STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165601	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony West Des Moines	5010 Grand Ridge Drive West Des Moines, IA 50265

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on clinical record review, staff, resident and provider interview and facility policy review, the facility failed to report an allegation of abuse within the required two hour time frame for one of three residents reviewed (Res #4). The facility reported a census of 98 residents.Findings include:The Minimum Data Set (MDS) Assessment of Resident #4 dated 4/20/26 documented a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderate cognitive impairment. The MDS recorded the resident experienced mood symptoms: little interest or pleasure in things over 7-11 of the last 14 days and feelings of being down, depressed or hopeless over 2-6 of the last 14 days. The MDS recorded the resident was frequently incontinent of urine and occasionally incontinent of bowel. The MDS recorded the resident had diagnoses including Parkinson's Disease and Bipolar Disorder. The Care Plan for Resident #4 identified a Focus Area of Mood State Disturbance, dated 4/20/26. The Interventions included for staff to intervene when inappropriate behavior is observed. The intervention further identified that the resident had a history of false accusations and making derogatory remarks to African American Staff.The General Progress Note dated 4/28/26 at 10:10 am, authored by Staff A, Registered Nurse (RN, former staff member) documented the resident reported spilling some water overnight to the Occupational Therapist and when staff came in to clean it, they hit his head, hit his leg and 'sucked his guts out'. Staff D, the Occupational Therapist (OT), documented in the Occupational Therapy Treatment Encounter Note, dated 4/28/26, that Resident #4 displayed increased behaviors when asked if he could put on his shorts. The note stated the resident then said, I spilled my soda last night and when they came to clean it up with that machine - they hit me in the head and legs then sucked out all my insides. The OT documented she reported this to a nurse, as well as the Assistant Director of Nursing and the Nurse Practitioner (a single report when all three were present). On 5/18/26 at 2:40 pm, Resident #4 stated he had concerns regarding an employee who entered his room at night and ripped his clothes off. He denied ever being hit or struck. He was only able to desribe the staff member as an African Woman and could not provide a name. He stated he had not seen her recently. The resident further stated he feels safe with the current staff and had no concerns at the time of the interview. On 5/18/26 at 3:28 pm, Staff A, RN stated that Staff D, OT, approached her on 4/28/26 while she was on her way to a morning management meeting and reported allegations of abuse made by Resident #4. Staff A said she went straight to the meeting after this conversation. She voiced the former Administrator, the Director of Nursing, the Advanced Registered Nurse Practitioner (ARNP), corporate employees (including the now current Administrator) and several other managers were present in the meeting. She stated she reported the allegations immediately and the other staff did not acknowledge this but continued the meeting. On 5/19/26 at 11:33 am, Staff D, OT stated she documented Resident #4's allegations in her therapy note. She stated after the resident made the allegations, she reported it to a staff nurse, as well as Staff A, and also stated the ARNP was present. She stated the machine the facility uses to clean floors is never used in resident rooms, only in hallways. When asked if when he said they sucked outside his insides if he meant with the floor cleaner machine she said she was not clear what he meant by the comment. She provided a copy of her therapy note. On 5/19/26 at 1:26 pm, the ARNP stated other staff had (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported the allegation of abuse to Staff A. She stated she recalled the police were in the building for this allegation. She stated she was not present when the allegation was made but she was present when Staff A reported it in the meeting. She believed the police arrived the following day, not the day of the meeting. She could not recall the date of the meeting but felt the police were not called until the following day. The local Police Department was contacted for a copy of the police report. The report documented the call from the facility was received on 4/29/26 at 12:45 pm. The facility filed a Facility Reported Incident (FRI) to the State Agency regarding the allegations of abuse on 4/29/26 at 12:42 pm, just prior to calling the police department. The FRI documented Resident #4 reported an abuse allegation on 4/29/26 at approximately 10:45 am, just over 24 hours after the initial progress note detailing the allegations was written. On 5/19/26 at 2:53 pm, the Administrator stated she was in the building on 4/29/26 with the prior Administrator, Staff F. She stated the two of them were looking over the prior 24 hour report and Staff F asked her to review the note regarding Res #4. The Administrator stated Staff F asked her if Staff A had reported this to her. She reported she and Staff F then went to discuss this with Staff A about her note. The Administrator stated Staff A responded that she had reported it in the morning meeting the prior day but nobody discussed it. The Administrator detailed that Staff A then said that she knows she sometimes speaks quietly. The Administrator stated following the conversation about the importance of reporting allegations of abuse immediately, Staff A was suspended for an investigation and was eventually terminated. The Administrator stated the FRI was worded as the allegation being reported on 4/29/26 because that is when the resident confirmed the allegations after they found the progress note and interviewed him. On 5/19/26 at 3:38 pm Staff G, Licensed Practical Nurse (LPN) stated she worked in the afternoon on 4/27/26 and 4/28/26 . She recalled when she came into work, Staff A, RN told her about the allegation of abuse made by Resident #4. She added that Staff A told her she had reported this in the morning meeting. She could not recall if the conversation with Staff A was on the 27th or 28th. On 5/19/26 at 4:00 pm, Staff H, Maintenance Director stated he did not recall Staff A reporting an allegation of abuse in a morning meeting. He added that Staff A was very softspoken so it is possible that she did say it and he did not hear it. On 5/20/26 at 11:07 am, the Administrator stated she had visited with Staff D, OT regarding the allegations of abuse. She said Staff D told her that when she spoke to Staff A in the presence of another nurse and the ARNP, this was regarding concerns of disease progression of Resident #4 and 'use of the machine' that he reported bumped him. The Administrator clarified when she spoke to Resident #4 on 4/29/26, he initially was telling her that he felt staff needed education in regards to being bumped by the machine and he was referring to the full mechanical lift hitting him during transfers. She stated at that time, he did not feel that was abuse, it was something that the staff needed education about. Further into this conversation between the Administrator and Resident #4, she stated he then added reported concerns about a specific Certified Nurse Aide (CNA), and made allegations of abuse about her. When he made these allegations, that was when the facility immediately suspended the CNA who was accused, and reported the FRI to the State Agency. The Care Plan for Resident #4 was reviewed on 5/20/26 at 11:43 am, including resolved items. The Care Plan failed to document any history of Resident #4 every having been care planned to transfer with a full mechanical lift. An intervention dated 2/26/26 stated dependent with assist x 2 with non-mechanical lift. The non mechanical lift does not have an apparatus that can strike a resident in the head. On 5/20/26 at 11:55 am, the Administrator clarified her previous comments referred to a full mechanical lift, commonly known as a Hoyer Lift. She confirmed the boom apparatus (which raises and lowers during transfers) was what Resident #4 stated struck him in the head. Upon being shown a photograph of a different lift (photo taken in a hallway of the facility during the survey) the Administrator confirmed this device is what is referred to when a resident is care planned as using a non-mechanical lift for transfers. The facility policy titled Patient Protection Guidelines Abuse Prevention, Reporting, and Investigation, revision date 09/2025 documented the following:Training:Upon initial employment each employee will be educated on the facilities abuse (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	guidelines and reporting requirements. Within six months of hire each employee shall be required to complete an initial 2-hour training course approved by Iowa Department of Human Services. Each employee will take a 2-hour training every three years thereafter. Documentation of training will be tracked by Human Resources or designee. See Iowa Code S 235B.16(5)(b); Iowa Code S 235E.4. In addition, nurses' aides shall receive initial and annual resident abuse prevention training. The training will educate on: Prohibiting and preventing all forms of abuse, neglect, exploitation, mistreatment, or misappropriation of patient property.Recognizing signs of abuse, neglect, exploitation, mistreatment, or misappropriation of patient property. Ways to deal with aggressive behaviors. Ways to deal with catastrophic patient reactions. Catastrophic reaction are extraordinary reactions of patients to ordinary stimuli such as an attempt to provide care.Procedures on immediately reporting suspicions or allegations of abuse (including injuries of unknown source), neglect, exploitation, mistreatment, and misappropriation of patient property or crime against a patient. How to report knowledge related to abuse allegations without fear of reprisal. How to recognize signs of burnout, frustration and stress that may lead to abuse. Timeframe requirements for reporting suspicion of crime

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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, staff interview, and policy review, the facility failed to attach foot pedals on the wheelchair while transporting a resident for 2 of 3 residents (#2, #7) observed for transfers. The facility reported a census of 98 residents.Findings include:Resident #2's Minimum Data Set (MDS) assessment dated [DATE] was unable to identify a Brief Interview for Mental Status (BIMS) score because the resident was rarely/never understood. It included diagnoses of seizure disorder, legal blindness, bilateral hearing loss, and hydrocephalus (abnormal buildup of fluid in the brain). It revealed he required supervision with eating and was dependent with all other Activities of Daily Living (ADLs) and all forms of mobility. It also indicated the resident used a manual wheelchair for mobility in the 7-day look-back period.The Care Plan initiated 3/13/24 revealed the resident required assistance with ADLs and used a wheelchair for mobility. It directed staff to use foot pedals.On 5/20/26 at 8:08 AM, Staff E, Certified Nurse Aide (CNA) transported Resident #2 in his wheelchair from the nurses' station to the dining room. His right foot was positioned on the foot pedal and his left foot was dangling between the pedals with his toes dragging the floor.At 8:15 AM, Staff I, CNA moved Resident #2 in his wheelchair from his position at the table to another position at the same table. His left foot was observed dragging the floor during the transport. 2. Resident #7's MDS assessment dated [DATE] identified a BIMS score of 04 out of 15 which indicated severely impaired cognition. It included diagnoses of non-Alzheimer's dementia, paraplegia (one-sided paralysis), seizure disorder, and psychotic disorder. It revealed he required setup assistance with eating and oral hygiene, maximal assistance with bathing and bed mobility, and was dependent with all other ADLs and mobility. It also indicated the resident used a manual wheelchair for mobility in the 7-day look-back period.The Care Plan initiated 10/08/25 revealed the resident required assistance with ADLs and used a wheelchair for mobility.At 8:16 AM, Staff E transported Resident #7 in his wheelchair from his position at the dining table to another position at the same table. His wheelchair did not have a left foot pedal and the resident was able to transport himself in his wheelchair.At 10:15 AM, Staff J, Licensed Practical Nurse (LPN) stated two (2) foot pedals are required for residents' wheelchairs when transported by staff. She stated Resident #2's dangling foot should be placed on a foot pedal before transporting. She also stated his foot would stay on the pedal once positioned on it.At 10:18 AM, Staff B, CNA stated Resident #2's feet should be on foot pedals and should not be dangling during transport. At 10:29 AM, Staff E stated she didn't think about Resident #2's foot dragging the floor when she transported him. She also stated Resident #7's foot pedal should've been applied to his wheelchair before transporting him.At 10:35 AM, Staff I stated Resident #2's left foot should've been positioned on his foot pedal before transporting him to the other side of the dining table. She stated she didn't notice it dangling and dragging the floor.On 5/20/26 at 12:11 PM, the Administrator stated staff should have ensured the foot pedals were on the residents' wheelchairs during transports.On 5/20/26 at 1:05 PM, the Administrator stated the facility did not have a policy specific for applying foot pedals on a wheelchair during resident transport.