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	12/12/2024

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 44972 Based on resident, family and staff interviews and policy review, the facility failed to maintain the confidentiality of a resident's private personal and medical records for 1 of 1 resident reviewed (Resident #27). The facility reported a census of 55 residents. Findings included: In an interview on 12/10/24 at 10:39 AM, Resident #27 reported their family member found another resident of the facility's death certificate who passed away on 11/23/34 on a bedside table in his room. He stated the family member turned it into the head nurse. He reported he didn't know it was there and didn't look at it prior to their family member finding the document. In an interview on 12/10/24 at 1:00 PM, Resident #27's family member reported a couple of weeks before they saw a paper on Resident #27's night stand below his television (TV). They thought it was a list of his upcoming appointments. When they opened it, they found it was actually another resident from the facility's death certificate. They explained they took the paper to the Director of Nursing (DON) and reported finding it in Resident #27's room. They added the DON told them that shouldn't be left in Resident #27's room. In an interview on 12/12/24 at 8:35 AM, the DON stated she remembered Resident #27's family member bringing her another resident from the facility's death certificate from 11/23/24. Resident #27's family member reported they worked in the health care field and knew finding the Death Certification was a confidentiality issue. The DON reported she didn't know how the certificate ended up in Resident #27's room and stated no staff admitted to leaving it in his room. She stated she expected everything resident related remain confidential. In a facility document labeled Compliance Plan last revised 1/1/24, instructed the facility and facility staff would protect the confidentiality of Protected Health Information (PHI) in accordance with state and federal privacy laws. This included all information about the facility's residents, including the fact if they are or were a resident of the facility.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46513 Based on observations, clinical record review, staff interviews, resident interview and facility policy, the facility failed to follow physician orders and manage oxygen use for 1 of 1 resident sampled for respiratory care (Resident #5). The facility reported a census of 55 residents. Findings include: Resident #5's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS included diagnoses of acute and chronic respiratory failure with hypoxia (low blood oxygen levels), unspecified cardiac arrest, and ventricular fibrillation (abnormal heart rate). The MDS reflected Resident #5 used special treatments of oxygen therapy while a resident. Resident #5's Physician Order dated 10/11/24 instructed to use oxygen (O2) at 3 liters per nasal cannula (L/NC). Resident #5's December 2024 Medication Administration Record (MAR) included an order dated 10/11/24 to use 3 L/NC of O2 as needed for shortness of breath (SOB). The MAR lacked documentation of administration of the O2 for Resident #5, indicating they didn't use the O2. Resident #5's December 2024 Treatment Administration Record (TAR) included an order dated 10/10/24 for the staff to complete a respiratory assessment every night shift for congestive heart failure, respiratory failure acute or chronic. The initials indicated the nurse completed an assessment of a minimum of five minutes of Resident #5's respiratory system. The assessment included auscultation (listening) of lung sounds, pulse, respirations and O2 saturation monitoring. The TAR lacked documentation about if Resident #5 breathed room air or received O2 at the time of assessment. The Care Plan Focus dated 11/11/24 indicated Resident #5 had a risk for an ineffective breathing pattern related to acute on chronic respiratory. The Interventions directed the following: a. Elevate head of bed b. Encourage coughing, deep breathing and forced expiratory c. Monitor use of accessory muscles d. Provide calm, reassurance and administer O2 as ordered. On 12/9/24 at 2:43 PM, observed Resident #5 sitting in her room with O2 per nasal cannula. The O2 machine delivered O2 at a rate of 4.5 L/NC. Resident #5 reported the staff ensure the setting. Resident #5 explained she needed oxygen most of the time. On 12/11/24 at 12:48 PM, witnessed Resident #5 sitting in her wheel chair in the common area without oxygen. Resident #5 reported doing well and she could be off of the O2 about an hour before becoming SOB. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 12/12/24 at 8:59 AM Resident #5 sitting in her room with O2 per nasal cannula, O2 setting at 4.5 liters. During an interview on 12/9/24 at 2:43 PM, Resident #5 relayed staff ensure the O2 cannister setting and needed oxygen most of the time. During an interview on 12/12/24 at 9:10 AM, Staff A, Licensed Practical Nurse, stated they needed to look at the physician's order regarding Resident #5's oxygen order, as they didn't know details of her orders. Staff A looked at the orders and stated O2 should be kept at 3 L/NC to keep saturation above 90% saturation. Staff A confirmed the order didn't include a titrate order, instructing to change the oxygen delivery rate. On 12/12/24 at 9:15 AM the Administrator reported the staff should follow the physician orders, and question if needed. The facility policy titled Physician Orders, Transcription of Ordered revised July 2023 directed orders must contain name, strength, route, dose, quantity, diagnosis, indication for use, and specific duration of therapy indicated. The order must contain specific and clear parameters if parameters are indicated. Active orders should be followed and carried out as written.