STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165034	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Waterloo	201 West Ridgeway Avenue Waterloo, IA 50701

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46513 Based on observation, interviews and record reviews, the facility failed to treats residents with dignity for 4 residents (Resident #2, #6, #7, and #8). Observations revealed the 4 residents left in the dining room for extended periods after meals. The facility reported a census of 84 residents. Findings include: 1. Resident #2's Minimum Data Set (MDS) dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 10, indicating moderately impaired cognition. The MDS coded Resident #2 as dependent for mobility, transfers, and they didn't attempt to walk him due to a medical condition. The MDS included a diagnosis of amyotrophic lateral sclerosis (ALS). The Care Plan Focus dated 4/10/24 indicated Resident #2 required assistance with activities of daily living (ADLs). The Intervention described him as dependent for eating and needed assistance of two for transferring. In an interview on 8/6/24 at 1:45 PM Resident #2 reported the staff left in the dining room for long periods of time after meals. He explained he had waited up to three hours for the staff to assist back to his room. 2. Resident #6's MDS dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS coded Resident #6 as dependent for mobility, chair to chair transfers, and listed walking as non applicable. The MDS included a diagnosis of Parkinson's disease. The Care Plan Focus initiated 3/1/24 reflected Resident #6 required assistance with ADLs. The Interventions indicated he required partial assistance with supervision with eating. In addition, he required two assist and a mechanical standing lift to transfer. On 8/5/24 at 9:00 AM witnessed 4 residents in the dining room who required assistance with eating. Of the 4 residents, observed Resident #6 asleep in a geriatric wheelchair. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165034	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Waterloo	201 West Ridgeway Avenue Waterloo, IA 50701

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 8/6/24 at 9:05 AM Resident #6 sat in the main dining room in his wheelchair. He stated the staff usually started assisting him out of bed about 6:30 AM. They wheel him to the dining room right after they get him up. He ate breakfast around 8:00 AM and then has to wait for someone to push wheelchair back to his room. Resident #6 explained he wanted to go back to his room but he had to wait for someone to take him. He declared the wait could be a long time after the meal. In an interview on 8/6/24 at 1:30 PM Resident #6 explained that day the staff brought him right back to the room after lunch. He felt it had to do with the surveyor's presence. Sometimes they take everyone else, then he waited an hour or more alone, as he couldn't propel the wheelchair himself. Resident #6 stated, he felt alone and forgotten. He had another resident push him once because he waited so long. The other also sat in a wheelchair and pushed him in his wheelchair. 3. Resident #7's MDS dated [DATE] identified a BIMS score of 14, indicating intact cognition. The MDS listed Resident #7 used a wheelchair. The MDS included a diagnosis of multiple sclerosis. The Care Plan Focus initiated 2/20/23 reflected Resident #7 demonstrated physical aggression as evidenced by running his wheelchair into staff. In an interview on 8/6/24 at 1:15 PM Resident #7 reported he could take himself back in his wheelchair but residents that couldn't had to wait a long time for help back. Resident #7 explained around 10:00 PM, he attempted pushing Resident #6 back to his room while in his wheelchair because he still sat in the dining room. The staff often said they would be back again and again. 4. Resident #8's MDS dated [DATE] identified a BIMS score of 15, indicating intact cognition. The MDS coded Resident #8 needed partial to moderate assistance with transfers and walking. The MDS included diagnosis of stroke with hemiplegia (one-sided paralysis). The Care Plan Focus initiated 4/16/24 indicated Resident #8 required assistance with ADLs. The Interventions instructed Resident #8 required assistance of one person with transferring and used a wheelchair with a right side armrest. On 8/5/24 at 9:00 AM observed Resident #8 with her head on the table, asleep after breakfast. In an interview on 8/6/24 at 12:30 PM, Staff A, Certified Nursing Assistant (CNA), said the staff could get very busy. They said the residents did wait a very long time in the dining room if they can't get back to their room independently. Staff A reported a resident recently complained they waited until 8:00 PM to be brought back from supper. A facility policy titled Resident Rights, Dignity and Respect revised April 2024 directed each resident has the right to considerate and respectful care, 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165034	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Waterloo	201 West Ridgeway Avenue Waterloo, IA 50701

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46513 Based on clinical record review, resident interview, staff interview and pharmacist interview, the facility failed to ensure anxiety medications administered for 1 of 3 residents reviewed (Resident #2). The facility reported a census of 84 . Findings include: Resident #2's Minimum Data Set (MDS) dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 10, indicating moderately impaired cognition. The MDS coded Resident #2 as dependent for mobility, included dependent for transfers, and they didn't attempt to walk him due to medical condition. The MDS included a diagnosis of amyotrophic lateral sclerosis (ALS), weakness, anxiety disorder and depression. The Care Plan Focus initiated 6/3/24 indicated Resident #2 utilized psychotropic medications for anxiety. The Interventions directed to administer medications as ordered. On 8/8/24 at 11:55 AM Resident #2 said he didn't receive his anxiety medication because the facility ran out. Resident #2 relayed this is not the first time the facility didn't have his medications. Resident #2's August 2024 Medication Administration Record included the following orders: a. Started 7/5/24 at 12:00 AM: Diazepam 5 milligrams (mg) by mouth one time a day for anxiety, while awake. i. Discontinued 8/6/24. b. Started 8/6/24: Diazepam 5 mg by mouth every 6 hours for anxiety. i. On 8/7/24 at 12:00 PM dose not given, coded unavailable (UV). ii. On 8/7/24 at 6:00 PM dose not given, coded UV. iii. On 8/8/24 at 12:00 AM dose not given, coded UV. iv. On 8/7/24 at 6:00 AM dose not given, coded nurses note (NN). - Hospice notified Resident #2 needed a script. v. On 8/7/24 at 12:00 PM dose not given, coded UV. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165034	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Waterloo	201 West Ridgeway Avenue Waterloo, IA 50701

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/8/24 at 12:05 PM Staff B, Registered Nurse (RN), explained the facility ordered the medications on demand. She reported Resident #2 received his last dose of diazepam on 8/6/24. The narcotic count sheet reflected zero diazepam left. Staff B voiced the ordering process for medication is on demand, the nursing staff need to notified the pharmacy when a medication has 3 to 4 left. They typically receive the medications the next day. Staff B couldn't find that someone ordered the diazepam medication before being depleted. On 8/8/24 at 12:56 PM Staff C, Pharmacist, said the pharmacy didn't receive a reorder for Resident #2's daily diazepam. If they did Resident #2 wouldn't have ran out of his diazepam medication. The Pharmacist added the new order to increase the daily dose didn't have a physician's signature. The pharmacy sent a request to the primary care doctor who responded, they no longer managed Resident #2's medication. The Pharmacist identified the need to contact the hospice affiliated physician which led to further delays in Resident #2 receiving his medication. On 8/8/24 at 1:00 PM the Director of Nursing (DON) explained the staff should order the controlled medications when the resident had three or four doses left. The DON added that hospice may give a new order but fail to have the physician sign the order. Then sends it to the pharmacy which delayed the residents from getting their medications. The DON believed that resulted in Resident #2 not receiving his diazepam. The DON explained she contacted Hospice that morning to inform them the pharmacy still didn't have a script. The DON acknowledged Resident #2 missed several doses of medication. They confirmed they needed to work to ensure the pharmacy received new orders from hospice appropriately and that staff order medications timely. The Physician Orders/Transcription of Orders policy dated July 2023 instructed to carry out active orders as written and transcribed.