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	05/18/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, interviews, and policy review the facility failed to ensure cold food items were maintained at or below 40 degrees Fahrenheit (4 degrees Celsius) and served immediately to prevent potential bacterial growth. Specifically, a half-gallon of milk sat out at room temperature without an ice bath for at least eight minutes, reaching a temperature of 53 degrees Fahrenheit before Staff B, Certified Nurse's Aide (CNA), poured and served a glass of it to a resident. Additionally, the facility left breakfast trays exposed to the open air on a dining room half wall before serving to a resident. One resident, Resident #13 who received one of the meals reported the breakfast was cold as usual. The facility reported a census of 50 residents.Findings include:On 5/12/26 from 8:40 AM to 9:00 AM, Staff A, Cook, dished up four plates for room trays and sat them on the half wall in the dining room in front of the steam table. The trays consisted of foam plates, and Staff A used another foam plate to cover them, which left the sides of the food exposed to open air. Next to the plates sat a half-gallon of milk, not in an ice bath or anything else to maintain its temperature. Staff A then told a nurse to call for staff to come get the room trays. At 8:47 AM, Staff B, Certified Nurse's Aide (CNA), came and poured a glass of milk from the half-gallon of milk sitting next to the tray tables. Staff B then took the milk with one of the plates dished up to a resident's room. At 8:48 AM, Staff A took the temperature of the half-gallon of milk sitting out. The temperature registered 53 degrees, and Staff A reported the milk shouldn't have been used.On 5/12/26 at 8:50 AM, an interview with Staff A revealed the temperature of milk should be below 45 degrees.On 5/12/26 at 9:10 AM, an observation of the last room tray being delivered showed the last room tray was taken to Resident #13's room.On 5/12/26 at 9:15 AM, an interview with Resident #13 revealed the breakfast was cold, but it usually is, so it wasn't the best.On 5/13/26 at 9:06 AM, an interview with Staff A reported for room trays, she's to let the CNAs know they're ready to serve, dish the meal, and then put it up on the half wall. She reported the CNAs will then get the drinks and deliver the trays, which should be delivered right away. She reported the milk is to be on ice to keep its temperature. On 5/13/26 at 9:20 AM, the Administrator reported the temperature of the milk wasn't at the correct temperature and the staff shouldn't have served the milk.The Food Brought In From Outside Source/Safe Food Handling policy revised January 2024 directed cold items should be 40 degrees Fahrenheit (4 degrees Celsius) or below.

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews and policy review the facility failed to maintain a sanitary kitchen; failed to serve and prepare food in accordance with professional standards for food safety to reduce the risk of cross contamination and food borne illness. The facility reported a census of 50 residents. Findings include:On 5/12/26 from 8:34 AM to 9:00 AM, a continuous observation revealed Staff A, Cook, licked the thumb of her hand at 8:34 AM and proceeded to serve food without performing hand hygiene. Staff A picked up bacon with her hands and placed it on a plate when serving residents. At 8:38 AM, Staff A touched her food-soiled apron with her hands, picked up bacon with her hands, and didn't use the tongs on the steam table.On 5/12/26 at 9:05 AM, a walkthrough of the kitchen revealed the floor in the dry storage area had dried leaves, dried liquid, and food particles on it. A box of soups sat on the floor. In the refrigerator, a liquid eggs box and a sliced ham box of food were stored on the floor. In the kitchen, the flour and sugar bins were covered in flour and food particles.On 5/13/26 at 9:06 AM, an interview with Staff A revealed she'd been an employee for 5 years. Staff A reported staff are to use tongs to serve bacon. She acknowledged she served the bacon with her hands and licked her thumb.On 5/13/26 at 9:20 AM, during a second walkthrough of the kitchen the Administrator reported staff are to use tongs when handling bacon. Throughout the walkthrough, she acknowledged the floors in the dry storage areas remained dirty with dried food particles, dried liquids, and leaves. The boxes of food supplies still on the floor should've been stored up off the floor. The undated General Food Preparation and Handling policy instructed staff to store food items properly as soon as possible, with the exception of dry goods which should be stored by the end of the shift, and food will be prepared and served with clean utensils.The Food Brought In From Outside Source/Safe Food Handling policy revised January 2024 directed cross-contamination can occur when harmful substances, chemicals, or disease-causing microorganisms are transferred to food by hands.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interviews, the facility failed to implement standard infection control practices and Enhanced Barrier Precautions (EBP) (involves the use of gowns and gloves during high-contact resident care activities for residents known to be colonized, infected and at increased risk of Multidrug Resistant Organisms (MDRO) (bacteria that are resistant to three or more families of antibiotics) for 3 of 3 residents (Resident #15, Resident #24 and Resident #4). The facility also failed to review their infection policy yearly. The facility reported a census of 50 residents. Findings include:1. Resident #15's Minimum Data Set (MDS) assessment dated [DATE] documented he had severe cognitive impairment. The MDS included diagnoses of chronic respiratory failure (long-term inability of the lungs to clear carbon dioxide and provide oxygen) and a resistance to unspecified antibiotics. The MDS documented he's dependent, meaning a helper does all of the effort, the resident does none of the effort to complete the activity, or the assistance of two or more helpers is required for the resident to complete the activity, for toileting, personal hygiene, and bed mobility. The MDS documented he had multiple pressure ulcers (bedsores).On 5/12/26 from 1:00 PM to 2:10 PM, a continuous observation showed Staff C, Agency Registered Nurse (RN), performed wound care on Resident #15. Staff C verified the treatments. Staff D, Certified Nurse's Aide (CNA), came to assist her with Resident #15's wound care. Both donned a gown, gloves, and mask. The treatment supplies sat in the room on a tray table. The first areas Staff C did were the left heel and right ankle where she painted betadine on the areas and let them dry. Staff C did the right hip next. Staff C cleansed the side with wound wash and gauze. The old dressing was already off due to a shower. The wound wash was in a bottle, and throughout the cleaning process of the hip wound, Staff C sprayed gauze with the wound wash, wiped the wound, and then threw away the gauze. With the same gloved hand that just cleaned the wound, Staff C pulled out gauze from the bulk package of gauze, sprayed wound wash on the gauze, and continued to clean the area. Staff C repeated this process 3 times. Staff C set the bottle of wound wash on the bed without a barrier with each gauze cleaning. Staff C then took gauze out and took the Dakin's solution (wound care solution), opened the bottle, and poured it on the gauze, all with the same gloves she used to cleanse the wound. Staff C took the gauze and applied it to the wound bed. She repeated the process again with the Dakin's solution. Staff C then took the ABD pad (highly absorbent dressing) and put it over the wound area and secured it with tape. Staff C removed her gloves, performed hand hygiene, and applied new gloves. At 1:12 PM, when Staff C went to start the wound on the coccyx (tailbone), Resident #15 had a bowel movement. Staff D began cleaning him using the same wipe multiple times and didn't always wipe from front to back. Staff D handed Staff C a pillow which Staff C touched with the same gloves she just cleaned Resident #15 with. Resident #15's catheter fell to the floor, which wasn't in a protective bag, and Staff C then picked up the catheter and placed it on the clean bedding on the bed that they just changed due to feces on other sheets. Once they cleaned Resident #15 on that side, they rolled him back to his left side, laying him on the clean sheets with dried feces noted on the bandage to the left hip to pull the clean sheets through, which Staff C applied with the same gloves she used to clean Resident #15 with. Staff C and Staff D removed their gloves, performed hand hygiene, and applied new gloves. Staff C removed the dressing to the left hip area, removed her gloves, and then performed hand hygiene. Staff C applied new gloves and took gauze from the bulk pack, then sprayed it with wound cleaner, placed the bottle on the bedding, and then cleansed the wound. Staff C repeated this process 3 times while wearing the same gloves and touching the wound cleaner bottle and bulk gauze, and cleansing the wound with the same gloved hands. Staff C removed her gloves and applied new gloves. Staff C then took gauze out of the bulk package, applied Dakin's solution, and put it on the wound bed. She grabbed another gauze out and repeated the same process. She took an ABD pad, covered the wound, and secured it with tape. She then removed her gloves. At 1:40 PM, Staff C applied new gloves, removed the dressing (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from the sacral (lower spine) area, and removed her gloves. Staff C applied new gloves, took gauze from the bulk package, sprayed it with wound cleaner from the bottle, and set the bottle on the bed. She then washed the wound bed. Staff C repeated this process 3 times with the same gloves and touched the bulk package with her gloved hands each time. Staff C removed her gloves, performed hand hygiene, and applied new gloves. She then took gauze from a bulk package, applied Dakin's solution to the gauze, and applied it to the wound bed. Staff C repeated this process 3 times. She applied an ABD pad and secured it with tape. At 1:55 PM, Staff C removed the dressing to the right scapular (shoulder blade) area and then removed her gloves. Staff C applied new gloves, took gauze from the bulk package, sprayed it with wound cleaner from the bottle, and set the bottle on the bed without a barrier. She then washed the wound bed. Staff C repeated this process 3 times with the same gloves and touched the bulk package with her gloved hands each time. Staff C then took gauze from a bulk package, applied Dakin's solution to the gauze, and applied it to the wound bed. Staff C repeated this process 2 times. She applied an ABD pad and secured it with tape.On 5/12/26 at 2:20 PM, an interview with the Assistant Director of Nursing (ADON) who was in the room during the dressing changes revealed she acknowledged the concerns with staff not always performing hand hygiene between glove changes, touching the supplies with dirty gloves, not always changing gloves between the clean and dirty processes, and using a wipe multiple times for incontinence care. The ADON reported staff should've used the wipe just once and wiped front to back.2. Resident #24's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included a diagnosis of a stage 4 pressure ulcer, which means full-thickness tissue loss with exposed muscle, fascia (connective tissue), tendon, or bone.On 5/13/26 at 2:45 PM, an observation showed Staff G, Agency Licensed Practical Nurse (LPN), performed wound treatments on Resident #24. Staff G donned a gown and gloves. Staff G had her supplies on a bedside table. Staff G pulled bandage scissors out of her scrub pocket and set them on the barrier on the bedside table. Staff G didn't clean the scissors prior to using them. Staff G removed the bandage to the right foot and removed her gloves. Staff G applied new gloves she pulled out from a bulk package, took some gauze, and dampened it with wound cleanser. Staff G used the dampened gauze to cleanse the wound bed. Staff G removed her gloves and applied new gloves. Staff G then took more gauze from the package, dampened it with Vashe (wound cleansing solution), and applied it to the wound bed. Staff G wrapped the foot with gauze wrap and secured it with tape. Staff G removed her gloves and applied new gloves. Staff G then removed the upper dressing on the right upper hip, removed her gloves, and applied new gloves. Staff G pulled some gauze out from a bulk package and dampened it with Vashe. She used the dampened gauze to cleanse the wound bed. She removed her gloves and applied new gloves. Staff G applied Calmoseptine (moisture barrier ointment) to the skin around the wound using a cotton swab. Staff G then took more gauze from the package, dampened it with Dakin's solution, and applied it to the wound bed. Staff G covered it with an ABD pad and secured it with tape. Staff G performed the same process with the buttock wound. At 3:12 PM, Staff G then moved to the right upper thigh wound vac treatment. Staff G applied new gloves, removed the old wound dressing, and removed her gloves. Staff G applied new gloves, pulled gauze out of the bulk package, dampened it with Dakin's solution, and cleansed the wound bed. Staff G grabbed more gauze and patted it dry. Staff G then removed her gloves and applied new gloves. Staff G picked up the scissors and cut the black foam to size for the wound. Staff G placed the foam in the wound bed, covered it with a single-lumen suction bell (a cup-shaped device with tubing used to connect to the wound vac), and secured it with an adhesive drape, which is a clear film dressing. She then connected the tubing to the wound vac and turned the machine on. Throughout the process, Staff G didn't perform any hand hygiene between glove changes, and didn't clean the scissors prior to use.On 5/13/26 at 3:22 PM, an interview with the ADON revealed Staff G should've performed hand hygiene with each glove change and should've cleaned the scissors prior to using them.3. Resident #4's Minimum Data Set (MDS) assessment dated [DATE] identified a BIMS score of 15, indicating (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	intact cognition. The MDS documented he's dependent for toileting. The MDS included a diagnosis of respiratory failure and dependent on a respirator (ventilator) status.On 5/14/26 at 10:42 AM, an observation showed Staff F, CNA, and Staff E, CNA, checked and changed Resident #4. Staff F wore a gown and gloves. Staff E wore a gloves and a gown but didn't have his arms in the armholes and only wore it around his neck. Staff E set up supplies with a barrier underneath. Staff E used the wipe only once and wiped from front to back. Staff E changed his gloves from dirty to clean and performed hand hygiene between. Once Resident #4 was clean, Staff E removed the gown and gloves and washed his hands.On 5/14/26 at 10:56 AM, an interview with Staff E acknowledged he forgot to put his arms in the gown so he didn't wear it correctly.The Hand Hygiene policy revised October 2023 directed staff to perform hand hygiene using an alcohol-based hand rub before and after doing a dressing change and with glove changes during dressing changes.The Enhanced Barrier Precautions policy revised March 2024 directed staff to use enhanced barrier precautions in conjunction with standard precautions for residents with medical devices such as a ventilator.