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

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, clinical record review, facility policy review, and staff interviews, the facility failed to serve the correct portion size of the protein entree for 8 of 9 (Resident #1, #31, #43, #54, #77, #79, #89 and #96) residents with a mechanical soft diet order. The facility identified a census of 89 residents.Findings include:Review of the Week 1 Wednesday Noon Menu, approved by the Dietician directed to provide a 3- ounce (oz) portion of pork loin for the mechanical altered diet. The Diet Roster listed Resident #1, #31, #43, #54, #77, #79, #89 and #96 as receiving a mechanically altered diet. The Center for Medicare and Medicaid (CMS) Matrix provided by the facility listed Resident's #43 and #96 as having significant weight loss. During an observation of the Crow Creek Dining Room on 5/13/26 from the start of meal at 11:38 AM until 12:29 PM, Staff O, [NAME] used a #16 (2 Oz.) scoop to serve the ground pork loin to eight residents on the mechanical soft diet. During an interview on 5/13/26 at 12:56 PM, Staff O, [NAME] stated she used a #16 scoop for the ground pork loin. She thought it was a 2 oz scoop, but was not 100 percent sure. Staff O stated she didn't know if it was a correct portion of the mechanical soft meat, but it was the size of scoop they used to serve out the mechanical soft meat. During an interview on 5/13/26 at 1:38 PM the Certified Dietary Manager (CDM) reported she would expect the dietary staff to following the serving sizes on the menu. If there is significant weight loss, she would expect the full portion of each item to be served. During an interview on 5/13/26 at 3:04 PM, the facility Dietician explained she was told by the CDM the cook just pulled the wrong scoop size for serving the ground pork for the lunch meal. She had no knowledge the #16 scoop was used regularly to serve the ground meat and would have to check on that. The Dietician voiced the cook should have used the correct scoop according to the signed menu. Review of the facility policy Menus-Planning, Preparation, Services and Record-Keeping Policy revised 5/25 included Guidelines that menus are planned to meet the resident therapeutic diet requirements and nutritional parameters.

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, kitchen record review, facility policy review, the US Food Code (2017) and staff interviews, the facility failed to maintain clean and sanitary equipment in the main kitchen and in a kitchenette. The facility identified a census of 89 residents.Findings include:During the initial tour of the kitchen on 5/11/26 at 10:09 AM the following observations were made:a. A dried on black/brown substance 1.5 - 2 inches from the front of the stove running approximately 2.5-3-foot down the length of the stove. A dried on black/brown substance approximately 8-10 inches high in three areas and to the top of the stove backsplash in one area; all areas ran the entire length of the stove black splash. b. The walk-in cooler had 1-1.5 inches of a black substance running where the door seal connects to the cooler door around the entire cooler door frame and a build-up of a thick, black substance, along the cooler door threshold approximately four foot in length. c. A build-up of a black/brown/orange substance running approximately 4 feet down the front of the griddle.A revisit to the kitchen on 5/13/26 at 8:18 AM revealed:a. An approximate 24-inch dirty skillet positioned at the middle burner of the six-burner stove. A tacky, black/brown substance measuring approximately 1.5-2 inches came out from the front of the stove and ran the length of the stove approximately 2.5-3-foot. A large metal spoon lay on top of the black brown substance. A stuck down black/brown substance approximately 8-10 inches high in three areas and one area approximately 16 inches high to the back of the stove top ran the entire length of the backsplash. b. The walk-in cooler noted with 1-1.5 inches of a black substance along the entire door seal. The cooler door had a thick brown substance built up running the length of the cooler door threshold. c. A built-up of a black/brown/orange substance running approximately 4 feet down the front of the griddle. During an interview on 5/13/26 at 8:24 AM, the Certified Dietary Manager CDM) explained the Maintenance Director cleaned the cooler door seal and door threshold monthly. She didn't know if there was a checklist on the cleaning of the cooler door, but she would check. During an observation on 5/13/26 at 8:30 AM, the two-tier shelf underneath the coffee area with black/brown gritty circular rings throughout the first shelf with 15 clean coffee carafe stored upside down in direct contact with the gritty substance. The second shelf under the coffee area noted with a brown, stuck down, gritty substance saturated through a white non-slip matting throughout the second shelf with 8 pitchers stored upside down in direct contact with the dirty gritty substance. A review of the Weekly Cleaning List revealed the following:a. A deep clean of the stove and oven scheduled for a weekly cleaning. The Weekly Cleaning List dated 3/13/26 - 3/20/26 provided by the CDM showed Staff K, [NAME] signed off the Weekly deep clean of the stove X 2. b. The 3/13/26-3/20/26 Weekly Cleaning List directed to clean the coffee/area shelves weekly. Staff L, Dietary Aid signed the task as completed on 3/13/26. c. The 4/29/26 - 5/06/26 Weekly Cleaning List showed Staff K completed the deep clean of the stove/oven on 5/03/26 and Staff M, [NAME] completed the cleaning of the coffee area/shelves on 5/01/26. During an interview on 5/13/26 at 9:34 AM Staff M, [NAME] stated they don't really use the griddle that much, just mainly for making grilled cheese sandwiches at suppertime. The following observations were completed 5/13/26 at 11:10 AM in the Crow Creek Kitchenette:a. The steam table back inside supports had two inches of exposed rust by three inches of peeling paint and rust. The right side of the steam cart had approximately three inches of exposed metal with the paint off by three inches of peeling paint and a brown, white crumbly substance on the inside of the support. b. The front of the steam table had a 1-inch circular white crumbly substance ahead of the second steam well and various food crumbs on top of three of the four steam pan lids. c. A cart across from the steam table held a plate warmer unit which was surrounded by food crumbs on all sides. d. The wall across from the steam table observed with an approximate eight-inch open gash in the dry wall; 1-1.5 inches deep and three inches above the floor base cover. e. The front countertop by the condiment holder revealed five 1-centimeter (CM) areas of a red sticky substance stuck down on the counter. During an interview on 5/13/26 at 1:38 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PM, the CDM looked at the stove and reported they usually do not have anything oil based when cooking or frying when using the stove. There is no grease trap. The CMS stated ideally, the staff should be addressing the grease built up on the stove, but it is probably hard to get off. During an interview on 5/13/26 at 2:15 PM, the CDM stated the build-up on the stove is carbon build up. They did get some of the grease build-up on the back splash cleaned up. Carbon buildup on a stove is a hard, black, charred residue caused by burnt food, polymerized grease, and carbonized oil from high-heat cooking or accumulated debris. It acts as a thermal barrier, causes uneven cooking, and cannot be cleaned with soap and water. Special cleaning agents are required. During an interview on 5/13/26 at 3:04 PM, the facility Dietician reported the CDM creates daily, weekly and monthly cleaning schedules as well as they contract cleaning for the kitchen. She doesn't know what they clean the stove with, but they haven't been able to get the carbon build up off the stove. The Dietician stated she believed the carbon build-up on the stove had been there a long time and they would have to hire someone to come in and clean the stove. She voiced even if the Maintenance Director cleaned the cooler door seal and floor threshold, the CDM should still direct how often it should be cleaned. On 5/13/26 at 3:31 PM the Administrator reported the Maintenance Director may have information regarding the walk-in cooler door in the TELS system. During an interview on 5/13/26 at 3:38 PM, the CDM reported the Weekly Cleaning List provided were the only cleaning list that she could find. She did not have any cleaning lists prior to 3/13/26 or since 5/06/26 to show staff had completed the kitchen cleaning. She completes random kitchen walk throughs and looks at the cleaning of the kitchen to monitor. She expects the staff to complete the cleaning according to the cleaning list. During an interview on 5/13/26 at 3:41 PM, the Maintenance Director reported the facility implemented the refrigerator/cooler door seal and threshold checks and cleaning today. He hadn't seen the actual verbiage come out but assumes he will check and clean weekly. Prior to today, he had nothing in his TELS or monitoring/cleaning that he was doing for it. During an interview on 5/14/26 at 7:24 AM, the CDM reported the facility does not have any cleaning lists for the smaller serving kitchenettes. The dietary staff are supposed to clean the area after they serve the meal and housekeeping mops the dining rooms floors. She completes walk-throughs of the areas daily. She inspected the Crow Creek dining room around 10:30 AM on 5/13/26 and didn't see anything. She didn't think anything had been put in for maintenance to fix the wall in the Crow Creek kitchenette. She expects the dietary staff to clean the kitchenettes after each meal. During an interview on 5/14/26 at 9:19 AM, the Administrator reported when she see gashes in the walls, she takes a picture of it and puts it in the TELS system for maintenance to repair it. Review of the facility policy titled Kitchen Sanitation and Cleanliness Policy revised 5/25, directed food service areas would be maintained in a clean and sanitary condition. The Procedure directed food service areas would be assessed on a periodic basis to develop and edit appropriate cleaning schedules for each area. Posted cleaning schedules would clearly communicate the location, frequency and may include the person responsible for the assigned area with a way to sign off the completion. The cleaning and sanitations tasks for the kitchen would be recorded by the person completing the task. The Dietary Manager or designee would be responsible for ensuring areas that require professional cleaning are completed on a periodic basis. The 2017 US Food Code under 4-6 Cleaning of Equipment and Utensils directs at 4-601.11 (B) food contact surfaces of cooking equipment shall be kept free of encrusted grease deposits and other soil accumulations; (C) nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, residue and other debris.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, clinical record review, facility policy review, staff and resident interviews the facility failed to determine if 1 of 1 resident (Resident #4) with an inhaler at their bedside could safely self-administer the medication. The facility reported a census of 89 residents.Findings include:Review of Resident #4's Minimum Data Set (MDS) assessment, dated 4/16/26 revealed a Brief Interview for Mental Status (BIMS) with a result of 15 out of 15, which indicated intact cognition. The list of diagnoses in the MDS included stroke, atrial fibrillation (irregular heartbeat), and asthma.Review of Physician Orders revealed an order for ProAir RespiClick Inhalation Aerosol Powder Breath Activated 108 (90 Base) MCG/ACT (Albuterol Sulfate) inhaler to provide 2 puffs inhaled orally every 4 hours as needed for wheezing/SOB. Start Date: 3/2/26. Review of Resident #4's Care Plan, dated 5/2/25, revealed a Focus area to address Resident is at risk for ineffective breathing pattern r/t (related to) asthma. Interventions included, in part: Medications as ordered. Date Initiated: 5/5/25.During an observation on 5/13/26 at 7:53 AM, Resident #4 in her room, and had an inhaler (albuterol sulfate0 rested on her bedside table. Resident #4 stated she has had the inhaler at her bedside since last May [2025] and has been using the inhaler on her own. Staff E, Licensed Practical Nurse (LPN) also present and acknowledged the inhaler rested on the overbed table. Staff E stated she had not previously seen the inhaler in Resident #4's room. Staff E stated Resident #4 did not have an order to self-administer the inhaler. During an interview on 5/13/26 at 8:01 AM, the Director of Nursing (DON) confirmed Resident #4 didn't have an order to have medication at beside to self-administer.Review of the facility policy titled, Self-Administration of Medication revised June 2023 revealed the following:1. The Interdisciplinary team (IDT) will assign a staff to evaluate resident's ability to safely administer medication. A Self-Administration Evaluation Form will be filled out to determine capability. A return demonstration will be done to accurately evaluate resident's ability after teaching.2. The resident may store the medication at bedside if there is a physician order to keep it at bedside. The medication should be secured.3. The nurse on duty will document administration of medication in the MAR.4. The medication will be administered by the resident.5. The resident's ability to self-administer medication will be assessed by the facility to coincide with the MDS assessment or any notable change in status.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, Centers for Medicare and Medicaid Services (CMS) Long-term Care (LTC) Facility Resident Assessment Instrument (RAI) 3.0 User's Manual and staff interviews, the facility failed to ensure he Minimum Data Set (MDS) assessments coded accurately to reflect resident use of an indwelling catheter and use of an antidepressant and hypnotic for 2 of 2 resident (Resident #32 and Resident #83) reviewed. The facility reported a census of 89 residents.Findings Include: 1. Review of Resident #32's MDS assessment, dated 5/4/26, revealed an admission date of 4/29/26. The list of diagnoses included: neurogenic bladder (lose of control due to nerve damage); multiple sclerosis and depression. The MDS identified Resident #32 with no appliance (such as a catheter or ostomy). Review of a Hospitalist Progress Note, dated 4/27/27 revealed an Assessment/Plan section which included, in part: Neurogenic bladder MS on chronic foley catheter (name of an urinary catheter). Review of the electronic health record (EHR) revealed an Admission/readmission Assessment for the 4/29/26 admission. The assessment Bladder section identified Resident #32 with an indwelling urinary catheter with an insertion date of 4/24/26. Review of Physician Orders revealed an order for Foley Catheter 16 Fr (size) 10 ml [NAME] (a balloon filled with sterile water to keep the catheter from slipping out). During an interview on 5/13/26 at 10:09 AM, Staff D, MDS Coordinator stated she is responsible for completing the MDS Assessments. Staff D stated Resident #32 had an indwelling catheter and the MDS had been coded incorrectly. During an interview on 5/13/26 at 10:13 AM, the Director of Nursing (DON) stated the expectation is the MDS assessments are coded to accurately reflect the resident's condition. 2. Review of Resident #3's 4/27/26 MDS revealed a list of diagnoses which included depression. The Medications section of the MDS did not identify if Resident #3 is taking or there is an indication of the need for an antidepressant. Review of the Medication Administration Records for February, March and April 2026 revealed the following medications administered to Resident #3: a. Trazodone (an antidepressant that is also used off-label as a sedative-hypnotic) Give 25 mg (milligrams) by mouth at bedtime for insomnia. Start Date: 2/27/26. End Date: 3/1/26. b. Trazodone Give 25 mg by mouth at bedtime. Start Date: 3/2/26. End Date: 4/10/26 c. Trazodone Give 25 mg by mouth at bedtime. Start Date: 4/13/26. d. Mirtazapine (an antidepressant) 15 mg Give 1 tablet by mouth for depression. Start date: 4/11/26. D/C (discontinue) date: 4/13/26. During an interview on 5/13/26 at 10:45 AM, Staff D, MDS Coordinator reported she didn't see the (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	antidepressant on Resident #3's medication orders. Staff D explained Trazodone is an antidepressant and Mirtazapine should have been coded as such on the MDS. Staff D reviewed the 4/27/26 MDS and stated she miscoded the MDS. She stated sometimes Trazodone is ordered for insomnia, but it should still be coded as an antidepressant on the MDS. Staff D stated she didn't know if the facility had an MDS policy, but she follows the RAI for coding the MDS. The CMS RAI Manual, Chapter 3, Section N, Page N-9 directed all high-risk drug class medications (including antidepressant medication) coded according to their pharmacological classification, not how the medications are used. The CMS LTC RAI User's Manual, October 2025, Version 1.20.1, Page 1-4 documented the RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require the assessment accurately reflects the resident's status. In an email correspondence dated 5/13/26 facility staff reported the facility did not have MDS policy, and follows the RAI manual in coding the MDS assessment.

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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. Based on observation, clinical record review, facility policy review and staff interview the facility failed to provide complete shaving care for 2 out of 2 residents dependent residents (Resident#1 and Resident #67) reviewed for activities of daily living care. The facility reported a census of 89 residents.Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #1 dated 3/4/26, listed diagnoses of coronary artery disease and non-Alzheimer's dementia. The MDS Brief Interview for Mental Status (BIMS) score of 2 out of 15 indicated a severe cognitive impairment. The MDS also reflected Resident#1 required partial/moderate assistance for personal hygiene, including shaving.The Care Plan for Resident#1 dated 02/20/2024, directed assistance of 1 staff for grooming.During an observation on 05/11/2026 at 12:16 PM, Resident#1 facial hair appeared unkempt with several days' growth. During an observation on 05/13/2026 at 7:50 AM, Resident #1 sat in his wheelchair at the nurse's station. His facial hair appeared long on both sides of his face and longer on his chin. During an observation 05/14/2026 at 7:44 AM, Resident #1 sat in the w/c in the hall outside the dining room. Resident #1 facial hair remained long and uneven. 2. The MDS assessment for Resident #67 dated 4/8/26, listed diagnoses of stroke, dementia, high blood pressure, and aphasia (inability or impaired ability to understand or produce speech). The BIMS score of 2 out of 15 indicated a severe cognitive impairment. The MDS assessed Resident #67 required partial/moderate assistance for personal hygiene, including shaving. The Care Plan for Resident #67 dated 2/21/24, directed for Dressing & Grooming the assist of 2 staff members to complete this ADL (activities of daily living such as shaving, nail care, brushing teeth, etc.). During an observation on 05/12/2026 at 9:20 AM, Resident #67 sat in his wheelchair, while in the hallway outside of the dining room. His facial hair appeared unkempt and about a quarter of an inch in length. During an observation on 05/12/2026 at 2:10 PM, Staff P, Certified Nursing Assistant (CNA) walked by Resident #67 and asked him when he was going to get a shave. During an observation on 05/13/2026 at 8:58 AM, Resident #67's facial hair continued to appear unkempt. During an observation on 05/14/2026 at 7:45 AM, Resident #67 in his room, dressed for the day and sat in his wheelchair. Resident $67's facial hair continued to appear unkempt on his face and neck. The facial hair appeared to be over a half inch in length.During an interview on 05/14/2026 at 8:52 AM, the Unit Manager/Infection Preventionist reported shaving is done as needed and every shower/bath day. At 8:55 AM, the Unit Manager checked on Resident #67 and the CNA present stated she needed to find the electric razor to shave the resident. During an interview on 05/14/2026 at 9:44 AM, the Director of Nursing (DON) reported she expected the residents are assisted with shaving at least on shower/bath days which is 2 times a week.Review of the facility policy titled Hygiene - Bathing/Shower dated 3/2024, directed staff to shave residents' facial area as needed.

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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 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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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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	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

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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.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, manufacturer guidelines and staff interviews, the facility failed to use the correct size full-body mechanical lift sling based on resident weight during a transfer for 1 of 3 (Resident #67) reviewed for accidents. The facility reported a census of 89 residents.Findings include:Review of Resident #67's Minimum Data Set (MSD) assessment dated [DATE], revealed a list of diagnoses which included stroke, dementia, and aphasia (inability or impaired ability to understand or produce speech) The Brief Interview for Mental Status (BIMS) score of 2 out of 15 indicated a severe cognitive impairment. The MDS assessed Resident #67 dependent for chair to bed transfer. The MDS listed the resident's weight as 183 pounds.Review of Resident #67's Care Plan dated 2/21/24, revealed a Focus area to address Resident requires assistance with ADL's (activities of daily living). Interventions included, in part: Transferring: assist 2;1 with hoyer (hoyer is a brand name of a mechanical lift and also has become a genericized trademark for mechanical lifts) lift. Review of the electronic health record (ERH) revealed a Nutrition note entered on 4/14/26 at 8:41 AM with a Present weight: 183.5 # (pounds). During an observation on 05/13/2026 that started at 1:50 PM, Staff I, Certified Nurse Aide (CNA) and Staff R, CNA entered Resident #67's room, completed hand hygiene and put on gloves. Staff R placed a full body mesh sling with blue trim under Resident #67 in anticipation of a transfer. At 1:53 PM, Staff I and Staff R informed Resident #67 they needed to check and change him. They proceeded to hook the sling to the lift and as Staff I started the mechanical lift, the cushion under Resident #67 started to slide of the seat of the wheelchair. Resident #67 bottom appeared to go too far through the opening of the sling. Staff I verbalized the need to move Resident #67 back down into his wheelchair. As Staff I lowered Resident #67 into his wheelchair she pushed the cushion back into place. Staff R stated Resident #67 needed the sling placed better under his backside as tucked the sling under the resident. Staff I stated the sling is too big for Resident #67. On 05/13/2026 at 1:53 PM both of the CNAs hooked to the lift sling to the lift. The CNAs told Resident#67 they needed to check and change him. As Staff I lifted Resident #67 the cushion under him started to slide off the seat of the wheelchair (w/c). Resident #67 bottom appeared to go far through the opening of the sling. Staff I reported the need to put Resident#67 back down in the w/c. As Staff I lowered him into the w/c she pushed the cushion back in place on the seat in the w/c. Staff R reported Resident#67 needed the sling placed better under his backside as she tucked the sling under Resident#67. Staff I stated the sling 's too big for him. Staff R stated the sling is tucked under his bottom better and it's fine. Staff I raised Resident #67 in the full body lift. Staff I kept him over the wheelchair until high enough to get over the bed. Staff I moved him over the bed and lowered him onto the bed.During an interview on 05/13/2026 at 1:59 PM, Staff I, CNA stated the sling with blue trim is for heavy set residents. Staff I stated Resident #67 needed a sling with the green trim. Staff I stated there is nothing in the care plan or the record for Resident #67 that tells the staff the size of sling to use. Staff R, CNA explained they [CNA's] just know how big the slings and the residents are. Staff R added if they don't know what size sling to use, they go ask the Unit Manager. Staff R reported no one has fallen during any transfers from the lift. The tag on the blue trimmed lift sling failed to show a size of the sling.During an interview on 05/13/2026 at 2:58 PM, Staff F, Registered Nurse/Unit manager stated she knew the size of the sling because of the chart that hung in the room on the South wing on the 1st floor. Staff F went to the room and the referred to sling size chart was not present. Staff F stated she used to work as a CNA and the chart hung in the room. She reported none of the residents have fallen from any of the lifts in the past 2 years she's been here as a nurseDuring an interview on 05/13/2026 at 3:25 PM, the Director of Nursing (DON) stated the facility staff know to pick the sling by the size of the resident. She reported they look for the chart that tells them what color for the weight of the resident. Review of the mechanical lift manufacturer Sling Color/Size guide (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed a green sling should be used for the weight range of 154 - 264 lbs. (pounds). The guide listed the blue sling is for a weight range of 308 to 440 lbs.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, clinical record review, facility policy review, resident and staff interviews, the facility failed to respond to a call light in a timely manner for 1 out of 4 residents (Resident 3#) reviewed for call lights. The facility reported a census of 89 residents.Findings include:Review of Resident #3's Minimum Data Set (MSD) assessment dated [DATE], revealed a list of diagnoses which included amputation, heart failure, and diabetes mellitus. The MDS listed a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated intact cognition. The MDS assessed Resident#3 needed supervision or touching assistance for chair/bed to chair transfers. Review of Residents #3 Care Plan, dated 10/9/2024, revealed a Focus area to address Resident requires assistance with ADL's (activities of daily living - grooming, transfers, etc). Interventions included, in part: Transferring: 1:1 slide board to complete this ADL, and Call light within reach.Review of Resident Council Minutes, dated 2/2026 indicated residents felt more staff are needed and that the Certified Nurse Aide (CNAs) need to follow through with what theyare doing. They will leave the room and not return.During an observation on 05/12/2026 that started at 2:40 PM, Resident#3's call light activated. Staff P, CNA went into the room asked what Resident #3 needed and turned the call light off. Staff P exited Resident#3's room, and informed Staff Q, CNA the call light had been turned off and what Resident #3 needed. At 2:53 PM, Resident #3 call light activated. The sound of banging came from the room.At 2:55 PM, Resident #3 called out hello. No facility staff in hallway. The call light remained on, with 15 minutes elapsed since activated.At 2:56 PM, banding coming from Resident #3's room heard. The call light remained activated.At 2:59 PM, banging again heard from Resident #3 room. The call light remained activated. At 3:00 PM, Resident #3 called out hello. No facility staff in hallway. The call light remained activated, with 20 minutes elapsed since activated.At 3:01 PM, Resident #3 called out hello and banging heard coming from the resident's room. No facility staff in hallway. The call light remained activated.At 3:03 PM, three facility staff stood at the nurse's station. Resident #3 call light remained activated.At 3:04 PM Staff Q, CNA exited another resident's room, and went into Resident #3's room. The call light turned off after 24 minutes elapsed since activated. At 3:05 PM, Resident #3 told Staff Q, CNA he's been waiting for help for the last 1/2 hour. At 3:11 PM, Staff Q, CNA opened the room door, Resident #3 exited the room and thanked the staff.During an interview on 05/13/2026 at 1:14 PM, Resident #3 stated he was upset yesterday when it took a half an hour for the staff to get him up for his scheduled activity. He reported the other residents were upset as well because he had the equipment for the activity. He reported Staff P, CNA went into his room shut off his light and told him Staff Q, CNA would help in a minute. Resident#3 reported after he waited 15 minutes for Staff Q he started banging his light and yelling for help. Resident #3 stated this happened to him at least 3 times a month. Resident#3 reported he's talked to the Unit Manager about the call lights when they take too long. Resident#3 confirmed he banged and called out for help to get the staffs attention. During an interview on 05/13/2026 1:32 PM Staff R, CNA stated the staff are expected to answer the call lights in 10-15 minutes. Staff R said the facility told them frequently get the lights. Staff R reported if nursing staff go get a call light, they are expected to meet the need of the resident. Staff R said the CNA who went in the room first needed to provide the care the resident needed.During an interview on 05/13/2026 at 3:21 PM, the Director of Nursing (DON) reported she expected call lights answered in 5 minutes which is the best, but 15 minutes is maximum. The DON explained if a CNA went in a resident's room and turned off the light they needed to meet the need of that resident, not turn off the light and tell another CNA to take care of the resident. Review of the facility policy titled, Call Light Policy dated 9/2023, revealed a Purpose statement which declared To ensure that there is a prompt response to the resident's call for assistance. The facility also ensures that the call system is in proper working order. The Procedure section directed, in part: Facility shall answer call lights in (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a timely manner. When answering a call light, respond to the requests. If immediate assistance cannot be provided and there is not an emergent need, call light may be turned off and resident informed that a staff member will be back to assist shortly.

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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 observations, clinical record review, facility policy review, and staff interviews, the facility staff failed to implement Enhanced Barrier Precautions when doing wound care for 1 of 4 residents (Resident #83) reviewed for infection control. The facility reported a census of 89 residents. Findings include:Review of Resident #83's Minimum Data Set assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 5 out of 15, which indicated a severe cognitive impairment. The MDS listed diagnoses of non-Alzheimer's dementia, urinary tract infection, and pressure ulcer, stage 3. Review of Resident 83's Care Plan revealed the following Focus area's:a. At risk for alteration in skin integrity related to impaired mobility and diabetes mellitus. admitted with a stage 3 pressure injury lt (left) buttock. Interventions included, in part: Administer Treatment per physician orders. Date Initiated: 3/25/26.b. EBP (enhanced barrier precautions - an infection control practice used to prevent the spread of multi-drug resident organisms) related to: Pressure injury. Interventions included, in part: 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, Caring for or using an indwelling medical device (central venous catheter/PICC, urinary catheter, feeding tube care, tracheostomy/ventilator care), Performing wound care) Date Initiated: 04/02/2026.During an observation on 5/11/26 at 1:38 PM, EBP and Contact Precautions signage posted on the door of Resident #83's room. During an observation on 5/12/26 at 4:23 PM, Staff A, Registered Nurse (RN) and Staff B, Certified Nursing Assistant (CNA) donned gloves and masks. Staff A also donned a gown. Staff B assisted in repositioning Resident #83, lower her pants and incontinent brief and held Resident #83 on her right side. Staff A performed the pressure area treatment. During an interview on 5/12/26 at 4:33 PM, Staff A, RN reported Resident #83 required EBP due to wound care. Staff A verbalized she was not sure if Staff B should have had a gown on. Staff A acknowledged Staff B should have donned a gown after reviewing the EBP and Contact Precaution signage on the door. During an interview on 5/12/26 at 4:34 PM, the Director of Nursing (DON) verbalized Resident #83 is on EBP precautions. The DON verbalized staff are to wear gloves and gowns when providing cares. Review of the Enhanced Barrier Precautions facility policy revised on March 2024 revealed the following:1.EBP will be used in conjunction with standard precautions for residents with any of the following (if/when Contact Precaution requirements are not in place):a. Infection or colonization with a Centers for Disease Control (CDC)-targeted Multi-Drug-Resistant Organisms (MDRO) when contact precautions do not otherwise apply;b. Wounds and/or indwelling medical devices (even if the resident is not known to be infected or colonized with a targeted MDRO)NOTE: Wounds generally include chronic wounds including but not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. This would not include shorter-lasting wounds, such as skin breaks/tears covered with an adhesive bandage or similar dressing2. For residents whom EBP are indicate; gowns and gloves should be used during high contact resident care activities that provide opportunity for MDROs to be transferred to staff hands and clothing. High contact resident care activities include: Dressing, Bathing/Showering, Transferring, Providing hygiene, Changing linens. Changing briefs or assisting with toileting, Device care or use: central lines/PICC, urinary catheter, feeding tube, tracheostomy/ventilator, Wounds care: any skin opening requiring a dressing

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F 0865 Level of Harm - Potential for minimal harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on review of the Certification and Survey Enhanced Report (CASPER) from the Centers for Medicare & Medicaid Services (CMS), facility policy review, and staff interviews, the facility failed to ensure an effective QAPI program to address previously cited deficiencies which resulted in five deficiencies being re-cited during the current Health Recertification survey. The facility reported a census of 89 residents.Findings include:A review of the facilities 4/21/25 Statement of Deficiencies and Plan of Correction revealed the following citations: F641 (Accuracy of Assessments); F684 (Quality of Care); F689 (Free of Accident Hazards/Supervision/Devices); F812 (Food Procurement, Store/Prepare/Serve-Sanitary); F880 (Infection Prevention and Control)The Health Recertification survey completed on 5/14/26 resulted in the following citations: F641, F684, F689, F812, and F880.During an interview on 5/14/26 at 10:55 AM, the Administrator reported the facility worked on all previously cited deficiencies in the Quality Assurance Performance Improvement (QAPI) and all deficiencies continued to be ongoing and tracked for years.The facility provided a policy titled QAPI Plan dated 11/10/2025 included the administrator, as chair of the QAPI Committee is responsible and accountable for ensuring the QAPI:a. Is defined, implemented, maintained and address identified prioritiesb. Is sustained during transitionsc. Receives adequate resources to functiond. Identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indictor data, resident, and staff input and other informatione. Corrective actions address gaps in systems and are evaluated for effectivenessThe policy also stated the QAPI Committee is responsible for:a. Identifying and prioritizing problems based on performance indicator datab. Including patient, patient representative, and staff input into the processc. Ensuring corrective actions are effectived. Analyzing QAPI program performance to identify and follow up on areas of concern or opportunities for improvement