STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165385	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Marshalltown	910 East Olive Marshalltown, IA 50158

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 48003 Based on observation of equipment, staff interview, and Smart Stand Lift (a sit to stand machine used to help move a resident) Manual, the facility failed to have adequate equipment to ensure residents safety during transfers for 2 of 4 lifts observed. The facility reported a census of 59 residents. Findings include: The Smart Stand Lift Service Manual dated 6/7/24 directed to check the safety tabs to make sure they are installed correctly, not missing or torn. Any detected deficiency must be rectified before the stand is put back into service. On 9/21/24 at 11:00 AM observed one Smart Stand Lift missing the safety hook spring tab on one side and the other both tabs missing the safety hook spring tabs. In an interview on 9/21/24 Staff A, Certified Nurse Aide (CNA), and Staff B, CNA, reported the Smart Stand Lift didn't have any safety tabs since they have worked at the facility. In an interview on 9/23/24 at 11:20 AM, the Maintenance Man reported the Smart Stand Lifts should have the safety tabs on the machine for safety where the loops connect to the harness.

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