

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165017	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/23/2025
NAME OF PROVIDER OR SUPPLIER Harmony Cedar Rapids		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>Based on clinical record review, staff and resident interviews, manufacturer's recommendation and facility policy review the facility failed to transfer one of four residents reviewed in a safe manner (Resident #1). On 11/13/25, Resident #1 fell backwards from the stand lift, reported pain 9 out of 10 to the left hip, was sent to the hospital, and had a femur fracture which required surgical repair. The facility reported a census of 83 residents. The facility corrected the deficient practice per past noncompliance on 11/28/25 through the following actions: *Nursing staff re-educated on the proper use of mechanical lifts *Facility wide audit of mechanical lift equipment. *Nursing staff completed a skills check-off for standing lift and full body mechanical lift. *Audits of resident transfers using mechanical lifts. *Nursing staff interview related to refusal of safety straps and use for Resident #1. *Resident interviews regarding use of stand lift. Findings include: The Minimum Data Set (MDS) assessment for Resident #1 dated 10/15/2025 listed diagnoses of multiple sclerosis (MS), multidrug-resistant organism (MDRO), and anxiety. The MDS reflected the Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. The MDS revealed Resident #1 was dependent on staff for transfers in and out of the bed, dependent for sitting to standing, and for toilet transfer. The MDS revealed Resident #1 lacked a history of falls. The Care Plan for Resident #1 dated 12/26/24 identified the resident required assistance with activities of daily living (ADL) due to progressive MS. The Care Plan goal dated 2/28/24 with target date 10/22/25 reflected [Resident #1] will maintain current transfer status. An intervention dated 12/27/24 directed transferring: stand lift with assistance of 2 staff. Nonambulatory. The Change of Condition Progress Note dated 11/13/2025 at 11:46 PM reflected a CNA (Certified Nurse Aide) notified the nurse that during the transfer of Resident #1 with the stand lift Resident #1 let go of stand lift handlebars suddenly while telling CNA that she felt dizzy mid transfer. The CNAs reported that resident fell backwards onto floor hitting head on floor and lying supine. Resident stated that she had all of a sudden felt dizzy while transferring and that was the last thing she remembered about the transfer. Assessed resident and she had no visible injuries from fall on back of head but did have 9/10 pain on left hip and requested to wait until emergency medical services (EMS) arrived to be moved. The facility Fall Investigation Report for date of incident 11/13/25 reflected Resident #1 had not fallen at the facility prior to the fall on 11/13/25. The Incident Summary reflected on 11/13/2025 at approximately 9:21 p.m., Resident #1 requested to go to bed from her wheelchair (w/c). Staff B, CNA and Staff A CNA attempted to transfer Resident #1 from the w/c to the bed using the stand lift. The summary reflected during the transfer, Resident #1 reported she felt dizzy, released her hands from the lift, and slipped through the sling, resulting in a backward fall to the floor. The resident stated she that she struck her head and landed in a supine position. A post-fall assessment revealed Resident #1 reported 9/10 pain localized to the left hip. The Fall Investigation Report included the following staff statements: a. Staff B's statement revealed, in part, while Staff A was positioning Resident #1 in the stand lift, Staff B informed Staff A that she would need to move Resident #1 back slightly so that Staff B could reposition the wheelchair. After Staff A adjusted Resident #1, Staff B proceeded to move the wheelchair. As Staff B was turning down the bed, Staff B heard a crash. Initially Staff B believed the tray table had been bumped; however, Staff B then observed Resident #1 on the floor, lying on her back. Resident #1 was not secured with the belt, as she typically declines its use. b. Staff A's statement reported Resident #1 refuses to use the safety belt during transfers, and also declines the use of the leg straps, stating they are too tight. Staff A's statement revealed Staff A was unsure how the fall occurred, as she was positioned in front of Resident #1 and Staff B was positioned behind her. Staff B moved to reposition the wheelchair, and at that moment Resident #1 stopped talking, released her grip from the handles, and fell. Resident #1's statement reflected she knew who attempted to transfer her, and staff were in process of transferring her when she suddenly found herself on the floor. Resident #1 revealed she never refused to use the safety straps. The History and Physical (H&P) dated 11/14/25, with date of service 11/13/25, reflected Resident #1 presented to the ER for evaluation of left hip pain after a fall. The note revealed during the transfer Resident #1 fell out of the sling of the stand lift, and had an acute intertrochanteric fracture of the left femur. The hospital Consult note dated 11/14/25 identified Resident #1's emergency room (ER) x-rays revealed a subtrochanteric displaced fracture (a break in the upper part of the thigh bone) with severe osteopenia (significantly low bone density but not yet osteoporosis). The General Progress Note dated 11/15/2025 at 9:59 PM staff called hospital for report on Resident #1, the hospital reported a femur fracture that resulted in surgery performed on 11/14/2025. The Progress Notes dated</p>		