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	10/30/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, resident and staff interviews and policy review, the facility deprived a resident of care by failing to communicate in a respectful manner during bedtime care, abandoned the resident in a vulnerable state and failed to respond to the resident's requests for necessary care resulting in the resident's ongoing fear and anxiety. Resident #4 stated on 10/13/25 one of the two nursing staff was arguing with her about her preference of care. Both nursing staff knowingly left Resident #4 on her bed, soiled with urine, without a cover and no staff answered the light for approximately an hour. Resident #4 began crying and expressed fear as her phone was placed out of reach by staff and she had no way of getting assistance as staff would not come when she called out for help. When Resident #4 requested the staff to get the Director of Nursing (DON) so she could report the abuse, the DON refused to respond. The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of October 13, 2025 on October 29, 2024 at 12:20 p. m. The facility staff removed the Immediate Jeopardy on October 30, 2025 by implementing the following actions:1. On 10/14/25 resident #4 had a skin assessment completed by DON with no findings and had a routine skin alternation sheet completed on 10/16/2025 by Staff A, Licensed Practical Nurse (LPN).2. On 10/16/25 resident #4 was assessed by Staff B, Advanced Registered Nurse Practitioner (ARNP), new orders received and followed. 3. On 10/22/25 resident #4 was assessed by Staff C, Nurse Practitioner (NP) psychiatric provider, new orders received and followed. Resident #4 will continue to receive services from Staff C weekly for 4 weeks and reassessment will be completed after that. 4. The alleged staff will no longer provide care to resident #4. 5. Interviews with alert and oriented residents on 10/14/25 regarding abuse and call light response completed. 6. Education was completed on 10/29/25 at 1:30pm with staff regarding reporting allegations of abuse and to whom, preventing abuse and neglect. The abuse policy and guidelines will be utilized for training and education of reporting requirements. Education and training will include chain of command, how to access administrative staff and on-call numbers. Staff will be instructed on preventative measures and protocols to ensure prompt responses and clear communication to prevent similar incidents. Staff unavailable to receive education will receive the education prior to clocking into their next shift. Following education random questionnaires will be completed with staff to prevent potential neglect and abuse. 7. Communication with Residents Skilled Nursing Facility (SNF) Clinic course assigned to all staff on 10/30/2025. The scope lowered from J to G at the time of the survey after ensuring the facility implemented education and their policy and procedures. The facility identified a census of 72 residents. Findings Include:The Minimum Data Set (MDS) dated [DATE] for Resident #4 revealed the diagnoses of congestive heart failure, diabetes mellitus, morbid obesity, anxiety, depression, need for assistance with personal care and was dependent on 2 or more staff for transfers, dressing, toileting and personal hygiene. The brief interview for mental status (BIMS) score for Resident #4 was 15 which suggested an intact cognition. The Care Plan for Resident #4 directed staff to provide clear, concise explanation of anything that was about to occur, talk in a low pitch, calm voice and if strategies were not working, leave (if safe to do so) and reapproach later. Allow for flexibility in activities of daily living (ADL) routine to accommodate Resident #4's mood, preferences, and customary routine. Staff were also directed to reassure Resident #4 if she was upset about her care and discuss her concerns. Resident #4 required the assistance of 2 staff for transfers, dressing and grooming. During an interview on 10/22/25 at 3:52 pm, Resident #4 stated on 10/13/25 about 7:15 pm she had pressed the call light to notify staff she was ready for her usual night time routine that was to be transferred from the recliner to bed with the mechanical lift, remove the sling, cleaned, a clean brief and changed into clean bed clothes. Resident #4 stated Staff D Certified Nursing Assistant (CNA) and Staff E, CNA responded and Staff D began to argue with Resident #4 regarding her preferences of care. Resident #4 stated she told Staff D that she did not want her to come back into her room anymore and the two staff placed her onto the bed, disconnected the mechanical lift, exited the room without changing her and shut the door. Resident #4 stated she turned her call light on with no response for over an hour. Resident #4 stated her phone, I-pad, TV controller and water was on a night stand that was pushed into the bathroom, out of her reach so she was unable to call for help and the TV was on loud so no one heard her when she shouted for help. Resident #4 stated she was thirsty, freezing cold due to air conditioner blowing over her and her brief, the mechanical lift sling that was still under her was soaked with urine and she did not have a blanket to cover herself with. Resident #4 stated she became frantic, sobbing, could not catch her breath and was