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	11/21/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40907 Based on clinical record review, staff interviews, family interviews and policy review, the facility failed to complete a full assessment to include neurological assessments and failed to notify family and the provider timely for 1 of 4 residents reviewed (Resident #1). Resident #1 fell out of her wheelchair and landed on her face. The fall was witnessed by Staff A, Registered Nurse (RN). The facility reported a census of 79 residents. Findings include: A Minimum Data Set (MDS) assessment dated [DATE], documented diagnoses for Resident #1 included non-Alzheimer's dementia, unspecified dementia with other behavioral disturbances, and repeated falls. A Brief Interview for Mental Status (BIMS) score revealed that this resident was rarely/never understood. This resident was dependent on staff for transfers. Resident #1's Progress Notes documented the following: On 10/27/24 at 8:45 p.m., (completed as a late entry on 10/28/24 by Staff A) Resident #1 had been attempting to get out of her chair and bed all shift. At some point, the resident fell and hit her right forehead, leaving a 5cm bruise. Resident is now in a new room, and is lying comfortably in bed. Neuro's (neurological checks) started and all aware. On 10/27/24 at 10:30 p.m., Staff C documented unable to get vital signs (VS) due to resident cooperation at this time. Resident #1 was lying in bed holding her head and yelling out. Upon assessment, there was a 5 cm (centimeter) in diameter hematoma (bruise) noted to the right side of her forehead at the hairline. Resident was asked what happened but she just groaned and continued to cry and yell out. No falls were noted recently. Attempted neuros (neuro checks). Unable to obtain VS or neuro eval due to resident cooperation. It does not appear there was a change in LOC (Level of Consciousness). 5mg (milligrams) of Morphine sulfate solution (narcotic pain medication) administered via oral syringe. Staff A stayed with resident at bedside while this nurse contacted the Nurse Practitioner. Contacted Resident #1's daughter and she does not want to send resident out to the hospital at this time. Facility nurse on call also notified. Will continue to monitor resident frequently throughout the overnight shift. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/19/24 at 11:34 a.m., Staff C stated she had gone into work the night of 10/27/24 and received shift report. Staff C heard Resident #1 call out and Staff C went to check on the resident. Staff A had told Staff C that the resident had been in her room and her roommate opened a window and as it was getting cold out, Staff B had moved Resident #1 to a different room that was close to the nurses' station, the one that was next to the lounge. Staff A had not told Staff C that Resident #1 had fallen. Staff C stated Resident #1 falling should have been on report. Staff C did ask Staff A before Staff A left if Staff A had noticed that Resident #1 had a bruise on her forehead and Staff A said no. She stated Staff A did not tell her that Resident #1 had fallen and Staff C did not hear that Resident #1 had fallen until she returned to work a few days later. It was not long after Staff C got to work when she went to assess Resident #1 and she was kind of smacking her forehead and reaching out. That prompted Staff C to pull back Resident #1's hair because this resident normally doesn't hit/smack her head. That's when Staff C noticed a hematoma right along her hairline. It was like a purple goose egg. Staff C stated she got vital signs first and then called the Nurse Practitioner who wanted to send Resident #1 out for evaluation. The on call provider called the daughter with Staff C on the phone to ask the daughter if she wanted to send her mother out to the ER. The daughter at that time said no because she didn't want her mother to go back on Hospice. When dayshift came on Staff C shared all of the information with the day nurse. Resident #1 had been moved to the other end of the hall as her room was too cold for her. Staff C thought it was Staff D that she gave shift to shift report to. She told Staff D that she had done neuro checks on Resident #1 through the night. On 11/19/24 at 12:51 p.m., Staff B stated the night shift reported Resident #1 had fallen the evening before, hit her head and had a goose egg on her head. Resident #1 was being restless in bed. Staff B had staff get the resident up. Resident #1 wasn't acting right. They offered Resident #1 a banana, she loves bananas. The resident kind of glanced at the banana but really didn't track it. It was like she didn't recognize it as food. She was up in her wheelchair for like 15 minutes. She could hear your voice but really didn't follow, like turn her head toward a voice. The resident had kind of a blank stare on her face. That's why it was decided to send her out around 7:30/8:00 a.m. Staff B stated she had not done any neuros as she hadn't made it in to Resident #1's room yet. When asked if the resident's pupils were fixed, Staff B stated that a few of the staff noticed that Resident #1 kind of had a fixed stare, she wasn't tracking. Staff B along with other staff decided Resident #1 wasn't acting right and she needed to be sent out. Staff B stated she sent her out for AMS (Altered Mental Status). Staff B called the daughter and told her that Resident #1 had a huge bruise on her forehead. Staff B told her about the banana. The daughter agreed to send her mom up to the hospital. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/19/24 at 3:28 p.m., Staff A stated Resident #1's roommate had been keeping the room at a freezing cold temperature and Resident #1 kept trying to get out of her bed. It was getting close to the end of shift. Resident #1 was in her wheelchair (w/c) and she dropped her baby doll on the floor and tried to reach for it and fell out of the w/c. Staff A saw it happen but couldn't get to the baby doll in time to hand it back to Resident #1. This happened in the hallway. Staff E, Certified Nurse Aide (CNA), and Staff A helped this resident back into her w/c. Staff A assessed Resident #1 but didn't start the neuros. Staff C came in shortly after the fall. When report was over Staff A ran out of the facility and forgot to do neuros or document anything but Staff C had started neuros. Staff A reported to Staff C that Resident #1 had a fall. Staff A stated that when Resident #1 fell out of the w/c, her forehead wasn't anything like the goose egg and bruising. Staff A thought that during the 15 minutes when they were giving report the goose egg and bruise happened. Staff A called the daughter to tell her what happened and she didn't answer the phone. Staff A didn't leave a message. Staff A was then shown the late entry she documented on 10/28/24 the day after the fall, regarding the fall where Staff A had documented that the entry should have been put in on 10/27/24 at 8:45 p.m. The entry was read to her to include that at some point the resident fell and hit her forehead, leaving a 5 cm bruise. Staff A stated the above time of the late entry for the effective date is an error. She said it wasn't at 8:45 p.m., it was more like 9:45 p.m. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/19/24 at 3:56 p.m., Staff E stated she worked 2nd shift the evening of 10/27/24 with 2 other CNA's. Staff E had walked in the room because they were going to lay Resident #1's roommate down. It looked like Resident #1 was cold, so Staff E changed the resident's clothes and put her in her w/c with a blanket on her. Staff E stated it was around 4:45 p.m. to 5:00 p.m., before supper. Staff E didn't recall if Resident #1 ate supper that night. Resident #1 started down the hallway. She was propelling herself down the hall. Then Staff A asked Staff E to help Staff A put Resident #1 back into the chair. Staff E helped Staff A pick this resident off of the floor and back into her wheelchair. Staff E did not see Resident #1 fall. Staff E then went back into the resident's room to help lay Resident #1's roommate down. Staff A pushed Resident #1 down by the nurses' station. Then Staff A called for Staff E's assistance again. Staff E went down to the lounge area (across from the nurses' station) and Staff A said that Resident #1 was very antsy and Staff A was worried this resident was going to roll off the couch. Staff E stated that it was a long time in between from when Staff E helped Staff A get this resident off of the floor and into her w/c, to Staff E helping Staff A lay this resident on to the couch in the lounge. Staff E went down again when Staff A asked for help to lay this resident onto the floor as Resident #1 was getting antsy and acting like she was going to roll off of the couch. Staff A wanted to prevent this resident from falling off the couch so Staff A had grabbed blankets and the pillows and placed them on the floor. Staff E stated she thought they laid this resident on the couch around 8:45 p.m. Then around 9:30/9:45 p.m., Staff A and Staff E lifted this resident back into her wheelchair. Staff A and Staff E then brought this resident into a different room, room [ROOM NUMBER] and not her regular room which was room [ROOM NUMBER]. Staff E then transferred Resident #1 into bed. Staff E stated that Resident #1 was shivering all through the shift. Staff E stated the resident's regular room, room [ROOM NUMBER], was like 66 degrees (Fahrenheit(F)). Staff E repeated that Resident #1 was shaking and was doing the shaking thing for the rest of the shift. Staff E thought Resident #1's shaking was maybe related to dementia and maybe Resident #1 was stuck on thinking she was cold. Staff E told Staff A that she (Staff E) still thought that Resident #1 was cold. Resident #1 looked drowsy, which was a normal look that she would get. Staff A had just come to Staff E earlier and as she needed help because Resident #1 had slid out of her chair. Staff E went to lift Resident #1 up and Resident #1 was like dead weight. Staff E looked at Staff A for help and then Staff A helped. Staff E stated that resident #1 really didn't want to get off of the floor. Staff E didn't notice any bump or bruising. The only assessment Staff E saw Staff A do was take Resident #1's temperature. Staff E laid Resident #1 down (in room [ROOM NUMBER]), and Staff A was in there. Staff E saw a little bruise on the side of this resident's forehead. Staff E pointed this out to Staff A and asked Staff A how Resident #1 got a bruise. Staff A responded that she didn't know how that happened. Staff E asked Staff A to take this resident's temperature. Staff E thought Staff A said this resident's temperature was 96. 5/F. Staff E did not know if Staff A did anything further as far as assessment. Staff E just assumed Staff A would do an incident report and whatever her other duties were. When asked if the time of fall could have been closer to the end of the shift like around 9:30, Staff E said no. When told that was the timeframe given by Staff A, Staff E stated this resident's fall happened before supper. Staff E stated that this resident's roommate always wants to lay down at 5/5:30 p.m., that's how Staff E can remember about what time it was. Staff E stated at around 5/5:30 was when she went into the room to assist another CNA. Staff E noticed this resident was shivering. Staff E then stopped and tended to Resident #1, getting her dressed and up out of bed and into her wheelchair, then Resident #1 propelled herself down the hall. Staff E then assisted getting the roommate in the bed and when she was finished with that, Staff A asked Staff E to come help as Resident #1 was on the floor. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 9:52 a.m., Resident #1's daughter stated she never received a call from Staff A the evening of her mother's fall. Resident #1's daughter stated she had looked back at her call log when she found out from the Administrator that the fall had happened on the second shift. The daughter stated there were absolutely no calls until Staff B called the daughter with the on call provider service around 11:00 p.m. On 11/20/24 at 2:09 p.m., Staff A stated she could not put an exact time on the fall. She stated it was maybe bed time but it was not supper time. When Staff A saw Resident #1 fall, it was in the hallway and no one would come to help but Staff F. When Resident #1 fell she was in the hall approximately 10 feet in front of the nurse's station. Resident #1 was falling asleep in her wheelchair and her baby doll fell on the floor. Resident #1 reached down to grab her baby doll and fell face first onto the floor. Staff A hollered at Staff E. Staff E and Staff A then got Resident #1 up off of the floor and into the wheelchair. Staff A checked her arms and legs and noted Resident #1 was talking. Staff A waited until she could get a hold of management so that Staff A could put this resident in a different room. Staff B came onto her shift and found the bump on Resident #1's head. Staff C started doing neuros. It was not supper time. Staff A stated she should have started neuros at the time of the fall but it was in the middle of medication (med) pass and Staff A was just everywhere. Staff A stated that Resident #1 had fallen a lot, and was acting fine, so that's why she didn't start neuro checks. Staff A didn't see the bump on Resident #1's forehead at that time. Staff A stated that policy directs that the nurse has to do an assessment and IR (incident report) and they are to inform everybody. Staff A stated she called a provider. Staff A used the company phone to call the daughter and Staff A left a message. Staff A stated she did call the daughter and she had the proof. When asked to see the proof of the call, Staff A said she could not show proof as it wasn't on the company phone. The proof was in Staff A's head. Staff A said that Staff C then called the daughter again later. When told that the provider service had no record of a call previous to the one Staff C had made, Staff A stated that it was Staff C who called the provider not Staff A. Staff A was just sitting by Staff C when Staff C made the call. On 11/20/24 at 2:43 p.m., the DON stated that she talked to Staff A and Staff A thought that maybe Staff E had confused the night of the fall with another fall that had happened earlier in the month. When asked about the shivering and chills, laying on the couch then the floor, then moving to a different room happened after both falls, the DON acknowledged it did not. All of the above only happened on the evening of 10/26/24. The Administrator stated that the on-call phone showed that on 10/27/24 Staff A called the on-call phone at 8:26 p.m. and 8:48 p.m. On 11/20/24 at 3:00 p.m., Staff G, MDS Coordinator, RN, stated she was the on-call nurse the night of 10/27/24. Staff G stated she received a call from Staff A that night as the roommate (Resident #5) was hot and Resident #1 was cold. Staff G gave permission to move Resident #1 into an empty room for the night. Staff G stated that Staff A did not tell Staff G that Resident #1 had fallen. Staff G stated that Staff A should have told her. The DON was in the room during this conversation and stated that it was an expectation that the on call nurse was to be notified of all resident falls. It was acceptable that if it was a fall with no injury that the nurse could text the on-call nurse and let her know. The DON stated that in this case there was a hematoma and the on call nurse should have been called. She stated neuros should have been started at the time of the fall. On 11/20/24 at 3:37 p.m., the DON stated there were no texts sent by Staff A about the fall to the on-call phone. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 3:40 p.m., Staff E was asked if there was any way she had confused the two recent falls that Resident #1 had in November. Staff E said there was no way she was confusing the two falls. She said she absolutely did not confuse them. She stated she knows for sure because it was the day after her son's birthday. She said there is no way the fall happened at 8:00 p.m. or 8:30 p.m. on 10/27/24. She stated the fall was between 5:30 p.m. and 6:00 p.m. She said she knows what happened and nobody is going to change her mind. A Fall Occurrence policy dated 2/24 directed staff: Purpose: It is the policy of the facility to ensure that residents are evaluated for fall risks and implement interventions to minimize risk for falls and/or risk for injury from falls Procedure: 1. A Fall Risk Assessment is completed by the nurse upon admission, readmission, and as necessary. 2. Based on assessment, interventions are implemented and placed on care plan. 3. An incident report will be completed by the nurse each time a resident has a fall. 4. Residents will be assessed by a licensed nurse prior to being moved after a fall. 5. Nurse will notify physician and resident representative. 6. Additional intervention(s) will be implemented post fall. IDT may change the intervention(s) if IDT investigation identifies a more appropriate intervention for the individual fall. 7. The resident's care plan will be updated with any new or revised intervention(s). 8. Neurological assessment will be initiated for unwitnessed falls and/or falls that are witnessed and resident hits their head (neuros completed as directed on neuro flowsheet, see below). 9. Documentation and monitoring to be completed for 72 hours post fall.