STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165033	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/06/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, facility policy review, resident and staff interviews, the facility failed to implement the infection control practices of hand hygiene and use of Enhanced Barrier Precautions during wound care treatment and the cleaning of a g-tube insertion site for 4 of 6 residents (Resident #1, Resident #2, Resident #5, Resident #64, and Resident #) reviewed for infection control. The facility reported census of 68 residents. Findings include:1. Review of the Minimum Data Set (MDS) assessment for Resident#2, dated 12/30/25 revealed a list of diagnoses which included diabetes mellitus, high blood pressure and schizophrenia. The MDS indicated the resident dependent for personal hygiene, bath/shower and transfers. The MDS cognitive assessment for Resident#2 showed short- and long-term memory problems and severely impaired decision daily decision making. Review of Resident #2 Care Plan, dated 3/17/26, revealed a Focus area to address at risk for alteration in skin integrity related to impaired mobility diabetes, incontinence, morbid obesity.Interventions included, in part: a. Administer medications as ordered. Date Initiated: 3/17/26. b. Administer treatments per physician orders. Date Initiated: 3/17/26. c. Facility policies/protocols for the prevention/treatment of skin breakdown. Date Initiated: 3/17/26. Review of the April 2026 Treatment Administration Record (TAR) revealed an order (L – left) inner elbow: Cleanse wound NS (normal saline)/wound cleaner. Dry thoroughly. Apply double layer of xeroform to wound. Change dressing twice daily and as needed (PRN).Start Date: 3/20/26. During an observation on 04/02/2026 at 7:28 AM, Resident #2 in bed. Enhanced Barrier Precaution (precautions taken in an effort to reduce the spread of multidrug resident organisms (MDROs) supplies include gloves and gowns) supply caddy present and hung over the room door. Staff K, Licensed Practical Nurse (LPN) in room. He washed his hands, and donned (put on) gloves. Staff K did not don a gown. Staff K removed the old dressing from the residents left elbow placed it in the trash can. Without a change of gloves and completing hand hygiene, Staff K cleaned the wound. Without a change of gloves and completing hand hygiene, Staff K applied a new dressing to Resident #2's left elbow. During an interview on 04/02/2026 at 7:33 AM, Staff K, LPN stated he did not use the gown for EPB, and he did not change gloves or complete hand hygiene during wound care. During an interview on 4/2/26 at 3:30 PM, the Administrator stated she expects staff to wear gloves and a gown for EBP, and to change gloves and complete hand hygiene between tasks. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165033	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/06/2026
NAME OF PROVIDER OR SUPPLIER Harmony Davenport		STREET ADDRESS, CITY, STATE, ZIP CODE 815 East Locust Street Davenport, IA 52803	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #64's MDS, dated [DATE], revealed a list of diagnoses which included stroke and osteomyelitis (bone infection). The MDS identified the resident with a Stage III pressure ulcer (a full-thickness loss of skin, in which subcutaneous fat may be visible) and a Stage IV pressure ulcer (a full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer), and pain. The Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicated intact cognition. During an interview on 3/30/26 at 11:38 AM, Resident #64 stated he had three wounds on his buttocks. Resident #64 stated he had to wear a depend (incontinence brief) instead of the commode to defecate and occasionally the feces got in his pressure sore and that hurt. Review of Resident #64 Care Plan, dated 12/23/24 revealed a Focus area to which addressed resident at risk for alteration in skin integrity.Interventions included, in part: a. Administer medications as ordered. Date Initiated: 4/02/26. b. Administer treatments as ordered. 4/02/26. c. Facility policies/protocols for the prevention/treatment of skin breakdown. Date Initiated: 4/02/26. d. Treat/assess pain as per orders prior to treatment/turning to ensure resident's comfort. Date Initiated: 4/02/2026. Review of the April 2026 TAR revealed an order Coccyx wound - cleanse with normal saline, pat dry. Apply lidocaine ointment 5% topically. Apply primary dressing aquacel Ag advantage and gauze sponges. Cover with ABD pad/tape. Change dressing BID and PRN every day and eve. Start Date: 3/26/26. During an observation on 4/01/2026 at 1:07 PM, Staff N, LPN and Staff R, LPN donned gowns and gloves from the EBP supplies. Staff R placed the dressings, saline, tape and medicated dressings on the sheets of Resident #64's bed. Staff N repositioned Resident #64, and opened the incontinence brief which had been soiled. Without removing the brief, Staff R cleaned the large wound. Without a change of gloves or completing hand hygiene, Staff R patted the wound dry and applied lidocaine cream. Staff N rolled Resident #64 two times to remove the soiled brief, and without a change of gloves or completing hand hygiene applied a clean dressing and attempted to secure with tape. Staff N placed the soiled brief on the resident's bed. Without a change of gloves or completing hand hygiene, Staff N repositioned Resident #64, and Staff R placed tape over the dressing, and put a clean incontinence brief on the resident. Staff N and Staff R removed their gloves, and without putting on new gloves or completing hand hygiene threw away the soiled brief and without a change in linens covered Resident #64 with the bed sheet. 3. Review of Resident #1 MDS, dated [DATE] revealed a list of diagnoses which included diabetes mellitus, gastric reflex disease, and respiratory failure, The BIMS score of 15 out of 15 indicated intact cognition. During an interview on 3/31/26 at 12:22 PM, Resident #1 stated the staff do not use his feeding tube for medications or feedings. Review of Resident #1's Care Plan, dated 11/26/25 revealed the follow Focus areas: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. EBP (Enhanced Barrier Precautions) related to Urinary Catheter, Feeding tube). Interventions included, in part: EBP Precautions: Staff to wear a gown and gloves while performing high-contact care activities (High Contact Care Activities to include: Bathing/showering, Transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, caring for or using an indwelling medical device (central venous catheter/PICC, urinary catheter, feeding tube care, tracheostomy/ventilator care), Performing wound care) Date Initiated: 11/26/2025 Review of the April 2026 TAR revealed an order to Cleanse enteral tube feeding site with normal saline and apply dry dressing every day shift. Start Date: 11/25/2025. During an observation on 4/01/2026 at 1:54 pm, an EBP sign noted on the door to Resident #1 door, with gowns and gloves available. Staff N, LPN entered Resident #1's room that and placed treatment supplies on the residents stand without first cleaning the stand or placing a barrier down. Staff N donned gloves without washing her hands prior, and without donning began the treatment process. Resident #1 pulled off the soiled split gauze from around the g tube insertion site and handed it to Staff N. Without a change in gloves or completing hand hygiene, Staff N cleansed around the G -tube with gauze and normal saline and assessed the site. Without a change in gloves or completing hand hygiene, Staff N prepared a syringe with 25 milliliters of water and flushed it into the G-tube. Staff N then removed her gloves and threw them away with the used supplies. Staff N did not wash her hands prior to leaving the room. 4. Review of Resident 5's MDS, dated [DATE], revealed a list of diagnoses which included stroke, obstructive uropathy (urine flow obstructed), and diabetes mellitus. The MDS identified the resident dependent for transfers, and lower body tasks. The MDS indicated Resident #5 had pressure ulcer/injury care, which included the application of non-surgical dressings, and ointments/medications; and utilized an indwelling catheter. Review of Resident #5's Care Plan, dated 5/2/25, revealed the following Focus areas: a. At risk of alteration in skin integrity.Interventions included, in part: Administer medications as ordered. Date Initiated: 05/05/2025; Administer treatment per physician orders; Follow facility policies/protocols for the prevention/treatment of skin breakdown Date Initiated: 05/05/2025. b. EBP (Enhanced Barrier Precautions) related to urinary catheter. Interventions included, in part: EBP Precautions: Staff to wear a gown and gloves while performing high-contact care activities. Date Initiated: 05/05/2025. Review of the April 2026 TAR revealed an order for Left heel apply skin prep daily every day shift for skin protection. Start Date: 3/20/26. During an observation on 4/1/26 at 8:05 AM, EBP sign noted on resident's door, and supplies available in a caddy. Staff C, LPN donned gloves and without putting on a gown, performed the treatment to Resident's #5's left heel. During an interview immediately following the 4/1/26 treatment to Resident #5 heel, Staff C stated Resident #5 had EBP due to having a urinary catheter. Upon reviewing the EBP posted on the door, Staff C acknowledged she should have donned a gown prior to performing the treatment to the left heel. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/1/26 at 8:10 AM, the Director of Nursing stated Resident #5 had EBP due to a urinary catheter. The DON acknowledged gloves and gown should be worn when providing wound care. Review of the EBP poster used in the facility directed providers and staff to: 1. Wear gloves and gown for the following high-contact resident care areas: a. Dressing b. Bathing/showering c. Transferring d. Changing linens e. Providing hygiene f. Changing briefs or assisting with toileting g. Device care or use: central line, urinary catheter, feeding tube, tracheostomy h. Wound care: any skin opening requiring a dressing Review of the policy titled, Dressing Change, revised 11/2023 revealed a Procedure section which directed, in part: a. Evaluate patient's need for pain reducing interventions, administer if indicated and allow time for intervention to achieve effectiveness. b. Set up the area by placing a clean or sterile barrier on the over bed table then place hand sanitizer and supplies on top of barrier. Sanitize the over the bed table after treatment completed. c. Perform hand hygiene and apply gloves before and after remove soiled dressing, cleansing of wound, preparing supplies, anytime a soiled item is touched, and after procedure. The Policy titled Enhanced Barrier Precautions (EBP) are implemented to minimize the transmission of novel or targeted multi-drug-resistant organisms (MDROs) during high-contact resident care. These precautions supplement, rather than replace, standard or transmission-based precautions. a. Presence of wounds (e.g., pressure ulcers, diabetic foot ulcers, unhealed surgical wounds) or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, or tracheostomies/ventilators). b. PPE Requirements: Staff must wear gowns and gloves during high-contact care activities, such as dressing, bathing, transferring, providing hygiene, changing linens, changing briefs, toileting, or performing device/wound care. c. Duration: EBP is generally intended for the duration of a resident's stay or until the wound resolves or the indwelling medical device is discontinued.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review and staff interview the facility failed to maintain accurate Advance Directive decisions for 1 of 16 residents reviewed (Resident #43). The facility reported a census of 68.Findings include:The Minimum Data Set (MDS) assessment for Resident #43, dated [DATE], documented a Brief Interview for Metal Status (BIMS) score of 8 out of 15, which indicated a moderate cognitive impairment. The MDS listed diagnoses of coronary artery disease, Alzheimer's disease, and non-Alzheimer's dementia. Review of Physician Orders in the electronic health record (EHR) revealed a Full Code order dated [DATE].The Care Plan Report initiated on [DATE] included a Focus are to address Advance Directives. Facility staff are directed to:1. Document the advance directive on the Physician Orders sheet in the EMR system.2. Educate resident and or representative about their options addressing life sustain care.3. EMR chart to identify code status. Review of the paper chart for Resident #43, revealed an undated red piece of paper with black bold print Do Not Resuscitate (DNR). The red piece of paper was located in the same plastic sleeve as the Iowa Physician Orders for Scope of Treatment (IPOST). The front page of the IPOST indicating cardiopulmonary resuscitation (CPR or Full Code) faced the back of the red paper. The physician signed the IPOST on [DATE].On [DATE] at 3:51 PM, the Administrator stated the IPOST documents are not uploaded to the EHR. The Administrator indicated the red paper in the paper chart indicated DNR. The Administrator indicated staff are to follow code status in the EHR. On [DATE] at 8:32, Staff C, Licensed Practical Nurse (LPN) verbalized she would look in the paper chart for a residents code status in the event of an emergency. ON [DATE] at 8:37 AM, the Director of Nursing (DON) stated there are several places code status is listed. The DON explained the first place staff are to look is the paper chart. The DON acknowledged the EHR listed Resident #43 as a full code. The DON acknowledge the paper chart had a red paper with DNR in front of the IPOST. The DON stated staff would look at the red paper versus pulling out the IPOST in an emergency. The DON acknowledged the IPOST listed CPR. The DON reported Social Services places red papers in each chart for DNR and [NAME] papers for CPR. The facility policy, the Code Status Identification and CPR revised on [DATE], Code Status Identification section directed: a. Physician's orders related to a resident's code status and/or DNR/limited treatment documentation is completed by the licensed nurse or social services director/designee and entered into electronic medical record (EMR).b. Direct care staff with [name of electronic medical record brand redacted] access are educated during orientation and as needed on system identification of patient code status.c. If center has an EMR failure or utility loss, follow back up procedures and EMR failure plan. Code status is then identified on the paper MAR/TAR.The Procedure section directed, in part:1. Upon determination that a resident is in cardiopulmonary or respiratory arrest, CPR will be immediately initiated by nursing staff and 911 called for advanced cardiac life support unless one of the exceptions applies:a. When the resident or resident representative has indicated that resuscitation is not desired, and the attending physician has issued a written do not resuscitate (DNR) order that is maintained in the facility's clinical record; orb. When there is the presence of obviously clinical signs of irreversible death (rigor mortis or dependent lividity)2. Each resident's resuscitation status will be maintained in the clinical record and identified as described above (Code Status Identification).

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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, facility policy review, and resident and staff interview and facility policy review the facility failed to maintain a homelike environment due broken wall tiles in the shower room, stained and crumbling ceiling tiles in a resident's room, window curtains unable to be completely closed to provide privacy, and maintaining mouse traps in timely manner. The facility reported a census of 68 residents.Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #8 dated 4/24/26, listed diagnoses of anemia, high blood pressure, and arthritis. The MDS showed a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated a moderate cognitive impairment. During an observation on 03/30/2026 at 2:07 PM, Resident #8 sat in his room, and reported having seen mice in his room every day. A black mouse trap, next to the resident's recliner, observed to contain a dead mouse. The trap remained in this condition when observed on 3/31/26 at 12:19 PM, on 4/1/26 at 12:16 PM, and on 4/2/26 at 9:19 AM. During an interview on 4/2/26 at 9:21 AM, Resident #8 stated a Certified Nursing Assistant (CNA) told him about the dead mouse in the trap earlier on this morning. During an interview on 04/02/2026 at 9:21 AM, Staff G, Housekeeper stated she checked the mouse traps one time a week. Staff G said she planned to remove the dead mouse yesterday but got busy and forgot. 2. During an observation on 04/01/2026 at 12:21 PM, broken wall tiles found in the 2nd floor Central Bath/Shower room. The were tiles located in the left corner of the room, approximately 2 feet inside the door, and 2 to 3 feet up from the floor. On 04/01/2026 at 12:38 PM, Staff I, CNA reported the tiles on the wall at the corner in the 2nd floor Central Bath/Shower room broke a few weeks ago. Staff I stated a work order in place and they are getting the parts to fix the corner. On 04/02/2026 at 11:29 AM, Staff J, Registered Nurse (RN) reported the broken tiled felt sharp and he wanted to cover the edges. During an interview on 04/02/2026 at 1:25 PM, Staff I, Maintenance Director stated he did not know about the broken wall tiles in the 2nd floor Central Bath/Shower room. Staff I said the staff don't fill out the work orders, they tell him in the hall and he can't remember everything. When queried about emptying mouse traps, Staff I stated he goes every day and checks the glue traps for the mice. He reported he did not know of the mouse in Resident #8's room or that Staff G, Housekeeping saw the mouse in the trap on 4/1/26 and the trap had yet to be removed. 3. Review of Resident #55's MDS assessment, dated 2/26/26 revealed a list of diagnoses which included coronary artery disease, bipolar disorder and schizophrenia. The BIMS score of 13 out of 15 indicated intact cognition. Review of the census records documented Resident #5 moved to room [ROOM NUMBER] on 3/4/26. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 3/31/26 at 8:29 AM, room [ROOM NUMBER] noted to have a two panel curtain with a gap of approximately 16 inches between the panels. The panels were not attached to the rod to allow for complete closure, leaving a view into the residents room. The ceiling noted to have a stain which started at the corner of the doorway and reached over the first bed. The stained ceiling area appeared bubbled. During an interview on 4/1/26 at 2:18 PM, Staff D, CNA acknowledged the curtains could not be closed all of the way. Staff D stated she attempted to hang them up, but was unable to get them to close and stated maintenance needed to help. Staff D stated the ceiling looked bad and didn't know how long it appeared that way. On 4/1/26 at 2:26 PM, Staff E, RN entered room [ROOM NUMBER] and stated he did not know how long the curtains were unable to be closed. Resident #55 laid in his bed, and stated the curtains had been unable to be closed all of the way since he moved into the room. During an interview on 4/1/26 at 2:50 PM, Staff M, Maintenance reported he had not received any work orders for room [ROOM NUMBER] until this day. Staff M explained that work orders are to be entered into an electronic work order tracking program. Staff M walked into room [ROOM NUMBER] and acknowledged he hadn't known about the curtains or ceiling discoloration and bubbling texture. Staff M acknowledged the room had not been maintained as a homelike environment. During an interview on 4/1/26 at 3:21 PM, the Administrator viewed room [ROOM NUMBER] and acknowledged the room had not been maintained as a homelike environment. On 4/2/26 at 7:08 AM, the Administrator provided the electronic work order tracking report. The Administrator reported there were no work orders submitted for room [ROOM NUMBER] prior to 4/1/26.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on clinical record review, facility record review and staff interview, the facility failed to notify the the Long-Term Care Ombudsman of a discharge for 1 of 3 residents (Resident #77) reviewed. The facility reported a census of 68 residents.Findings include:Review of the electronic health record (EHR) Clinical Census information for Resident #77 revealed an entry of STOP BILLING effective 1/24/26.A Progress Note dated 1/24/26 at 7:19 PM, documented Resident #77 discharged against medical advice (AMA). Review of the Action Summary report dated 3/30/26 did not list Resident #77 as discharged . Review of the Notice of Transfer From to Long Term Care Ombudsman did not list Resident #77's 1/24/26 discharge. During an interview on 4/2/26 at 12:17 PM, Staff B, Social Services reported Resident #77 had not been included on the Notice of Transfer From to Long Term Care Ombudsman as he did not appear on the Action Summary report. Staff B acknowledged Resident #77 left AMA on a weekend. During an interview on 4/2/26 at 12:29 PM, the Administrator stated it is her expectation the LTC Ombudsman office is notified of discharges. In an email on 4/2/26 at 12:40 PM, the Administrator revealed the facility does not have a policy which directed the notification of discharges to the LTC Ombudsman.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on clinical record review, staff interview and the 2025 Resident Assessment Instrument (RAI) manual, the facility failed to transmit Minimum Data Set (MDS) Assessments within the Federal Guidelines timeframe for 1 of 24 residents (Resident #31) reviewed. The facility reported a census of 68. Findings include:The discharge MDS of Resident #31 was dated for his discharge date of 11/25/25. The MDS was signed as completed on 12/9/25. The clinical record revealed that the MDS assessment was never transmitted to the Centers for Centers for Medicare & Medicaid Services (CMS) as required.On 4/1/26 at 9:07 am, the MDS Coordinator stated she would unlock the MDS and transmit it. She was not aware of why the assessment had not been transmitted. She stated she does run reports on missing assessments but Res #31 had not been included on any of the reports and she had not been aware the assessment had not been transmitted. She stated she would transmit the assessment immediately.On 4/1/26 at 10:54 am, the administrator stated, via email, that the facility does not have an MDS policy and they utilize the RAI manual. The 2025 RAI manual states the MDS must be transmitted (submitted and accepted into the iQIES [Internet Quality Improvement and Evaluation System]) electronically no longer than 14 calendar days after the MDS Completion date.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review and staff interview, the facility failed to accurately list known mental health diagnoses on a Pre-admission Screening and Resident Review for 1 of 2 residents reviewed (Resident #15) for Pre-admission Screening and Resident Reviews. The facility reported a census of 68 residents. Findings include: Review of the Minimum Data Set (MDS) assessment for Resident #15, dated 1/10/26 revealed a list of diagnoses which included depression, post-traumatic stress disorder (PTSD-a mental health condition triggered by experiencing or witnessing terrifying events), and adjustment disorder with mixed anxiety and depressed mood. The MDS identified 1/5/16 as the admission date to the facility.Review of the electronic health record (EHR) revealed Resident #15 had an initial admission to the facility on 9/27/25 for skilled care after a hospitalization. Resident #15 discharged to home on [DATE] with no expectation with return. Resident #15 had a new admission to the facility on 1/5/26. Review of the EHR Medical Diagnosis section revealed the following mental health diagnoses:a. Adjustment disorder with mixed anxiety and depressed Mood. Date: 9/29/25.b. Anxiety disorder, unspecified. Date: 3/6/26.c. Major depressive disorder, recurrent severe without psychotic features. Date: 10/15/25.d. Post traumatic stress disorder, unspecified. Date: 9/29/25.Review of the Pre-admission Screening and Resident Reviews (PASARR - a federal requirement ensuring individuals with serious mental illness or intellectual/developmental disabilities area not inappropriately placed in nursing facilities) revealed:a. PASARR dated 9/22/25 with determination No Level II Required - No SMI/ID/RC (serious mental health, intellectual disability, related conditions). Mental Health Diagnoses submitted: Major depression, current; Anxiety disorder, current.b. PASARR dated 1/03/26 with determination No Level II Required - No SMI/ID/RC. Mental Health Diagnoses submitted: No mental health diagnoses is known or suspected.During an interview on 4/2/26 at 8:58 AM, Staff B, Social Services reported the nurse liaison reviewed the PASRR prior to admission. Staff B, reported she reviewed the PASRR once admitted and is responsible for submitting updated PASRR when needed. Staff B, acknowledged the PASRR completed prior to admission lacked accurate diagnoses for Resident #15. Staff B, acknowledged Resident #15 hadn't been evaluated for [NAME] II PASRR (an in-depth, person-centered evaluation triggered when a Level I screen indicates a potential serious mental illness (SMI), intellectual disability (ID), or related condition).During an interview on 4/2/26 at 9:07 AM, the Administrator stated the Administrator and Social Services are responsible for reviewing the Notice of PASRR Level I prior to/at admission. The Administrator stated someone with a diagnosis of PTSD would need to be evaluated for Level II PASRR. The Administrator acknowledged the Notice of PASRR Level I needed updated for Resident #15. Review of the facility undated facility policy, titled PASRR Process QRG directed the following:1. admission staff member validate PASRR completion prior to admit2. All Level II PASRR's and renewals are monitored and manage by Social Services3. Psychotropic medication changes and new or updated diagnosis should be discussed as part of the daily inter disciplinary team (IDT) meetings. Social Services would then update PASRRs with the information necessary.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165033	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/06/2026
NAME OF PROVIDER OR SUPPLIER Harmony Davenport		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on clinical record review, family representative interview, resident and staff interviews the facility failed to develop comprehensive Care Plans for 3 of 8 residents (Resident #1, Resident #19, and Resident #30) reviewed for Care Plans. The facility reported a census of 68 residents.Findings include: 1. Review of the Minimum Data Set (MDS) for Resident #1, dated 2/26/26 revealed diagnoses of diabetes mellitus, gastric reflex disease, and respiratory failure. The Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicated intact cognition. The MDS did not identify Resident #1 utilized a Gastric tube (G-tube) for medications or tube feedings. During an interview on 3/31/26 at 12:22 pm, Resident #1 stated the staff no longer use his feeding tube for medications or feedings.Review of Physician Orders revealed the following orders:a. Regular diet, Regular texture. Thin liquids consistency. Start date: 2/3/26.Review of the Care Plan for Resident #1, dated 11/26/25, revealed a Focus area to address Tube feeding related to dysphagia. Interventions included, in part: Provide enteral nutrition as ordered. The Medication Administration Record (MAR) dated March 2026 for Resident #1 revealed the last medication administration through the Gastric-tube was 3/4/26. The medications are administered oral since 3/4/26.During an interview on 4/01/2026 at 8:06 am, Staff N, Licensed Practical Nurse (LPN) stated Resident #1 took his medications orally and did not use the G-tube anymore. Staff N stated the G tube was to be flushed and the site was to be cleaned and the dressing changed daily.2. Review of the MDS for Resident #19, dated 3/20/26 list of diagnoses revealed end stage renal disease, diabetes mellitus and a special procedure of hemodialysis via AV fistula. The BIMS score of 15 out of 15 indicated intact cognition. Review of Resident #19's Care Plan, dated 3/30/26 revealed a Focus area to address Resident requires dialysis related to Diagnosis of End Stage Renal Disease. HD (hemodialysis) device (AV or arteriovenous - a surgical created access for dialysis created by joining an artery directly to a vein) left arm, IJ device (dialysis access in the neck via internal jugular managed by the HD unit). Interventions listed in the Care Plan did not include directions to complete a daily assessment of the AV site for pulse, listening for bruit (a swishing noise heard by stethoscope), palpation of the AV site for the feel of a thrill (a vibration) to assure adequate blood flow, assessment of the extremity for bruising, vein distention, or pain. 3. Review of the MDS for Resident #30, dated 2/19/26 revealed a list of diagnoses which included end stage renal disease and identified received a special treatment of dialysis. The BIMS score of 14 out of 15 indicated intact cognition. Review of Resident #30's Care Plan, dated 12/1/25 revealed a Focus area to address Resident requires dialysis related to Diagnosis of End Stage Renal Disease. AV fistula left upper extremity, pt often declines to go to dialysis proving various rational for refusals. The Interventions listed in the Care Plan did not include directions to assess the AV site for site for thrill, bruit and pulse.During an interview on 4/06/2026 at 10:53 AM, Staff M, Registered Nurse, and MDS & Care Plan Coordinator stated Care Plans are completed by the Interdisciplinary Team (IDT). Staff M stated the IDT also revised the plans, or a floor nurse could also make a change in their scope of practice.

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

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, clinical record review, resident and staff interviews, the facility failed to assist dependent residents with shaving, nail care and toothbrushing for 2 of 4 residents (Resident #6 and Resident #40) reviewed for activities of daily living. The facility reported a census of 68 residents.Findings include:1. Review of the Minimum Data Set (MDS) assessment for Resident #6, dated 12/30/25, revealed a list of diagnoses which included diabetes mellitus (DM), and non-Alzheimer's dementia. The Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicated a moderate cognitive impairment. The MDS identified Resident #6 dependent for toileting, bathing and showering; and required substantial to maximal assistance for personal hygiene. During an observation on 03/31/2026 at 2:44 PM, Resident #6 sleeping in bed. His hair appeared greasy, fingernails long with a brown substance underneath the nail. Review of the Care Plan, dated 2/19/24, for Resident #6 revealed a Focus area which addressed ADL (activities of daily living) Resident requires assistance with ADL's needed, related to DM.Interventions included, in part: a. Assist resident with shower/bathing per schedule. Date Initiated: 2/19/24. b. Dressing & Grooming with assist of 1. Date Initiated: 2/19/24. Review the electronic health record (EHR) Response History for Did the resident take a shower, bath or bed bath revealed a 30 day look back period which documented Resident #6 bathed on 3/5/26 and 3/12/26, with refusals documented on 3/16/26, 3/19/26, and 3/23/26. During an interview on 04/01/2026 at 12:00 PM, Resident #6 stated gets a bed bath, and staff do not clean his finger nails or cut them much. Resident #6 added they get his hair washed at times. During this interview Resident #6 hair looked oily and unkempt, and nails remained long and had a black/brown resident under the nail. During an interview on 4/2/26 at 3:30 PM, the Administrator stated if a resident refused a bath or cares the Certified Nursing Assistant should tell the nurse. Review of the EHR revealed a lack of communication regarding Resident #6 refusals of assistance with activities of daily living. 2. Review of the MDS assessment for Resident #40, dated 1/8/26, revealed diagnoses of stroke and arthritis. A BIMS score of 13 out of 15 indicated intact cognition. The MDS identified Resident #40 dependent on staff for oral care and hygiene needs. Review of Resident #40's Care Plan, dated 1/21/26 revealed a Focus area which addressed At risk for Oral/Dental health problems related to own natural teeth. Interventions included, in part: a. Encourage/assist to perform oral hygiene. Date Initiated: 1/21/26. Another Focus area addressed Resident requires assistance with ADL's related to disease process.Interventions included, in part: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Oral Care with assist of 1. Date Initiated: 1/21/26. b. Grooming: with assist of 1. Date Initiated: 1/21/26. During an interview on 3/31/2026 at 12:42 PM, Resident #40 stated he did not think the staff had brushed his teeth in a month. A Resident Representative present during the interview stated the family had voiced concern with the residents' teeth not getting brushed, and also the resident not getting assistance with shaving. During this interview, Resident #40 had noticeable beard growth. During an observation on 4/1/26 at 11:42 AM, Resident #40 had noticeable beard growth. During conversation, Resident noted to have bad breath and debris stuck in his teeth. During an interview on 4/01/2026 at 11:35 AM, Staff I, Certified Nursing Assistant (CAN) stated the Care Plan provided direction for ADL care. Staff I added she had not been assigned to care for Resident #40 on this date. During an interview on 4/01/2026 at 11:37 AM, Staff N, Licensed Practical Nurse (LPN) stated the staff have a schedule for shaving, no resident was shaved every day, and Resident #40's family will shave him. During an interview on 4/01/2026 at 11:39 AM, Staff H CNA stated she shaved men on their shower day. Staff H stated she brushed Resident #40's teeth a little this morning but staff have been very busy. During an interview on 4/01/2026 at 3:12 PM, Staff O, CNA stated she used the mouth swap for Resident #40 when his tooth hurt. Staff O stated he had bad breath and white stuff on his tongue that won't come off even after you brush. Staff O stated Resident #40 was to get shaved on shower day and thought his mom shaved him a few days ago in the dining room. Staff O stated Resident #40 had a shower yesterday and was unsure why he did not get shaved and she would go shave him.