

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165034	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2025
NAME OF PROVIDER OR SUPPLIER Harmony Waterloo		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133</p> <p>Based on observation, clinical record review, document review, policy review, resident and staff interviews, the facility failed to keep resident's free from financial exploitation (abuse) when a staff member utilized a resident's credit card to pay their personal cell phone bill for 1 of 4 resident's sampled (Resident #7). The residents gave the staff money, credit, and/or debit cards to purchase pop for them from the vending machine. The staff reported they always did this, especially for residents who couldn't get out of bed to get the pop themselves. After 1 resident discharged from the facility, the resident received a phone call from her bank regarding an overdraft charge for a cellular phone bill, the resident contacted the police who started an investigation. The investigation determined the name on the cellular phone account belong to a staff member, Staff A, Certified Nurse Aide (CNA), who worked at the facility during the time Resident #7 lived at the facility. The facility identified a census of 74 residents.</p> <p>Findings include:</p> <p>Resident #7's Clinical Census reflected she admitted to the facility on [DATE] and discharged on [DATE]. She resided in room [ROOM NUMBER]-B in the back hallway at that time.</p> <p>Resident #7's Minimum Data Set (MDS) assessment dated [DATE] indicated she had adequate hearing, clear speech, the ability to understand communication and be understood. She had adequate vision without corrective lenses. The MDS identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #7 did not exhibit any behaviors. The MDS listed Resident #7 as dependent upon staff for bed to chair transfers, she couldn't walk, and required full staff assistance once up in a wheelchair. Resident #7 had frequent pain, that she rated a level 4 out of 10 which required scheduled and as needed pain medication. The MDS included diagnoses of paraplegia (loss of movement and sensation in the lower part of the bod), stage four (deep wounds into the bone) pressure ulcers of the sacrum, right hip, left hip, osteomyelitis (bone infection) of the vertebra, lumbosacral (lower spine) region, diabetes mellitus, anxiety and depression. The MDS reflected Resident #7 had 3 pressure ulcers that received care.</p> <p>The Compliance Plan Receipt and Acknowledgement signed by Staff A on 11/5/24 reflected she acknowledged she received a personal copy of the company Code of Ethics. In addition, she read and fully understood the Code of Ethics and agreed to comply with the Code of Ethics.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An Iowa Incident Report dated 12/2/24 at 3:46 PM identified the police officers responded to a call about credit card fraud. The Iowa Incident Report listed Resident #7 as the victim. Resident #7 stated her bank notified her someone used her credit card on 11/19/24 to (pay) a cellular phone bill for \$417 or \$418 dollars. Resident #7 did not utilize that cellular phone services. Resident #7 reported she lived at the facility from 10/14/24 to 11/27/24 and thought an employee of the facility used her card.</p> <p>An Investigation Summary dated 2/25/25 - 2/28/25 completed by the facility listed the Summary of Alleged Incident as a Police Officer notified the Administrator on 2/25/25 that Resident #7, contacted the police department after she left the facility about credit card fraud. The Police Officer showed the Administrator a subpoenaed cellular phone bill with Staff A's name on it as the account holder. The Critical Information Obtained During the Investigation summary noted Resident #7 gave her cash app card and her bank card to staff to get her pop from the vending machine. Resident #7 reported Staff B, Licensed Practical Nurse (LPN), reported she couldn't take her card, but other staff took her card to the vending machine to get her pop. Resident #7 reported Staff C, CNA; Staff D, CNA; Staff E, CNA; and Staff F all got her pop from the vending machine. Resident #7 identified other staff also got her pop, but she couldn't remember who else, other than both nurses and CNAs. Resident #7 believed someone stole her credit card information when the staff got her pop from the vending machine. She received a call from her bank when a charge to her card made her account negative. At that time, she contacted the police. In addition, Resident #7 reported to the Administrator a staff member helped her pay her WIFI bill on-line. That CNA didn't have a pen or paper during the incident so she didn't believe it happened then. The Administrator called Staff A on 2/26/25. Staff A reported she didn't take any residents' card to pay her phone bill. She didn't know who Resident #7 was and didn't work at the facility long. Staff A reported she never worked in the back hall.</p> <p>A review conducted on 3/17/25 at 1:00 PM of Staff A's Employee File revealed an Iowa Record Check Request Form S dated 5/17/24. The results section had an X marked for computerized criminal history (CCH).</p> <p>The Record Check Evaluation completed on 5/20/24 reflected Staff A may work at the facility.</p> <p>The Single Contact License & Background Check complete as of 10/30/24 listed the report required further research.</p> <p>The Iowa Criminal History Results dated 11/4/24 indicated the search resulted with an Iowa Criminal History Record Found. The section labeled Criminal History Record Information listed a history of third-degree theft that turned into a fourth-degree theft. The charge resulted in a non-conviction with a deferred judgement of \$315 civil penalty and a 12-month probation.</p> <p>Staff A's Employee File contained a verbal One-to-One In-service Record review dated 11/8/24 regarding her unsatisfactory work performance including, but not limited to, her failure to complete work assignments, incompetence, or poor performance of work assignments.</p> <p>An Iowa Incident Report Supplemental (Police Department) dated 4/2/25 documented on 2/14/25 the officer received with the name of the cellular phone service account holder. The account paid with Resident #7's credit card returned as Staff A.</p> <p>A 4/28/25 review of Staff A's Iowa Time Card Report revealed the following work hours:</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>a. 11/6/24 In at 9:38 PM; out at 6:06 AM; total hours 7.45.</p> <p>b. 11/7/24 In at 9:47 PM; out at 6:02 AM; total hours 7.45.</p> <p>c. 11/10/24 In at 9:42 PM; out at 6:09 AM; total hours 8.0.</p> <p>d. 11/11/24 In at 9:33 PM; out at 6:04 AM; total hours 8.0.</p> <p>e. 11/11/24 In at 9:42 PM; out at 6:09 AM; total hours 8.0.</p> <p>Review of the Daily Staffing Schedules listed Staff A as scheduled to work the back hallway where Resident #7 lived on 11/7/24 and 11/12/24.</p> <p>Interview on 4/28/25 at 2:18 PM Staff G, CNA, voiced the facility had a vending machine in the breakroom with pop machines in the back-hallway lounge and in rehabilitation unit. She reported Resident #14 asked the staff to get her Mountain Dew out of the pop machines. She had a small wallet, that she gave the staff. The staff went right down to the pop machine, used it and brought it right back with the pop. She used the pop machine right across from another resident's room. She assumed other staff get pop for Resident #14. Staff G reported she only worked at the facility for a few weeks, but she didn't receive direction about getting pop for residents when she started at the facility.</p> <p>Interview on 4/28/25 at 2:22 PM Staff H, LPN, reported if a resident wanted a pop, the resident needed to ask the activity coordinator to assist them to the vending machines to get a pop. The staff aren't to assist or take money/cards from a resident to get them pop. She reported it as always supposed to be that way.</p> <p>Interview on 4/18/25 at 3:00 PM Staff J, CNA, reported they used to take Resident #7's money or credit card and swipe it in the pop machine. Afterwards Staff J took her the pop and the card back to her. That happened probably six months to one year ago, then management stopped that. Staff J recalled Staff A worked at the facility, but she didn't stay long. She believed Staff A told her, this isn't enough money, then she just disappeared and didn't work at the facility any longer.</p> <p>On 4/28/25 at 3:18 PM the Provisional Administrator stated obviously it (incident) happened. The statements brought in by the police documented the incident. She thought it happened when Resident #7 gave her card to staff to get her pop. Resident #7 reported she gave the staff her card on the third shift, but couldn't recall the names of all the staff she gave her card. They thought Staff A may have took a picture of her card. Resident #7 didn't reside at the facility when it happened. The facility didn't have other residents who identified any misuse of their cards when they got pop.</p> <p>Interview on 4/28/25 at 3:36 PM Staff E, stated she primarily worked the night shift, usually assigned to the back hallway. The residents gave the staff money or a card to get them pop from the pop machine. The rehabilitation unit and the back-hallway lounge had pop machines with a vending machine containing candy/chips in the staff breakroom. Resident #7 asked the staff to get her a pop. She reported she did get Resident #7 a pop once. Management knew the residents who couldn't get out of bed gave the staff money or credit cards to get them a pop. She didn't know for sure if the facility had any stipulations that only managers could get residents a pop.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 4/28/25 at 3:51 PM Staff C, reported she worked at the facility for approximately [AGE] years. Staff C stated she never got pop for any residents, then changed her response and stated she actually had residents give her cash to get them pop from the pop machine. Resident #7 asked her to get her a pop from the vending machine. Resident #7 offered to give her a credit card, but she refused to take it. Staff C instead, bought Resident #7 a pop using her own card. Staff C verbalized the facility didn't allow staff to carry cell phones when they worked the floor. Staff C explained the facility didn't want staff to take resident credit cards anymore as something happened with a resident's credit card.</p> <p>Interview on 4/28/25 at 4:05 PM Staff K, CNA, voiced she worked at the facility for close to nine years, primarily working the third shift (10:00 PM to 6:00 AM). When asked if residents gave the staff cash or credit cards to get them a pop, Staff K responded, ya. She got a pop for Resident #19 as he couldn't get out of bed. One time Resident #19 gave her cash and another time he gave her a card. She told Resident #19 she didn't feel comfortable with that, but she did get him pop a few times. The facility had a meeting about a month ago and where she told the staff they couldn't take residents' cards any longer. She missed the meeting but she learned that they couldn't take cards or the facility would terminate them. She worked with Staff A and it seemed like she disappeared from the floor every now and then. The staff have cell phones but they are not to have them out when they worked. Staff K said Staff A may have had a pen and paper on her because when they train they have report sheets they write the resident assistance levels on and keep it in their pockets.</p> <p>During an interview on 4/20/25 at 12:23 PM Staff L, LPN, voiced she primarily worked night shift on the front, center, and back hallways. In regards to the staff taking residents' credit/debit cards to purchase pop from the pop machines, Staff L reported it probably happened. She added if they did it, they did it behind her back. Any resident on the back hallway probably tried to get the staff to get them pop. Resident #7 lived in the back hallway and she always tried to give staff her credit card, cash app card, or cash to go to the gas station to get things for her. Staff L didn't know what direction the facility gave staff about taking residents' money or credit/debit cards.</p> <p>Interview on 4/29/25 at 12:55 PM Staff M, CNA, reported he worked at the facility for around 2 years. When asked about staff taking residents' cash or credit/debit cards to get pop, he responded it happened. The facility had a meeting because of that as residents had issues about missing money. They directed to not accept money or cards from residents. The facility had two residents in the rehabilitation unit and a few residents in the back hallway who would ask staff to go get them a pop. Some of the residents couldn't get out of bed, so it was convenient for staff to go get them a pop. The residents gave staff both cash and credit/debit cards. He added it happened for as long as he worked at the facility.</p> <p>During a telephone interview on 4/29/25 at 4:13 PM Staff A voiced she worked at the facility last year (2024), but not long. She worked the overnight shift (10:00 PM to 6:00 AM). She worked all the hallways (areas) at the facility. Staff A verbalized she didn't have any residents give her cash, cash app cards, or credit cards to get them pop from the vending machines. She added the facility locked that stuff up in the business office. Staff A reported they didn't have issues during her employment at the facility.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/30/25 at 11:10 AM observed a pop machine in the back hallway approximately 60-65 feet from Resident #7's room when she lived at the facility. The path from Resident #7's room to the pop machine went directly by the back-hallway nurses' station. The nurses' staff included access to paper, pens, pencils, and a photocopy machine.</p> <p>On 4/30/25 at 11:20 AM witnessed 2 cell phones sitting on the back-hallway nurses' station desk. Staff N, LPN, reported the staff kept their cell phones on the nurses' station desk and checked them off and on as long as they didn't take and use them in resident care areas.</p> <p>During an interview on 4/30/25 at 12:16 PM the Director of Nursing (DON) stated a CNA who no longer worked at the facility must have taken a picture of the card. Resident #7's card had a charge of \$400-\$600. Resident #7 gave her card to the CNA to get her pop. The CNA would have had her cell phone on her. The DON explained the staff aren't supposed to have cell phones in patient care areas, but the staff still had phones in their pockets. The DON voiced she didn't want staff to have their cell phones at the nurses' station. The DON reported staff took residents' credit cards to go get them pop from the pop machines. The DON confirmed the staff shouldn't take residents' money or cards, unless the resident can accompany the staff member to the pop machine. The DON thought the employee handbook outlined this under abuse, but she hadn't read the handbook in years. She remarked you can't trust anybody.</p> <p>During an interview on 4/30/25 at 2:13 PM the Provisional Administrator reported in conclusion it had happened, but as an isolated incident. The facility didn't have the issue prior. They implemented all staff abuse training on their training software and they provided one to one education regarding all types of abuse, missing money, property, or credit card is a form of financial abuse. The reviewed with residents about missing items and provided them lock boxes. The staff do a weekly angel round to check with residents, which included missing items.</p> <p>Interview on 4/30/25 at 2:30 PM Staff B voiced she worked at the facility since February 2020 on the 2:00 PM to 10:00 PM shift in the back hallway. Residents would give staff their credit/debit cards. Then the staff would take the card, tap on the pop machine, and take the pop and card back to the resident. They used the machine in back hallway lounge. The staff did get pop for Resident #7 once in a while. Before Christmas, the facility instructed them to not to take residents' credit cards to get pop.</p> <p>The Patient Protection Guidelines, Abuse Prevention, Reporting and Investigation Policy revised September 2023 directed residents must not be subjected to abuse by anyone, including, but not limited to the facility staff. The Policy defined misappropriation of resident property as the deliberate wrongful, temporary or permanent use of a patient's belongings or money without the patient's consent. The policy lacked direction to the staff regarding handling of a resident's cash app, debit, or credit cards.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's Employee Handbook, 2023, regarding Ethics and Confidentiality directed the company had the responsibility of safeguarding the privacy of all patients so that no patient is caused unnecessary embarrassment or discomfort, or is made the object of scorn, ridicule or exploitation as a result of their stay at the facility. Examples of Confidential Information included patient records and information including financial information. The Handbook directed each patient had the right to be free from financial abuse. The Company would promote and protect the rights of each patient. The staff behavior must reflect the belief in those patient rights. The Handbook specifically prohibited the use of a personal cell phone use during worktime.</p>