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	06/30/2026

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and policy review the facility failed to ensure 1 of 3 resident received necessary care and services in accordance with professional standards of practice, her comprehensive assessment, and her plan of care (Resident #1). Specifically, staff failed to administer ordered respiratory treatments by omitting or allowing the refusal of tracheostomy (breathing tube) cares on six occasions in May 2026, and failed to provide ordered nutrition by failing to administer her full tube feeding regimen on 13 separate days in May 2026. The facility reported a census of 51 residents. Findings include:Resident #1's Minimum Data Set (MDS) assessment dated [DATE] documented that Resident #1 entered the facility on 1/4/26. The MDS assessment documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #1 depended on staff for toileting and bathing, didn't get out of bed, and required supervision and physical assistance with rolling in bed. Resident #1 had diagnoses of diabetes, malnutrition (poor nutrition), depression, psychotic disorder (mental illness), anxiety, respiratory failure (lung failure), dependence on a respirator (ventilator) status, tracheostomy (breathing tube), and myotonic muscular dystrophy (genetic muscle wasting). The May 2026 Treatment Administration Record (TAR) showed that tracheostomy cares required completion twice daily in the morning and evening and as needed. Resident #1 refused care on 5/7/26 at AM, 5/11/26 at AM, 5/17/26 at PM, and 5/25/26 at AM. Staff omitted documentation regarding whether completion occurred on 5/27/26 at AM and 5/30/26 at AM. The May 2026 Medication Administration Record (MAR) documented an order for scheduled feedings four times a day. The Electronic Health Record (EHR) showed an order to offer feedings five times a day at AM, AM, Lunch, mid-afternoon (MA), and bedtime (HS) starting on 4/16/26. For the month of May 2026, Resident #1 didn't receive the order as scheduled, and documentation showed refusals. Resident #1 received only three feedings on 5/1/26, 5/2/26, 5/4/26, 5/5/26, 5/7/26, 5/11/26, 5/14/26, 5/18/26, 5/22/26, 5/24/26, 5/30/26, and 5/31/26, and received only two feedings on 5/8/26. The Progress Notes for Resident #1 showed a lack of documentation regarding alternative feeding options for May 2026. The Progress Notes only contained the notes listed below, with nothing recorded for the other dates staff missed feedings. The Nutrition and Dietary Note dated 5/13/26 at 7:32 PM indicated the current tube feeding regimen might not adequately meet estimated nutrition needs due to frequent refusals of feedings. Significant weight loss and pressure areas remained concerns. The note recommended continued encouragement and education regarding the importance of nutrition for weight maintenance and wound healing. The note recommended nursing documentation of tube feeding acceptance percentages and intake trends. The note also suggested a review of the feeding schedule and method for improved tolerance and acceptance, and directed staff to monitor weights, skin integrity, hydration status, and overall nutritional status closely. The note recommended Zinc and concentrated liquid medical foods and protein supplements 30 milliliters (ml) twice daily via tube for increased protein. The Nutrition and Dietary Note dated 5/18/26 at 10:27 AM indicated Resident #1's weight increased three pounds over the past week to 118.6 pounds, which staff intended and viewed as favorable. Resident #1 remained nothing by mouth (NPO) with all nutrition (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided via enteral (tube) feeding of Jevity 1.5 at 240 ml bolus four times daily with a 50 ml water flush before and after each feeding. The current feeding regimen continued to meet estimated nutritional needs when fully administered. Resident #1 continued to refuse feedings at times, which might impact the consistency of nutrient delivery. The note instructed staff to encourage acceptance of feedings and monitor weights, tolerance, hydration status, and skin integrity, and referred to the recommendations dated 5/13/26 regarding additional supplementation to support skin integrity. The Orders and Administration Note dated 5/18/26 at 4:57 PM documented that staff held an enteral feed order due to a stomach residual of 100 ml. The Orders and General Note from eRecord dated 5/18/26 at 9:19 PM documented that staff held the mid-afternoon feeding due to a residual of 100 ml. Resident #1 reported feeling full. Resident #1's residual at 8:00 PM totaled 40 ml, so staff administered the feeding and medications. Staff elevated the head of the bed, and family remained at the bedside. Resident #1 denied any complaints or needs. The Orders and Administration Note dated 5/24/26 at 7:15 AM documented an enteral feed order four times a day related to gastrostomy (surgical stomach opening) status for Jevity 1.5 240 ml bolus four times per day, with a 50 ml water flush before and after. Resident #1 stated, Later, and refused the feeding. The Orders and Administration Note dated 5/26/26 at 8:34 PM documented that Resident #1 refused her last feeding. Her husband remained at the bedside and knew about the refusal. On 6/22/26 at 1:20 PM Resident #1 Representative/Power of Attorney (POA) stated staff didn't complete scheduled tracheostomy cares twice a day as required. Resident #1 Representative/POA stated Resident #1 didn't like to wake up early and'd consistently accept all feedings, but staff scheduled them differently than how her day went. Resident #1 Representative/POA further stated that after a care conference, the facility then worked to change her schedule of feedings to start later at 10:30 AM to allow her to sleep in. On 6/23/26 at 7:00 PM Resident #1 and Resident #1 Representative/POA stated Resident #1 didn't receive her 2:30 PM feeding until 5:00 PM because a new nurse didn't arrive at the scheduled time. They denied any complaints at this time, and noted some good nurses worked at the facility, including traveling staff. On 6/25/26 at 11:40 AM Staff I, Certified Nursing Assistant (CNA), stated she cared for Resident #1 and described her as a sweet lady. Staff I stated she didn't know of any late feedings for Resident #1 because she didn't handle that task, but she hoped they didn't occur. On 6/25/26 at 12:04 PM Staff J, CNA, stated Resident #1 refused a lot of interventions, and staff had to encourage her to get changed. Staff J stated Resident #1 refused her tube feedings frequently. On 6/25/26 at 1:21 PM Staff K, Respiratory Therapist (RT), stated Resident #1 only wanted her tracheostomy inner cannula (inner tube) changed once a day and never accepted albuterol (breathing medication) treatments. Staff K stated Resident #1 had thick, yellow secretions and required suctioning of her mouth and tracheostomy 5 to 10 times a day. Staff K stated she always offered and reattempted the treatments, but Resident #1 declined. Staff K noted the open times to change the inner cannula occurred between 6:00 AM to 2:00 PM and 2:00 PM to 10:00 PM rather than a specific time, and she usually performed it around 2:00 PM. On 6/29/26 at 11:10 AM Staff M, RT, stated Resident #1 had orders to receive tracheostomy cares twice a day, but Resident #1 told her that the agency RT didn't even come in once to perform them. On 6/29/26 at 1:36 PM Staff O, Nurse Practitioner (NP), stated Resident #1 refused almost 50 percent of her feedings and had a diagnosis of failure to thrive (progressive decline in vitality). Staff O stated Resident #1 refused at least one if not two feedings daily, didn't want hospice care, and didn't support her own nutritional needs. Staff O expressed concern regarding staff not cleaning Resident #1's tracheostomy twice a day, stating that it definitely should be done along with monitoring her settings and keeping a close eye on her. The Enteral Tubes: Intermittent/Continuous (Pump) Feedings policy dated June 2024 instructed staff on feeding protocols but lacked instructions regarding resident choice, accommodation of preferences, and the management of dietary refusals. Specifically, the policy failed to direct staff on the necessary protocols to follow when a resident declines a feeding, requests an alternative schedule to match personal routines, or reports clinical intolerance such as feeling full. It omitted requirements for staff to offer alternative feeding options, (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provide nutritional substitutes, or notify the physician and dietitian when consistent refusals impact a resident's nutritional status.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, family, and staff interviews, the facility failed to provide consistent showers to 1 of 3 residents reviewed (Resident #2). The facility reported a census of 51 residents. Findings include:Resident #2's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 99, indicating Resident #2 couldn't complete the interview. Staff noted Resident #2 experienced severe impairment with decisions regarding tasks of daily life and had short-term and long-term memory problems. The MDS assessment revealed Resident #2 had upper extremity (arm) and lower extremity (leg) impairment to both sides and used a wheelchair. The MDS assessment revealed Resident #2 depended on staff for toileting, dressing, bathing, transfers, and rolling in bed, and didn't walk or stand. Resident #2 had diagnoses of traumatic brain injury (TBI; brain damage from an external force), anxiety, depression, contracture (permanent muscle tightening), and dysphagia (swallowing difficulty) following a cerebral infarction (stroke). Resident #2 didn't complete a restorative nursing program in the previous 7 days. The Care Plan Focus revised 10/28/24 indicated Resident #2 required assistance with Activities of Daily Living (ADLs) related to TBI and limited mobility. The interventions directed that Resident #2 required total assistance from 1 to 2 staff members to complete baths. Review of Resident #2's March 2026 Documentation Survey Report Version 2 lacked documentation to indicate he received a shower on 3/5/26, 3/6/26, 3/10/26, 3/12/26, 3/13/26, 3/17/26, and 3/28/26. Resident #2's April 2026 Documentation Survey Report Version 2 lacked documentation to indicate he received a shower on 4/25/26. Resident #2's May 2026 Documentation Survey Report Version 2 lacked documentation to indicate he received a shower on 5/3/26 and 5/23/26, and staff documented no on 5/24/26. On 6/22/26 at 2:18 PM, Resident #2 Representative stated during a facility visit on 6/1/26, Resident #2 appeared absolutely filthy. Resident #2 Representative stated Resident #2 had an order for a medicated shampoo for dandruff but possessed approximately an inch of thick white buildup over the back of Resident #2's head and in Resident #2's beard, noting this hadn't happened for the first time. Resident #2 Representative stated she walked up and down the halls to find a staff member, and a Certified Nursing Assistant (CNA) stated she'd locate the Head Nurse. When asked to check the last recorded bath, this nurse didn't know how to look in the chart because CNAs tracked the baths. Resident #2 Representative located a different nurse who believed Resident #2 received a shower the previous day, but Resident #2 Representative disputed this due to a severe odor and had staff smell Resident #2. The nurses agreed Resident #2 smelled poorly. On 6/22/26 at 4:38 PM, the Director of Nursing (DON) stated staff completed all scheduled showers. DON informed that management tried to assign a designated shower assistant, but if that became impossible, the staff remained responsible for their own showers on their assigned hallways. On 6/25/26 at 11:40 AM, Staff I, a CNA, stated Resident #2 can be rough to get up in the morning. Staff I stated the ordered medicated shampoo isn't always available, which requires staff to order it. Staff I stated Resident #2 received a shower today, but staff couldn't locate the medicated shampoo, so she used Head and Shoulders shampoo and scrubbed Resident #2's scalp thoroughly instead. Staff I stated that when she began working at the facility at the end of May 2026, Resident #2 possessed a significant amount of white dandruff and a red, itchy area on the right side of Resident #2's scalp. Staff I noted Resident #2 becomes stiff frequently and develops what she thinks are yeast infections, which required a medical topical powder that she applied to Resident #2's hands. Staff I noted that sometimes when the weather became very hot, staff placed a washcloth in Resident #2's hand, but they didn't do this every day. Staff I stated she previously applied baby powder, but staff informed her today about the medical topical powder when she asked for the shampoo. On 6/29/26 at 2:17 PM, Resident #2's family member stated Resident #2 didn't receive proper cleaning and routinely had food on Resident #2's face. The Hygiene - Bathing / Shower policy dated March 2024 instructed that the purpose includes cleaning the skin, promoting cleanliness, and preventing infection.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents with contractures (shortened muscles) received necessary restorative nursing care to maintain or improve functional potential. Specifically, management canceled passive range of motion (PROM), active range of motion (AROM), and walking programs for Resident #2, Resident #6, Resident #7, Resident #8, and Resident #10 without documenting a clinical rationale in the progress notes. The facility lacked trained or dedicated staff to deliver restorative care interventions. The facility reported a census of 51 residents.Findings include:Review of an undated list titled Contractures identified eight residents currently living in the facility with contractures (shortened muscles). The list included Resident #2, Resident #5, Resident #6, Resident #7, Resident #8, and Resident #10. 1. Resident #2's Minimum Data Set (MDS) assessment dated [DATE] listed Resident #2 sometimes understood others and sometimes could make others understand them. The MDS assessment showed a Brief Interview for Mental Status (BIMS) score of 99, indicating the interview couldn't be completed. The Staff Assessment for Mental Status listed Resident #2 possessed short- and long-term memory problems, with severely impaired cognitive skills for daily decision making. Resident #2 exhibited a functional limitation in range of motion impairments to both sides of the body on the upper and lower extremities. Resident #2 required total assistance from staff with personal hygiene. Diagnoses included contracture (permanent muscle tightening) of the right elbow, unspecified lack of coordination, hemiplegia (one-sided paralysis) or hemiparesis (one-sided weakness), and other dystonia (involuntary muscle contractions). Resident #2 received Occupational Therapy (OT) and Physical Therapy (PT) for 15 minutes a day on one or more days in the last 7 days. The Restorative Nursing Programs section indicated Resident #2 didn't receive restorative care for at least 15 minutes in the look-back period. The Care Plan Focus revised 6/22/26 indicated Resident #2 carried a risk for alteration in skin integrity (skin breakdown) due to contractures and limited physical mobility. The interventions directed the following: monitor skin to bilateral upper extremities (both arms) before applying resting hand splints (supportive hand braces); use prevention/positioning devices as needed; utilize a rolled-up washcloth in palms of hands until new splints arrive; and utilize a rolled-up washcloth between the right shoulder and neck. On 6/22/26 at 2:18 PM Resident #2 Representative stated Resident #2 previously lived at a different facility and could feed himself, but he no longer maintained that ability because his muscles completely contracted. The Encounter Note dated 3/10/26 at 12:00 AM reflected Resident #2 received PT and OT for 7 days under a restoration care plan. The Encounter Note dated 3/17/26 at 12:00 AM identified Resident #2 had contractures that kept his neck and arm tight to his body with contractures at the elbow and wrist. The staff reported he had redness and moisture in those areas, specifically the right neck, right antecubital fossa (inner elbow crease), and right axilla (armpit). Resident #2 experienced chronic issues with drooling and excessive sweating. The note indicated staff discussed no specific changes or interventions. The Communication - with Physician dated 3/17/26 at 10:03 AM documented the Primary Care Provider (PCP) gave new orders to apply Calmoseptine (healing ointment) to the right neck and axilla twice a day until resolved, then use Vaseline (petroleum jelly) to areas of moisture to protect the skin. Resident #2's Task Description listed a task to apply rolled wash towels for grip while in the wheelchair and remove them while in bed. The task required staff to replace the towels daily or sooner if soiled. The description instructed staff to apply a cervical cushion (neck pillow) or towel roll on the right side of the neck in the morning, remove it at lunch, reapply it at 2:30 PM, and remove it at dinner. The Task Description listed the following tasks as resolved:Neck pillowRestorative Active Assistive Range of Motion (AAROM): aquatics program twice a week5/8/26: Restorative Passive Range of Motion (PROM): cervical, upper extremities, and lower extremitiesUpper extremity splints Resident #2's March 2026 Documentation (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Survey Report v2 listed the following interventions and tasks: restorative PROM: cervical, upper extremities, and lower extremities. Documentation indicated Resident #2 refused restorative care on 3/18/26. The location for documentation remained blank for the following dates: 5/4/26, 5/11/26, 5/23/26, and 5/30/26. For the splint or brace (upper extremities, neck) task, the documentation lacked entries for the following times and dates:8:00 AM: 3/1/26, 3/5/26, 3/26/26, 3/11/26 - 3/13/26, 3/17/26, 3/20/26, 3/22/26, 3/24/26, 3/26/26, 3/29/26, and 3/31/2612:00 PM: 3/1/26, 3/5/26, 3/26/26, 3/10/26 - 3/13/26, 3/17/26, 3/20/26, 3/22/26 - 3/24/26, 3/26/26, and 3/31/262:30 PM: 3/6/26, 3/9/26, 3/10/26, and 3/28/266:00 PM: 3/6/26, 3/9/26, 3/10/26, and 3/28/26 Resident #2's May 2026 Documentation Survey Report v2 listed the following interventions and tasks: restorative PROM: cervical, upper extremities, and lower extremities. The location for documentation included x's indicating the tasks did not fall due for the month except on 5/4/26 and 5/6/26. On 5/4/26, the documentation reflected Resident #2 refused to do restorative care, and 5/6/26 remained blank. For the splint or brace (upper extremities, neck) task, the documentation lacked entries for the following times and dates:8:00 AM: 5/6/26 and 5/25/2612:00 PM: 5/6/26 and 5/25/262:30 PM: 5/3/26, 5/4/26, and 5/23/266:00 PM: 5/3/26, 5/4/26, and 5/23/26 Resident #2's June 2026 Documentation Survey Report v2 printed 6/29/26 listed the following interventions and tasks: apply rolled wash towels for grip while in the wheelchair; remove the towel while in bed; replace daily or sooner if soiled; and apply a cervical cushion or towel roll on the right side of the neck in the morning, remove at lunch, reapply it at 2:30 PM, and remove at dinner. The location for documentation remained blank on the following times and dates:2:30 PM: 6/2/26, 6/9/26, and 6/24/268:00 PM: 6/2/26, 6/9/26, 6/16/26, 6/24/26, and 6/27/26 Resident #2's June 2026 Treatment Administration Record (TAR) listed the following orders:6/6/26: Apply bilateral resting hand splints while up in the wheelchair every day and evening shift. The facility discontinued the order on 6/22/26. The record lacked documentation on 6/19/26 for the 6:00 AM - 2:00 PM shift and 6/20/26 for the 2:00 PM - 10:00 PM shift.6/6/26: Remove bilateral resting hand splints while in bed (wipe off splints and hands after removing) every day and evening shift. The facility discontinued the order on 6/22/26. The record lacked documentation on 6/19/26 for the 6:00 AM - 2:00 PM shift and 6/20/26 for the 2:00 PM - 10:00 PM shift.6/23/26: Apply rolled up washcloth into bilateral palms when out of bed (cleanse hands and inspect prior to application) every day and evening shifts for contractures. The record lacked documentation on 6/27/26 for the 6:00 AM - 2:00 PM shift.6/23/26: Apply rolled up washcloth between the right shoulder and neck when out of bed (cleanse neck and inspect prior to application) every day and evening shifts for contractures. The record lacked documentation on 6/27/26 for the 6:00 AM - 2:00 PM shift.6/23/26: Remove rolled up washcloth into bilateral palms when out of bed (inspect palms after removing) every day and evening shifts for contractures. The record lacked documentation on 6/27/26 for the 6:00 AM - 2:00 PM shift.6/23/26: Apply rolled up washcloth between the right shoulder and neck when out of bed (inspect neck after removing) every day and evening shifts for contractures. The record lacked documentation on 6/27/26 for the 6:00 AM - 2:00 PM shift. The Orders - Administration Note dated 6/4/26 at 1:43 PM reflected Resident #2 received an order for betadine swabs to the small open area midline right collarbone area until resolved for skin healing for 5 days. The Encounter Note dated 6/5/26 at 12:00 AM identified the provider saw Resident #2 due to a new area of skin breakdown on the right clavicle (collarbone)/right neck. The provider considered the area pressure-related and described it as resembling moisture-associated skin damage (MASD) (moisture skin damage). The section for skin/breast reflected MASD and a stage 2 pressure ulcer. The section related to skin listed a stage 2 pressure injury over the right clavicle/right neck region measuring 2 centimeters (cm) x 2 cm. The wound bed appeared pink and dry, consistent with MASD. The General Progress Note dated 6/5/26 at 11:42 AM indicated the PCP gave new orders to clean Resident #2's wound on the right side of his neck, apply Xeroform dressing (medicated gauze) to the wound, cover it with 2x2 gauze and tape, and place an ABD pad (absorbent pad) to keep it dry every day until healed. The General Progress Note dated (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/9/26 at 2:40 PM reflected the Administrator (facility manager) notified the Dietitian (nutrition manager) of the pressure ulcer to Resident #2's right clavicle. The Dietitian planned to review Resident #2's information for recommendations. The General Progress Note dated 6/11/26 at 1:15 PM described Resident #2's wound on his neck as healing well. The wound measured 1.75 x 1.75, and staff noted scant serous drainage (clear fluid) on the dressing. The General Progress Note dated 6/15/26 at 8:50 PM indicated the Administrator talked to the doctor and Nurse Practitioner (NP). The doctor reported neither provider believed his wound related to pressure, but rather resulted from moisture from sweat and drooling. The providers classified the area as MASD at the time. The Encounter Note dated 6/16/26 at 12:00 AM listed Resident #2 possessed an area that the provider described as a stage 2 pressure ulcer. The provider described the area as very moist and associated the moisture with Resident #2 keeping his head tilted toward the area. The order for Calmoseptine and Mepilex (foam dressing) kept the area too moist. Resident #2 had contractures to his right wrist and right ankle. The section related to skin listed an open, very moist pressure ulcer (stage 2) over the right clavicle/right neck region. The plan listed a referral to dermatology (skin specialty) per his mother's request to the facility for neck redness. The Order Note dated 6/17/26 at 3:38 AM indicated the NP gave an order to discontinue Calmoseptine to the neck area, apply xeroform to the right clavicle area twice a day, and cover it with a 2x2 gauze and tape. The order directed staff not to use Mepilex because it kept the area too moist. On 6/24/26 at 1:56 PM Staff D, an Agency Licensed Practical Nurse (LPN), stated Resident #2 has never spoken to her. She stated he previously had a skin issue on the right side of his neck, but the condition improved. On 6/25/26 at 11:40 AM Staff I, a Certified Nursing Assistant (CNA), stated Resident #2 becomes stiff frequently and develops yeast infections she thinks, which required a medical topical powder that she applied to his hands. She noted that sometimes when the weather became very hot, staff placed a washcloth in his hand, but they didn't do this every day. She stated she previously applied baby powder, but staff informed her today about the medical topical powder when she asked for the shampoo. She stated she doesn't believe a consistent restorative nursing program exists for Resident #2, but believes Resident #2 would benefit from one. On 6/25/26 at 12:04 PM Staff J stated Resident #2 is stiff when he gets up in the morning, and his morning routine includes a brace on his right arm and a collar on his neck. She stated she has observed staff perform range of motion exercises with Resident #2 only once while shaving him, and she has never completed any range of motion programs with him. On 6/29/26 at 11:48 AM Staff L, a Certified Occupational Therapy Assistant (COTA), stated that she is currently working with him in therapy. She revealed if staff do not apply braces routinely, a resident's contractures can worsen or remain unchanged. She stated he recently got a new brace and that even when she removes Resident #2's braces now, his hands return immediately to a contracted position due to his brain injury. Staff L stated Resident #2's fingers are severely contracted, and when she attempts to apply the braces, he signals that his wrist hurts by blinking his eyes. She stated therapy ordered resting hand splints made of soft plastic, but because they lacked adaptability, staff used rolled washcloths to absorb sweat. She noted she recently ordered a different pair with adaptable metal braces that can be adjusted. Staff L stated Resident #2's muscles pull down severely, and his neck requires a rolled towel to stay contracted as it is, rather than trying to stretch it. She stated she does passive range of motion exercises with him. Staff L completed an Occupational Therapy Discharge Summary for services from 9/19/25 to 12/4/25. Staff L revealed she didn't recommend passive or active range of motion programs because the facility lacked staff to perform them, though she believed Resident #2 would benefit from one. Staff L stated she didn't believe the facility had a restorative program since July 2025. She noted staff just started washing clothes last week and it could've resulted from a miscommunication since she didn't see staff use them prior. On 6/29/26 at 12:57 PM Staff N stated a restorative program would work well for Resident #2, noting she ordered therapy for multiple residents and Resident #2's Representative becomes upset because he doesn't receive a restorative program. On 6/29/26 at 2:17 PM Resident #2's family member stated the family (continued on next page)

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	brought Resident #2 to the facility specifically for water therapy because it contained a pool, but he no longer gets into the water. She stated she visited every week and felt the staff didn't know how to care for him, noting they didn't place anything in his hands to keep them open or perform exercises to make him stronger. Resident #2's family member stated his speaking ability has declined significantly, though he can say yes, no, good night, I love you, goodbye, and thank you. She noted he raised his arm to signal yes and frowned without moving his arm to signal no. She stated the facility lacked the necessary help to assist him into the pool, causing him to decline physically, and expressed that only a handful of staff members truly care. On 6/29/26 at 3:11 PM the Administrator stated she worked at the facility for 4 weeks. Regarding Resident #2's discontinued aquatic pool program, she stated she is looking into obtaining a lifeguard and setting up a training course to restart the program. Regarding Resident #2's restorative program, the Administrator stated she is unsure if management will hire someone for the role or train CNAs, noting they need to review all residents to determine who requires a program. She noted an individual informed her on 6/23/26 at 2:48 PM that the restorative program discontinued for Resident #2 because he saw therapy starting in May, and the aquatics program discontinued for everyone as they currently don't have a lifeguard to run the program. 2. Resident #5's Minimum Data Set (MDS) dated [DATE] documented an admission date of 12/10/24. Resident #5 experienced short-term and long-term memory problems alongside severely impaired cognitive daily decision-making skills. Resident #5 possessed functional limitations in range of motion (ROM; joint movement) on both sides of the upper and lower extremities. Resident #5 depended on staff for all activities of daily living (ADL; everyday tasks) and couldn't stand or walk. Resident #5 required a feeding tube, a tracheostomy (breathing tube), and an invasive mechanical ventilator (breathing machine). Resident #5 didn't complete a restorative program for at least 15 minutes a day over the past seven days. Review of Resident #5's Diagnosis Report dated 6/30/26 revealed current diagnoses with an onset date of 12/10/24, which included spastic quadriplegic cerebral palsy (stiff limbs), dependence on a respirator (ventilator), and spina bifida (spine defect). Review of Resident #5's tasks in the Electronic Health Record (EHR) on 6/30/26 revealed Resident #5 didn't have a restorative program in place and hadn't since admission to the facility. 3. Resident #6's Minimum Data Set (MDS) dated [DATE] revealed an admission date of 3/13/25. Resident #6 had short-term and long-term memory problems and severely impaired cognitive daily decision-making skills. Resident #6 experienced functional limitations in ROM on both sides of the upper and lower extremities. Resident #6 depended on staff for all ADLs and couldn't stand or walk. Resident #6 required a feeding tube, a tracheostomy, and an invasive mechanical ventilator. Resident #6 didn't complete a restorative program for at least 15 minutes a day over the past seven days. Review of Resident #6's Diagnosis Report dated 6/30/26 revealed current diagnoses with an onset date of 3/13/25, including spastic quadriplegic cerebral palsy and dependence on a respirator. Review of Resident #6's tasks in the EHR on 6/30/26 revealed Resident #6 didn't have a restorative program in place at this time. Review of Resident #6's task history revealed a passive range of motion (PROM; assisted movement) program to both upper extremities that management canceled on 5/12/26. Review of Resident #6's progress notes for May 2026 lacked documentation explaining the rationale for why the facility canceled the restorative program. 4. Resident #7's Minimum Data Set (MDS) dated [DATE] documented an admission date of 1/29/25. The MDS revealed a BIMS score of 12, indicating moderately impaired cognition. Resident #7 had limited upper and lower functional extremity ROM on one side. Resident #7 required substantial to maximal assistance with transfers and standing, couldn't walk, but moved in a wheelchair independently. Resident #7 didn't complete a restorative program for at least 15 minutes a day over the past seven days. Review of Resident #7's admission Record dated 6/30/26 revealed diagnoses of spastic quadriplegic cerebral palsy, mild intellectual disabilities, hemiplegia (one-sided paralysis) affecting the left nondominant side, and a contracture (shortened muscle) of the left shoulder. Review of Resident #7's tasks in the EHR on 6/30/26 revealed Resident #7 didn't have a restorative program in place at this time. Review of Resident #7's (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	task history revealed a walking restorative program as tolerated and an active range of motion (AROM; unassisted movement) program for grip strength for 15 minutes a day as tolerated that management canceled on 5/8/26. Review of Resident #7's progress notes for May 2026 lacked documentation explaining the rationale for why the facility canceled the restorative program. 5. Resident #8's Minimum Data Set (MDS) dated [DATE] documented an admission date of 5/26/15. Resident #8 had short-term and long-term memory problems and severely impaired cognitive daily decision-making skills. Resident #8 experienced functional limitations in ROM on both sides of the upper and lower extremities. Resident #8 depended on staff for all ADLs and couldn't stand or walk. Resident #8 required a feeding tube and a tracheostomy. Resident #8 didn't complete a restorative program for at least 15 minutes a day over the past seven days. Review of Resident #8's Diagnosis Report dated 6/30/26 revealed a current diagnosis with an onset date of 7/22/25 for a contracture of another specified joint. Review of Resident #8's tasks in the EHR on 6/30/26 revealed Resident #8 didn't have a restorative program in place at this time. Review of Resident #8's task history revealed a PROM restorative program for the upper and lower extremities scheduled twice a week that management canceled on 5/13/26. Review of Resident #8's progress notes for May 2026 lacked documentation explaining the rationale for why the facility canceled the restorative program. 6. Resident #10's Minimum Data Set (MDS) dated [DATE] documented an admission date of 2/6/18. The MDS revealed a BIMS score of 15, indicating intact cognition. Resident #10 had functional limitations in ROM in both lower extremities. Resident #10 depended on staff for all ADLs except upper body dressing and couldn't walk. Resident #10 didn't complete a restorative program for at least 15 minutes a day over the past seven days. Review of Resident #10's Diagnosis Report dated 6/30/26 revealed current diagnoses with an onset date of 2/6/18, including an intracranial injury (brain injury) with loss of consciousness of unspecified duration, chronic pain due to trauma, spastic diplegic cerebral palsy (paralytic stiffness), and quadriplegia (four-limb paralysis). Review of Resident #10's task history revealed an assisted AROM aquatic program that management canceled on 8/11/25 and a PROM restorative program scheduled twice a week that management canceled on 5/19/26. Review of Resident #10's progress notes for August 2025 and May 2026 lacked documentation explaining the rationale for why the facility canceled the restorative programs. On 6/23/26 at 2:48 PM the Administrator stated the facility discontinued the aquatics program for everyone because they currently didn't have a lifeguard to run the program. On 6/24/16 at 1:39 PM Staff B, Certified Nursing Assistant (CNA), stated CNAs didn't have time to do restorative care and didn't do any ROM. Staff B noted the facility used to have a restorative program where she performed ROM, walking, and the bicycle. Staff B stated when the outside management company took over, they stopped the restorative program, and now only a contracted therapy company performed it. Staff B indicated management knew about the issue and blamed the new company. On 6/24/16 at 1:44 PM Staff C, CNA, stated she gave Resident #4 showers and performed stretches with Resident #4 in the morning, but she didn't do anything restorative for other residents. On 6/24/16 at 2:14 PM Staff F, Human Resources (HR) Coordinator, stated he'd never heard of a restorative aide or staff, and he didn't staff an aide for that role. Staff F noted he'd worked at the facility for six months. On 6/25/16 at 11:40 AM Staff I, CNA, stated she didn't know if anyone performed a restorative program. Staff I didn't think they maintained a consistent, routine restorative program. Staff I noted Resident #2's roommates walked to the dining room, and another resident had a walking program but refused it. Staff I stated Resident #4 asked for ROM, but she couldn't think of any other restorative programs. On 6/25/16 at 12:04 PM Staff J, CNA, stated she saw Physical Therapy (PT) and Occupational Therapy (OT) staff working with residents, but she only witnessed staff performing restorative care with Resident #4 because Resident #4 requested it. On 6/29/16 at 11:48 AM Staff L, Certified Occupational Therapy Assistant (COTA), stated the facility didn't use the pool because they lacked a lifeguard on duty. Staff L noted the facility maintained a restorative care program in the past, but not currently. Staff L revealed she worked for a contracted therapy company rather than the facility, and she had to add a (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	few residents on Medicaid to her caseload. Staff L believed a restorative program would've prevented those residents from needing therapy again. Staff L stated all long-term residents at the facility would benefit from a restorative program, and the process grew harder as they aged. Staff L indicated restorative care would help every resident. Staff L explained that if a resident had a clinically diagnosed contracture, they'd likely develop another one, so a restorative program could potentially prevent it. Staff L revealed she didn't include recommendations for PROM or AROM programs on her discharge summaries because the facility lacked staff to implement them, though she believed residents would benefit from them. Staff L stated she didn't believe the facility maintained a restorative program since July 2025 for any residents in the building. On 6/29/16 at 12:57 PM the Nurse Practitioner (NP) stated a restorative program would help many residents; however, the facility didn't provide it. The NP didn't know why the facility lacked the program. The NP noted she ordered therapy for multiple residents and believed a restorative program would work very well for them. On 6/29/16 at 3:11 PM the Administrator stated she looked into hiring a lifeguard and finding a train-the-trainer lifeguard course to restart the pool program. Regarding the restorative program, the Administrator didn't know if they'd assign someone to the role or train the CNAs. The Administrator noted they needed to evaluate every resident to determine who required specific programs. The Nursing Rehabilitation/Restorative Care Policy dated May 2025 directed the facility to incorporate restorative programs assisting a resident to maintain or improve physical functioning based upon completing a comprehensive assessment. The policy instructed that candidates for restorative nursing care required appropriate assessment, care planning, and progress evaluation. It defined rehabilitation or restorative care as nursing interventions promoting a resident's maximum functional potential. The policy required care plans to contain measurable objectives and interventions, and required a licensed nurse to conduct periodic evaluations in the clinical record. It further mandated that nursing assistants received training in techniques promoting resident function under nursing staff supervision. Exercise groups couldn't exceed four residents per caregiver, and activities required a total practice time of at least 15 minutes over a 24-hour period. The undated Facility Assessment revealed the General Staff Guidelines directed the facility required restorative care 5-7 days per week.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, policy review, the facility failed to ensure specialized respiratory care was safely provided by qualified personnel for 4 of 4 residents on mechanical ventilation (a life-support treatment that uses a machine to move air in and out of your lungs when you cannot breathe adequately on your own). The facility utilized floor staff to work in the respiratory therapy department and allowed a Licensed Practical Nurse (LPN) to function as the sole licensed nurse onsite without a Registered Nurse (RN) or Respiratory Therapist (RT) present in the building (Resident #1, #5, #6, and #11). The facility reported a census of 51 residents. Findings include:The facility provided an undated document titled Residents with Vents (Ventilators) that revealed four residents at the facility required mechanical ventilation (life-support breathing treatment). The list included Resident #1, Resident #5, Resident #6, and Resident #11. Review of the facility's May June Respiratory and Nursing schedule revealed on [DATE] from 6:00 PM to 6:00 AM, [DATE] from 6:00 PM to 6:00 AM, and [DATE] from 10:00 PM to 6:00 AM, Staff E, a Licensed Practical Nurse (LPN), worked as the only licensed nurse onsite. 1. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] documented an admission date of [DATE]. Resident #1 achieved a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #1 depended on staff for toileting and bathing, didn't get out of bed, and needed supervision or touching assistance with rolling in bed. Resident #1 had diagnoses of diabetes (high blood sugar), malnutrition (poor nutrition), depression, psychotic disorder (severe mental condition), anxiety, respiratory failure (breathing failure), dependence on respirator status, and myotonic muscular dystrophy (progressive muscle weakness). Resident #1 didn't complete any restorative nursing programs in the past seven days. 2. Resident #5's Minimum Data Set (MDS) assessment dated [DATE] documented an admission date of [DATE]. Resident #5 had short-term and long-term memory problems and severely impaired cognitive daily decision-making skills. Resident #5 depended on staff for all activities of daily living (ADLs) and couldn't stand or walk. Resident #5 required a feeding tube, a tracheostomy (breathing tube), and an invasive mechanical ventilator (breathing machine). 3. Resident #6's Minimum Data Set (MDS) assessment dated [DATE] revealed an admission date of [DATE]. Resident #6 had short-term and long-term memory problems and severely impaired cognitive daily decision-making skills. Resident #6 depended on staff for all ADLs and couldn't stand or walk. Resident #6 required a feeding tube, a tracheostomy, and an invasive mechanical ventilator. 4. Resident #11's Minimum Data Set (MDS) assessment dated [DATE] documented an admission date of [DATE]. Resident #11 achieved a BIMS score of 13, indicating intact cognition. Resident #11 needed supervision or touching assistance with transfers and walking. Resident #11 had diagnoses of anxiety, respiratory failure, and dependent on respirator status. On [DATE] at 1:56 PM, Staff D, an Agency Licensed Practical Nurse, stated the facility pulled LPNs to do respiratory care. Staff E worked as a Respiratory Therapist (RT), and the facility had no Registered Nurses (RN) on duty and no RT in the building. Staff E worked by herself and quit. It happened maybe three to four weeks ago. On [DATE] at 2:50 PM, Staff F, the Human Resources (HR) Coordinator, informed that Staff E worked three days as an RT. Staff E worked as the RT on [DATE], [DATE], and [DATE]. She worked as the only one in the role those days. On [DATE], [DATE], [DATE], [DATE], and [DATE], the facility had Staff H, an RN, working. On [DATE] at 1:21 PM, Staff K, a Respiratory Therapist, stated an RT program requires a two-year degree with five semesters and four months of clinical experience. She expressed that an RN couldn't manage a vent; they could do a breathing treatment, but they couldn't manage anything with the vent. An LPN couldn't do it because it requires a lot of school. Really bad things could happen if no RT worked onsite because staff cannot mess with the vents and it's risky. Staff would have to bag (manually pump air into) the resident and do Cardiopulmonary Resuscitation (CPR) until the ambulance arrived. The facility had no RT onsite a couple of times that she heard of, and it's too risky. If a trach fell out, they'd take the patient off the (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	vent and start bagging through the trach until the ambulance arrived. If they still couldn't get a good oxygen saturation (blood oxygen level), staff would have to cover the stoma (surgical neck opening) and go by mouth to figure out if the airway remained clear. It requires a lot of critical thinking. On [DATE] at 3:13 PM, the Director of Nursing (DON) stated typically one RT covers the facility and works from 6:00 AM to 6:00 PM. The facility experienced turnover in that department and utilized floor staff to work in the RT department. The nurses completed competencies and took a quiz before they could do the RT role, and preferably the respiratory therapist should go over it with them. She honestly didn't know offhand what nurses completed training in that role. Usually they worked as the RT during the day. She personally did it during the day, and she did it this past Saturday. The RT completes all trach care, breathing treatments, inner cannula (inner tube) changes, vent checks, and vent alarm checks. They have four residents on ventilators. Staff M and Staff P, both RTs, trained the DON, and a corporate nurse consultant provided the competencies to go over. The first time a nurse worked as an RT occurred probably in December on Christmas, and involved her. On [DATE] at 11:10 AM, Staff M stated they had to adjust vent settings for the residents, including changing the mode, tidal volume (breath volume), and respiratory rate (breathing speed). She changed the mode for Resident #5. She didn't feel like an RN or LPN could work in the facility alone without an RT onsite. She voiced her concern because they had nurses working the floor. She felt concerned with the trachs if they fell out. Management instructed staff to just bag the resident, and that's not going to save them. She also found tubing that a nurse rotating as an RT took off. She felt staff didn't have enough knowledge to safely care for the residents. Nothing really bad happened but it could. Staff don't have in-depth diagnostic training or the training besides just suctioning. RTs know how to look for leaks because they're drilled in school since this is intensive care. If a trach falls out, that's their main airway, and if a blockage occurred, she questioned how staff bagged them. She didn't think a resident would last very long. If a mucus plug occurred, they probably needed deep suctioning. RTs can take care of that pretty fast, and she didn't feel sure if nurses knew how to look or do that. Resident #11 dropped to the 70s when she got sick, and depending on her situation, she might need a different mode. It acted pretty fast. She thought the nurses might know how to assess to give an as-needed Albuterol (bronchodilator) (breathing medicine) treatment, but they cannot wait four hours and have to override that for an asthmatic exacerbation (asthma attack). If low levels occurred, staff must critically think to try and do everything in-house. Sometimes they'll try many things and then change the trach as a last resort. She completed some of the training with the nurses, but they didn't really pay attention. She had to train them and tell them to focus on her because they kept going back to nursing. On [DATE] at 12:57 PM, the Nurse Practitioner (NP) stated she wasn't very familiar with regulations and the nurses they have working are knowledgeable. She preferred an RT be on duty in case something happened to cause a distraction. It caused more concern if only an LPN worked on duty. On [DATE] at 1:36 PM, Staff O, a Nurse Practitioner, stated it concerned her if no RT remained in the building. On [DATE] at 3:11 PM, the Administrator stated she received education and instruction that LPNs will no longer work as RTs. They're piecing together RN training to ensure they have proper training to work as RTs. The Medication Administration policy dated as an undated document instructed that the corporation doesn't have a policy for medication administration but follows the national standard of the 5 rights of administration. The Professional Nurse Coverage policy dated as an undated document instructed that the corporation doesn't have a professional nurse coverage policy but follows professional standards of nursing delegation. The Vent Check Competency policy dated [DATE] instructed only the Respiratory Therapist adjusted settings. Nurses who completed training in RT received direction to call 911 if vent settings required changes and an RT didn't work in the facility.

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview, record review, and policy review, the facility failed to provide sufficient nursing staff to respond to call lights in a timely manner for 1 of 3 residents reviewed (Resident #1). The facility reported a census of 51 residents. Findings include: Review of the Employee Warning Notice for Staff R, Certified Nursing Assistant (CNA), dated 5/8/26 revealed that on 6/6/26 the facility failed to answer Resident #1's call light within 15 minutes, with one instance lasting 54 minutes and another lasting 16 minutes. The form revealed the incident violated policy and procedure. Review of the Employee Warning Notice for Staff S, CNA, dated 6/16/26 revealed that on 6/12/26 Resident #1's call light remained on for 30 minutes. The form revealed the delay violated policy and procedure. On 6/22/26 at 11:48 AM Resident #1 stated that staff responded to call lights poorly at all times of the day, and responses took up to an hour. On 6/22/26 at 1:20 PM Resident #1 Representative, Power of Attorney (POA), stated that when they first arrived at the facility, call lights took two to two and a half hours to answer. Resident #1 Representative noted that although responses improved, times still pushed over 15 minutes. Staff entered the room and shut off the lights to look good, but the Respiratory Therapist (RT) didn't arrive for up to 45 minutes to help Resident #1. On 6/24/26 at 1:25 PM Staff A, Licensed Practical Nurse (LPN), stated that residents didn't complain about call lights. On 6/24/26 at 1:39 PM Staff B, CNA, stated she tried to answer call lights timely, but she couldn't stop in the middle of a task. She noted staff used a phone to alert them of call lights, and she experienced issues with it daily. She expressed a need for a lock on the device so staff couldn't shut off the sound as it should chime. She stated some staff acted lazy, including both nurses and CNAs, and they sometimes didn't have enough time in the day to take care of residents properly. On 6/24/26 at 1:44 PM Staff C, CNA, stated staff used an app on a phone for call lights. She felt her workload felt tolerable and she could answer call lights in 15 minutes, though the facility ran a little short of staff on Fridays sometimes. On 6/24/26 at 1:56 PM Staff D, LPN, stated that most days brought enough time to get work done, but it depended on the situation and staffing. On 6/24/26 at 2:14 PM Staff F, Human Resources (HR) Coordinator, stated he became aware of Resident #1's delayed call light on 6/24/26. He typed a written warning for the involved CNA but hadn't caught her to deliver it yet. He didn't have concerns with the call light system and ensured all sound audios remained on. On 6/25/26 at 11:40 AM Staff I, CNA, stated that if they didn't have any call-ins, they maintained perfect staffing. Most days they could answer call lights within 15 minutes, depending on the day and resident needs. She noted that CNAs shouldn't answer call lights alone, and it would help if others pitched in. On 6/25/26 at 12:04 PM Staff J, CNA, stated she didn't think they had enough staff to get everything done. She noted they could answer call lights within 15 minutes if everyone pitched in, and stated they needed five CNAs and a shower aid. She revealed Resident #1 put her call light on a lot, but it just involved little things. On 6/25/26 at 1:21 PM Staff K, RT, stated the workload felt heavy because they had many tracheostomies (artificial airways) that required suctioning. It took around 8 minutes to suction a resident on average, but it could be more. She confirmed she had to suction Resident #1 a lot. On 6/29/26 at 11:10 AM Staff M, RT, stated the shift could become busy, and some residents wanted frequent suctioning. On 6/29/26 at 3:11 PM Administrator stated that upon hire, staff received orientation on the call light system and how to use it. She brought it up during an all-staff in-service meeting when a major trend appeared, and they reviewed the 15-minute response time standard. The Call Light Policy dated September 2023 directed a prompt response to a resident's call for assistance. The policy instructed the facility ensured the call system remained in proper working order. It required staff to answer call lights in a timely, prompt, and courteous manner, knocking before entry and introducing themselves. When answering a call light, staff needed to respond to the request. If they couldn't provide immediate assistance and no emergency existed, staff could turn off the light and inform the resident that a staff member would return shortly.