STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165152	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony House Health Care Center	2950 West Shaulis Road Waterloo, IA 50701

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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	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, resident and staff interview, clinical record review, and facility policy review, the facility failed to communicate to Residents #3, #4, and #12 in a dignified manner and ensure communication between staff, within hearing distance of Resident #3, was conducted in a dignified manner for 3 of 4 residents (R#3, R#4, and R#12) reviewed for resident rights. The facility reported a census of 42 residents. Findings include: 1. Resident #3's Minimum Data Set (MDS) assessment, dated 2/27/26, identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of paraplegia (impairment of motor and sensory function in lower body), seizure disorder, respiratory failure, and malnutrition. The Care Plan Focus, dated 3/3/26, indicated Resident #3 had a psychosocial well-being complication and a mood state disturbance related to diagnoses of major depressive disorder (MDD), antisocial personality disorder, and post traumatic stress disorder (PTSD). The Interventions dated 3/3/26 directed the following:Assist Resident #3 to process feelings and find positive outcomes. Encourage Resident #3 to verbalize feelings, perceptions and fears.Provide assistance and support to identify causative factors contributing to issues with psychosocial well-being.Encourage Resident #3 to communicate feelings.Acknowledge and validate Resident #3's concerns. Collaborate with Resident #3 to address complaints. During an interview on 3/19/26 at 2:30 PM, Resident #3 reported an incident occurred when Staff G, Respiratory Therapist (RT) suctioned his tracheostomy tube (surgical procedure creating an opening in the neck to provide a direct, stable airway). Staff G told him she would put some saline down his tube before suctioning, but had put the saline in his tracheostomy tube, while he was talking, causing him to choke, cough and gag. Resident #3 reported Staff G poured a lot of saline down his tracheostomy tube and stated it seemed Staff G wanted to shut him up. Resident #3 stated he told Staff G she was going to drown him. Resident #3 stated when Staff G suctioned his tracheostomy tube it felt rough. Resident #3 reported when Staff G left his room he could hear her talking to another female staff member in the hallway outside of his room. He heard Staff G say, he said she was going to drown him, in a mocking tone. Resident #3 reported Staff G played it off and made light of it. During an interview on 3/18/26 at 5:00 PM, Staff H, RT, recalled Resident #3 reported an incident on 2/22/26 involving Staff G. Staff H stated Resident #3 told her when Staff G left his room and went into the hallway outside his room, he could hear her laughing with another staff member about his reported concern. Review of a facility provided document titled, Statement, dated 2/22/26, recorded an interview with Resident #3 about how he asked Staff G for moist toothette and she talked over him saying why it was a bad idea to have a moist toothette. She asked if he wanted suctioned. The first pass she warned him she would try saline, he stated she poured the saline down and sucked hard while he was talking. He stated the second pass she did not warn him about saline, he felt every time he would start to talk, she would start to suction. He felt as though she was trying to get him to shut up. He added Staff G left the room and laughed in the hallway. During an interview on 3/24/26 at 3:47 PM, Staff G confirmed they worked with Resident #3 on 2/22/26 in the early morning. They suctioned his tracheostomy tube per Resident #3's request at approximately 5:00 AM. Staff G stated Resident #3 had very dry secretions and she (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	told him she would use saline to loosen the secretions. He didn't object. Staff G reported she squirted saline down the tube just before the second pass of suction. Staff G reported Resident #3 started yelling that she tried to drown him. Resident #3 told Staff G, she took his voice. Staff G recalled Resident #3 said he was trying to talk when she put the saline down. She recalled she responded, he didn't say anything to her when she put the saline in. Staff G reported she instructed Resident #3 to take a few breaths and stated the more she tried to talk to him, the more agitated he got. When she left Resident #3's room, Staff A, Licensed Practical Nurse (LPN), was coming down the hallway. Staff G told Staff A she wouldn't go back into Resident #3's room without someone with her because he accused her of trying to drown him. Staff G confirmed having a conversation with Staff A in the hallway outside of Resident #3's room. During an interview on 3/25/26 at 10:45 AM, Staff A confirmed they worked on 2/22/26 in the early morning with Resident #3 and Staff G. Staff A recalled at approximately 5:00 AM, as she walked down the hallway near Resident #3's room, Staff G had come out of Resident #3's room. Staff G told Staff A she wouldn't go in his room because he's accused her of trying to kill him. Staff A recalled Resident #3 started banging on the wall and screaming. Staff A reported she entered Resident #3's room and asked him to not bang on the wall. Resident #3 stopped and didn't report any concerns to her. The Health Status Note, dated 2/22/26 at 5:15 AM, documented by Staff A reflected as they walked down the hall to answer a call light, Staff G came out of Resident #3's room. They said they were done because he just accused her of trying to drown him. At that point Resident #3 started to bang on the wall. Staff A went and told him he needed to stop banging on the wall because he was waking up the other residents. He didn't voice any other concerns at that time. 2. Resident #4's MDS assessment dated [DATE] identified they had moderately impaired cognitive skills for daily decision making. The MDS included diagnoses of myotonic muscular dystrophy (a type of muscle disease that causes prolonged muscle contractions and general muscle weakness), chronic respiratory failure with hypoxia (low oxygenation to the tissues), anxiety disorder, and MDD. The Care Plan Focus initiated 1/5/26, indicated Resident #4 used psychotropic medication related to a psychotic disorder for targeted behavior of delusions, disorganized speech, speech that doesn't make sense or is off-topic, highly disorganized or unusual body movements, and negative symptoms like showing less emotion, not being able to feel pleasure, and difficulty starting or finishing planned activities. The Care Plan lacked identification of impaired communication and lacked an intervention related to Resident #4's use of a communication board to assist with their ability to communicate. During an interview on 3/19/26 at 1:30 PM, when asked if they had any concerns with Staff G, Resident #4 nodded their head, yes, and spelled out rude on her communication board. During an interview on 3/24/26 at 2:25 PM, Staff J, Certified Nursing Assistant (CNA), reported they witnessed on an unknown date, Staff G entering Resident #4's room and responding what do you want? As they were just in there. Staff J recalled Staff G's had a rude tone during the interaction and had made Resident #4 cry. 3. Resident #12's MDS assessment, dated 2/26/26, identified a BIMS score of 4, indicating severe cognitive impairment. The MDS included diagnoses of traumatic brain injury, seizure disorder, and depression. The Care Plan Focus revised 9/15/25, reflected Resident #12 had impaired cognitive function and thought processes related to traumatic brain injury. The interventions instructed staff to allow Resident #12 time to respond and process tasks as he gets frustrated easily when he can't get the words out he wants to say. If this happened, he would cuss and yell. During an observation on 3/17/26 at 8:18 AM, Resident #12 sat outside the shower room in his wheelchair, waiting for a staff member to return and assist him with a bath. Resident #12 made a loud exhaling noise and a staff member standing nearby at a medication cart repeated the sound he made and said to Resident #12, life is so tough isn't it, it's so terrible. Resident #12 did not respond. During an interview on 3/24/26 at 5:00 PM, the Administrator explained they expected the staff to treat all residents with dignity and respect. They added laughing or talking about a resident within hearing distance is never okay. Review of the facility policy, titled Residents Rights - Dignity and Respect, revised April 2024 directed to treat all residents with dignity and respect while maintaining and (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	enhancing his or her self-esteem and self-worth. Residents have the right to considerate and respectful care, which includes being treated with honesty and dignity and having their individual needs reasonably accommodated. This right is upheld unless accommodating those needs would endanger the health, safety, or rights of the resident or other individuals within the facility, as outlined in the Procedure.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, clinical record review, and facility policy review, the facility failed to thoroughly investigate an allegation of abuse. The facility omitted written witness statements and documentation of additional residents' interviews from the investigation. The facility reported a census of 42 residents. Findings include:Resident #3's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of paraplegia (impairment of motor and sensory function in lower body), seizure disorder, respiratory failure, and malnutrition. Review of the Care Plan, dated 3/3/26, revealed Focus areas for Resident #3 having psychosocial well-being complication and a mood state disturbance related to diagnoses of Major Depressive Disorder (MDD), antisocial personality disorder, and Post Traumatic Stress Disorder (PTSD). The Interventions dated 3/3/26 directed the following:Assist Resident #3 to process feelings and find positive outcomes. Encourage Resident #3 to verbalize feelings, perceptions and fears. Provide assistance and support to identify causative factors contributing to issues with psychosocial well-being. Encourage Resident #3 to communicate their feelings. Listen to concerns and assure Resident #3 that concerns are validated. Work cooperatively with Resident #3 to resolve complaints. The facility's investigation of their self-reported incident, submitted to the State Agency on 2/26/26, related to Resident #3's allegation of physical abuse against a staff member, revealed the following: The heading titled, Conclusion, documented: After completing Resident #3 and staff interviews, Resident #3s report feeling safe with Staff G, Respiratory Therapist (RT), while she is working. Resident #3s deny ever feeling like Staff G was physically rough with them in any way. Resident #3s deny having any care without the care being explained first. Staff report that they feel strongly that Staff G is competent in her skills. Staff deny ever witnessing that Staff G completes any cares or tasks without first explaining herself to the Resident #3. After completing staff and Resident #3 interviews, it is concluded that there is no evidence to support the allegation against Staff G. The heading titled, Action Plan, documented: Resident #3 was assessed by the facility Administrator and no injuries were observed. Staff G was suspended from job duties until the investigation is concluded. The primary care provider was notified, and no new orders were given.Staff G's competencies will be reviewed to ensure her skills meet professional standards and uphold Resident #3s' rights, with a continued emphasis on providing compassionate and professional care.The Investigation included the following Statements dated 2/22/26:Staff F, MDS Coordinator, interviewed Resident #3.Staff F interviewed Staff H. The document lacked Staff H's signature to acknowledge their statement.The DON interviewed Staff G. The document lacked Staff G signature to acknowledge their statement. On 3/19/26 at 3:01 PM, upon request for documentation of any additional residents and/or staff interviewed, as documented in the facility's investigation of a self-reported incident under the heading, Conclusion, the DON provided a list of 3 residents and 3 staff names. During an interview on 3/18/26 at 5:00 PM, Staff H, confirmed they worked 2/22/26 with Resident #3. Resident #3 made an allegation of abuse to her against Staff G. Staff H immediately notified the Administrator and Staff F, the nurse on-call, of the abuse allegation. Staff H stated she wrote her witness statement, then sat with Resident #3 to help him write his statement with Staff D, Licensed Practical Nurse (LPN), present in the room. Staff H reported Staff F came into the facility and took the statements she wrote. During an interview on 3/24/26 at 3:47 PM, Staff G, confirmed they worked Resident #3 in the early morning of 2/22/26. Staff G stated the DON contacted her on 2/23/26 about the alleged incident. She didn't receive any other contact from the facility following the conversation on 2/23/26. During an interview on 3/25/26 at 1:55 PM, Staff F, confirmed Staff H notified them on 2/22/26 regarding an allegation of abuse made by Resident #3 against Staff G. Staff F reported she came into the facility and spoke to Staff H, Staff D, and Resident #3 about the allegation. Staff F stated she reviewed Staff H's written statement and (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	used it to write a statement for Staff H and Resident #3. Review of Staff G's Employee File, included a document titled, One-On-One Inservice Record, dated 3/2/26, signed by DON. The document indicated the DON discussed with Staff G about explaining what she is doing with a Resident #3, prior to completing task/care. The document lacked Staff G's signature. The document included Staff G gave verbal understanding via phone. Review of the facility policy titled, Patient Protection Guidelines Abuse Preventions, Reporting, and Investigation, revised September 2025, indicated the 7 Key Components of an Abuse Prevention System as screening, training, prevention, identification, investigation, protection, reporting/response. The section related to Investigation instructed according to the Centers of Medicare and Medicaid Services (CMS), the facility must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress. Key to investigating abuse allegations is an environment that facilitates the reporting of such allegations. Once reported, the facility conducts a timely, thorough, and objective investigation of the consideration of the indicators of possible abuse. The administrator or designee will complete documentation of the allegation of resident abuse and collect any supporting documents relative to the alleged incident. The facility evaluates, processes, and measures compliance against established indicators derived from policies and procedures and industry standards.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interview, and facility policy review the facility failed to administer medications as ordered for 3 out of 6 residents reviewed (Residents #1, #4, and #8). The facility reported a census of 42 residents.Findings include:1. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. The MDS included diagnoses of traumatic hemorrhage cerebrum (life threatening brain bleed caused by physical injury), seizure disorder, Dysarthria (a motor speech disorder characterized by weak, damaged, or paralyzed speech muscles (lips, tongue, vocal cords, diaphragm), leading to slurred, slow, or difficult-to-understand speech) and Anarthria (the severe, total loss of the ability to articulate speech due to brain damage or neurological disorders, preventing control of muscles for speaking while often leaving language comprehension intact. Often considered an extreme form of dysarthria, it results from lesions impacting motor pathways, causing complete muteness). The MDS showed Resident #1 required a tube feeding for nutrition. The Care Plan dated 12/16/24 identified Resident #1 had a risk for altered neurological status related to a seizure disorder. The Interventions directed to give medications as ordered. Resident #1's January 2026 Medication Administration Record (MAR) included the following orders: Famotidine (reduces stomach acid) 20 mg two times a day. The MAR lacked documentation to indicate Resident #1 received famotidine on: 1/6/26, 1/16/26, and on 1/21/26 at bedtime (HS). Keppra (prevent seizures) 250 milligrams (mg) via peg tube two times a day for convulsions. The MAR lacked documentation to indicate Resident #1 received Keppra on 1/21/26 Baclofen (muscle relaxant) 20 mg via feeding tube four times a day for muscle spasms. The MAR lacked documentation to indicate Resident #1 received Baclofen on: 1/6/26 at HS, 1/10/26 at lunch, 1/16/26 at HS, 1/18/26 at lunch, 1/21/26 at lunch and HS, 1/25/26 at lunch. The Incident Report Medication Event dated 1/22/26 at 22:33 PM reflected staff found Resident #1 failed to get medications (Baclofen 20 mg Keppra 250 mg) for the PM shift on 1/21/26. The Progress Note dated 1/26/26 at 1:12 AM reflected no adverse effects from the medication omission on 1/21/26. Resident #1's February 2026 MAR included the following orders: Keppra 250 mg via peg tube two times a day for convulsions. The MAR lacked documentation to indicate Resident #1 received Keppra on 2/25/26 mid afternoon. Famotidine 20 mg two times a day. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MAR lacked documentation to indicate Resident #1 received famotidine on 2/8/26 at HS. Baclofen 20 mg via G-tube four times a day. The MAR lacked documentation to indicate Resident #1 received Baclofen on 2/8/26 at HS and 2/25/26 in the afternoon. The Medication Event - Missing Medication dated 2/20/26 at 4:00 PM reflected Resident #1 failed to get Baclofen 20 mg and Keppra 250 mg in the afternoon and Baclofen 20 mg at bedtime. 2. Resident #8's Minimum Data Set (MDS) assessment dated [DATE] Cognitive assessment indicated Resident #8 rarely or never understood, with short and long term memory problems. Resident #8 had severely impaired daily decision making skills. The MDS included diagnoses of traumatic brain injury (TBI), traumatic brain dysfunction, and quadriplegia (paralysis that affects all four limbs, both the arms and the legs). The Care Plan dated 12/2/24 directed to give Resident #8 medications as ordered. Resident #8's March 2026 MAR lacked documentation to show the facility provided ipratropium-albuterol solution 0.5-2.5 3 MG/3 milliliter (Ml)1 vial via trach four times a day related to tracheostomy status. The Progress Note dated 2/4/26 at 11:02 PM reflected when the evening shift administered medication and they found the AM (morning) glycopyrrolate (reduces stomach acid) tab 1 mg and AM Baclofen 10 mg and 5 mg dose still in the medication card. The note indicated the agency staff failed to give the medication. The Incident Report - Medication Event dated 2/6/26 identified when the facility attempted to contact Resident #8's Representative, they got their voicemail. The facility left a message to call the facility to update missed medication. On 3/23/26 at 5:00 PM Staff K, Licensed Practical Nurse (LPN), reported found medications not given on the day shift by other nurses. Staff K said she did the incident report and let the doctor know. On 3/25/26 at 2:09 PM Staff F, MDS Coordinator, reported she knew Resident #1 missed their medications. On 3/25/26 at 3:15 PM the Director of Nursing (DON) agreed that, as is basic in nursing, if you don't write it down, it didn't happen. She acknowledged the gaps on Resident #1's MAR. The DON reported the facility followed the 6 rights for medication administration and lacked a policy directing the staff how to administer medication. 3. Resident #4's Minimum Data Set (MDS) assessment, dated 2/16/26, identified they had moderately impaired cognitive skills for daily decision making. The MDS included diagnoses of myotonic muscular dystrophy (a type of muscle-wasting disease that causes prolonged muscle contractions), diabetes mellitus, and malnutrition (not getting enough nutrients, or too much of the wrong ones). The Care Plan dated 1/5/26 directed to administer Resident #4's medications as ordered. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #4's February 2026's MAR indicated they received all bedtime medications on 2/19/26 and 2/20/26. The Health Status Note, dated 2/21/26 at 3:28 PM, documented as the staff got Resident #4's medications ready that morning, they noticed they still had medications in the card for the evening and bedtime on 2/19/26. The medications included Midodrine (a medication used to raise blood pressure) 2.5 milligrams (mg), Eliquis (a blood thinner) 2.5 mg, escitalopram (a common medication for depression and anxiety) 10 mg, and quetiapine (an antipsychotic medication used to treat conditions like schizophrenia and bipolar disorder) 50 mg. The facility notified the husband of the missed medications while he visited the facility. The nurse on-call and physician still needed notified. The Incident Report titled, Medication Event/Missing Medication, dated 2/20/26, reflected the facility notified the physician, responsible party, and on-call nurse of the incident. The Incident Report included a handwritten note indicating the nurse no longer picked up shifts at the facility.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on staff interview, clinical record review, facility Grievance log review, and facility policy review, the facility failed to bath residents at least once per week for 2 of 3 resident (Resident #2 and Resident #4) reviewed for resident's rights. The facility reported a census of 42 residents. Findings include:1. Resident #2's Minimum Data Set (MDS) assessment, dated 1/8/26, identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of respiratory failure, heart failure, morbid (severe) obesity with hypoventilation (condition where breathing is too shallow to meet the resident's needs), and methicillin resistant staphylococcus aurorus (MRSA) infection (an infection that certain antibiotics don't work to treat). The MDS indicated Resident #2 required a partial to moderate amount of staff assistance with bathing. The Care Plan, initiated 1/2/26, revealed a Focus area for Resident #2 required assistance with Activities of Daily Living (ADLs) with an intervention that instructed to assist Resident #2 with a bath or shower per schedule. The facility provided Grievance Logs, revealed a concern reported by Resident #2 on 2/16/26, which documented they weren't getting showers. Resident #2 told staff she had not received one in a week. The Grievance Log indicated the facility changed the showers to second shift and discussed Resident #2 refused showers. The Grievance Log dated 2/16/26 indicated they resolved the concern on 2/18/26. Resident #2's Electronic Health Records (EHR) revealed bath/showers documentation for the month of February, 2026, listed they only refused to take a shower on 2/2/26 and only received a shower on 2/16/26. 2. Resident #4's Minimum Data Set (MDS) assessment, dated 2/16/26, identified they had moderately impaired cognitive skills for daily decision making. The MDS included diagnoses of myotonic muscular dystrophy (a type of muscle-wasting disease that causes prolonged muscle contractions), diabetes mellitus, and malnutrition (not getting enough nutrients, or too much of the wrong ones). The Care Plan Focus initiated 1/5/26, indicated Resident #4 required assistance with activities of daily living (ADLs). The Interventions directed the following:1/5/26: Assist Resident #4 with a shower or bath per schedule. Date initiated: 1/5/26. 3/24/26: Resident #4 preferred to take bed baths versus showers. Staff will still offer Resident #4 a shower. Resident #4's EHR, revealed bath/shower documentation for the month of February, 2026, the staff documented Resident #4 only received a shower on 2/28/26. They left 2/2/26, 2/4/26, and 2/9/26 blank. Resident #4 refused to shower on 2/7/26, 2/11/26, 2/18/26, 2/21/26, and 2/23/26. The staff documented Resident #4 didn't receive a shower on 2/14/26, 2/16/26, or 2/25/26.During an interview on 3/23/26 at 10:00 AM, Staff L, Certified Medication Assistant (CMA), stated since the facility implemented a decreased staff to resident ratio, the residents haven't received showers. During an interview on 3/24/26 at 2:25 PM, Staff J, Certified Nursing Assistant (CNA), reported a resident told her that he didn't get a shower for 2 weeks, between being hospitalized and returning to the facility. When he asked another CNA for a shower, she claimed she would do it, but never returned to help him. During an interview on 3/25/26 at 1:55 PM, Staff F, MDS Coordinator, reported being disappointed with the lack of care going on at the facility. She added she believed it had to do with not having enough staff due to the strict staffing numbers implemented by the facility. Staff F stated residents told her they hadn't got a shower in a week. She suggested to facility leadership to use a bath aide to assist with completing showers, but they told her to delegate the bathing task. During an interview on 3/25/26 at 4:00 PM, the Director of Nursing (DON), stated completing resident baths/showers needed room for improvement. The DON revealed they expected residents to receive a bath or shower two times a week. The DON stated they had enough staff to complete baths between nurses, medication aides, and CNAs. The facility policy titled, Hygiene - Bathing/Shower, dated March 2024, instructed to cleanse skin, promote cleanliness, and prevent infection. The policy instructed staff to document in the EHR when they completed a bath or shower.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interviews and facility policy review the facility failed identify a change in condition that required physician notification for 2 of 4 residents reviewed (Residents #3 and #5). The facility failed to provide necessary care for two residents. When Resident #5's CAT scan on 2/18/26 diagnosed a pulmonary embolism (PE). The facility delayed treatment until 2/20/26, despite a call from his Guardian and a staff assessment noting a low pulse ox. The Medical Director expected immediate provider notification. When Resident #3, had two episodes of unresponsiveness and dizziness on 2/28/26, and a dangerously low blood pressure (60/40) on 3/1/26. The facility delayed nursing documentation, assessment, and physician notification until 3/2/26. The facility reported a census of 42 residents. Findings included:1. Resident #5's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate problems with thinking and memory. The MDS included diagnoses of atrial fibrillation (irregular heart beat), mild intellectually disabled, and need for assistance with personal care. The Care Plan Focus dated 4/29/25 identified Resident #5 required assistance with activities of daily living (ADL's) related to weakness and decreased strength. The Interventions directed the following: Resident #5 dependent on 1 or 2 staff for grooming, dressing, and bed mobility. Resident #5 dependent on 2 staff with a full-body mechanical lift to transfer. The Progress Notes dated 2/18/26 at 7:30 AM indicated facility staff transported Resident #5 to an appointment for a CAT scan (a special kind of X-ray that takes pictures of the inside of your body). The Progress Notes dated 2/18/26 at 12:59 PM documented Resident #5 returned from the CAT scan, but the nurses' station couldn't print the paperwork. The staff would make a follow-up call in a few days to check for any faxed dictation. The Progress Notes dated 2/18/26 at 3:10 PM, Staff B, Registered Nurse (RN) documented Resident #5's Guardian contacted the facility regarding possible abnormal blood clot results in the lungs. The Guardian asked for an update on the resident's condition. Staff B assessed Resident #5's vitals, noting only his low pulse ox (oxygen in blood). Staff B placed Resident #5 on oxygen, and his pulse ox returned to the normal range (90-100%). Resident #5 denied troubles breathing or pain issues. A Certified Nurse Aide (CNA) entered the room, assisted Resident #5 into the wheelchair for transfer to the dining room. The staff didn't note any incident or concerns at the time. The Progress Note dated 2/18/26 at 3:15 PM Staff B, updated Resident #5's Responsible Party. The Progress Note dated 2/20/26 at 11:17 AM indicated Staff F, MDS Coordinator, received a call from a provider with CT scan results showed lung pulmonary embolism (LPE, a serious, life-threatening condition where a blood clot, usually from the leg, travels to the lungs and blocks an artery). The provider gave an order to send Resident #5 to the emergency department (ED). The Progress Note dated 2/20/26 at 6:48 PM reflected Resident #5 returned to the facility on anticoagulant (blood thinners) medication. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165152	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The After Visit Summary dated 2/20/26 listed a diagnosis of pulmonary embolism. On 3/23/26 at 3:45 PM the Medical Director reported he expected the facility to notify the provider as soon as they knew of the PE in Resident #5's lung. He confirmed Resident #5 had a delay in treatment. On 3/24/26 at 6:07 PM Staff B reported he assessed Resident #5 after Resident #5's Representative called about the concern with blood clots. Staff B said Resident #5 seemed stable with no complaints. Staff B explained he talked to the Director of Nursing (DON) and she told him he needed to wait for the documentation of the PE or a call from the provider to validate the PE. On 3/25/26 at 2:14 PM, Staff F reported it took 2 days for the facility to get an order for the treatment for Resident #5's PE took. Staff F said the hospital called and left a message for the DON on her voicemail (VM). Staff F reported the DON failed to check her VM on a regular basis. On 3/25/26 at 3:20 PM the DON reported Resident #5 CAT scan identified a PE. She explained they called her with the results of the CAT scan and she notified the provider who ordered to send Resident #5 to the ED. The DON said she thought it all happened in one day. The DON denied she knew Staff B got a phone call from Resident #5's Representative about the PE on 2/18/26. The DON reported she expected the staff to notify the provider of a change in conditions. 2. Resident #3's Minimum Data Set (MDS) assessment, dated 2/27/26, identified a BIMS score of 15, indicating intact cognition. The MDS included diagnoses of paraplegia (impairment of motor and sensory function in lower body), seizure disorder, coronary artery disease (CAD), respiratory failure, and malnutrition. The Respiratory Therapy Notes, dated 2/28/26, revealed the following entries documented by Staff H, Respiratory Therapist (RT): On 2/28/26 at 8:03 AM: Staff H assisted the CNA transfer Resident #3 from the bed to a wheelchair. During the transfer, Resident #3 reported feeling dizzy, then exhibited a fixed gaze (looking forward without blinking) and became unresponsive to verbal stimuli. He stayed in that state for approximately eight minutes after they laid Resident #3 in a wheelchair. During that time, Resident #3's respirations measured 12-14 breaths per minute. (Note: Resident #3 is known to sleep with their eyes open.). As Resident #3 began to recover, they experienced uncontrolled arm swinging. Following this, Resident #3 became responsive to verbal cues, stated they were thirsty, and returned to their normal state. On 2/28/26 at 5:00 PM: Staff H helped transfer Resident #3 from the bed to the wheelchair as the CNAs and nurse remained in the room. They transferred Resident #3 using a full-body mechanical lift and full-body sling. Just above the wheelchair, Resident #3 displayed the same blank stare he had that morning, but this time it lasted over 15 minutes. Staff H tried to get a pulse oximeter reading but failed. Resident #3's breathing slowed to 7-8 breaths per minute. Resident #3's lips turned grayish. Staff H administered 10 Liters (L) of oxygen and attempted to suction them with no response. Staff H performed a sternum rub; but Resident #3 did not respond. Staff H lifted Resident #3's eyelid and saw no pupil response; his pupils resembled pin dots. In a split second, Resident #3 moved his jaw and awoke. When Staff H said Resident #3's name, he responded that he felt thirsty. He stated he felt dizzy, but otherwise okay and hungry. The nursing staff knew about the incident due to their presence at the time. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #3's Electronic Health Records (EHR), lacked nursing documentation, assessment, or physician notification of the two unresponsive episodes occurring on 2/28/26. The Respiratory Therapy Notes, dated 3/1/26, documented by Staff H identified the following: On 3/1/26 at 12:31 PM: Staff H talked with the DON about Resident #3's episodes of going unresponsive. They both agreed to track Resident #3's blood pressure when the episodes happened and documenting when they took place. On 3/1/26 at 3:31 PM: Staff H notified the nurse that Resident #3 reported to them that he had low blood pressure and took medication to raise his blood pressure at the other facility. Staff H had Resident #3 try to sit up in bed at an angle of 70 degrees. After 20 minutes, Resident #3 got dizzy, he said would pass out and needed lowered. Staff H lowered the bed to the 30-degree angle, and Resident #3 described that as better. After 10 minutes, Resident #3 had Staff H lower the bed again to 20 degrees due to still feeling dizzy and felt like he would pass out. Staff H notified the nurse about the incident. On 3/1/26 at 4:36 PM: Resident #3's blood pressure was recorded as 60/40 (significantly lower than the average of 120/80) after he became lightheaded at a 30-degree angle and was then positioned at a 20-degree angle. Resident #3's Electronic Health Records (EHR), lacked nursing documentation, assessment, or physician notification of Resident #3's episodes of dizziness or the blood pressure of 60/40 noted on 3/1/26. The Communication - with Physician Note, dated 3/2/26 at 12:34 PM documented by the DON indicated staff called regarding apneic (not breathing) spells and hypotension (low blood pressure) with position changes. His vital signs measured a blood pressure of 115/58, 91 heart beats per minute, 8 respirations per minute, 94% oxygen saturation on room air. When Resident #3 minimally responded to verbal stimuli and his face appeared pale, the staff elevated the feet of his chair above his heart to promote blood flow. The received a new order to send Resident #3 to the ED for further evaluation. The staff called 911 for transport to the ED. The Order Note labeled Late Entry, dated 3/2/26 at 12:40 PM documented by DON identified the facility received a new order to increase Midodrine (medication used to treat severe orthostatic hypotension or drop in blood pressure upon sitting or standing) to 5 milligrams (mg) three times a day (from 2.5 mg three times a day). Resident #3 out at hospital. The Health Status Note, dated 3/2/26 at 7:49 PM, reflected Resident #3 returned from the ED via ambulance with no new orders and to follow up with their provider as soon as possible for a visit in 2 days. The Care Plan, initiated 2/20/26, lacked identification or interventions related to Resident #3's episodes of orthostatic hypotension and unresponsive episodes during changes in position. During an interview on 3/18/26 at 5:00 PM, Staff H reported that the RT staff would notify nursing staff of any changes in a resident's condition and nursing would communicate with the provider to obtain any new orders. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/25/26 at 4:00 PM, the DON reported they expected nursing staff to notify the physician of low blood pressures and anything outside of a resident's normal condition. The Notification for Change in Condition policy, revised June 2023, directed the facility to provide care to residents and provide notification of resident changes in status. The Procedure section listed the following: The facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is: An accident involving the resident which results in injury and has the potential for requiring physician intervention. A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or A decision to transfer or discharge the resident from the facility. Additionally, the policy instructed, per federal guidance, physicians need notification if a resident experiences symptoms such as chest pain, loss of consciousness, or other signs or symptoms of heart attack or stroke.

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	165152	A. Building B. Wing	03/25/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, facility grievance form review, and facility policy review, the facility failed to provide supervision of Resident #6 while outside smoking on 1/4/26. In addition the facility failed to complete smoking or elopement assessments for 1 of 6 residents (Resident #6) reviewed for inadequate staff supervision. The facility did not consistently follow its own safety procedures for Resident #6, identified as a dependent smoker with a risk of wandering. The facility failed to complete the required annual updates to the resident's smoking and elopement risk assessments after 2024. A nurse left the resident unattended outside while smoking, which violated the Care Plan requiring supervision due to the resident's inability to smoke safely. The facility documented addressing the incident with staff education and discipline but could not produce evidence the follow-up occurred, nor documented the incident in the resident's medical records as required. The facility failed to maintain safety monitoring and internal accountability for a resident who required close supervision. The facility reported a census of 42 residents. Findings include: Resident #6's Minimum Data Set (MDS) assessment, dated 1/20/26, identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of traumatic brain damage (TBI), aphasia (inability or impaired ability to understand or produce speech, as a result of brain disease or damage), and seizure disorder. The Care Plan Focus initiated 10/21/24, indicated Resident #6 used tobacco. The goal indicated Resident #6 would adhere to the smoking policy. The Interventions dated 10/21/24 directed the following:Complete a smoking evaluation as needed. Inform resident and/or responsible party of the smoking policy. Dependent smoker: Staff to assist Resident #6 to the designated smoking areas at designated smoking times. Dependent smoker: Staff to supervise while smoking. Independent smoker: Must keep smoking accessories secured when not in use (via lockbox or in control of facility staff). Independent smoker: Must smoke only in designated areas/designated times (unless able to independently get to and from the designated areas). The Smoking assessment dated [DATE], reflected Resident #6 had cognitive loss and couldn't light a cigarette safely. Resident #6's Electronic Health Records (EHR), lacked additional Smoking Assessments completed after 10/21/24. The Elopement Risk Assessment, dated 10/21/24, revealed a score of 9, indicating they had risk to wander. Resident #6's EHR, lacked additional Elopement Risk Assessments completed after 10/21/24. Review of the facility provided Grievance Logs, revealed a concern reported to the facility Administrator, on 1/5/26, regarding Resident #6. On 1/5/26, the Administrator and Director of Nursing (DON) learned on 1/4/26, a nurse took Resident #6 outside to smoke, lit their cigarette, and then returned inside, leaving them unattended. A signed, typed document from the Administrator accompanied the concern. According to the Grievance Log, the facility resolved the issue by 1/8/26, after staff education and disciplinary action. When requested, the facility couldn't produce the completed staff education and discipline as indicated in the Grievance Log dated 1/5/26. Resident #6's EHRs lacked documentation related to the reported concern on 1/4/26. During an interview, on 3/25/26 at 4:00 PM, the DON stated the facility completed Smoking Assessments and Elopement Risk Assessments on residents at admission and annually. The DON reported the facility did a verbal education with an agency nurse related to leaving Resident #6 outside unsupervised to smoke. The DON stated the staff need to document a progress note or incident report related to any occurrence outside of the resident's plan of care. The Smoking Policy revised January 2024, instructed to establish and maintain safe resident smoking practices. Determine if a resident is an independent or dependent smoker prior to the resident exercising the privilege to smoke. Facilities, at their discretion, may choose to not allow smoking on their premises, may allow smoking only when the resident requires no supervision to smoke, or may offer smoking times and supervised smoking only. The section Guidelines Smoking Facilities, instructed the (continued on next page)

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	165152	A. Building B. Wing	03/25/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following:The facility would require residents determined to be a dependent smoker wear a protective smoking vest or apron if needed. They will be supervised while smoking and be assisted during designated smoking times. The facility would update the Care Plan for smokers to include, but not limited to, assistance required if needed, safety interventions or protective equipment needed if indicated, storage of materials. Care Plans will be reviewed and revised as necessary.

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	165152	A. Building B. Wing	03/25/2026

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based staff interview, clinical record review, and facility policy review, the facility failed to maintain a resident's nutritional status for 1 of 5 residents reviewed (Resident #4). As evidenced by a significant, unexplained weight loss from 130 pounds on 1/05/26 to 119.5 pounds on 3/25/26. The facility failed to consistently follow the Care Plan intervention to notify the physician and dietitian of significant weight change. Furthermore, the facility did not follow its own policy for Notification for Change in Condition by failing to consult with the resident's physician and notify the Dietitian of a significant change in status (weight loss) and the significant alteration of treatment (reduction of enteral feedings from five times to two times per day) without a documented physician's order or indication. The Registered Dietitian denied receiving report of the resident's frequent refusal of tube feedings throughout February 2026 and the subsequent decrease in feedings, indicating a breakdown in communication and a failure to implement necessary nutritional interventions in a timely manner. The facility reported a census of 42 residents.Findings include:Resident #4's Minimum Data Set (MDS) assessment, dated 2/16/26, identified they had moderately impaired cognitive skills for daily decision making. The MDS included diagnoses of myotonic muscular dystrophy (a type of muscle-wasting disease that causes prolonged muscle contractions), diabetes mellitus, and malnutrition (not getting enough nutrients, or too much of the wrong ones). The MDS indicated Resident #4 required tube feedings while a resident at the facility. The Care Plan Focus initiated 1/5/26, reflected Resident #4 had the potential/actual risk for altered nutrition status related to a nothing by mouth (NPO) diet. The goal indicated Resident #4 would maintain weight with no significant changes. The Interventions dated 1/5/26 directed the following:Provide diet as ordered - NPO. Monitor weights. Notify the physician and Dietitian of significant weight change. The Care Plan Focus initiated 1/16/26 identified Resident #4 had tube feedings related to gastrostomy status (a feeding tube inserted through the abdomen into the stomach to deliver nutrition, fluids, or medications directly). The goal indicated Resident #4 would tolerate the tube feedings and remain free of complications. The Intervention dated 1/29/26 instructed Resident #4 may refuse feedings. The Nutrition Assessment, completed by the Dietitian, dated 1/13/26, reflected Resident #4's had a diet of NPO and enteral feeding (feeding through a tube into the stomach or small intestine) provided all of their nutrition. The Dietitian made a recommendation to increase his nutritional solution amount from 240 milliliters (mL) 5 times per day to 250 mL 5 times per day and increase water flushes, before and after feedings, from 30 mL to 60 mL, due to Resident #4 being below her estimated needs. Resident #4's February 2026 Medication Administration Record (MAR) included the following orders:1/16/26: Enteral feedings 250 milliliters (mL), five times a day, (total of 1,250 mL nutritional solution per day) related to gastrostomy status, with 50 mL water before and after feedings. The facility discontinued the order on 2/25/26. The MAR indicated between the dates of 2/1/26 and 2/25/26, Resident #4 refused the following scheduled tube feedings times: 6:00 AM tube feeding: refused 1 time. 10:00 AM tube feeding: refused 15 times.2:00 PM tube feeding: refused 2 times. 6:00 PM tube feeding: refused 15 times. 10:00 PM tube feeding: refused 17 times. 2/26/26: Enteral feedings 300 mL, two times a day (total of 600 mL nutritional solution per day), related to gastrostomy status, with 50 mL water before and after feedings. The facility discontinued the order on 3/4/26. Resident #4's March 2026 MAR included an order started 3/5/26 for enteral feedings 300 mL, two times a day (total of 600 mL nutritional solution per day), related to gastrostomy status, with 50 mL water before and after feedings. Resident #4's Electronic Health Records (EHR) revealed the following recorded weights:On 1/5/26, Resident #4 weighed 130 pounds. On 1/10/26, Resident #4 weighed 130 pounds. On 2/19/26, Resident #4 weighed 121.1 pounds. During an electronic mail (Email) correspondence, on 3/25/26 at 1:06 PM, upon request for Resident #4's most recent weight, the Director of Nursing (DON) reported that Resident #4's weighed 119.5 pounds on 3/25/26. During an interview on 3/25/26 at 1:07 PM, the Registered Dietitian (RD) reported visiting the facility on 3/24/26 and made a recommendation to (continued on next page)

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	165152	A. Building B. Wing	03/25/2026

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F 0692 Level of Harm - Actual harm Residents Affected - Few	return Resident #4's tube feedings back to 5 times per day. The Dietitian denied receiving a report from the facility that Resident #4 refused multiple feedings throughout February 2026. Additionally, they denied receiving notification from the facility that they reduced the feedings to twice per day on 2/26/26. The Dietitian stated she couldn't find an order or indication from physician to decrease the number of Resident #4's feedings. The Dietitian reported the weight entered into Resident #4's EHR on 3/25/26 showed a significant weight loss. The Dietitian stated she planned to contact the DON and recommend to check Resident #4's weights weekly. During an interview on 3/25/26 at 4:00 PM, the DON reported they expected the nurses to notify physician and Dietitian of resident's refusal of tube feedings if it happened more than 2 times. The DON reported she didn't know why Resident #4's feedings decreased to twice per day and couldn't find documentation to indicate the reason for the decrease. Review of the facility policy titled, Notification for Change in Condition, revised June 2023, directed the facility to provide care to residents and provide notification of resident changes in status. The section titled Procedures, instructed the following: The facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is: A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); Additionally, the policy instructed, per federal guidance, the need to alter treatment significantly meant a need to stop a form of treatment because of adverse consequences (e.g., an adverse drug reaction), or commence a new form of treatment to deal with a problem (e.g., the use of any medical procedure, or therapy that has not been used on that resident before).

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	165152	A. Building B. Wing	03/25/2026

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interview and facility policy review the facility failed to provide tube feeding care per the physician's orders for 2 out of 5 residents reviewed (Residents #1 and #10). The facility failed to ensure to administer and document medically necessary nutritional feedings, water flushes, and g-tube (a feeding tube that goes through the skin directly into the stomach) residual checks as ordered for Resident #1. Additionally, the facility failed to ensure staff followed physician's orders for the required water flush amounts before and after medication administration via tube feeding for Resident #10, providing unverified standard amounts, and lacked a clear policy to guide staff on proper tube feeding medication procedures. The facility reported a census of 42 residents. Finding include:1. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. The MDS included diagnoses of traumatic hemorrhage cerebrum (life threatening brain bleed caused by physical injury), seizure disorder, Dysarthria (a motor speech disorder characterized by weak, damaged, or paralyzed speech muscles (lips, tongue, vocal cords, diaphragm), leading to slurred, slow, or difficult-to-understand speech) and Anarthria (the severe, total loss of the ability to articulate speech due to brain damage or neurological disorders, preventing control of muscles for speaking while often leaving language comprehension intact. Often considered an extreme form of dysarthria, it results from lesions impacting motor pathways, causing complete muteness). The MDS showed Resident #1 required a tube feeding for nutrition. The Care Plan for Resident#1 revised on 11/14/2025 identified a focus on gastrostomy tube (G-tube) feeding related to dysphagia (difficulty swallowing, often caused by neurological conditions) and risk for dehydration. The Care Plan directed provide enteral nutrition (tube feed) as ordered NPO (nothing by mouth). Resident #1's January 2026 Medication Administration Record (MAR) directed the following orders: Enteral feed (providing liquid nutrition through a tube directly into the stomach or small intestine) Fibersource HN 375 milliliters (ml) four times a day for nutritional supplement.The MAR revealed the facility failed to document the feeding provided to Resident #1 on: 1/6/26 at hour of sleep (HS), 1/10/26 at lunch, 1/16/26 at HS, 1/18/26 at lunch, 1/21/26 at lunch and HS, and 1/25/26 at lunch.The MAR dated 1/2026 directed enteral feed order four times a day flush G-tube with 150 ml of water with feedings.Water flush of 150 ml with each feed The facility failed to document on:1/6/26 at HS, 1/10/26 at lunch, 1/16/26 at HS, 1/18/26 at lunch, 1/21/26 at lunch and HS, and on 1/25/26 at lunch.Check placement of g-tube with residual (5-20ml) prior to every medication pass or feeding every shift for medication and nutrition via tube.The facility staff failed to document completion of the checking the residual on: 1/1/26 on the overnight shift, 1/16/26 on evening shift, and 1/21/26 on the evening shift. Enteral feed order every shift 60 ml of water before and after medications.The MAR showed the facility failed to document the completion of administered water before and after medication on: 1/1/26 on the overnight shift, 1/16/26 on evening shift, and 1/21/26 on the evening shift. Resident #1's February 2026 MAR directed the following orders:Enteral feed order Fibersource HN 375 four times a day for nutritional supplement ml four times a day.The MAR revealed the facility failed to document the feeding provided to Resident #1 on 2/8/26 at PM, and 2/25/26 at mid afternoon.Enteral feed order four times a day flush G-tube with 150 ml of water with feedings.The MAR showed the facility failed to document the flush completed on: 2/8/26 at hs, 2/11/26 at mid afternoon and 2/25/26 at mid afternoon. On 3/23/26 at 3:40 PM the Medical Director reported he knew Resident #1 missed a few feedings. He confirmed he expected the staff to follow the providers' orders as written. On 3/25/26 at 9:57 AM Staff D, Licensed Practical Nurse (LPN), reported she knew Resident#1 failed to get a few of his feedings. On 3/25/26 at 2:09 PM Staff F, MDS Coordinator, reported she knew about Resident #1's missed feedings. Staff F reported she talked to the Director of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165152	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony House Health Care Center	2950 West Shaulis Road Waterloo, IA 50701

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing (DON) about the gaps on the MARs and the DON directed her to follow up on the gaps. The MDS Coordinator reported she failed to have time for that. The MDS Coordinator said if it's not documented it's not done. She reported the facility failed to complete audits. 2. Resident #10's MDS assessment dated [DATE], identified a BIMS showed a score of 14, indicating intact cognition. The MDS included diagnoses of stroke, heart failure, high blood pressure, and diabetes mellitus. The MDS reflected Resident #10 required tube feedings for nutrition. The Care Plan dated 12/31/25 identified Resident #10 had a risk for dehydration related to dependence on tube feeding for hydration. The Care Plan directed flush the feeding tube as ordered. Resident #10's March 2026 MAR failed to direct the amount of water to flush the feeding tube before and after medication administration. On 3/25/26 at 8:35 AM, observed Staff I, Registered Nurse (RN), set up for medication administration and asked the DON if she could check the amount of water needed for flushing medication before and after. The DON left the room, when she returned the DON told Staff I she needed to flush the tube feeding line with 60 cubic centimeter (cc) of water before and after the medication. Staff I flushed the tube with 60 cc of water, then administered some of the medications. Staff I reported she felt some resistance during the administration, the DON took over and started to flush the tube. The DON administered 30 cc flush and Staff I flushed the other 30 cc of water. On 3/25/26 at 10:37 AM the Assistant Director of Nursing (ADON) reported she failed to see the order for Resident #10's water flush amount before and after medication. On 3/25/26 at 10:50 AM Staff I confirmed the DON told her she needed to flush with 60 cc water before and after Resident #10's medication administration. Staff I opened the MAR and reported she didn't see the water flush on the MAR. On 3/25/26 at 10:53 AM the DON reported she said the 60 cc for the water flush because that's the standard amount. On 3/25/26 at 3:15 PM the Director of Nursing (DON) confirmed nursing 101 that if a task or action is not documented, it is not done. She acknowledged the gaps on the MAR for Resident#1. The DON reported the facility followed the six rights for medication administration and lacked a policy directed the staff how to administer medication. The facility provided a policy titled Enteral Tubes: Intermittent/Continuous (pump) Feedings dated June 2024 directed to verify physician's orders for formula, rate, and frequency.

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	165152	A. Building B. Wing	03/25/2026

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, clinical record review, facility Grievance Log review, call light log review and facility policy review, the facility failed to answer call lights in a timely manner to meet resident needs for 3 of 3 residents (Resident #4, #9, and #11) reviewed for call lights. The facility failed to answer residents' calls for assistance in a timely manner, with logged wait times for multiple residents frequently exceeding acceptable limits (greater than 15 minutes), sometimes lasting over an hour and a half. The failure persisted despite residents reporting concerns through interviews and the facility's own grievance logs and after staff were reportedly re-educated on the importance of responding to call lights and carrying communication devices. Furthermore, staff, including the Director of Nursing, failed to respond to a prolonged audible alarm indicating an issue with a resident's essential feeding tube pump, and the facility did not have a written policy to ensure timely call light response. The facility reported a census of 42 residents. Findings include: 1. Resident #4's Minimum Data Set (MDS) assessment, dated 2/16/26, identified they had moderately impaired cognitive skills for daily decision making. The MDS included diagnoses of myotonic muscular dystrophy (a type of muscle-wasting disease that causes prolonged muscle contractions), diabetes mellitus, and malnutrition (not getting enough nutrients, or too much of the wrong ones). The Care Plan Focus initiated 1/5/26 indicated Resident #4 required assistance with activities of daily living (ADLs) and had a risk for falls. The Intervention instructed the staff to keep Resident #4's call light within reach. During an interview on 3/16/26 at 2:20 PM, Resident #4 reported it took up to 2 hours for someone to answer her call light. During an interview on 3/24/26 at 2:25 PM, Staff J, Certified Nursing Assistant (CNA), stated while they worked the overnight shift on 3/21/26, she noticed Resident #4's call light on for over an hour. Staff J added no one reported it to the nurse on duty, because the nurse stated she was going to quit. Review of the Call Light Log System on 3/25/26 at 11:30 AM, with the Human Resources (HR) Director present, revealed the following call light wait times for Resident #4:On 3/20/26, the call light pressed at 10:42 AM and answered after 46 minutes, 29 seconds.On 3/20/26, the call light pressed at 11:25 PM and answered after 27 minutes, 1 second.On 3/21/26, the call light pressed at 9:57 AM and answered after 37 minutes, 53 seconds.On 3/21/26, the call light pressed at 1:59 AM and answered after 1 hour, 21 minutes, 10 seconds.On 3/22/26, the call light pressed at 9:57 AM and answered after 37 minutes, 53 secondsOn 3/22/26, the call light pressed at 3:30 PM and answered after 18 minutes, 37 seconds.On 3/22/26, the call light pressed at 5:59 PM and answered after 19 minutes, 34 seconds. 2. Resident #9's MDS assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS listed Resident #9 as dependent on staff assistance for toileting hygiene, bed mobility, and transferring. The MDS included diagnoses of type 2 diabetes mellitus, anxiety disorder, depression, chronic respiratory failure with hypoxia (low oxygen saturation), and asthma. The Care Plan Focus initiated 10/30/25, reflected Resident #9 required assistance with ADLs and had a risk for falls. The Intervention directed the staff to keep Resident #9's call light within reach. Review of the facility provided Grievance Logs, revealed a concern reported by Resident #9 on 1/27/26. Resident #9 reported the staff refused to lay her down. The staff went into her room, turned off the call light and left. She had her call light on for over an hour. The Grievance Log indicated the facility re-educated the staff on call lights, carrying the iPod and walkies. Additionally, the facility educated to lay down Resident #9. The Grievance Log dated 1/27/26 lacked a date of concern resolution. Review of the Call Light Log System on 3/25/26 at 11:30 AM, with the HR Director present, revealed the following call light wait times for Resident #9, in part:On 3/20/26, the call light pressed at 3:16 PM and answered after 33 minutes, 36 seconds.On 3/20/26, the call light pressed at 7:04 PM and answered after 56 minutes, 51 seconds.On 3/20/26, the call light pressed at 9:51 PM and answered (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165152	A. Building B. Wing	03/25/2026

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	after 32 minutes, 59 seconds.On 3/21/26, the call light pressed at 6:03 PM and answered after 31 minutes, 59 seconds.On 3/22/26, the call light pressed at 2:03 AM and answered after 1 hour, 47 minutes, 53 seconds.On 3/22/26, the call light pressed at 12:33 PM and answered after 20 minutes, 38 seconds.On 3/22/26, the call light pressed at 9:07 PM and answered after 29 minutes, 37 seconds.On 3/22/26, the call light pressed at 9:39 PM and answered after 33 minutes, 19 seconds. 3. Resident #11's MDS Assessment, dated 12/31/25, identified a BIMS score of 15, indicating intact cognition. The MDS listed Resident #11 as able to transfer and ambulate independently. The MDS included diagnoses of diabetes mellitus, arthritis, anxiety disorder, depression, post traumatic stress disorder (PTSD), asthma, and unspecified intellectual disabilities. The Care Plan Focus initiated 10/3/25, reflected Resident #11 had a risk for falls with occasional bladder incontinence related to inability to make it to the bathroom quickly. The Intervention instructed the staff to keep Resident #11's call light within reach. Review of the facility provided Grievance Logs, revealed a concern reported by Resident #11 on 2/11/26. Resident #11's reported on 2/11/26 from 1:00 AM to 3:00 AM, she had her call light on and no one answered. Reported she had her roommate press her call light because Resident #11 didn't have hers in reach. The Grievance Log indicated the facility provided staff re-education on call lights and they had no further complaints. The Grievance Log dated 2/11/26 listed the concern resolved on 2/14/26. Review of the Call Light Log System on 3/25/26 at 11:30 AM, with the HR Director present, revealed the following call light wait times for Resident #9:On 2/11/26, the call light pressed at 3:13 AM and answered after 51 minutes, 7 seconds.On 2/11/26, the call light pressed at 8:03 AM and answered after 36 minutes, 59 seconds. 4. Resident #3's Minimum Data Set (MDS) assessment, dated 2/27/26, identified a BIMS score of 15, indicating intact cognition. The MDS included diagnoses of paraplegia (impairment of motor and sensory function in lower body), seizure disorder, coronary artery disease (CAD), respiratory failure, and malnutrition. Resident #3 required a feeding tube for 51% or more of total daily calorie intake and 501 mL or more of total daily fluid intake. During a continuous observation on 3/18/26 between the times of 8:09 AM and 9:05 AM:At 8:09 AM: Resident #3 appeared sleeping in bed with a tube feeding pump on a pole placed next to his bed. The feeding tube pump's digital screen flashed yellow and made a continuous beeping alarm that could be heard from the hallway. The feeding tube pump's digital screen indicated a cassette error.At 8:12 AM, observed a housekeeping staff present in the hallway outside of Resident #3's room. They didn't respond to the alarm.At 8:25 AM a male staff member exited an office at the end of the hall, walked past Resident #3's room. They didn't respond to the alarm. Then at 8:33 AM the same staff member walked past the room again and returned to the office.At 9:04 AM, witnessed the Director of Nursing (DON) present in the hallway near Resident #3's room. The DON went into another resident's room and didn't respond to the alarm in Resident #3's room.At 9:05 AM Staff K, Licensed Practical Nurse (LPN), stood at a medication cart, located at the other end of the hallway, and didn't respond to the alarm. The Surveyor reported to Staff K they heard alarm in Resident #3's room. Staff K proceeded to Resident #3's room and checked Resident #3's feeding tube pump. Staff K stated that the alarm occurred when the tubing for tube feeding got occluded causing a pause in the resident's tube feeding. During an interview on 3/25/26 at 4:00 PM, the DON revealed they expected call lights to be answered as soon as possible. The DON confirmed residents have complained about call light wait times and they re-educated staff about promptly answering call lights. The DON confirmed that 1 hour and 47 minutes was too long for a call light to be unanswered and stated clearly more call light audits needed done. The facility couldn't provide a policy related to call light timeliness.

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	165152	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on staff interview, facility document review, and facility policy review, the facility failed to keep record of the distribution for controlled substance Lorazepam (medication used to treat anxiety, insomnia, and seizures) for 1 of 6 residents (Resident #3) reviewed for medication administration. The facility reported a census 42 residents. Findings include: Resident #3's Minimum Data Set (MDS) assessment, dated 2/27/26, identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of paraplegia (impairment of motor and sensory function in lower body), seizure disorder, respiratory failure, and malnutrition. The Care Plan included the following Focuses:Resident #3 had a mood state disturbance related to diagnoses of major depressive disorder, antisocial personality disorder, and post traumatic stress disorder (PTSD).Resident #3 had a history of substance overuse that may impact psychosocial functioning. The Interventions instructed the following:3/4/26: Administer medications as ordered. 3/4/26: Remain non-judgmental and be alert to changes in behavior such as restlessness or increased tension. 3/3/26: Initiate increased monitoring and supervision of Resident # 3 as needed. 3/3/26: Medication review with pharmacy per facility protocol. Resident #3's hospice admission orders, dated 3/6/26, noted by the facility on 3/7/26, revealed a written physician's order for lorazepam concentrate 2 milligrams (mg) per 1 milliliter (mL) (2mg/mL). The instructions directed to give 0.25 mL (0.5 mg) by mouth/sublingual (under the tongue) every 2 hours as needed for anxiety or restlessness. Resident #3's March 2026 Medication Administration Record (MAR) included an order dated 3/7/26 at 11:30 AM to give lorazepam oral concentrate 2 mg/mL 0.5 mL by mouth every 2 hours as needed for anxiety or restlessness. The facility discontinued the order on 3/10/26 at 4:29 PM. The MAR included the following Medication administrations, documented by various staff:On 3/7/26 at 2:19 PM, 3/8/26 at 1:11 AM, 3/8/26 at 9:09 AM, 3/8/26 1:30 PM, 3/8/26 at 4:27 PM, 3/9/26 7:15 AM, 3/9/26 at 3:45 PM, and 3/10/26 at 5:26 AM. The facility couldn't locate a controlled substance log (a document used to log and track the disposition of controlled substances) for Resident #3's lorazepam solution. The Incident Report note, electronically signed by Director of Nursing (DON), dated 3/10/26 at 4:31 PM, documented Resident #3 received lorazepam concentrate 2 mg/mL, 0.5 mL every 2 hours as needed for anxiety or restlessness. The facility notified Resident #3, hospice, and provider of the incident. During an interview on 3/25/26 at 1:55 PM, Staff F, MDS Coordinator, confirmed she transcribed Resident #3's order for lorazepam into the EHR on 3/7/26. Staff F reported being in a rush to enter the orders due to working as the floor nurse that day and didn't have another nurse to double check the orders. Staff F stated she gave Resident #3 0.5 mL of lorazepam on 3/7/26, later identified as an incorrect dosage. Staff F reported they should use a controlled substance log to document distribution of lorazepam. During an interview on 3/25/26 at 4:00 PM, the Director of Nursing (DON) revealed they expected the nurses to administer medications as ordered by the provider and double check orders with another nurse to ensure accuracy. The DON reported they expected a controlled substance log to be initiated and completed with each administration of lorazepam. On 3/25/26 at 4:59 PM the Administrator denied having policies and procedures for medication administration. They stated the facility followed the industry standard of following the 6 rights of medication administration: the right patient, dose, medication, route, time, and documentation.

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	165152	A. Building B. Wing	03/25/2026

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on staff interview, facility narcotic logs, clinical record review, and facility policy review, the facility failed to correctly transcribe physician orders for two controlled substances morphine sulfate concentrate oral solution (opioid narcotic used to treat severe pain) and lorazepam concentrate oral solution (benzodiazepine, which acts as a central nervous system depressant, used to treat anxiety disorders, insomnia, and seizures) which resulted in Resident #3 receiving an 8 times greater dose of morphine than ordered on 3/8/26 at 1:11 AM, followed by administration of naloxone (Narcan- nasal spray to rapidly reverse an overdose of opioid medications) on 3/8/26 at 1:45 AM, as well as, a 2 times greater dosage of Lorazepam than ordered, administered 8 times between the dates of 3/7/26 and 3/10/26 for 1 of 6 residents (Resident #3) reviewed for medication administration. Findings include: Resident #3's Minimum Data Set (MDS) assessment, dated 2/27/26, identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of paraplegia (impairment of motor and sensory function in lower body), seizure disorder, respiratory failure, malnutrition, and cachexia (severe involuntary loss of weight, muscle and fat caused by chronic diseases). Resident #3's hospice admission orders, dated 3/6/26, noted by the facility on 3/7/26, revealed the following written physician orders: Morphine Sulfate concentrate 20 milligrams (mg) per milliliter (mL), with instructions to give 0.25 mL (5 mg) by mouth/sublingual every 2 hours as needed for pain or shortness of breath. Lorazepam concentrate 2 mg per 1 mL (2mg/mL), with instructions to give 0.25 mL (0.5 mg) by mouth/sublingual every 2 hours as needed for anxiety or restlessness. Review of Resident #3's Electronic Health Records (EHR), listed the created and discontinued dates for the following medication orders:Morphine Sulfate (concentrate) oral solution 100mg/5mL directed the following instructions:3/7/26: Give 2 mL by mouth every 2 hours as needed for pain or shortness of breath, was created on 3/7/26, and discontinued on 3/8/26 at 1:39 AM. 3/8/26: Give 0.25 mL by mouth every 2 hours as needed for pain or shortness of breath. Lorazepam oral concentrate 2mg/mL directed the following instructions:3/7/26: Give 0.5 mL by mouth every 2 hours as needed for anxiety or restlessness. The facility discontinued the order on 3/10/26 with the note, clarified with hospice. The Health Status Note labeled Late Entry electronically signed entry by Staff A, Registered Nurse, dated 3/8/26 at 1:11 AM, documented they gave Resident #3 morphine concentrate 100mg/5mL, 2 mL at 1:11 AM for a pain level 8, indicating severe pain. The note order indicated they updated the order to reflect the correct dose. The Health Status Note labeled Late Entry electronically signed entry by Staff A, dated 3/8/26 at 1:45 AM, documented: they gave Resident #3 Narcan at that time for prophylaxis (preventive treatment for disease). Staff A went into Resident #3's room and explained the plan. Staff A told Resident #3, they planned to give them Narcan because they gave him too much morphine. Resident #3 asked if they were going to wash all the morphine out of him. Staff A responded yes, that's what Narcan is for. Resident #3 threw his hands in the air. He acted asymptomatic (showing no symptoms of disease), and showed no signs or symptoms of respiratory distress at the time of administration. Staff A administered one dose of Narcan. The Encounter note, dated 3/10/26, revealed Resident #3 had an acute care visit with Provider for follow up after a medication error over the weekend that required naloxone (Narcan) administration. The note documented Resident #3 admitted to hospice on 3/6/26 with orders for comfort medications including morphine concentrate 100mg/5mL, 0.25 mL every 2 hours as needed and lorazepam concentrate 2mg/mL, 0.25 mL every 2 hours as needed. Due to a transcription error, the Medication Administration Record (MAR) listed morphine as 2 mL every 2 hours as needed. During the incident, the patient received morphine 0.25 mL, but there was concern that 2 mL could have been administered. Additionally, the patient received lorazepam 1 mg every 2 hours instead of the intended 0.5 mg tablet every 2 hours for restlessness. The staff notified the DON and on-call Provider and administered naloxone as a precaution. Resident #3 did not experience any adverse effects from the medication error, appeared pain-free, and rested comfortably since the incident. Resident #3's March (continued on next page)

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	165152	A. Building B. Wing	03/25/2026

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2026 MAR included the following orders:Morphine Sulfate (concentrate) oral solution 100mg/5mL. Give 2 mL by mouth every 2 hours as needed for pain or shortness of breath. Start date: 3/7/26 at 11:30 AM. Discontinue date: 3/8/26 at 1:39 AM. Medication administration, documented by Staff A, on 3/8/26 at 1:11 AM. Lorazepam oral concentrate 2mg/mL. Give 0.5 mL by mouth every 2 hours as needed for anxiety or restlessness. Start date: 3/7/26 at 11:30 AM. Discontinue date: 3/10/26 at 4:29 PM.Medication administrations, documented by various staff, on 3/7/26 at 2:19 PM, 3/8/26 at 1:11 AM, 3/8/26 at 9:09 AM, 3/8/26 1:30 PM, 3/8/26 at 4:27 PM, 3/9/26 7:15 AM, 3/9/26 at 3:45 PM, and 3/10/26 at 5:26 AM.Naloxone (Narcan) nasal liquid 4mg/.1mL. Give one spray in alternating nostrils, one time only, for opioid overdose for one day. Start date: 3/8/26 at 1:45 AM. Medication administration, documented by Staff A, on 3/8/26 at 1:45 AM. Review of the facility document used to log and track the disposition of controlled substances for Resident #3's morphine sulfate, revealed the following logged entries:On 3/7/26 at 11:30 AM, the current balance of morphine solution 30 mL, the amount dispensed 0.25 mL and the remaining amount 29.75 mL. On 3/7/26 at 2:00 PM, the current balance of morphine solution 29.5 mL, the amount dispensed 0.25 mL, and the remaining amount 29.5 mL. On 3/8/26 at 1:12 AM, the current balance of morphine solution 29.5 mL, the amount dispensed 2 mL, and the remaining amount 27.5 mL. The facility couldn't locate a controlled substance log for Resident #3's lorazepam solution. The Incident Report Note, electronically signed by Staff A, dated 3/10/26 at 2:55 PM, documented a nurse and an orientee changed a colostomy and urostomy for Resident #3 who then asked for pain medication. The MAR and order tab incorrectly showed an order for 2 mL of morphine sulfate every two hours as needed. The staff gave Resident #3 the morphine sulfate and lorazepam. However, when the nurse went to sign out the narcotic book, they immediately discovered the book stated the correct order of only 0.25 mL of morphine sulfate. This meant Resident #3 received a significantly higher dose than ordered. The nurse promptly informed the Nurse Manager, who instructed her to call Resident #3's doctor. Resident #3 didn't appear to be in pain prior to receiving the medication. The note listed his vital signs as blood pressure 68/58 (a typical person usually measures 120/80), temperature 97.7, heart rate of 59, respirations of 19, and an oxygen level of 96% on room air. The Incident Report note, electronically signed by Director of Nursing (DON), dated 3/10/26 at 4:31 PM, documented Resident #3 received lorazepam concentrate 2 mg/mL, 0.5 mL every 2 hours as needed for anxiety or restlessness. The facility notified Resident #3, hospice, and provider of the incident. The Care Plan Focus revised 3/9/26, identified Resident #3 received the opioid medication, morphine. The goal indicated Resident #3 would remain free of complications related to use of opioid medication. The Interventions instructed staff to monitor for medication side effects such as: feelings of euphoria, dry mouth, headache, flushing, mental fog, constipation, drowsiness, itching, respiratory depression, lethargy, addiction, irregular heart beat, depression, and severe abdominal pain. The Care Plan Focus revised on 3/4/26, reflected Resident #3 complained of pain, described as chronic, related to paraplegia (paralysis that affects the lower half of the body, including both legs) and pressure wounds. The Intervention directed to administer pain medication per physician orders. During an interview on 3/25/26 at 10:45 AM, Staff A confirmed they worked on 3/8/26 and that Resident #3 needed morphine for pain. Staff A checked Resident #3's doctor's orders and medication record, both listed a 2 mL dose of morphine. However, Staff A admitted they didn't check the controlled substance log before preparing and giving the medication. Although Staff A questioned the 2 mL dose as being too high because Resident #3 recently started hospice and was very thin, she couldn't find the original hospice orders to check. Staff A and a nurse in training gave the 2 mL dose. When Staff A returned to the nurse's station to sign out the medication in the controlled substance log, she discovered a medication error: Resident #3's received only 0.25 mL for their last dose. Immediately after realizing the mistake, Staff A called the Nurse Manager and the on-call doctor, informed Resident #3, and documented the event. Staff A gave Resident #3 Narcan (naloxone) nasal spray as instructed. They watched Resident #3 closely all night and he didn't show any harmful side effects. During an interview on 3/25/26 at 1:55 PM, Staff F, the MDS Coordinator, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165152	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony House Health Care Center	2950 West Shaulis Road Waterloo, IA 50701

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed that she entered the orders for Resident #3's morphine and lorazepam into the electronic health record (EHR) on 3/7/26. She explained that another nurse received the orders on 3/6/26, but hadn't transcribed them. Staff F stated she felt pressured to enter the orders quickly because she also worked as a floor nurse that day and didn't have another nurse available to double-check her work. Staff F reported she gave Resident #3 the prescribed 0.25 mL dose of morphine and 0.5 mL of lorazepam, though they later determined the lorazepam dose to be incorrect. She also noted that a controlled substance log should be used to record the dispensing of both morphine and lorazepam. During an interview on 3/25/26 at 4:00 PM, the Director of Nursing (DON) revealed they expected the nurses to administer medications as ordered by the provider and double check orders with another nurse to ensure accuracy. On 3/25/26 at 4:59 PM the Administrator denied having policies and procedures for medication administration. They stated the facility followed the industry standard of following the 6 rights of medication administration: the right patient, dose, medication, route, time, and documentation.