Citation Number	er:				Date:	
#6142					June 22	2, 2023
Facility Name:			Survey D	ates:	II .	
Harmony Ceda	r Rapids			2022		
•	s/City/State/Zip:	TAG	iviay 15,	2023 – 1	May 31, 2	2023
1940 First Aver Cedar Rapids, I						
Coudi Hapius, ii						
Rule or				Fine A	mount	Correction
Code Section	Natur	e of Violation	Class			date
			1	I		
58.19(2)j		quired nursing services for t shall receive and the facility	CLASS I	\$9,000		UPON
		ppriate, the following required		(HELD SUSPE	IN NSION)	RECEIPT
			,			
	•	ncillary coverage as set forth in				
	these rules: 58.19(2) <i>Medication an</i>	d treatment.				
	j. Provision of accurate assessment and timely					
		sidents who have an onset of				
		hich represent a change in hysical condition. (I, II, III)				
	mental, emotional, or p	mysical condition. (1, 11, 111)				
	DESCRIPTION:					
		n Hospital Record review,				
	of Death review, Medic	eview, State of Iowa Certificate al Director and staff				
	·	document review, the facility				
	•	prough assessment, contact the				
	' '	ely to request transport to the freatment for 1 of 5 residents				
	· ·	, when a serious change in				
		resident. This failure resulted				
	in the resident not bein					
		n a timely manner to receive reatment and subsequently				
	caicai interventions/ t	catheric and subsequently	1	1		Page 1 of 2
Facil	ity Administrator	Da	ate			

Citation Number: #6142					Date: June 22	, 2023
Facility Name: Harmony Cedar Rap	pids		Survey D	Dates:	Ц	
Facility Address/City 1940 First Avenue N Cedar Rapids, IA 52	IE	TAG	May 15,	2023 – I	May 31, 2	023
Rule or Code Section	Natur	e of Violation	Class	Fine Amou		Correction date
Find The diag hen (sev the (ED obs Res 3/1 The Sec incl seco	se or respirations. The residents. dings Include: Pre-Admission Hosp gnoses including COV matemesis, esophage were) esophagitis. The resident presented of on or around 2/27/served coffee ground sident #2's Minimum 6/23, documented and luding esophageal valuding es	eal varices, and Grade D ne hospital record documents to the Emergency Departmen /23 after his daughter I emesis. Data Set (MDS) dated in admission date of 3/16/23. ecord (EHR) Medical Diagnosi mission medical diagnosis mission medical diagnosis arices without bleeding and varices with bleeding. een on 3/16/23 at 5:55 PM nt was admitted from a local ation service. He was in the g. The resident was oriented to TV remote. Medication order macy and the Doctor (MD) was	t S S S S			Page 2 of

2

Facility Administrator

Citation Number #6142 Facility Name: Harmony Cedar Facility Address 1940 First Aven Cedar Rapids, I	r Rapids s/City/State/Zip: nue NE	TAG	Date: June 22, 2023 Survey Dates: May 15, 2023 – May 31, 2023 Fine Amount Correction			
Rule or Code Section	Natur	e of Violation	Class	Fine A	mount	Correction date
	any nursing documental documentation for 3/17. The Progress Note writt documented the reside COVID positive with interespirations were even. The Progress Note writt documented the reside and diminished and his sounds in all 4 quadrant. The Progress Note writt documented the reside his eyes closed. His respirations observed. The recough. The Progress Note writt documented the reside his medications. The cough.	ten on 3/18/23 at 5:53 AM, and had a quiet night, was sermittent cough. His without distress. ten on 3/18/23 at 8:23 PM, and an active bowels are abdomen had active bowels ats. ten on 3/19/23 at 4:46 AM, and was resting peacefully with pirations were even and no resident had an intermittent aten on 3/19/23 at 9:48 AM, and the was vomiting and refused clinical record lacked ysical assessment, vital signs or				
	_	ten on 3/19/23 at 11:15 AM, entered the resident's room at				

Facility Administrator Date

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to lowa Code section 135C.43A (2013).

Page **3** of **22**

Citation Number	er:		Date: June 22, 2023			2023		
Facility Name: Harmony Ceda	r Rapids		Survey D					
Facility Address 1940 First Aver Cedar Rapids, I		TAG	May 15, 2	May 15, 2023 – May 31, 2023				
Rule or Code Section	Natur	e of Violation	Class	Fine Amount		Correction date		
	and had an emesis basi blood. The resident ask die that day and began heavy. The nurse encoubreath through his nose he was "exhibiting signs pulse was 102 beats pe saturation was 100 % of the resident's daughter the resident did not apphistorian. The daughter sent to the Emergency nurse documented she an emergency situation resident was given Zofr nausea) and water, covenurse told the resident Zofran helped. At 11:05 resident's room to see to pupils fixed, his mouth He did not have a pulse documented an overhee "Code Blue" and chest of The nurse, another nurse to tresident). At Director of Nursing (AD	was making retching noises in with spit and a tinge of ed the nurse if he was going to to get worked up and breath traged the resident to deep and out through his mouth as of an anxiety attack." His in minute and his oxygen in room air. The nurse called to ask medical questions as oear to be an accurate requested the resident be Room (ER) immediately. The told the daughter this was not in, he was just anxious. The an (medication given for ered with a blanket and the she would be back to see if the SAM, the nurse entered the the resident with a blank stare, and chin were blood stained. For respirations. The nurse ad page was made for the compressions were started. See and the Activity Assistant and the Ambu bag (to provide 11:06 AM, the Assistant ON) called 911. At 11:13 AM, rived and took over care. At				Page 4 c		

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

Date

Facility Administrator

Citation Number #6142	er:				Date: June 22,	2023	
Facility Name: Harmony Ceda	r Rapids		Survey D				
Facility Address 1940 First Aver Cedar Rapids, I		TAG	May 15, 2023 – May 31, 2023				
Rule or Code Section	Natur	e of Violation	Fine Amount Class		mount	Correction date	
	The State of lowa Certification the date and time of de The immediate cause or exsanguination (sever be esophageal varices with being COVID-19. During an interview on Director of Nursing (DO family member was required the ED, she would expecompleted, the Doctor the request and assessment explained the nurse would time. She would expecompleted. She explained the nurse would expect the time. She would expect that doesn't necessarily was an emergency or so the nurses mind. During an interview on Licensed Practical Nursemember requested a redo an assessment, vitals	olood loss) secondary to nother significant conditions 5/15/23 at 1:59 PM, the PM) explained if a resident or questing a resident be sent to				Page 5 of	

22

Facility Administrator

Date

Citation Number #6142	er:		Date: June 22, 2023			, 2023
Facility Name: Harmony Ceda	r Rapids		Survey D			
Facility Address 1940 First Aven Cedar Rapids, I		TAG	May 15,	2023 – N	May 31, 2	023
Rule or Code Section	Natur	e of Violation	Class	Fine A	mount	Correction date
	requesting the resident assessment and notify to During an interview on Registered Nurse (RN), requesting to go to the assessment, call the Doresident to the ER. She was requesting the transferred, the requesting the transferred, the requesting an interview on RN explained the passes in this facility. She recal well and had a little blothe resident was anxiou and he was in the facility nauseated and she gave vomit but spit up. She cresident's cell phone wiremembers the cell phone wiremembers the cell phone of the company of the resident sputum and the daught that he was anxious, this she was calling to get a history and background	5/16/23 at 8:58 AM, Staff D, explained if a resident was ER she would do an ctor and would send the explained if a family member asfer, the resident gets t can't be declined. 5/16/23 at 9:15 AM, Staff A, d away on her last day working led the resident wasn't feeling od in his mouth. She explained as that day (March 19, 2023) by for COVID. The resident felt is him a Zofran. He did not called the daughter from the				

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to lowa Code section 135C.43A (2013).

Date

Facility Administrator

Citation Number: #6142			Date: June 22	, 2023
Facility Name: Harmony Cedar Rapids		Survey Dates		
Facility Address/City/State/Zip: 1940 First Avenue NE Cedar Rapids, IA 52402	TAG	May 15, 2023	8 – May 31, 2	023
Rule or Code Section Nat	ure of Violation	Fin Class	e Amount	Correction date
light and went to tend was done with the ot check on the resident stare, pupils fixed. Sh and felt for a pulse. Sexplained she knew he saving measures), she called for the crash careported bright red be the resident's mouth she was not aware the varices at that time. During an interview of RN, Unit Manager expand the part of the bepage. She explained 2 Cardiopulmonary Resident and 911. She went back in machine going and the very quickly. She recacoming from somewhere was completely pale. resident's daughter a on his way to the hos	as feeling nauseated and his call d to another resident. When she her resident, she went back to and found him with a blank e stated she shouted his name he did not find one. She e was a Full Code (wanted life called the code overhead and art and began compressions. She lood clots were coming out of with compressions. She stated e resident had esophageal In 5/16/23 at 11:42 AM, Staff F, plained she was working in uilding when she heard the code nurses were doing uscitation (CPR) when she got to d she ran and grabbed the took it into the room and called the room to get the suction e ambulance crew was there lied the resident had blood here on or near his face. His color She explained she called the notified her the resident was pital. Staff F explained if a family he resident be sent to the ER the			Page 7 of 2

Facility Administrator

Citation Numb	er:				Date: June 22	, 2023
Facility Name: Harmony Ceda	r Rapids		Survey D			
1940 First Aver		TAG	May 15, 2	2023 — r	viay 31, 2	023
Cedar Rapids, I	A 32402					
Rule or Code Section	Natur	e of Violation	Class	Fine Amount Class		Correction date
	When asked about a nushe stated "That would nurse needed to put for and let the Doctor known happen next. During an interview on acknowledged Staff A hardenested that in it would not be appropared to the state of	the resident to the hospital. Urse refusing to call the Doctor, be wrong." She stated the rth the effort to call the Doctor w and decide what would 5/16/23 at 11:59 AM, the DON and received a request from the the resident to go to the ER aformation later. She explained riate for the nurse in the y no, this is not an emergency resident or even call the				
	Medical Director explai member requests to go That's standard, we do further explained if it is can call 911 and send that taken care of and then team). If it's not emergahead of time so we ca He explained he would	5/30/23 at 4:12 PM, the ned when a resident or family to the ER we send them. It refuse to send them. He an emergent situation they he resident to the ER, get them notify us (himself and his ent we like to be notified in give the order and be aware. expect a new set of vitals and enurse's interaction with the				
		rd. If they call and don't have				
						Page 8 of 2
Facil	ity Administrator	Da	 ate			

Citation Number	er:	Date: June 22, 2023			., 2023		
Facility Name: Harmony Ceda	r Rapids		Survey D				
Facility Address 1940 First Aver Cedar Rapids, I		TAG	May 15,	2023 – ľ	May 31, 2023		
Rule or Code Section Natu		e of Violation	Class	Fine A	Fine Amount Correct		
	information and call ba The facility document to dated 11/2016 directed resident's Physician for a decision to transfer the The document further conotify the Physician for apparent discomfort the	itled Change in Condition, I staff to consult with the any need to alter treatment or ne resident from the facility. Idirected staff to immediately					
58.43(9)	resident shall receive ki times and shall be free and verbal abuse, explo- injury. 58.43(9) Allegations Allegations of depen	dent abuse prohibited. Each nd and considerate care at all from mental, physical, sexual, pitation, neglect, and physical of dependent adult abuse, dent adult abuse shall be ated pursuant to lowa Code -Chapter 52. (I, II, III)	CLASS II	\$500.0 (HELD SUSPE		UPON RECEIPT	

Facility Administrator Date

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to lowa Code section 135C.43A (2013).

Page **9** of **22**

Citation Number #6142	er:				Date: June 22	, 2023
Facility Name: Harmony Ceda	r Rapids		Survey [NA 24 2	022
1940 First Aver		TAG	May 15,	2023 –	May 31, 2	023
Cedar Rapids, I	A 52402					
Rule or Code Section	Natur	e of Violation	Class	Fine A	Amount	Correction date
	DESCRIPTION:					
	Based on clinical record review, document review, lowa Department of Inspection and Appeals On-Line Facility Reported Incident Report review, Facility Investigation, Abuse Policy and staff interviews, the facility failed to ensure allegations of misappropriation of resident narcotic medications had been reported to the State agency within 24 hours of the allegation of abuse for 1 of 1 resident's sampled (Resident #3). The facility identified a census of 79 residents.					
	Findings include:					
On-Line Facility Report documented the Adm Rapids filed an on-line at 6:33 p.m. for a crin alleging on 3/19/23 h Narcotic Record for R report type of a crimi at 8:00 a.m. The Incid during the Narcotic C (RN) noticed it seeme		Inspection and Appeals (DIA) Incident Report (FRI) histrator from Harmony Cedar report with the DIA on 3/21/23 hal act regarding a nurse r signatures were forged on a hident #3. The FRI detailed a hal act that occurred on 3/18/23 hat Summary documented hunt, Staff G, Registered Nurse like her signature had been Count Sheet. "She" had signed				
					и	Page 10 o
Facil	ity Administrator		 ate			

Citation Number: #6142 Facility Name: Harmony Cedar Rapids Facility Address/City/State/Zip: 1940 First Avenue NE Cedar Rapids, IA 52402		TAG	Survey D May 15,		Date: June 22, Vlay 31, 2	
Rule or Code Section	Natur	e of Violation	Fine Amo		Amount	Correction date
	stated that had not occudocumented one pill of 3/18/23 at midnight and Medication Administrated documentation these numbers of documentation these numbers of documented as action of Stated she had good around 2:00 a.m. on 3/2 Good stated the Pharmacy #3's oxycodone. The Phoxycodone had been decound 3/18/23 at 5:22 a.m. The possibly given the medical a.m. Staff Good had handed around 6:00 a.m. Staff Coordinates for Resident #3 being 30 The next dose had been This led the facility to surdoses of medication and narcotic sheet. The FRI incident had been report Department. The Facility Department within 24 his misappropriation of resident provided by the facility Investigation, provided by the facility					Page 11 of

22

Facility Administrator

Citation Number #6142 Facility Name: Harmony Ceda			Date: June 22, 2023 Survey Dates:			2023
_	s/City/State/Zip: nue NE	TAG	May 15,	2023 – N	May 31, 2	023
Rule or Code Section	Natur	e of Violation	Class	Correction date		
	drug administration recisions and out two pills of of G stated that had not of documented one pill of midnight on 3/18/23 and 4:00 a.m. to Resident #3 not reflect the two dose been administered. Stat Tylenol around 2:00 a.m. patients pain. The med been documented in the patient's oxycodone had on 3/18/23 at 5:22 a.m. administered the medica.m. Staff G had handed duty, Staff A around 6:00 narcotic count being 30 she had just received the pharmacy. The next do a.m. by Staff A leading took the two doses and narcotic sheet. A Statement hand writt Director of Nursing (DO Director of Nursing (AD 3/17/23 documented the signal of t	een forged on the controlled ord (CDAR) and "she" had oxycodone for a patient. Staff occurred. The narcotic sheet oxycodone had been given at ad one pill given 3/18/23 at 3. The March 2023 EMAR did as of narcotic medication had off G stated she had given and and a staff G stated she had given and and a staff G stated the deen delivered to the facility at Therefore, she couldn't have station at midnight and 4:00 d the keys to the next nurse on and a.m. Staff G recalled the for the card of oxycodone as the medication from the se given had been around 8:00 them to suspect that Staff A signed Staff G's name on the signed Staff G's name on the name of the pharmacy had been unable for Patient #3 until the morning				

Facility Administrator

Date

Citation Number	er:				Date: June 22,	2023
Facility Name: Harmony Ceda	r Rapids		Survey Da			
Facility Address 1940 First Aver Cedar Rapids, I.		TAG	May 15, 2	2023 – N	Лау 31, 2	023
ocaai iiapias, ii						
Rule or Code Section	Natur	e of Violation	Class	Fine A	mount	Correction date
code section	Itatai	C OI VIOIGIOII	Cluss			date
	on Linn Hallway when Spharmacy had delivered 30 tablets of oxycodone detailed in her stateme 975 milligrams (mg) of since the oxycodone hapharmacy. Staff G documorning to Staff A, RN anarcotics before she lef 3/18/23 for the 10 p.m. her signature had been of oxycodone at midnig documented she had not on her shift on 3/17/23 March 2023 EMAR and verification. The March G administered 975 mg order 3/18/23 at 2:04 a for pain control.	18/23 between 5 a.m 6 a.m. Staff G had been ann Hallway when Staff I, RN, informed her the macy had delivered medications. Staff G counted blets of oxycodone for Resident #3. Staff G led in her statement she had given Resident #3 milligrams (mg) of Tylenol for complaints of pain the oxycodone had not been available from the macy. Staff G documented she gave report that sing to Staff A, RN and they both counted the otics before she left shift. Staff G returned /23 for the 10 p.m 6:30 a.m. shift to find that ignature had been forged to show administration cycodone at midnight and 4 a.m. Staff G mented she had never administered oxycodone er shift on 3/17/23. She attached a copy of the h 2023 EMAR and the Pharmacy Delivery Slip for cation. The March 2023 EMAR documented Staff ministered 975 mg of Tylenol per the physician r 3/18/23 at 2:04 a.m. which had been effective				
	had been 1:40 a.m. who her signature being forg signature had been forg Assistant Director of Nu and informed her of wh Staff G to write a staten	wrote a statement noting it en Staff G alerted her about ged. Staff E wrote Staff G's ged twice. Staff G called Staff F, irsing (ADON)/Unit Supervisor hat had happened. Staff F told ment and leave a copy for her ton Monday 3/20/23. Staff E				
						Page 13 of 2
Facil	ity Administrator	 Da	 ite			

Citation Number #6142 Facility Name:	er:		Survey D	oates:	Date: June 22	, 2023
Harmony Ceda	r Rapids		'			
Facility Address 1940 First Aver Cedar Rapids, I		TAG	May 15, 2023 – May 31, 2023			023
Rule or Code Section	Natur	e of Violation	Class	Fine A	Amount	Correction date
	had counted with Staff narcotics on the Medbr some CDARs had forged names, Staff I, RN, Staff same day. Staff E wrote she hadn't been satisfie clearly pills were taken suspicious ways. Staff E the situation. During an interview on DON reported she received in the issue with Staff E came to the facility. Staff E came to the facility in the narcotics were not efform Staff A on 3/18/23 3/18/23. The DON voiced she from Staff A on 3/18/23 3/18/23. The DON voice hours to report abuse, I Administrator for report with the process at that DON for about one year she called the Human R to the facility and notifi	of, she knew how many pills she G since there were not many idge hallway. Staff E noticed disignatures with different M, RN and Staff D, RN for the she asked Staff A about it and ed with the answer because illegally or administered in E called the DON and reported in E called the DON and reported in the late afternoon notifying aff A. Staff E noted something in the late afternoon notifying aff A. Staff E noted something is sign out and she had tried to seemed pretty upset so she aff E showed her the narcotic signature on it at a time when even in the facility for Resident e did not receive any messages and she thought they had 24 but she had to go through the ting. She had not been familiar it time. She had only been the r. After she came to the facility, esource Coordinator to come ed the Administrator. They ffice. She interviewed Staff A,				Page 14 o

2

Facility Administrator

Facility Name: Harmony Cedar Rapids Facility Address/City/State/Zip: 1940 First Avenue NE Cedar Rapids, IA 52402 Rule or Code Section Nature of Violation The Amount She asked Staff A if she had documented every time she administered a scheduled narcotic and as needed (PRN). Staff A responded she tried too, but couldn't say if she had missed one. The DON reported she point blank asked Staff A if she signed out narcotics that were not administered. Staff A told her no. Staff A gave no explanation at all for that and appeared tearful as the DON walked her out of the facility. Staff A understood being suspended until they could complete an investigation. At 11:31 a.m., the DON concluded that Staff A had been stealing narcotics. The DON reported she did not know how to file an on- line report with the State of lowa. She had heve rhad to do that. She did not call the State hot-line number to report. The Administrator had been made aware on the 19th that Staff A had been suspended due to missing medications and forged signatures. The DON did not know if the Administrator had reported the incident via phone to DIA prior to 3/21/23. On 5/17/23 at 12:56 p.m., Staff F reported she had been called by Staff G in the wee hours of the morning. She doesn't recall the date she received the call. She reported Staff G as a very upstanding nurse. She couldn't remember exactly what Staff G told her. Staff G had either reported a narcotic medication had been missing or someone had falsely signed out a	Facility Address/City/State/Zip: 1940 First Avenue NE Cedar Rapids, IA 52402 Rule or Code Section Nature of Violation Class Fine Amount Correction date then walked her out of the facility. The DON reported she arrived at the facility sometime after 2:00 p.m. She asked Staff A is he had documented every time she administered a scheduled narcotic and as needed (PRN). Staff A responded she tried too, but couldn't say if she had missed one. The DON reported she point blank asked Staff A if she signed out narcotics that were not administered. Staff A told her no. Staff A gave no explanation at all for that and appeared tearful as the DON walked her out of the facility. Staff A understood being suspended until they could complete an investigation. At 11:31 a.m., the DON concluded that Staff A had been stealing narcotics. The DON reported she did not know how to file an on- line report with the State of lowa. She had never had to do that. She did not call the State hot-line number to report. The Administrator had been made aware on the 19th that Staff A had been suspended due to missing medications and forged signatures. The DON did not know if the Administrator had reported the incident via phone to DIA prior to 3/21/23. On 5/17/23 at 12:56 p.m., Staff F reported she had been called by Staff G in the wee hours of the morning. She doesn't recall the date she received the call. She reported Staff G as a very upstanding nurse. She couldn't remember exactly what Staff G told her. Staff G had either reported an arcotic medication had been missing or someone had falsely signed out a	Citation Number	er:				Date: June 22,	, 2023
Rule or Code Section Rule or Section Nature of Violation Class Fine Amount Correction date then walked her out of the facility. The DON reported she arrived at the facility sometime after 2:00 p.m. She asked Staff A if she had documented every time she administered a Scheduled narcotic and as needed (PRN). Staff A responded she tried too, but couldn't say if she had missed one. The DON reported she point blank asked Staff A if she signed out narcotics that were not administered. Staff A told her no. Staff A gave no explanation at all for that and appeared tearful as the DON walked her out of the facility. Staff A understood being suspended until they could complete an investigation. At 11:31 a.m., the DON concluded that Staff A had been stealing narcotics. The DON reported she did not know how to file an online report with the State of lowa. She had never had to do that. She did not call the State hot-line number to report. The Administrator had been made aware on the 19th that Staff A had been suspended due to missing medications and forged signatures. The DON did not know if the Administrator had reported the incident via phone to DIA prior to 3/21/23. On 5/17/23 at 12:56 p.m., Staff F reported she had been called by Staff G in the wee hours of the morning. She doesn't recall the date she received the call. She reported Staff G as a very upstanding nurse. She couldn't remember exactly what Staff G told her. Staff G had either reported an arcotic medication had been missing or someone had falsely signed out a	Rule or Code Section Rule or Nature of Violation Class Then Amount Correction Code Section The malked her out of the facility. The DON reported she arrived at the facility sometime after 2:00 p.m. She asked Staff A if she had documented every time she administered a scheduled narcotic and as needed (PRN). Staff A responded she tried too, but couldn't say if she had missed one. The DON reported she point blank asked Staff A if she signed out narcotics that were not administered. Staff A told her no. Staff A gave no explanation at all for that and appeared tearful as the DON walked her out of the facility. Staff A understood being suspended until they could complete an investigation. At 11:31 a.m., the DON concluded that Staff A had been stealing narcotics. The DON reported she did not know how to file an online report with the State of lowa. She had never had to do that. She did not call the State hot-line number to report. The Administrator had been made aware on the 19th that Staff A had been suspended due to missing medications and forged signatures. The DON did not know if the Administrator had reported the incident via phone to DIA prior to 3/21/23. On 5/17/23 at 12:56 p.m., Staff F reported she had been called by Staff G in the wee hours of the morning. She doesn't recall the date she received the call. She reported Staff G as a very upstanding nurse. She couldn't remember exactly what Staff G told her. Staff G had either reported an arcotic medication had been missing or someone had falsely signed out a	-	r Rapids					
then walked her out of the facility. The DON reported she arrived at the facility sometime after 2:00 p.m. She asked Staff A if she had documented every time she administered a scheduled narcotic and as needed (PRN). Staff A responded she tried too, but couldn't say if she had missed one. The DON reported she point blank asked Staff A if she signed out narcotics that were not administered. Staff A told her no. Staff A gave no explanation at all for that and appeared tearful as the DON walked her out of the facility. Staff A understood being suspended until they could complete an investigation. At 11:31 a.m., the DON concluded that Staff A had been stealing narcotics. The DON reported she did not know how to file an online report with the State of Iowa. She had never had to do that. She did not call the State hot-line number to report. The Administrator had been made aware on the 19th that Staff A had been suspended due to missing medications and forged signatures. The DON did not know if the Administrator had reported the incident via phone to DIA prior to 3/21/23. On 5/17/23 at 12:56 p.m., Staff F reported she had been called by Staff G in the wee hours of the morning. She doesn't recall the date she received the call. She reported Staff G as a very upstanding nurse. She couldn't remember exactly what Staff G told her. Staff G had either reported a narcotic medication had been missing or someone had falsely signed out a	then walked her out of the facility. The DON reported she arrived at the facility sometime after 2:00 p.m. She asked Staff A if she had documented every time she administered a scheduled narcotic and as needed (PRN). Staff A responded she tried too, but couldn't say if she had missed one. The DON reported she point blank asked Staff A if she signed out narcotics that were not administered. Staff A told her no. Staff A gave no explanation at all for that and appeared tearful as the DON walked her out of the facility. Staff A understood being suspended until they could complete an investigation. At 11:31 a.m., the DON concluded that Staff A had been stealing narcotics. The DON reported she did not know how to file an online report with the State of Iowa. She had never had to do that. She did not call the State hot-line number to report. The Administrator had been made aware on the 19th that Staff A had been suspended due to missing medications and forged signatures. The DON did not know if the Administrator had reported the incident via phone to DIA prior to 3/21/23. On 5/17/23 at 12:56 p.m., Staff F reported she had been called by Staff G in the wee hours of the morning. She doesn't recall the date she received the call. She reported Staff G as a very upstanding nurse. She couldn't remember exactly what Staff G told her. Staff G had either reported a narcotic medication had been missing or someone had falsely signed out a	1940 First Aver	nue NE	TAG	May 15, 2	2023 – N	Лау 31, 2 ¹	023
then walked her out of the facility. The DON reported she arrived at the facility sometime after 2:00 p.m. She asked Staff A if she had documented every time she administered a scheduled narcotic and as needed (PRN). Staff A responded she tried too, but couldn't say if she had missed one. The DON reported she point blank asked Staff A if she signed out narcotics that were not administered. Staff A told her no. Staff A gave no explanation at all for that and appeared tearful as the DON walked her out of the facility. Staff A understood being suspended until they could complete an investigation. At 11:31 a.m., the DON concluded that Staff A had been stealing narcotics. The DON reported she did not know how to file an online report with the State of Iowa. She had never had to do that. She did not call the State hot-line number to report. The Administrator had been made aware on the 19th that Staff A had been suspended due to missing medications and forged signatures. The DON did not know if the Administrator had reported the incident via phone to DIA prior to 3/21/23. On 5/17/23 at 12:56 p.m., Staff F reported she had been called by Staff G in the wee hours of the morning. She doesn't recall the date she received the call. She reported Staff G as a very upstanding nurse. She couldn't remember exactly what Staff G told her. Staff G had either reported a narcotic medication had been missing or someone had falsely signed out a	then walked her out of the facility. The DON reported she arrived at the facility sometime after 2:00 p.m. She asked Staff A if she had documented every time she administered a scheduled narcotic and as needed (PRN). Staff A responded she tried too, but couldn't say if she had missed one. The DON reported she point blank asked Staff A if she signed out narcotics that were not administered. Staff A told her no. Staff A gave no explanation at all for that and appeared tearful as the DON walked her out of the facility. Staff A understood being suspended until they could complete an investigation. At 11:31 a.m., the DON concluded that Staff A had been stealing narcotics. The DON reported she did not know how to file an online report with the State of Iowa. She had never had to do that. She did not call the State hot-line number to report. The Administrator had been made aware on the 19th that Staff A had been suspended due to missing medications and forged signatures. The DON did not know if the Administrator had reported the incident via phone to DIA prior to 3/21/23. On 5/17/23 at 12:56 p.m., Staff F reported she had been called by Staff G in the wee hours of the morning. She doesn't recall the date she received the call. She reported Staff G as a very upstanding nurse. She couldn't remember exactly what Staff G told her. Staff G had either reported a narcotic medication had been missing or someone had falsely signed out a							
then walked her out of the facility. The DON reported she arrived at the facility sometime after 2:00 p.m. She asked Staff A if she had documented every time she administered a scheduled narcotic and as needed (PRN). Staff A responded she tried too, but couldn't say if she had missed one. The DON reported she point blank asked Staff A if she signed out narcotics that were not administered. Staff A told her no. Staff A gave no explanation at all for that and appeared tearful as the DON walked her out of the facility. Staff A understood being suspended until they could complete an investigation. At 11:31 a.m., the DON concluded that Staff A had been stealing narcotics. The DON reported she did not know how to file an online report with the State of Iowa. She had never had to do that. She did not call the State hot-line number to report. The Administrator had been made aware on the 19th that Staff A had been suspended due to missing medications and forged signatures. The DON did not know if the Administrator had reported the incident via phone to DIA prior to 3/21/23. On 5/17/23 at 12:56 p.m., Staff F reported she had been called by Staff G in the wee hours of the morning. She doesn't recall the date she received the call. She reported Staff G as a very upstanding nurse. She couldn't remember exactly what Staff C told her. Staff G had either reported a narcotic medication had been missing or someone had falsely signed out a	then walked her out of the facility. The DON reported she arrived at the facility sometime after 2:00 p.m. She asked Staff A if she had documented every time she administered a scheduled narcotic and as needed (PRN). Staff A responded she tried too, but couldn't say if she had missed one. The DON reported she point blank asked Staff A if she signed out narcotics that were not administered. Staff A told her no. Staff A gave no explanation at all for that and appeared tearful as the DON walked her out of the facility. Staff A understood being suspended until they could complete an investigation. At 11:31 a.m., the DON concluded that Staff A had been stealing narcotics. The DON reported she did not know how to file an online report with the State of Iowa. She had never had to do that. She did not call the State hot-line number to report. The Administrator had been made aware on the 19th that Staff A had been suspended due to missing medications and forged signatures. The DON did not know if the Administrator had reported the incident via phone to DIA prior to 3/21/23. On 5/17/23 at 12:56 p.m., Staff F reported she had been called by Staff G in the wee hours of the morning. She doesn't recall the date she received the call. She reported Staff G as a very upstanding nurse. She couldn't remember exactly what Staff G told her. Staff G had either reported a narcotic medication had been missing or someone had falsely signed out a					Fine A	mount	Correction
she arrived at the facility sometime after 2:00 p.m. She asked Staff A if she had documented every time she administered a scheduled narcotic and as needed (PRN). Staff A responded she tried too, but couldn't say if she had missed one. The DON reported she point blank asked Staff A if she signed out narcotics that were not administered. Staff A told her no. Staff A gave no explanation at all for that and appeared tearful as the DON walked her out of the facility. Staff A understood being suspended until they could complete an investigation. At 11:31 a.m., the DON concluded that Staff A had been stealing narcotics. The DON reported she did not know how to file an online report with the State of Iowa. She had never had to do that. She did not call the State hot-line number to report. The Administrator had been made aware on the 19th that Staff A had been suspended due to missing medications and forged signatures. The DON did not know if the Administrator had reported the incident via phone to DIA prior to 3/21/23. On 5/17/23 at 12:56 p.m., Staff F reported she had been called by Staff G in the wee hours of the morning. She doesn't recall the date she received the call. She reported Staff G as a very upstanding nurse. She couldn't remember exactly what Staff G told her. Staff G had either reported a narcotic medication had been missing or someone had falsely signed out a	she arrived at the facility sometime after 2:00 p.m. She asked Staff A if she had documented every time she administered a scheduled narcotic and as needed (PRN). Staff A responded she tried too, but couldn't say if she had missed one. The DON reported she point blank asked Staff A if she signed out narcotics that were not administered. Staff A told her no. Staff A gave no explanation at all for that and appeared tearful as the DON walked her out of the facility. Staff A understood being suspended until they could complete an investigation. At 11:31 a.m., the DON concluded that Staff A had been stealing narcotics. The DON reported she did not know how to file an on- line report with the State of Iowa. She had never had to do that. She did not call the State hot-line number to report. The Administrator had been made aware on the 19th that Staff A had been suspended due to missing medications and forged signatures. The DON did not know if the Administrator had reported the incident via phone to DIA prior to 3/21/23. On 5/17/23 at 12:56 p.m., Staff F reported she had been called by Staff G in the wee hours of the morning. She doesn't recall the date she received the call. She reported Staff G as a very upstanding nurse. She couldn't remember exactly what Staff G told her. Staff G had either reported a narcotic medication had been missing or someone had falsely signed out a	Code Section	Natur	e of Violation	Class			date
rage 10 or 2	<u> </u>					Page 15 of 2		

Facility Administrator

Citation Number #6142	er:				Date: June 22	, 2023
Facility Name: Harmony Ceda	r Rapids		Survey D			
Facility Address 1940 First Aver Cedar Rapids, I		TAG	May 15,	2023 – 1	May 31, 2	023
•						
Rule or				Fine A	Amount	Correction
Code Section	Natur	e of Violation	Class			date
	narcotic using her signal narcotic record had not had been one of those had been one narcotic. She doesn't recall the sto Staff G but did tell he situation to the DON are She did remember that stated she had not give medication and Staff A to handle the narcotic reshe had been the nurse remembered she had be the call. She could not but it had been a narcotrecall which resident had it occurred on the Med policy is to alert the DOD did not call the DON rigicalled her later the same DON investigated it but actually reported-off to resident property she and Administrator. She would state office. If she saw report to the State immittems, she would just read Administrator.				Page 16 of	
						Page 16 of 2
Facil	ity Administrator	 Da	 ate			

Citation Number: #6142 Facility Name: Harmony Cedar Rapids Facility Address/City/State/Zip: 1940 First Avenue NE Cedar Rapids, IA 52402		TAG	Survey D May 15,		Date: June 22, May 31, 2	
Rule or Code Section	Natur	e of Violation	Class	Fine A	Mount	Correction date
	to call Staff F who had be (3/19/23), but Staff F co called the DON and left call Staff F on her perso informed her to write a office and she would ad came in. A Missed Puncthe facility documented from 10 a.m 2:40 p.m. During an interview on reported she is not the Coordinator is the Admithey first looked at it th looking at a forgery for sheets. They weren't aw been going on at that poor of 5/17/23 at 6:34 p.m. had first become aware evening of 3/19/23 by the facility and got a statem suspended her from duthink they had an allegate counts were not off, but He had not been able to	5/17/23 at 1:24 p.m., the DON Abuse Coordinator. The Abuse inistrator. She stated when ey had thought they were signatures on the narcotic vare of everything that had oint. ., the Administrator voiced he of the situation on the he DON. The DON went to the nent from Staff A and ty. At that point they didn't ation of abuse. The narcotic t something had been "fishy." to verify Staff G's statement 0/23 when the pharmacy				Page 17 of 2

22

Facility Administrator

Date

Facility Name: Harmony Cedar Rapids Facility Address/City/State/Zip: 1940 First Avenue NE Cedar Rapids, IA 52402 Rule or Code Section Medication had been received by the facility. That confirmed Staff G's story. Looking back, he stated he got it, they probably should have been looking at it from a different perspective, but he likes to think the best of people. Getting the Pharmacy Receipt had been the verification he needed. He reported the incident to the State Department on 3/21/23. He had verified with the DON on 3/19/23 that the narcotic count had been accurate. They thought it may have been a simple case of someone forgetting they had administered a dose of medication and it turned into someone stealing medications. He had never seen anything like it. From their final investigation, it had affected up to 9 residents and showed a trend that Staff A had taken the pills. He stated they had reported Staff A would be terminated. He didn't feel this had been the first time that Staff A had taken medications. She seemed to know exactly what she was doing. He wondered if it had happened at other facilities and they never did anything about it. They tried to do the right thing and get it reported into the State. On 5/18/23 at 9:41 a.m., the Pharmacist/Director of Quality reported the customer service representative had been contacted on 3/20/23 by the DON from Harmony. He didn't have an exact time but felt that he did respond with getting her the information	Citation Number: #6142					Date: June 22	, 2023
Facility Address/City/State/Zip: 1940 First Avenue NE Cedar Rapids, IA 52402 Rule or Code Section May 15, 2023 – May 31, 2023 May 15, 2023 – May 31, 2023	-	pids		Survey D	ates:	II	
medication had been received by the facility. That confirmed Staff G's story. Looking back, he stated he got it, they probably should have been looking at it from a different perspective, but he likes to think the best of people. Getting the Pharmacy Receipt had been the verification he needed. He reported the incident to the State Department on 3/21/23. He had verified with the DON on 3/19/23 that the narcotic count had been accurate. They thought it may have been a simple case of someone forgetting they had administered a dose of medication and it turned into someone stealing medications. He had never seen anything like it. From their final investigation, it had affected up to 9 residents and showed a trend that Staff A had taken the pills. He stated they had reported Staff A vould be terminated. He didn't feel this had been the first time that Staff A had taken medications. She seemed to know exactly what she was doing. He wondered if it had happened at other facilities and they never did anything about it. They tried to do the right thing and get it reported into the State. On 5/18/23 at 9:41 a.m., the Pharmacist/Director of Quality reported the customer service representative had been contacted on 3/20/23 by the DON from Harmony. He didn't have an exact time but felt that	Facility Address/Ci 1940 First Avenue	ty/State/Zip: NE	TAG	May 15, 2023 – May 31, 2023		023	
medication had been received by the facility. That confirmed Staff G's story. Looking back, he stated he got it, they probably should have been looking at it from a different perspective, but he likes to think the best of people. Getting the Pharmacy Receipt had been the verification he needed. He reported the incident to the State Department on 3/21/23. He had verified with the DON on 3/19/23 that the narcotic count had been accurate. They thought it may have been a simple case of someone forgetting they had administered a dose of medication and it turned into someone stealing medications. He had never seen anything like it. From their final investigation, it had affected up to 9 residents and showed a trend that Staff A had taken the pills. He stated they had reported Staff A to the Board of Nursing. He further reported Staff A would be terminated. He didn't feel this had been the first time that Staff A had taken medications. She seemed to know exactly what she was doing. He wondered if it had happened at other facilities and they never did anything about it. They tried to do the right thing and get it reported into the State. On 5/18/23 at 9:41 a.m., the Pharmacist/Director of Quality reported the customer service representative had been contacted on 3/20/23 by the DON from Harmony. He didn't have an exact time but felt that		Natur	e of Violation	Class	Fine A	Mount	
Page 18 of	co go fro be be ind ve co be ad so an aff Sta rej thi me wa fac tri Sta	onfirmed Staff G's stored it, they probably shown a different perspected of people. Getting een the verification here ident to the State Descrified with the DON of punt had been accurated a simple case of someone stealing medic bything like it. From the fected up to 9 resident aff A had taken the piported Staff A to the liported Staff A would is had been the first the dications. She seemed as doing. He wondered it is and they never it is done to do the right thire ate. In 5/18/23 at 9:41 a.m. and been contacted on armony. He didn't have	ry. Looking back, he stated he could have been looking at it cive, but he likes to think the the Pharmacy Receipt had a needed. He reported the epartment on 3/21/23. He had an 3/19/23 that the narcotic re. They thought it may have been forgetting they had medication and it turned into cations. He had never seen reir final investigation, it had not and showed a trend that lls. He stated they had Board of Nursing. He further be terminated. He didn't feel ime that Staff A had taken red to know exactly what she red if it had happened at other of did anything about it. They had and get it reported into the stomer service representative 3/20/23 by the DON from the read and exact time but felt that				Page 18 of

Facility Administrator

Date

Facility Name: Harmony Ceda Facility Address 1940 First Aver Cedar Rapids, I	r Rapids s/City/State/Zip: nue NE	TAG	Survey D May 15,	Ju	Date: une 22, ny 31, 20	
Rule or Code Section	Natur	e of Violation	Class	Fine Amo	ount	Correction date
	with a copy of the phart signature from the nurs delivery for Resident #3 the unsigned packing slithe copies were sent to at 8:35 p.m. Due to the technology, she could ninformation. On 5/23/23 at 11:42 a.r when Staff G brought for affected Resident #3. The but didn't know about the until later into the investigation and Report provided by the facility, all residents have the right neglect misappropriation exploitation, corporal personal pe	m. the DON reported initially orward the concern, it had only ney initiated an investigation, the other residents affected stigation. Use Prevention, Identification, rting Policy, dated July 2019, included a Policy Statement: ght to be free from abuse, on of resident property, unishment, involuntary ical or chemical restraint not sident's medical symptoms. g nursing facility staff from				

Facility Administrator

Date

Citation Number #6142	Citation Number: #6142				Date: June 22	, 2023
Facility Name: Harmony Ceda	r Rapids		Survey Dates: May 15, 2023 – May 31, 2023			
Facility Address 1940 First Aver Cedar Rapids, I		TAG				023
Rule or Code Section	Natur	e of Violation	Class	Fine A	Amount	Correction date
	guardians, friends, or or policy of this facility to to prohibit abuse, negle misappropriation of res. The Policy included the 1. Misappropriation of deliberate misplacement temporary or permaner belongings or money withis includes misappropriations. The Policy under Report 1. All allegations of Resi exploitation, mistreatm and misappropriation sito the charge nurse. The for immediately reportithe Administrator or de 2. All allegations of Resito the Iowa Departmentater than two (2) hours 3. All allegations of Resimistreatment, injuries of misappropriation shall I Department of Inspections.	following definition: Resident Property means the nt, exploitation, or wrongful nt use of a Resident's ithout the Resident's consent. Oriation or diversion of resident ting directed the following: ident abuse, neglect, ent, injuries of unknown origin hould be reported immediately the charge nurse is responsible ng the allegation of abuse to esignated representative. Ident abuse shall be reported to f Inspection and Appeals not after the allegation is made. Ident neglect, exploitation,				Page 20

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to lowa Code section 135C.43A (2013).

Date

Facility Administrator

		•			ir-	
Citation Number:					Date:	
#6142					June 22	, 2023
Facility Name:			Survey D	ates:	ll	
Harmony Ceda	r Rapids		•			
Facility Address	s/City/State/Zip:	TAG	May 15,	2023 – ľ	May 31, 2	2023
1940 First Aver	· · · · · ·	.,,,				
Cedar Rapids, I						
l court inapiece, in						
Rule or			_	Fine A	Mount	Correction
Code Section	Natur	e of Violation	Class			date
			<u> </u>		- 1	
		llegation result in serious				
		er than twenty-four (24) hours				
		the allegation involve neglect,				
		ent, injuries of unknown origin				
		out do not result in serious				
	bodily injury.					
		suspicion that the allegation				
		es a crime committed against				
	the resident by any per					
		mployed by the facility, the				
	-	es the matter must also be				
	•	ement. While the federal				
	regulations require all a	_				
	· ·	2 hours, the Elder Justice Act				
	has a different time frame	egations of abuse (that results				
	-	serious bodily injury to a				
	-	be made to law enforcement				
	•	ours after the allegation is				
		of abuse does not result in				
		report must be made to law				
		han twenty-four 24) hours.				
		de by calling the Department of				
	•	reporting hotline at (877) 686-				
		nail to the Department at				
		wa.gov, submitting an online				
	report or sending a fax					
		ge is the alleged abuser, the				
	,	ctly report the abuse to the				
	Table to the state of the state	, sport and abdoc to the				

Page **21** of **22**

Facility Administrator

Date

Citation Number: #6142			Date: June 22	Date: June 22, 2023		
Facility Name: Harmony Ceda			Survey D			
Facility Address 1940 First Aven Cedar Rapids, I		TAG	May 15,	2023 – May 31, 2	023	
	A 32402					
Rule or Code Section	Natur	e of Violation	Class	Fine Amount	Correction date	
	Department immediate established above.	ely pursuant to the deadlines				
	FACILITY RESPONSE:					
					Page 22 of 2	
Facil	ity Administrator		Date			