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	03/03/2026

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

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and facility policy review the facility failed to respond to call lights in a timely manner for 3 of 3 residents reviewed (Residents#12,#14,#27). The facility reported a census of 78 residents. 1.The Brief Interview for Mental Status (BIMS) assessment for R#12 dated 2/25/26 revealed the resident scored 15 out of 15, which indicated intact cognition. On 2/24/26 at 9:04 AM Resident #12 relayed the call light response had taken up to an hour, used either the phone or clock for timing the response. 2. The BIMS assessment for Resident #14 dated 2/3/26 revealed the resident scored 9 out of 15, which indicated moderately impaired cognition. On 2/24/26 at 9:03 AM Resident #14 relayed the call light response varied, quick at times or up to an hour, was not specific to a shift, varied. Resident #14 relayed timed the responses with the phone or clock. 3. The BIMS assessment for Resident #27 dated 2/16/26 revealed the resident scored 14 out of 15, which indicated intact cognition. On 2/23/26 at 3:45 PM Resident #27 relayed thought if staff were not in the hall to see the call light would have to wait, for example relayed last night on 2/23/26 roommate needed help and activated the call light, after ten minutes Resident #27 relayed went looking for staff propelled in wheel chair through halls could not find staff in the hall or in the break room and was about 35 more minutes before staff answered. On 2/26/26 at 12:40 PM, the room call lights were observed on for rooms [ROOM NUMBERS]. Continuous observation revealed the call light for room [ROOM NUMBER] was on for 20 minutes before being answered. Continuous observation revealed the call light for room [ROOM NUMBER] was on for 29 minutes before being answered. Several staff members were observed walking by the rooms without stopping to see if they could assist and numerous staff members were observed walking into and out of the staff break room during this time period. Two staff members were observed going into a resident's room at approximately 12:35 PM. During this observation, one of the staff members were observed coming out of the resident's room for more supplies and then returning. During this time, Staff K, Nurse Manager was observed at the nurse's station. When asked about call lights, Staff K advised the hall wasn't really short staffed but a lot of residents and staff are sick and it was a busy time of day so it is taking awhile for them to get call lights answered. She advised the (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	expectation is call lights be answered as soon as possible and between 5 and 10 minutes. On 2/26/26 at 1:55 PM, Staff H Certified Nursing Assistant (CNA), was queried about call lights. She advised they try to answer the resident call lights within a couple minutes or at least go check on the resident and make sure the resident is okay and that the resident is aware that staff know they need something and they will return as soon as possible. Staff H advised she feels there is usually enough staff but there are always times depending on what time of day it is and what else is going on that it takes longer. Staff H advised there are times they are unable to answer call lights timely. When asked if there were staff members to assist in the hall Staff H advised she believed they were helping in the dining room. On 2/26/26 at 3:15 PM, the Director of Nursing (DON) advised it is her expectation that call lights be answered as soon as possible and they ask between 5 and 10 minutes. If the CNA's are unable to assist the resident at that time they should stop in and make sure they are okay and tell the resident they will be right back. It was the DON's expectation that staff were not walking past call lights without seeing if they could assist. The facility Call Light Policy dated 9/2023 was reviewed. The policy identified the purpose was to ensure that there was prompt response to the resident's call for assistance. The policy further revealed, The facility shall answer call lights in a timely manner.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident, family, and staff interviews, and facility assessment review, the facility failed to ensure residents had a safe, homelike environment for three of four residents reviewed (#10, #27, #38).The facility reported a census of 78 residents.Findings include: 1. Resident #38's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating moderate cognitive impairment. The MDS documented Resident #38 required partial to moderate assistance with toileting and frequently incontinent of urine. On 2/23/26 at 11:50 AM, Resident #38's room was observed. The resident was asleep in their wheelchair. Soiled linens and bedding were observed on the resident's bed. The sheets had a dried brown substance on them. There was a distinct foul smell throughout the room. On 2/23/26 at 1:32 PM, the soiled linens remained on Resident #38's bed. The bed pad and soiled sheets were observed in the same state as earlier in the day. The soiled linens had not been changed and the resident's bed had not been sanitized. Bed padding and sheets were soiled with what appeared to be a dark dried substance. On 2/23/26 at 4:16 PM, during a representative interview concern was expressed that Resident #38 was frequently incontinent of urine and often observed in wet and soiled clothes. On 2/24/26 at 10:30 AM, Resident #38 was observed in her room, sitting in her wheelchair, watching TV. There were no sheets on the resident's bed. When queried, Resident #38 indicated staff had taken the dirty sheets off the bed his morning and hadn't put any back on. Staff had not cleaned or sanitized the resident's mattress. When asked, the resident shared staff usually don't make her bed until she yells at them to make it. An offensive odor was coming from the vicinity of the bed and flooring. On 2/24/26 at 1:42 PM, Resident's room was observed and the bed was still not made and there were no linens on either bed in the room. When asked, the resident shared they don't always make it right away. On 2/24/26 at 2:06 PM, Resident #38 was in her room sitting in her wheelchair and reading a book. Resident's bed was still not made. On 2/25/26 at 7:55 AM Resident #38 was observed sitting in her room in her wheelchair. Her bed had been made from the previous afternoon but was again observed soiled sheets with dried feces that had not been cleaned up. When asked, the resident shared she had been up for awhile. On 2/25/26 at 12:30 PM, the resident's room had been cleaned and there was clean bedding. On 2/26/26 8:50 AM, Resident #38's linen was observed soiled. The resident advised she had been up for awhile. Resident was asked if staff removed the soiled linens, sanitized her bedding and put new clean linen on. the resident shared, staff usually make the bed when they get around to making it, sometimes in the evening. On 2/26/26 at 1:55 PM, Staff H, Certified Nursing Assistant (CNA) advised if a resident's bed was soiled the CNA's would remove the soiled linens right away and clean and sanitize the bed and (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	flooring if necessary. Staff H also advised she has seen Resident #38 bed still soiled much later in the day that if should have been. On 2/26/26 at 3:15 PM, the Director of Nursing (DON) was queried about soiled linens and bedding. She advised it is her expectation that all staff are meeting standard housekeeping and sanitary expectations. It is her expectation that soiled linens be taken care of as soon as possible. On 3/3/26 the Facility Resident Room-Daily Cleaning list dated 10/2023 was provided. The purpose of the duty list stated it is to provide a clean and sanitary room for each resident. The Facility Assessment with an Administration review date of 1/21/26 was reviewed and indicated the resident is provided with a clean and sanitary environment which included linen, sheets, towels, bath blankets, blankets, pillows and bedspreads. 2.Resident #27's MDS dated [DATE] revealed a BIMS assessment score of 15 out of 15, which indicated intact cognition. On 2/23/26 on 3:49 PM relayed could not recall when the bedding was done, thought was several weeks or more and was supposed to be done when had a shower. Resident #27 relayed requested a new pillow cover yesterday and that part of the bedding was changed. 3. Resident #10's MDS dated [DATE] revealed the BIMS assessment scored 15 out of 15, which indicated intact cognition. On 2/26/26 at 9:00 AM during a confidential interview was relayed, had observed Resident #10 sheets and bed pad soaked and stained with wet and dry urine due to the nursing facility staff not changing the sheets.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to code dental concerns appropriately on the quarterly and annual Minimum Data Set (MDS) assessments for 1 of 2 residents reviewed (Resident #10). The facility reported a census of 78 residents. Findings include:Review of Resident #10's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed diagnoses of Traumatic Spinal Cord Dysfunction, paraplegia, diabetes and renal disease. The Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicated intact cognition. The MDS lacked any coding in the dental section for mouth, facial pain or discomfort. Review of Resident #10's Annual Minimum Data Set (MDS) assessment dated [DATE] again lacked any coding in the dental section for mouth, facial pain or discomfort. A Progress Note dated 8/28/25 revealed Resident #10 said My mouth hurts, had history of cracked teeth, presented with dental pain, caries noted on the left upper teeth, and initiated antibiotic therapy due to concern or potential gum infection. A Progress Note dated 11/13/25 documented, Resident #10 relayed tooth pain, 3 different teeth, cracked, likely exposing the root, significant decay and several teeth that are cracked. A Progress Note dated 11/17/25 documented, Resident #10 with persistent dental pain despite completing antibiotics, had not improved with antibiotics.A Progress Note dated 11/18/25 documented, Resident #10 continued on antibiotics for mouth pain and teeth infection.A Progress Note dated 12/16/25 documented, Resident #10 reports pain in the left upper and right lower teeth, several decayed and cracked teeth noted.A Progress Note dated 2/6/26 documented, Resident #10 presents with dental pain dental pain in the upper and lower teeth, described as zingers.A Progress Notes dated 2/16/26 documented, Resident #10 presents with dental pain requested pain medication, reported primarily for the lower teeth.On 3/3/26 at 9:03 AM the Administrator email documented the facility followed the Resident Assessment Instrument (RAI) user manual for MDS assessment completion.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on the resident interview, staff interviews, clinical record review, and dialysis contract/agreements the facility failed to direct staff of transfer requirement for dialysis appointments on the resident's care plan (Resident #4), and failed to address a resident's teeth pain and the related infections on the care plan (Resident #10) for two of twenty-one residents reviewed for care plans. The facility reported a census of 78 residents.Findings included:1.Resident #4, Minimum Data Set (MDS) assessment dated [DATE] listed diagnoses of end stage renal disease (ESRD) and dependence on renal dialysis. The Care Plan initiated 4/17/25 documented Resident #4 required dialysis on Monday, Wednesday and Friday. The Care Plan did not direct staff to ensure the sling is required to be sent to enable transfer to dialysis chair. On 2/23/2026 at 11:13 AM Resident #4 relayed was not able to get dialysis today because the staff did not put the transfer sling under me on the chair that is required by dialysis. Resident #4 relayed not all staff know about the requirement and felt she was at fault for not telling the staff.On 2/26/25 at 2:30 PM the Administrator and Director of Nurses(DON) acknowledged the Care Plan should direct residents care and needs.A document titled, Nursing Home Dialysis Transfer Agreement, signed 4/11/22 documented the facility desired to assure the availability and timeliness of dialysis treatments for the residents with End Stage Renal Disease (ESRD). A document titled, Dialysis-off site, revision date 12/24 documented , there must be coordination of care and services provided between the facility and the dialysis center and this is documented in the patient care plan.2. Review of Resident #10's MDS dated [DATE] documented diagnoses included traumatic spinal cord dysfunction, paraplegia, diabetes and renal disease. The BIMS assessment scored 15 out of 15, which indicated intact cognition.A Progress Note dated 11/18/25 documented, Resident #10 continued on antibiotics for mouth pain and teeth infection. A Progress Note dated 12/16/25 documented, Resident #10 reports pain in the left upper and right lower teeth, several decayed and cracked teeth noted. A Progress Note dated 2/6/26 documented, Resident #10 presents with dental pain dental pain in the upper and lower teeth, described as zingers. A Progress Notes dated 2/16/26 documented, Resident #10 presents with dental pain requested pain medication, reported primarily for the lower teeth.The Care Plan focus for Resident #10 initiated 6/16/25 documented had complaints of pain related to obesity, gout, spinal cord injury, substance abuse history, kidney disease and diverticulitis, and had acute pain due to abdominal distention and recent diagnosis of stercoral colitis (inflamed bowel). The Care Plan did not address Resident #10 repeated complaints of teeth pain including abscesses. The Care Plan lacked interventions for teeth related pain or treatments for the infections. The Facility Policy titled Care Plan Policy, revised March 2025, directed to put in place person-centered plans outlining care for the resident, to be reviewed and revised after completion of MDS assessments when applicable and with changes that warrant a care plan revision.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, resident interview and policy review the facility failed to follow professional standards when returned medications refused back to the medication cart to administer at a later time for 1 of 5 residents observed during medication administration (Resident #13), and failed to provide medications by the proper route for 1 of 1 reviewed for tube feeding (Resident #1). The facility reported a census of 78 residents. Findings include: 1.Review of Resident #13's Minimum Data Set (MDS) dated [DATE] documented took medications which included antipsychotic, antidepressant and anticonvulsants. The MDS further documented the resident had diagnosis included high blood pressure, anxiety, depression and seizure disorder. The February 2026 Medication Administration Record (MAR) documented Resident #13 medications for the AM included: a. amlodipine (antihypertensive)b. aripiprazole (for depression) c. atenolol (antihypertensive)d. bisacodyl (for constipation)e. clopidogrel (related to stroke)f. losartan (antihypertensive)g sertraline (for anxiety disorder)h. levetiracetam (for seizures)i. Tylenol (for arthritic pain) On 2/25/26 at 8:47 AM Certified Medication Aide (CMA) Staff A reported she had the morning medications for Resident #13. Staff A counted and relayed had 12 pills in a medication cup. Staff A proceeded to Resident #13's room. Resident #13 was lying in bed relayed did not want the medications. Staff A went back to the medication cart and placed a piece of tape over the med cup and wrote the residents first name and room number on the tape and relayed the process with resident refusals is the nurse would try to give them if the CMA was not able to. On 2/25/26 at 10:01 AM CMA, Staff A alerted the Licensed Practical Nurse (LPN) Staff B that Resident #13 refused morning medications. Staff LPN, Staff B took the medication cup of pills from the CMA, walked away with the medication cup. Queried Staff B, agreed had planned to offer the medications to Resident #13 and acknowledged she did not dispense the medications into the cup. Staff B agreed at this time not to give for resident safety. On 2/25/2026 at 10:10 AM met with the Director of Nursing (DON) and the Administrator for updates regarding medication observation, discussion of setting up medications and another staff giving the medications. The DON relayed not sure that this was a problem, perhaps the CMA would watch the nurse. Queried about giving medications that were not dispensed by the person administering, the DON and the Administrator relayed would have to look into the process's. The Facility Policy titled, Medication Administration-Medication Pass revised 5/2023 directed for refusals to dispose of the medication appropriately, document refusal and provide notification. 2. Resident #1's MDS assessment dated [DATE] documented a BIMS score of 11 out of 15, indicating moderate cognitive impairment. The MDS documented Resident #1 had a feeding tube. The MDS documented Resident #1 received antipsychotic, antidepressant, antibiotic, opioid, antiplatelet and anticonvulsant medications. The MDS listed diagnoses of pneumonia, dysphagia (difficulty swallowing), dyskinesia of the esophagus (a condition where the muscles of the esophagus contract abnormally or fail to coordinate, preventing food from moving smoothly to the stomach), and schizophrenia. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan Report initiated on 9/8/25 identified Resident #1 with altered nutritional status and a history of G-Tube (gastrostomy tube) feedings. Tube feedings discontinued in February 2026 for comfort measures, oral diet resumed at her request for comfort. The Care Plan Report identified Resident #1 took psychotropic, opioid pain, and anticonvulsant medications directing staff to administer medications as ordered. A Physician Order dated 2/3/26 listed a regular diet of pureed texture with thin liquids. The Physician Orders listed the following medication with route of administration:a. Acetaminophen oral tablet - give1000 mg via G-Tube three times a dayb. Acetaminophen oral tablet 325 MG - give 650 mg via G-Tube every 6 hours c. Amitriptyline HCl oral tablet 25 MG - give 25 mg via G-Tube at bedtimed. Calcium 600+D oral tablet 600-10 MG-MCG (microgram) - give 1 tablet via G-Tube one time a [NAME]. Calcium Carbonate oral tablet chewable 500 MG - give 1000 mg via G-Tube every 4 hours as neededf. Guaifenesin oral liquid 100 MG/5ML -give 20 ml via G-Tube every 6 hours as neededg. Lamotrigine oral tablet 100 MG – give 100 mg via G-Tube two times a dayh. Lansoprazole oral capsule delayed release 30 MG - give 30 mg via G-Tube one time adayi. Magnesium hydroxide oral suspension 400 MG/5ML- give 30 ml via G-Tubej. Melatonin oral tablet 3 MG - give 3 mg via -G-Tube every 24 hours as neededk. Midodrine HCl oral tablet 10 MG - give 10 mg via G-Tube three times a day l. Polyethylene Glycol 3350 powder -give 17 gram via G-Tube every 24 hoursm. Prednisone oral tablet 20 MG - give 20 mg via G-Tube one time a dayn. Multivitamin oral tablet -give 1 tablet via G-Tube one time a dayo. Zyprexa Zydis oral tablet disintegrating 15 MG - give 15 mg via G-Tube at bedtimeThe Order Review Summary Report was reviewed and electronically signed by Resident #1's physician on 2/24/26. On 2/25/26 at 10:04 AM, Staff E, Licensed Practical Nurse (LPN) verbalized Resident #1 had a feeding tube in place. Staff E reported she administered Resident #1's morning medications (crushed) orally (by mouth). Staff E acknowledged the Physician Orders directed medications to be administered via G-tube. On 2/25/26 at 10:21 AM, Resident #1 stated she takes her medication orally with pudding. Resident #1 verbalized she has a pureed diet and received medications orally for about a month. On 2/25/26 at 10:42 AM, Staff D, Advanced Registered Nurse Practitioner (ARNP) reported Resident #1 was comfort focus and when someone was comfort focus medications could be provided orally. Staff D verbalized Resident #1 had a history of aspiration (accidental inhalation of foreign material such as food or liquid) but opted for comfort focus. Staff D reported G-Tube feedings stopped about a month ago. Staff D didn't know when the order to administer medications changed from G-Tube to orally. On 2/25/26 at 10:53 AM, Director of Nursing (DON) verbalized the facility didn't have an order to provide medications orally for Resident #1 prior to 2/25/26. On 2/25/26 at 11:05 AM, a Progress Note documented Staff D, ARNP gave an order for medications to be administered by orally. On2/25/26 at 11:35 AM, the Administrator verbalized the expectation is medications are administered as ordered. On 2/25/26 at 12:42 PM, Staff F, LPN acknowledged Resident #1's medications are administered crushed orally in pudding. Staff F reported Resident #1 likes to have her medications in chocolate (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pudding. Staff F reiterated medications hadn't been administered via her G-Tube. On 3/02/26 at 4:04 PM, Staff E recalled Resident 1's diet order changed around 2/4/26. Staff E verbalized she had conversations with Staff D about the medications. Staff E acknowledged she hadn't transcribed the order to change the route of administration. Staff E verbalized it was a mistake on her part. Review of the Medication Administration Record for February 2026, revealed Staff E administered medications on 2/9/26, 2/15/26, 2/23/26 and 2/25/26. Staff F administered medications on 2/6/26, 2/7/26, 2/10/26, 2/11/26, 2/12/26, 2/13/26, 2/18/26, 2/20/26, and 2/21/26. Review of the undated Medication Administration – Medication Pass facility policy listed the 5 rights of medication administration as:1. Right patient2. Right medication3. Right dose4. Right route5. Right time Review of the Physician Orders/Transcription of Orders facility policy revised on July 2023 revealed, in part, Orders must contain name, strength, route, dose, quantity, diagnosis/indication for use, and specific duration of therapy indicated.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, and clinical record review the facility failed to ensure safe transport of resident in a wheelchair for 1 of 5 residents reviewed for accidents (Resident #60). The facility reported a census of 78 residents.Findings include: The Minimum Data Set (MDS) dated [DATE] revealed Resident #60 scored 4 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severe cognitive impairment. Per this assessment the resident utilized a wheelchair for mobility and had the ability to wheel at least 150 feet in a corridor or similar independently.Review of the Care Plan intervention dated 2/27/24 revealed Resident #60 was an assist of two staff for transferring, and was non ambulatory. On 2/25/26 at 10:45 AM, Staff G, Activities Assistant pushed Resident #60 in their wheelchair while the wheelchair did not have foot pedals applied. Staff G approached the resident from behind, advised the resident they would push them to the activity area and swiftly pushed the resident down the hallway to the activity area, approximately 125 feet. The wheel chair did not have foot pedals, residents' feet scuffled rapidly on the floor in front of the wheelchair in response to being accustomed to locomoting themselves. During an interview on 2/25/26 at 10:50 AM, when queried about the assistance provided to Resident #60 in their wheelchair, Staff G explained they had not intended to push her all the way to the activity area but since they had already assisted, went ahead and pushed the resident the rest of the way. Staff G shared they came up behind the resident and started pushing her because the resident had blocked another resident from getting through the hall. Staff G advised they were aware foot pedals must be on a wheelchair when a resident was pushed. When queried, Staff G advised he was not aware of what was included in Resident #60's Care Plan. Staff G explained he did not think about how the resident shuffles her feet on the floor in front of her and this could have lead to an injury. During an interview on 2/25/26 at approximately 11:30 AM the Activities Director was interviewed and advised her staff are not Certified Nursing Assistants and for the most part do not transport residents. They will occasionally assist but they all know foot pedals have to be on the wheelchair or they can not push a resident in their wheelchair. It is her expectation a resident is only pushed in a wheelchair if the foot pedals are in place. During an interview with the Facility Administrator on 2/25/26 at approximately 12:30 PM, She advised it is her expectation if a resident is pushed or assisted in their wheelchair their foot pedals must be on. Footrests are a required safety component and must be in place prior moving a resident. On 2/26/26 at 1:55 PM Staff H, Certified Nursing Assistant (CNA) was queried in regards to wheelchair transports. Staff H advised if a resident is not able to propel themselves in their wheelchair they can only be assisted if they have their wheelchair pedals on and both feet are on the pedals. If the resident's feet are not securely on the pedals their feet could drag or get caught on something or bended back. On 2/26/26 at approximately 3:15 PM the Director of Nursing (DON) was interviewed. The DON advised the facility does not have a policy specifically for wheelchairs. The facility practices and follows the standards of care. The DON advised it is their expectation no resident should be pushed in a wheelchair without foot pedals. The DON advised staff are required to complete ongoing training including training regarding safety during wheelchair transportation and education is provided with facility compliance checks. The DON relayed the expectation is that staff are aware of the potential dangers and use foot pedals on wheelchairs when pushing a resident.

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	165017	A. Building B. Wing	03/03/2026

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

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the resident interview, staff interviews, and record review the facility failed to ensure a resident had a transfer sling before leaving for a dialysis appointment, which caused missed dialysis treatment for 1 of 3 residents reviewed for dialysis (Resident #4). The facility reported a census of 78 residents.Findings include: Review of Resident #4's Minimum Data Set (MDS) assessment dated [DATE] listed diagnoses of end stage renal disease (ESRD) and dependence on renal dialysis.The Care Plan focus area for dialysis, dated 5/8/25, documented Resident #4 required dialysis related to ESRD, and the intervention dated 5/8/25 revealed resident received dialysis on Monday, Wednesday and Friday. On 2/23/26 at 11:13 AM, Resident #4 relayed was not able to get dialysis today because the staff did not put the transfer sling under the resident on the chair that is required by dialysis, and the dialysis clinic staff said the resident had to go back to the facility. Resident #4 relayed there would not be enough time going back and forth and it was frigid cold weather so had to wait until next appointment of Wednesday for dialysis (refers to filtering of the blood when the kidney cannot). Review of the Progress Note dated 2/23/26 at 5:08 PM revealed, Resident was transported to dialysis without the proper [Brand Name Lift] sling in place. Dialysis staff notified transportation and facility that required transfer equipment was not present. Resident was given the option to return to the facility to retrieve the sling and then return to dialysis; however, resident was informed that the dialysis session would be shortened due to time constraints. On 2/23/25 at 5:10 PM the Administrator relayed awareness that Resident #4 did not get dialysis today and reported education to staff had already begun. On 2/23/26 at 5:17 PM the Director of Nurses relayed it was a hectic morning with many residents not feeling well and felt staff just missed putting the required sling on the chair before resident transferred to it. A document titled nursing home dialysis transfer agreement signed 4/11/22 by facility representative revealed the facility contracted to assure the availability and timeliness of dialysis treatments for the residents with ESRD.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview and facility policy the facility failed to ensure a medication error rate of less than 5% when two errors were observed from thirty-one opportunities for 1 of 5 residents observed during medication observations (Resident #9). This resulted in a medication error rate of 6.45%. The facility reported a census of 78 residents.Findings include: Review of Resident #9's Minimum Data Set (MDS) dated [DATE] documented the resident took medications which included high risk medications, hypoglycemic for diabetes control and diuretics. The MDS further documented the resident had diagnoses which included heart disease and diabetes. Beginning observation on 2/25/26 at 9:27 AM Staff A, Certified Medication Aide (CMA) placed in a medication cup the following medications ordered for Resident #9.One of each of the following oral medications for Resident #91. methocarbamol , 500 milligrams (mg) 2. primidone, 50 mg3. furosemide, 40 mg4. atenolol, 50 mg5. jardiance, 10 mg6. potassium, 10 milliequivalent (MEQ)7. omeprazole, 20 mg8. senna, 8.6 mg9. metformin, 1000 mg10. ezetimibe, 10 mg11. iron, 325 mg12. fish oil, 1000 mg13. aspirin, 81 mg14. cetirizine, 10 mg15. pregabalin, 200 mgand two each of the 16th medication, acetaminophen 500 mg tabs to total 17 medications. On 2/25/26 at 9:52 AM CMA, Staff A relayed was ready to deliver the medications and counted the number of pills per request. Staff A relayed had 17 pills in the medication cup. Potassium capsule was a 10 Milliequivalent (MEQ) dose and the order was for 20 MEQ. The primidone tablet was a 50 milligram (mg) tab and the physician ordered 150 mg. Staff A confirmed had only one of each of those medications in the cup. On 2/25/2026 at 10:10 AM, met with the Director of Nursing and the Administrator for updates regarding medication observation, was relayed Staff was new CMA and agreed to send facility policy.A Document, undated, titled Medication Administration-Medication Pass documented the five rights of medication administration included the five rights: patient, medication, dose, route and time.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident interview, staff interview, and policy review the facility failed to ensure ongoing coordination of dental services for 2 of 2 residents reviewed for dental services (Resident #10, # 76). The facility reported a census of 78 residents. Findings include: 1.Review of Resident #10's Minimum Data Set (MDS) annual assessment dated [DATE] listed diagnoses of Traumatic Spinal Cord Dysfunction, paraplegia, diabetes and renal disease. The Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicated intact cognition. The MDS did not code for dental, mouth or pain discomfort. The Care Plan focus for Resident #10 initiated 6/16/25 documented had complaints of pain related to obesity, gout, spinal cord injury, substance abuse history, kidney disease and diverticulitis, and had acute pain due to abdominal distention and recent diagnosis of stercoral colitis (inflamed bowel). The Care Plan did not address Resident #10 repeated complaints of teeth pain, which included abscesses. The Care Plan lacked interventions for teeth related pain or treatments for the infections. On 2/23/26 8:47 AM, Resident #10 relayed had tooth ache, had reported to nurse today on duty and received medications.On 2/24/26 at 11:00 AM, Advanced Registered Nurse Practitioner (ARNP), Staff D relayed Resident #10 is in agreement for dental services due to two abscesses. Staff D added major obstacle to locate dental services for those on Medicaid. On 2/26/26 at 11:06 AM the Staff K, Social Services relayed Resident #10 had just made an appointment set up for next week due to the emergency related dental needs, tooth abscess, and need for antibiotics. On 3/2/26 at 11:35 AM the facility contracted dental provider, Staff I, relayed the facility application for Resident #10 was received September 2025 and Resident #10 became eligible October 1, 2025. On 9/3/25 the facility Business Office Manager (BOM) relayed to hold the process because Resident #10 had no Client Participation (CP)(money to contribute). The NF also relayed would check with family and never heard back from the facility. Staff I relayed felt Resident #10 fell through the cracks because if a resident cannot contribute with a CP than this dental provider could bill Medicaid directly. Staff I explained would plan a follow up visit Resident #10 this week and relayed many procedures could be done at the facility for Resident #10.On 3/2/26 at 12:47 PM the BOM relayed the Nurse Manager determined Resident #10 would not qualify for dental services with the facility contracted provider since had no CP to contribute. The BOM relayed all that could be done is to call around to find a provider that would accept Medicaid. On 3/2/26 at 1:00 the Nurse Manager, Staff J relayed since Resident #10 does not qualify for services with the facility contracted dental provider, would have to try to get a local dentist that accepted Medicaid. Relayed didn't handle all the attempts to find a dental provider for Resident #10, and further explained thought there were transportation problems, the facility had a van, but Resident #10 was too long. The DON said Resident #10 would need therapy to work him and his wheel chair before Resident #10 could use the transportation. On 3/2/2026 at 2:46 PM R#10 relayed he had not refused going to dentist, did not go because was informed would not fit in the van. Relayed looked forward to going tomorrow, would not have refused, said that would be crazy, needed the teeth looked at. Relayed still having pain related to teeth. On 3/3/26 at 9:02 AM the Administrator relayed Resident #10 was coordinated for a trip out of town for a Medicaid approved dental appointment today, was able to go by local transit, felt he was good to go alone since he is alert and oriented. Relayed Resident could not have dental work done by their contracted provider since had no client participation. A Progress Note dated 8/28/25 documented dental concerns, Resident #10 said My mouth hurts history of cracked teeth. Resident #10 reported dental pain involving two teeth in the upper left quadrant, which began two days ago. Dental caries noted on the left upper teeth, initiated antibiotic therapy due to concern for potential gum infection. Advised patient to seek dental evaluation for further management, cracked tooth identified in the lower back region, recommended dental consultation for definitive treatment.A Progress Note dated 11/13/25 revealed Resident #10 relayed tooth pain came on all of a sudden and is worst in right lower (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	as well as left lower, stated are 3 different teeth, aware the three teeth are cracked and are likely exposing the root which is causing pain, on examination there is no significant signs of infection, no redness or swelling noted but he does have significant decay and several teeth that are cracked. Resident #10 stated due to his insurance, noncompliance in the past he is unable to go to a dentist or have the facility dentist see him. Significant acute decay but no obvious sign of infection, However, given concern for possible infection or underlying infection in the gum, treated with antibiotics for ten days, ordered special mouthwash and pain medication. The Advanced Registered Nurse Practitioner (ARNP) relayed, discussed with the Director of Nurses, (DON) again regarding need for dental care.A Progress Note dated 11/17/25 revealed Resident #10 with persistent dental pain, had not improved with antibiotics. The pain is most bothersome in the lower jaw, specifically in in area with a cracked tooth. The patient has not been taking tramadol (pain medication) for pain relief, as they were unaware it was available PRN (as needed).The patient had a prior dental appointment scheduled but was unable to attend due to transportation issues, specifically sliding out of the chair on the bus. The patient stated would go to the dentist if transportation could be arranged, as the dental pain is significant. A Progress Note dated 11/18/25 revealed Resident #10 continued on antibiotics for mouth pain and teeth infection, palpated neck and sides of jaw, noted to have large lump, hardened area on right lower jaw area with neck lymph on right side more edematous than left, noted to be painful.A Progress Note dated 11/21/25 revealed Resident #10 encouraged to collaborate with therapy for transportation assistance, discussed this with therapy and they are in agreement to work with him again so that he can get his teeth fixed.A Progress Note dated 12/16/25 revealed Resident #10 presents for evaluation of dental pain. The patient reports pain in the left upper and right lower teeth. He has not been taking tramadol for pain relief, instead using Tylenol .several decayed and cracked teeth noted-no changes. A Progress Note dated 2/6/26 revealed Resident #10 presents with dental pain. The patient reports dental pain in the upper and lower teeth, described as zingers. He reports some relief with pain medication. He states he is willing to do whatever needs to be done to get in to see the dentist.A Progress Note dated 2/16/26 revealed Resident #10 presents with dental pain, requests pain medication, reported primarily for the lower teeth, noted a dental prosthesis or fragment that was previously causing discomfort is now gone, with only small fragments remaining. Resident #10 is inquiring about when he can get in to see someone to have his teeth pulled Previously noted split posterior lower tooth now absent with only small fragments remaining. A Progress Note dated 2/24/26 at 9:53 AM revealed Social Services, Staff K wrote, reached out to a dental provider about an upcoming appointment in March, reported back needed additional lab work. 2. Review of Resident #76's MDS dated [DATE] listed diagnoses of heart and lung disease, anxiety, and depression. The Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicated intact cognition. The Care Plan for Resident #76 initiated 10/22/24 documented chronic pain, did not address specifics related to teeth pain and abscess (infection). A Progress Note dated 2/23/26 documented, Resident #76 started on Cephalexin, antibiotic for dental abscess.The Medication Administration Record (MAR) for February 2026 revealed Resident #76 took Cephalexin, 500 milligram (mg) three times a day for infection for five days, started 2/21/2026.On 2/24/2026 at 8:16 AM Resident #76 relayed took antibiotics for tooth abscess, thought the Social Worker (SW) was looking at setting up a dental appointment. On 2/26/2026 at 11:22 AM, Staff K relayed looking for a provider to accept Resident #76, last referred would not accept, Relayed Resident #76 said could only pay ten dollars a month and the provider declined to service.The Facility Assessment, approved date 1/26/26 documented provision for dental services included (names redacted) of two dental providers.