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	03/12/2026

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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, staff interview, Nurse Practitioner (NP) interview, physician office staff interview, resident interview, and resident family member interview, the facility failed to ensure a resident received effective pain management interventions that included the administration of analgesic and other medications that enhanced pain control as ordered and directed by the physician for 1 of 4 residents reviewed for pain management (Resident #9). This deficient practice resulted in the resident experiencing sleep disturbance due to pain. On 2/16/26 Resident #9 called 911 themselves for transfer to the hospital for pain management when the resident experienced pain at level 10 out of 10. The facility reported a census of 55 residents.Findings include:The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #9 admitted to the facility on [DATE] from the hospital. The resident scored 13 out of 15 on the Brief Interview for Mental Status (BIMS) cognitive assessment, which indicated intact cognition. Resident #9's diagnoses included arthritis, anxiety, depression and encounter for other specified surgical aftercare. Per the MDS assessment, the resident reported the worst pain over the last five days as level eight on a zero to ten scale, with zero being no pain and ten as the worst pain [the resident] could imagine. Per the assessment, the pain frequency was almost constant, and it frequently impacted his sleep. The assessment further revealed pain occasionally impacted his day to day function and rarely impacted his ability to participate in therapy. Per the MDS assessment, the resident required partial/moderate staff support and assistance to transfer to and from bed or chair, to dress their lower body, for toileting hygiene, and for ambulation of 10 feet or less on a level surface.A Hospital Discharge summary dated [DATE] and Hospital Records for date of service 1/29/26 revealed the resident had an L4-L5 (4th and 5th disc of lumbar spine) anterior interbody fusion with microdiscectomy and placement of intervertebral cage (hardware used for stabilization), and an L5-S1 (5th lumbar disc and 1st sacral disc area) anterior interbody fusion with radical discectomy. Per the hospital documentation, the procedures were completed by 2 different surgeons on 1/26/26. Resident #9 had 2 different incisions, one on the anterior right lateral lower flank area, and the other from the left posterior lateral sacral area. The hospital documents detailed the resident's transfer to the facility with therapy orders and continued care by the neurosurgeon with follow-up appointment scheduled on 2/10/26 at 8:30 a.m. Pain management medication directed by the neurosurgeon that included:1. Oxycodone (a very strong opiate narcotic analgesic) 5 milligrams (mg) tablet, 1 administered oral every 4 hours as needed for moderate pain, ordered 1/30/26.2. Oxycodone 10 mg (two 5 mg tablets) administered oral every 4 hours as needed for severe pain, ordered 1/30/26.3. Methocarbamol (known as Robaxin, a strong skeletal muscle relaxant medication) 750 mg administered oral every 6 hours as needed, ordered 1/30/26.4. Tylenol 325 mg, with directions to take one to two tablets (325-650 mg total) administered oral every 4 hours as needed, ordered 1/30/26.5. Lidoderm (a topical numbing medication) 5% patch applied topical daily, ordered 1/31/26.6. Lyrica (a prescription medication used to treat neuropathic pain) 75 mg administered oral twice daily, ordered 2/3/26. The resident's Nursing Care Plan included the following focus area initiated on 1/31/26: Resident has complaints of pain described as Acute related to post surgery spinal infusion. The goal initiated on 1/31/26 revealed the (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165104	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026

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F 0697 Level of Harm - Actual harm Residents Affected - Few	resident would not have an interruption in normal activities due to pain. Interventions per Resident #9's Nursing Care Plan included: a. Administer pain medication per physician orders, initiated 1/31/2026.b. Encourage/Assist to reposition frequently to position of comfort, initiated 1/31/2026.c. Evaluate efficacy of pain management, initiated 1/31/2026.d. Evaluate pain level as ordered, initiated 1/31/2026.e. Monitor for factors / activities that precipitate or aggravate pain, initiated 2/12/2026.f. Notify MD (Medical Doctor) if inadequate pain relief as indicated, initiated 2/12/2026.g. Notify the physician if interventions are unsuccessful or if current complaint is a significant change from my past experience of pain, initiated 2/12/2026.h. Observe for non-verbal signs of pain, initiated 1/31/2026.i. Refer to Therapy as needed, initiated 2/12/2026.j. Staff to observe any behavior changes in usual routine, sleep patterns, decrease in functional abilities, decrease ROM (range of motion), withdrawal or resistance to care, initiated 1/31/2026. Orders transcribed by the facility's Nurse Practitioner (NP), not the resident's surgeon, included:1. Lorazepam (an anti-anxiety medication that is a controlled medication) 0.5 mg administered oral every 4 hours as needed, ordered 2/5/26.2. On 2/12/26 at 2:05 p.m., discontinued Oxycodone 10 mg order.3. On 2/12/26 at 2:15 p.m., administer Tramadol (an opioid narcotic analgesic used for moderate pain) 50 mg oral every 6 hours as needed.4. On 2/12/26 at 8:45 p.m., re-ordered Oxycodone 10 mg oral every 4 hours for severe pain, because facility could not access Tramadol at that time.5. On 2/13/26 at 10:29 a.m., discontinued Oxycodone 10 mg order.6. On 2/13/26 at 10:30 a.m., Oxycodone 5 mg administered oral every 4 hours as needed for moderate pain. A Physician's Progress Notes and orders from Resident #9's surgeon's office dated 2/10/26 following the appointment that day revealed, Patient states it is difficult to get pain meds as ordered. Having significant pain .Give meds as ordered (Oxycodone, Robaxin, Lyrica and Tylenol). Ok for heat application. Staff B, Registered Nurse (RN) noted the document on 2/11/26 (indicated acknowledgement of receipt and review).The resident's February 2026 Medication Administration Record (MAR) revealed the resident received Oxycodone 10 mg at the following dates/times, with the following pain assessment score documented from 0 to 10 on the MAR:2/6/26:a.1:06 a.m., pain score 8b. 5:28 a.m., pain score 9c. 9:53 a.m., pain score 7d. 3:02 p.m., pain score 7e. 8:32 p.m., pain score 82/7/26: a.12:41 a.m., pain score 8b. 6:10 a.m., 9 (Oxycodone 10 mg was administered after Tylenol given at 4:16 a.m. that morning)c. 10:16 a.m., pain score 7d. 3:59 p.m., pain score 7e. 9:00 p.m., pain score 72/8/26: a.1:22 a.m., pain score 7b. 6:05 a.m., pain score 7d. 4:46 p.m., pain score 7 (Oxycodone 10 mg was administered after Tylenol 650 mg given at 11:25 a.m. that morning)e. 8:47 p.m., pain score 82/9/26:a.12:59 a.m., pain score 10b. 5:00 a.m., pain score 9 (Oxycodone 10 mg was administered after Tylenol 650 mg given at 4:09 a.m. that morning)c. 9:22 a.m., pain score 6d. 1:49 p.m., pain score 7e. 6:10 p.m., pain score 7 f. 11:31 p.m., pain score 72/10/26:a.3:35 a.m., pain score 7b. 10:45 a.m., pain score 7 c. 2:59 p.m., pain score 7 (Oxycodone 10 mg was administered after Tylenol given at 1:27 p.m. that afternoon)d. 7:30 p.m., pain score 8 (After the administration of Oxycodone 10 mg, resident given Tylenol 650 mg at 11:11 p.m.)2/11/26: a.7:45 a.m., pain score 7 (After the administration of Oxycodone 10 mg, Tylenol 650 mg administered at 4:05 p.m.)b. 11:04 p.m., pain score 82/12/26: a.8:02 a.m., pain score 7b. 1:36 p.m., pain score 5The resident's pain scores revealed on 2/12/26 at 4:29 p.m., the resident's pain score of 6. On 2/12/26 at 8:46 p.m., the resident's pain score was 9. On 2/13/26, Oxycodone was administered at the following times, with the corresponding pain assessment score documented from 0 to 10 on the MAR:a. 6:07 a.m., pain score 8 (Oxycodone 10 mg)b.12:37 a.m., pain score 7 (Oxycodone 5 mg)c. 10:24 a.m., pain score 8 (Oxycodone 5 mg was administered after Tylenol given at 7:30 a.m. that morning)d. 2:42 p.m., pain score 7 (Oxycodone 5 mg)e. 7:29 p.m., pain score 9 (Oxycodone 5 mg)The Progress Note dated 2/13/26 at 12:00 AM by the Nurse Practitioner (NP) revealed the resident was at the facility for skilled therapies post lumbar fusion. The resident was on 1-2 tablets of oxycodone 5 mg every 4 hours PRN for pain. He took it around the clock, every 4 hours. The Progress Note revealed it was unsafe to send someone home on that much medication, and discussion was had with the resident on weaning this medication. The Progress Note further revealed the resident was on board, saw Dr. (continued on next page)

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165104	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026
NAME OF PROVIDER OR SUPPLIER Harmony Dubuque		STREET ADDRESS, CITY, STATE, ZIP CODE 901 West Third Street Dubuque, IA 52001	

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F 0697 Level of Harm - Actual harm Residents Affected - Few	[Name Redacted] the day prior, and changed him (resident) to 5 mg of oxycodone every 4 hours as needed and 50 mg of Tramadol every 6 hours as needed. The facility had not received the Tramadol yet. The order was then put back in for the 5-10 mg of oxycodone every 4 hours as needed. The Progress Note further revealed unsure where order came from, but NP adjusted it back to the 5 mg of Oxycodone every 4 hours as needed and sent in the script for the Tramadol order. Per the Progress Note, the resident needed to wean off the oxy before discharge. On 2/14/26, Oxycodone 5 mg and Tramadol 50 mg were administered at the following times, with the corresponding pain assessment score documented from 0 to 10 on the MAR:a.12:01 a.m., pain score 8 (Oxycodone 5 mg administered)b. 1:29 a.m., pain score 7 (Tramadol 50 mg administered)c. 5:00 a.m., pain score 8 (Oxycodone 5 mg administered)d. 9:48 a.m., pain score 6 (Tramadol 50 mg administered)e. 2:59 p.m., pain score 8 (Oxycodone 5 mg administered)f. 7:38 p.m., pain score 8 (Tramadol 50 mg administered)g. 9:54 p.m., pain score 7 (Oxycodone 5 mg administered)On 2/15/26, Oxycodone 5 mg and Tramadol 50 mg were administered at the following times, with the corresponding pain assessment score documented from 0 to 10 on the MAR: a. 2:52 a.m., pain score 8 (Tramadol 50 mg administered)b.8:29 a.m., pain score 7 (Oxycodone 5 mg administered)c. 2:11 p.m., pain score 6 (Tramadol 50 mg administered)b. 8:47 p.m., pain score 7 (Oxycodone 5 mg administered, with Tylenol administered prior at 2:14 p.m.)On 2/16/26 at 3:15 a.m., Tramadol 50 mg was administered for a documented pain score of 10. A Patient Care Record from [City Redacted] Fire/EMS (Emergency Medical Services) for Resident #9 dated 2/16/26 detailed arrival to facility at 4:30 a.m. Per the Patient Care Record, the resident with complaints of back pain rated 10 on a 0 to 10 pain scale with 10, and the resident was transported to a hospital Emergency Room. Per the Narrative section, the patient appeared to be in a mild amount of stress due to pain in the back. The back pain was caused by a spinal fusion performed at [Name Redacted Hospital] approximately three weeks ago. The hospital Emergency Department [ED] Provider Note dated 2/16/26 revealed the resident was treated for acute bilateral low back pain with bilateral sciatica, pain rated at 10 out of 10 upon his arrival, and required medication administration that included:1. Robaxin 1000 mg given intravenous (IV) at 5:50 a.m.2. Tylenol 1000 mg oral at 5:51 a.m.3. Methylprednisolone (a steroid used for acute pain management) 40 mg IV at 5:53 a.m.4. Toradol (a very strong non opioid, non-steroidal anti-inflammatory drug or NSAID) 15 mg IV at 5:53 a.m.5. Zofran (a medication for nausea) 4 mg IV at 5:53 a.m.6. Dilaudid (a very strong opiate narcotic) 0.5 mg IV at 6:51 a.m.On 3/4/26 at 7:40 p.m., Resident #9's family member stated the facility staff were not good about giving the resident his pain medication as prescribed by the surgeon. Per the family member, the resident had to constantly ask, then wait. Resident #9's family member explained that made the pain worse and increased their (resident's) anxiety. Some of the nurses were good about getting his medication to him, but there was a couple, especially one on the night shift that didn't want to give him his pain medication. The family member explained they reported that to the facility and were told that the nurse had been fired. On 3/9/26 at 10:08 a.m., the resident stated he had a very difficult time getting the pain medication that his doctor ordered after his surgery. He had severe pain from the surgery, and Oxycodone 10 mg was ordered as often as every 4 hours. Per Resident #9, it did provide some relief but did not completely relieve his pain. The resident explained there was a nurse on the night shift (the resident identified Staff A by name) that would not give him his pain medication when he asked for it. He would sit in his wheelchair by the Nurse's Station, wait for her to get done with her work on the computer and ask her if he could have his medication. The resident explained she acted like she didn't see him or hear him. Resident #9 further explained he would continue to ask for it and she would tell him that it was too soon, or that he couldn't be in that much pain, and he would have to wait longer before she administered the medication. The last night he was there he had horrible pain, and they had reduced the amount of pain medication he could have. The resident explained his pain level had been at 10 for several hours and couldn't take it anymore, and wanted to go to the hospital. Resident #9 explained the nurse didn't call the doctor until 4:20 a.m., after he had already called 911 because the nurse hadn't called the doctor about his pain. They (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	treated his pain in the emergency room and he did get relief from the medications that were given there.On 3/4/26 at 12:29 p.m. and during a follow up interview on 3/9/26, Staff A, Licensed Practical Nurse (LPN) stated she worked at the facility on the 6 p.m. to 6 a.m. night shift. On the evening of 2/15/26 the resident was asleep when she arrived for her shift and difficult to arouse. He woke up and wanted his Oxycodone shortly after she got there and she administered it. Staff A explained the resident usually asked for the medication every 4 hours, often earlier than when it could be administered. The resident complained of increased pain and it was not normal to have as much pain as what he said he had 2 weeks after surgery. Later that evening the resident requested the Oxycodone again, she checked his blood pressure (BP) to administer his diltiazem (heart and BP medication) at that time, his BP was 90 over something and she held the medication, also concerned about analgesic administration with low BP. She checked his BP again about a half hour later when he asked for pain medication again, his BP was lower, 86/63, and she instructed the resident she could not give the pain medication when his BP was that low. Staff A stated the resident reported severe pain of 10 at that time, and kept begging her to give his Oxycodone. Staff A stated she administered Tramadol to him at 3:15 a.m. against her better judgement, as his BP was low, the resident wanted his Oxycodone, said he couldn't take the pain anymore and wanted to go to the hospital. Staff A stated she tried to call the provider a couple of times that night, they didn't answer and she left a message. The resident asked if he could call 911 to go to the hospital, when the provider called her back the resident had already called 911 and the ambulance was on the way there. The resident was upset with her because he didn't understand what a time-consuming process it was to contact the provider and get an order for him to go to the hospital.On 3/4/26 at 10:28 a.m. Staff B, RN, stated the resident asked for pain medication early, before 4 hours since the last administration. She only gave the medication every 4 hours because given early, that set a precedent that made it worse for staff. On 2/10/26 he had a doctor appointment and transported by bus at 7:30 a.m. He last received the Oxycodone at 3:35 a.m. and she would not administer the medication 5 minutes too early, she did not administer any pain medication before he went to the appointment. On 3/4/26 at 5:02 p.m. Staff C, RN stated he worked on the 6 p.m. to 6 a.m. night shift, the resident had back surgery and was in a lot of pain, often complained of pain at 7 to 10 level and required Oxycodone 10 mg about every 4 hours. The resident could function when he received the analgesics, mobile in his wheelchair, but he had non-verbal signs of pain such as grimacing, guarding his back and slow body movements. Staff C was certain the resident had severe pain, he was not acting or drug-seeking. Staff C stated he was not aware of a time the resident's BP or pulse was low, or a contraindication to administer his analgesics when needed.On 3/4/26 at 3:18 p.m. Staff D, Certified Nursing Assistant (CNA), stated he worked the night shift assigned to the resident's hall. Per Staff D, the resident had a lot of pain and was often up during the night several times because of the pain. The night of 2/15/26 that ended 2/16/26, the resident complained of a lot of pain, said he couldn't take it anymore and wanted to go to the hospital. He heard Staff A tell the resident his BP was low and it was not safe to give him pain medicine, she had to call the doctor to get an order to send him to the hospital and the resident asked if he could call 911. To his recollection the resident had been up most of the night between 11 or 12 a.m. and 4 a.m. and it seemed like the resident had a lot of pain because he was unable to sleep or lay in bed that night.On 3/6/26 at 9:32 a.m., Staff F, Supervisor at the facility's physician provider group stated there were only 2 calls from the facility between 9 p.m. on 2/15/26 and 5 a.m. on 2/16/26. A call from the facility at 4:09 a.m. went to voicemail, but there was no message left. The second call was at 4:17 a.m., and the nurse spoke to the on-call provider. A note timed at 4:30 a.m. summarized the call and they directed the nurse to send the resident to the hospital for assessment of increased pain and low BP.On 3/9/26 at 12:41 p.m. Staff E, Office Manager stated she was responsible for transportation arrangements for medical appointments and had made the arrangements for the resident's appointment on 2/10/26. Staff E stated it could take as long as an hour after the appointment for the transport service to pick up the resident. Per Staff E, she had a few calls because he was at the (continued on next page)

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