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	01/14/2026

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on observations, and staff interview the facility failed to keep the daily nurse staff posting current for 2 of 4 days during the survey. In addition, the facility failed to post the number of hours nursing staff worked for 4 of 4 days during the survey. The facility reported a census of 71 residents. Findings include: On 1/11/26 at 11:23 AM witnessed the facility's Nurse Staff Posting dated 1/10/26 (the day before) posting up. In addition, it lacked the number of hours staff worked. On 1/12/26 at 2:03 PM observed the facility's Nurse Staff Posting lacked the number of hours staff will work. On 1/13/26 at 12:51 PM witnessed the facility's Nurse Staff Posting lacked the number of hours staff will work. On 1/14/26 at 9:14 AM observed facility's Nurse Staff Posting dated 1/13/26 (the day before) staff posting up. In addition, it lacked the number of hours staff worked. On 1/14/26 at 10:04 PM the Administrator reported the facility's night shift nurse completed the Nurse Staff Posting. The Administrator explained it should be current every day. She acknowledged the staff didn't complete the section for nurse hours worked 1/12/26 and 1/13/26 staff posting. She added she didn't have one completed for 1/11/26 and 1/14/26.

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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, staff interviews, and policy review the facility failed to have 2 of 2 cooks able to explain the puree process and procedure. The facility reported a census of 71 residents. Findings include: The review of the Week 4, Week at a Glance with Portion (facility menu) instructed to serve 3 ounces (oz.) of roast beef and 4 oz. of roasted butternut squash. On 1/13/26 at 10:59 AM observation of the puree process for 4 residents revealed Staff E, Cook, didn't measure the roast beef or squash after pureeing in the blender to ensure they provided equal portions. On 1/13/26 at 11:12 AM Staff E reported she didn't use a measuring cup after pureeing the food. She instead uses the scoop size as directed on the menu and never got trained to measure the pureed food. She asked Staff D, Cook, who oversaw the kitchen while the Certified Dietary Manager is off, to help her. Staff D explained they didn't measure the pureed food after pureeing; they use the scoop size directed on the menu. Staff D and Staff E added they didn't use a guide to instruct them on what serving size to use. On 1/13/26 at 12:20 PM after completion of meal service, Staff D informed 1 of 4 residents who received a pureed diet is not at the facility. The explained that is why they had extra puree left. Observation of the roast beef and butternut squash revealed they had about one serving remaining. In an interview on 1/14/26 at 12:19 PM the Administrator, Director of Nursing (DON), and Infection Preventionist reported Staff D and Staff E did have training on the puree process. They didn't know why did not measure the pureed food on 1/13/26 during the meal observation. Review of the facilities, Pureed Food Preparation policy reviewed 2020 instructed staff to serve with an appropriate scoop number or to divide the food equally to provide an equal number of portions and all of the pureed food must be used in order to deliver the correct nutrient density to each resident. The number of servings obtained from the pureed recipe must equal to the number of servings from which it started. For example, if ten servings of the regular recipe are to be pureed, follow the pureed recipe for ten servings. The yield of the pureed recipe must give you ten equal pureed servings. If the recipe was altered, the scoop size may also need to be altered. Due to the nature of variance in foods, it is possible that slight alterations or not using all the liquid in a recipe will be required. Therefore, the division of an equal portion of final product to the starting number of servings insures equal nutritive value in each portion.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, staff interviews, and policy review the facility failed to use an 8 ounce (oz.) scoop to serve mashed potatoes as the menu instructed and instead used a 6 oz. scoop resulting in an unknown amount of room trays and 13 of 13 residents in the dining room receiving less mashed potatoes than the menu instructed. The facility reported a census of 71 residents. Findings include: The review of Week 4, Week at a Glance with Portion (facility menu) instructed to serve mashed potatoes with a #8 scoop and roast beef with a 3-ounce (oz.) scoop. On 1/13/26 at 12:28 PM after completion of meal service Staff D, Cook, reported she used a green scoop and thought it was a #8 scoop but instead it was a #6 scoop. She explained she used it for all residents she served mashed potatoes. She added she used a 6 oz. scoop to serve roast beef to all the residents as well and not a 3 oz. as the menu instructed. An observation on 1/13/26 at 12:29 PM of the dining room revealed 8 of 13 resident plates had no mashed potatoes left on their plates, indicating they ate them all. In an interview on 1/14/26 at 12:19 PM the Administrator, Director of Nursing (DON), and Infection Preventionist, reported they expected the staff to follow the menus.Review of Menu Planning and Requirement policy, reviewed 2020 instructed menus are planned to provide nourishing, palatable, attractive meals that meet the nutritional needs of residents served.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review, staff, and resident interviews, the facility failed to serve rooms trays at or above 135 degrees Fahrenheit (F) for 3 of 3 test trays and 4 of 12 resident interviews (Resident #54, #34, #78, and #63). The facility reported a census of 71 residents. Findings include: 1. Resident #54's Minimum Data Set (MDS) assessment for Resident #54 dated 10/13/25 documented a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. On 1/12/26 at 9:00 AM Resident #54 reported she ate in her room and the food is not always the hottest. 2. Resident #34's MDS assessment dated [DATE] documented a BIMS of 13, indicating no cognitive impairment. On 1/12/26 at 10:36 AM Resident #34 said sometimes the food is not hot enough. 3. Resident #78's MDS assessment dated [DATE] documented a BIMS of 15, indicating no cognitive impairment. On 1/11/26 at 11:02 AM Resident #78 reported the hot food is not always hot enough. 4. Resident #63's MDS assessment dated [DATE] documented a BIMS of 11, indicating moderate cognitive impairment. On 1/12/26 at 12:07 PM Resident #63 stated the food is not good and she had cold tomato soup the other day. She added the staff will reheat it if you ask them too. On 1/13/26 the noon meal observation revealed food temperatures prior to serving on the steam table at 11:24 AM: Mashed potatoes 207 F Roast beef 195.6 FSquash 177 F. On 1/13/26 at 11:34 AM the observation of the PARS meal tray cart leaving the kitchen of the test tray food temperatures for the facilities PARS cart on 1/13/26 at 11:45 AM revealed the following temperatures below 135 F: Mashed potatoes 134.7 FSquash 126.3 F. On 1/13/26 at 11:58 AM the observation of test tray food temperatures for the facilities Front and Center cart revealed the following below 135 F: Roast beef 133.1 F Squash 127.4 F.On 1/13/26 at 12:19 PM the observation of test tray food temperatures for the facilities Back cart revealed the following below 135 F: Squash 133 F.Observation of the steam tables final temperatures after completion of meal services on 1/13/26 at 12:11 PM revealed the following: Roast beef 200 FNo mashed potatoes left to checkSquash 169.9 F.During the observation of rooms trays on 1/13/26 from 11:24 AM to 11:58 AM revealed dietary staff preheated hot plates prior to using, and left them sitting on the counter. On 1/14/26 at 12:19 PM the Administrator, Director of Nursing (DON), and Infection Preventionist reported they expected the dietary staff to heat the hot plates up as they use them and not in advance. Review of the facility's policy Monitoring Food Temperatures for Meal Service, reviewed 2020 instructed food temperatures of hot foods on room trays at the point of service are preferred to be at 120 F or greater to promote palatability for the resident.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, policy review, resident and staff interviews the facility failed to implement and maintain a restorative program for 2 of 2 residents reviewed (Resident #17 and # 26). The facility reported a census of 71 residents. Findings include:1. Resident #17's Minimum Data Set (MDS) assessment dated [DATE] the Staff Assessment for Mental Status listed her with severely impaired cognition. Resident #17 required maximal assistance to roll in bed. The staff didn't attempt sit to stand due to medical conditions. The MDS listed Resident #17 as dependent with bed to chair transfers. The MDS included diagnoses of encephalopathy (disease or disorder that changes brain function causing altered mental state), leukemia (cancer of the blood), high blood pressure, chronic kidney disease (gradual loss of kidney function), hyperlipidemia (high cholesterol), dementia (decline in mental ability), convulsions, anxiety, depression, irregular heartbeat, and reduced mobility. The MDS lacked documentation of a restorative program. The Occupational Therapy (OT) Discharge summary dated [DATE] listed the prognosis to maintain current level of function (CLOF) as excellent with consistent staff support. Resident #17's husband would verbalize and demonstrate understanding of safe Restorative Nursing Program techniques with no more than 1 verbal cue from OT. The Husband demonstrated proper passive range of motion (PROM) techniques. The Husband demonstrated proper PROM techniques. The Summary listed a Restorative Program to provide gentle PROM to both upper extremities 1-2 times a day to maintain comfort and joint mobility. Stop if Resident #17 showed discomfort and don't force any range. The Summary lacked direction of who would provide the Restorative Program. The Care Plan Focus initiated 8/4/25 indicated Resident #17 complained of pain described as chronic generalized discomfort. The Goal reflected Resident #17 wouldn't have an interruption of normal activities due to pain. The Care Plan lacked the OT recommended Restorative Program from 12/26/25. Resident #17 Kardex/Tasks lacked documentation of a Restorative Program. On 1/12/26 at 9:26 AM Resident #17's Representative verbalized the staff just didn't do the Restorative Program consistently. On 1/13/26 at 2:23 PM Staff B, Certified Nursing Assistant (CNA), verbalized Resident #17 didn't have a Restorative Program. If a resident had a Restorative Program, the staff chart on it in the Electronic Health Record (EHR). On 1/13/26 at 2:25 PM Staff C, CNA, explained if they needed to do exercises for a resident, they are in the EHR. On 1/13/26 at 2:48 PM the Director of Nursing (DON) and Administrator reported when therapy discharges a resident with a program, the Director of Rehab let the DON and Administrator know. The staff document the program in the EHR for a resident with a Restorative Program. The progress of residents with a restorative program is reviewed at the weekly staff meeting. The DON and Administrator reported they expected if therapy recommended a restorative program, then the program is started and ensured that it is done correctly. On 1/13/26 at 3:53 PM the DON and Administrator spoke to the Director of Rehab. The Director of Rehab described Resident #17's Restorative Program as more for the husband to do. The facility policy titled Nursing Rehabilitation/Restorative Care revised May 2025 defined the Purpose as to improve or maintain function in physical abilities, activities of daily living (ADL), and prevent further impairment. The policy directed a rehabilitation, or restorative practice should attempt to meet the criteria of the activities carried out or supervised by members of the nursing staff. The staff would determine the need for rehabilitation/restorative care through a comprehensive assessment and/or skilled evaluation. 2. Resident #26's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) of 15, indicating no cognitive impairment. Resident #26 required supervision (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for toileting, transfers, walking, and lower body dressing. The MDS included diagnoses of hypertension (high blood pressure), respiratory failure (a condition where your lungs cannot properly perform their primary job), and Parkinson's disease (a brain disorder that makes it hard to control movement, causing symptoms like shaking or tremors, stiffness, slow movements, and balance problems because the brain doesn't produce enough dopamine, a crucial chemical for smooth motion). The Care Plan Focus initiated 5/8/25 reflected restorative active ROM (AROM) to upper and lower extremities for 3 repetitions (reps) for 3 sets or attend group exercise for 15 minutes per day as tolerated. The Goal listed Resident #26 would improve or maintain walking ability of 200 feet with a front wheeled walker (FWW) with one assist as tolerated within next review. The Interventions instructed the staff the following: Follow therapy recommendations as applicable Encourage to participate in restorative programs Provide ROM exercises per resident needs. The Physical Therapy Initial Evaluation document dated 4/20/25 recommended Resident #26 walk with nursing staff 4 times a day in the halls. Encourage active exercises of upper extremities and lower extremities. The review of Resident #26's Restorative documentation on 1/13/26 related to her walking to improve/maintain walking ability of 200 feet with FWW with one assist as tolerated revealed staff documented completion 1 time out of 13 days in January 2026 and 2 times out of 31 days in December 2025. Both month lacked documentation of refusal to complete the Restorative Program. On 1/12/26 at 3:16 PM Resident #26 reported she would like to walk more. Therapy told her she should walk more and she would like to participate in a Restorative Program. On 1/13/26 at 4:30 PM the Administrator explained the staff should complete the walking restoratives for the Resident #26 and informed staff have only been documenting restoratives as needed. On 1/13/26 at 4:31 PM the Director of Nursing (DON) acknowledged the staff didn't document Resident #26's walking restoratives. They expected the staff to document the completion of her Restoratives.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, policy review, manufactures instructions for use, and staff interviews, the facility failed to properly prime an insulin pen before administering for 1 of 2 residents observed (Resident #22). The facility reported a census of 71.Findings include:On 1/12/26 at 11:20 AM, observed Staff A, Licensed Practical Nurse (LPN), attempt to prime the insulin pen. Staff A turn the dial on the Humalog insulin pen to 2 units without the needle on and pressed the plunger of the insulin pen. After Staff A placed the needle on the pen and set the insulin pen to 10 units, she indicated being ready to administer the insulin to Resident #22. Resident #2's Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS listed a diagnosis of diabetes mellitus. Resident #2 used insulin seven days a week in the lookback period. The Order Review History Report acknowledged by the provider on 1/8/26 listed the following physician orders:Humalog Injection solution 100 units (U) per milliliter (ML) injection 4 units subcutaneously 3 times a day for diabetes.Humalog Injection solution 100 U/ML inject 6 units per sliding scale for a blood sugar of 251-300 subcutaneously 3 times a day.On 1/12/26 at 11:20 AM observation of Staff A insulin administration. Staff A wiped insulin pen with alcohol prep, turned the pen dial to 2 units before pen needle was attached to the pen, turned the dial to 10 units. Staff A verbalized she was ready to administer insulin. On 1/12/26 at 11:21 AM Staff A said she thought she prepped the pen to get the air out of the pen. She didn't know the pen needed to have the needle in place to clear the needle of air. On 1/13/26 at 2:10 PM the Administration reported she knew of the medication error and the facility already started educating the nurses on prepping the insulin pen prior to administration.On 1/14/26 at 11:24 AM the Director of Nursing (DON) explained she expected the nurse to place the needle on the insulin pen prior to priming. The DON added she already started providing staff education. The facility's Medication Administration: Injections policy revised April 2024 instructed to prime the insulin per manufacturers guidelines. The Manufacturer's Step by Step guide to using a Humalog KwikPen directed the following to prime the insulin pen: Wipe the pen tip (rubber seal) with an alcohol swab.Remove the protective seal from the new needle.Line the needle up straight with the pen and screw the needle on. Dial a test dose of 2 Units.Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose.Press the injection button all the way in and check to see that insulin comes out of the needle. The dial will automatically go back to zero after you perform the test.If no insulin comes out, repeat the test 2 more times. If there is still no insulin coming out, use a new needle and do the safety test again.