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	06/30/2026

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, and staff and resident interviews, the facility failed to ensure that residents were able to choose sleeping and waking schedules per their preference for 4 residents (Resident #11, Resident #16, Resident #24 and Resident #25) when an intoxicated resident (Resident #8) frequently woke the residents during the night due his being loud and argumentative with staff. The facility reported a census of 71 residents.Findings include:Review of Resident 8's Minimum Data Set (MDS) assessment tool dated 5/28/26, revealed Resident #8 scored 7 out of 15 points possible on the Brief Interview for Mental Status (BIMS)score of 7 out of 15, indicating a severe cognitive impairment. The diagnoses list included alcohol dependence, tobacco dependence, alcohol abuse, and COPD (chronic obstructive pulmonary disease) with dependence on supplemental oxygen. The assessment indicated Resident #8 demonstrated verbal behaviors, other behaviors not directed towards others and rejected care from 1 to 3 days of the 7 days that preceded the assessment.Review of Resident #8's Care Plan dated 3/18/26, revealed a Focus area to address Resident has a mood state disturbance related to anxiety, alcohol use; refusal of cares, refusal of assessments, poor compliance; restlessness, fatigue, difficulty concentrating, irritability, easily annoyed and sleep problems, derogatory or yelling behavior towards staff, refuses to follow safe food storage, refusal and/or poor compliance with prescribed plan of care. Interventions initiated on 3/18/26 included, in part:a. Encourage adequate rest periods.b. Evaluate causative factors contributing to mood disturbance.c. If resistive to care, attempt to reapproach at a later time.d. Notify practitioner of significant changes in mood or behavior.e. Psych evaluation as needed as patient wishes.f. Utilize relaxation techniques such as exercise, music, low lighting, going outside etc.g. Approach/speak in a calm manner.f. Communicate clearly and assertively what behaviors are unacceptable and inappropriate.h. Document behaviors and response to intervention.i. Remove resident from situation and take to alternate location as needed.j. Staff to maintain respect for resident rights to make own lifestyle choice.Review of the electronic health record (EHR) revealed the following:a. On 4/4/26 at 4:59 PM: Resident consumes more than the allotted dosage of alcohol, Resident is very intoxicated and yelling out being belligerent singling out staff and yelling at staff member. Resident behaviors have a negative effect on other residents causing disruption to other residents here on the floor. Some of the other residents are becoming upset with this resident and yelling and threatening physical violence towards this resident which causes this resident to use foul language and yell even louder to other residents on the floor. Resident is unable to be redirected by staff, unable to move resident from the area he is sitting in, resident gets louder with yelling at staff and other residents. b. On 5/9/26 at 6:00 AM: Resident out to nurses' station, yelling loudly, cursing at staff and other residents. Disruptive, waking other residents, yelling loudly down the hallway. Many attempts to redirect resident without success. Cursing at staff yelling shut the fuck up Res called 911 stating this nurse was not providing cares and he needed help. When asked Resident what he needed help with he said I don't know, not a damn thing, just do your job Continued difficulty with redirection. Refusing to go to his room as other residents complaining. 0500 this am as staff assisting others, (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident sitting by patio door inside, in his wheelchair with oxygen in place and lit a cigarette. As nurse came around corner Resident threw cigarette on the ground and stomped it out. Resident educated on fire and explosion risks with smoking and oxygen with Resident stating that wasn't me I don't care I don't know what you are talking about Continued to be loud, cursing at staff and other residents. On call nurse notified of residents behavior. c. On 5/11/26 at 7:54 AM: Resident highly intoxicated this Am shift. Resident out to nurses station, yelling loudly, cursing at staff and other residents. Disruptive, waking other residents, yelling loudly down the hallway. Many attempts to redirect resident without success. Resident refusing to go to his room as other residents complaining. Resident sitting by patio door inside, in his WC with oxygen. Resident playing music on his phone and is loud and is heard on entire floor and refused to turn down and or off. d. On 5/17/26 at 9:11 PM: Resident got up out of bed and into his wheelchair, has a bottle of alcohol on him. Resident sitting at the nurses station by the patio door waiting to go outside and smoke, is very loud when speaking and other residents are becoming upset and coming out to the nurses station to tell him to quiet down. Other resident is verbally making physical threats but not acting on threat towards this resident. This resident then went outside to smoke, resident could be heard from inside nurses station yelling when talking outside. Staff reported residents got into a verbal altercation and this resident reports another resident pushed him, put his fingers in this resident's face causing this residents to call the police. e. On 5/25/26 at 9:06 PM: Resident continues to consume large amounts of alcohol resulting in obnoxious behaviors which is disturbing to other residents on the floor. Resident loud yelling out during conversations causing other residents to awaken and become upset with him related to behavior, management aware of behaviors. f. On 5/25/26 at 11:07 PM: Monitoring of Substance Use Disorder. signs and symptoms related to substance use and potential overuse. See nurses notes if symptoms are present, notify provider and complete documentation every shift related to ALCOHOL ABUSE WITH INTOXICATION, UNSPECIFIED.Was a behavior observed? YES resident is inebriated being loud, rude and obnoxious to staff and other residents. g. On 5/29/26 at 6:55 AM: Resident sitting at nurse station in his wheelchair and appears to be intoxicated. Resident yelling outward at staff and toward co-residents. Resident expressing verbal outburst toward staff, resident was and unable to redirect. h. On 6/3/26 at 12:49 AM: Monitoring of Substance Use Disorder. signs and symptoms related to substance use and potential overuse. See nurses notes if symptoms are present, notify provider and complete documentation every shift related to ALCOHOL ABUSE WITH INTOXICATION, UNSPECIFIED.Was a behavior observed? YES resident being loud, rude and obnoxious to staff and other residents.i. On 6/4/26 at 12:13 AM: Monitoring of Substance Use Disorder. signs and symptoms related to substance use and potential overuse. See nurses notes if symptoms are present, notify provider and complete documentation every shift related to ALCOHOL ABUSE WITH INTOXICATION, UNSPECIFIED.Was a behavior observed? YES resident returned from the neighbors with 5 beers and a bottle of liquor being loud and obnoxious. Attempted to send multiples of beer with the neighbor, resident very loud and refused to allow. j. On 6/18/26 at 6:34 AM: Sitting at nurses station this Am and appears to be intoxicated. Speech slurred and leaning in his wheelchair. Sitting in his wheelchair with a bottle of alcohol and drinking at intervals. Resident declined to give bottle to staff for safety. Resident talking in loud tone which indicates he has signs/symptoms of obnoxious behaviors. Resident continues to use derogatory words and not easily redirected. When asked to lower his voice and or calm down he gets louder. Resident continues to talk, yell outward in loud tone. Will continue with plan of care. k. On 6/29/26 at 6:00 AM: Resident has been drinking alcohol, black bag sitting behind resident in his wheelchair. Refuses to give to staff. Resident yelling loudly, slurred speech, eyes glossed over, yelling/cursing loudly and demanding towards staff to assist with cares. Sitting at nurses station coughing, spitting mucous/secretions on the floor despite having tissues and asked multiple times to not. Resident waking other residents, unable to redirect, states I don't give a fuck Monitored frequently. Verbal altercation with another resident on patio, yelling, cursing, derogatory statements regarding nationality. Unable to redirect. Continued behaviors. On call supervisor informed (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of difficulty with residents behavior. Will continue to monitor and call for support if continued. Resident returned to his room around 0330. In his chair resting at this time. During an interview on 6/25/26 at 9:36 AM, Resident #24 stated she had been woken up in the middle of the night quite a few times by another resident yelling and causing problems, the last time was around a week or so ago. Resident #24 identified the resident yelling as Resident #8. The staff tried to calm him down but that just made things worse with him. She preferred to sleep through the night if she could. A MDS dated [DATE], indicated Resident #24 had intact cognition based on a BIMS score of 15 out of 15. During an interview on 6/25/26 at 9:44 AM, Staff B, Licensed Practical Nurse (LPN), stated Resident #8 has been inebriated on her shift before, but it's usually on the evening or night shift that they have the problems with him and his drinking. When he's inebriated, he's unreasonable, he can't be redirected and he just doesn't care. They try to redirect him to his room or away from the other residents, sometimes he will go out to smoke but they usually have to get the other residents away from him. If they try harder to get him to his room or out of the common area and away from other residents, he becomes argumentative, yells, curses at staff and they can't really control what he says/does when he's that way. During an interview on 6/25/26 at 10:55 AM, Resident #25, stated he had been woken up in the middle of the night many times by a resident yelling. The staff can't make him stop yelling, when they yell at him that makes it worse and he yells more. Resident #25 identified the resident yelling as Resident #8. Resident #25 stated he would rather sleep through the night without someone yelling like that. A MDS dated [DATE], indicated Resident #24 had intact cognition based on a BIMS score of 15 out of 15.During an interview on 6/25/26 at 1:32 PM, Resident #16 stated he had been woken up in the middle of the night several times by a resident who gets very loud, yells, curses and it's not pleasant at all. Resident #16 identified the resident who has woken him up yelling as Resident #8. A MDS dated [DATE], indicated Resident #24 had intact cognition based on a BIMS score of 15 out of 15. During an interview on 6/25/26 at 1:47 PM, Resident #8 stated he got the care he needed, staff usually treated him with dignity but there were too many rules. Resident #8 stated he's always been a night owl, he's up at night and slept during the day, they don't like that but that was their problem, not his and he's not going to change. He's going to go outside and smoke when he wants to, he can drink alcohol, he's an adult and can do that when he wants to, but the staff want to argue with him about thatDuring an interview on 6/25/26 at 2:05 PM, Staff J, LPN stated when Resident #8 has been intoxicated, he yells at the nurse's station, wakes other residents, and there is nothing staff can do to make him stop yelling or acting that way. She stated Resident #8's leaves the facility, usually late evening between 10:00 PM and 11:00 PM and returns anytime between 12:00 AM and 2:30 AM. Staff J stated she usually documents the time, and the resident has to sign the in and out book. Staff J stated the resident will not let anyone touch his wheelchair or search him for alcohol, and he starts yelling and cursing if attempted. Staff J added Resident #8 wakes up other residents when returns intoxicated. Staff J stated she has called the manager on call when this happens and the decision has been if the resident is not hurting himself or others to leave him be, keep everyone safe, no other actions taken. During an interview on 6/25/26 at 2:12 PM, Resident #11 stated he had been woken up several times during the night by a resident that goes out, gets drunk and then yells and argues with the staff when he comes back in the middle of the night. This has happened a lot, the last time was the night before last. Staff tried to help the resident but he doesn't want their help and curses at them. Resident #11 identified the resident yelling as Resident #8. Resident #11 stated he preferred to sleep through the night and didn't want to listen to that. A MDS dated [DATE], indicated Resident #24 had intact cognition based on a BIMS score of 14 out of 15. During an interview on 6/25/26 at 3:38 PM. Staff K, Registered Nurse (RN) stated Resident #8 frequently leaves the facility during the late evening/night shift, and when he returns, he is often drunk. She stated when he is drunk, he yells, curses, becomes argumentative and wakes up other residents. She stated despite closing room doors, some residents still woke up. Staff K described one night when Resident #8 demanded she call his debit card company to check his balance. She stated there was a call light going off at the time, and (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	he didn't want to wait. Staff K stated after she told him the balance, he demanded that she put the phone on speaker because he didn't believe her. Staff K stated when she told Resident #8 she had to answer the call light he called 911. During an interview on 6/30/26 at 8:10 AM, the Administrator stated she looked closer at Resident #8's conditions, found his BIMS at 7, spoke to him about safety and he was not safe to leave the facility given the nature of his cognition. She spoke with him about alcohol treatment to which he said he did need to do something about the alcohol. He went out over the weekend, came back with alcohol and intoxicated, the nurse tried to take his alcohol but he refused and became more agitated. She called an inpatient alcohol detox/treatment center to inquire about a referral and hoped to hear from them with a decision later that day. She spoke to staff yesterday and directed them they were not to let Resident #8 leave the building without someone signing him out. Review of the facility policy titled Dignity and Respect policy, dated 4/2024 revealed a Purpose statement with declared: To lay the foundation for treating all residents with dignity and respect and maintaining and enhancing his or her self-esteem and self-worth.The Procedure section directed, in part: 1. Each Resident has the right to considerate and respectful care and to be treated with honesty, dignity, respect and with reasonable accommodation of individual needs except where the health, safety, or rights of the resident or other individuals in the facility would be endangered.2. Each Resident has the right to be free from physical, verbal, sexual or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms.3. Each Resident has the right to retain and use personal possessions, including furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.4. Each Resident has the right to participate in their own care and treatment.5. Each resident has the right to manage their own finances.6. Each resident has the right to file grievances.7. Each resident has the right to access their own information.8. Each resident has the right to have visitors.9. Each resident has the right to be free of discrimination and reprisal from the facility in exercising his/her rights.10. Each resident has the right to equal access to quality care regardless of diagnosis, severity of condition, or payment source11. Each resident has the right to exercise his/her rights of the facility as citizen/resident of the United States.

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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, clinical record review, resident and staff interview, the facility failed to ensure resident safety by not storing smoking materials in a safe location for a resident using oxygen and ensuring a resident's feet are on the foot pedals during a wheelchair transport for 2 of 5 residents (Resident #6 and Resident #22) reviewed for safety. The facility reported a census of 71 residents.Findings include:1. Review of the Minimum Data Set (MDS) dated [DATE] identified Resident #6 as cognitively intact with a Brief Interview for Mental Status score of 14 out of 15. The list of diagnoses included chronic diastolic congestive heart failure, multiple sclerosis and COPD (chronic obstructive pulmonary disease). The MDS identified Resident #6 required supervision/touch staff assistance with most activities of daily living and required oxygen therapy. Review of Resident #6's Care Plan revealed the following Focus areas: a. Resident is at risk for ineffective breathing.date Initiated: 5/9/25. Intervention included, in part: Administer oxygen per order. b. Tobacco Use, date initiated: 3/29/26. Interventions included, in part: Independent Smoker: Must keep smoking accessories secured when into in use (via lockbox or in control of facility staff). Review of the most recent Smoking assessment dated [DATE] identified Resident #6 as an Independent Smoker.Resident is considered a safe smoker and May use/access smoking materials consistent with facility policy. Staff is not required to remain in attendance while resident is smoking. RESIDENT AGREES TO FOLLOW SMOKING RULES During an observation with interview on 6/3/26 at 9:38 AM, Resident #6 stated he kept his pack of cigarettes and his cigarette lighter on him. Resident #6 then pulled put each from his shirt pocket. Resident #6 using continuous oxygen via oxygen concentrator (a machine that pulls in room air, separates out the nitrogen and delivers concentrated oxygen) set at 4 liters per minute via nasal cannula. During an interview on 6/4/26 at 7:44 AM, Staff B, Licensed Practical Nurse (LPN) stated she was not sure if residents were allowed to keep cigarette lights in their room with use of continuous oxygen. She stated it was not a safe practice, however, if the resident was alert, then it should be safe. During an interview on 6/4/26 at 10:39 AM, the Assistant Director of Nursing (ADON) reported residents who have continuous oxygen should not have their cigarette lighters kept in the same room. During an interview on 6/4/26 at 12:01 PM, the Director of Nursing (DON) reported it is not safe for a resident to keep a cigarette lighter in a room where there is continuous oxygen running. Review of the facility policy titled Smoking Policy revised January 2024, revealed a Purpose section which declared: To establish and maintain safe resident smoking practices and determine if a resident is an Independent or Dependent smoker prior to the resident exercising the privilege to smoke. Facilities, at their discretion, may choose to not allow smoking on their premises, may allow smoking only when the resident requires no supervision to smoke, or may offer smoking times and supervised (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	smoking only The Guidelines section for Smoking Facilities directed, in part: Residents determined to be an Independent Smoker may smoke without assistance or supervision. Independent Smokers must follow smoking guidelines including keeping smoking accessories secured when not in use (via lockbox or in control of center staff), smoking only in designated areas/designated times (unless resident is able to independently get to and from the designated smoking area). 2. The Minimum Data Set (MDS) dated [DATE] identified Resident #22 as cognitively intact with a BIMS (Brief Interview for Mental Status) of 14 and had the following diagnoses: Epilepsy, Anxiety Disorder and COPD (Chronic Obstructive Pulmonary Disease). The MDS also identified Resident #22 required supervision/touching assistance from staff with showers and required set up or cleanup assistance with showers and toileting. The MDS also identified Resident #22 has had two or more falls since admission, however, none which resulted in injury. An observation on 6/3/26 at 2:15 PM revealed the Assistant Director of Nursing (ADON) who pushed Resident #22 in a wheelchair in the hallway without foot pedals and feet skimming the floor. The ADON informed Resident #22 don't forget to lift up your feet Resident properly positioned and appeared comfortable. On 5/21/26, the Care Plan identified Resident #22 to be at risk for unavoidable falls related to seizures, impatient, impulsive, does not wait for supports. The Care Plan failed to identify intervention to ensure foot pedals are on the wheelchair prior to transporting the resident. During an interview on 6/4/26 at 7:31 AM, Staff A, CNA, reported when transporting a resident in a wheelchair, she would need to put the foot pedals on the wheelchair first then place the resident's feet on the foot pedals. If this isn't done, the resident could flip out of the wheelchair if their feet get caught. She also stated Resident #22 has a history of falls. During an interview on 6/4/26 at 7:44 AM, Staff B, LPN reported before staff transport a resident in a wheelchair, they should make sure there are foot pedals on the wheelchair and make sure their feet are placed on the foot pedals. If this isn't done, the resident could fall out of the wheelchair. During an interview on 6/4/26 at 10:39 AM, the ADON reported staff should make sure the foot pedals are on the wheelchair and put the resident's feet on the foot pedals before transporting them and if they forget to, the resident could flip out of the wheelchair. She verified she pushed Resident #22 in her wheelchair without the foot pedals as she is usually independent and self-propels on her own. She also admitted she did have a history of falls and that it was her mistake. During an interview on 6/4/26 at 12:01 PM, the DON reported before staff transport residents in a wheelchair, she would expect them to place the foot pedals on the wheelchair and feet should be placed on the foot pedals. If this is not done, residents could fall out of the chair and fracture something. Upon request for a facility policy which addressed safe wheelchair transport, the Administrator reported the facility did not have one.