STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165033	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Davenport	815 East Locust Street Davenport, IA 52803

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 - 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, clinical record review, and staff interview, the facility failed to ensure a resident with a history of poly substance overuse smoked safety when under the influence for 1 of 1 (Resident #1) residents reviewed for smoking safety. The facility reported a census of 70 residents. Findings include: Review of the Minimum Data Set (MDS) assessment tool dated 4/10/25 revealed Resident #1 admitted to the facility on [DATE]. A score of 14 out of 15 on the Brief Interview for Mental Status (BIMS) indicated intact cognition. The MDS list of diagnoses included anxiety, asthma and respiratory failure. Review of the document Smoking Program assessed the following areas to determine if a resident is an unsafe smoker of cigarettes. Per the instructions the assessor to evaluate or observe the resident in the following areas. Any check will make the resident unsafe smoker using a cigarette: a. Unable to comprehend facility-smoking policy? b. Smokes in unauthorized areas? c. Careless with smoking materials? d. Burn holes observed on clothing or wheelchair? e. Inappropriately extinguishes cigarettes or matches? f. Provides smoking materials to others? g. Unaware of surroundings? h. Poor judgement or decision-making skills? i. Inability to control movements or maintain control of cigarette? j. Inability to follow instructions? (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	k. Unable to safety light cigarette? l. Falls asleep while smoking? m. Other physician limitations or behaviors that interfere with safe smoking? n. None of the above. Review of the Smoking Program assessments completed on 4/16/25 and 6/3/25 revealed no areas checked. The section Program Independent Smoking Program listed a Focus area: Tobacco use, with the Goal: Resident will adhere to smoking policy. Intervention: Independent Smoker: May smoke without assistance. The 6/3/25 assessment added the Intervention: Independent Smoker: Must smoke only in designated areas/designated times (unless able to independently get to and from the designated areas). The Smoking Program assessments completed on 4/16/25 and 6/3/25 did not address if Resident #1 unsafe smoker using cigarettes when under the influence. Review of the Care Plan, dated 4/2/25, revealed a Focus area to address Tobacco Use. Interventions included, in part: a. Independent Smoker: May smoke without assistance. Date Initiated: 4/17/25. b. Independent Smoker: Must smoke only in designated areas/designated times (unless able to independently get to and from the designated areas). Date Initiated: 6/3/25. Review of the Care Plan, dated 6/3/25, revealed a Focus area to address History of poly substance overuse that may impact psychosocial functioning. Interventions did not address general safety or safety when smoking. Review of a facility self-report, dated 5/31/25 at 8:21 AM revealed, in part: The morning of 5/31/25 at approximately 7 am DON [name redacted] was called to this facility as the police department was contacted due to a noise complaint related to residents on the smoking patio. When DON arrived at facility approximately 7:15 resident [name redacted, Resident #1] was on the smoking patio being very loud and belligerent. (continued on next page)

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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 - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/12/25 at 2:43 p.m., Staff A, Registered Nurse (RN) stated on the evening of 5/30/25 Resident #1 left with his family and returned between 10:15 p.m. - 10:30 p.m. Staff A stated when he first returned he was pleasant and did not act that intoxicated. She stated as the night progressed he became increasingly belligerent, extremely loud, and uncooperative. Staff A stated he was drunk, and demanded to smoke. She explained he was out on the smoking patio for several hours during the night shift. She stated she had gone out to check on him, at least 3 times, encouraged him to come inside so she could check his oxygen levels. She stated he allowed her to check one time between 3:30 a.m. and 4:00 a.m. Staff A stated Resident #1 was loud and yelling when out on the patio, despite her asking him to keep it down and lower his voice. She stated the resident was unable to be reasoned with. While on the patio Resident #1 had a can of beer, which he surrendered when she requested. Staff A stated there was less than an ounce of beer left in the can. She stated around 5 a.m., a neighbor called the facility and reported a resident was yelling loudly outside and asked if there was anything the facility could do to make the resident stop yelling. Staff A stated she notified the Director of Nursing (DON) at that time, and the police did come to the facility. During an interview on 6/19/25 at 3:10 p.m., Staff D, Licensed Practical Nurse (LPN), stated she did not think the resident was safe to smoke independently when he was intoxicated. Staff D stated but try telling him that, he does whatever he wants. Staff D state had not observed Resident #1 dropping a cigarette when outside or burning a hole in clothing, but had heard this had happened. During an observation on 6/19/25 at 3:18 p.m., Resident #1 in his room with two staff members. Resident #1 had returned to the facility after a family outing. Resident #1 yelled loudly, speech appeared slurred, and demanded to go outside to smoke. The staff were unable to calm the resident or get him to lower his voice. During an interview on 6/19/25 at 3:20 p.m., the Administrator stated the Smoking Program assessments reflected one point in time. She stated a resident's condition could vary, someone who could smoke independently today may not be able to smoke independently tomorrow if their condition changed. When asked if she thought Resident #1 should smoke independently in his current condition per the observation at 3:18 p.m., the Administrator stated she would have to assess further and went to the resident's room During an interview on 6/19/25 at 4:51 p.m., Staff A, RN stated Resident #1 was under the influence he was not safe to smoke. She stated when he is intoxicated there is no reasoning with him. Staff A stated there were times when he was intoxicated that he would let the cigarette burn down to his fingers, she wasn't aware of any injury from that. She heard that he burned a hole in one of his jackets when smoking outside and he probably needed to wear a smoking apron (a fire-retardant garment worn to protect clothing from burning ashes/cigarettes). During another interview on 6/23/25 at 8:07 a.m., the Administrator stated that she put a new plan in place for Resident #1. She explained he would be supervised when smoking at all times, and there was a staff member assigned on each shift to do so.