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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>165033  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                       | (X3) DATE SURVEY COMPLETED<br><br>09/03/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Harmony Davenport  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>815 East Locust Street<br>Davenport, IA 52803 |  |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |  |  |
| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>26529</p> <p>Based on observation, clinical record review, resident and staff interviews the facility failed to treat residents with dignity and respect, in full regard of the resident's stated needs and right to refuse a shower, for 1 of 8 resident's reviewed (Resident #5). The facility reported a census of 67 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) Assessment tool, dated 7/23/24, revealed Resident #5 scored 13 out of 15 points possible on the Brief Interview for Mental Status (BIMS) Cognitive assessment, indicating intact cognition. Diagnoses listed on the MDS included: adult failure to thrive, anxiety, depression, and contractures in left hand, and feet. The resident required substantial/maximal staff assistance for personal hygiene, bathing and dressing the upper body, completely dependent on staff for dressing the lower body, toileting/hygiene, and unable to stand or ambulate. The MDS indicated the residents speech is clear, usually understood by others and usually understands others.</p> <p>A review of the Care Plan, dated 7/17/24, revealed a Focus Area to address Resident requires assistance with ADL's (Activities of Daily Living). Interventions, dated 7/17/24, included in part: to assist the resident with showering/bathing per schedule, prior to initiating an ADL task, staff will explain the task to resident, provide sufficient time for completion of ADL tasks, and allow resident independence to the best of their ability with ADL task.</p> <p>The Care Plan, dated 7/17/24, also included a Focus Area to address Resident is at risk of pain related to low back pain, contractures of multiple of multiple sites, constipation, HTN (hypertension) and depression. Interventions, dated 7/17/24, included in part: Administer pain medication per physicians order, Encourage/assist to reposition frequently to position for comfort, Evaluate pain level as ordered, Implement non-pharmacological interventions massage, relation techniques, counseling, warm/cool compress, positioning as indicated, and Observe for non-verbal signs of pain.</p> <p>Documentation in the resident's record revealed she received bed baths on 7/29/24 and 7/31/24, and no history of a shower bath.</p> <p>(continued on next page)</p> |  |  |

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>A Nursing Progress Note transcribed at 7:13 p.m. on 7/31/24 by Staff A, Licensed Practical Nurse (LPN) stated: Resident was assisted into the Hoyer lift and transferred onto the reclining shower chair. Resident continued to yell out and shout profanities to staff during shower. Resident is currently on the phone with her family at this time about how upset she is about getting a shower.</p> <p>An observation on 8/27/24 at 11:21 a.m. revealed Resident #5 positioned on her back in bed, head of the bed elevated approximately 15 degrees, awake and alert, with a cell phone in her right hand, all fingers of her left hand very contracted and the resident would not have been able to hold the phone or grasp anything with it.</p> <p>During an interview on 8/27/24 at 11:22 a.m., the resident stated prior to admission to the facility, she lived in her home, completely dependent on family for care, she hadn't been out of bed for around 2 years. When she came to the facility staff provided bed baths for her, then 1 day staff came and told her she was getting a shower, she told them no, she didn't want a shower, but they got her up anyway. She stated she had horrible pain in her legs when they had her up in the air with the lift, and was afraid.</p> <p>During an interview 8/27/24 at 12:34 p.m., Resident #5 stated on the day that staff showered her, she never agreed to a shower, staff came with the mechanical lift and said I was getting up and going to get a shower. When they started lifting her with the mechanical lift it really hurt and she started yelling/screaming due to the pain. They never offered to lay her back down, or not to have the shower she would have accepted a bed bath but staff didn't offer that option.</p> <p>During an interview on 8/27/24 at 11:31 a.m., the Director of Nursing stated he had been unaware of Resident #5 having a problem with a shower, would have to look into it, and stated the resident had bed baths on 7/29/24 and 7/31/24.</p> <p>During an interview on 8/27/24 at 11:38 a.m., the Administrator stated she heard there was an issue with the resident having a shower, she spoke to the resident, her Power of Attorney (POA), and the staff involved, it was Staff B, Certified Nursing Assistant (CNA). The resident told the Administrator she agreed to the shower until she became uncomfortable, then she wasn't in agreement. The resident reported staff offered to stop but she agreed to continue with the shower, and didn't want a shower again. The resident told her she called the Elder Abuse hotline about it. They have changed her care plan to bed baths only since then.</p> <p>During an interview on 8/27/24 at 11:56 a.m., the resident's POA stated the resident called her on the telephone her right after she was showered and was very upset. The resident was bedridden, completely dependent for all care, the resident said staff made her take a shower even though she said no and screamed because the mechanical lift hurt her knees. It caused the resident mental distress, and the POA spoke with Staff E about it, they agreed that if the resident refused a shower staff should have honored the resident's wishes.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During an interview on 8/28/24 at 2:48 p.m., Staff B, CNA, stated 1 day when she worked, staff from the evening shift, Staff C, CNA, went in to change the resident after she had been incontinent with bowel. Staff B stated she did not think it was possible to clean up the resident with wet wipes and they felt the resident required a shower. Resident #5 said she hadn't had a shower for a long time, Staff B stated she tried to reassure the resident, that she would make it as quick as possible, and the resident was okay with it until they got her up in the air with the mechanical lift and transferred her to the recumbent shower chair, that's when she started screaming that she didn't want a shower, and didn't want to be at the facility any more. Once in the shower, as she washed her perineal area the resident yelled that Staff B was degrading her. Staff B stated she completed the shower as quickly as she could and notified the nurse of the events afterward.</p> <p>During an interview on 8/28/24 at 4:36 p.m., Staff C, CNA, stated she assisted Staff B to transfer the resident to the shower chair with the mechanical lift, the resident didn't say she didn't want a shower until they had her up in the air and were in the process of moving her to the shower chair, that's when she screamed/yelled and cursed at them and said she didn't want a shower. Staff C stated Staff B did try to reassure the resident, she remained present in the shower room as she was showered, the resident continued to yell profanities at them during the shower, stopped after the shower was completed and they returned her to her room.</p> <p>During an interview on 8/28/24 at 1:58 p.m. Staff D, LPN, stated Staff B told her after she showered the resident that the resident said she didn't want a shower, and once in the shower room she said staff washed her inappropriately. When Staff D spoke to the resident she said she never got out of her house, never took showers and was upset that she got a shower, she didn't say that she was hurt by the mechanical lift or anything like that.</p> <p>During an interview on 8/28/24 at 11:55 a.m., Staff E, facility Social Worker, stated when the resident came to the facility she hadn't bathed for some time and had an odor. When they showered the resident she could hear the resident's screams when she was in her office, approximately 50 feet away and separated by several walls. After the shower the resident agreed she felt better but didn't want to have a shower again, she only wanted bed baths.</p> |  |  |