STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165575	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Utica Ridge	3800 Commerce Blvd Davenport, IA 52807

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. **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 complete physician ordered treatments for 1 of 4 residents (Resident #4) reviewed for wound care. The facility failed to reported a census of 89 residents.Findings include: 1.Review of Resident #4's Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS identified Resident #4 with the skin problem of moisture associated skin damage (often referred to as MASD, skin damage caused by prolonged exposure to moisture such as for example urine, or perspiration), with the need for treatments such as non-surgical dressings and ointments/medications. Review of Resident #4 Care Plan dated 5/2/25, revealed a Focus area which addressed At Risk for alteration in skin integrity related to impaired mobility, incontinence and DM (diabetes).MASD to groin, buttocks, perineum and abd (abdomen) folds. Will frequently refuse treatments, even after education & encouragement. Interventions included, in part:a. Administer treatments per physician orders.b. Apply barrier cream to peri area/buttocks/abdominal folds as needed.During an interview on 5/11/26 at 11:37 AM, Resident #4 stated treatments had been missed.Review of Physician Orders revealed the following:a. Abdomen: cleanse w/NS (with normal saline) normal saline, apply calcium alginate and secure with boarded gauze. Every day shift every Monday, Wed and Fri. Start Date: 5/1/26. Review of May 2026 Treatment Administration Record (TAR) revealed no documentation present on 5/4/26 to indicate if the treatment completed, held or refused. Review of Progress Notes found no documentation to explain further.b. Left buttocks: Cleanse with NS, apply foam dressing every day shift for MSAD. Start Date: 3/14/26. D/C (discontinue) date: 5/6/26. Review of the May 2026 TAR revealed no documentation present on 5/2/26 or 5/4/26 to indicate if the treatment completed, held or refused. Review of Progress Notes found no documentation to explain further.c. Right buttocks: Cleanse with NS, apply zinc oxide paste every day shift for MASD. Start Date: 5/1/26.Review of the May 2026 TAR revealed no documentation present on 5/4/26 to indicate if the treatment completed, held or refused. Review of Progress Notes found no documentation to explain further.d. Right labia: Clean with NS, apply zinc, leave open to air every day shift for wound care. Start Date; 5/1/26.Review of the May 2026 TAR revealed no documentation present on 5/4/26 to indicate if the treatment completed, held or refused. Review of Progress Notes found no documentation to explain further.e. Nystatin external powder 100,000 unit/GM: apply to groin topically every shift for rash. Start Date: 3/2/26.Review of the May 2026 TAR revealed no documentation present on 5/4/26 to indicate if the treatment completed, held or refused. Review of Progress Notes found no documentation to explain further.During an interview on 5/13/2026 at 10:06 AM, Staff E, Licensed Practical Nurse (LPN) stated when treatments are provided, they are documented in the electronic health record under the TAR. Staff E stated if a TAR box is left blank it means the treatment wasn't provided.During an interview 5/13/2026 at 1:08 PM, the Director of Nursing (DON) stated when a treatment is provided, it's documented on the TAR. If a resident would refuse a physician ordered treatment, the nurse would document the refusal on the TAR and note it in the Progress Notes. The DON reported if a box is left blank on the TAR, it meant the treatment wasn't completed. The DON verbalized the expectation is (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physicians' orders are followed with appropriated documentation in place.Review of the facility policy titled, Physician Orders/Transcription of Orders revised July 2023, directed, in part: Active orders should be followed and carried out as written/transcribed.

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review and staff interview the facility failed to implement pressure reducing interventions per the wound nurse practitioner's recommendations for 1 of 2 (Resident #11) reviewed for pressure injuries. The facility identified a census of 89 residents.The CMS RAI Manual defines the following pressure injury (PI) (a pressure ulcer/injury is a localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of intense and/or prolonged pressure or pressure in combination with shear. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful) stages:Stage 1: Non-blanchable Erythema: Intact skin with persistent red/blue/purple discoloration; color does not blanch.Stage 2: Partial Thickness Loss: Shallow, open wound with red-pink bed (no slough) or a serum-filled blister.Stage 3: Full Thickness Skin Loss: Subcutaneous fat may be visible, but bone/muscle is not exposed; slough (moist, stringy, dead tissue) may be present.Stage 4: Full Thickness Tissue Loss: Exposed bone, tendon, or muscle; slough/eschar (dry, black dead tissue) and tunneling often present.Unstageable: Full-thickness loss where slough or eschar obscures the true depth, which is revealed to be Stage 3 or 4 upon removal.Deep Tissue Injury (DTI): Purple/maroon localized area of discolored intact skin or blood-filled blister.Findings include:Review of Resident #11's Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 9 out of 15, which indicated a moderate cognitive impairment. The list of diagnoses included stroke, coronary artery disease, diabetes, Non-Alzheimer's Dementia, anorexia, palliative care and an unstageable pressure ulcer to the left heel. The MDS indicated Resident #11 required partial to moderate assistance with positioning side to side in bed. The MDS documented the resident had an unhealed, unstageable PI and utilized a pressure reducing device for the bed, chair, pressure injury care, and application of dressings to the feet. The MDS identified Resident #11 received hospice care. The MDS listed the admission date as 4/6/26.A review of the admission Assessment, dated 4/6/26 identified Resident #11 with a Stage 3 PI on the right heel, which measured 2.5 cm (centimeters) by 1.1 cm to the right heel.Review of the Care Plan dated 4/6/26 revealed a Focus area to address At Risk for alteration in skin integrity related to pressure ulcer to the Left Heel Care Plan. Interventions included, in part:a. Pressure reducing device on bed.b. Pressure reducing deice on chair.A review of the electronic health record (EHR) Skin Evaluation Pressure Wound Assessments revealed;a. On 4/14/26.the left heel PI measured 2.5 cm in length (L) x 2 cm in width (W) by 0.1 cm in depth (D); stage three. The wound bed described as filled with slough. The Nurse Practitioner (NP) documented the area as a new area and recommended frequent repositioning and to use heel protectors.b. On 4/22/26.the left heel PI measuring 1.2 cm x 2.8 cm x 0.2 cm; stage three. The wound bed described as filled with slough. The NP recommended frequent repositioning, the use of heel protectors and to provide a medical grade honey with border gauze treatment.c. On 4/29/26.the left heel PI measured 1.4 cm x 2.8 cm x 0.2 cm; unstageable. The wound bed described as filled with slough. The NP recommended frequent repositioning, the use of heel protectors and a medical grade honey alginate border gauze treatment three times a week.d. On 5/5/26.the left heel PI measured 1.4 cm x 2.6 cm x 0.2 cm; unstageable and to continue the same recommendations as prior.Review of the electronic health record revealed a Skin and Wound Note entered by the NP on 4/19/26 at 10:48 PM: Upon exam Resident #11 presented with an unstageable PI to the left ankle. The NP recommended an alternating air mattress for pressure redistribution, ensure settings were maintained appropriate for the patient's needs and body habitus, and float heels while in bed with use of heel boots.During an interview on 05/11/2026 at 11:05 AM, Resident #11 stated they were treating an area to her heel. She lifted her left foot into while lying in bed on her back. She wore gripper booties on her feet. Further observation revealed two padded blue boots laying in a chair across from the foot of the bed. Resident #11 reported she had her gripper booties on and preferred to lay in bed. Resident #11 observed laying with her heels in direct contact (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with the mattress. The resident's bed did not have an air mattress.During an observation on 5/11/26 at 1:53 PM, Resident #11 in her room, in bed positioned on her left side. Two blue padded boots sat in a chair across from the foot of the resident's bed. The resident's bed did not have an air mattress. During an interview on 5/11/26 at 3:40 PM, Resident #11 reported the dressings on her left heel was changed one to two times per week. Resident #11 added or at that is what happened last week. During an observation on 5/11/26 at 4:05 PM, Staff H, Licensed Practical Nurse (LPN) and Staff F, Unit Manager, Registered Nurse (RN) completed scheduled wound care. Resident #11 bed continued to have an air mattress in place; and the blue padded boots remained on the chair across from the foot of the resident's bed.During an observation on 5/12/26 at 7:33 AM, Resident #11 sat on the edge of her bed, and wore gripper booties on her feet. The residents bed remained without an air mattress in place. During an interview on 05/12/2026 at 11:30 AM, the Hospice Case Manager stated the goal for Resident #11's left heel wound is to heal with no pain. During an interview on 5/12/26 at 11:55 AM, Staff F, RN stated the believed the goal was for Resident #11's PI to be free of pain but that would be the role of the NP to make that decision. Staff F stated the Wound NP sees Resident #11 weekly on Wednesdays and documented her visit notes in the EHR.During an interview on 5/12/2026 at 1:57 PM, Staff J, Certified Nursing Assistant stated heel protectors are to be used or a resident's feet should be positioned so their heels float on a pillow. Staff J stated heel protectors are offered to the resident when she lays in bed, and she used to refuse the blue boots. Staff J looked into Resident #11's room where she lay in bed on her back with no padded boots on her heels. When queried if she had offered Resident #11 the blue padded boots, Staff J stated she had not offered the blue boots to Resident #11 today. Staff J stated Resident #11 did not have an air mattress on her bed and as far as she knew she had only used a regular mattress. During an interview on 5/12/26 at 4:20 PM. Resident #11stated the staff do not offer her the padded boots when she lays down. The resident stated she tries to lay on her side because she doesn't want her heels to get worse. Resident #11 bed noted to not have an air mattress in place.During an observation on 5/13/26 at 7:15 AM, Resident #11 lay in bed on her back with her heels in direct contact with the mattress. The blue padded boots laid at the foot of the bed.During an interview on 5/13/26 at 11:25 AM, the NP stated as Resident #11 received hospice care, the goal is maintenance and prevent the heel wound from getting worse. The NP explained she first saw the wound about a month ago and it was unstageable. The NP stated she had recommended the heel boots and the air mattress. She explained the Resident can be non-adherent with using the boots but the staff should still offer them. When queried if Resident #11 should have an air mattress, the NP reported yes and thought hospice provided one to her. During an interview on 5/13/2026 at 3:53 PM Staff F, RN reported she thought Resident #11 had an air mattress on her bed. At 3:58 PM Staff F went to Resident #11's room and confirmed there was no air mattress in place. Staff F voiced it is her responsibility to monitor the wound care notes and ensure the wound interventions get implemented. Staff F added Hospice could also provide an air mattress for her. When queried if staff should offer her the padded boots when she lays down in bed, Staff F stated, yes and added the staff should offer the padded boots every time they lay the resident down. Staff F explained she needed to do a better job of checking the NP wound progress notes.During an interview on 5/13/26 at 4:16 PM, the Director of Nursing (DON) reported the air mattress should have gone in timelier and the CNA's should be offering the heel boots when she lays down. During an interview on 5/14/26 at 10:17 AM, the Administrator reported Resident #11 had a room change, and she had an air mattress on her bed but the bed was not moved with her. The Administrator stated the facility is implementing a room change checklist so that all safety interventions will go with the resident.The Physician Orders/Transcription of order Policy revised 7/2023 directed active orders should be followed and carried out as written/transcribed.