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	08/05/2025

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 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 facility policy review, resident, and staff interviews, the facility failed to treat a resident with respect and dignity in a manner that promotes maintenance or enhancement of his or her quality of life for 1 out of 4 resident reviewed (Resident #1). The facility identified a census of 51 residents. Findings include:Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS documented Resident #1 didn't have behaviors during the lookback period. The MDS listed Resident #1 as independent with activities of daily living (ADLs). The MDS included diagnoses of non-Alzheimer's dementia, anxiety, depression and dizziness.The Care Plan Focus related to tobacco use initiated 5/16/25 included the following Interventions:5/16/25: Smoking evaluation will be completed as needed.7/14/25: As of 7/8/2025 Independent Smoker: Must keep smoking accessories secured when not in use control of facility staff.7/14/25: Resident would check in and out and carry a cell phone while smoking.5/16/25: Independent Smoker: Must smoke only in designated areas/designated times (unless able to independently get to and from the designated areas).Interview on 7/14/25 at 3:30 PM, Resident #1, reported when she got left her outside all night long on 7/7/25-7/8/25, the Director of Nursing (DON) and Administrator told her, she needed to make sure to take her cell phone with her at all times so she could get back into the facility. Resident #1 stated she felt degraded and disrespected for not taking her cell phone with her. She felt the facility thought it was her fault. Now she didn't go outside alone. Interview on 7/16/25 at 1:30 PM, the Administrator and DON, stated they expected Resident #1 to make sure she had her cellphone with her at all times. It is Resident #1's responsibility to make sure she had a way back into the facility.Interview on 7/17/25 at 12:30 PM, the DON reported they expected the staff to treat all residents with dignity and respect.The facility policy titled Resident Rights - Dignity and Respect revised date April 2024, instructed staff to treat all residents with dignity and respect while maintaining and enhancing his or her self-esteem and self-worth. Each Resident has the right to 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.

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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Harmony Marshalltown	910 East Olive Marshalltown, IA 50158

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, and staff interview, the facility failed to notify the facility's physician of a incident related to a resident left outside all night long for 1 of 3 residents reviewed (Resident #1). The facility identified a census of 51 residents.Finding include:Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS documented Resident #1 didn't have behaviors during the lookback period. The MDS listed Resident #1 as independent with activities of daily living (ADLs). The MDS included diagnoses of non-Alzheimer's dementia, anxiety, depression and dizziness.The Care Plan Focus related to tobacco use initiated 5/16/25 included the following Interventions:5/16/25: Smoking evaluation will be completed as needed.7/14/25: As of 7/8/2025 Independent Smoker: Must keep smoking accessories secured when not in use control of facility staff.7/14/25: Resident would check in and out and carry a cell phone while smoking. 5/16/25: Independent Smoker: Must smoke only in designated areas/designated times (unless able to independently get to and from the designated areas).The Concern Form dated 7/8/25 reflected Staff A, Dietary Aide, heard pounding on the courtyard door. When she opened the door, Resident #1 told her she got locked outside all night. The Administrator and Director of Nursing (DON) visited with Resident #1, who educated her the facility didn't have the door locked. Resident #1 described the door as heavy and she couldn't open it fully to get back in facility. The form labeled Resident #1 as cognitively intact. The form reflected they educated Resident #1 to take her cellphone when she went out to smoke moving forward. Additionally, they installed a doorbell with receivers at each nurses' station. They educated the staff and smoking residents. They ordered the doorbell on 7/11/25 and installed it 7/16/25.The General Progress Notes dated 7/8/25 at 2:00 PM, documented Resident #1 reported she had difficulty opening the door. She described herself as to weak to pull it open as she normally had before. The nurse notified the doctor of her reported weakness. The nurse waited for a call back from the doctor to see if he would like to complete any labs for Resident #1.Interview on 7/23/25 at 8:15 AM, the facility physician reported they didn't know Resident #1 got left outside all night long. They expected the facility to notify him of the incident and added what a horrible thing to happen to Resident #1.Interview on 8/4/25 at 10:20 AM, the DON verified the clinical record lacked documentation that the facility notified the physician of Resident #1 being left outside. They expected the staff to notify the physician of any changes in a resident, an incident, a fall, or if they need a treatment.The facility policy titled Notification for Change of Condition revised June 2023, listed the purpose as the facility would provide care to residents and provide notification of resident change in status. The facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when an accident occurred involving the resident which resulted in injury and had the potential for requiring physician intervention, health, mental, or psychosocial status in either life-threatening conditions or clinical complications.

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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 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident interview, and staff interviews, the facility failed to provide a safe discharge for 1 out of 1 resident reviewed (Resident #2). On 7/3/25 at approximately 6:15 PM, Resident #2 exited the building to go see his support animal without staff knowledge. On 7/4/25 around 3:00 AM, Resident #2 requested to return to the facility. Due to the frustration of not being able to get a ride back to the facility, Resident #2 used his electric wheelchair and transported himself to a convenience store at 3:00 AM. At 5:30 AM the police notified the Administrator they found Resident #2. On 7/4/25 at 5:50 AM, the Administrator went to the convenience store and had Resident #2 sign a form indicating he left the facility against medical advice (AMA). The facility lacked documentation of education provided to Resident #2 for leaving AMA.On 7/23/25 at 3:30 PM, the Iowa Department of Inspections and Appeals and Licensing (DIAL) staff contacted the facility staff to notify them the Department staff determined an Immediate Jeopardy (IJ) situation existed at the facility. The facility staff removed the immediacy on 7/25/25 at 1:30 PM, after the staff competed the following:The facility updated their Point of Contact form on 7/17/25 to include additional resident emergency contacts to reach if an emergency situation occurs, such as elopement, or a potentially unsafe resident-initiated discharge.The facility provided staff education on 7/23/25 regarding the Point Of Contact form and the process regarding the chain of command if a resident refused to return from an elopement or their therapeutic leave including calling law enforcement if the resident left the premises and refused to return.The facility added administrative oversight regarding every facility or resident initiated discharge (including AMA) must be reviewed and cosigned by an administrative leader (i.e. Administrator, DON, SW, MDS or designee) before the resident leaves or AMA paperwork is initiated to verify full compliance with the Federal Regulations regarding notice and discharge planning requirements. The administrative team leader would verify the following checklist: Administrative Reviewer -Unplanned Discharge Checklist prior to resident discharge from facility:Right to remain: Verify resident (and representative, if any) was clearly told they may stay at the facility and receive continued care; discussion is documented. Offer root cause analysis and appropriate alternatives concerning their desire to leave the facility in order for the facility to encourage the resident to stay at the facility.Refusal captured: If the resident still chooses to leave, ensure refusal / AMA form is completed and scanned into the record.Medication safety: Confirm medication reconciliation is done and an adequate supply-or prescription-plus written instructions were offered/provided.Post-discharge supports: Confirm offers to arrange / initiate:Home-health or other appropriate community care services.b. A safe place to stay (e.g., confirmed address, shelter, family).Transportation: Ensure safe transportation to the chosen destination is arranged or offered and documented (method, driver, address). The facility educated the nursing staff and social services on 7/25/25 regarding a safe return escort:Any resident off premises who calls or appears without transport is met by facility staff and escorted back in a facility vehicle if available, family member, authorized representative, law enforcement, or emergency services.Staff must immediately notify the facility administrative staff to ensure no resident reentered the facility alone or is stranded and they complete an unplanned discharge checklist to ensure the resident's safety.The scope was lowered from an IJ to a G (harm that is not immediate) on 7/25/25 after ensuring the facility implemented the removal plan. The facility identified a census of 51 residents.Finding include:Resident #2's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. Resident #2 required partial to moderate assistance with transfers. In addition, listed Resident #2 as dependent with dressing and personal hygiene. The MDS included a diagnosis of need assistance with activities of daily living (ADLs). The MDS indicated Resident #2 didn't smoke.Resident #3's Clinical Census listed an admission date of 7/3/25.The BIMS evaluation conducted 7/3/25 listed a score of 15.Resident #2's admission assessment dated [DATE] at 3:04 PM identified a BIMS score of 15. The assessment listed Resident #2 as dependent with activities of daily living and used a motorized wheelchair mobility. The assessment included diagnoses of diabetes mellitus, muscle weakness, need for assistance with personal cares, anxiety, chronic atrial fibrillation (an irregular often rapid heart rate that commonly causes poor blood flow), bilateral (both sides) below knee amputation, and substance abuse.The Care Plan included the following Focuses initiated7/3/25 indicated Resident #2 used tobacco. The Goal listed he would adhere to the smoking policy. The Interventions directed:7/14/25: Complete a smoking evaluation as needed. 7/14/25: Inform Resident and/or Responsible party of the smoking policy 7/14/25: Must keep smoking

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Harmony Marshalltown	910 East Olive Marshalltown, IA 50158

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, clinical record review and policy review the facility failed to provide interventions to prevent a deep tissue injury (a type of pressure injury that occurs when underlying soft tissue is damaged due to prolonged pressure, often over bony prominence.) from performing for 1 of 2 residents reviewed (Resident #3). The facility identified a census of 51 residents. Findings include: Determining the Stage of Pressure Injury:Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.Resident #3's Minimum Data Set (MDS) assessment dated [DATE] identified they had memory problems with severely impaired daily decision-making abilities. Resident #3 required substantial to maximal assistance for all activities of daily living (ADLs), except listed them as totally dependent on putting on/off of footwear and moving from one position to another. The MDS reflected Resident #3 admitted with a Stage 2 and a Stage 3 pressure area.Resident #3's Medical Diagnoses reviewed 7/21/25 included diagnoses of anxiety, mild cognitive impairment, osteoarthritis,(type of arthritis that occurs when flexible tissue at the ends of bones wears down), osteoporosis (a disease that weakens bones that gets worse over time and increases the risk for a bone fracture) and restless leg syndrome (a condition characterized by a nearly irresistible urge to move the legs, typically in the evenings), and chronic pain.The Care Plan Focus initiated 5/12/25, identified Resident #3 had a risk for alteration in skin integrity related to cognitive impairment, osteoporosis with limited mobility, pressure areas to coccyx (a small triangular bone located at the bottom of the spine, just below the sacrum, also known as the tail bone), and right buttock on admit. The Focus included the go for Resident #3 to not develop skin alterations outside of the disease process. The Interventions directed staff the

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Harmony Marshalltown	910 East Olive Marshalltown, IA 50158

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff and resident interviews, and facility policy, the facility failed to ensure residents safely returned to the building from smoking for 3 of 5 residents reviewed (Residents #1, #2, and #5). On 7/7/25 around 8:00 PM Resident #1 went outside to smoke. After smoking, she couldn't get back into the to the building and remained outside on 7/7/25 at 8:00 PM until 7/8/25 at 6:00 AM. The staff failed to do visual checks on Resident #1 for 10 hours. During the time Resident #1 couldn't get back into the building, the weather had a forecast of heavy rain shower with thunder and lightning. The rain began at 5:00 AM to 6:00 AM, this resulted in a temperature drop from 90 degrees Fahrenheit (F) to 72 degrees F. At that Resident #1 began to panic, became fearful, scared, and crying. Resident #1 reported she wouldn't go out alone to smoke in the evening in fear of it happening again. Resident #1 experienced serious actual psychosocial harm due to being left outside overnight and refused to go outside without another person. While touring the facility and courtyard with the Administrator, the door from the courtyard back in the building failed to open without excess force to move the handle on the door. This resulted in a serious likelihood of serious injury, impairment, or death to occur due the weather conditions and hazards in the courtyard. In addition, on 7/17/25 at 12:40 PM, observed Resident #5 yelling at staff because he couldn't open the courtyard door to come back in from smoking. He reported he rang the doorbell and no staff responded. The incident resulted in an immediate jeopardy situation to the safety of residents who went out to the courtyard.On 7/17/25 at 1:45 PM, the Iowa Department of Inspection, Appeals, and Licensing (DIAL) staff notified the facility staff the Department staff determined an Immediate Jeopardy (IJ) situation existed at the facility. The facility placed a doorbell in the courtyard area that can be heard at both nurses' stations. The designated smoking area has been moved from this courtyard.The facility changed the designated smoking area to the front of the building.The facility completed checks on all entrance/exit doors to ensure functionality. The front door functioned and any resident who couldn't independently open the door would have staff escort or supervision.The facility identified like residents who resided in the facility that smoke. The facility completed a smoking program on 7/17/25 and updated the residents' Care Plans. The facility completed assessment on safety with their ability to exit and enter the designated smoke area independently. The facility deemed any resident who couldn't enter or exit the door independently to the designated smoke area as a dependent smoker and would be supervised by staff during the designated smoking hours.The facility started to educate staff on 7/17/25 specific to visual rounds of residents, the smoking policy, and the change to designated smoking area.The courtyard door continued to have a functioning door alarm system to alert staff if any resident attempted to exit.In addition, the facility failed to ensure the safety of a cognitive resident (Resident #2) who left the facility unsupervised. When the Resident #2 attempted to call the facility to return, the facility failed to ensure he returned safely to the facility. The facility didn't go to Resident #2 until the police called around 5:30 AM. Due to Resident #2 not returning to the facility independently until around 9:30 AM, he missed his evening medications. The investigation determined Resident #2 used his electric wheelchair to go approximately 3 miles to return to the facility. The incident resulted in an immediate jeopardy situation.On 7/23/25 at 3:30 PM, the Iowa Department of Inspections and Appeals and Licensing (DIAL) staff contacted the facility staff to notify them the Department staff determined an Immediate Jeopardy (IJ) situation existed at the facility. The facility staff removed the immediacy on 7/25/25 at 1:30 PM, after the staff completed the following:The facility updated their Point of Contact form on 7/17/25 to include additional resident emergency contacts to reach if an emergency situation occurs, such as elopement, or a potentially unsafe resident-initiated discharge.The facility provided staff education on 7/23/25 regarding the Point of Contact form and the process regarding the chain of command if a resident refused to return from an elopement or their therapeutic leave including calling law enforcement if the resident left the premises and refused to return.The facility added administrative oversight regarding every facility or resident-initiated discharge (including AMA) must be reviewed and cosigned by an administrative leader (i.e. Administrator, DON, SW, MDS or designee) before the resident leaves or AMA paperwork is initiated to verify full compliance with the Federal Regulations regarding notice and discharge planning requirements. The administrative team leader would verify the following checklist: Transportation: Ensure safe transportation to the chosen destination is arranged or offered and documented (method, driver, address). The facility educated the nursing staff and social services on 7/25/25 regarding a safe return

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, and the facility policy review, the facility failed to consistently answer call lights within a reasonable amount of time (defined as 15 minutes or less) for 4 of 4 residents reviewed (Residents #2, #5, #18 and #19). The residents and staff reported low staffing caused missed or delayed resident care. The facility reported a census of 51 residents. Finding include:1. Resident #2's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. Resident #2 required partial to moderate assistance with transfers. In addition, listed Resident #2 as dependent with dressing and personal hygiene. The MDS included a diagnosis of need assistance with activities of daily living (ADLs). On 7/21/25 at 11:30 AM, Resident #2 verified it took staff over 15 minutes to answer his call light to get him up for meals. He added he arrived late for some meals.2. Resident #5's MDS assessment dated [DATE] identified a BIMS score of 14, indicating no cognitive impairment. Resident #5 required substantial to maximal assistance with all ADLs. The MDS included diagnoses of muscle weakness and multiple sclerosis. On 7/17/25 at 1:15 PM, Resident #5 verified it took staff over 15 minutes to answer his call light. He added getting upset and arrived late to some meals. 3. Resident #18's MDS assessment dated [DATE] identified a BIMS score of 15, indicating no cognitive impairment. Resident #18 required partial to moderate assistance with transfers, dressing and personal hygiene. The MDS included diagnoses of diabetes mellitus and anxiety.On 7/21/25 at 1:10 PM, Resident #18 verified it took over 15 minutes for staff to answer her call light. She described it as upsetting.4. Resident #19's MDS assessment dated [DATE] identified a BIMS score of 15, indicating no cognitive impairment. Resident #19 required partial to maximal assistance with ADLs. The MDS included diagnoses of congested heart failure (impaired heart function that results in a build up of fluid in the body) and muscle weakness. On 8/5/25 at 1:00 PM, Resident #19 reported being upset a couple of days ago she had her call light on from 6:23 AM -7:36 AM. She added being angry because the staff have to take the smokers outside, which resulted in her having to wait for someone to answer her call light. On 7/21/25 at 10:10 AM, Staff I, Certified Medication Aide (CMA), verified call lights can go unanswered for longer than 15 minutes. Staff I described it as frustrating the other residents didn't get the care they deserve because the facility worried about the rights of the residents who go out and smoke. On 7/21/25 at 10:30 AM, Staff K, Certified Nursing Assistant (CNA), reported having difficulty being able to answer the call lights within 15 minutes when you have to take one staff off the floor to take a resident outside to smoke. The facility policy titled Call Light Policy revised September 2023 instructed staff to ensure a prompt response to the resident's call for assistance. The facility also ensured proper working order of the call system. The facility shall answer call lights in a timely manner.

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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 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. (continued on next page)

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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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, facility document review, and policy review, the facility failed to maintain complete and accurate medical records for each resident. The facility failed to document an incident when a resident got left outside all night long in the electronic health record (EHR) for 1 of 3 residents reviewed (Resident #1). The facility reported a census of 51 residents.Finding include:Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS documented Resident #1 didn't have behaviors during the lookback period. The MDS listed Resident #1 as independent with activities of daily living (ADLs). The MDS included diagnoses of non-Alzheimer's dementia, anxiety, depression and dizziness.The Care Plan Focus related to tobacco use initiated 5/16/25 included the following Interventions:5/16/25: Smoking evaluation will be completed as needed.7/14/25: As of 7/8/2025 Independent Smoker: Must keep smoking accessories secured when not in use control of facility staff.7/14/25: Resident would check in and out and carry a cell phone while smoking.5/16/25: Independent Smoker: Must smoke only in designated areas/designated times (unless able to independently get to and from the designated areas).The Concern Form dated 7/8/25, with no time, described the concern, Staff A (dietary Aide) heard pounding on courtyard door. Opened door for Resident #1 who stated she was locked out and has been outside all night. Administrator and Director of Nursing (DON) visited with resident, educated resident door was not locked. Resident states it was heavy and unable to open fully to get back in facility. Resident cognitively intact, Educated resident to take cell phone out smoking moving forward. Additionally, door bell installed, receivers at each nurses station. Educated staff and smoking residents ordered 7/11/25 and installed 7/16/25.The General Progress Notes dated 7/8/25 at 2:00 PM, documented Resident #1 reported she had difficulty opening the door. She described herself as to weak to pull it open as she normally had before. The nurse notified the doctor of her reported weakness. The nurse waited for a call back from the doctor to see if he would like to complete any labs for Resident #1.Review of a handwritten document dated 7/8/25 at 6:30 AM, reflected Resident #1 had no injuries to her head, had equal pupils to both eyes that reacted to light, had clear speech, had pink, warm, intact skin, without redness, bruising or other injuries to arms, legs, or torso. Resident #1 could bend and straighten extremities without difficulty. She denied pain, had clear lung sounds auscultation (listened to), they heard a strong and unremarkable apical pulse (specific location of the chest to listen to the heart). The note described Resident #1 as alert and walked with a wheelchair. When Resident #1 entered the facility , she voiced concerns that the door wouldn't open. She denied discomfort, the staff escorted her to her room to perform a thorough examination. Resident #1 changed her clothes and requested to go to dining room for breakfast. The note reflected Resident #1 had an improved mood and socialized with her peers.On 7/16/25 at 5:20 PM, Staff F, Licensed Practical Nurse (LPN), stated they received a directive to chart the incident on a concern form and administration would take care of it. They added to not to chart in Resident #1's clinical record. Staff F explained they didn't feel comfortable with not charting the incident but they did as a directed and charted on a plain piece of paper.On 7/17/25 at 7:45 AM, Staff G, LPN, reported the Administrator directed to not chart the incident with Resident #1 in the clinical record, do a concern form, and administration would handle the incident. Staff G, felt this went against professional standards of practice but followed the directive.On 7/22/25 at 4:30 PM, the DON acknowledged the staff should have charted the incident with Resident #3 in the clinical record and not just on a concern form. The DON reported they would provide education to all nursing staff to chart incidents, an unusual occurrence, or anything to do with a resident in the clinical record. The facility policy titled Alert Charting Guidelines revised October 2023 instructed staff to provide a guide to monitor documentation that may be needed following a change in a resident's condition or status. Residents are entered on the Alert Charting Log when they are identified as requiring continued follow-up and documentation. Residents should remain on the log for a minimum period of 72-hours unless their condition improved. Documentation in the electronic clinical record may include, but is not limited to patient evaluation findings, interventions planned to manage the patient's condition, physician notification and response.

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	08/05/2025

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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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have policies on smoking. (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	08/05/2025

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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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, facility policy, the facility failed to provide adequate smoking policies for residents in regards to smoking times, smoking areas, and smoking safety for 4 of 4 resident reviewed (Residents #1, #2, #17, and #18). The facility identified a census of 51 residents.Finding include1. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS documented Resident #1 didn't have behaviors during the lookback period. The MDS listed Resident #1 as independent with activities of daily living (ADLs). The MDS included diagnoses of non-Alzheimer's dementia, anxiety, depression and dizziness.The Care Plan Focus related to tobacco use initiated 5/16/25 included the following Interventions:5/16/25: Smoking evaluation will be completed as needed.7/14/25: As of 7/8/2025 Independent Smoker: Must keep smoking accessories secured when not in use control of facility staff.7/14/25: Resident would check in and out and carry a cell phone while smoking.5/16/25: Independent Smoker: Must smoke only in designated areas/designated times (unless able to independently get to and from the designated areas).On 7/16/25 at 11:35 AM, Resident #1 reported the smokers used to smoked out front of the facility and didn't have any time frames. She added staff and visitors complained about the smoke when they came into the facility, so they moved the smoking area to the back court yard by the dining room. Resident #1 added, since she got left outside over night, they went back to the front of the building. She explained they had smoking times and needed an assessment to see if they could smoke by themselves without staff supervision. She expressed confusion and she didn't know where to go anymore.2. Resident #2's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. Resident #2 required partial to moderate assistance with transfers. In addition, listed Resident #2 as dependent with dressing and personal hygiene. The MDS included a diagnosis of need assistance with activities of daily living (ADLs). The Care Plan initiated date 7/14/25, the resident will adhere to smoking policy and interventions include to, smoking evaluation will be completed as needed, Inform resident and/or responsible party of smoking policy, Dependent Smoker: Staff to assist resident to designated smoking areas atdesignated smoking times, Dependent Smoker: Staff to supervise while smoking, Wear protective smoking vest or apron if needed, dependent Smoker: Must keep smoking accessories secured when not in use in control of facility staff.On 7/21/25 at 11:45 a.m., Resident #2, said that a couple of days ago around the 7:00 p.m. smoke times, a staff member took him out for a smoke, there were no smoking aprons available so she took me out anyway. Resident #2 stated that the smoking area once was out front, then it was changed to the court yard by the dining room, now it is back out front of the facility and that times vary depending on who is working and if they have time to take me out, due to being supervised by staff, I depend on their schedule when smoke breaks are. 3. Resident #17's MDS assessment dated [DATE] identified a BIMS score of 14, indicating no cognitive impairment. The MDS reflected they didn't have behaviors during the lookback period. Resident #17 required substantial to maximal assistance with transfers. The MDS listed Resident #17 as independent in the facility with an electric wheelchair for mobility.The Care Plan Focus related to tobacco use initiated 4/17/25 included the following Interventions:Smoking evaluation will be completed as neededResident #17 received education to sign himself in and out of facility when he left the premise. Resident #17 received education the facility is a smoke free facility, and he would leave the property to use tobacco product.Inform resident and/or responsible party of smoking policy.Dependent Smoker:Staff to assist resident to designated smoking areas at designated smoking times.Dependent Smoker: Staff to supervise while smoking.Wear protective smoking vest or apron if needed. Must keep smoking accessories secured in lock box when not in use.On 7/17/25 at 1:15 PM, Resident #17, sat in his room in his electric wheelchair. He reported being very upset the facility moved the smoking area to the front of the facility, as the visitors got upset because they had to walk through secondhand smoke. The facility moved the smoking area to the courtyard by the dining room, but then a lady got left outside all night. Now they moved the smoking area again, he never had smoke times, and now the facility would be enforcing smoke times. Resident #17 reported he had no idea what is going on. He used to be able to go out and smoke by himself, now they changed the rules again, so he needed supervision with a smoking apron. 4. Resident #18's MDS assessment dated [DATE] identified a BIMS score of 15, indicating no cognitive impairment. Resident #18 required partial to moderate assistance with transfers, dressing and personal hygiene. The MDS included