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	08/06/2025

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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, resident, and staff interviews, the facility failed to report an allegation of abuse to the Administrator, as well as the State Survey Agency within the mandated timeframe (2 hours). This resulted in a failure to protect a resident from further harm. Resident #51 reported he told staff about a staff member who grabbed his arms, hurt him, and resulted in multiple dark purple bruises to forearms. The facility's failure to report an allegation of abuse prevented an investigation into the incident, as a result, the harm continued to occur. This failure resulted in Immediate Jeopardy to the health, safety and security of the resident.The State Agency informed the facility of the Immediate Jeopardy (IJ) on 8/5/25 at 4:15 PM. The facility staff removed the Immediate Jeopardy on 8/6/25 through the following actions:The facility completed staff education on 8/5/25 regarding the reporting of allegations and suspicions of abuse, and injury of unknown source. The facility would use the abuse policy and guidelines for training and education of the reporting requirements. The education and training would include the chain of command, how to access administrative staff, and the on-call numbers. The staff unavailable that day to receive the education, would receive the education prior to clocking into their next shift. The Staff would validate understanding by verbally reiterating the process, actions, and steps to take when an allegation is made.The facility interviewed alert and oriented residents. In addition, the facility conducted body audits of residents with a Brief Interview for Mental Status (BIMS) score lower than 13, to rule out any additional unknown allegations of abuse. The scope lowered from J to D at the time of survey after ensuring the facility implemented education and their policy and procedure. The facility reported a census of 49 residents. Findings include:Resident #51's Minimum Data Set (MDS) assessment dated [DATE] identified Brief Interview For Mental Status (BIMS) score of 9, indicating a moderate cognitive impairment. The MDS indicated Resident #51 didn't exhibit the behavior of rejecting care. Resident #51 required maximal assistance for lying to sitting on the side of the bed. The MDS listed Resident #51 as dependent on staff for all transfers. Resident #51 was unable to walk 10 feet. The MDS included diagnoses of chronic obstructive pulmonary disease, mild intellectual disabilities, cognitive communication deficit, abnormalities of gait, and mobility.The Care Plan Focuses with a target date of 7/7/25 reflected Resident #51 had:The tendency to refuse medications and showers. The Interventions directed the following: Staff to approach or speak in a calm manner.Assure the resident that concerns are validated and staff are willing to address legitimate concerns.Encourage to participate in care activities and respect the resident's rights to make his own lifestyle choice. A risk for falls. The Interventions directed the following:Staff provide assistance of 2 staff with the standing mechanical lift for all transfers to the wheelchairPlace the call light within reachOrient to surroundings Consult with therapy as needed.Used anticoagulant (blood thinner) medication. The Interventions directed the staff to monitor for signs and symptoms of bleeding to include bruising.A document titled Therapy Recommendation from Physical/Occupational Therapy (PT/OT) to Nursing dated 6/18/25 directed staff to use the standing mechanical lift for all transfers. The document directed staff to direct Resident #51 to explain before completing task to hold hands, assist or guide the patient's arm to (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	safely grip the handle. Resident #51 required time to set up in the standing mechanical lift. During an interview on 7/28/25 at 4:02 PM, Resident #51 reported the staff pulled him from his bed. He added it happened day and night and received bruises to his forearms. Resident #51 stated he had thin skin and could bruise when touched. Resident #51 stated he reported it to staff because being pulled from bed wasn't good for him. Resident #51 pointed out several bruises to both of his forearms about the size of half dollar coins. Resident #51 stated, he reported this one.The Progress Notes lacked documentation of Resident #51's dark purple bruises. In addition, the progress notes lacked documentation of notification to the nursing staff, administration, his family, or physician for Resident #51's bruises.During an interview on 8/4/25 at 1:42 PM, Staff O, Certified Nursing Assistant (CNA), stated Resident #51 blamed her and a coworker for the bruises to his arms. Staff O stated she received direction to get Resident #51 up to the wheelchair with a gait belt, then stand him and pivot (turn) him.During an interview on 7/30/25 at 3:04 PM, Staff B, CNA, stated she never had a problem with Resident #51 and didn't hear him say someone pulled him out of bed or hurt him. Staff B stated they noticed the bruising on his arms. Staff B stated if a CNA noted bruises on a resident, they chart it in the electronic health record (EHR) then they tell the nurse. Staff B stated the nurses did a good job assessing a concern right away when staff report a change in a resident's condition. She explained no staff reported how Resident #51 received the bruising.During an interview on 7/30/2025 at 3:31 PM, Staff J, CNA stated she noticed Resident #51 had bruising on his arms but didn't know how he got them.During an interview on 7/30/25 at 3:44 PM, Staff M, CNA, stated on 7/28/25, 2-10 shift, Resident #51 reported that a staff person came into his room and grabbed him too hard by the arm to get him out of the bed. Staff M stated Resident #51 had dark bruises on his arms. Staff M stated they reported the incident to the nurse, but they couldn't recall the time, but claimed to reported it to the nurse that evening. On 7/30/25 at 4:00 PM, notified the facility Administer about how Resident #51's claimed the staff pulled him out of bed by his arms. In addition, he informed the staff of the incident as it hurt his arms, and he had visible bruising to both wrists and forearms. The Administrator stated no one informed her about the claim.The Incident Report Note dated 7/31/25 at 11:52 AM reflected Resident #51 had bruising and a skin tear to his left posterior (back of) forearm. His range of motion remained at baseline, and Resident #51 denied pain. Resident #51 required staff assistance for activities of daily living (ADL). Resident #51 received Eliquis 2 times a day for atrial fibrillation (abnormal heart rhythm) which increased the risk for bruising.During an interview on 7/31/25 at 1:31 PM Staff I, Infection Preventionist, described Resident #51 as not cooperative. Staff I stated Staff H, MDS Coordinator, assisted her with the skin sheet and the initial measurements. They asked Resident #51 how the injuries occurred. Staff I stated the skin sheets included the bruises Resident #51 sustained when he fell, but they healed them on 7/16/25. Staff I stated he didn't have any other bruising. Staff I couldn't say how Resident #51's bruises occurred, and she didn't ask him. She thought they happened from his fall. Staff I reported Resident #51 didn't act delusional but would get agitated. Staff I stated she didn't know Resident #51 claimed the staff hurt him recently and denied the staff reporting it to her. Staff I stated Resident #51 may have resisted care. During an interview on 7/31/25 at 1:50 PM, Staff H stated Resident #51 always had some reddish discoloration of his arms. Staff H stated on 6/27/25 he assessed dark purple bruises and a week later it faded and yellowed. Staff H stated he heard in the past Resident #51 made a claim of people being mean to him. Staff H stated he didn't know about Resident #51's recent claim of being pulled from the bed and new bruises. Staff H stated if Resident #51 reported abuse, he would complete an assessment of Resident #51's body for injuries, call the DON, and law enforcement.During an interview on 8/4/25 at 12:49 PM, Staff S, Advanced Registered Nurse Practitioner (ARNP), stated they didn't know about Resident #51's new bruising to his arms. Staff S described Resident #51 as very clear when he explained how he fell over his shoes the previous month when he hit his arm and head. Resident #51 could explain what happened to his arms. Staff S stated she would absolutely expect someone to follow-up on Resident #51's claim that someone hurt him and caused the bruising to his arms. During an interview (continued on next page)

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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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	on 8/5/25 at 10:43 AM, Staff P, Registered Nurse (RN), said she worked the evening of 7/28/25. She reported a CNA didn't approach her and she couldn't remember what staff worked that night. Staff P claimed she didn't know Resident #51 reported to staff that someone grabbed him and pulled him from bed. Staff P described Resident #51 as an assist of 1 staff for care and transfers but, she didn't see him get transferred.During an interview on 8/5/25 at 11:03 AM, Staff T, Licensed Practical Nurse (LPN), stated she didn't know Resident #51 reported to a CNA claiming someone hurt his arm. Staff T stated she visualized the bruises to Resident #51's arms. Staff T stated she didn't report the bruises because someone told her the nurses inform the skin nurse about bruises or skin injuries and then that nurse would follow-up with the assessments. Staff T stated she failed to inform the skin nurse, being new to this facility.During an interview on 8/5/25 at 11:12 AM, Staff R, CNA, stated she visualized bruises on his arms recently and reported the findings to the female nurse on duty.The document Patient Protection Guidelines: Abuse Prevention, Reporting, and Investigation revised May 2025:The facility staff are required to notify the charge nurse and Abuse Coordinator immediately.Employees are educated upon hire and annually on the abuse prevention program including the immediate reporting of any suspicion of abuse, neglect, exploitation, or mistreatment. The Administrator is responsible for the investigating, reporting, and coordinating of the investigation process of any alleged or suspected abuse regardless of the source of the concern.All allegations of resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation shall be reported to the Iowa Department of Inspections, Appeals and Licensing (DIAL) and any other required state agency if applicable (law enforcement). Reports of abuse or if the incident resulted in bodily injury, the facility should report immediately and no later than two (2) hours.

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, resident, and staff interviews, the facility failed to conduct a thorough investigation of an allegation of abuse, resulting in failure to protect a resident from further harm. Resident #51 reported he told staff about a staff member who grabbed his arms, hurt him, and resulted in multiple dark purple bruises to forearms. The facility's failure to investigate the allegation of abuse resulted in further harm to occur. This failure resulted in Immediate Jeopardy to the health, safety and security of the resident.The State Agency informed the facility of the Immediate Jeopardy (IJ) on 8/5/25 at 4:15 PM. The facility staff removed the Immediate Jeopardy on 8/6/25 through the following actions:The facility completed education on 8/5/25 with the Abuse Coordinator regarding reporting allegations and suspicions of abuse as above. The staff would receive education to separate an alleged staff perpetrator immediately per the Abuse policy and guidelines. The facility would commence investigations immediately. The staff unavailable that day to receive the education would receive the education prior to their next scheduled shift. The facility interviewed alert and oriented residents. In addition, the facility conducted body audits of residents with a Brief Interview for Mental Status (BIMS) score lower than 13, to rule out any additional unknown allegations of abuse.The facility re-educated the nursing staff on the care Kardex and reapproach the identified resident to prevent additional occurrences.The facility re-interviewed the nursing staff who worked with the identified resident from 7/28/25-8/5/25 and the investigation continued. The facility suspended 2 staff members pending the Department of Inspection, Appeals and Licensing (DIAL) investigation. The scope lowered from J to D at the time of the survey after ensuring the facility implemented education and their policy and procedure. The facility reported a census of 49 residents. Findings include:Resident #51's Minimum Data Set (MDS) assessment dated [DATE] identified Brief Interview For Mental Status (BIMS) score of 9, indicating a moderate cognitive impairment. The MDS indicated Resident #51 didn't exhibit the behavior of rejecting care. Resident #51 required maximal assistance for lying to sitting on the side of the bed. The MDS listed Resident #51 as dependent on staff for all transfers. Resident #51 was unable to walk 10 feet. The MDS included diagnoses of chronic obstructive pulmonary disease, mild intellectual disabilities, cognitive communication deficit, abnormalities of gait, and mobility.The Care Plan Focuses with a target date of 7/7/25 reflected Resident #51 had:The tendency to refuse medications and showers. The Interventions directed the following: Staff to approach or speak in a calm manner.Assure the resident that concerns are validated and staff are willing to address legitimate concerns.Encourage to participate in care activities and respect the resident's rights to make his own lifestyle choice.A risk for falls. The Interventions directed the following: Staff provide assistance of 2 staff with the standing mechanical lift for all transfers to the wheelchairPlace the call light within reachOrient to surroundingsConsult with therapy as needed.Used anticoagulant (blood thinner) medication. The Interventions directed the staff to monitor for signs and symptoms of bleeding to include bruising.A document titled Therapy Recommendation from Physical/Occupational Therapy (PT/OT) to Nursing dated 6/18/25 directed staff to use the standing mechanical lift for all transfers. The document directed staff to direct Resident #51 to explain before completing task to hold hands, assist or guide the patient's arm to safely grip the handle. Resident #51 required time to set up in the standing mechanical lift. During an interview on 7/28/25 at 4:02 PM, Resident #51 reported the staff pulled him from his bed. He added it happened day and night and received bruises to his forearms. Resident #51 stated he had thin skin and could bruise when touched. Resident #51 stated he reported it to staff because being pulled from bed wasn't good for him. Resident #51 pointed out several bruises to both of his forearms about the size of half dollar coins. Resident #51 stated, he reported this one.During an interview on 7/30/25 at 3:44 PM, Staff M, CNA, stated on 7/28/25, 2-10 shift, Resident #51 reported that a staff person came into his room and grabbed him too hard by the arm to get him out of the bed. Staff M stated Resident (continued on next page)

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	#51 had dark bruises on his arms. Staff M stated they reported the incident to the nurse, but they couldn't recall the time but claimed to report it to the nurse that evening. On 7/30/25 at 4:00 PM, notified the facility Administer about how Resident #51's claimed the staff pulled him out of bed by his arms. In addition, he informed the staff of the incident as it hurt his arms, and he had visible bruising to both wrists and forearms. The Administrator stated no one informed her about the claim.A document TimeLine of Investigation dated 7/30/25 for Resident #51 reflected the following:At 6:00 PM, the Assistant Director of Nursing (ADON), the Director of Nursing (DON), and Staff U, Regional Nurse Consultant, completed an interview and assessment with Resident #51.They completed measurements of areas to his right hands, left hands, and arms completed. They determined the prior left elbow skin tear healed when assessed at 2:00 PM that day. The skin assessment revealed the following: Left lateral elbow maroon (reddish purple coloring) bruising 4 cm x 2.5 cm.The back o0f right-hand light purple/maroon bruising 9 cm x 4.5 cmThe right posterior forearm light purple/maroon 15 cm x 8 cmThe left posterior forearm skin tear 0.5 cm x 2 cm - edge of skin flap is scabbed. The back of left-hand maroon and yellow bruising 5.5 cm x 9.5 cmThe left posterior forearm bruising maroon and yellow 17 cm x 9 cmResident #51's range of motion to left arm moved at his baseline and he denied pain.Resident #51 reported he bumped his right arm getting out of bed.During the interview with Resident #51 stated 2 young black staff members assisted him from bed and grabbed his left arm. He explained it happened in the day time. He told the ADON he wanted to tell her, but just hadn't yet.The staff conducted a review of Resident #51's July 2025 behavioral documentation, the nursing schedule, and compiled a staff interview list based on his behavior and interview.The facility completed the initial self-report.They spoke with the Police Department and received a case number.The staff reported Resident #51 refused to transfer with the standing mechanical lift. They placed an order for a PT and OT evaluation.They initiated the staff interviews.They interviewed all staff who worked with Resident #51 on 7/29/25 - 7/30/25.The staff didn't report any injury or incidents to his arms to account for the bruising on 7/30/25 at 6:00 PM.The Root Cause Analysis revealed: Resident #51 had no evidence of staff-inflicted injury to his arms.Resident #51 recently experienced significant mobility and cognitive decline.Resident #51 used an anticoagulant medication, making him prone to bruising easily.The bruises likely resulted from self-injury while attempting to get out of bed without assistance.The progress notes lacked documentation for falls or attempted transfers that resulted in a self-injury from 6/5/25 through 7/30/25.The Incident Report Note dated 7/31/25 at 11:52 AM reflected Resident #51 had bruising and a skin tear to his left posterior (back of) forearm. His range of motion remained at baseline, and Resident #51 denied pain. Resident #51 required staff assistance for activities of daily living (ADL). Resident #51 received Eliquis 2 times a day for atrial fibrillation (abnormal heart rhythm) which increased the risk for bruising.During an interview on 7/31/25 at 1:31 PM Staff I, Infection Preventionist, described Resident #51 as not cooperative. Staff I stated Staff H, MDS Coordinator, assisted her with the skin sheet and the initial measurements. They asked Resident #51 how the injuries occurred. Staff I stated the skin sheets included the bruises Resident #51 sustained when he fell, but they healed them on 7/16/25. Staff I stated he didn't have any other bruising. Staff I couldn't say how Resident #51's bruises occurred, and she didn't ask him. She thought they happened from his fall. Staff I reported Resident #51 didn't act delusional but would get agitated. Staff I stated she didn't know Resident #51 claimed the staff hurt him recently and denied the staff reporting it to her. Staff I stated Resident #51 may have resisted care.During an interview on 7/31/25 at 1:50 PM, Staff H, Registered Nurse (RN) MDS Coordinator, stated Resident #51 always had some reddish discoloration of his arms. Staff H stated on 6/27/25 he assessed dark purple bruises and a week later it faded and yellowed. Staff H stated he heard in the past Resident #51 made a claim of people being mean to him. Staff H stated he didn't know about Resident #51's recent claim of being pulled from the bed and had new bruises. Staff H stated if Resident #51 reported abuse, he would complete an assessment of Resident #51's body for injuries, call the DON, and law enforcement. During an interview on 8/4/25 at 12:49 PM, Staff S, ARNP, stated (continued on next page)

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	they didn't know about Resident #51's new bruising to his arms. Staff S described Resident #51 as very clear when he explained how he fell over his shoes the previous month when he hit his arm and head. Resident #51 could explain what happened to his arms. Staff S stated she would absolutely expect someone to follow-up on Resident #51's claim that someone hurt him and caused the bruising to his arms. During an interview on 8/4/25 at 1:42 PM, Staff O, Certified Nursing Assistant (CNA), stated Resident #51 blamed her and a coworker for the bruises to his arms. Staff O stated Resident #51 didn't have bruises the morning of 7/28/25. When she returned to work the morning of 7/30/25, the night shift reported finding bruises to both forearms. Staff O stated she received direction to get Resident #51 up to the wheelchair with a gait belt, then stand him and pivot (turn) him. Staff O stated Resident #51 refused to allow her to transfer him that day (8/4/25) to take him to lunch. Staff O stated she offered 3 times and notified the nurse of his refusal. Staff O claimed she didn't know if someone delivered food to Resident #51.During an interview on 8/5/25 at 10:08 AM Staff A, CNA, stated Resident #51 didn't usually speak to her except to say no he didn't want to get up or no he didn't want to eat. Staff A stated when Resident #51 told her no, she reported it to the nurse who directed her to get him up. Staff A explained the other CNAs directed to her use the standing mechanical lift when she transferred Resident #51. She reported she got him up with the assistance of 2 staff, one on each side. Once he stood up, he grabbed the wheelchair. Staff A stated she used the gait belt and would place her other hand under his arm.During an interview on 8/5/25 at 10:43 AM, Staff P, RN, said she worked the evening of 7/28/25. She reported a CNA didn't approach her and she couldn't remember what staff worked that night. Staff P described Resident #51 as an assist of 1 staff for care and transfers but, she didn't see him get transferred. During an interview on 8/5/25 at 11:03 AM, Staff T, Licensed Practical Nurse (LPN), stated she didn't know Resident #51 reported to a CNA claiming someone hurt his arm. Staff T stated she visualized the bruises to Resident #51's arms. Staff T stated she didn't report the bruises because someone told her the nurses inform the skin nurse about bruises or skin injuries and then that nurse would follow-up with the assessments. Staff T stated she failed to inform the skin nurse, being new to this facility.During an interview on 8/5/25 at 11:12 AM, Staff R, CNA, stated the facility hired her and trained her in March 2025. Staff R reported they needed assistance from 2 staff to transfer Resident #51 with a gait belt to stand and pivot (turn) to a wheelchair. Staff R stated Resident #51 reached out to grab her hand or arm. Staff R stated she visualized bruises on his arms recently and reported the findings to the female nurse on duty. Staff R stated she followed directions on a paper at the nurses' station that listed the resident's hall, room number. The list also contained how the resident transferred, ate, the briefs they wore, and if they wore hearing aids. The facility provided the document to staff as direction on how to transfer the residents. During a follow up interview on 8/5/25 at 2:28 PM, when questioned if Resident #51 feared the staff who transferred him to the wheelchair who caused the bruising he reported to the surveyor, Resident #51 responded yes. When asked if he would be comfortable with the staff to continue providing his care, Resident #51 responded well and clinched his teeth put his arms across his body and shook back and forth in his bed and stated, they did it again and I told them not to but they did it again. When asked if he someone pulled him by his arms again, he nodded and stated, they did it again.The document Patient Protection Guidelines: Abuse Prevention, Reporting, and Investigation revised May 2025:Any allegation requires an investigation.The facility staff are required to notify the charge nurse and Abuse Coordinator immediately. According to the CMS, the facility must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress. Employees are educated upon hire and annually on the abuse prevention program including the immediate reporting of any suspicion of abuse, neglect, exploitation, or mistreatment. The Administrator is responsible for the investigating, reporting, and coordinating of the investigation process of any alleged or suspected abuse regardless of the source of the concern. Upon receiving a report of an allegation of resident abuse, neglect, exploitation, injuries of unknown origin or misappropriation, the facility shall immediately implement measures to (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	prevent further potential abuse of residents from occurring while the facility investigation is in process.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure their staff treated residents respectfully for 2 out of 3 residents reviewed (Residents #4 and #51). Staff A, Certified Nurse Aide (CNA), and Staff B, CNA, directed Resident #4 to leave the dining room while she talked with another resident. The facility didn't have expectations or guidelines that Resident #4 couldn't be in the dining room. In addition, Staff A reported to the Charge Nurse that Resident #51 refused to get out of bed and go to the evening meal. The Charge Nurse directed Staff A to get him anyway to the dining room. The facility reported a census of 49 residents. Findings include: 1. Resident #4's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented Resident #4 felt down, depressed, or hopeless for 2-6 days out of the 7-day lookback period. Resident #4 didn't have any verbal, physical, or other behavioral symptoms towards others during the 7-day lookback period. The MDS listed Resident #4 as dependent on staff for eating. The MDS included diagnoses of quadriplegia (inability to move all four extremities), anxiety, depression and post-traumatic stress disorder (PTSD). The Care Plan Focus with a target date of 8/28/25 indicated Resident #4 used an antidepressant and anti-anxiety medication related to a history of trauma related to sexual abuse, arthrogryposis multiplex congenita (AMC occurrence of more than one contracture (fixed joint) at birth) and dependence on staff for all Activities of Daily Living (ADLs). The Interventions directed the staff to try non-pharmacological interventions prior to use of psychotropic medications. The non-pharmacological interventions included the following: Music therapy Phone call Talk therapy and ask about life events or interests. Social Services will meet with resident as needed Use of headphones Going for a walk outside when nice. On 7/28/25 at 3:42 PM, Resident #4 described Staff A, Certified Nurse Aide (CNA), and Staff B, CNA, as disrespectful. Resident #4 stated Staff B slammed Resident #4's snack in front of them and said somebody else will have to feed you. Resident #4 asked Staff B why they couldn't (Staff B) feed them. Staff B answered she had something else to do. They told Resident #4, she needed to leave the dining room because she can't be in the dining room while other people ate. Resident #4 stated Staff A got on the phone with Resident #4's Mom. Resident #4 stated Staff A and Staff B said she couldn't be in the dining room because of a rule. Resident #4 said she talked with management, who reported the facility didn't have a rule. Resident #4 requested Staff A and Staff B didn't provide her care. On 7/30/25 at 10:37 AM, the Administrator and the Director of Nursing (DON), stated they met with both Staff A and Staff B regarding Resident #4's reported concerns about them being rude. They stated both Staff A and Staff B received written discipline. They explained one of them denied saying (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	anything and the other said she could have handled a situation better. On 7/30/25 at 12:45 PM, Staff A reported she asked Resident #4 to leave the smoking area when she smoked outside because they someone told her, she [Resident #4] shouldn't be out there. Staff A stated Resident #4 cussed them out and called them bitches. Staff A stated later she asked Resident #4 to leave the dining room as she came in when they assisted other residents. Staff A stated she asked Resident #4 to leave because she distracted the other residents. When asked what type of distractions, Staff A replied she asked Resident #4 to leave the dining room out of respect of the other residents still eating. She stated after the smoking incident; Resident #4 went down the hall and asked Staff A to open another resident's door for her. Staff A stated Resident #4 talked on the phone with her mom. Staff A stated she shouldn't have said what she said next, but she told Resident #4 that she, Staff A, wouldn't open the door because she caused problems here and there. She acknowledged what she told Resident #4 as disrespectful. Staff A then overheard Resident #4's Mom tell her to not talk to her daughter like that because Resident #4 had her cell phone on speaker. Staff A said she wouldn't talk to Resident #4's mother but said she could call the facility and talk with administration. Staff A stated the Administration brought her in and disciplined her for being disrespectful. She stated the Administration asked if she asked Resident #4, why should they help her. Staff A said she didn't and wouldn't ever say that to a resident. On 7/30/25 at 2:39 PM, the Administrator acknowledged the situation as a dignity concern when they told Resident #4 to leave the dining room. The Administrator didn't know about a rule for Resident #4 to not be in a dining room while other residents ate. The Administrator acknowledged the concern of Staff A telling Resident #4 you've caused problems here and there. On 7/30/25 at 3:31 PM, Staff B verified she had a couple of incidents with Resident #4. Staff B stated Resident #4 technically couldn't go out with the other residents while they smoked. Staff B asked Resident #4 to leave the smoking area while the other residents smoked. When Resident #4 became upset, Staff B told her to go talk with the Assistant Director of Nursing (ADON) if she had a problem. Inside of the dining room she came into a dining room on the A wing. Resident #4 didn't eat in that dining room. Staff B stated Resident #4 distracted other residents from being able to eat. When asked how, Staff B stated she talked to the other residents, and they only have 1 hour to eat. Staff B stated the other staff directed them to tell Resident #4 to leave the dining room. Staff B stated that one of the residents made a comment like get her out of here. When asked which resident, Staff B described the resident who said it as a big jokester and added they probably were just joking around with Resident #4. She repeated the other resident was just joking. When asked if Staff B had any other residents tell her before she was being rude, she responded she did. Staff B stated Resident #4 talked about her, so Staff B went over to her and asked what she was talking about. Resident #4 answered she felt like Staff B picked on her, treated her rudely, and didn't treat the other residents like that. Staff B stated she thought they got along better and cleared the air. Staff B added they might still have a little tension between Resident #4 and her. On 7/31/25 at 12:00 PM, the ADON and the DON stated Resident #4 couldn't go near her boyfriend a few months back because she yelled at him. They stated the staff didn't receive direction to tell Resident #4 to leave a dining room when she didn't eat herself. They acknowledged the situation as a dignity issue and stated they talked with the staff about it being unacceptable. On 8/4/25 at 2:45 PM, Staff M, Certified Medication Aide (CMA), stated Resident #4 told her things all the time. Resident #4 told Staff M that Staff B pushed their head into the railing. Staff M described Resident #4 as pretty with it. Staff M stated she saw Staff B and Resident #4 argue before, adding it (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	gets really heated. Staff M said Resident #4 and Staff B both had tempers and they just clashed. Staff M stated Staff B asked Resident #4 what their problem was with her. Resident #4 answered Staff B had an attitude when she asked her for help. Staff M didn't believe Staff B responded to Resident #4's answer. Staff M said Staff B just sat there and listened to Resident #4. A Resident Rights- Dignity and Respect policy dated April 2024, directed staff to lay the foundation for treating all residents with dignity and respect while maintaining and enhancing his or her self-esteem and self-worth. The procedure each resident had the right to the following: Considerate and respectful care and to be treated with honesty, dignity, respect and with reasonable accommodation of individual needs except where the health, safety, or rights of the resident or other individuals in the facility would be endangered.Have visitors #2. Resident #51's Minimum Data Set (MDS) assessment dated [DATE] identified Brief Interview For Mental Status (BIMS) score of 9, indicating a moderate cognitive impairment. The MDS indicated Resident #51 didn't exhibit the behavior of rejecting care. Resident #51 required maximal assistance for lying to sitting on the side of the bed. The MDS listed Resident #51 as dependent on staff for all transfers. Resident #51 was unable to walk 10 feet. The MDS included diagnoses of chronic obstructive pulmonary disease, mild intellectual disabilities, cognitive communication deficit, abnormalities of gait, and mobility. The Care Plan Focus with a target date of 7/7/25 reflected Resident #51 had the tendency to refuse medications and showers. The Interventions directed the following: Staff to approach or speak in a calm manner. Assure the resident that concerns are validated and staff are willing to address legitimate concerns. Encourage to participate in care activities and respect the resident's rights to make his own lifestyle choice. During an interview on 7/28/25 at 4:02 PM, Resident #51 reported the staff pulled him from his bed. He added it happened day and night, and received bruises to his forearms. Resident #51 stated he had thin skin and could bruise when touched. Resident #51 stated he reported it to staff because being pulled from bed wasn't good for him. During an observation on 7/28/25 at 4:02 PM, Resident #51 pointed out several bruises to both of his forearms about the size of half dollar coins. A document titled Therapy Recommendation from Physical/Occupational Therapy (PT/OT) to Nursing dated 6/18/25 directed staff to use the standing mechanical lift for all transfers. The document directed staff to direct Resident #51 to explain before completing task to hold hands, assist or guide the patient's arm to safely grip the handle. Resident #51 required time to set up in the standing mechanical lift. During an interview on 8/4/25 at 1:42 PM, Staff O, CNA, stated when she first met Resident #51, he rejected every offer of care from her. Staff O explained the other staff directed her to offer his favorite things, such as offering coffee and chocolate milk. Staff O stated Resident #51 accepted care in the morning, then in the afternoon, he requested to lay down. Staff O stated she got trained to (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	follow what he likes to do. Staff O explained they direct her to get Resident #51 up from bed with a gait belt, stand him, and pivot him to the wheelchair. Staff O stated Resident #51 didn't have a bruise the morning of 7/28/25 and when she returned to work on 7/30/25, the night shift noticed the bruises and reported them to her. During an interview on 7/31/25 at 1:31 PM, Staff I, Infection Preventionist / Registered Nurse (RN), stated Resident #51 didn't act real cooperative, not delusional, but he would get agitated when she cut his hair. During an interview on 8/5/25 at 10:08 AM Staff A, stated Resident #51 didn't usually speak to her except to say no he didn't want to get up or no he didn't want to eat. Staff A stated when Resident #51 told her no, she reported it to the nurse who directed to get him up. Staff A explained the other CNA's directed to her use the standing mechanical lift when she transferred Resident #51. She reported she got him up with 2 staff assist, one on each side, and once he stood up, he grabbed the wheelchair. Staff A stated she used the gait belt and would place her other hand under his arm. During an interview on 8/5/25 at 10:43 AM, Staff P, RN, said she worked the evening of 7/28/25. She reported a CNA didn't approach her and she couldn't remember what staff worked that night. Staff P described Resident #51 as an assist of 1 staff for care and transfers but, she didn't see him get transferred. During an interview on 7/31/2025 at 1:50 PM, Staff H, MDS Coordinator, explained it was all in the approach with Resident #51. Staff H stated staff would come get him to convince Resident #51 to get up but, if he absolutely said no then it is a no. A document titled Patient Protection Guidelines Abuse Prevention, Reporting, and Investigation Prevention revised May 2025 instructed the facility to provide a supportive and safe environment for all residents to the extent possible through the deployment of trained and qualified staff to meet residents' needs. The individual resident Care Plans and facility assessment identified the resident's needs while honoring the residents' wishes to restrict visitors, and providing information to staff, residents, and visitors on how and to whom they may report concerns without the fear of retaliation and providing feedback to those expressing concerns.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interviews and policy review the facility failed to accommodate all residents by placing call lights in reach at all times for 1 of 6 residents (Resident #11). The facility reported a census of 49 residents. Findings include: Resident #11's Minimum Data Set (MDS) dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS identified Resident #11 was dependent on staff assistance for bed mobility and all transfers. The MDS documented Resident #11 had limited range of motion to upper and lower extremities to both sides. Residents #11 MDS included diagnosis of Cerebral Vascular Accident (CVA/Stroke) with hemiplegia affecting both sides and seizure disorder.The Care Plan Focus with a target date of 9/1/25 documented Resident #11 had alteration in communication related to CVA (stroke) dysarthria (weakness in muscles used for speech) and anarthria (complete loss of speech motor ability). The Goal reflected Resident #11 would make his basic needs known by answering yes and no questions through the movement of his right foot/leg.The Care Plan lacked direction or information regarding the use of adaptive call light and placement. The Kardex (used by the facility certified nursing assistant CNA as snap shot of resident care) dated 7/30/25 lacked information regarding Resident #11's adaptive call light and placement. On 7/29/25 at 10:15 AM, observed Resident #11 in his wheelchair in his room without a call light within reach. Resident #11's had his call light on his lower left side of his abdomen, near his upper left thigh. Resident #11 had goose bumps and hair standing up on his arms and legs. When asked if he was cold, Resident #11 replied yes by moving his right foot forward and backwards. At 10:55 AM, Resident #11 attempted to call out. When notified the MDS Coordinator went in his room and readjusted his call light. A continuous observation revealed Resident #11 didn't have his call light within reach for 40 minutes at the time the MDS Coordinator went into the room. On 7/30/25 at 10:42 AM, observed Resident #11 had his call light attached with clips to the sheet on the edge of the bed on his right side. When asked Resident #11 if he normally had his call light positioned by his right foot, he replied yes by moving his right foot back and forth. An interview with Staff C, CNA, verified Resident #11 didn't have his call light within reach. Adding, the call light should be positioned next to his right foot so he could reach it. Staff C repositioned the call light next to his right foot.On 7/30/25 at 11:00 AM, the Director of Nursing (DON) reported she expected the staff to position Resident #11's call light next to his right foot. The DON verified the Kardex didn't address his call light. The facility policy titled Call Light Policy revised September 2023 instructed to ensure prompt response to the resident's call for assistance. The policy further directed to place call lights within reach for residents who could use them. In addition, the policy documented the facility could use soft touch call lights if needed.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the electronic health record (EHR), facility records and staff interviews, the facility failed notify the resident or their Responsible Party when the facility initiated a change in their level of care and services for 2 of 5 residents reviewed (Residents #38 and #59). The facility reported a census of 49 residents.Findings Include:The facility completed Entrance Conference Worksheet regarding Beneficiary Notice reflected the following discharges from Medicare part A (skilled nursing facility care following a qualifying hospital stay) services on:3/10/25: Resident #38 remained in the facility.3/10/25: Resident #59 remained in the facility.1. Resident #38's Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review listed their last day covered with Medicare Part A services as 3/10/25. The form reflected the facility initiated the discharge from Medicare Part A services when they had benefit days remaining. The facility provided a Notice of Medicare Non-Coverage (NOMNC) but didn't provide the SNF Advance Beneficiary Notice of Non-Coverage (ABN). The reason why the SNF ABN form didn't get provided listed other without an explanation.Resident #38's Clinical Census reviewed 7/31/25 documented the following:2/19/25: Medicare part A services started.3/10/25 Medicare part A services ended, Resident #38 remained in the facility.The facility provided the NOMNC but lacked documentation the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN) had been provided informing her of the cost for services. 2. Resident #59's SNF Beneficiary Protection Notification Review listed his last covered day as 3/10/25. The form indicated the facility initiated the discharge from Medicare Part A Services with benefit days remaining. The facility provided the NOMNC but not the SNF ABN. The reason for not providing the SNF ABN listed he planned to discharge home but choose to stay at the facility.Resident #59's Clinical Census reviewed 7/28/25 identified the following:admitted on [DATE] under Medicare part A services.discharged from Medicare part A services on 3/11/25 and remained in the facility.The Progress Notes lacked documentation, the facility informed Resident #59 of the change in services making him responsible for payment following his discharge from Medicare part A services on 3/11/25.Resident #59's clinical record lacked documentation he received a SNF ABN.In an interview on 7/31/25 at 9:26 AM, Staff D, Social Services, reported being the person responsible for providing notification to the resident or the Resident's Representative when Medicare part A services changed. Staff D verbalized she didn't receive proper training. She didn't provide the NOMNC or the SNF ABN appropriately. Staff D verbalized she got taught if the resident had Medicaid for their payor source, she didn't need to provide the SNF ABN.In an interview on 7/31/25 at 10:31 AM, the Administrator acknowledged the facility didn't provide NOMNC's and SNF ABNs as required regardless of payor source. The Administrator reported they had Staff D scheduled for additional training on providing proper notifications.The facility failed to provide a policy related to the notification of services to a resident and/or the Resident's Representative.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, resident, and staff interviews, the facility failed to prevent all residents from abuse. The facility failed to provide care for Resident #51 as recommended by the Physical Therapist to facilitate transfers from bed to wheelchair and wheelchair to bed that are necessary to avoid physical harm, pain, mental anguish or emotional distress. The facility reported a census of 49 residents. Findings include:Resident #51's Minimum Data Set (MDS) assessment dated [DATE] identified Brief Interview For Mental Status (BIMS) score of 9, indicating a moderate cognitive impairment. The MDS indicated Resident #51 didn't exhibit the behavior of rejecting care. Resident #51 required maximal assistance for lying to sitting on the side of the bed. The MDS listed Resident #51 as dependent on staff for all transfers. Resident #51 was unable to walk 10 feet. The MDS included diagnoses of chronic obstructive pulmonary disease, mild intellectual disabilities, cognitive communication deficit, abnormalities of gait, and mobility.The Care Plan Focuses with a target date of 7/7/25 reflected Resident #51 had:The tendency to refuse medications and showers. The Interventions directed the following: Staff to approach or speak in a calm manner.Assure the resident that concerns are validated and staff are willing to address legitimate concerns.Encourage to participate in care activities and respect the resident's rights to make his own lifestyle choice. A risk for falls. The Interventions directed the following:Staff provide assistance of 2 staff with the standing mechanical lift for all transfers to the wheelchairPlace the call light within reachOrient to surroundings Consult with therapy as needed. Used anticoagulant (blood thinner) medication. The Interventions directed the staff to monitor for signs and symptoms of bleeding to include bruising.A document titled Therapy Recommendation from Physical/Occupational Therapy (PT/OT) to Nursing dated 6/18/25 directed staff to use the standing mechanical lift for all transfers. The document directed staff to direct Resident #51 to explain before completing task to hold hands, assist or guide the patient's arm to safely grip the handle. Resident #51 required time to set up in the standing mechanical lift. During an interview on 7/28/25 at 4:02 PM, Resident #51 reported the staff pulled him from his bed. He added it happened day and night, and received bruises to his forearms. Resident #51 stated he had thin skin and could bruise when touched. Resident #51 stated he reported it to staff because being pulled from bed wasn't good for him. Resident #51 pointed out several bruises to both of his forearms about the size of half dollar coins. The Encounter Note dated 6/10/25 written and signed by Staff S, Advanced Registered Nurse Practitioner (ARNP) on 6/23/25 at 7:48 AM identified the following:Resident #51 fell on 6/6/25. An X-Ray of the left elbow showed a mild distortion (twisting, or something out of its true natural, or original form) of the soft tissue dorsal (back) to left elbow, laceration or soft tissue contusion with no acute fracture.A skin tear to the left elbow measured 2.5 centimeters (cm) x 1 cm with a superficial abrasion (surface scrape of the skin).A superficial 1.5 cm x 1 cm abrasion noted to the left knee.Resident #51 tripped over a shoe attempting to self-transferring.An order for Physical Therapy (PT), Occupational Therapy (OT) and speech therapy (ST) for an evaluation and treatment. The staff recently noted a decline in his overall health.Resident #51 needed more assistance at meals and the staff noted him as weaker with transfers.The family knew of his decline and would accept Hospice services when needed.The primary diagnosis is mild Mental Retardation/Intellectual Disability (MR/ID) without behavioral disturbance. Atrial Fibrillation and on Eliquis (blood thinner). The Communication with Family/Related Party Note dated 6/11/25 at 12:29 PM indicated Resident #51 had a decline in transferring. He needed staff to assist him to and from bed to the wheelchair because of being unsteady and the inability to bear weight well. The Skin Condition Note dated 6/25/25 at 5:32 PM, indicated Staff I, RN Infection Preventionist (IP), documented they noted a scabbed skin tear on Resident #51's right hand that measured 0.9 x 1.2 cm. In addition, the observed a smaller skin tear noted to the left elbow with (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bruising scattered across the left forearm, unable to measure due to Resident #51's behavior of him pulling away and yelling. The Health Status Note dated 6/27/25 at 2:21 PM reflected the ARNP at the facility and noted Resident #51's skin condition. She gave no new orders.During an interview on 8/4/25 at 1:42 PM, Staff O, Certified Nursing Assistant (CNA), stated she started at the facility after 7/4/25. She explained the staff trained her to transfer Resident #51 from bed to wheelchair with a gait belt, stand and pivot technique. Staff O stated Resident #51 didn't have a bruise the morning of 7/28/25 and when she returned to work the morning of 7/30/25, the night shift reported finding bruises to both forearms. Staff O stated Resident #51 blamed her and a coworker for the bruises to his arms. Staff O stated she received direction to get Resident #51 up to the wheel chair with a gait belt, stand and pivot. Staff O stated Resident #51 refused to allow her to transfer him that day (8/4/25) and take him to lunch. Staff O stated she offered 3 times, and notified the nurse of his refusal. Staff O claimed she didn't know if Resident #51 had food delivered to him.During an interview on 7/30/25 at 3:04 PM, Staff B, CNA, explained she learned about the PT's recommendation to use the standing mechanical lift to transfer Resident #51 during report and it would be added to the care plan. Staff B stated she never had a problem with Resident #51 and didn't hear him say someone pulled him out of bed or hurt him. Staff B stated had noticed the bruising on his arms. Staff B stated if a CNA noted bruises on a resident, it's chart it in the electronic health record (EHR) then they tell the nurse. Staff B stated the nurses did a good job assessing a concern right away when staff report a change in a resident's condition. She explained no staff reported how Resident #51 received the bruising. Staff B claimed to have the abuse training.During an interview on 7/30/25 at 3:19 PM, Staff Q, CNA, stated Resident #51 used to walk in the past with the assistance of 1 staff and a walker but now the staff use the standing mechanical lift. Staff Q stated the CNA's receive report during the walking rounds with the CNA leaving their shift. Staff Q stated CNA's report bruises to the nurse and document on the skins sheet in the EHR every shift. During an interview on 7/30/25 at 3:31 PM, Staff J, CNA, stated the facility hired her in June 2025. Staff J stated Resident #51 could be a little hard to work with until the staff figure out his needs. Staff J stated Resident #51 required 2 staff assistance with the Standing mechanical lift and did very well with it. Staff J stated she noticed Resident #51 had bruising on his arms but didn't know how he got them. During an interview on 7/30/25 at 3:44 PM, Staff M, CNA, stated on 7/28/25 during the 2-10 shift, Resident #51 reported a staff person came into his room and grabbed him too hard by the arm to get him out of the bed. Staff M stated Resident #51 had dark bruises on his arms. Staff M stated they reported the incident to the nurse, but they couldn't recall the time they reported it that evening. Staff M claimed the facility didn't have enough staff on the 2-10 shift and it took all night to complete the residents' care.On 7/30/25 at 4:00 PM, notified the facility Administer about Resident #51's claim the staff pulled him out of bed by his arms and that he informed staff of the incident as it hurt his arms and he had visible bruising to both wrists and forearms. The Administrator stated no one informed her about the claim.A document TimeLine of Investigation dated 7/30/25 for Resident #51 reflected the following:At 6:00 PM, the Assistant Director of Nursing (ADON), the Director of Nursing (DON), and Staff U, Regional Nurse Consultant, completed an interview and assessment with Resident #51.They completed measurements of areas to his right hands, left hands, and arms completed. They determined the prior left elbow skin tear healed when assessed at 2:00 PM that day. The skin assessment revealed the following:Left lateral elbow maroon (reddish purple coloring) bruising 4 cm x 2.5 cm. The back of right-hand light purple/maroon bruising 9 cm x 4.5 cmThe right posterior forearm light purple/maroon 15 cm x 8 cmThe left posterior forearm skin tear 0.5 cm x 2 cm - edge of skin flap is scabbed. The back of left-hand maroon and yellow bruising 5.5 cm x 9.5 cm The left posterior forearm bruising maroon and yellow 17 cm x 9 cmResident #51's range of motion to left arm moved at his baseline and he denied pain.Resident #51 reported he bumped his right arm getting out of bed. During the interview with Resident #51 stated 2 young black staff members assisted him from bed and grabbed his left arm. He explained it happened in the day time. He told the ADON he wanted to tell her, but just hadn't yet.The staff conducted a (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review of Resident #51's July 2025 behavioral documentation, the nursing schedule, and compiled a staff interview list based on his behavior and interview. The facility completed the initial self-report.They spoke with the Police Department and received a case number. The staff reported Resident #51 refused to transfer with the standing mechanical lift. They placed an order for a PT and OT evaluation.They initiated the staff interviews.They interviewed all staff who worked with Resident #51 on 7/29/25 - 7/30/25.The staff didn't report any injury or incidents to his arms to account for the bruising on 7/30/25 at 6:00 PM. The Root Cause Analysis revealed: Resident #51 had no evidence of staff-inflicted injury to his arms. Resident #51 recently experienced significant mobility and cognitive decline.Resident #51 used an anticoagulant medication, making him prone to bruising easily.The bruises likely resulted from self-injury while attempting to get out of bed without assistance.The progress notes lack documentation for falls or attempted transfers that resulted in a self-injury from 6/5/25 through 7/30/25. The Incident Report Note dated 7/31/25 at 11:52 AM reflected Resident #51 had bruising and a skin tear to his left posterior (back of) forearm. His range of motion remained at baseline, and Resident #51 denied pain. Resident #51 required staff assistance for activities of daily living (ADL). Resident #51 received Eliquis 2 times a day for atrial fibrillation (abnormal heart rhythm) which increased the risk for bruising. During an interview on 7/31/25 at 1:31 PM Staff I described Resident #51 as not cooperative. Staff I stated Staff H, MDS Coordinator, assisted with the skin sheet, and the initial measurement. They asked Resident #51 how the injuries occurred. Staff I stated the skin sheets revealed the bruises Resident #51 sustained when he fell but they healed on 7/16/25. Staff I stated he didn't have any other bruising. Staff I couldn't state how Resident #51's bruises occurred, she did not ask him. She thought they happened from his fall. Staff I reported Resident #51 didn't act delusional but would get agitated. Staff I stated she didn't know Resident #51 claimed he staff hurt him recently and denied staff reporting it to her. Staff I stated Resident #51 may have resisted care. During an interview on 7/31/25 at1:50 PM, Staff H stated Resident #51 always had some reddish discoloration of his arms. Staff H stated on 6/27/25 he assessed dark purple bruises and a week later it faded and yellowed. Staff H stated he heard in the past Resident #51 made a claim of people being mean to him. Staff H stated he didn't know about Resident #51's recent claim of being pulled from the bed and had new bruises. Staff H stated if Resident #51 reported abuse, he would complete an assessment of Resident #51's body for injuries, call the DON, and law enforcement. During an interview on 8/4/25 at 12:49 PM, Staff S, ARNP, stated they didn't know about Resident #51's new bruising to his arms. Staff S described Resident #51 as very clear when he explained how he fell over his shoes the previous month when he hit his arm and head. Resident #51 could explain what happened to his arms. Staff S stated she would absolutely expect someone to follow-up on Resident #51's claim that someone hurt him and caused the bruising to his arms. During an interview on 8/5/25 at 10:08 AM Staff A, stated Resident #51 didn't usually speak to her except to say no he didn't want to get up or no he didn't want to eat. Staff A stated when Resident #51 told her no, she reported it to the nurse who directed her to get him up. Staff A explained the other CNAs directed to her use the standing mechanical lift when she transferred Resident #51. She reported she got him up with the assistance of 2 staff, one on each side. Once he stood up, he grabbed the wheelchair. Staff A stated she used the gait belt and would place her other hand under his arm. During an interview on 8/5/25 at 10:43 AM, Staff P, RN, said she worked the evening of 7/28/25. She reported a CNA didn't approach her and she couldn't remember what staff worked that night. Staff P described Resident #51 as an assist of 1 staff for care and transfers but, she didn't see him get transferred. During an interview on 8/5/25 at 11:12 AM, Staff R, CNA, stated the facility hired her and trained her in March 2025. Staff R reported they needed assistance from 2 staff to transfer Resident #51 with a gait belt to stand and pivot (turn) to a wheelchair. Staff R stated Resident #51 reached out to grab her hand or arm. Staff R stated she visualized bruises on his arms recently and reported the findings to the female nurse on duty. Staff R stated she followed directions on a paper at the nurses' station that listed the resident's hall, room number. The list also contained how the resident transferred, ate, the (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	briefs they wore, and if they wore hearing aids. The facility provided the document to staff as direction on how to transfer the residents. Staff C, CNA, identified the documents in a pocket folder on the nurses' station as the list the CNAs followed for providing care. The documents provided resident names in the facility, room numbers, and directions for the staff to provide care for each resident. The documented listed Resident #51 as 1 assist with all cares and transfers.During a follow up interview on 8/5/25 at 2:28 PM, when questioned if Resident #51 feared the staff who transferred him to the wheelchair who caused the bruising he reported to the surveyor, Resident #51 responded yes. When asked if he would be comfortable with the staff to continue providing his care, Resident #51 responded well and clinched his teeth put his arms across his body and shook back and forth in his bed and stated, they did it again and I told them not to but they did it again. When asked if he someone pulled him by his arms again, he nodded and stated, they did it again. During an interview on 8/5/25 at 3:00 PM, the Administrator stated she didn't know of a document they gave to the newly hired staff and agency staff that listed resident care. The Administrator requested to see the paper immediately. The Administrator stated the staff must follow the resident Care Plan in the EHR Kardex. During an interview on 8/5/25 at 3:00 PM, The DON stated she didn't know of any document at the nurses' station they provided to the newly hired staff and agency staff that listed resident care. During an interview on 8/6/25 at 3:30 PM, The ADON stated that she and Staff H, RN MDS Coordinator, complete the Care Plans and they haven't added the fine details therapy gave them on a paper document for the nursing staff on recommendations for resident's in the past. The ADON stated they would individualize the Care Plans going forward. The document Patient Protection Guidelines: Abuse Prevention, Reporting, and Investigation revised May 2025:Any allegation required an investigation.Center staff are required to notify the charge nurse and Abuse Coordinator immediately.According to the CMS, the facility must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress. Employees are educated upon hire and annually on the abuse prevention program including the immediate reporting of any suspicion of abuse, neglect, exploitation, or mistreatment. The Administrator is responsible for the investigating, reporting, and coordinating of the investigation process of any alleged or suspected abuse regardless of the source of the concern. Upon receiving a report of an allegation of resident abuse, neglect, exploitation, injuries of unknown origin or misappropriation, the facility shall immediately implement measures to prevent further potential abuse of residents from occurring while the facility investigation is in process.All allegations of resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation shall be reported to the Iowa Department of Inspections, Appeals and Licensing (DIAL) and any other required state agency if applicable (law enforcement). Reports of abuse or if the incident resulted in bodily injury, the facility should report immediately and no later than two (2) hours.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on record review, Preadmission Screening and Resident Review (PASRR) review, and interview, the facility failed to submit a new PASRR review for 1 resident reviewed (Resident #31). After Resident #31 received a new diagnosis of bipolar disorder, the facility failed to submit a new PASRR for review. The facility reported a census of 49 residents. Findings include:Resident #31 Clinical Census reviewed 8/5/25 documented his admission date as 8/15/24. Resident #31's PASRR Level 1 completed 6/5/24 documented a positive Level 1 PASRR, with no status change (indicating he didn't require further evaluation at the time).Resident #31's Medical Diagnosis reviewed 7/30/25 included a diagnosis of bipolar disorder added 3/27/25. The Care Plan Focus with a target date of 8/12/25 identified a PASRR Baseline Care Plan: New admission to the facility. The Goal reflected Resident #31 would state satisfaction with living arrangements and the facility would meet his needs based on recommendations. The Interventions directed to follow PASRR recommendations as applicable for the position of Social Services Designee (SSD). On 7/30/25 at 11:45 AM, the SSD, stated she didn't know of Resident #31's new diagnosis. She stated she talked with the team about notifying her when they add new diagnoses so she can resubmit a PASRR accordingly. An undated PASRR Process policy, directed the following: Admissions staff member validates PASRR completion prior to admit, enters patient into assessment pro on admission. All level II PASRR's and renewals are monitored and managed by social services Psychotropic medication changes and new or updated diagnosis should be discussed as part of daily IDT (Interdisciplinary Team) meetings. Social service would update PASRRs with the information as necessary.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility document review, and clinical record review, the facility failed to implement the Care Plan Interventions for 2 of 2 residents reviewed (Residents #22 and #26) for positioning. The facility failed to put in Resident #22's splints/brace as directed by the Care Plan and Therapy. In addition, the facility failed to follow the therapy recommendations as directed by Resident #26's Care Plan. The facility failed to use Resident #26's Chest Strap as directed by Therapy on multiple occasions, with 1 incident resulting in Resident #26 falling from her wheelchair. The faciltiy reported a census of 49 residents.Findings include:1. Resident #22's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment. The MDS listed Resident #22 as dependent (helper does all of the effort. The resident didn't do effort to complete the activity or, the needed the assistance of 2 or more help to complete the activity) for eating, oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, personal hygiene, roll left and right, sit to lying, and chair/bed-to-chair transfer. Resident #22 used a manual (nonelectric) wheelchair. The MDS listed active diagnoses of hemiplegia (paralysis that affected only one side of the body), traumatic brain injury (TBI), stroke, and stiffness of an unspecified joint. An untitled communication form from Occupational Therapy (OT) signed by a Certified Occupational Therapy Assistant (COTA) dated 5/29/25 recommended the following:Splints Apply when Resident #22 woke up in the morning.Remove splints at lunchApply at 2:30 PM. Take off at dinner.Elbow extension splint - blackPalm protectors or towel rollsCervical cushion or towel roll on right side of neck. The Care Plan Focus with a target date of 9/15/25 identified Resident #22 required assistance with activities of daily living (ADL's) related to limited mobility. The Goal documented Resident #22 will receive assistance with ADLs as required. The Interventions directed the staff to do the following:Splint/Brace: left hand splint, right palm protector, right elbow splintOn after breakfastRemove for lunch, Reapply after lunchRemove before supper. On 7/28/25 at 3:51 PM, observed Resident #22 sit in the dining area in his wheelchair without splints and/or braces. On 7/29/25 at 9:37 AM saw Resident #22 sit in his wheelchair in the hallway. He had his left hand in a fist over the seatbelt buckle without a splint. On 7/30/25 at 9:48 AM, witnessed Resident #22 in the common area in front of the television (TV) without a splint and/or braces noted to his upper extremities. On 7/31/25 at 8:30 AM, saw Resident #22 in dining room with a splint/brace on his right arm with a towel roll in each hand. On 7/31/25 at 8:54 AM, observed a typed note on an 8 by 12-inch paper on the wall above Resident #22's bed. A calendar cover the top of the paper. The visible bold print stated the following:Up wash rags in each palmOn when he gets up in the AMOff at lunchOn at 2:30 PMOff at supper time In an interview on 7/31/25 at 10:57 AM, Staff F, Certified Nursing Assistant (CNA), verbalized Resident #22 had splints. Staff F explained they need to put his splints on before he got up and remove them before lunch. Staff F confirmed Resident #22 had a poster above his bed reminding staff to apply his splints and/or braces. Staff F verified she saw Resident #22 without his splints and/or braces during the schedule time he needs to wear them. In an interview on 7/31/25 at 10:00 AM, Staff E, CNA, reported Resident #22 had splints, but didn't know if he had anything for his hands. Staff E reported she frequently saw Resident #22 without his splints and/or braces due to the difficulty of putting them on. In an interview on 7/31/25 at 11:34 AM Staff G, Licensed Practical Nurse (LPN), explained Resident #22 did have splints and/or braces. She reported he had a sign above his bed to remind staff to apply them. Staff G acknowledged she observed Resident #22 without his splints and/or braces during his schedule time to wear them. During an interview on 7/31/25 at 12:01 PM, the Assistant Director of Nursing (ADON) acknowledged Resident #22 did have splints and/or braces. The ADON reported Resident #22 had severe contractures. 2. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #26's Minimum Data Set assessment (MDS) dated [DATE] identified a Brief Interview for Mental (BIMS) score of 9, indicating moderate cognitive impairment. The MDS listed Resident #26 as dependent with toileting hygiene, propelling his wheelchair, shower/bathe self, upper and lower body dressing, personal hygiene, roll left and right, sit to lying, chair/bed-to-chair transfer, and tub/shower transfer. Resident #26 used a manual wheelchair. The MDS included diagnoses of cerebral palsy (disorders that affect movement, balance, and posture due to damage to the developing brain), mild intellectual disabilities, and type II diabetes mellitus without complications. The Summary of Daily Skilled services electronically signed by a COTA identified fall risk precautions documented the following:On 9/11/24 encountered Resident #26 in the common room seated in his wheelchair with safety concerns, as she didn't have her chest strap applied properly. The COTA educated the staff on proper procedure for applying chest strap. The staff returned a correct demonstration for applying the chest strap.On 9/17/24 encountered Resident #26 in the common room seated in her wheelchair, without her chest strap applied. The COTA located and applied a chest strap for safety and proper seated positioning. On 9/25/24 encountered Resident #26 in the common room seated in her wheelchair, agreeable to do therapy. Resident #26 didn't have on her chest strap for proper seated positioning. The COTA discussed the concern with nursing and staff. The COTA learned Resident #26 lost her chest strap to increase proper seated positioning for safety. Resident #26 stated she didn't know what happened to the missing strap. The COTA looked for the strap without success. The COTA looked for an alternative process for keeping Resident #26 safe in her wheelchair.On 10/1/24 encountered Resident #26 in the common room seated in her wheelchair, agreeable to do therapy. The COTA attempted to reassemble her chest strap for safety. The COTA couldn't reassemble due to missing straps. They checked with staff, who said no one saw them. The COTA informed the nursing staff. They knew and reported therapy needed to find a way to attach the straps to her wheelchair, so straps didn't get lost. The COTA discussed with Resident #26 and explained the would try again. All to increase proper seated positioning and safety while in her wheelchair. The Care Plan Focus with a target date of 8/12/25 identified Resident #26 had a risk for alteration in skin integrity related to incontinence of bowel and bladder and impaired mobility. The Interventions directed staff to use pillows/positioning devices as needed and to follow therapy recommendations as applicable.Resident #26's Order Review History Report reviewed and electronically signed by Resident #26's primary provider listed the following orders:10/21/16: Seatbelt on when in wheelchair.8/19/18: Chest harness to be on when up in wheelchair for positioning. Staff to remove every 2 hours for 10 minutes.On 7/29/25 at 11:44 AM observed Resident #26 in the dining area sitting at a table with her Resident Representative. Resident #26 wore a harness vest and a seat belt. On 7/30/25 at 9:49 AM saw Resident #26 in the common area in front of the TV in her wheelchair. She wore a seat belt, but no chest harness noted. Resident #26 sat in the upright position. On 7/31/25 at 8:49 AM observed Resident #26 in the dining area sitting in her wheelchair, holding a tablet with her seatbelt buckled. The observation revealed Resident #26 didn't wear a chest harness. In an interview on 7/31/25 at 9:58 AM, Staff E, Certified Nursing Assistant (CNA), verbalized Resident #26 recently fell. Staff E didn't know if Resident #26 had a chest harness. In an interview on 7/31/25 at 10:52 AM Staff F, CNA, reported Resident #26 recently fell. Staff F didn't know what interventions they implemented following her recent fall and verbalized Resident #26 had a seatbelt. Staff F acknowledged Resident #26 did have a chest harness and has seen her up in her wheelchair without it on. Staff F approached Resident #26 in the sitting area of the dining room where Resident #26 sat tilted back in her wheelchair. Staff F reported Resident #26 didn't have the chest harness in place. Staff F reached behind the wheelchair, pulled the harness up over Resident #26 and buckled it into place. Staff F verbalized she didn't know if she needed the chest harness on all the time when she sat in the wheelchair.In an interview on 7/31/25 at 11:34 AM Staff G, Licensed Practical Nurse (LPN), reported Resident #26 needed to wear a chest harness when she sat in her wheelchair. Staff G reported she observed Resident #26 in her wheelchair without the harness. In an interview on 7/31/25 at 4:07 PM, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Assistant Director of Nursing (ADON) acknowledged Resident #26 needed to have the chest harness on when in her wheelchair. On 8/4/25 at 11:11 AM, the Administrator reported the facility lacked a policy for positioning devices. The facility had therapy evaluate the resident to determine the need. If the resident is determined to have the need, the plan of care is updated with the recommended device. On 8/5/25 at 9:02 AM the Administrator provided the Nursing Assistant Skin Quick Reference revised November 2023 that directed the CNAs to do the following:Use elbow and heel protection per patient specific plan of care if applicableOff-load (float) heels off mattress surface if applicableApply braces/splints per patient specific plan of care, report pain or skin alterations to the nurseWheelchair cushionsAssistive devices for positioning per patient specific plan of care

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, resident, and staff interviews, the facility failed to revise the Comprehensive Care Plan for 1 of 3 residents (Resident #51) reviewed to meet individualized care needs. The facility staff provided care to Resident #51 according to outdated information written on a Resident List document. In addition, the facility failed to revise the Care Plan to include the Physical Therapy recommendations to meet Resident #51's needs. The facility reported a census of 49 residents. Findings include:Resident #51's Minimum Data Set (MDS) dated [DATE] identified Brief Interview For Mental Status (BIMS) score of 9, indicating a moderate cognitive impairment. The MDS indicated Resident #51 didn't exhibit the behavior of rejecting care. Resident #51 required maximal assistance for lying to sitting on the side of the bed. The MDS listed Resident #51 as dependent on staff for all transfers. Resident #51 was unable to walk 10 feet. The MDS included diagnoses of chronic obstructive pulmonary disease, mild intellectual disabilities, cognitive communication deficit, abnormalities of gait, and mobility.The Care Plan Focus with a target date of 7/7/25 identified Resident #51 had a risk for falls. The Interventions directed the following:Staff provide assistance of 2 staff with the standing mechanical lift for all transfers to the wheelchairPlace the call light within reachOrient to surroundings Consult with therapy as needed. The Care Plan Focus with a target date of 7/7/25 reflected Resident #51 had the tendency to refuse medications and showers. The Interventions directed the following:Staff to approach or speak in a calm manner.Assure the resident that concerns are validated and staff are willing to address legitimate concerns.A document titled Therapy Recommendation from Physical/Occupational Therapy (PT/OT) to Nursing dated 6/18/25 directed staff to use the standing mechanical lift for all transfers. The document directed staff to direct Resident #51 to explain before completing task to hold hands, assist or guide the patient's arm to safely grip the handle. Resident #51 required time to set up in the standing mechanical lift. During an interview on 7/28/25 at 4:02 PM, Resident #51 reported the staff pulled him from his bed. He added it happened day and night, and received bruises to his forearms. Resident #51 stated he had thin skin and could bruise when touched. Resident #51 stated he reported it to staff because being pulled from bed wasn't good for him. During an observation on 7/28/25 at 4:02 PM, Resident #51 pointed out several bruises to both of his forearms about the size of half dollar coins. During an interview on 8/4/25 at 1:42 PM, Staff O, CNA, stated when she first met Resident #51, he rejected every offer of care from her. Staff O explained the other staff directed her to offer his favorite things, such as offering coffee and chocolate milk. Staff O stated Resident #51 accepted care in the morning, then in the afternoon, he requested to lay down. Staff O stated she got trained to follow what he likes to do. Staff O explained they direct her to get Resident #51 up from bed with a gait belt, stand him, and pivot him to the wheelchair. Staff O stated Resident #51 didn't have a bruise the morning of 7/28/25 and when she returned to work on 7/30/25, the night shift noticed the bruises and reported them to her. During an interview on 7/30/25 at 3:04 PM, Staff B, CNA, said she learned of the PT recommendation to utilize the standing mechanical lift to transfer Resident #51 during a verbal report and they would put in the Care Plan. During an interview on 8/5/25 at 10:08 AM Staff A, stated Resident #51 didn't usually speak to her except to say no he didn't want to get up or no he didn't want to eat. Staff A stated when Resident #51 told her no, she reported it to the nurse who directed to get him up. Staff A explained the other CNA's directed to her use the standing mechanical lift when she transferred Resident #51. She reported she got him up with 2 staff assist, one on each side, and once he stood up, he grabbed the wheelchair. Staff A stated she used the gait belt and would place her other hand under his arm. During an interview on 8/5/25 at 10:43 AM, Staff P, RN, said she worked the evening of 7/28/25. She reported a CNA didn't approach her and she couldn't remember what staff worked that night. Staff P described Resident #51 as an assist of 1 staff for care and transfers but, she didn't see (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	him get transferred. During an interview on 7/30/25 at 3:31 PM, Staff J, CNA, explained the facility hired her in June 2025. Staff J described Resident #51 as a little hard to work with until you figure out his needs. Staff J stated Resident #51 required assistance from 2 staff with the standing mechanical lift and added he did very well. Staff J stated she noticed he had bruising on his arms but didn't know how he got them. During an interview on 7/30/25 at 3:19 PM, Staff Q, CNA, stated Resident #51 use to walk with the assistance of 1 staff and a walker but now the staff used the standing mechanical lift. On 7/30/25 at 4:00 PM, when notifying the Administrator about Resident #51's claims that he got pulled out of bed by his arms by the staff and stated he informed staff of this because it hurt his arms and he had visible bruising to both wrists and forearms, the Administrator responded that no one informed her of that.During an interview on 8/05/25 at 11:12 AM, Staff R, CNA, reported the facility hired and trained her in March 2025. Staff R stated they transferred Resident #51 with the assistance of 2 staff with a gait belt, stand and pivot to a wheelchair. Staff R stated Resident #51 reached out to grab her hand or arm. Staff R stated she saw bruises on his arms and reported the findings to the female nurse on duty. Staff R said she followed the directions on a paper at the nurses' station that listed the resident's hall, room number and how they transferred, ate, the briefs they wore and if they wore hearing aids.The documents located in a pocket folder on the nurses' station identified by Staff C, CNA, as the list the CNAs followed for providing care. The document listed resident names in the facility, room numbers and directions for staff to provide care for each resident. The document listed Resident #51 as a 1 assist with all cares and transfers.A follow up interview on 8/5/25 at 2:28 PM, Resident #51 responded yes when asked if he was fearful of staff who transferred him to the wheelchair and caused bruising as he previously reported. When asked if he would be comfortable with the staff to continue providing his care, Resident #51 responded well and clinched his teeth put his arms across his body and shook back and forth in his bed and stated, they did it again.During an interview on 8/5/25 at 3 PM, the Administrator stated she didn't know of a document given to newly hired staff and agency staff that listed resident care. The Administrator stated the staff are to follow the resident Care Plan in the electronic health record (EHR) Kardex. During an interview on 8/6/25 at 3:30 PM, the Assistant Director of Nursing (ADON) stated that she and Staff H, RN MDS Coordinator, completed the Care Plans. They didn't add the fine details therapy gave them on a paper document for recommendations in the past. The ADON stated they would individualize the Care Plans going forward.

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff, resident, and resident representative's interview the facility failed to report an incident at the time it occurred, resulting in a delay in assessment for 1 of 1 resident reviewed (Resident #4). As Staff B, Certified Nurse Aide (CNA), repositioned Resident #4 in bed, she hit her head on the siderail. Staff L, Licensed Practical Nurse (LPN), reported she learned of the incident when Resident #4 called the facility hours later and reported it herself to the Director of Nursing (DON). Staff L explained she didn't get to assess Resident #4 immediately after the incident because no one reported the incident to her until the DON did hours later. The facility reported a census of 49 residents. Resident #4's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS listed Resident #4 as dependent on staff to roll from left to right in bed. The MDS included diagnoses of quadriplegia (inability to move all parts of the body from the neck down), anxiety, and post-traumatic stress disorder (PTSD). The Care Plan Focus with a target date of 8/28/25 indicated Resident #4 required assistance with activities of daily living (ADLs) related to arthrogryposis multiplex congenita (multiple joint contractures present at birth) as evidence by impaired mobility in bilateral arms and legs. The Interventions listed Resident #4 as dependent on 1 to 2 staff members for bed mobility. The Incident Report Progress Note dated 6/25/25 at 9:23 PM, authored by Staff L documented Resident #4 reported during her evening cares, as the aides rolled her, they rolled her into the side rail striking the right side of her head. The assessment reflected Resident #4 complained of a headache and her range of motion (ROM) remained at baseline. The nurse-initiated Neuro's (assessments to evaluate a person's neurological status) when Resident #4 reported the incident. The assessment revealed no noted injury to her head. On 7/31/25 at 9:20 AM, Resident #4's friend reported Resident #4 told them a staff member bumped her head into the side rail during a transfer in the last couple of months. Resident #4 told her friend the incident ended in a concussion. On 7/31/25 at 1:19 PM, Resident #4 reported Staff B rolled her in bed and she hit her head on the side rail. Resident #4 explained the incident as not purposeful. When asked if she had a bad outcome, Resident #4 stated she had a headache for like 3 days. She denied having a concussion or anything like that. She stated Staff B didn't tell anyone what happened. Resident #4 stated Staff B did say sorry, but she didn't feel like Staff B meant it, otherwise Staff B would have told a nurse. Resident #4 said she called the facility and the Director of Nursing (DON), answered, so she told her about the incident. On 7/31/25 at 4:00 PM, the Assistant Director of Nursing (ADON) and the DON stated they talked with Resident #4 and followed up with the staff. On 8/4/25 at 2:16 PM, Staff B stated she rolled Resident #4 (in bed) one night when Staff B checked and changed her. She rolled Resident #4 too far, and she bumped her head. Resident #4 said ow. When Staff B rolled Resident #4 back over, she looked and didn't see a red mark. Staff B stated the incident occurred later, probably after 8:00 PM and she made sure she apologized to Resident #4. Staff B said she didn't mean to roll Resident #4 that hard. Staff B stated Resident #4 complained earlier in the shift that her head hurt. Staff B let the nurse know about Resident #4's head hurting then. Later on, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when Staff B hurt this resident's head on the bed rail, Resident #4 said her head hurt and she told the nurse it hurt because she hit her head on the side rail. On 8/4/25 at 2:45 PM, Staff M, Certified Medication Aide (CMA), stated she worked the night of the incident. Staff M stated Resident #4 told her things all the time. Resident #4 told Staff M that Staff B pushed her head into the railing. Staff M stated she didn't do anything with the information, as Resident #4 just told her a couple of days ago. Resident #4 didn't tell Staff M the night of the incident. Staff M described Resident #4 as pretty with it. Staff M said she encouraged Resident #4 to go say something as she is more than able to tell someone. Staff M assumed Resident #4 already told someone about the incident. On 8/4/25 at 3:44 PM, Staff N, CMA, explained when she went to give Resident #4, her medications that night, she told her Staff B turned her and her head hit the side rail. Staff N went and reported the incident to the covering nurse but didn't know for sure which nurse. Staff N stated she didn't remember Staff B saying anything to her about the incident the night it happened. On 8/5/25 at 9:45 AM, Staff L, LPN (covering nurse), stated she worked the night Staff B rolled Resident #4 rolled in bed and she hit her head on the siderail. Staff L stated she found out about it from the DON. Staff L stated Resident #4 reported it herself by calling the facility and the DON answered the phone. When asked if Staff B reported the incident to Staff L, she replied no. When asked if Staff N reported it to Staff L, she responded no. When asked if Staff L felt Staff B should have reported the incident to her, she replied yes. Staff N stated she didn't find out about the incident until a few hours after it happened when Resident #4 reported the incident herself. Staff L said it caused a delay in her initial assessment. She stated she wished Resident #4 reported it sooner as well. When asked if she felt it the CNA had the responsibility to report it immediately after it happened, Staff L responded absolutely. Staff L stated again it caused a delay in assessing Resident #4 because they didn't know about the incident. On 8/5/25 at 12:48 PM, the DON stated she talked with Staff B about reporting the incident right away. The DON explained Staff B said she did report the incident, but she couldn't validate or confirm it from anyone she spoke to. The DON confirmed the nurse and her found out about the incident because Resident #4 reported it herself. The DON stated she expected the staff to report incidents immediately so the staff could do timely assessment and interventions. This DON stated she would look for a policy that supported the expectation to report incidents right away. In an email dated 8/5/25 at 1:26 PM, the DON wrote the facility didn't have a policy for when a CNA should report those things to the nurse. It is standard practice that they should report anything abnormal to the nurse, as soon as it happens.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, clinical record reviews, and facility document reviews, the facility failed to provide pressure relieving measures to a resident with a stage 3 pressure wound for 1 of 4 residents reviewed (Resident #19) for pressure wounds. The facility failed to put on Resident #19's pressure relieving boots. In addition, the facility failed to ensure Resident #19's bandage to her pressure wound remained secure. The facility reported a census of 49 residents. Findings include:Resident #19's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognition. The documented Resident #19 used a wheelchair for mobility. Resident #19 needed setup or clean-up assistance (helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.) for upper and lower body dressing and personal hygiene. The MDS listed Resident #19 as independent with a manual wheelchair. The MDS documented active diagnoses of paraplegia, lumbar spina bifida without hydrocephalus (where the spinal column doesn't fully close in the lumbar (lower back) region, but the condition does not involve an abnormal buildup of cerebrospinal fluid in the brain (hydrocephalus)), pressure ulcer of left heel (stage 2), and type II diabetes mellitus with hyperglycemia.The Care Plan Focus with a target date of 10/26/25 indicated Resident #19 had a for alteration in skin integrity related to a history (hx) of open areas/pressure ulcers, diabetes, and impaired mobility. Resident #19 had a stage 3 pressure ulcer to her left heel. The wound clinic follows her for her pressure ulcer of the left heel. Resident #19 completed intravenous (IV) antibiotics for osteomyelitis (bone infection) on 7/28/25. The Care Plan Interventions directed the staff the following:Administer medications as ordered.Administer treatment per physician ordersApply bilateral (both sides) heel protectors as indicated to float heelsApply tubi grip (a support bandage) in the morning, and remove in the eveningPressure reducing device on chairThe Order Review History Report electronically reviewed and signed 7/1/25 by Resident #19's primary provider included the following orders:Heels floated at all times-pillow under the lower leg to elevate off the chair. Pressure relieving boot to left foot at all times every shift for skin healing until healedOn 7/28/25 at 3:31 PM, observed Resident #19 sitting in her wheelchair with both feet extended and bare resting on the calf support pad of the wheelchair. Her left heel had a bandage. Resident #19 had a pillow placed under her calves with the left heel touching the calf support pad of the wheelchair. On 7/29/25 at 9:14 AM, observed Resident #19 in the hallway sitting in her wheelchair. She had a pillow and round cushion under her left calf. She didn't have any pressure relieving boots on her feet and had an unsecured bandage on left heel. On 7/29/25 at 9:26 AM witnessed Resident #19 in the hallway sitting in her wheelchair. She had a second pillow placed under her left calf with a pressure relieving boot on her left foot. Resident #19 verbalized the staff can't figure out what she needed for her foot. Resident #19 reported she didn't have boot on for a while and they told her, she needed to float her heels. In an interview on 7/30/25 at 2:18 PM Staff J, Certified Nursing Assistant (CNA), verbalized Resident #19 had a skin area to her left heel. Staff J reported Resident #19 usually didn't have anything on her feet and they never put any pressure relieving boots on her feet. In an interview on 7/30/25 at 2:22 PM Staff K, CNA, reported Resident #19 had pressure relieving boots for her foot. Staff K reported she saw her with and without the boot on. In an interview on 7/30/25 at 2:41 PM, Staff I, Registered Nurse (RN)/Infection Preventionist (IP), verbalized Resident #19 had tubi grips and pressure relieving boots. Staff I reported she saw Resident #19 without wearing her pressure relieving boots a number of occasions. Staff I acknowledged Resident #19 had a skin area on her left heel. On 7/31/25 at 8:30 AM, observed Resident #19 sitting in the dining room eating breakfast. Resident #19 sat upright in her wheelchair with her left foot on the calf support of the wheelchair. She didn't have anything on her left foot, no pressure relieving boot, and she didn't have her bandage secured to her skin. On 8/4/25 at 11:11 AM, the Administrator reported the facility didn't have a policy for positioning devices. They had therapy evaluate to (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	determine the need, if the resident needed a device, they updated the plan of care with the recommended device. On 8/5/25 at 9:02 AM the Administrator provided the Nursing Assistant Skin Quick Reference revised November 2023 that directed the CNAs to do the following:Use elbow and heel protection per patient specific plan of care if applicableOff-load (float) heels off mattress surface if applicableApply braces/splints per patient specific plan of care, report pain or skin alterations to the nurseWheelchair cushionsAssistive devices for positioning per patient specific plan of care

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, facility document review, staff, resident, and resident representative interviews, the facility failed to prevent a fall for 1 of 1 resident reviewed (Resident #26). The facility failed to use Resident #26's chest strap as order by the physician, recommended by therapy, and as written on the Care Plan. While the staff adjusted the recline of Resident #26's wheelchair, she fell to the floor. At the time Resident #26 didn't wear her chest strap as directed for safety and proper seated positioning. The facility reported a census of 49 residents.Findings include:Resident #26's Minimum Data Set assessment (MDS) dated [DATE] identified a Brief Interview for Mental (BIMS) score of 9, indicating moderate cognitive impairment. The MDS listed Resident #26 as dependent with toileting hygiene, propelling his wheelchair, shower/bathe self, upper and lower body dressing, personal hygiene, roll left and right, sit to lying, chair/bed - to-chair transfer, and tub/shower transfer. Resident #26 used a manual wheelchair. The MDS included diagnoses of cerebral palsy (disorders that affect movement, balance, and posture due to damage to the developing brain), mild intellectual disabilities, and type II diabetes mellitus without complications. The Summary of Daily Skilled services electronically signed by a COTA identified fall risk precautions documented the following:On 9/11/24 encountered Resident #26 in the common room seated in his wheelchair with safety concerns, as she didn't have her chest strap applied properly. The COTA educated the staff on proper procedure for applying chest strap. The staff returned a correct demonstration for applying the chest strap.On 9/17/24 encountered Resident #26 in the common room seated in her wheelchair, without her chest strap applied. The COTA located and applied a chest strap for safety and proper seated positioning. On 9/25/24 encountered Resident #26 in the common room seated in her wheelchair, agreeable to do therapy. Resident #26 didn't have on her chest strap for proper seated positioning. The COTA discussed the concern with nursing and staff. The COTA learned Resident #26 lost her chest strap to increase proper seated positioning for safety. Resident #26 stated she didn't know what happened to the missing strap. The COTA looked for the strap without success. The COTA looked for an alternative process for keeping Resident #26 safe in her wheelchair.On 10/1/24 encountered Resident #26 in the common room seated in her wheelchair, agreeable to do therapy. The COTA attempted to reassemble her chest strap for safety. The COTA couldn't reassemble due to missing straps. They checked with staff, who said no one saw them. The COTA informed the nursing staff. They knew and reported therapy needed to find a way to attach the straps to her wheelchair, so straps didn't get lost. The COTA discussed with Resident #26 and explained the would try again. All to increase proper seated positioning and safety while in her wheelchair. The Care Plan Focus with a target date of 8/12/25 identified Resident #26 had a risk for alteration in skin integrity related to incontinence of bowel and bladder and impaired mobility. The Interventions directed staff to use pillows/positioning devices as needed and to follow therapy recommendations as applicable.The Care Plan lacked documentation related to falls.Resident #26's Order Review History Report reviewed and electronically signed by Resident #26's primary provider listed the following orders:10/21/16: Seatbelt on when in wheelchair.8/19/18: Chest harness to be on when up in wheelchair for positioning. Staff to remove every 2 hours for 10 minutes.The Incident Report Note dated 7/28/25 at 12:29 PM documented as the Resident #26 sat reclined in her wheelchair in the dining room, the staff attempted to put her wheelchair in the upright position. At this time, the wheelchair tipped forward and Resident #26 slid to the floor. The nurse's assessment reflected she had Range of Motion (ROM) at her baseline, denied pain. The note listed the following vital signs blood pressure 120/80, pulse 52, respirations 20, temperature 98.1 and oxygen at 97% on room air. The assessment reflected Resident #26 didn't have injuries at the time. The staff assisted Resident #26 back to her wheelchair via a mechanical lift and the assistance of 2 staff. The recommendation of preventative measures indicated (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to ensure to secure Resident #26's seat belt and provide staff education on wheelchair operation.The Progress Note lacked documentation on the chest harness.In an interview on 7/31/25 at 9:58 AM, Staff E, Certified Nursing Assistant (CNA), verbalized Resident #26 recently fell. Staff E didn't know if Resident #26 had a chest harness. In an interview on 7/31/25 at 10:52 AM Staff F, CNA, reported Resident #26 recently fell. Staff F didn't know what interventions they implemented following her recent fall and verbalized Resident #26 had a seatbelt. Staff F acknowledged Resident #26 did have a chest harness and has seen her up in her wheelchair without it on. Staff F approached Resident #26 in the sitting area of the dining room where Resident #26 sat tilted back in her wheelchair. Staff F reported Resident #26 didn't have the chest harness in place. Staff F reached behind the wheelchair, pulled the harness up over Resident #26 and buckled it into place. Staff F verbalized she didn't know if she needed the chest harness on all the time when she sat in the wheelchair.In an interview on 7/31/25 at 11:34 AM Staff G, Licensed Practical Nurse (LPN), reported they implemented the recent intervention to prevent falls as to have the seatbelt on while in her wheelchair. Staff G reported Resident #26 needed to wear a chest harness when she sat in her wheelchair. Staff G reported she has observed Resident #26 in her wheelchair without the harness. In an interview on 7/31/25 at 4:07 PM, the Assistant Director of Nursing (ADON) acknowledged Resident #26 needed to have the chest harness on when in her wheelchair. On 8/4/25 at 11:11 AM, the Administrator reported the facility lacked a policy for positioning devices. The facility had therapy evaluate the resident to determine the need. If the resident is determined to have the need, the plan of care is updated with the recommended device. On 8/5/25 at 9:02 AM the Administrator provided the Nursing Assistant Skin Quick Reference revised November 2023 that directed the CNAs to do the following:Use elbow and heel protection per patient specific plan of care if applicableOff-load (float) heels off mattress surface if applicableApply braces/splints per patient specific plan of care, report pain or skin alterations to the nurseWheelchair cushionsAssistive devices for positioning per patient specific plan of care

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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 observations, interviews and record review, the facility failed to provide services to residents in accordance with acceptable infection control practices for 3 out of 3 residents reviewed (Resident #9, Resident #19 and Resident #40). While performing perineal (peri) care on Resident #9, the staff failed to complete hand hygiene after removing their dirty gloves and applying clean gloves. While performing wound care on Resident #19, the staff laid the scissors down on the bed without a barrier and then used the scissors to cut a wound dressing cover. While transferring Resident #40 with a mechanical lift after being in a shower chair, the staff removed the mechanical lift and shower chair from this resident's room without sanitizing the items after they bled on them. The facility reported a census of 49 residents. Findings include:Resident #6's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 9, indicating moderately impaired cognition. The MDS listed Resident #6 as dependent on staff for toileting hygiene. The MDS reflected Resident #6 had an indwelling catheter. The MDS included diagnoses of epilepsy (seizure disorder), chronic kidney disease, and bipolar disease. The Care Plan Focuses with a target date of 10/16/25 reflected the following: Enhanced barrier precautions (EBP) related to a positive type of protein that breaks down antibiotics preventing them from working against certain bacteria (KPC gene). The goal was to minimize risk for transmission during high contact care activities. The Interventions instructed the staff on the EBP Precautions for the staff to wear a gown and gloves while performing high-contact care activities including changing briefs, assisting with toileting, and caring for an indwelling medical device such as a urinary catheter. Resident #6 had an indwelling catheter related to obstructive and reflux uropathy (blockage and backflow of urine flow). On 7/30/25 at 11:23 AM, observed Resident #6 lie in bed as Staff A, Certified Nurse Aide (CNA), and Staff O, CNA, donned gown and gloves. Staff A proceeded to provide cares to Resident #6's groin, testicles, penis, and catheter tube with soap and water and a washcloth. They folded the washcloth to a new area before each swipe. After rinsing and drying the areas, Staff A removed her gloves, threw them away, and applied new gloves. Staff A failed to complete hand hygiene to her hands prior to putting on the clean gloves. Staff A proceeded to provide care to Resident #6's back side, then applied a barrier cream with the same gloves. Observed Resident #6 with open, red, and inflamed groin. Resident #6 reported it burned when Staff A did his care. Staff A failed to wash his hips. On 7/30/25 at 12:30 PM, when questioned about the care Staff A and Staff O provided to Resident #6, the Director of Nursing (DON) acknowledged Staff A didn't sanitize or wash her hands between changing from dirty gloves to clean gloves. The DON added Staff A should have done hand hygiene. On 7/30/25 at 12:45 PM, Staff A confirmed she didn't complete hand hygiene between removing dirty gloves and applying new ones. She reported she knew she was supposed to. She acknowledged she didn't wash Resident #6's hips. On 8/4/25 at 2:00 PM, Staff B stated she noticed as they provided care to Resident #6, that Staff A didn't wash her hands between removing her gloves and putting new gloves on. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/4/25 at 3:45 PM, Staff N, Certified Medication Aide (CMA), reported the residents didn't get good peri care. She stated some staff didn't even wipe the residents or even wash them. Staff N added the facility had so many Urinary Tract Infections (UTIs). An Incontinence Care policy dated August 2023, directed staff to provide perineal care to ensure cleanliness and comfort to the resident, to prevent infection and skin irritation, and to observe the resident's skin condition. The policy directed to Perform hand hygiene, put on gloves Cleanse the peri-area with cleansing agent or disposable wipe wiping from front of perineum toward rectum. Turn patient from side to side to cleanse affected area, as needed. Rinse with water if needed per cleansing agent manufacturer's instructions. Wash hands if visibly soiled and apply new gloves. Apply non-medicated skin protectant product, if applicable Remove gloves and dispose to designated container Perform hand hygiene 2. Resident #19's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognition. The documented Resident #19 used a wheelchair for mobility. Resident #19 needed setup or clean-up assistance (helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.) for upper and lower body dressing and personal hygiene. The MDS listed Resident #19 as independent with a manual wheelchair. The MDS documented active diagnoses of paraplegia, lumbar spina bifida without hydrocephalus (where the spinal column doesn't fully close in the lumbar (lower back) region, but the condition does not involve an abnormal buildup of cerebrospinal fluid in the brain (hydrocephalus)), pressure ulcer of left heel (stage 2), and type II diabetes mellitus with hyperglycemia. The Care Plan Focus with a target date of 10/26/25 indicated Resident #19 had a for alteration in skin integrity related to a history (hx) of open areas/pressure ulcers, diabetes, and impaired mobility. Resident #19 had a stage 3 pressure ulcer to her left heel. The wound clinic follows her for her pressure ulcer of the left heel. Resident #19 completed intravenous (IV) antibiotics for osteomyelitis (bone infection) on 7/28/25. The Care Plan Interventions directed the staff the following: Administer medications as ordered. Administer treatment per physician orders Apply bilateral (both sides) heel protectors as indicated to float heels Apply tubi grip (a support bandage) in the morning, and remove in the evening Pressure reducing device on chair The Order Review History Report electronically reviewed and signed 7/1/25 by Resident #19's (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165152	A. Building B. Wing	08/06/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	primary provider included the following orders: Wash wound to left heel, every other day with soap and (et) water, rinse well, pat dry. Apply AquaCell AG over wound, cover with gauze pads-secure with rolled gauze or tape as needed for wound care and one time a day every Tuesday, Thursday, and Saturday. The Order Entry dated 7/30/25 at 7:22 AM directed staff to wash wound Resident #19's left heel with soap et water, and pat dry. Apply Prisma wound et cover with Mepilex border. Change every (q) 3 days. On 7/30/25 at 7:54 AM, observed Staff H, Registered Nurse, set up a barrier and supplies to perform the treatment to Resident #19's left heel. Resident #19 sat on the bed with her left foot held over the edge of the mattress. Staff H placed a barrier on the bed linen. Staff H used scissors to cut the gauze dressing off the left foot. Staff H placed the scissors directly on bed linen rather than on barrier he placed on the bed. Staff H cleansed the wound with soap and patted the area dry. Staff H measured the area as 1.4 cm x 0.8 cm x 0.3 cm. Staff H used scissors without sanitizing or disinfecting them to cut the Prisma pad. The nurse placed the Prisma pad directly on the pressure area on the left heel. Staff H applied the Mepilex border to her heel and placed a pressure relieving boot to the left heal. Staff H acknowledged he should have sanitized or disinfected the scissors prior to using them to cut the Prisma pad. In an interview on 7/30/25 at 8:25 AM, the DON reported they expected the staff to set the scissors on barrier and sanitize/disinfect the scissors. On 7/31/25 at 1:00 PM, Staff I, Infection Preventionist, reported she expected the staff to disinfect the scissors between residents with a disinfectant wipe. Staff I verbalized the staff shouldn't keep the scissors in the staff's pocket. Staff I reported the staff should use a barrier and not set the scissors directly on the bed. Staff I verbalized if they set the scissors on the bed and then used to cut a dressing for a wound, they would consider them contaminated. The facility provided Dressing Change policy revised November 2023 instructed if dressings need to be cut to size, use clean scissors (disinfect the scissors with an EPA approved disinfectant before and after using). 3. Resident #40's MDS assessment dated [DATE] identified a BIMS score of 1, indicating severely impaired cognition. The MDS listed Resident #40 as totally dependent on staff for toileting, showering, and dressing. The MDS included diagnoses of anemia (low blood iron levels), stroke affecting the right side, diabetes mellitus. The Care Plan Focuses with a target date of 8/12/25 reflected the following: Resident #40 required assistance with activities of daily living (ADLs). The Interventions directed the staff to Bathe Resident #40 with 1 or 2 staff. Transfer Resident #0 with a mechanical lift. Use Enhanced Barrier Precautions (EBP) precautions. The Interventions directed to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Wear a gown and gloves while performing high-contact care activities to include bathing, transferring, and changing of linens. The Care Plan lacked direction if Resident #40 bled. The Clinical Physician Orders printed 7/31/25 included the following orders dated: 7/29/25: Monitor vital signs due to prolonged bleeding/passing of clots. 7/30/25: Refer to OBGYN (physician specific for women related concerns) to assess for possible abnormal vaginal bleeding. The Health Status Note dated 7/28/25 at 10:46 PM identified the Certified Nurse Aide (CNA) called the nurse to Resident #40's room to assess her for bleeding bright/dark red blood and a clot the size of a tennis ball in the resident's brief. Resident #40 received a new order to hold Plavix and Eliquis blood thinners and continue to monitor for bleeding. On 7/30/25 at 7:10 AM, watched Staff V, Respiratory Therapist (RT), assist Staff C, CNA, transfer Resident #40 using the mechanical lift, using a shower sling, from the bed to shower chair. Resident #40 only wore a gown. Staff C maneuvered the mechanical lift while Staff V monitored Resident #40, as they lowered her onto the shower chair. Resident #40 bled onto the shower chair and floor, then Staff C rolled the shower chair through the blood. The Assistant Director of Nursing (ADON) monitored the transfer, intervened by pointing out the approximate 11-inch diameter blood spatter on the floor and left the room. Staff C asked Staff V where the ADON went. The ADON returned with the Director of Nursing (DON) and a blood spill kit. The DON sprinkled the powered substance onto the blood spatter. Staff V stepped around the shower chair and the edge of her shoe went into the powdered substance absorbed with blood then left the room without sanitizing her shoe. The ADON wiped the top of the wheels of the shower chair and the lower part of the chair with disinfecting wipe. Staff C backed the shower chair through the powdered substance soaked in blood and out of the resident room, over the carpeted hall and into the shower room next to this resident's room. The ADON and DON cleaned the floor. Then they put all substances with wipes into a red bag then removed their gloves and gown, placing them into the trash with a clear bag and washed their hands. Staff C returned with Resident #40 in the shower chair covered with a bath blanket with a smear of blood that appeared to be a handprint, draped over her. The DON wore personal protective equipment (PPE) and assisted with transferring Resident #40 back to bed to get dressed. Staff C wearing PPE from the shower room, maneuvered the mechanical lift and lifted Resident #40 to the bed with a spot of blood the size of a quarter on it. Staff C removed the sling by rolling Resident #40, revealing additional smears of blood onto the disposable bed protector under Resident #40. The staff removed the disposable bed protector after they applied the brief and placed them into the trash with clear bag. The bath blanket and shower sling was placed into a clear bag. The staff dressed Resident #40, placed a new sling under her and transferred her to the Geri (special type of wheelchair that reclines) chair. Staff C removed the shower chair and mechanical lift to the shower room over the carpet without sanitizing it. Staff C proceeded to brush Resident #40's teeth and changed her gloves but failed to remove the gown before completing Resident #40's oral care. Staff W, Register Nurse (RN), entered the room to assist a resident in the same room. Resident #40 removed the trash bags and placed the trash that contained the blood debris into the regular trash cart in the hall and sanitized their hands. No one told her the bag contained blood contaminated items in it and/or the laundry that had blood smears. They placed the clear bag into the regular laundry cart in the hall. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/30/25 at 3:31 PM, Staff J, CNA, stated she saw Resident #40 actively bleed. Staff J added they had to change the laundry from the bed and placed them into clear plastic bags then sent them to the laundry room. Staff J stated they place the disposable wipes they used to clean her into the clear trash bags and placed them into the trash. During an interview on 7/30/25 at 3:44 PM, Staff M, CMA, reported Resident #40 had her cycle, and they placed the disposable bed protectors and bloody depends in the clear bags and place that into the regular trash. In addition, they placed the laundry into clear bags as the facility didn't offer other bags to place them into. Staff M stated she didn't see red- or yellow-colored bags. During an interview on 7/30/25 at 9:00 AM, the DON stated she expected the staff to follow the blood borne pathogen guideline and infection control policy. The policy titled Infection Control Manual Exposure Control Plan revised March 2024 instructed to remove PPE after it became contaminated and before leaving the work area. Clean and decontaminate the equipment, the environment, and working surfaces after contact with blood or other potentially infectious materials. Place the primary regulated waste is placed in secondary containers that are closable, constructed to contain all contents and minimize risk of leakage, labeled, or color-coded and closed prior to removal.