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	01/14/2026

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

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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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on staff interviews, facility record review and facility policy review the facility failed to ensure an effective Quality Assurance Performance Improvement (QAPI) process to address previously identified quality deficiencies, resulting in repeated deficiencies cited on the current survey that were cited in previous surveys. The facility reported a census of 57 residents.Findings include: The Centers for Medicare and Medicaid Services (CMS) 2567 form dated 10/24/24 reflected deficiencies identified for the QAPI program (F865), and infection control (F880) . The current survey conduction 1/5/26 though 1/14/26 also identified the above concerns. In an interview on 1/12/26 at 3:52 PM, the Administrator reported that the Infection Preventionist developed interventions for the past deficiency of F880. A review of the interventions which the Infection Preventionist implemented included, in part, the following: Medication Pass Audits which include watching hand washing, blood sugar checks, cleaning of the glucometers, Insulin administration, eye drops and inhalers. Treatment Audits which include hand washing, barrier technique, changing of gloves after removing old dressing and applying new dressing. Also includes EBP (Enhanced Barrier Precautions). A review of the facility's QAPI Plan dated 10/23/25 had documentation of the following: The QAPI Plan addresses the element of systemic analysis and systemic action using the following processes and systems: root cause analysis, use of a continuous cycle to evaluate the effectiveness or performance improvement initiatives, communication of performance improvement project efforts and re-evaluation of the center's QAPI Plan annually.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interviews, the facility failed to don isolation gowns while providing cares to two of three residents in Enhanced Barrier Precautions (Resident #5 and Resident #35). The facility also failed to use proper hand sanitation during an observation of a Medication Pass on 1/7/26. The facility reported a census of 57 residents. Findings included:1.The Minimum Data Set (MDS) dated [DATE] identified Resident #5 as cognitively impaired with a BIMS (Brief Interview for Mental Status) score of 03 out of 15. The MDS also identified Resident #5 as always incontinent of urine and bowel, and had one Stage IV pressure ulcer and one unstageable pressure ulcer. Observations of Resident #5 revealed the following: On 1/5/26 at 10:39 AM, the resident was asleep in bed, covered with a bath blanket from waist to feet. On Resident #5's door there was a caddy for PPE (Personal Protective Equipment) and a sign for Enhanced Barrier Precautions (EBP). On 1/7/26 at 1:55 PM, Staff E, CNA (Certified Nursing Assistant)/CMA (Certified Medication Aide) and Staff C, RN (Registered Nurse) both entered room, donned gloves, however, did not don isolation gowns. At 1:57 PM, neither staff member donned an isolation gown before removing the blanket and unfastening incontinent brief. At 1:58 PM, neither staff member donned an isolation gown before they repositioned Resident #5 up in bed. At 1:59 PM, Staff E removed her gloves and washed her hands then used Alcohol Hand Rub (AHR) and donned new gloves, however did not don an isolation gown before she cleansed the resident's perineal area. At 2:02 PM, Staff E did not don an isolation gown before she turned resident to lie on her right side. At 2:03 PM, Staff C removed her gloves, used AHR, and donned new gloves. At 2:04 PM, Staff C removed her gloves, washed her hands and donned new gloves, however she did not don an isolation gown before she cleansed the pressure ulcer. At 2:07 PM, Staff C then removed her gloves, washed hands and opened up the foam dressing. She donned new gloves, however neither Staff C or Staff E donned isolation gowns for the remainder of the wound care. In an interview on 1/12/26 at 1:14 PM, Staff E, CNA reported she thought the type of isolation Resident #5 should be in would be precautions. She also reported before providing cares for Resident #5, staff should wear a mask, isolation gown and gloves. When she provided cares on Resident #5 on 1/7/26, she admitted she did not don an isolation gown during cares. She usually did not work that hallway. She also reported she would know a resident is on EBP if there was a sign posted on the door. In an interview on 1/12/26 at 1:25 PM, Staff C, RN reported Resident #5 should be in contact isolation and staff need to don isolation gowns and gloves when providing cares. She also reported Resident #5's room did have a caddy for PPE with a sign on her door. When she and Staff E provided cares for her on 1/7/26, she verified they both forgot to don isolation gowns. Staff C acknowledged it was an oversight on her part. 2. The MDS dated [DATE] identified Resident #35 as cognitively impaired with a BIMS score of 9 out of 15. The MDS also identified Resident #35 had an indwelling urinary catheter, incontinent of bowel frequently, and had one unstageable (full thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) pressure ulcer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation of Foley (catheter) and incontinence care revealed the following on 1/7/26 at the following times: At 9:12 AM, Staff B, CNA entered room to assist Staff D, CNA. Staff D did not don an isolation gown before she provided cares after Resident #35 was incontinent of BM (bowel movement). There were sheets soiled with BM on the floor beside the bed. Staff B left the room to obtain more clean towels and cloths. At 9:14 AM Staff D, did not don an isolation gown before she used disposable wipes to cleanse Resident #35's groin. At 9:15 AM, Staff B returned to room and wore a face shield, isolation gown and gloves. Staff D did not don an isolation gown. After she removed her gloves, Staff B did not use hand sanitizer or wash her hands before she donned new gloves. Staff D pulled the incontinent brief into place with BM still noted on the brief. When asked to recheck the brief, Staff D pulled it back and noted BM still on the brief and reported he constantly oozes BM. At 9:18 AM, Staff B removed the soiled brief and placed it in a plastic bag, removed her gloves, used AHR and donned new gloves. and removed fitted sheet and placed new sheet underneath the resident. At 9:20 AM after Staff B changed the linens on the bed, Staff D did not don an isolation gown before she assisted Resident #35 to turn to his side. At 9:24 AM, Staff D placed the soiled sheets in a plastic bag in trash can, removed her gloves, however, she did not wash hands or use AHR before she donned new gloves. Then both aides secured the brief into place. At 9:26 AM Staff D removed her gloves, did not use AHR or wash her hands before she donned new gloves. She did not don an isolation gown before she handled soiled linens and gown and placed all in a plastic bag. In an interview on 1/7/26 at 1:26 PM, Staff D, CNA reported when providing cares to a resident with pressure ulcers or a urinary catheter, staff should wear an isolation gown and gloves. When she provided cares today on Resident #35, she did not don an isolation gown and could not remember why. She admitted she placed the linens with BM on the floor when she should have placed them in a plastic bag. She reported she did see BM on his bottom when she went to secure his brief into place but he was constantly oozing BM. She admitted she should have made sure to clean it all off completely as his pressure sores could become infected. In an interview on 1/7/26 at 1:42 PM, Staff B, CNA reported residents with pressure ulcers or an indwelling catheter should be placed in Enhanced Barrier Precautions and staff should don an isolation gown, gloves and face mask when providing cares. She also reported when she walked into Resident #35's room on 1/7/26 she did see linens on the floor that were soiled with BM and they should have been placed in a plastic bag. When she assisted Staff D with incontinence cares, she verified there was still BM on the brief after Staff D had placed it on him, however he is constantly oozing BM all the time. Staff B explained should try to make sure to clean off the BM off the wounds to his bottom as it can worsen the wounds, or he can develop new wounds or get an infection. In an interview on 1/13/26 at 2:31 PM, the Director of Nursing (DON) reported Residents #5 should be placed in Enhanced Barrier Precautions and she would expect the staff to don gloves, gown and mask when providing cares. She also verified had a PPE caddy, however was unsure if had a sign on the door. A review of the Facility Policy titled: Enhanced Barrier Precautions dated as last revised March 2024 revealed, in part, the following: For residents whom EBP are indicate; gowns and gloves should be used during high contact resident (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care activities that provide opportunity for MDROs (Multi-Drug Resistant Organisms) to be transferred to staff hands and clothing. High contact resident care activities include: Dressing, Bathing/Showering , Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, Device care or use urinary catheter .Wounds care: any skin opening requiring a dressing 3. On 1/7/26 at 7:23 AM during observation of medication administration Staff F, RN administered eye drops to Resident # 30 and did not wash hands before or after she administered medication. She then pushed another resident to the dining room and came back to the medication cart. Staff F, RN did a blood sugar on resident and did not wash hands or use hand sanitizer. On 1/7/26 at 7:35 AM Staff F, RN completed a blood sugar on Resident #3 and did not wash hands or use hand sanitizer. She drew up the residents insulin and administered it and then sanitized hands after she administered the medication. On 1/07/26 at 3:22 PM Staff C, RN stated with medication pass you should wash hands between each resident. She also indicated before checking a residents blood sugar you should wash hands or use hand sanitizer in between residents. On 1/08/26 at 12:52 PM the DON stated when staff are doing medication pass they should use hand sanitizer in between residents. She would expect stuff to do the same thing before or after blood sugars, and to use gloves while obtaining the blood sugar and then sanitize hands and change gloves between residents. The facility provided the Infection Control Practice Guide, revised 9/2023, which revealed, Hand hygiene has been proven to reduce the risk of infections.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident and staff interviews, the facility failed to ensure dignity was maintained for one of four residents observed during cares (Resident #35). The facility reported a census of 57 residents. Findings include: The MDS dated [DATE] identified Resident #35 as moderately cognitively impaired with a BIMS score of 9 out of 15. The MDS also identified Resident #35 had an indwelling urinary catheter and was incontinent of bowel frequently. The Care Plan initiated 10/7/25 identified Resident #35 required assistance with activities of daily living. In an observation of incontinence care on 1/7/26 at 9:22 AM, the Facility Nurse Practitioner entered the room without knocking on the door and asked CNAs (Staff B, CNA and Staff D, CNA) to help her in a different room when they were finished. When she entered the room, the privacy curtain was not pulled around the bed and Resident #35 was not covered with a sheet when she entered. The resident's gown was pulled up above his waist, exposing his lower abdomen and groin area. In an interview on 1/7/26 at 1:26 PM, Staff D, CNA reported before entering a resident's room, staff should knock on the door first, wait for staff in the room to say resident care, ok to come in. When providing cares on Resident #35 on 1/7/26, she verified she didn't think she heard the Nurse Practitioner knock on the door before she walked into the room during cares. In an interview on 1/7/26 at 1:42 PM, Staff B, CNA reported before any staff enters a resident's room, they should knock on the door first. She also verified the Nurse Practitioner did not knock on the door before she came in when she provided cares on Resident #35 on 1/7/26. In an interview on 1/12/26 at 1:25 PM, Staff C, RN reported before entering a resident's room, staff should knock on the door first. In an interview on 1/13/26 at 2:31 PM, the interim DON (Director of Nursing) reported when staff are ready to enter a resident's room when the door is closed, she would expect them to knock on the door first, if the staff says cares and wait for staff to say it would be alright to enter. A review of the Facility Policy titled: Resident Rights - Dignity and Respect dated as last reviewed April 2024 revealed, Each Resident has the right to considerate and respectful care and to be treated with honesty, dignity, respect and with reasonable accommodation of individual needs except where the health, safety, or rights of the resident or other individuals in the facility would be endangered.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on observation, clinical record review, police reports, interviews, facility investigation documentation, and policy review the facility failed to protect residents from being taken advantage of financially for 2 of 3 residents reviewed (Residents #2 and Resident #11). An employee took one resident's bank card information and paid personal bills with it, and accepted $25 from another resident. The facility reported a census of 57 residents.Findings include:1. The Minimum Data Set (MDS) for Resident #2 dated 11/26/25 documented diagnoses of amputation, cancer, depression, and malnutrition. The resident scored 15/15 on the Brief Interview for Mental Status (BIMS) assessment which indicated intact cognition.On 1/05/26 at 3:06 PM observed Resident #2 in his bed and talking with his [family member] who was seated in a chair near the foot of the bed. The resident's phone rested on his chest, and it had an attached sleeve on the back to hold cards. He pointed to it and slipped his identification out to show how it worked. His debit card was under the phone on his chest. He confirmed that was the bank card information that was stolen. At this time Resident #2 and his [family member] were interviewed together. The resident's [family member] stated while reviewing their bank statement she noticed charges she did not believe were theirs. She learned one was to a water company in another state and one to an electric company. She noted a third attempted charge for $330 was declined by the bank. Resident #2 added that his phone and cards were with him unless he was sleeping, and he thought someone must have removed the bank card or copied the numbers while he slept. His [family member] said the water department provided her with a last name for the billed account. The electric company would not provide information. She reported this information to the police and told the nursing home administrator about the report so they knew an officer was coming to talk to Resident #2. The administrator told her they would start an internal investigation at that time. Resident #2 stated the officer interviewed him for 30-45 minutes and he thought the investigation was ongoing. Review of a Concern Form dated 12/11/25 and Investigation Summary provided by the facility indicated the last name given by the water company matched that of a Certified Nurses Aide (CNA), Staff K, who worked in the facility the day of the charges. The follow up included suspension of the CNA and interviews with other residents. The interview process determined that a second resident gave Staff K $25.00 in cash.A document titled Daily Schedule dated 12/8/25 documented Staff K was a CNA in the facility on that day.A police report dated 12/11/25 at 7:58 PM documented the unauthorized use of Resident #2's card on 12/8/25 with a total loss estimated at $297. It documented the resident did not give anyone permission to use his card and identified a facility CNA who worked the day of the charges had the same last name as the accounts charged. It included an address and and invoice number tied to the water department billing. The last 4 numbers of the card used matched the last 4 numbers of the resident's card.The address listed in the police report as part of the water department billing invoice was determined to be a business address. On 1/7/26 at 2:56 PM the human resources department of that business revealed Staff K was a former employee. They were not aware she was using their address for any purpose.On 1/7/26 at 3:32 PM the city manager for the water department verified that the name, home address, phone number, and account number paid with Resident #2's card belonged to Staff K.2. The MDS for Resident #11 dated 10/29/25 documented diagnoses of Parkinson's disease, non-Alzheimer's dementia, depression, and anxiety. The resident scored 15/15 on the BIMS assessment which indicated intact cognition.During an interview on 1/8/26 at 8:44 AM Resident #11 confirmed he gave Staff K $25.00. He reported Staff K told him she went to the bathroom and someone stole her bank card while she was in there. He stated he gave it directly to her for a cab ride home. He denied putting it in a Christmas card and repeated that he just gave it to her. He indicated she didn't ask for it but implied she needed money to get home. A document titled Course Completion History indicated Staff K attended abuse and resident rights related trainings on 10/27/24, 11/14/24, and 6/30/25.During an interview with Staff K on 1/7/26 at 12:28 PM she stated she was terminated from the facility (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	because she was told she stole from one resident (Resident #2) and took money from another. She denied stealing a bank card or banking information. Staff K stated that was stupid and who would do something like that. She reported she did tell Resident #11 that someone stole her money out of the break room, and said he gave her a Christmas card with money in it. Staff K said she did not tell anyone about the money or bring it back, and that if that was taking money from a resident 'I guess I did.'On 1/8/26 at 2:42 PM the Administrator reported she led the investigation into the theft from Resident #2 which led to learning about Staff K accepting money from Resident #11. Once she learned of the charges to Resident #2's card, she determined Staff K was in the building and immediately pulled her from the floor. Staff K was interviewed and denied responsibility for the charges. She was escorted out of the building and suspended pending investigation. At the resident's request the Administrator witnessed the interview with the police officer. She reported the water company gave some information but the electric company would not. The Administrator directed the facility Assistant Directors of Nursing (ADON) to interview their residents to determine if there were any other victims. Resident #11 told them he did not want to get Staff K in trouble but he felt bad for her and she said she needed money. The Administrator stated she reassured the resident that his safety was more important and the facility reimbursed him. She provided documentation that staff were educated about not accepting gifts or money from residents, and reinforced policy. A policy titled Patient Protection Guidelines Abuse Prevention, Reporting, and Investigation revised 9/25 documented exploitation as taking advantage of a patient for personal gain through the use of manipulation, intimidation, threats, or coercion. Misappropriation of resident property included the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a patient's belongings or money without the patient's consent. Training included recognizing signs of exploitation and misappropriation of resident property and how to report suspicions or allegations.