| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165104 | A. Building<br>B. Wing | 10/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Harmony Dubuque | 901 West Third Street<br>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 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>49976<br><br>Based on record review, resident and staff interviews, and policy review the facility failed to provide showers as scheduled for 1 of 2 residents reviewed (Resident #2). The facility reported a census of 52 residents.<br><br>Findings include:<br><br>The Minimum Data Set (MDS) report dated 10/02/24 for Resident #2 indicated a Brief Interview for Mental Status (BIMS) score of 15/15, indicating no cognitive impairment. The MDS further indicated diagnoses including: acute and chronic respiratory failure, mild intellectual disabilities, and other specified disorders of muscle. It documented the resident as fully dependent on staff for assistance with showering/bathing.<br><br>The Care Plan revised 7/10/24 instructed staff to assist the resident with shower/bathing per schedule.<br><br>The Station 1 Shower List, updated 10/03/24 listed Resident #2 shower days as Tuesday and Friday.<br><br>The Follow Up Question Report compiled 10/22/24 revealed the resident missed showers on the following dates in the last three months: 8/6, 8/20, 8/27, and 9/27.<br><br>In an observation on 10/21/24 at 9:54 AM Resident #2's hair appeared greasy and matted, his shirt had food stains on it, and there was a moderate smell of body odor emanating from him.<br><br>In an observation on 10/22/24 at 8:02 AM the resident remained in the same clothing as the prior day. There were additional food stains on the shirt and shorts, his hair remained matted and greasy, and body odor was present.<br><br>In an interview on 10/21/24 at 9:54 AM Resident #2 reported he gets a shower once per week and would like an additional shower or two.<br><br>In an interview on 10/22/24 at 11:11 AM Staff A, Certified Nursing Aide (CNA) and Staff B, CNA reported they fill out a shower sheet and chart showers in the Electronic Medical Record (EMR). The sheets are given to the nurse to sign off and then the Unit Manager files them. They reported Resident #2 got showers twice per week in the afternoons on Tuesdays & Friday. They explained the shower schedule was posted at the CNA desk.<br><br>(continued on next page) |



| 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: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165104 | A. Building<br>B. Wing | 10/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Harmony Dubuque | 901 West Third Street<br>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 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 10/22/24 at 12:14 PM the Unit Manager, Station 1, explained if the shower reports are not there on paper they would be in the EMR where the CNA's chart.<br><br>In an interview on 10/22/24 at 1:20 PM Staff C, CNA confirmed the resident is supposed to get a shower twice per week. She noted it could be a staffing issue. There are not enough staff to get showers done during the day.<br><br>In an interview on 10/22/24 at 1:23 PM Staff B, CNA reported there were times where there were not enough staff to get all the showers in for the week.<br><br>In an interview on 10/22/24 at 1:24 PM Staff A, CNA explained they have Sundays as a make-up shower day in case they couldn't do it another day.<br><br>In an interview on 10/23/24 at 12:03 PM the Director of Nursing explained she expected residents to be offered a shower twice a week. She further explained showers have to be documented by the CNA's on the shower sheets and then the nurse signs off on it. The Unit Managers double check everything and then give it to her. She reported she was not aware of residents not getting offered a shower twice a week.<br><br>The facility policy titled Hygiene- Bathing/Showering, revised 3/2024 failed to indicate a frequency for baths/showers to be offered to residents. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165104 | A. Building<br>B. Wing | 10/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Harmony Dubuque | 901 West Third Street<br>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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>37072<br><br>Based on observation, staff interview, and record review the facility failed to label and date food appropriately to prevent a food borne illness during initial tour of the kitchen. The facility failed to serve food in a way that prevents food borne illness for 1 out of 1 meals observed. The facility reported a census of 52 residents.<br><br>Findings include:<br><br>1. ) During the initial tour of the kitchen on 10/21/24 at 9:20 AM the following items were observed in a refrigerator across from the stove not labeled or dated:<br><br>- meat sandwiches<br><br>- tater tot casserole<br><br>- sliced cheese open to air in original package<br><br>- sliced cheese and bologna stored together in a plastic container<br><br>- tomato juice in a pitcher<br><br>- box of bacon open to air and not dated<br><br>- large container of strawberries<br><br>- large container of barbeque pork<br><br>During an interview on 10/21/24 at 9:45 AM Staff D, cook, stated everything should be labeled and a use by date on it that is stored in the refrigerator.<br><br>On 10/21/24 at 9:50 AM the dietary manager stated the items would need to be tossed because no date on them. She said all food should be labeled and dated when opened and stored in the refrigerator.<br><br>The facility provided a policy titled: Labeling and Dating, with a revision date of 12/2023 it directed staff once opened, all ready to eat, potentially hazardous food will be re-dated with a use by date according to current safe food storage guidelines or by the manufacturers expiration date.<br><br>2.) During a continuous meal observation on 10/22/24 from 11:29 AM to 12:40 PM Staff D, cook, during meal service used her gloved hands to touch the quiche and cake she was serving to residents on plates. She changed her gloves multiple times but would touch the counter, the lids to serving pans, and the serving utensils then would use a spatula to scoop up the cake or quiche and use her other gloved hand to remove them from the spatula onto the plate.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165104 | A. Building<br>B. Wing | 10/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Harmony Dubuque | 901 West Third Street<br>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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 10/23/24 at 10:54 AM Staff D, stated she does have the Serve Safe certificate for food handling. She stated she should not have used her gloves to touch the food during meal service. I am supposed to use tongs or other utensils to serve the food.<br><br>On 10/23/24 at 1:21 PM the Dietary Manager discussed the cooks practice of food handling the prior day at lunch and she stated she noticed how she served the food - not proper food handling. She stated she even attempted to hand her tongs and she did not use them correctly. The changing of the gloves and touching all the food is not correct food handling, she should have used the tongs. I would expect her to use tongs and utensils and not touch the food.<br><br>The facility provided a policy titled: Food Handling, with a revision date of 10/23 it directed Purpose: To adhere to the food safety standards described in the local Food Code and as per Center for Medicare Services (CMS) food safety standards for long-term care<br><br>Procedures:<br><br>1. Employees must perform hand hygiene prior to handling food and maintain safe food handling practices.<br><br>2. Employees wear approved hair restraints and clean uniforms.<br><br>3. Ready-to-eat food must not be touched with bare hands. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165104 | A. Building<br>B. Wing | 10/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Harmony Dubuque | 901 West Third Street<br>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 0851<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.<br><br>48452<br><br>Based on Payroll Based Journal (PBJ) Data, schedule review, and staff interview the facility failed to submit complete and accurate payroll data to CMS during the third quarter of the 2024 fiscal year. The facility reported a census of 52 residents.<br><br>Findings include:<br><br>A document titled PBJ Staffing Data Report for Fiscal Year 2024 Quarter 3 (April 1-June 30) documented the facility triggered for excessively low weekend staffing.<br><br>On 10/22/24 at 8:12 PM the Administrator stated she became aware there was an issue with the PBJ data the day before. She had already reached out to their main office for a report of what was submitted and to try to learn what caused the facility to trigger for low staffing. She reported they were the ones who submitted PBJ data for the facility, and she was not aware of any days with excessively low staff.<br><br>On 10/23/24 the Administrator provided paper copies of staff schedules for the months of April, May, and June. They documented hours worked by nurses, certified medication aides, and certified nursing aides for three shifts each day and included staff who called off or did not show for their shift. The documentation included both facility and agency staff.<br><br>On 10/24/24 at 10:17 AM the Administrator reported she had not received an email response with the report, apologized, and said she would have to try to reach someone again. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165104 | A. Building<br>B. Wing | 10/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Harmony Dubuque | 901 West Third Street<br>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 0865<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Have a plan that describes the process for conducting QAPI and QAA activities.<br><br>49976<br><br>Based on the Centers for Medicare and Medicaid Services (CMS) Statement of Deficiencies forms, the facility Quality Assessment and Performance Improvement (QAPI) Plan, and staff interview the facility failed to carry out Quality Assurance (QA) activities to ensure effective measures had been taken to correct deficiencies and prevent their ongoing prevalence. The facility reported a census of 52 residents.<br><br>Findings include:<br><br>The CMS 2567, dated 10/20/22 listed, in part, the following concerns:<br><br>F880<br><br>The CMS 2567, dated 11/07/23 listed, in part, the following concerns:<br><br>F677, F812<br><br>The current survey, conducted 10/21/24-10/24/24 also identified the above concerns.<br><br>In an interview on 10/24/24 at 10:48 AM the Administrator explained the QAPI Committee monitors improvement projects for 4-6 weeks depending on what the issue is. After that, they review things monthly and then every other month if there is consistency. She acknowledged she was not aware of the repeat deficiencies.<br><br>The facility policy titled QAPI Plan, updated 8/16/24 instructed the following:<br><br>The QAPI Committee is responsible and accountable for:<br><br>1. Identifying and prioritizing problems based on performance indicator data;<br><br>2. Including patient, patient representative, and staff input into the process;<br><br>3. Ensuring corrective actions are effective;<br><br>4. Analyzing QAPI program performance to identify and follow up on areas of concern or opportunities for improvement.<br><br>Method of Monitoring Multiple Data Sources:<br><br>Regulatory outcomes are monitored and trended at the center level. Regulatory outcomes include licensure survey results, certification survey results, life safety survey results, complaint survey results, and additional focused survey results.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165104 | A. Building<br>B. Wing | 10/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Harmony Dubuque | 901 West Third Street<br>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 0865<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The QAPI Committee directs these activities and reviews these data sources for the identification of trends, comparison to available benchmarks, and identifying and monitoring additional performance improvement projects (PIP) needed.<br><br>Identifying Change as an Improvement:<br><br>Areas of opportunity identified in the QAPI Assessments are corrected through the PIP. Completion of the Investigation stage and review of those findings should demonstrate that process improvement initiative implemented in the initial stage have been sustained and the focus area has not been re-identified in the investigation stage. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165104 | A. Building<br>B. Wing | 10/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Harmony Dubuque | 901 West Third Street<br>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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>48452<br><br>Based on clinical record review, observation, staff interview, and facility policy review the facility failed to maintain proper infection control practices to prevent cross contamination and potential infection of residents. During medication administration staff touched medication with their bare hands. While in community areas of the building Resident #3's catheter dignity bag and tubing dragged on the floor. The facility reported a census of 52 residents.<br><br>Findings include:<br><br>1. The Minimum Data Set for Resident #3, dated 9/16/24, documented diagnoses of cancer, obstructive uropathy, and non-Alzheimer's dementia. The Brief Interview for Mental Status Assessment revealed a score of 10, which indicated moderately impaired cognition.<br><br>Resident #3's Care Plan, with a focus area dated 5/30/24, indicated the resident required the use of an indwelling Foley catheter related to urinary retention due to obstructive uropathy. A goal with the same date was to remain free of complications related to catheter use. Interventions also dated 5/30/24 documented the use of a catheter securement device, ensuring the dignity bag remained in place, monitoring tubing for kinks and leaks, and keeping the tubing off of the floor.<br><br>During a meal observation on 10/21/24 at 12:14 PM the resident was eating in the dining room. The blue dignity bag holding the catheter bag rested on the floor below his wheelchair, near the left wheel.<br><br>On 10/22/24 at 07:46 AM observed the resident enter the dining room. Staff reminded him not to put his brakes on and to use the wheels and his feet to propel himself. Resident #3's catheter bag was in a dignity bag under his wheelchair and dragged along the floor near the right wheel as he moved toward a table.<br><br>On 10/22/24 at 05:58 PM observed the resident leaving the dining room after dinner. His catheter tubing dragged along the floor between the two wheels, with visible urine stopped in the tube. As he used a combination of his feet and hands to move himself forward, his right foot hit the tubing twice. The catheter bag was in a dignity bag, and it skidded along the floor near the left wheel.<br><br>An interview with Staff E, Registered Nurse (RN) on 10/24/24 at 9:08 AM revealed she had not seen the resident's bag or tubing dragging on the ground. She stated the resident did try to self transfer at times and the bag or tubing hanging low or dragging would be a good indicator that he tried. She stated the CNAs have to check that and make sure it is secured.<br><br>During an interview with the Infection Preventionist on 10/24/24 at 09:14 AM she confirmed CNAs were responsible for making sure the bag and tubing were off of the floor. She stated the dignity bag was supposed to be strapped up with clips and the tube tucked so it didn't hang that low. She stated she would have to look into why both were dragging on the ground and said the way it was supposed to be positioned should ensure it did not do that.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165104 | A. Building<br>B. Wing | 10/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Harmony Dubuque | 901 West Third Street<br>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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A policy titled Catheter Care: Indwelling Catheter, documented as Rev. 12/2023, noted the purpose was to provide hygiene for patients with indwelling catheters. Numbers 12-14 of the procedure section documented to secure the catheter to the patient's leg using a securement devise or Velcro leg strap to prevent tension on the urethra. Check that tubing is not kinked, looped, clamped, or positioned above the level of the bladder. Validate drainage bag is off the floor and in a dignity bag.<br><br>2. During observation of a medication pass on 10/22/24 at 6:49 PM Staff E, Registered Nurse (RN) took a stock bottle of acetaminophen from the medication cart drawer for Resident #52. She removed the lid, emptied out two pills, and put them in the medication cup with ungloved fingers. When each of the resident's medications were in the cup, she administered them.<br><br>At 7:46 PM on 10/22/24 observed Staff E prepare medications for Resident #8. She prepared the resident's acetaminophen, senna plus, and melatonin by shaking them out of the bottles and putting them in the medication cup with ungloved fingers. When each of the resident's medications were in the cup, she administered them.<br><br>On 10/22/24 at 07:57 PM the Administrator was seated at the nurses station. When asked how medications should be administered from the bottle, she said the nurse should pour the stock meds into the cup and not touch them.<br><br>During an interview on 10/23/24 at 2:16 PM the Director of Nursing stated she expected staff to gel in and gel out with medications administration. She expected they would not touch the medication itself and would work with one resident at a time.<br><br>On 10/24/24 at 8:59 AM the Infection Preventionist stated staff should not be using their bare hands to administer medication, and they should put medications in the lid and then put in the med cup. They also should be washing their hands. She reported they would provide in-services and education regarding both medications and catheter care.<br><br>On 10/24/24 at 9:08 AM Staff E stated she was an agency nurse and did not receive medication administration training at the facility. She was trained as part of her education and had 'extensive' training through her agency.<br><br>A policy titled Medication Administration - Medication Pass, documented as Rev. 5/2023, indicated the purpose was to safely and accurately prepare and administer medication according to physician order and patient needs. The general instructions section documented staff should not touch medication or inside of the medication cup. The tablets/capsules section noted if the medication was obtained from a bottle, it should be transferred to the cap and then into the souffle cup. |