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	04/10/2025

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 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. 50500 Based on electronic health record review, staff interview, and state regulation review, the facility failed to initiate and complete resident assessments in a timely manner for 1 of 3 residents reviewed nursing for supervision (Resident #1). On 2/17/25, the facility staff observed a bruise to Resident #1's face. The facility failed to conduct neurological assessments following the injury to Resident #1's face, even after Resident #1 reported someone knocked her into the wall. Then on 4/7/25, after Resident #1 returned to the facility from exiting independently without staff knowledge, the facility failed to conduct a thorough assessment of her. The facility reported a census of 52. Findings include: Resident #1's Minimum Data Set (MDS) assessment, dated 3/6/25, identified a Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment. Resident #1 required substantial to maximum assistance with transfers and moving from sitting to standing. The MDS included diagnoses of Alzheimer's disease, generalized muscle weakness, history of an ischium (the bones humans sit on that connect 3 strong bones together) fracture, and respiratory failure. The Care Plan last reviewed 3/7/25 included the following Focus areas: a. 9/16/24: Resident #1 required assistance with activities of daily living (ADLs). i. Transfer with substantial to maximal assistance of 2 staff with a front wheeled walker (FWW). ii. Resident #1 walked with partial to moderate assistance of 2 staff with her FWW in her room, only to complete the walking ADL. b. 10/7/24: Resident #1 had a risk for falls related to dementia, weakness, and impaired safety awareness. i. Encourage the use of assistive devices as needed (PRN). ii. Assist Resident #1 with ambulation and transfers PRN. (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
	165385	A. Building B. Wing	04/10/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The General Progress Noted dated 2/17/25 at 7:30 AM, labeled Late Entry reflection a completion date of 2/18/25 at 1:38 PM, identified Staff A, Registered Nurse (RN), observed Resident #1 with facial bruising to her right eye and temple area. Resident #1 indicated another resident knocked her into a wall. Staff A documented Resident#1 denied pain and vision issues. The clinical record lacked an in depth nursing head to toe assessment or initiation of neurological checks with a start date of 2/17/25, when staff first identified Resident #1's facial bruising. A Neurological Evaluation Flow Sheet initiated 2/18/25 listed one entry completed by a staff member on 2/18/25 at 3:00 PM. Another staff member completed an entry on 2/18/25 without time identified. The flowsheet lacked further entries completed as staff, documented Resident #1 went to the hospital. Resident #1's electronic medical record lacked consistent documentation of vitals. The Incident Note dated 2/22/25 at 5:57 AM reflected Resident #1's roommate called for help due to Resident #1 lying on her back on the floor in front of the bedroom door. The assessment reflected Resident #1 hit her head and had a large bump on the right backside of her head. After notifying the provider, the facility received an order to transfer Resident #1 to the hospital. The General Progress Note dated 2/22/25 at 11:10 AM identified the hospital admitted Resident #1 to the hospital due to a fractured right hip. The Physician's Order Note dated 4/7/25 at 3:07 PM documented the nurse notified the physician Resident #1 eloped on the third shift. The clinical record lacked an in depth head-to-toe nursing assessment related to the elopement. During an interview on 4/8/25 at 10:40 AM, Staff B, Licensed Practical Nurse (LPN), reported they complete neurological (neuro) checks with falls (witnessed or unwitnessed) or with any head strike. They complete the checks every 30 minutes for 4 times, every 1 hour for 4 times, every 2 hours for 2 times, and every shift for 3 days. Staff B indicated they didn't need a physician order to initiate neurological checks. During an interview on 4/8/25 at 4:25 PM Staff C, RN, confirmed no one conducted an in depth head to toe assessment after they located Resident #1 after she eloped on 4/7/25. Staff C described Resident #1 as their normal self and didn't appear to have any acute medical concerns. Staff C voiced they didn't know they needed to do further resident assessment. During an interview on 4/9/25 at 9:00 AM, Staff D, RN, reported they worked as the nurse on call during the overnight hours on 4/6/25. At approximately 5:30 AM on 4/7/25, the facility staff called to inform them of Resident #1's elopement. Staff D acknowledged they should have informed the nurse on duty (Staff C) to complete a physical assessment on Resident #1. (continued on next page)

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	04/10/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/9/25 at 3:15 PM, Staff A confirmed they first saw the facial bruising on Resident #1 on 2/17/25. They described the bruising as newer with a puffy eye lid. Staff A assumed someone previously identified the area and didn't assess it further besides a brief physical overview. Staff A described Resident #1 as a little tearful but otherwise their usual self. Staff A explained they would have done an assessment if they knew Resident #1 didn't have facial bruising before. During an interview on 4/10/25 at 11:30 AM, the Director of Nursing (DON) explained the staff need to complete a nursing head-to-toe assessment with any falls (witness or unwitnessed), significant changes, resident-to-resident altercations, or elopements. The DON confirmed they didn't need a physician's order to initiate neurological checks. They record the checks on paper and not in the electronic health record. Per an email dated 4/8/25, the Administrator confirmed the facility didn't have policy related to the completion of nursing head-to-toe assessments or neurological checks.

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	04/10/2025

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 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. 50500 Based on electronic health record review, facility document review, staff interviews, and policy review, the facility failed to provide adequate supervision resulting in a resident elopement for 1 of 1 resident reviewed (Resident #1). The facility reported a census of 52. Findings include: Resident #1's Minimum Data Set (MDS) assessment, dated 3/6/25, identified a Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment. Resident #1 required substantial to maximum assistance with transfers and moving from sitting to standing. The MDS included diagnoses of anxiety, Alzheimer's disease, generalized muscle weakness, history of an ischium (the bones humans sit on that connect 3 strong bones together) fracture, and respiratory failure. The MDS reflected Resident #1 used a wander/elopement alarm. The Care Plan last reviewed 3/7/25 included the following Focus areas: a. 9/16/24: Resident #1 required assistance with activities of daily living (ADLs). i. Transfer with substantial to maximal assistance of 2 staff with a front wheeled walker (FWW). ii. Resident #1 walked with partial to moderate assistance of 2 staff with her FWW in her room, only to complete the walking ADL. b. 10/7/24: Resident #1 had a risk for falls related to dementia, weakness, and impaired safety awareness. i. Encourage the use of assistive devices as needed (PRN). ii. Assist Resident #1 with ambulation and transfers PRN. c. 8/26/24: Resident #1 had a risk for elopement/wandering related to dementia. i. Resident #1 had a left ankle wander guard ii. Check wander guard placement every shift and function every day. iii. Provide care in a calm and reassuring manner. iv. Providing reorientation to the surroundings and environment. v. Resident #1 is non compliant with the wander guard and at times attempted to remove the bracelet. (continued on next page)

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	04/10/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Elopement Risk Evaluation, completed 11/25/24, indicated Resident #1 had a known history of elopement, roamed/wandered throughout the facility and has attempted to leave the facility unsupervised. In addition, Resident #1 didn't respond favorably to staff redirection. The evaluation directed if a response of yes to the questions 2, 3, 4, or 5, assess the use of an alert bracelet and complete the Elopement Care Plan. The Physician's Order Note dated 4/7/25 at 3:07 PM documented the nurse notified the physician Resident #1 eloped on the third shift. Staff E's, Certified Nursing Assistant (CNA), written staff statement and investigation questionnaire dated 4/7/25 reflected at approximately 5:00 AM on 4/7/25 as Staff E assisted other residents she heard a door alarm sound. At the time, Staff E walked down the hallway and didn't notice Resident #1 in their room. Staff E checked outside and in Resident #1's room again without finding her. Staff E notified the nurse on duty (Staff C) as well one of the other CNAs. Staff E looked around the inside of the building as well as outside again. As Staff E looked in every resident's room, she heard the wander guard alarm sound at approximately 5:30 AM. When Staff E went to the front door, she discovered Resident #1 standing there. Staff E placed Resident #1 in a wheelchair. Resident #1 wore a 2 piece jumpsuit, socks, and shoes. Staff E described Resident #1 as extremely cold and cold to the touch with her wander guard on her ankle. Resident #1 tried to elope the previous morning/afternoon. Another resident reported he saw Resident #1 going down the hall around 4:00 AM very fast. Staff F's, CNA, written staff statement and investigation questionnaire dated 4/7/25 identified at 5:15 AM on 4/7/25, Staff E asked if they saw Resident #1 as they did their rounds. At that time, the 2 CNAs began looking for Resident #1. At 5:30 AM, Resident #1 casually walked in the front door without her walker with a runny nose, cold hands, and appeared very confused. Staff F reported Resident #1 attempted to leave the facility (exit seek) all day the previous day. Staff C's, Registered Nurse (RN), written staff statement and investigation questionnaire dated 4/7/25 indicated at approximately 5:00 AM on 4/7/25, he left the building to place belongings in his car. Staff C reported he entered the code to exit the building, waiting until the light turned green before proceeding. Staff C quickly placed his belongings in the car and re entered the building through the front door without triggering the alarm. As Staff C verify the narcotic count, Staff F alerted him about Resident #1 missing. Staff C searched the building and couldn't locate Resident #1. At approximately 5:45 AM, Staff C heard an alarm. The CNAs (Staff E and Staff F) ran to the front door where Resident #1 stood. Staff C described Resident #1 as cold and unable to say where or how they could exit the building. Resident #1 wore her wander guard on her left ankle and he verified it worked. Resident #1 wore a long-sleeved shirt and pants. During an interview on 4/8/25 at 10:20 AM, Staff G, CNA, voiced she understood Resident #1 may have went outside by herself but came back on their own over the weekend. During an interview on 4/8/25 at 10:40 AM, Staff B, Licensed Practical Nurse (LPN), stated during the end of shift report on 4/7/25, Staff C reported Resident #1 got out at approximately 5:00 AM and they found her at the front door. (continued on next page)

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	04/10/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/8/25 at 11:45 AM, Staff E stated Resident #1 eloped the morning of 4/7/25. Staff E reported they saw Resident #1 sitting in their recliner in their room at 3:45 AM. At 5:00 AM the front door alarm went off and she assumed Staff C set it off going out to their car. Staff E went to the front door, looked outside and didn't notice anything. While she walked down the hallway, Staff E didn't see Resident #1 in their room. Staff E alerted Staff C and the staff on the other side of the facility. Staff E reported they looked in Resident #1's room again before they looked outside the facility. At 5:30 AM, Staff E heard the wander guard alarm go off and they found Resident#1 at the front door. During an interview on 4/8/25 at 1:20 PM, Staff H, LPN, reported Resident #1 told the staff they were going home and she stood close enough to the front door the wander guard alarmed. This was towards the end of their 6:00 AM to 2:00 PM shift on 4/6/25. During an interview on 4/8/25 at 3:15 PM, Staff J, RN Consultant, explained all the doors are alarmed to a panel. The front door had the only wander guard alarm and they didn't have operational cameras. During an interview on 4/8/25 at 3:15 PM, Staff K, Administrative Assistant, explained they lock the outside sun room door nightly under the previous facility management, per policy. With the new management company in place, Staff K didn't know if they still had the procedure in place. During an interview on 4/8/25 at 4:25 PM, Staff C reported he went out to his car at approximately 5:00 AM on 4/7/25. Staff C denied hearing or seeing anyone behind them. Staff C returned to the building immediately after he placed his personal belongings in the car. They didn't see anything upon entering the building. Shortly after, Staff E alerted him about Resident #1 missing. Staff C and Staff E began looking for Resident #1 outside the building and in the parking lot. While he searched the inside of the building, Staff C heard an alarm go off as Staff E attended to it. Staff C saw Resident #1 in a wheelchair with other staff members. He described Resident #1 as cold and she couldn't remember what happened. Resident #1 wore sweatpants, hoodie, and shoes. During an interview on 4/9/25 at 8:00 AM, Staff I, CNA, reported they worked the day shift on 4/7/25. Towards the end of their shift, Resident #1 set off the wander guard alarm twice. The first time, Resident #1 didn't make it out the door as staff could redirect her. The second time, Resident #1 made it out the front door to the sun room but not out the door that lead to the outside. The staff managed to redirect Resident #1 back inside which set off the alarm. The Missing Patient Response Plan, revised January 2024, outlined the following staff procedures: a. Upon determining that a patient cannot be located, the nursing supervisor will notify the Administrator and the Director of Nursing b. All nursing staff will return to their area and search all areas accessible to patients c. Maintenance and available staff will search exterior areas once released from their own department

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	04/10/2025

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 50500 Based on electronic health record review, staff interview and policy review, the facility failed to ensure the nursing staff had the knowledge to initiate appropriate responses during resident care for 1 of 3 residents reviewed for nursing supervision (Resident #1). The facility reported a census of 52. Findings include: Resident #1's Minimum Data Set (MDS) assessment, dated 3/6/25, identified a Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment. Resident #1 required substantial to maximum assistance with transfers and moving from sitting to standing. The MDS included diagnoses of anxiety, Alzheimer's disease, generalized muscle weakness, history of an ischium (the bones humans sit on that connect 3 strong bones together) fracture, and respiratory failure. The MDS reflected Resident #1 used a wander/elopement alarm. The Care Plan last reviewed 3/7/25 included the following Focus areas: a. 9/16/24: Resident #1 required assistance with activities of daily living (ADLs). i. Transfer with substantial to maximal assistance of 2 staff with a front wheeled walker (FWW). ii. Resident #1 walked with partial to moderate assistance of 2 staff with her FWW in her room, only to complete the walking ADL. b. 10/7/24: Resident #1 had a risk for falls related to dementia, weakness, and impaired safety awareness. i. Encourage the use of assistive devices as needed (PRN). ii. Assist Resident #1 with ambulation and transfers PRN. c. 8/26/24: Resident #1 had a risk for elopement/wandering related to dementia. i. Resident #1 had a left ankle wander guard ii. Check wander guard placement every shift and function every day. iii. Provide care in a calm and reassuring manner. iv. Providing reorientation to the surroundings and environment. v. Resident #1 is non compliant with the wander guard and at times attempted to remove the bracelet. (continued on next page)

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	04/10/2025

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The General Progress Noted dated 2/17/25 at 7:30 AM, labeled Late Entry reflection a completion date of 2/18/25 at 1:38 PM, identified Staff A, Registered Nurse (RN), observed Resident #1 with facial bruising to her right eye and temple area. Resident #1 indicated another resident knocked her into a wall. Staff A documented Resident#1 denied pain and vision issues. The clinical record lacked an in depth nursing head to toe assessment or initiation of neurological checks with a start date of 2/17/25, when staff first identified Resident #1's facial bruising. The Physician's Order Note dated 4/7/25 at 3:07 PM documented the nurse notified the physician Resident #1 eloped on the third shift. The clinical record lacked an in depth nursing head-to-toe assessment within 1 hour of when the staff located Resident #1 during the third shift elopement. In addition, the clinical record lacked neurological checks. During an interview on 4/9/25 at 3:15 PM, Staff A, Registered Nurse (RN), confirmed they first saw the facial bruising on Resident #1 on 2/17/25. They described the bruising as newer with a puffy eye lid. Staff A assumed someone previously identified the area and didn't assess it further besides a brief physical overview. Staff A described Resident #1 as a little tearful but otherwise their usual self. Staff A explained they would have done an assessment if they knew Resident #1 didn't have facial bruising before. During an interview on 4/8/25 at 4:25 PM, Staff C, RN, reported they didn't know they needed to do a head to toe nursing assessment after they found Resident #1 after they left the faciity on their own on 4/7/25. Staff C described Resident #1 as cold and appeared to be her normal self. During an interview on 4/9/25, Staff D, RN, explained they directed Staff C to complete alarm checks and provide a written statement when he notified them of Resident #1's elopement. Staff D later realized they should have directed Staff C to also complete a head to toe nursing assessment. Per an email dated 4/8/25, the Administrator confirmed the facility didn't have policy related to the completion of nursing head-to-toe assessments or neurological checks. The Missing Patient Response Plan, revised January 2024, instructed the staff to examine the patient and record findings in the chart. Based on electronic health record review, staff interview and policy review, the facility failed to ensure the nursing staff had the knowledge to initiate appropriate responses during resident care for 1 of 3 residents reviewed for nursing supervision (Resident #1). The facility reported a census of 52. Findings include: (continued on next page)

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	04/10/2025

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1's Minimum Data Set (MDS) assessment, dated 3/6/25, identified a Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment. Resident #1 required substantial to maximum assistance with transfers and moving from sitting to standing. The MDS included diagnoses of anxiety, Alzheimer's disease, generalized muscle weakness, history of an ischium (the bones humans sit on that connect 3 strong bones together) fracture, and respiratory failure. The MDS reflected Resident #1 used a wander/elopement alarm. The Care Plan last reviewed 3/7/25 included the following Focus areas: a. 9/16/24: Resident #1 required assistance with activities of daily living (ADLs). i. Transfer with substantial to maximal assistance of 2 staff with a front wheeled walker (FWW). ii. Resident #1 walked with partial to moderate assistance of 2 staff with her FWW in her room, only to complete the walking ADL. b. 10/7/24: Resident #1 had a risk for falls related to dementia, weakness, and impaired safety awareness. i. Encourage the use of assistive devices as needed (PRN). ii. Assist Resident #1 with ambulation and transfers PRN. c. 8/26/24: Resident #1 had a risk for elopement/wandering related to dementia. i. Resident #1 had a left ankle wander guard ii. Check wander guard placement every shift and function every day. iii. Provide care in a calm and reassuring manner. iv. Providing reorientation to the surroundings and environment. v. Resident #1 is non compliant with the wander guard and at times attempted to remove the bracelet. The General Progress Noted dated 2/17/25 at 7:30 AM, labeled Late Entry reflection a completion date of 2/18/25 at 1:38 PM, identified Staff A, Registered Nurse (RN), observed Resident #1 with facial bruising to her right eye and temple area. Resident #1 indicated another resident knocked her into a wall. Staff A documented Resident#1 denied pain and vision issues. The clinical record lacked an in depth nursing head to toe assessment or initiation of neurological checks with a start date of 2/17/25, when staff first identified Resident #1's facial bruising. The Physician's Order Note dated 4/7/25 at 3:07 PM documented the nurse notified the physician Resident #1 eloped on the third shift. (continued on next page)

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	04/10/2025

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The clinical record lacked an in depth nursing head-to-toe assessment within 1 hour of when the staff located Resident #1 during the third shift elopement. In addition, the clinical record lacked neurological checks. During an interview on 4/9/25 at 3:15 PM, Staff A, Registered Nurse (RN), confirmed they first saw the facial bruising on Resident #1 on 2/17/25. They described the bruising as newer with a puffy eye lid. Staff A assumed someone previously identified the area and didn't assess it further besides a brief physical overview. Staff A described Resident #1 as a little tearful but otherwise their usual self. Staff A explained they would have done an assessment if they knew Resident #1 didn't have facial bruising before. During an interview on 4/8/25 at 4:25 PM, Staff C, RN, reported they didn't know they needed to do a head to toe nursing assessment after they found Resident #1 after they left the faciity on their own on 4/7/25. Staff C described Resident #1 as cold and appeared to be her normal self. During an interview on 4/9/25, Staff D, RN, explained they directed Staff C to complete alarm checks and provide a written statement when he notified them of Resident #1's elopement. Staff D later realized they should have directed Staff C to also complete a head to toe nursing assessment. Per an email dated 4/8/25, the Administrator confirmed the facility didn't have policy related to the completion of nursing head-to-toe assessments or neurological checks. The Missing Patient Response Plan, revised January 2024, instructed the staff to examine the patient and record findings in the chart.

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	04/10/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 50500 Based on electronic health record review, staff interviews, and policy review, the facility failed to ensure the resident's medical record contained sufficient and adequate medical information for 2 of 3 residents reviewed for nursing supervision (Residents #1 and #3). The facility reported a census of 52. Findings include: 1. Resident #1's Minimum Data Set (MDS) assessment, dated 3/6/25, identified a Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment. Resident #1 required substantial to maximum assistance with transfers and moving from sitting to standing. The MDS included diagnoses of anxiety, Alzheimer's disease, generalized muscle weakness, history of an ischium (the bones humans sit on that connect 3 strong bones together) fracture, and respiratory failure. The MDS reflected Resident #1 used a wander/elopement alarm. The Care Plan last reviewed 3/7/25 included the following Focus areas: a. 9/16/24: Resident #1 required assistance with activities of daily living (ADLs). i. Transfer with substantial to maximal assistance of 2 staff with a front wheeled walker (FWW). ii. Resident #1 walked with partial to moderate assistance of 2 staff with her FWW in her room, only to complete the walking ADL. b. 10/7/24: Resident #1 had a risk for falls related to dementia, weakness, and impaired safety awareness. i. Encourage the use of assistive devices as needed (PRN). ii. Assist Resident #1 with ambulation and transfers PRN. c. 8/26/24: Resident #1 had a risk for elopement/wandering related to dementia. i. Resident #1 had a left ankle wander guard ii. Check wander guard placement every shift and function every day. iii. Provide care in a calm and reassuring manner. iv. Providing reorientation to the surroundings and environment. v. Resident #1 is non compliant with the wander guard and at times attempted to remove the bracelet (continued on next page)

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	04/10/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Noted dated 4/7/25 at 3:07 PM documented the physician communication of Resident #1's elopement on the third shift. No further Progress Note identified in the medical record detailing the elopement event (time, summary of event, resident condition, etc.,). The Incident Report #2819 dated 4/7/25 at 5:00 AM, reflected a Certified Nurse Aide (CNA) reported to the nurse they didn't know the location of Resident #1. At the bottom of the report had a disclaimer stating Privileged and Confidential Not part of the Clinical Record Quality Assurance Only Not Discoverable. During an interview on 4/10/25 at 11:30 AM, the Administrator declared the Progress Note dated 4/7/25 at 3:07 PM as sufficient documentation of Resident #1's elopement event. The Administrator added the late entry Progress Note dated 4/7/25 at 12:19 PM should have linked to the Incident Report within the facility's electronic health record. The Progress Note didn't get properly formatted, leaving the link non operational, and caused it to not link to the Incident Report. 2. Resident #3's MDS assessment, dated 1/22/25, identified a BIMS score of 6, indicating severe cognitive impairment. Resident #3 used a wheelchair for mobility. The MDS listed her as dependent on staff for transfers and bed mobility. The MDS included diagnoses of non Alzheimer's dementia and age related physical debility. The Care Plan Focus initiated 9/16/24 indicated Resident #3 required assistance with activities of daily living (ADLs). The Interventions reflected the following: a. Bathing: Dependent on assistance from 1 staff member b. Bed Mobility: Dependent with assistance from 2 staff members c. Transferring: Dependent with assistance from 2 staff members and a full-body mechanical lift. The Progress Noted dated 12/10/24 at 2:15 PM, identified Resident #3 had a skin tear to her left lower shin. The note reflected Resident #3 hit her leg on the full-body mechanical lift and tore open her skin. The nurse cleaned the area and applied steri strips. A Non Pressure Skin Condition Report, dated 12/10/24, reflected Resident #3 had a skin tear to her left shin. Resident #3's clinical record lacked further skin assessments or documentation of the skin tear on her left shin. The Skin/Wound Note dated 2/21/25 at 4:59 PM, identified Resident #3 had 2 3 bruises to the left shin. She reported they happened during a transfer. The note indicated they initiated a skin sheet to monitor the area. Resident #3's clinical record lacked a skin condition report for bruises to her left shin. In addition, the clinical record didn't have assessments or documentation of bruising identified. (continued on next page)

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	04/10/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Noted dated 3/11/25 at 10:53 AM, identified a skin tear to the left outer calf measuring 2.5 x 1. 5 cm. The area was cleansed with a triple antibiotic applied and covered. A Non Pressure Skin Condition Report for the injury wasn't initiated. No further assessment or documentation for the injury identified in the medical record. During an interview on 4/10/25 at 11:30 AM, the Director of Nursing (DON) explained the nursing staff complete the weekly skin audits. They document in the Treatment Administration Record, if they don't identify skin injuries, or by the Non Pressure Skin Condition Report, if they identify a skin injury. If a Non Pressure Skin Condition Report is initiated, the nursing staff documents further assessments of the injury, if present, on that report. If the injury resolves by the time nursing completes the weekly assessment, the staff document on the skin condition report or writes a Progress Note listing the injury as healed or resolved, thus, closing out the injury assessments/documentation. The DON reported she expected the nursing staff moving forward to close out all skin injuries. Per an email dated 4/10/25, the Administrator confirmed the facility didn't have a policy related to staff documentation. The Skin Management Guide, revised November 2023, instructed skin alterations are evaluated and documented by the licensed nurse. The Skin Evaluation Non-Pressure form is initiated upon identification of a skin injury, used to document healing status, and wound details weekly.