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	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony House Health Care Cent	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 - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 42134 Based on observation, resident and staff interview, the facility failed to treat residents with respect and dignity for 2 of 5 residents (Residents #5 and #33) reviewed for dignity. The facility reported a census of 43 residents. Findings include: On 9/9/24 at 11:50 AM, observed Resident #5 looking out of their doorway into the hallway. As the surveyor was walked through the hall, Resident #5 explained he didn't have sheets on his bed. An observation confirmed the bed didn't have a fitted or flat sheet. At the same time Staff J, Certified Nursing Assistant (CNA), approached Resident #5. He told her he didn't have a sheet on his bed. Staff J told him, the bed had a sheet, but it had a stain on it, as she held her hands in a circle approximately 5-6 centimeters, but it was just fine. After a brief pause, Staff J told Resident #5 she would see what she could find and turned to walk down a different hall. On 9/9/24 at 11:55 AM, Staff J returned to Resident #5's room and handed him a plastic bag with linens. After a brief pause, she asked if he needed help putting the sheet on his bed, Resident #5 responded yes. Staff J walked into the room, put the sheet on the bed and walked out without speaking to the resident. During an interview on 9/11/24 at 2:40 PM, Staff K, Licensed Practical Nurse (LPN), explained the facility had an incident in July with a CNA. They became loud and used profanity at the Nurse's Station beside the dining room, with residents in the dining room at the time. She explained they attempted to deescalate the CNA throughout the evening. During an interview on 9/11/24 at 3:03 PM, Staff F, Registered Nurse (RN), talked about an incident from July when he returned to the Nurse's Station after redirecting a resident from the dining room. Staff F explained a CNA at the Nurse's Station became loud while using profanity, with residents in the dining room at that time. He added himself and Staff K actively addressed an acute resident concern while attempting to deescalate the CNA. During an interview on 9/11/24 at 3:57 PM, Resident #33 explained the staff sometimes did get too loud and use profanity when addressing each other. He explained he hadn't heard any for a while but remembered an incident from a couple months ago. He further explained he didn't like to hear the staff get loud and use profanity, as it made him feel bad.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42133 Based on observation, United States Food and Drug Administration (FDA) 2022 Food Code and staff interview, the facility failed to promote good food handling when the staff touched the resident's food with dirty gloves for 4 residents observed (Residents #9, #13, #22, and #31). The facility identified a census of 43 residents. Findings include: The Week 4 Monday Lunch Menu listed the following menu: a. 1 each fish sandwich b. #12 scoop macaroni salad On 9/9/24 at approximately 11:38 AM witnessed Staff A, Cook, rolled the steam cart from outside the A hallway dining room up to the main dining room. Before starting the meal service in the main dining room, Staff A didn't wash her hands. At 11:41 AM while wearing a glove on her right hand, Staff A touched a bun to make a fish sandwich, then touched a scoop to scoop macaroni salad onto a plate. Staff A handed the plate to another staff member to serve out to a resident. Staff A, wearing the same glove on her right hand removed the tie on a bag of buns, reached in with her right gloved hand and took a bun from the package to lay on a plate. Staff A grasped the tongs with her right gloved hand, placed a piece of fish on the bun, then used her right gloved hand to place the top of the bun on the sandwich. Staff A then grasped the scoop with her right gloved hand to place salad on the plate. Staff A prepared a total of four fish sandwiches using the same technique. At 11:44 AM after serving fish sandwiches to Residents #9, #13, #22, and #31, with the same dirty glove, the Certified Dietary Manager (CDM) came to the steam table and quietly instructed Staff A. Staff A replied turned as the CDM walked away and asked, what she meant that she couldn't use a glove? Staff A obtained tongs from the kitchen and finished serving out the 11:30 AM main dining room. Staff A already served the fish sandwiches to the A wing dining room prior to being corrected on her technique by the CDM. The Early Meal Service Dining Seating Chart showed 14 residents in the A wing dining room. Observed over seven residents in the A wing dining room receive the fish sandwiches. During an interview on 9/10/24 at approximately 11:05 AM the CDM reported she expected the dietary staff to use tongs and not touch the food with gloves that touched other items. She verbalized she is constantly re educating the dietary staff. On 9/11/24 at 5:07 PM the Administrator responded the facility didn't have a food handling policy, as they followed the most up to date food code. The FDA 2022 Food Code under 3 301.11 Preventing Contamination from Hands directed food employees wash their hands as specified under S 2 301.12. Food Employees may not contact exposed, ready to eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single use gloves, or dispensing equipment.

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ staff that are licensed, certified, or registered in accordance with state laws. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42134 Based on employee file review, job descriptions review and staff interview, the facility failed to ensure professional nursing staff held current and valid licenses for 1 of 2 professional nursing employee files reviewed (Staff F, Registered Nurse). The facility reported a census of 43 residents. Findings include: Staff F's, Registered Nurse (RN), employee file contained a license verification from Nursys (online database of nursing licenses in Iowa) reflecting their license expired on [DATE]. The facility schedule and employee time clock punches showed Staff F continued to work in the role of floor nurse and Health Services Supervisor (HSS) from [DATE] through and including [DATE]. The Charge Nurse (floor nurse) job description reviewed [DATE] signed by Staff F on [DATE] included qualifications of a current and active license. The Unit Manager (HSS) job description reviewed [DATE] signed by Staff F on [DATE] included qualifications of Registered Nurse or License Practical Nurse with knowledge in long term care. During an interview on [DATE] at 3:03 PM, Staff F explained he missed the email from the Board of Nursing for renewal. He explained the facility notified him his license expired when they pulled his personnel file (as part of DIAL survey). During an interview on [DATE] at 3:53 PM the Administrator explained they had a system in place for tracking professional licenses. She added they overlooked Staff F and didn't include him on their spreadsheet. During an interview on [DATE] at 4:58 PM the Director of Nursing (DON) explained she expected all nurses to have a valid license.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133 Based on observation, clinical record review, Center for Disease Control and Prevention (CDC) Guidance, policy review, and staff interview, the facility failed to have an adequate supply of personal protective equipment (PPE) for 1 of 1 resident reviewed for COVID 19 isolation (Resident #146). In addition, the facility failed to cover laundry during transport and ensure laundry remained free from cross contamination. The facility identified a census of 43 residents. Findings include: Resident #146's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 6, indicating a severe cognitive loss. Resident #146 required supervision/touch assistance for eating, oral hygiene, toileting hygiene, and set up/clean up assistance for upper/lower body dressing and putting on/taking off footwear. The MDS included diagnoses of atrial fibrillation (abnormal heart rate), coronary artery disease (CAD, impaired arterial blood flow), hypertension (high blood pressure), diabetes mellitus, and cerebrovascular accident (stroke). A Progress Note dated 9/9/24 at 7:59 AM documented the facility notified Resident #146's family member he tested positive for COVID 19 and would be in isolation. On 9/9/24 at 4:28 PM the Surveyor entered the room of a COVID-19 positive resident for initial pool screening. A sign on door directed all persons entering the room to wear PPE including eye protection. The sign also indicated PPE should be removed prior to leaving the room. The cart of supplies outside room contained all PPE necessary, including 1 face shield with foam where the mask would rest on the forehead and 1 face shield with glasses type frame. The Surveyor wore the glasses frame type face shield. Upon exiting the room, there were no supplies to sanitize the face shield on the supply cart. On 9/9/24 at 4:34 PM when asked expectations for eye wear when coming out of a COVID-19 isolation room, the Administrator replied she had more face shields on order and the face shields would be in the next day. When asked if they should dispose or sanitize and reuse the shields, she reiterated she had shields on order and they would arrive to the facility the next day. The Administrator didn't respond regarding what she expected about if eye protection should be disposed of or sanitized for reuse. On 9/10/24 at 8:09 AM watched Staff B, Certified Nurse Aide (CNA), donned (put on) an isolation gown, gloves, NIOSH (National Institute for Occupational Safety and Health) 95 mask (an N95 respirator is a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles) and wore her prescription eye glasses into Resident #146 COVID-19 isolation room. Staff B failed to don a face shield over her prescription eye glasses or wear side shields on her prescription glasses for appropriate PPE. Observation of Resident #146 Room at the time revealed two posting: CDC Enhanced Barrier Precaution Sign, everyone must: a. i. Clean their hands, including before entering and leaving the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ii. Providers and staff must also: wear gloves and a gown for the following high contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy, wound care: any skin opening requiring a dressing. Do not wear the same gown and gloves for the care of more than one person. United States Department of Health and Human Services, CDC. b. Isolation: only staff enter room. Must have all the following PPE on before entering isolation gown, hair cover, gloves, booties, N95 mask or respirator. Do not bring equipment in the room. Room has disposable equipment that stays in the room. Remove all PPE before leaving the room and use hand sanitizer or wash hands. During an interview on 9/10/24 at 11:50 AM Staff B said she knew she is to wear eye protection into a COVID-19 room. She reported she didn't wear a face shield that morning for Resident #146's care as they didn't have face shields in the isolation bin. If they bin had face shields, she would have worn one. On 9/11/24 at 4:40 PM the Administrator reported she put a whole package of face shields in Resident #146 isolation bin, so they had face shields available for use. Interview on 9/12/24 at 8:30 AM with Staff C, Respiratory Therapist, explained the facility required the staff to wear an isolation gown, gloves, and an N95 mask into a COVID-19 isolation room. On 9/12/24 at 8:32 AM Staff D, CNA, verbalized they need to wear gloves, an isolation gown, and a mask (failed to specify type of mask) when a resident is on isolation for COVID-19. On 9/12/24 at 8:33 AM Staff E, Licensed Practical Nurse (LPN) reported the facility required the staff wear an isolation gown, gloves, N95 mask, and face shield for COVID-19 isolation. The staff received education at the beginning of the shift of who needed PPE. Staff E responded eye glasses are a form of eye protection. When asked if the eye glasses had side shields, Staff E responded she didn't know that was a requirement. Staff E added all the nurses and Certified Medication Aides (CMAs) on duty are responsible to monitor staff wore the correct PPE. On 9/12/24 at 8:40 AM watched Staff B leave room C-5 wearing her prescription eye glasses as they fell down and she tried bumping them back up with the back of her hand. Staff B reported she didn't know she needed to disinfect her prescription eye glasses when coming out of a COVID-19 room. She didn't disinfect her eye glasses when she exited Resident #146 room. She reported management assigned them a wing but the aides also go where needed on the A, B, and C wings for resident care. She provided care to other residents on 9/10/24 in addition to Resident #146. She reported she wouldn't know what to clean her glasses with after being in a COVID-19 isolation room. During an interview on 9/12/24 at 9:35 AM the Infection Preventionist verbalized she had the responsibility to monitor the staff wore the correct PPE into resident rooms. She expected the staff to wear an isolation gown, gloves, a N95 mask, face shield, and booties when providing care in a COVID-19 isolation room. The Infection Prevention and Control Program (IPCP) Guidelines Policy, revised September 2022, directed through a means of surveillance, investigation, prevention, control and reporting, the facility maintains an infection control program that: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Provided a safe, sanitary, and comfortable environment; b. Helped prevent the development and transmission of communicable diseases and infections. In addition, the policy instructed to initiate droplet precautions when determined the infection is transmitted directly from the respiratory tract of an infected individual to susceptible mucosal surfaces of the recipient. (Respiratory droplets are generated when an infected person coughs, sneezes, or talks). Since transmission generally occurs at close proximity, facial protection is necessary. (Respiratory viruses can enter the body via the nasal mucosa lining of the inside of the nose, conjunctiva helped to keep the eye moist by producing mucus and tears, and less frequently the mouth). The policy indicated the staff use a mask when within 3-10 feet of a resident where droplet precautions utilized. The CDC Infection Control Guidance: SARS-CoV-2 (Severe acute respiratory syndrome (SARS) is a viral respiratory disease caused by the SARS associated coronavirus), updated June 24, 2024 under Recommended Infection Prevention and Control (IPC) Practices when Caring for a Patient with Suspected or Confirmed SARS-CoV-2 infection specified health care personnel who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH Approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). 2. On 9/9/24 at 12:57 PM witnessed Staff G, Laundry, rolled an uncovered hanging laundry cart down the A hallway with clean laundry into several resident rooms. A bath blanket hung folded at the end of the cart. The Surveyor stood within 10 feet of the cart as Staff G passed laundry down the A hallway. Staff G never made any attempts to cover the hanging laundry with the bath blanket. The hanging laundry cart parked by Resident #146 room. On 9/11/24 at 9:30 AM observed the laundry room and saw a large, approximate 3 foot by 3 foot, 10 inch deep Black Hawk fan with a thick build up of gray lint, dust and debris through the front fan guard. The fan contained a heavy layer of gray dust on the three fan blades, inside the fan, and had a large build up of gray lint, dust, and debris build up throughout the rear fan guard. Witnessed the fan running on high blowing less than 8 10 feet of the folding table for clean laundry. On 9/11/24 at 9:34 AM Staff H, Laundry, parked a laundry bin in front of the end dryer less than 2-3 feet in front of the dirty fan. Staff H pulled clean clothes out of the dryer and hung the clean clothes over the side of the bin with the fan blowing on the clean clothes versus putting the linens down in the bin. On 9/11/24 at 9:43 AM Staff H reported they tried to wipe the fan down once a week with paper towels. It got really dusty down there. As far as she knew, they didn't document the fan cleaning. When asked if they had a cleaning list of what needed cleaned and how to clean in the laundry room, she responded, no, she just knew what needed wiped down. She reported they signed off on a Monthly Cleaning Documentation sheet. On 9/11/24 at 9:44 AM the review of the September 2024 Monthly Cleaning Documentation sheet reflected the following: a. 9/11/24 Daily sweep/mop at the end of shift already signed off by Staff I, Laundry. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. 9/11/24 Daily lint filters cleaned at the end of shift already signed off by Staff I. c. 9/11/24 Daily surfaces disinfected already signed off by Staff G, Laundry. d. 9/11/24 Duty of the day, see above (clean dirty linen barrels) already sign off by Staff G. The Monthly Cleaning Documentation sheet lacked direction and documentation of fan cleaning. On 9/11/24 at 9:44 AM Staff I verbalized she signed the sheet as she would complete the duties that day. On 9/11/24 at 9:50 AM the Environmental Services Coordinator reported they usually cleaned the fan once a week and it didn't get that bad. They clean the fan weekly either by wiping it with a Swiffer pad or by using a shop vacuum to blow out the fan. He added they didn't document the cleaning of the fan. During an interview on 9/12/24 at 9:37 AM the Infection Preventionist reported she didn't do anything with the laundry department for infection control, but a dirty fan shouldn't blow on clean clothes and they should cover the clothes when the clean laundry comes out to the floor. During an interview on 9/12/24 at approximately 11:00 the Administrator reported the facility didn't have a separate laundry policy or a fan cleaning policy. The facility utilizes the Infection Prevention and Control Program Policy. The Infection Prevention and Control Program (IPCP) Guidelines Policy, revised September 2022, lacked direction regarding prevent contamination (dirty or absorb infection) when transporting laundry.