on 06/17/2026 at 10:05 a.m., Resident #30 was assisted to the enclosed patio area to smoke. Staff provided one cigarette to each resident and lit each cigarette. No residents had supplemental oxygen or required clothing protection. During an interview on 06/17/2026 at 10:47 a.m., the DON stated the reason Resident #1's and Resident #30's smoking status was not included on the care plans was proper education with the staff had not been done. She stated she, the ADON, and the MDS Coordinator were responsible for the care plans. She stated her expectations were for the care plans to reflect all aspects of care each resident required. The DON stated the CNO conducted care plan audits approximately every month and a half to two months and the CNO was in the process of training the DON on care plans. She was unable to state a potential consequence to residents of failing to address smoking status on the care plan. She stated the safe smoking evaluation results, and the facility policy would be followed by staff regardless of if it was included on the care plan. During an interview on 06/17/2026 at 12:35 p.m., Resident #1 stated he had been a smoker a long time. He stated he could not recall at what age he started smoking. He stated the facility was aware of his tobacco use when he was admitted and the activity director purchased his cigarettes when she did the resident's shopping. During an interview on 06/17/2026 at 12:38 p.m., Resident #30 stated she had been smoking since age [AGE] or 19. She stated the facility was aware of her tobacco use when she was admitted . During an interview on 06/17/2026 at 1:00 p.m., LVN A stated a resident's smoking status should be included on the care plan. She stated the failure to address smoking on the care plan was probably due to miscommunication. LVN A stated nursing staff had input into the care plans. She stated the DON and ADON were responsible for the accuracy of the care plans. LVN A stated potential consequences for (continued on next page)

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	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Care at Stamford	1003 Columbia St 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 - Few	residents would be staff would not be aware which residents smoked. She stated smoking could cause an abnormal oxygen level result and if the staff did not know a resident smoked, the resident may not receive proper care. During an interview on 06/17/2026 at 1:13 p.m., LVN B stated smoking should be on the resident's care plan so staff were aware. She stated a possible reason Resident #1 and Resident #30's smoking status was addressed on the care plan was the resident may have been a new admission and the status was not recorded properly, someone may have forgot to enter the information in the system, the resident was not asked, or the resident picked up a new habit after admission. She stated the DON was responsible for the care plans. Stated potential consequences of failing to include smoking status on the care plan may be mental, emotional, or physical issues due to the staff not knowing to include the resident during smoke breaks. During an interview on 06/17/2026 at 1:48 p.m., the ADON stated he participated in care plan development and a resident's smoking status should be addressed. He stated a reason for the failure to address smoking may be the resident did not admit to being a smoker when admitted . The ADON state the nurses, DON and ADON had input into the care plans. He stated potential consequences of failing to address a resident's smoking status may be a resident could burn up. He stated if staff were not aware of a resident's smoking status, visitors may bring the resident cigarettes and lighter, the resident could go outside and smoke unsupervised. He stated physical harm could occur if staff were not aware a resident required supervision. Record review of the facility policy titled, Care Plans, Comprehensive Person-Centered , revised March 2022, revealed, 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. 7. The comprehensive, person-centered care plan: b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. Record review of the facility policy titled, Smoking Policy - Residents, revised October 2025, revealed, 6. Resident smoking status I evaluated upon admission, if a smoker, the evaluation includes ., 9. Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) are noted on the care plan, and all personnel caring for the resident shall be alerted to these issues. Record review of the facility policy titled, Resident Assessment Instrument Manual v1.19.1, dated October 2024, Section J1300: Current Tobacco Use, Item Rational, Planning for Care, revealed, . a care plan that allows safe and environmental accommodation of resident preferences is needed.

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	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Care at Stamford	1003 Columbia St 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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure residents who on interview, and record review, the facility failed to maintain medical records on each resident that were complete and accurately documented for 1 of 13 residents (Resident #4) reviewed for medical records. The facility failed to obtain physician orders with setting and parameters for use of CPAP for Resident #4.This failure could place residents at risk for respiratory illnesses and risk for respiratory failure. Findings included:Record review of Resident #4's electronic face sheet 06.15.2026, revealed a [AGE] year-old male, admitted 04.24.2025, with diagnosis Chronic respiratory failure with hypercapnia (too much carbon dioxide in the blood stream), morbid obesity, Congestive Heart Failure (chronic condition of heart muscle is too weak), Presence of Cardiac Pacemaker(battery operated implanted device to regulate abnormal heart rhythm) Record review of Resident #4's Physician orders, dated 06.01.2026, revealed no evidence of an order for use of CPAP machine. Record review of Resident #4's Annual MDS Assessment, dated 05.01.2026, revealed Resident #4, Section C Cognitive status, a BIMS score of 15, indicating cognitively intact Resident #4's, Section I Active Diagnosis, included heart failure, respiratory failure, morbid obesity, cardiac pacemaker. Resident #4's, Section P special treatments, procedures and programs therapy. Record review of Resident #4's Care Plan04.05.2026, revealed the resident had oxygen therapy related to sleep apnea, utilized and oxygen therapy when sleeping, and on room air, while awake. Interventions included position resident to facilitate ventilation/perfusion (ventilation refers to the flow of air into and out of your lungs while perfusion refers to the flow of blood through the lungs blood vessels). During an interview and observation on 06.15.2026 at 1:48 pm, Resident #4 stated he used CPAP machine (medical device that delivers a steady stream of pressurized air through a tube and mask) at night. He stated he was able to put the CPAP on without assistance most of the time. Resident #4 stated the staff checked to verify if he was using his CPAP at night. The CPAP machine and CPAP mask were observed in Resident #4's room located on table at the bedside. During an interview on 06.17.2026 at 11:03 a.m., the DON stated residents who required the use of a CPAP should have a written physician's order and parameters for use. The DON stated this failure occurred due to Resident #4 being readmitted and orders not put in the system. The DON stated she did not feel this had a negative effect on the resident. The DON stated she and the ADON were responsible for ensuring the physician orders are entered and accurate. She stated she did end of month reviews each month Review of facility's policy titled, CPAP/BiPAP Support dated March 2015 revealed: Purpose 1. To provide the spontaneously breathing resident with continuous positive airway pressure with or without supplemental oxygen.2. To improve arterial oxygenation (PaO2) in residents with respiratory insufficiency, obstructive sleep apnea, or restrictive/obstructive lung disease.3. To promote resident comfort and safety. Preparation 3. Record review the physician's order to determine the oxygen concentration and flow, and the PEEP pressure (CPAP, IPAP and EPAP) for the machine. Steps in the Procedure 8. Set mode, CPAP, IPAP and EPAP settings on the machine, as prescribed.

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	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Care at Stamford	1003 Columbia St 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to maintain medical records on each resident that were complete and accurately documented for 2 of 13 residents (Resident #28 and Resident #30) reviewed for medical records. The facility failed to ensure Resident #28, and Resident #30 had safe smoking assessments completed. This failure could place residents at risk of health and safety due to no updated safe smoking assessments.Findings included:Record review of Resident #28's electronic face sheet, dated 06.16.2026, revealed [AGE] year-old female, admitted n 03.01.2024, diagnosis included of bipolar disorder (a mental health condition that causes uncontrollable shifts in mood, energy and activity levels), Type II Diabetes Mellitus (metabolic disorder, high blood glucose levels), Hypertension (high blood Pressure), Major Depressive Disorder. Record review of Resident #28's Annual MDS dated 03.10.2026 revealed Resident #28 Section A Level II PASRR (Preadmission Screening and Resident Review) Serious Mental Illness Resident #28 Section C-cognitive status BIMS=15 (cognitively intact), Section I Active Diagnosis-Bipolar. Record review of Resident #28's Care Plan, dated ??, revealed the resident was a tobacco smoker and was at risk of injury. Interventions included perform smoking assessment according to facility policy. Record review of Resident #28's Smoking Assessment, dated 11.28.2025, revealed Resident #28 was assessed at that time to be a safe smoker with supervision. No other Smoking Assessments were found in the EMR. Record review of Resident #30's electronic face sheet, dated 06.16.2026, revealed an [AGE] year-old female, admitted 02.16.2026, with diagnosis Chronic Obstructive Pulmonary Disease (lung disease), Hypertension (high blood pressure), Depression, other lack of coordination. Record review of Resident #30's admission MDS Assessment, dated 05.29.2026, indicated Resident #30's BIMS was 15, indicating cognitively intact. Resident #30 Section I Active Diagnosis chronic obstructive pulmonary disease. Resident #30 Section O Special treatments, procedures and Oxygen therapy programs. Record review of Resident #30's electronic medical record, dated 06.16.2026, revealed a Safe Smoking Assessment completed on 2.18.2026 revealed Resident #30 requires supervision when smoking. There was no evidence that quarterly smoking assessment was completed in May 2026. During an interview on 06.17.2026 at 11:03 a.m., the DON stated smoking assessments for residents that smoke should have been conducted at admission and quarterly. She stated a recent change was made, and the Activity Director was responsible for completing the smoking assessments. The DON stated she was responsible for ensuring the assessments were completed. The DON stated she did not feel this failure affected the residents negatively. She stated she felt this failure occurred due to new process being initiated and staff needed re-education on process. Review of the facility's policy titled, Smoking Policy-Residents, revision date October 2025, indicated, Policy Statement.This facility has established and maintains safe resident smoking practices.Policy Interpretation and Implementation.8. A resident's ability to smoke safely is re-evaluated quarterly, upon a significant change (physical orcognitive) and as determined by the staff.