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	11/13/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, clinical record review, staff and resident interviews, and policy review the facility failed to ensure residents received care and services that allowed for a dignified existence and communication with friends and family for 3 of 4 residents reviewed for resident rights (Residents #1, #2, and #3). Resident #1 was left in the dining room leaning sideways in her wheelchair and spoken to disrespectfully by staff, Resident #2 reported being incontinent waiting for a call light to be answered, and Resident #3 was denied phone calls with family. The facility reported a census of 47 residents.Findings include: 1. The Minimum Data Set (MDS) for Resident #1 dated 8/20/25 documented diagnoses of pneumonia, Multiple Sclerosis (MS), Chronic Obstructive Pulmonary Disease (COPD), and Post Traumatic Stress Disorder (PTSD). The Brief Interview for Mental Status (BIMS) score totaled 14/15 which indicated intact cognition.The Care Plan (CP) for the resident with an admission date of 10/4/24 indicated she agreed to sit at an assisted table in the dining room for all 3 meals. She required assistance of 2 staff and a lift for transfers and used a custom tilt and space wheelchair with lateral supports, a head rest, and roho cushion. The CP directed staff that if the resident was leaning she should be repositioned in the wheelchair and to tilt the chair. If she continued to lean hard to left she needed to be laid down in bed secondary to her declining postural control.A document titled Physical Therapy Discharge Summary signed on 9/4/25 included the following discharge recommendations: Reposition frequently in the wheelchair and offer to tilt in space. If Resident #1 was falling over to the left side of the chair, staff needed to lay her down.During an observation on 11/13/25 at 12:38 PM Resident #1 was sitting alone at a table near the dining room door leaning over the left side of her chair. She appeared unable to reach her food. The nurses station was in view of the resident. At 12:46 PM Resident #1 was observed in the same position. Her right hand was holding the edge of the table, her knuckles white. Her right arm was sitting on a pillow. Her left arm was hanging over the side of her wheelchair with her hand grasping the wheel. Her body was leaning far to the left with her head below the level of the arm of the chair. Her right foot was on a pedal and her left foot was between the two pedals. She attempted to lift her foot up and was unable to. Two dining staff were present cleaning tables and did not assist or find a Certified Nurses Aide (CNA) to assist. At 12:52 PM Resident #1 was able to lift her head enough to get a cup and straw to her mouth for a drink. She was unable lift her body higher and put the cup back down. At 12:56 PM Resident #1 was observed using her right hand on the table and left hand on the wheel of her wheelchair to try to rock the chair back from the table. At that time she did not have the strength to do so. At 12:58 PM a CNA came in the dining room and spoke to the resident. She asked her why she moved her pillow and said that was why she was leaning over. The CNA asked again why the resident moved the pillow, said don't do that, asked the resident how she thought she could sit up without it, and asked the resident what she thought she was doing. After the CNA repositioned the pillow she firmly told the resident not to do that again and wheeled her out of the dining room.At 12:48 PM on 11/13/25 Staff A, Dietary was asked if Resident #1 usually sat alone. She stated a resident usually sat at the table with her but not staff.Interview with Resident #1 on 11/13/25 at 3:44 PM revealed she leaned to the left a lot due to her diagnosis of MS. She was observed sitting in her recliner leaning to her left with no pillow propped under her left side for support. Her call light was on her bed and not in reach. When asked how she would get help she indicated that she 'would be screaming.' She reported that she was not left like that in the dining room a lot but it had happened before. Resident #1 indicated that some staff got on her if the pillow moved but she couldn't help it. She stated she hated her wheelchair because it did not provide enough support for her and staff were supposed to keep her propped with pillows. During an interview on 11/13/25 at 4:11 PM the Director of Nursing (DON) stated she expected staff to give residents their call light buttons wherever they were in their room and staff were frequently educated and reminded about call lights. She expected staff to know what positioning requirements were needed for Resident #1 because it was on the kardex they used for care and the information came directly from the care plan. She confirmed both facility and agency staff had access to that information. She stated the resident's provider and insurance were aware of the resident's concerns about the wheelchair and that the resident's posture control continued to decline. She confirmed that the resident would be unable to sit herself up on her own or prop herself up independently with the pillow. 2. The MDS for Resident #2 dated 8/27/25 documented diagnoses of anxiety and depression, constipation, osteoarthritis, and repeated falls. The BIMS assessment was 14/15 which indicated intact cognition.The CP for the resident with an admission date of 5/21/25 indicated she required contact guard assist of 1 staff and a 4 wheel walker for transfers and ambulation to