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	05/20/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interviews and policy review, the facility failed to use Enhanced Barrier Precautions (EBP) during wound care for 2 of 2 residents observed (Resident #2 and Resident #3). The facility reported a census of 51 residents. Findings include: 1. Resident #2's Minimum Data Set (MDS), dated [DATE], included diagnoses of fractures (broken bones) and other multiple trauma (severe injuries), heart failure (weak heart), and hip fracture. The MDS indicated Resident #2 had a risk of developing pressure ulcers (bedsores)/injuries.The Care Plan Focus initiated 12/5/25, indicated Resident #2 had a risk for alteration in skin integrity (skin health) related to history of falls, impaired mobility (limited movement), and hyperlipidemia (high cholesterol). On 4/7/26, Resident #2 developed a right sacrum (lower spine bone) unstageable pressure ulcer (bedsore). The Care Plan Focus initiated 1/6/26 included an area for Enhanced Barrier Precautions (EBP) related to pressure wound. The interventions included EBP precautions: staff to wear a gown and gloves while performing high-contact care activities (high contact care activities to include: bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, performing wound care).On 5/20/26 at 10:10 AM, Staff A, Registered Nurse (RN), performed wound care for Resident #2. An observation noted EBP signage by the door and a 3-drawer cart of Personal Protective Equipment (PPE) supplies right outside the door to Resident #2's room. Staff B, Certified Nursing Aide (CNA), and Staff C, CNA, assisted with the wound care. They used a gait belt to assist Resident #2 to a standing position by Resident #2's walker, removed his pants, and lowered his brief. Staff B and Staff C remained by Resident #2's side during the wound care and then assisted Resident #2 after wound care by pulling up his pants and brief, then lowered Resident #2 back to his wheelchair. Staff A performed the wound care, cleaned the wound, applied medicated cream, and a new border foam dressing. Throughout the wound care process, Staff A, Staff B, and Staff C didn't wear a gown.2. Resident #3's Minimum Data Set (MDS), dated [DATE], included diagnoses of stroke (brain clot), renal failure (kidney failure), diabetes mellitus (high blood sugar), and pressure ulcer (bedsore) of the right heel, stage 2. The MDS indicated Resident #3 had a risk of developing pressure ulcers (bedsores)/injuries and had one or more unhealed pressure ulcers (bedsores)/injuries.The Care Plan Focus initiated 2/4/26, indicated Resident #3 had a risk for alteration in skin integrity (skin health) related to type 2 diabetes (high blood sugar), weakness, acute kidney failure (sudden kidney failure), and falls. On 1/22/26, Resident #3 developed a stage 3 left ankle pressure ulcer (bedsore), which reopened 3/12/26. The Care Plan Focus initiated 5/11/26 included an area for EBP related to pressure wound. The interventions included EBP precautions: staff to wear a gown and gloves while performing high-contact care activities.On 5/20/26 at 9:50 AM, Staff A performed Resident #3's wound care. Observed an EBP sign by the door and a 3-drawer cart of PPE supplies right outside the door to Resident #3's room. Staff A entered the room, performed hand hygiene, donned (applied) gloves, and removed the current foam border from Resident #3's left ankle. Staff A proceeded with the wound care, cleaned the wound, applied medicated cream, a new pad, and new border foam dressing. Staff A didn't wear a gown throughout the entire wound care process.On 5/20/26 at 10:20 AM, Staff A acknowledged she didn't perform appropriate EBP and stated she should've worn a gown during (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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound care for both Resident #2 and Resident #3. Staff A added the CNAs who assisted with Resident #2's wound care should've worn a gown as well.On 5/20/26 at 10:30 AM, the Director of Nursing (DON) stated they expected staff to wear gowns during wound care in accordance with EBP guidelines. The DON stated Staff A, Staff B, and Staff C should've worn gowns during wound care for Resident #2 and Resident #3.The Enhanced Barrier Precautions policy dated March 2024 instructed to focus on minimizing risk of transmission of novel or targeted Multi-Drug-Resistant Organisms (MDROs) during high contact resident care activities for residents requiring EBP. For residents whom EBP are indicated, staff should use gowns and gloves during high contact resident care activities that provide opportunity for MDROs to transfer to staff hands and clothing. High contact resident care activities included wounds care: any skin opening requiring a dressing.