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	01/14/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview and manufacturer's recommendations, the facility failed to ensure the dishwasher temperature reached 120 degrees during the final rinse cycle. The facility reported a census of 40 residents. Findings include: On 1/13/26 at 12:30 PM observed the kitchen dishwasher reach a temperature of 88 degrees during the rinse cycle with the Dietary Manager (DM) present. The DM confirmed they measured the temperature using the temperature gauge on the right side of the dishwasher. When the DM placed a Hydrion test strip (color-changing paper test strip to measure sanitizer concentration) on dishware it got lost during the dishwashing cycle. The DM reported the dishwasher got up to 110 degrees after staff washed dishes for approximately 30 minutes as they check the temperature at that time. On 1/13/26 12:45 PM the DM reported she expected the dishwasher temperatures meet the manufacturer's recommendations of a minimum of 120 degrees during the rinse cycle. On 1/13/26 at 1:10 PM observed Staff F, Cook, wash dishes following lunch service. Staff F placed a Hydrion test strip on dishware and activated the dishwasher. The test strip turned light purple; a color option not listed when compared to the colors on the test strip container. The observation of the highest dishwasher temperature at the time of the cycle reached 92 degrees. Review of facility form titled, Dishwashing Record Low Temperature/Chemical, dated October 2025, November 2025, December 2025 and January 2025 revealed staff consistently documented the dishwasher temperature twice a day to be 110 degrees. Review of the manufacturer's recommendation plaque located on the dishwasher listed the dishwasher rinse temperature to be a minimum of 120 degrees. Review of a recommendation from the American Dish Service provided by the facility revealed water supply is to reach a minimum of 120 degrees. The Dishwashing: Machine Operation, policy dated 2020 instructed all dishwashing machines should operate according to manufacturer recommendations. If the machine is found to be out of the acceptable range for either final rinse temperature or proper chemical sanitizing concentration, do not proceed to wash dishes.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, facility records, facility policies, resident and staff interviews, the facility failed to provide bath/shower at least two times for week. The facility reported a census of 49 residents.Findings include: Resident #18's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #18 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.) to shower/bathe self (washing, rinsing, and drying self). Resident #18 required substantial/maximal assistance (helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.) for tub/shower transfers (ability to get in and out of a tub/shower). The MDS included diagnoses of paraplegia (partial paralysis), post-traumatic stress disorder (PTSD or long-term effects of an incident that affects the person mental health), and cerebrovascular accident (CVA - stroke).The Documentation Survey Report for November 2025 documented bathing occurred 4 times on 11/1/25, 11/11/25, 11/21/25 and 11/25/25. The documentation reflected Resident #18 refused once on 11/14/25.The Documentation Survey Report for December 2025 documented bathing occurred 3 times on 12/2/25, 12/12/25, and 12/30/25. The documentation reflected Resident #18 refused once on 12/19/25.On 1/11/26 at 1:53 PM, Resident #18 verbalized he should've received a shower on Friday and still had received one. On 1/13/26 at 10:26, Staff J, Certified Nursing Assistant (CNA), reported residents receive baths twice per week unless they refuse. Staff J acknowledged baths are recorded in the electronic health record (EHR).During an interview on 1/13/26 at 10:28 AM, Staff B, Registered Nurse (RN), verbalized residents receive 2 baths per week unless requested otherwise or refused. Staff B stated refusals are documented in the (EHR) by the CNA. Staff B acknowledged Resident #18's EHR lacked documentation for baths. Staff B verbalized the documentation lacked baths marked indicating the staff received a bath/shower.During an interview on 1/13/26 at 11:33 AM, the Director of Nursing (DON) verbalized the facility provided baths 2 times per week unless a resident wanted them more often or refused to take them. The DON reported Resident #18's baths changed from Tuesday and Friday morning to Monday and Thursday evening effective 1/13/26. The DON reported staff document if baths were provided or refused in the EHR. The DON acknowledge the EHR lacked proof Resident #18 received a bath or refused them. The Hygiene-Bathing/Shower facility policy revised March 2024 directed staff to document in the EHR. The facility policy lacked the frequency of bath/shower or accommodating resident preferences/refusals.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, facility records and staff interviews the facility failed to post the daily nurse staffing data which included the facility name, total number and actual hours worked at the beginning of each shift. The facility reported a census of 49 residents. Findings include:On 1/12/26 at 9:46 AM, the facility's CMS Staffing Report listed staffing for 1/5/26, 1/6/26, 1/7/26 and 1/8/26. The facility had the posting taped at eye level on the door of the Staffing Coordinator's office. The CMS Staffing Report posting lacked the facility's name and the posting for the current date of 1/12/26.During an interview on 1/12/26 at 9:46 AM, Staff I, Staff Coordinator, reported she had the responsibility to post the daily nurse staff posting. Staff I reported she printed it after the day/weekend passed.During an interview on 1/13/26 at 9:55 AM, the Director of Nursing (DON) described Staff I as responsible for the daily nurse staff posting. The DON acknowledged the daily nurse staff posting didn't have the current date posted and it lacked the facility's name. The DON explained they expected the facility to follow the regulation.The facility lacked a policy for daily nurse staff posting.

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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 clinical record review, observation, staff interview, policy review, and guidance from the Centers for Disease Control and Prevention (CDC), the facility failed to follow Enhanced Barrier Precautions (EBP) practices during peri cares for 1 of 3 residents reviewed for bowel and bladder (Resident #6). In addition, the facility failed to perform hand hygiene for 1 of 1 resident reviewed for wound care (Resident #19) and failed to post Transmission Based Precautions (TBP) isolation signage for 1 of 6 residents reviewed for infection control (Resident #55).Findings include:1. Resident #6's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 5, indicating severe cognitive impairment. Resident #6 used a walker and a wheelchair in the previous 7 days. Resident #6 required Partial/moderate assistance (helper does less than half the effort. Helper lifts,holds, or supports trunk or limbs, but provides less than half the effort.) with putting on and/or taking off footwear. The MDS included diagnoses of diabetes mellitus and unspecified osteoarthritis (weakening of the cartilage between bones that causes stiffness, pain, and decreased mobility). Resident #6 had a risk for developing pressure ulcers/injuries. The MDS listed Resident #6 had 1 stage 2 pressure ulcer. Resident #6 received pressure ulcer/injury care.The Skin Evaluation - Pressure Wound - V3 evaluation dated 1/8/26 reflected Resident #6 had a Stage III pressure ulcer to her right heel with an onset date of 8/25/25.The Care Plan Focus initiated 6/19/25 indicated Resident #6 needed EBP precautions related to wounds. The Interventions directed the staff to wear a gown and gloves while performing high-contact care activities such as providing hygiene or changing briefs.On 1/13/26 at 9:40 AM observed an EBP sign hanging on the wall to the left of Resident #6's room. In addition, noted a plastic container next to the door containing personal protective equipment (PPE).On 1/13/26 at 9:45 AM watched Staff D, Certified Nurse Aide (CNA), and Staff C, CNA, perform perineal (peri) care for Resident #6. During the care, Staff B, Registered Nurse (RN), entered the room to apply an ointment. The observation revealed no of the staff wore gowns during the care.In an interview on 1/13/26 at 9:53 AM Staff C stated Resident #6 needed EBP for her foot wound, but they didn't need to wear EBP as they didn't mess with her wound.2. Resident #19's MDS assessment dated [DATE] identified a BIMS score of 3, indicating severe cognitive impairment. The MDS listed Resident #19 as dependent (helper does all of the effort) with toileting hygiene. The MDS reflected Resident #19 as always incontinent of bowel and bladder. The MDS included diagnoses of a stage 3 pressure ulcer of the right buttock and age-related physical debility (weakness due to age). Resident #19 had a risk for developing pressure ulcers/injuries. Resident #19 had 1 unhealed stage 3 pressure ulcer. Resident #19 received pressure ulcer/injury care.The LGHC (IA) Skin Evaluation - Pressure Wound - V3 dated 1/8/26 indicated Resident #19 had a Stage III pressure ulcer to her coccyx with an onset date of 9/17/25.On 1/13/26 at 9:00 AM watched Staff G, Licensed Practical Nurse (LPN), and Staff H, CNA, performed wound care to Resident #19's coccyx, her right cheek, and nose. Staff G completed wound care to Resident #19's coccyx and removed gloves. Without completing hand hygiene, she put on a new pair of gloves and completed wound care to Resident #19's right cheek. Staff G removed her gloves and without performing hand hygiene, applied new gloves to complete the last dressing change.3. Resident #55's admission Record reviewed 1/13/26 listed an admission diagnosis of COVID-19 on 1/8/26. The Order Summary Report reviewed 1/13/26 included an order dated 1/8/26 for transmission-based precautions of contact and droplet precautions for COVID-19 for 10 days (day 0 being 1/4/26).The Care Plan Focus initiated 1/13/26 indicated Resident #55 required isolation precautions related to COVID-19. The Interventions directed to maintain proper isolation precautions per facility policy.On 1/11/26 at 1:54 PM, observed Resident #55's door didn't have a TBP sign indicating his need for isolation and what PPE to use when entering the room. His room had a plastic container outside the door with PPE inside, including N95 face masks. On top of the container contained surgical masks and gloves.On 1/12/26 at 8:08 AM, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	witnessed Resident #55 door didn't have a TBP sign indicating his need for isolation and what PPE to use when entering the room.On 1/12/26 at 12:14 PM, noted Resident #55 door didn't have a TBP sign indicating his need for isolation and what PPE to use when entering the room.On 1/13/26 at 8:15 AM witnessed Staff A, Housekeeper, clean Resident #55's room wearing only a surgical mask and gloves. The door had a sign that directed to stop and not enter the room due to isolation precautions and to see the nurse for more information. The sign indicated isolation started 1/8/26 with an end date of 1/15/26.On 1/13/26 at 8:45 AM Staff B brought the surveyor the proper isolation sign for COVID. The sign indicated standard precautions plus airborne, contact, and droplet isolation. It also indicated that prior to entering the room, the person needed PPE needed of an N95 mask, eye protection, gown, and gloves.On 1/13/26 at 8:16 AM Staff A reported she didn't what PPE they should wear as the sign on the door didn't say. Staff A added the door didn't have a sign on 1/12/26, so she didn't wear any PPE that day.On 1/13/26 at 8:18 AM Staff B explained Resident #55 didn't have the correct sign on his door for COVID. She added she would make sure to put the correct sign on his door. Staff B explained to enter his room, the person should wear PPE of an N95 mask, face shield, gown and gloves. The correct sign indicated the proper PPE.On 1/13/26 at 8:20 AM Staff C, Certified Medication Aide (CMA), reported the facility put up the current sign on Resident #55's room some time the day before after lunch but before supper. Staff C confirmed the current sign isn't the correct sign. Staff C described the proper PPE as am N95 mask, face shield, gown, and gloves.On 1/13/26 at 11:55 AM the Administrator stated Resident #55's door should have had an isolation sign as he tested positive for COVID. She agreed hand washing should be performed between glove changes. When questioned about EBP, the Administrator replied the staff should use EBP with cares for Resident #6.On 1/13/26 at 12:14 PM Staff E, Infection Preventionist, stated the staff should've used EBP for Resident #6 due to her wound. Staff E added Resident #55 should have had a COVID isolation sign on his door. Also, acknowledged staff should preform hand hygiene between glove changes.On 1/13/26 at 1:35 PM the Director of Nursing (DON) stated hand hygiene should be performed between glove changes. She initially stated that Resident #6 wouldn't need EBP for peri care but then acknowledged the staff should use EBP for peri care. The DON added Resident #55 should have a COVID isolation sign on his door.The Hand Hygiene policy revised October 2023 instructed hand hygiene using alcohol-based hand rub is recommended after removing gloves including during wound dressing change.In a policy titled Infection Control Disease Specific Guidelines revised October 2023, it indicated that isolation for severe acute respiratory syndrome (SARS), also known as COVID, should be airborne, droplet, and contact with standard precautions.In a policy titled Enhanced Barrier Precautions revised March 2024, it directed to use EBP in conjunction with standard precautions for residents with wounds and/or indwelling medical devices. In addition, with residents for whom EBP is indicated, gowns and gloves should be worn during high contact care activities such as providing hygiene or changing briefs or assisting with toileting.The Centers for Disease Control and Prevention (CDC) document dated June 2021 titled Consideration for Use of Enhanced Barrier Precautions in Skilled Nursing Facilities instructed skilled nursing facilities should consider EBP for residents with wounds or indwelling medical devices, regardless of Multi Drug Resistant Organisms (MDRO) colonization status or infection or colonization with an MDRO.