STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165104	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Dubuque	901 West Third Street Dubuque, IA 52001

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19126 Based on clinical record reviews, staff and resident interviews, policy review, and observations the facility failed to notify a resident's physician of a change in condition in a timely manor for 1 of 6 residents reviewed (Resident #6). The facility reported a census of 59 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #6 had diagnoses which included fractured left femur neck, Parkinson's disease, and sepsis. The MDS revealed the resident had a Brief Interview for Mental Status score of 11, which revealed the resident had moderate cognitive impairment and may need extra help for daily tasks. The resident had a history of falls. The resident required supervision or touch assistance with transfers and partial to moderate assistance with walking. Review of the resident's Care Plan dated 12/10/23 directed the staff to assist the resident with ambulation and transfers as needed and on 3/27/2024 the Care Plan directed the staff to place a sign in the resident's room to remind him to use his call light. Review of the Nurses Progress Notes dated 1/16/25 at 5:49 pm the staff found the resident lying on the floor of his room, next to his roommates bed, complaining of left hip pain. The resident complained of his hip hurting and rated the pain as 3 on a scale of 0-10. The nurse called the on-call provider at 6:35 pm and gave a status report. The on-call provider ordered a mobile x-ray of the resident's left hip. The Nurse's Progress Notes revealed the mobile x-ray unit arrived at the facility at 11:00 pm and completed the ordered x-ray. The results of the x-ray were printed off and placed on the Primary Care Providers desk in the facility at 3:00 am for her to review on rounds the morning of 1/17/25. Review of the portable x-ray report dated 1/17/25 indicated Resident #6 had an acute mildly displaced subcapital left femoral neck fracture. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Staff B-RN on 1/29/25 at 12:15 pm, Staff B stated she was the Primary Nurse responsible for Resident #6 on 1/16-1/17 am. She reported he fell at change of shift on 1/16 at approximately 6:00 pm. On initial assessment he denied pain but at about 7:30-8:00 pm he complained of pain in his left hip. The nurse called the on-call provider to report the fall with pain. An x-ray was ordered and obtained at 11:00 pm. The facility received a phone call from the mobile x-ray provider between 1:30 and 2:00 am on 1/17/25 directing them to refer to the residents electronic health record. Staff B-RN stated at about 3:00 am they read the results and noted the resident had a fractured left hip. The resident was sleeping at the time so she decided to copy the results and placed them on the Nurse Practitioner desk to review when she came in that morning. Staff B stated she received a 1:1 In-service re-education from the Assistant Director of Nurses as directed by the Administrator. She stated she should have called the on-call physician when she noted the results of the fractured hip as soon as she read the results. Review of the One on One In-service Record dated 1/17/25, stated that on 1/16/25, Staff B-RN received an x-ray report on a patient which showed a fractured left hip. Staff B re-educated when she receives an x-ray report or critical lab result and its after hours, Staff B must call and report the findings to the on-call provider and not to wait until the following day. During an interview with Staff D-Administrator on 1/29/25 at 11:03 am. Staff D stated she did the investigation regarding the fall. She became aware the staff failed to call the provider with the fractured hip report. Staff D stated the staff should have called the provider immediately upon learning of the resident's fractured left hip. During an interview 1/29/25 at 11:35 am with Resident #6's Nurse Practitioner regarding the fractured hip the resident sustained on 1/16/25 fall. The on-call provider working the evening of 1/16 ordered a portable x-ray which was completed at 11:00 pm. The results returned to the facility on [DATE] around 3:00 am but the staff failed to call the on-call provider to report the findings. The Nurse Practitioner would have expected the staff to call the on-call provider to alert them of the resident's fractured hip and not to wait until the next morning when she was expected to make rounds to review the results. Hospital records dated 1/17/25 revealed the resident arrived at the emergency room with a diagnosis of left hip fracture. The resident underwent surgical repair of the left hip and returned to the facility on [DATE]. Review of a Notification of Change of Condition policy dated June 2023 directed the facility staff they must immediately consult with the resident's physician when an accident occurs which result in an injury and has potential for requiring physician intervention, a change in the resident's condition, a need to alter treatments or a decision to transfer or discharge a resident.