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	06/11/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and record and policy reviews, the facility failed to ensure that staff securely stored all medications for 2 of 2 residents reviewed (R#2 and R#8). The facility also failed to maintain a safe environment because staff left the medication carts and treatment carts unlocked and unsupervised. The facility reported a resident population of 68. Findings include: 1. Resident R#2's Minimum Data Set (MDS) admission assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment. The MDS listed diagnoses of major depressive disorder (severe depression), coronary artery disease (heart disease), high blood pressure, dementia (memory loss), stroke (brain tissue damage from blood flow blockage), sleep apnea (nighttime breathing interruptions), and chronic tension-type headaches (frequent severe headaches). The facility's Investigation reflected on 5/2/26 Staff J, Certified Medication Aide (CMA), passed out having seizure-like behavior at the nurses' station. The facility immediately called for an ambulance who took Staff J to the hospital. While at the hospital, the staff found a drug administration record sheet for a former resident, a package of fluconazole medication from a former resident, and R #2's sumatriptan 100 milligrams (mg) containing 4 tablets. The hospital called the facility and the Administrator went to investigate. R#2's May 2026 Electronic Medication Administration Record (EMAR showed an order for Sumatriptan 100 milligrams (mg), one tablet every 4 hours as needed for migraines, which staff could repeat once, up to a maximum of 2 tablets per day. A review of R#2's EMAR from April 2026 and May 2026, up to the time of the incident on 5/2/26, revealed R#2 didn't receive any doses of Sumatriptan. 2. Resident R#8's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. The MDS listed diagnoses of high blood pressure, diabetes (high blood sugar), Alzheimer's disease (progressive mental decline), and depression. On 5/2/26 at 2:45 PM, Staff member J went to the Emergency Department (ED). At the ED, the hospital staff opened her backpack and discovered one tablet of fluconazole (fungal infection medication) with a pharmacy label on the bag indicating the medication belonged to R#8. A review of R#8's Electronic Medication Administration Record (EMAR) for February 2026 revealed an (continued on next page)

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	order for fluconazole 150 mg to give one dose and repeat 72 hours later. The EMAR showed that staff administered both doses to R#8 as prescribed. On 6/8/26 at 9:26 AM, Staff C, Certified Medication Aide (CMA), stated that when a medication changes or finishes but medication remains in the blister pack, staff place it in a bag labeled return to pharmacy inside the locked medication room. Staff C didn't know when the pharmacy picked up the bag. On 6/8/26 at 11:53 AM, Staff H, Licensed Practical Nurse (LPN), stated that if a medication is discontinued or completed, she sends it back to the pharmacy using the bag in the locked medication room. On 6/10/26 at 12:52 PM, the Director of Nursing (DON) confirmed that the facility's protocol for discontinued medications involves placing them in a bin within the locked medication room for return to the pharmacy. She noted that although the pharmacy makes daily deliveries, she didn't know how frequently the pharmacy picked up the return bins. Furthermore, the DON acknowledged that the facility needs to improve this current process. On 6/8/26 from 3:06 PM to 3:20 PM, an observation revealed the medication cart and treatment cart left unattended in the back hallway. On 6/8/26 at 4:12 PM, Staff A, Licensed Practical Nurse (LPN), reported she hadn't used the treatment cart during her shift yet, which started at 2:00 PM, so she didn't know how long it remained unlocked. Staff A reported she sometimes has trouble remembering to lock the medication cart when she works down a certain hallway, and she acknowledged that staff left the carts unlocked and unattended. On 6/9/26 from 9:24 AM to 10:10 AM, an observation revealed the treatment cart in the back hallway unlocked while staff came and went from the area, and three residents wheeled past the cart. On 6/9/26 from 10:15 AM to 10:19 AM, an observation revealed the medication cart on the Pars hallway left unlocked and unattended. On 6/10/26 from 9:30 AM to 9:32 AM, an observation revealed the medication cart on the Pars hallway left unlocked and unattended. On 6/10/26 at 9:44 AM, the Administrator reported that when staff members working the medication and treatment carts aren't within arm's reach of the carts, they must lock them. She acknowledged that staff leaving the carts unlocked and unattended creates a problem. The facility policy titled Medication Administration-Medication Pass dated May 2023 directed staff to secure carts as required.