STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165017	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Cedar Rapids	1940 First Avenue NE Cedar Rapids, IA 52402

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 - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 42134 Based on observation, policy review, and staff interview the facility failed to treat residents with dignity, respect, and honor residents' rights for 2 of 5 residents reviewed (Residents #12 and #14). The facility reported a census of 71 residents. Findings include: During an observation on 11/5/25 at 11:37 AM, Resident #12 was in the doorway to her restroom, facing out of the restroom utilizing the mechanical stand. Staff A, Certified Nursing Assistant (CNA) was in the Resident's room, in front of the resident. Staff B, CNA was in the restroom, directly behind the resident. The resident was receiving incontinence cares from Staff A and Staff B. She was unclothed and exposed from her waist to her knees. The resident was in full direct view of her roommate. The privacy curtain was not pulled. While Staff B was providing cares to Resident #12, Staff C, Guest Services Aide, entered the room, without knocking, and walked through the room to the closet. While Staff C was entering the room, Resident #12 was visible to anyone in the hallway. While Staff A and Staff B were continuing to provide cares, Staff D, Licensed Practical Nurse (LPN) entered the room after knocking but not waiting for a response, again exposing the resident to anyone in the hall. Staff D walked over to the roommate and then pulled the privacy curtain. During an observation on 11/5/24 at 1:02 PM Staff E, CNA assisted Resident #14 to the restroom. Resident #14 had a strong odor of urine. When standing from her wheelchair, her pants were observed to be wet with urine. Staff E assisted Resident #14 to use the toilet, applied a clean brief and pulled up the resident's wet pants. The resident was assisted to return to her wheelchair in the wet pants. Facility Policy titled Incontinent and Perineal Care last revised on 7/31/24 directed staff to provide privacy and avoid unnecessary exposure of resident. The policy also directed staff to make the resident comfortable, groom and change clothing. Facility Policy titled Mechanical Lift Transfer last revised on 2/2024 directed staff to provide privacy. (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 - Few	Facility Policy titled Resident Rights - Dignity and Respect last revised 4/2024 directed staff to treat each resident with dignity, respect and reasonable accommodation of individual needs. During an interview on 11/6/24 at 11:18 AM, the Director of Nursing (DON) explained she would expect staff to knock on a resident room door and wait for a response prior to entering. She further explained she would expect residents to be provided privacy during cares and to have wet pants changed at the time of toileting.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 48452 Based on record review, policy review, and interviews the facility failed to ensure services provided to residents met professional standards of quality by failing to follow physician's orders for 1 of 5 residents reviewed (Resident #3). The facility reported a census of 71 residents. Findings include: The Minimum Data Set (MDS) for Resident #3 dated 9/23/24 documented diagnoses of benign prostatic hyperplasia (enlarged prostate), hemiplegia (loss of strength or paralysis) affecting the right dominant side, and non-Alzheimer's dementia. MDS Section C documented a Brief Interview for Mental Status (BIMS) of 10 out of 15, indicative of moderate cognitive impairment. The Care Plan dated 3/9/24 documented the resident required assistance with activities of daily living and had occasional urinary incontinence. A Progress Note labeled General Progress Note dated 10/20/24 at 6:56 PM indicated the resident was brought back to the facility from the emergency room at 6:56 PM. The note documented the cause of the resident's testicular pain was not clear. There was no evidence of a bladder infection. The ultrasound showed epididymal and testicular cysts. It included documentation that the resident was to have an appointment with a urologist on or around 10/27/24. An additional note at 7:22 PM documented a copy of the hospital note was faxed to the advanced registered nurse practitioner and a copy was placed in the Assistant Director of Nursing box to schedule the urology follow up the next day. A Progress Note completed 8 days later, dated 10/28/24 at 2:50 PM, revealed the call was made to urology and nursing was awaiting a return call. During an interview on 11/4/24 at 10:23 AM the resident indicated the cysts have caused some pain. He shrugged when asked when his appointment to have the cysts checked was. On 11/6/24 at 3:18 PM the Director of Nursing (DON) reviewed the resident's health record and stated her nurse should have made the appointment the next day (10/21/24). When she realized it had not been made, she called herself on 10/28/24. They said they would get back to her. On 11/7/24 at 8:36 AM the DON confirmed the information from the prior interview and stated the provider never called the facility back to say they were not going to see him. He was already established with another provider and was referred back to them. She stated she followed up today and the resident now had an appointment scheduled for Friday (11/8/24). A policy titled Physician's Orders, reviewed and revised 8/16/24, documented it was the policy of the facility to ensure all resident medications, treatments, and plan of care must be in accordance with the licensed physician's orders. The facility would follow physician orders as written and orders would be carried out in reasonable time.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 42134 Based on observation, clinical record review, and staff interview the facility failed to follow safe transfer techniques for 1 of 2 residents observed during a transfer (Resident #14). The facility reported a census of 71 residents. Findings include: The Minimum Data Set (MDS) for Resident #14, dated 9/26/24, documented the resident was frequently incontinent of urine. The Care Plan interventions for the resident included transfers with assist of 2, assist with toileting per the resident's routine, and the resident wears incontinence briefs. During an observation on 11/5/24 at 11:37 AM, Staff A, Certified Nursing Assistant (CNA) entered Resident #14's room with the mechanical stand lift. Staff A stated she did not know where her partner went and proceeded to attach the sling around the resident, fasten waist straps, connect the sling to the stand, and placed the resident's feet on the foot plate. Staff A turned to the surveyor, removed her mask and explained the resident was supposed to be an assist of 2 for transfers and there were supposed to be 2 people to run the stand lift but she didn't know where her partner was. She repeated she was supposed to have another person with her but didn't know where she was. Staff A then proceeded to use the stand lift to raise the resident from her wheelchair and move her from the wheelchair across the room towards the bathroom. As she approached the bathroom door, Staff B, CNA entered the room and assisted with completing the transfer to the toilet. The policy titled Mechanical Lift Transfer, last revised 2/2024, directed staff that it was advisable to have 2 staff members present (for use of the lift) and each person's plan of care should be followed. During an interview on 11/6/24 at 11:18 AM, the Director of Nursing (DON) explained she would expect the mechanical stand/lift to he used with 2 staff members.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 42134 Based on observation, policy review, and staff interview the facility failed to provide proper and complete incontinence and catheter care for 3 of 3 residents observed (Residents #12, #13, and #14). The facility failed to ensure staff wore masks in resident areas during the current COVID outbreak. The facility reported a census of 71 residents. Findings include: During an observation on 11/5/24 at 11:08 AM, Staff F, CNA and Staff G, CNA entered Resident #13's room to provide incontinence and catheter cares. Staff F and Staff G donned Enhanced Barrier Precautions (EBP) Personal Protective Equipment (PPE). Staff F removed the catheter drainage bag from the side of the bed. Staff F and Staff G worked collaboratively to remove the resident's pants and brief. Staff G cleansed the front perineal area and the catheter. The resident was assisted to turn on his right side. Staff F removed the resident's brief that had a small amount of BM observed. Staff F used personal cleansing wipes and wiped up the middle, between the buttocks. She did not clean the buttocks, hip or leg areas. The resident was assisted to roll onto his left side. Staff G cleansed the residents right buttock and placed a clean brief under the resident. The resident was assisted to roll onto his back. Staff F and Staff G worked collaboratively to fasten the brief. Staff G removed her gloves, did not perform hand hygiene, and put pants back on the resident up to his thighs. Staff F placed a plastic barrier on the floor, placed a graduate on the floor and proceeded to empty the catheter drainage bag. She dumped the urine in the toilet, rinsed the graduate using the faucet in the sink and placed cleaned graduate in storage area. Staff F and Staff G worked collaboratively, rolling the resident to his sides to finish pulling up the resident's pants. Staff F picked the resident's shoes up off the floor and put them on the resident. Both CNAs removed their gloves and washed their hands (this was the first time during the observation that Staff F removed her gloves or performed hand hygiene). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 11/5/24 at 11:37 AM Staff A, CNA entered Resident #14's room. Staff A removed her mask while standing within 6 feet of a resident, with both residents in the room, during a COVID outbreak to explain to the surveyor she did not know where her partner was and was going to proceed to provide care despite the resident being care planned for 2 staff members to assist. After repeating this a second time, she put her mask back on. After applying gloves, she pushed the mechanical stand up to the resident, put the sling around the resident, attached sling to the stand, ensured the resident's feet were on the foot plate. She used the lift to stand the resident and move towards the restroom. Staff B, CNA entered the room and applied gloves and guided the resident to the toilet, pulled the resident's pants and brief down. The resident was lowered to the toilet. Staff B removed gloves and left the room. Staff A remained in the room. A short time later Staff B reentered the room and washed her hands. Staff A removed her gloves and washed her hands. When she finished washing her hands, before drying or reaching for a paper towel, she shut off the water. Both CNAs applied gloves. The resident was assisted to stand using the mechanical stand lift run by Staff A while guided by Staff B. The resident was moved to the doorway allowing Staff B to stand directly behind the resident. Staff B cleansed the resident by reaching between the resident's legs from behind and wiping her perineal area. The reach from behind cleansing was only cleansing the middle. The resident's thighs, buttocks and hips were not cleansed. Staff A and Staff B worked collaboratively to pull up the resident's brief and pants. Staff B then removed her gloves. Staff A moved the resident to her wheelchair using the mechanical stand and lowered her to her wheelchair. Staff A removed her gloves and took the lift out of the room. She returned to the room, removed the concentrator tubing from the resident, placed the portable oxygen tubing in the resident's nose, turned on the portable oxygen and adjusted the resident's hearing aid before washing her hands. During an observation on 11/5/24 at 1:02 PM Staff E, CNA took Resident #12 to her room. Resident #12 had a strong urine odor when she was taken to her room. Staff E washed her hands and applied gloves. She then swung the foot pedals back on the wheelchair, angled the wheelchair towards the restroom and locked the brakes. She removed the resident's shawl, applied the gait belt, assisted the resident to stand and ambulate to the restroom. She then pulled down the resident's pants and brief. The brief was saturated with urine and discarded. She then removed the gait belt from the resident before removing her gloves and performing hand hygiene. When the resident was finished on the toilet, Staff E applied gloves, put a clean brief on the resident, pulled her brief and pants up to her knees, put the gait belt on the resident and assisted her to stand. She used personal cleansing wipes to clean the resident. She cleansed the perineal area, and inner thigh. She used the same wipe surface for multiple wipes. She failed to clean the hips and buttocks. Facility Policy titled Catheter Care: Indwelling Catheter, last revised 12/2023, directed staff to apply clean gloves before emptying a catheter drainage bag. Facility Policy titled Handwashing, last revised 5/20 directed staff to dry hands thoroughly with a paper towel and discard and then use a dry paper towel to turn off the water. Facility Policy titled Incontinent and Perineal Care directed staff to use clean gloves when putting on clean briefs. During an interview on 11/6/24 at 11:18 AM, the Director of Nursing (DON) explained she would expect staff to follow policy and procedure and EBP when emptying at catheter. She would expect clean gloves when going from dirty to clean, and would expect clean gloves between incontinent care and catheter emptying. She explained she would expect hand hygiene to be performed after glove removal.