STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165385	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Marshalltown	**910 East Olive , Marshalltown, Iowa, 50158**

(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
F0000 ✓	INITIAL COMMENTS Correction date: 6-1-26 The following deficiencies resulted from investigation of complaint #2801738-C, conducted May 19, 2026 to May 20, 2026. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F0000		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F0880	gmeerthand	5/26/26

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 reverse for further 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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F0880 SS = D	Continued from page 1 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observations, clinical record review, staff interviews and policy review, the facility failed to use Enhanced Barrier Precautions (EBP) during wound care for 2 of 2 residents observed (Resident #2 and Resident #3). The facility reported a census of 51 residents.	F0880		

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F0880 SS = D	Continued from page 2 Findings include: 1. Resident #2's Minimum Data Set (MDS), dated 3/13/26, included diagnoses of fractures (broken bones) and other multiple trauma (severe injuries), heart failure (weak heart), and hip fracture. The MDS indicated Resident #2 had a risk of developing pressure ulcers (bedsores)/injuries. The Care Plan Focus initiated 12/5/25, indicated Resident #2 had a risk for alteration in skin integrity (skin health) related to history of falls, impaired mobility (limited movement), and hyperlipidemia (high cholesterol). On 4/7/26, Resident #2 developed a right sacrum (lower spine bone) unstageable pressure ulcer (bedsore). The Care Plan Focus initiated 1/6/26 included an area for Enhanced Barrier Precautions (EBP) related to pressure wound. The interventions included 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, performing wound care). On 5/20/26 at 10:10 AM, Staff A, Registered Nurse (RN), performed wound care for Resident #2. An observation noted EBP signage by the door and a 3-drawer cart of Personal Protective Equipment (PPE) supplies right outside the door to Resident #2's room. Staff B, Certified Nursing Aide (CNA), and Staff C, CNA, assisted with the wound care. They used a gait belt to assist Resident #2 to a standing position by Resident #2's walker, removed his pants, and lowered his brief. Staff B and Staff C remained by Resident #2's side during the wound care and then assisted Resident #2 after wound care by pulling up his pants and brief, then lowered Resident #2 back to his wheelchair. Staff A performed the wound care, cleaned the wound, applied medicated cream, and a new border foam dressing. Throughout the wound care process, Staff A, Staff B, and Staff C didn't wear a gown. 2. Resident #3's Minimum Data Set (MDS), dated 4/30/26, included diagnoses of stroke (brain clot), renal failure (kidney failure), diabetes mellitus (high blood sugar), and pressure ulcer (bedsore) of the right heel, stage 2. The MDS indicated Resident #3 had a risk of developing pressure ulcers (bedsores)/injuries and had one or more unhealed pressure ulcers (bedsores)/injuries.	F0880		

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=0880 SS = D	Continued from page 3 The Care Plan Focus initiated 2/4/26, indicated Resident #3 had a risk for alteration in skin integrity (skin health) related to type 2 diabetes (high blood sugar), weakness, acute kidney failure (sudden kidney failure), and falls. On 1/22/26, Resident #3 developed a stage 3 left ankle pressure ulcer (bedsore), which reopened 3/12/26. The Care Plan Focus initiated 5/11/26 included an area for EBP related to pressure wound. The interventions included EBP precautions: staff to wear a gown and gloves while performing high-contact care activities. On 5/20/26 at 9:50 AM, Staff A performed Resident #3's wound care. Observed an EBP sign by the door and a 3-drawer cart of PPE supplies right outside the door to Resident #3's room. Staff A entered the room, performed hand hygiene, donned (applied) gloves, and removed the current foam border from Resident #3's left ankle. Staff A proceeded with the wound care, cleaned the wound, applied medicated cream, a new pad, and new border foam dressing. Staff A didn't wear a gown throughout the entire wound care process. On 5/20/26 at 10:20 AM, Staff A acknowledged she didn't perform appropriate EBP and stated she should've worn a gown during wound care for both Resident #2 and Resident #3. Staff A added the CNAs who assisted with Resident #2's wound care should've worn a gown as well. On 5/20/26 at 10:30 AM, the Director of Nursing (DON) stated they expected staff to wear gowns during wound care in accordance with EBP guidelines. The DON stated Staff A, Staff B, and Staff C should've worn gowns during wound care for Resident #2 and Resident #3. The Enhanced Barrier Precautions policy dated March 2024 instructed to focus on minimizing risk of transmission of novel or targeted Multi-Drug-Resistant Organisms (MDROs) during high contact resident care activities for residents requiring EBP. For residents whom EBP are indicated, staff should use gowns and gloves during high contact resident care activities that provide opportunity for MDROs to transfer to staff hands and clothing. High contact resident care activities included wounds care: any skin opening requiring a dressing.	F0880		

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910 East Olive St
Marshalltown, Iowa 50158

Plan of Correction (POC) related to survey completed 5/19/26 - 5/20/26
Date POC Sumbitted to DIAL: 5/26/26

Preparation and implementation of the plan of correction should not be construed as an admission of the deficiencies cited or as an agreement that the facts stated by DIAL are accurate or complete. This plan of correction is prepared solely because it is required under federal or state law. This plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal or state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance wih the requirements of participation or that corrective action was necessary.

F000 Correction Date: 6/1/26

F 0800 Infection Prevention and Control

1. Education regarding transmission-based precautions was provided to all licensed nursing staff and nursing assistants, with emphasis on appropriate infection prevention and control practices.
2. Transmission-based precaution pocket reference cards were distributed to nursing staff for use as a resource prior to providing resident care, as needed, to reinforce compliance with current infection control protocols.
3. Additional individualized re-education and competency training were provided to Staff Members A, B, and C related to transmission-based precautions and evidence-based infection prevention practices.
4. The Director of Nursing (DON) or designee will conduct random weekly audits for four (4) weeks to ensure infection control principles are consistently followed during wound treatments and for residents requiring transmission-based precautions, and to verify evidence-based practices (EBP) are implemented in accordance with facility policy and regulatory requirements. Audit findings will be reviewed during the monthly Quality Assurance and Performance Improvement (QAPI) meetings. The need for continued auditing after the initial four-week period will be determined based on audit results and compliance trends.

Jennifer Hand 5/26/26