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	06/09/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interview, and facility policy review, the facility failed to use non-pharmacological interventions prior to the administration of a medication prescribed for anxiety which caused for 1 of 1 resident (Resident #8) reviewed for chemical restraints to experience hypersomnolence (excessive sleepiness). The facility reported a census of 91.Findings includeReview of Resident #8's Minimum Data Set (MDS) annual assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. The list of diagnoses included depression, adjustment disorder with mixed anxiety and depression, and insomnia.Review of Resident #8's Care Plan dated 10/09/24, revealed a Focus area to address Resident is at risk for pain related to diagnosis neuropathy and history of bilateral BKA (below knee amputation). Interventions included, in part:a. Encourage/Assist to reposition frequently to position of comfort. Initiated: 10/09/24.b. Implement non-pharmacological interventions massage, relaxation techniques, counseling, warm/cool compress, positioning as indicated. Initiated: 10/09/24.Review of the June 2026 Review of the June Medication Administration Record (MAR), revealed an order for: hydroxyzine HCL Oral Tablet 25 mg (milligrams). Give 25 mg by mouth every 12 hours as needed for anxiety for 14 days. Start date: 5/26/26. Further review revealed hydroxyzine 25 mg administered on 6/02/26 at 1:43 AM by Staff documented that on 06/02/2026 Staff A, Licensed Practical Nurse (LPN).During an interview on 06/04/2026 at 11:07 AM, Resident #8 stated that on the evening of 06/01/2026 into the morning of 06/02/2026 he was experienced pain and anxiety. Around 1:00 AM he requested staff assist him to move out of bed into his wheelchair, as he felt it would help with the pain and help calm him down. Resident #8 recalled he was told no by nursing staff and was instead offered medication. Resident #8 stated he did not know he had an as needed (PRN), and it was explained to him that his psychiatrist had prescribed the medication. Resident #8 stated he again asked to get out of bed, and a staff he identified as Staff A, LPN told him to take his medication first and if he was still wanting to get out of bed after it was working, she would assist him to his wheelchair. He noted he took the medication and he does not remember the rest of the evening. He woke up very late that day, after activities he had planned on participating in were over. Resident #8 explained he woke up groggy and felt distressed to he had slept so long.During an interview on 06/09/2026 at 08:48 AM, Staff A, LPN, stated she was made aware of Resident #8 wanting to get out of bed into his wheelchair in the evening, though she did not recall what time. She stated when she met with the resident he requested to get out of bed into his wheelchair, but she suggested he take his medication first and offered to help him into his wheelchair if it did not work. Staff A recalled Resident #8 reported not knowing he had a PRN medication available, and she had to talk him into taking it. She reported the medication as being effective. Staff A stated she had been made aware the next day the resident had a hyper somnolent episode (difficulty being roused and waking up). She reported she was unaware of the interventions in the Care Plan for Resident #8. Staff A added she had only been working at the facility for a few weeks at this time.During an interview on 06/04/2026 at 01:27 PM, Staff B, Assistant Director of Nursing (ADON), stated she had been informed the nurse (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
	165575	A. Building B. Wing	06/09/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[Staff A, LPN] suggested medication first instead of getting Resident #8 up into his chair at his request. The ADON acknowledged that the nurse should have attempted a non-pharmacological intervention first, especially when requested.During an interview on 6/08/2026 at 12:39 PM, the Director of Nursing (DON) stated the nurse [Staff A, LPN] failed to utilize non-pharmacological measures first. The DON stated she expected that non-pharmacological measures are utilized first and medications should be administered if those measures fail. The DON stated Staff A should have respected Resident #8's request to get up into his chair instead of resorting to medication.Review of a facility provided document titled One-on-One Inservice Record documented that on 06/02/2026 Staff A was provided with a corrective action. It stated On 06/01/2026 it was charted resident was having aggressive behaviors so PRN anxiety med was given. The document included instruction for the staff member to always utilize non-pharmacological measures first.Review of a facility provided document titled Behavior Management Guide, documented non-pharmacological interventions should be attempted prior to the use of any psychoactive medication.

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	06/09/2026

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 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 clinical record review, staff and resident interview, and facility policy review, the facility failed to document the outcome of weekly skin assessments and implement a new wound care order in a timely manner for 1 of 7 residents (Resident #1) reviewed for pressure ulcer care. The facility reported a census of 91.Findings include:Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema (redness). In darker skin tones, the PI may appear with persistent red, blue, or purple hues. The presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes of intact skin may also indicate a deep tissue PI (see below).Stage 2 Pressure Ulcer: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. This stage should not be used to describe moisture associated skin damage including incontinence associated dermatitis, intertriginous dermatitis (inflammation of skin folds), medical adhesive related skin injury, or traumatic wounds (skin tears, burns, abrasions).Stage 3 Pressure Ulcer: Full-thickness skin loss Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. 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 wound bed, it is an Unstageable PU/PI.Stage 4 Pressure Ulcer: 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 on some parts of the wound bed. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the wound bed, it is an unstageable PU/PI.Unstageable Pressure Ulcer: 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 the wound bed is obscured by slough or eschar. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) should only be removed after careful clinical consideration and consultation with the resident's physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws. If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. If the anatomical depth of the tissue damage involved can be determined, then the reclassified stage should be assigned. The pressure ulcer does not have to be completely debrided or free of all slough or eschar for reclassification of stage to occur Review of Resident #1's Minimum Data Set (MDS) dated [DATE], indicated intact cognition based on a Brief Interview for Mental Status score (BIMS) score of 15 out 15. The list of diagnoses included heart failure, peripheral vascular disease, renal insufficiency (kidney failure), and multiple sclerosis. The MDS indicated the resident at risk for the development of pressure ulcers, and admitted with one stage 1 pressure ulcer. The MDS identified Resident #1 admitted after a short-term hospital stay on 4/07/26. fThe MDS dated [DATE] indicated Resident #1 discharged for a Short-Term General Hospitalization. During an interview on 05/28/2026 at 1:51 PM, Resident #1 stated she had issues waiting for staff members during her time at the facility. She stated staff were aware she had redness or an injury on her buttocks but they weren't treating it until days after the pain worsened. She stated the pain got worse after she was seen by a wound nurse, but she did not know the date. She said it was approximately a week after seeing the wound nurse that they began treating her buttocks.The Care Plan for Resident #1 dated 4/7/26, included a Focus area to address At risk for alteration in skin integrity related to impaired ADL (activities of daily (continued on next page)

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	06/09/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	living) function/mobility. Interventions included:a. Administer treatment per physician ordersb. Follow facility policies/protocols for prevention/treatment of skin breakdown. c. Observe skin condition with ADL care.Review of the admission summary dated [DATE] at 6:36 PM revealed, in part: Resident arrived into facility via ambulance x 2 attendants from [name of hospital redacted] .Surgical wound to back of neck/upper back measured and dressing reapplied.Redness noted to sacrum area, Tx (treatment) order obtained and performed. Resident refused weight, states she has lost a lot of weight recently but stated that movement caused her pain and she would like to wait on obtaining weight.Review of the admission Skin Evaluation-Non-Pressure Wound V2 dated 4/7/26, in the EHR revealed, in part: Section A: A. Resident has a skin alteration: Yes 1. Is this a NEW skin alteration: No. 4. Indicate where the skin alteration is located.Site: Sacrum. Type: Other. Length - 6 cm (centimeters) Width 4 cm. 6. Is there any drainage noted from the wound: No. 9. Is the resident experiencing pain: No. No other wounds noted on the evaluation. 1a. Narrative: Resident arrived into the facility with redness to this area. Tx (treatment) orders obtained from hospital and placed in [name of EHR redacted]. Review of the April 2026 Medication and Treatment Administration Record (MAR/TAR) revealed the following skin assessment orders:a. Skin assessment on admission and then weekly on Friday every evening shift. Start Date: 4/9/26. D/C Date (discontinue): 4/11/26.1. Documentation on April 2026 MAR/TAR indicated this order completed as scheduled.b. Body audit weekly Friday evening shift. Start Date: 4/10/26. D/C Date: 4/21/26.1. Documentation on April 2026 MAR/TAR indicated this order completed as scheduled.c. Weekly skin assessment update all skin -sheets full body audit every evening shift every Fri for skin assessment. Start Date: 4/24/26. D/C Date: 5/02/26.1. Documentation on April 2026 MAR/TAR indicated this order completed as scheduled.Review of facility documents titled Non-Pressure Skin Condition report revealed:a. For Site Location: Sacrum1. On 04/07/2026 - Measurement: Length (cm): 6 x 4 Width (cm) x Depth (cm): [blank]; Exudate: None.Wound Bed: Pink, pale tissue; Surrounding Skin: Normal for skin; Pain: No; Progress: Not changed; Treatment: Continue; Progress Note: MASD (moisture associated skin damage - inflammation, redness or erosion of skin prolonged by exposure to moisture or chemical irritants. 2. On 4/17/26 - Healed.b. For Site Location: Left gluteal cleft1. On 4/24/26 - Condition is: [no check box marked to indicate]. Measurement: Length (cm): 4 x 2 Width (cm x 0.5 depth; Characteristics: Partial Thickness; Exudate: None.Wound Bed: Dark pink/red tissue; Surrounding Skin: Normal for skin. Pain: No.During an interview on 06/03/2026 at 12:48 PM with the Director of Nursing (DON) stated it appeared there were not skin assessments documented from the 9th through the 15th. She stated she believed the wound assessments to be incomplete. The DON also stated the wound care NP orders were not started when they were ordered.A review of a HP Skin and Wound Note entered into the EHR on 4/19/26 by wound care provider revealed, in part: Date of Service: 4/15/26.Reason for visit: first evaluation of existing wound patient by new wound care team.Upon examination today, the patient presents with a surgical incision to her posterior neck that is closed. The patient also presents with an unstageable pressure injury to her sacrum and a pressure injury to her left buttock.Wound: 2 Location: Left buttock. Primary etiology (cause): Pressure ulcer/injury. Stage/Severity: Stage 3. Wound Status: First evaluation of existing wound by new provider.size 7 cm x 5 cm x0.1 cm.pain at rest: 3. Wound 3. Location: Sacrum. Primary etiology: Pressure ulcer/injury. State/Severity: Unstageable. Wound Status: First evaluation of existing wound by new provider.Size: 3.5 cm x4 cm x0.1 cm.WOUND TREATMENT.Wound #2 Left Buttock: Recommendations: 1. Cleanse with wound cleanser. 2. Apply hydrocolloid to base of the wound. 3. Secure with Leave open to air. 4. Change and PRN Every 3 days.Wound #3 Sacrum: Recommendations: 1. Cleanse with wound cleanser. 2. Apply hydrocolloid to base of the wound. 3. Secure with Leave open to air. 4. Change and PRN Every 3 daysReview of the April 2026 Medication and Treatment Administration Record (MAR/TAR) revealed the following wound treatment orders: a. Cleanse sacrum with soap and water, pat dry, apply zinc oxide Bid (twice daily), PRN (as needed) until healed. Two times a day for tx (treatment). Start Date: 4/8/26. D/C Date: 4/21/26.1. Documentation indicated this ordered administered twice daily from (continued on next page)

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	06/09/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/8/26 through 4/19/26; for 4/20/26 administered for AM, blank for PM; and administered for AM on 4/21/26 before discontinued. b. Sacrum: cleanse w (with) NS (normal saline) or wound cleanser, apply hydrocolloid dressing and leave open to air. Every day shift every Mon, Wed, Fri for wound care. Start date: 4/22/26. D/C date: 5/2/26.1. Documentation indicated this ordered administered as scheduled. 2. Order also PRN and administered as a PRN on 4/24/26 [second time for day].c. Left buttocks: cleanse with NS or wound cleanser apply hydrocolloid dressing leave open to air every day shift Mon, Wed, Fri. Start Date: 4/22/26. D/C Date: 5/2/26. 1. Documentation indicated this ordered administered as scheduled. 2. Order also PRN and administered as a PRN on 4/24/26 [second time for day].d. Cleanse wound to L (left) gluteal cleft with NS, apply xeroform, cover with foam dressing, QD (daily), PRN until healed. Start Date: 4/24/26. D/C Date: 5/2/26.1. Documentation indicated this ordered administered as scheduled. During an interview on 06/03/2026 at 10:38 AM, the wound care provider Nurse Practitioner (NP) stated she first saw Resident #1 4/15/26. She stated she the resident's husband had informed her the resident had issues on her bottom, and upon her assessment discovered two pressure ulcers. The NP described an unstageable pressure ulcer on the sacral area, and a stage 3 on her left buttock. The NP stated she believed the resident was being seen by [name of community based wound clinic redacted]. The NP stated she put in her recommended orders on 4/19/26 because she had a significant backlog of residents and did not follow up with the resident after this. The NP stated it is unlikely the wounds appeared in the timeframe of the resident admission [DATE]] to 4/15/26 as these wounds happen longer than a few weeks. During an interview on 6/3/26 at 12:06 PM, Staff D, Licensed Practical Nurse (LPN) stated the wound care NP saw Resident #1 on 4/15/26, but did not make the order recommendations until 4/19/26. Staff D stated nothing had been done with the orders from the 19th until the 24th, when she put in the orders.During an interview on 06/03/2026 at 12:48 PM with the Director of Nursing (DON) stated the wound care NP orders were not started when they were ordered. During an interview on 06/03/2026 at 03:47 PM, Staff E, LPN, stated she does not remember the day Resident #1 admitted , but remembered she admitted with a surgical wound and a coccyx wound. Staff E stated she believed the coccyx wound was at least a Stage 2 when she admitted from the hospital. Staff E stated she completed wound treatments, but did not remember the order, and added maybe it was with soap and water. Staff E stated the documentation of the area being healed on 4/17/26 was a mistake. She stated the wound needed debridement on that date. During a second interview on 6/3/26 at 3:50 PM, the wound care provider NP stated the wounds would have had to be present on 4/7/26. She explained the area of note on the coccyx was about the size of quarter. It was unstageable and she feels it could have been missed if not digging for it. There was also a minor wound on her left gluteal fold. She believes it could have been mistaken for MASD. The NP stated the order to wash the area with soap and water was appropriate for wound care. She stated if she had come in on the 7th the wound would have been there before the 7th. The NP added her conversation with Resident #1's husband indicated he knew of the wound. The NP stated there is no way it wasn't there before the 7th. A review of the ERH revealed the following notes entered by the wound care NP:a. On 4/22/26 - Skin and Wound Note: Patient unable to be evaluated by skin and wound team today; patient at PT/OT (physical therapy/occupational therapy) during time of visit. Attempted x3.b. On 4/30/26 - Skin and Wound Note: Patient was unable to be evaluated by the skin and wound team today; patient at PT/OT during time of visit, surgeon following surgical incision, wound clinic following other wounds, signing off.During an interview on 06/04/2026 at 08:25 AM, the facility Advanced Registered Nurse Practitioner (ARNP) stated she examined the resident once and noted the wounds but did not document them. The ARNP stated she made recommendations to refer to the resident to the wound clinic.During an interview on 06/04/2026 at 09:12 AM, Staff F, Certified Nurse Aide (CNA), stated she remembered Resident #1, and she remembers she had a spot on her lower back when she entered, she believed this to be MASD. She stated it was the CNAs responsibility to report skin status changes to the nurses but she did not often work with Resident #1 and does not remember reporting (continued on next page)

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	06/09/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	anything.Review of a facility provided document titled Dressing change instructs staff members to follow physician's orders. It documented Step 1 as verify physician's orders.