STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165152	A. BUILDING _____ B. WING _____	C 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HEALTH CARE CENT	2950 WEST SHAULIS ROAD WATERLOO, IA 50701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date_____ The following deficiency relates to the investigation of facility reported incident #85401 and complaint #85404 & #85408. (See Code of Federal Regulations (42CFR), Part 483, Subpart B-C). Complaint #86262 & #86812 was not substantiated.	F 000		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and resident interviews and observations the facility staff failed to assess a resident's right hip bruise and pain which delayed the resident in receiving treatment for 4 days for 1 of 6 open sampled residents (Resident #1). The facility reported a census of 56 residents. Findings include: According to Resident #1's Quarterly Minimum Data Set (MDS) dated 5/22/19, Resident #1 had diagnoses which included stroke, dysphasia,	F 684		

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
	165152	A. BUILDING _____ B. WING _____	C 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HEALTH CARE CENT	2950 WEST SHAULIS ROAD WATERLOO, IA 50701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 1	F 684		

epilepsy, anxiety, depression, aphasia and hemiplegia/hemiparesis. The resident could not participate in his mental status examination which indicated severe cognitive ability. Resident #1 had total dependence on 2 staff for transfers, dressing, hygiene, extensive assistance of 1 staff for nutrition and had impairment on both upper and lower extremities. The resident did not walk and had total dependence on staff to meet all his activities of daily living.

The care plan dated 8/22/19 directed the staff to monitor Resident #1 for side effects related to the use of anitplatelet (blood thinner) medications and to monitor for side effects which include low blood pressure, abdominal pain, constipation, bruising and rash. The care plan informed the staff Resident #1 may experience pain related to degenerative changes and decreased mobility and indicated the resident may show signs of pain which included yelling and screaming, facial grimace and grabbing at his painful extremity.

Review of the late entry progress note dated 8/8/19 revealed Staff A-LPN charted Resident #1 had bruising to his right femur extending to the knee and the guardian notified.

During an interview with Staff A-LPN on 11/18/19 at 1:22 p.m., Staff A stated she did notice bruises to the resident's right thigh extending from the hip to about mid thigh. She described the bruise as purple in the center and yellowish/green area around the purple colored area. The bruise went into the resident's groin area, around the front of the groin and into the right hip area. Staff A indicated the RN completed a head to toe assessment the evening before and she assumed the RN took care of all of the paper

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165152	A. BUILDING _____ B. WING _____	C 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HEALTH CARE CENT	2950 WEST SHAULIS ROAD WATERLOO, IA 50701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 2	F 684		

work and reporting of the bruise. Staff A stated she did not see a skin sheet in regards to the resident's bruise. Staff A stated she failed to chart the bruise on 8/8/19 but charted it on 8/12/19 as directed by the Director of Nurses on 8/12/19. Staff A reviewed the progress notes for Resident #1 from 8/8-8/12/19 and indicated it looks like no one assessed or documented anything about the bruises to the resident's right groin, hip and thigh during that time frame.

Review of a written statement dated 8/16/19, Staff A-LPN stated on the early morning of 8/8/19 she went into the residents room to administer medication and noticed the presence of a Foley catheter. Staff A pulled back the covers and noticed bruising to the resident's inner thigh. She indicated she assumed the previous evening nurse already addressed the bruises as per facility policy. On 8/8/19 Staff C-C.N.A called LPN into the room and reported the resident had swelling to the right knee, LPN informed Staff C that she was aware and as the resident returned from the hospital with it. The statement indicated on 8/8/19 Staff D-C.N.A called Staff A into Resident #1's room and reported the bruises. On 8/10/19 Staff E-C.N.A reported swelling to the resident's right knee. On 8/11/19 Staff D-C.N.A came to Staff A and reported how easy it is now to turn the resident as his leg is not so contracted anymore. Staff A and Staff D assessed the resident, Staff A stated she noted while rolling the resident she placed her hand on the resident's right hip and noted the feeling of moving bones. Staff A directed the aide to keep the resident comfortable and will request an intervention when the physician comes to the facility in the morning.

Review of the progress notes dated 8/12/19 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165152	A. BUILDING _____ B. WING _____	C 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HEALTH CARE CENT	2950 WEST SHAULIS ROAD WATERLOO, IA 50701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 3	F 684		

8:15 a.m. completed by Staff B-RN revealed the resident had noted increased pain with cares and with movement of the right side. Resident is noted to have continued bruising to the groin, right hip and inner thigh to the knee. Staff B notified the provider and received an order for x-ray of right hip, femur and knee immediately. Portable x-ray contacted as well as the guardian. The progress notes indicated at 10:11 a.m. the technician completed the ordered x-ray and at 10:51 a.m. the staff contacted emergency transport for transfer to a local hospital for fracture of right hip.

During an interview with Staff B-RN on 11/18/19 at 2:30 p.m. she stated in August 2019 she worked as the unit manager where Resident #1 resided. Staff B indicated on 8/12/19 Staff A LPN showed the bruises on Resident #1 to Staff B. Staff B indicated this is the first time she had knowledge of the bruises. Staff B reviewed the progress notes dated from 8/8-8/12 and stated it appears the staff failed to document the resident's bruises. Staff B revealed the staff failed to complete skin sheets for the right hip/groin bruises, failed to contact the physician regarding the bruises. Staff B stated the facility began an investigation to identify the cause of the bruise on 8/12/19.

During an interview with Staff C-C.N.A on 11/19/19 at 11:08 a.m., Staff C stated she worked with Resident #1, on the day shift on 8/8 and 8/10/19. Staff C stated on 8/8/19 she saw a purple/yellowish bruise on the resident's thigh, describing the bruise as very large. Staff C indicated she reported the bruising to Staff A-LPN. Staff C stated on 8/8 and 8/10 when rolling the resident to do cares, the resident would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165152	A. BUILDING _____ B. WING _____	C 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HEALTH CARE CENT	2950 WEST SHAULIS ROAD WATERLOO, IA 50701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 4	F 684		

yell out in pain. Staff C reported on 8/10/19 when getting the resident up in the Hoyer lift the resident seemed fine but when rolling him for cares he appeared to be in pain. Staff C stated she rolled the resident at least every 2 hours to complete cares.

During an interview with Staff D-C.N.A on 11/18/19 at 3:35 p.m. Staff D reported seeing the bruising on Resident #1 on 8/8, she indicated she could tell there was something wrong with the resident's right leg. Staff D described the bruise into the groin area, right hip and right leg . Staff D reported the bruise to Staff A on 8/8/19. On 8/11/19 Staff D again reported the bruising to Staff A and reported an additional observation. She reported to Staff A on 8/11/19 that Resident #1's right leg seemed "floppy" and described the area as not contracted anymore. Staff A assessed the resident and told Staff D the nurses know about it. Staff A asked C.N.A to get Resident #1 up out of bed on the weekend but she refused to do so reporting the resident had bruising and was having right hip/leg pain.

During an interview with Staff E-LPN on 11/18/19 at 3:17 p.m., Staff E stated she worked the evenings of 8/7, 8/8, 8/9 and 8/10, she reported she had no knowledge of the bruises to Resident #1's right hip/groin area.

During an interview with Staff F-LPN on 11/18/19 at 3:30 p.m. shared she worked the night shift on 8/7 and 8/8/19, the staff failed to report any bruises to Resident #1's right hip/groin area during that time frame.

Review of an undated written statement from Staff H-C.N.A, Staff H stated Resident #1 had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165152	A. BUILDING _____ B. WING _____	C 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HEALTH CARE CENT	2950 WEST SHAULIS ROAD WATERLOO, IA 50701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 5	F 684		

abnormal vocalizations on the day after returning from the hospital (8/8), she reported the resident more vocal than usual like he had pain. Staff H reported this observation to the day nurse-Staff A-LPN.

During an interview with Staff G-D.O.N. on 11/18/19 at 3:098 p.m., Staff G acknowledge the staff failed to make out skin sheets for the bruise to Resident #1's right groin, hip, thigh area, failed to document in the progress notes until 8/12/19, failed to notify the physician of the bruises. Staff G stated Staff A received re-education on the need to check and make sure a bruise is documented and not assume that it was already done. Also re-educated Staff A that she should have called the physician on Sunday, 8/11/19 to report the loose hip and symptoms of pain.

Review of a non-pressure skin condition record dated 8/12/19, the form revealed the staff first noted a bruise to the resident's right groin, right hip and inner knee. The staff described the whole right groin black/blue with edema and edema noted to the right hip extending to the right knee area.

During an interview with Resident #1's primary care Advanced Registered Nurse Practice (ARNP) on 11/18/19 at 2: 52 p.m. , ARNP indicated the resident returned from a local hospital about 3pm on 8/7/19. The staff called her to alert of the resident's return but failed to mention anything about bruising to the right hip/groin area. On 8/10/19 an ARNP from their practice visited the resident at the facility, the resident up in his wheelchair, fully clothed. The staff failed to report bruises to right groin/hip area. The ARNP indicated when she visualized the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165152	A. BUILDING _____ B. WING _____	C 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HEALTH CARE CENT	2950 WEST SHAULIS ROAD WATERLOO, IA 50701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 6	F 684		

bruises on 8/12/19 the bruise to the right groin/hip/thigh area were significant, describing the bruise as extensive over the right groin and anterior hip. The resident had a history of stroke and utilized anticoagulant medications which could have made the bruising more extensive. During a visit to the facility on 8/12/19, ARNP indicated the staff reported the resident yelled out in pain. ARNP felt it should have been reported to her on 8/8/19 when discovered so the bruise could have been evaluated and followed. On 8/12/19 when ARNP became aware x-rays were ordered, resident found with hip fracture and sent to local emergency room for evaluation and treatment.

Review of a portable x-ray report dated 8/12/19 revealed x-ray completed of Resident #1's right hip/groin area and right knee. The resident had a comminuted and displaced proximal femur fracture.

During a family interview on 11/19/19 at 9:43 a.m., the guardian for Resident #1 revealed they did not know about the resident's bruises until his transfer to the local emergency room on 8/12/19. The guardian reported taking a picture of the bruise on 8/12/19 at 7:00 p.m.. She reported the photo was of the resident's right femur just prior to surgery. The guardian provided a photo of the resident's bruises to the right hip/groin/thigh area.

Review of a non-pressure skin condition assessment and documentation policy dated July 2012. The policy directs staff that non-pressure skin impairments should be assessed upon onset; the results documented; and the status of the skin condition monitored weekly until resolved. Some examples of non-pressure skin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165152	A. BUILDING _____ B. WING _____	C 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HEALTH CARE CENT	2950 WEST SHAULIS ROAD WATERLOO, IA 50701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 7 impairments may be skin tears, abrasion, bruises, burns or excoriated skin conditions due to moisture, etc. The results of the assessment should be documented on the non-pressure skin condition report.	F 684		