STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165169	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan - Davenport	700 Waverly Road Davenport, IA 52804

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, resident and staff interviews and facility policy review the facility failed to serve a palatable meal for 2 out of 2 meals observed and four out of four residents reviewed (Resident#14, 3, 43 and 6). The facility reported a census of 98 residents.Findings include: 1. The Minimum Data Set (MDS) assessment for Resident#14, dated 10/18/25, list of diagnoses included heart failure and malnutrition (insufficient intake of calories and/or protein). The Brief Interview for Mental Status (BIMS) score as 14 out of 15, indicated the resident with intact cognition. The Care Plan for Resident#14 dated 10/28/25, directed educate resident not to skip meals. During an interview on 01/26/2026 at 2:05 PM, Resident #14 reported she did not like the food, and explained it is not hot and the taste is bad. 2. The kitchen staff provided the lunch menu for 1/27/26 which consisted of beef and broccoli, fried rice, peas, and egg roll. On 01/27/2026 at 12:20 PM, the State Agency received a test tray. The beef looked an unattractive dark color, the broccoli appeared pale with little green color, and tasted salty. The rice and peas tasted bland and were gummy in texture. The egg roll had a soggy texture, and the beef juice/gravy had an unsavory taste. 3. Review of the MDS assessment for Resident #3, dated 12/17/25, revealed a BIMS score of 15 out of 15, which indicated intact cognition. The list of diagnoses included heart failure and diabetes. During an interview on 1/27/26 at 9:09 AM, Resident #3 reported the food did not taste good. Resident #3 explained the food had no flavor and did not look appetizing. During an observation on 1/28/26 starting at 12:34 PM, Resident #3's door was partially shut, and a dietary food cart was sitting outside of the resident's room door. Staff I, Certified Nursing Assistant (CNA) called out she was providing cares when the surveyor knocked on the door. At 12:38 PM, Staff I, CNA exited Resident #3's room. Resident #3 observed to be sitting up in bed with her lunch on the bedside table positioned over the bed. Resident #3 had baked rosemary chicken, roasted red potatoes, cauliflower au gratin (covered in cheese) and a pumpkin cake. At 1:05 PM, Resident #3 reported the chicken was too tough to eat. The resident's plate had 50 percent of her meal left, with the majority of her chicken still on the plate. 4. Review of the MDS assessment for Resident #43, dated 11/19/25, revealed a BIMS score of 14 out of 15, which indicated intact cognition. The list of diagnoses included diabetes, high blood pressure, (continued on next page)

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

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	seizures and gastroesophageal reflux disease (GERD). During an interview on 1/26/26 at 12:59 PM, Resident #43 reported the food was either over or undercooked. The resident the food got soggy as it sat on the steam table. During an observation on 1/28/26 at 11:30 AM, Resident #43 served rosemary baked chicken, cauliflower au gratin, roasted potatoes, and a roll. At 11:44 AM, the resident had eaten the chicken and potatoes, but the majority of the cauliflower was still on the resident's plate. The resident requested and received another serving of roasted potatoes. Resident #43 reported the cauliflower was too tough to eat. 5. Review of the MDS assessment for Resident #6, dated 12/3/25, revealed a BIMS score of 15 out of 15, which indicated intact cognition. The list of diagnosis included high blood pressure and right hip fracture. During an interview on 1/26/26 at 11:15 AM, Resident #6 reported the food was not good. Resident #6 explained that when the menu had French dip, it didn't have the dip, and when the menu had Philly cheesesteak, there was no cheese. The resident reported the food was dry and missing flavor. On 1/28/26 at 12:00 PM, observation revealed Resident #6 received a room tray for lunch. The resident had ordered the rosemary baked chicken and nothing else. At 12:03 PM, observation revealed Resident #6 was eating the baked chicken. Resident #6 reported the chicken was dry and then stated, the chicken was always dry. 6. During an interview on 01/28/2026 at 12:26 PM, the kitchen staff provided a lunch meal tray that included baked rosemary chicken and cauliflower au gratin. The rosemary baked chicken taste was dry and bland. The cauliflower au gratin was a mixture of mushy texture little pieces and tough texture, large pieces. The cauliflower large pieces did not cut with a knife. During an interview on 1/29/26 at 11:36 AM, the Manager of Nutritional and Food Services reported she encouraged cooks to taste the food, and she ate at facility almost every day. The Manager of Nutritional and Food Services reported staff followed a Meal Service policy, and that she ran the resident food council meetings. Review of the Food Counsel meeting minutes, dated 1/12/26, revealed residents had complaints of kitchen staff serving cold lasagna, not serving breadsticks, French dip without dip, meatball and cheese sub sandwich served without cheese, and the spaghetti and meat sauce was dry. Review of the facility policy titled Food Preparation- Food and Nutrition dated 3/14/25 directed employees routinely sample the food before it's served to ensure good taste, texture and quality. The policy identified the plates should have an attractive appearance and be free of spillovers.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interview and facility policy review the facility failed to use Enhanced Barrier Precautions (EBP) and failed to completed hand hygiene for 2 out of 4 residents reviewed (Resident#2 and #92) and failed to transport clean laundry covered for 2 out of 2 days. The facility reported a census of 98 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #92, dated 11/28/25, list of diagnoses included anemia (lack of red blood cells), Parkinson's disease, and diabetes mellitus (DM). The MDS identified Resident#92 Brief Interview for Mental Status (BIMS) as 12 out of 15, which indicated moderately impaired cognition. The MDS indicated Resident#92 required a wheelchair for mobility, dependent on staff for toileting hygiene, lower body dressing and chair to chair transfer. The Care Plan for Resident #92, dated 5/20/25 revealed Resident #92 required EBP related to urine culture that held Extended-Spectrum Beta-Lactamases (ESBL) (enzymes from bacteria that make them resistant to standard antibiotics). The Care Plan directed staff to put on gown and gloves when performing high contact care activities including: dressing, bathing, transferring, providing hygiene, changing lining, repositioning checking and changing, device care and/or wound care. Review of a Provider's Progress Note, dated 1/25/26, revealed the resident had a positive urine culture showed ESBL. During an observation on 01/27/2026 at 8:04 AM, Resident #92 sat in the wheelchair (w/c) in her room. The resident stated she needed to use the bathroom, she said she's on antibiotic for a UTI. A sign indicating the need for EBP noted on the resident's door, and with EBP (gown and gloves) supplies available. During on observation on 01/29/2026 starting at 8:50 AM Staff A, Certified Nursing Assistant (CNA) reported Resident #92 goes to the shower room to use the commode. Staff A completed hand hygiene and applied gloves before he placed the gait belt on Resident#92. Staff L, CNA completed hand hygiene and put gloves on, both CNAs stood Resident#92 up to the shower wall, lowered her pants and moved the commode behind her. Resident#92 sat on the commode and emptied her bladder. Staff A reported her brief appeared dry. Both CNAs removed their gloves, completed hand hygiene and applied new gloves. At 9:04 AM, Staff A, CNA and Staff L, CNA stood Resident #92 up, Staff A used wipes to clean her, Staff L pulled her pants up and assisted her back in to the w/c. Neither Staff A and Staff L wore a gown during this observation. During an interview on 01/29/2026 at 9:07 AM, Staff L, CNA reported the EBP sign on Resident #92's room door is for her roommate, and she is not sure why. During an interview 01/29/2026 at 9:09 AM, Staff A, CNA reported the EBP is for Resident #92. He stated they needed to wear the EBP for her cares. Staff A stated Resident #92's urine is why the EBP is needed. During an interview on 01/29/2026 at 1:11 PM, the facility Infection Preventionist (IP) reported she expected the staff to use EBP as directed on the wall sign, she said the staff needed to completed hand hygiene when they enter and when they leave the room before and after cares. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the Resident #2's MDS assessment, dated 12/19/25, revealed a BIMS score of 15 out 15 which indicated intact cognition. The assessment identified diagnoses cerebral vascular accident (stroke), diabetes, and hemiplegia. The resident received nutrition both through a gastric feeding tube (g-tube) and a mechanically altered diet. Review of the Care Plan, last revised 12/22/25, revealed, in part, the resident required enhanced barrier precautions (EBP) related to her g-tube. An Intervention directed staff to don gown and gloves for high contact care activities including device care and/or use, and to doff gown and gloves inside the room and perform hand hygiene. Review of Clinical Physician Orders in the electronic health record (EHR), revealed a. An order, dated 9/20/24, to check and record residual amounts every shift and PRN (as needed) four times per day. b. An order, dated 6/18/25, for Isosource 1.5 Cal oral liquid, give 200 milliliters (ml) via g-tube four times per day for meals bolus feeding. c. An order, dated 9/24/24, for Calcium 600 milligrams (mg) one tablet every day via g-tube. d. An order, dated 4/11/25, for DuoNeb solution 0.5-2.5 mg/3 ml (Ipratropium/Albuterol) one inhalation four times per day. During an observation on 1/26/26 starting at 12:53 PM, the outside of the room door for Resident #2 revealed a sign that instructed staff to follow EBP when providing cares to the residents in the room. At 12:45 PM, Staff B, Licensed Practical Nurse (LPN), revealed Staff B was pushing Resident #2 in her wheelchair down the hallway into the resident's room, moved the resident's bedside table, and repositioned the wheelchair by the bedside table. Staff B stated that she had washed her hands prior to getting the resident. Staff B then donned gloves got a syringe out the resident's supplies, attached the syringe to the resident's g-tube and pulled back on the plunger of the syringe to check for residual. Staff B then removed the syringe, washed the syringe out, removed her gloves, left the room and used the alcohol-based hand sanitizer outside of the resident's room. Staff B did not wear a gown during the g-tube residual check. At 12:50 PM, Staff B, LPN, prepared a Calcium 600 mg tablet for administration. A pharmaceutical medication supplier approached Staff B and dropped off medications for another resident. Staff B took the new medication supply along with Resident #2's crushed Calcium, opened the medication room door near her cart with a key, and placed the supplies in the medication room. Without completing hand hygiene, Staff B exited the room, got on her computer, made a slurry mix with the calcium tablet, and then locked her medication cart. Staff B walked down the hallway to the resident's room and entered the resident's room. Without completing hand hygiene, or donning gloves and a gown Staff B poured water into a graduated cylinder, drew up the water with a syringe, got a wash cloth and put it on the resident's lap, connected the syringe to the g-tube port and flushed the g-tube with 30 cc of water. Staff B administered the calcium slurry via the g-tube. Staff B then washed the syringe and her hands in the bathroom sink, and put the syringe back in the residents' supplies. Staff B exited the room, and returned with the g tube feeding. Without performing hand hygiene, donning gloves or a gown, Staff B poured the Isosource in a graduated cylinder, removed the plunger from the syringe, connected the syringe to the g-tube port and slowly poured the Isosource into the syringe. Staff B (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	then flushed the g-tube with water through the syringe. Staff B removed the syringe, rinsed the syringe and cylinder in the resident's sink and washed her hands. At 1:14 PM, Staff B, LPN, left the resident's room and returned to her medication cart to prepare the resident's Ipratropium Bromide and Albuterol sulfate 0.5-2.5 mg/3 ml solution treatment. Without completing hand hygiene, donning gloves or a gown, Staff B entered the room moved the resident's nebulizer machine and set the machine up. Staff B got resident's mask, connected the tubing to the machine, put the medication in the reservoir below the mask, and put the mask on the resident without performing hand hygiene or donning gloves. Staff B set a timer on her phone, moved to the hallway outside of the resident's room, put her phone back in her pocket, and then sanitized her hands after handling her phone. At 1:24 PM, Staff B, LPN, after removing Resident #2's mask off the resident, turned off the nebulizer machine and returned it to the resident' night stand, took the mask into the bathroom and rinsed the mask and reservoir with soap and water, put the mask on a paper towel to dry, and then removed her gloves. Without performing hand hygiene, Staff B moved the resident's bedside table and pushed Resident #2 in her wheelchair to the activity room. During an interview on 1/28/26 at 4:02 PM, Staff B, LPN, reported she knew Resident #2 was on EBP and she knew that she had messed up by not wearing gloves or a gown while handling the resident's g-tube. She reported she was having an off day the previous day (1/27/26). During an interview on 1/29/26 at 11:11 AM, Staff J, LPN, reported staff needed to wear a gown and gloves for residents with EBP. Staff J reported staff should perform hand hygiene before starting cares, before gloving, between glove changes, and at the end of providing cares to a resident. During an interview on 1/29/26 at 11:43 AM, the Director of Nursing (DON), reported she had already provided education to Staff B on enteral feeding and PPE use. 3. During an observation on 01/28/2026 11:57 AM Staff K, Housekeeping/Laundry, pulled the open hanging laundry cart from the 3100 hall around the center hub down the hall 3300 hall. Staff K parked the cart in the hall and left the cart uncovered as she delivered clothes. During an observation on 01/29/2026 starting at 12:35 PM, Staff K, pushed the opened cart into the laundry from the station 2300 hall. At 12:43 PM, during an interview, Staff K reported she needed to cover the clean laundry cart when moving from one hall to the next. Staff K, stated she kept the cart uncovered as she delivered the clothes on the hall. Staff K reported the laundry delivery procedure is in her head. During an interview on 01/29/2026 at 1:11 PM The Infection Preventionist (IP) reported the laundry needed covered during transportation in the hall and while the cart sat in the hall. Review of the facility's policy, titled Hand Hygiene, dated 11/13/25, revealed, in part, .hand hygiene: a general term that applies to either handwashing or applying hand sanitizer. Handwashing includes washing hands with soap and water. Hand sanitizer involves using a waterless antiseptic agent .All employees in patient care areas (unless otherwise noted in their policy) will adhere to the 4 Moments of Hand Hygiene and 2 Zones of Hand Hygiene. 1. Entering room [ROOM NUMBER]. Before Clean Task 3. After Bodily Fluid/Glove Removal 4. Exiting room [ROOM NUMBER]. Zones: Patient zone and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Health-care zones. The facility provided a policy titled Standard, Enhanced Barrier Precautions (EBP) and Transmission-Based Precautions, All Service Lines- Enterprise dated 7/7/25 identified the purpose: To prevent the spread of infection and communicable diseases to residents/patients, employees, and visitors through infection prevention and control practices. Enhanced Barrier Precautions (EBP)(Rehab/Skilled Only) Enhanced barrier precautions expand the use of personal protective equipment beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of multidrug-resistant organisms (MDROs) to staff hands and clothing. Enhanced barrier precautions are used for residents who are infected or colonized with a CDC-targeted MDRO, or an epidemiologically important MDRO (per facility discretion), when contact precautions do not otherwise apply. See Multidrug- Resistant Organism policy. Enhanced barrier precautions are also used for residents with chronic wounds (i.e.,pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous statis ulcers) and residents with indwelling medical devices (i.e., central lines, hemodialysis catheters, indwelling urinary catheters, feeding tubes, and tracheostomies), even if the resident is not known to be infected or colonized with an MDRO. High-contact resident care activities include transfers, dressing, assisting during bathing, providing hygiene, changing briefs or assisting with toileting, working with resident in therapy gym (specifically when anticipating close physical contact while assisting with transfers and mobility), changing linens, indwelling medical device care or use (central line, urinary catheter, feeding tube, tracheostomy), and wound care. Enhanced barrier precautions are intended to be used for the duration of a resident's stay. For residents on enhanced barrier precautions for a wound or indwelling medical device only, precautions can be discontinued if the wound resolves or the device is removed. Procedure Post clear signage indicating the type of precautions and required PPE (i.e., gown and gloves). Signage should also clearly indicate the high-contact resident care activities that require the use of gown and gloves. Gowns and gloves should be readily available. Ensure access to alcohol-based hand rub. The facility provided a policy titled Laundry, Resource Packet dated 8/21/25 Transporting Clean Laundry/Laundry Passes. Package, transport and store clean clothes and linens to ensure their cleanliness and to reasonably protect them from dust and soil. Clean linen carts are to be covered at all times including during storage and distribution.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, facility policy review, resident and staff interviews, the facility failed to ensure dependent residents received assistance with personal care (showers and nail care) to maintain adequate personal hygiene for 3 of 3 residents (Resident #34, Resident #51, and Resident #84) reviewed for activities of daily living. The facility reported a census of 98 residents.Findings include:1. The Minimum Data Set (MDS) for Resident #34 dated 11/16/25 documented diagnoses of depression, diabetes mellitus, and rheumatoid arthritis. The Brief Interview for Mental Status (BIMS) score of 15/15 indicated intact cognition. The MDS indicated Resident #34 used a walker and a wheelchair for mobility, and required substantial/maximal assistance for bathing.The Care Plan for the resident with an admission date of 4/22/22 indicated the resident was a fall risk, had the potential for pressure ulcer development, and had a self-care performance deficit with limited range of motion and activity intolerance.Review of an electronic health record (EHR) report titled Documentation Survey Report v2 revealed Resident #34 scheduled to receive showers during the evening shift (2:15 PM to 10:15 PM) on January 3, 7, 10, 14, 17, 21, 24, 28, and 31. As of 1/27/26 at 1:20 PM the EHR indicated the resident did not receive showers on January 14, 17, 21, or 24. The facility was unable to provide additional documentation these showers occurred.During an observation on 1/26/26 at 2:27 PM, Resident #34's hair flat to her head on one side and clumped in raised [NAME] on the other side. Resident #34 stated she was supposed to get a shower Saturday and did not get it. She reported staff did not offer a bed bath or an alternate time for a shower and said she still hadn't had a shower or a bed bath 2 days later but wanted one. She stated she spoke to a staff about it that day but did not know if they were day or evening staff. 2. The MDS for Resident #51 dated 11/23/25 documented diagnoses of cerebrovascular accident (stroke), diabetes mellitus, and depression. The BIMS score of score of 99. A score of 99 is used to indicated a severe cognitive impairment. The MDS indicated Resident #51 used a wheelchair for mobility and required substantial/maximal assistance for bathing.The Care Plan for the resident with an admission date of 8/13/21 indicated the resident had impaired cognitive function, was incontinent, was a fall risk, and had a self-care performance deficit related to a fall with a subdural hematoma.Review of the EHR Documentation Survey Report v2 revealed Resident #51 scheduled to receive showers during the evening shift (2:15 PM to 10:15 PM) on January 2, 6, 9, 13, 16, 20, 23, 27, and 30. As of 1/28/26 at 2:21 PM the EHR indicated the resident did not receive showers on January 2, 6, 13, 20, or 27. The facility was unable to provide additional documentation these showers occurred.During an observation on 01/26/2026 at 2:00 PM, Resident #51 lay in his room in bed, with his right hand resting on the top of a blanket. The fingernails on the resident's hand noted to be about a quarter of an inch in length past the tip of his finger. The resident's fingertips were caked with a brown substance which also noted to be present under the fingernail. During a follow up observation on 1/28/26 at 2:36 PM Resident #51's fingernails noted to be long on his right and left hand with a brown and yellow substance under the nails on each hand. 3. The MDS for Resident #84 dated 11/13/25 documented diagnoses of cancer, non-Alzheimer's dementia, and cognitive communication deficit. The BIMS score of 99 indicated a severe cognitive impairment. The MDS indicated Resident #84 was not rejecting care, used a wheelchair for mobility, and required substantial/maximal assistance for bathing.The Care Plan for the resident with an admission date of 8/13/25 indicated the resident had impaired cognitive function, was non-complaint with cares, was a risk for pain and pressure sores, and had a self-care performance deficit related to a stroke with left sided hemiplegia (paralysis) and dementia.Review of the EHR report titled Bath/Shower revealed Resident #84 received a shower 1/10/26, a bed bath 1/17/26, and refused a shower on 1/3/26. As of 11:44 AM on 1/28/26 the facility was unable to provide additional documentation showers occurred, or were offered at alternate times/days due to non-compliance, to cover January 3, 7, 14, 21, or 24.During an observation (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	01/27/2026 at 10:06 AM, Resident #84 noted to have long and jagged nails with a brown, pasty substance present under the nail.During an observation on 01/28/2026 at 11:16 AM, Resident #84 fingernails remained long and jagged, different lengths, and with brown and yellow substances underneath. His right index fingernail also contained a brownish red oval that appeared to be a small scab. During an observation on 01/28/2026 at 11:45 AM, Staff E, Certified Nurse's Aide (CNA) served Resident #84 a food tray. The CNS did not offer to wash his hands before he ate the meal. During an interview at 11:47 AM, Staff E, CNA stated she did not offer to assist Resident #84 with washing his hands prior to eating his meal. Staff E stated she should have asked the resident. CNAs should help with washing hands before meals. She confirmed she did not do that when serving Resident #84.During an interview on 1/29/26 at 9:54 AM Staff E, CNA stated CNA's received a list at the start of their shift with residents who needed bathing. She explained showers were scheduled 2 times a week for residents and if a resident refused or was not available, they should be approached later. Staff E reported showers were supposed to be documented in the resident's electronic health record and on a paper document to sign off that the shower was completed.During an interview on 1/29/26 at 10:04 AM, the Director of Nursing (DON) stated a resident who did not get a bath or shower as scheduled could be reassigned to a different day or be assigned to Sunday to make sure they were bathed at least twice a week. She confirmed bathing should be documented in the EHR system and on paper. The DON stated the CNAs were responsible for this documentation but ultimately, she was responsible when it wasn't done. Review of the facility policy titled Bathing - R/S, LTC dated 12/22/25 indicated the policy was in place to promote cleanliness and hygiene, to stimulate circulation, promote comfort and wellbeing, observe a resident's condition, assist residents with personal care, and promote safety while bathing. It included tub/shower bathing, bed baths, and noted that bathing should be documented in the EHR system.

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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. Based on clinical record review, observation, review of facility policy, resident and staff interview, the facility failed to ensure a safe environment free from potential hazards for 3 of 7 sampled residents (Residents #6, #11 and #43). The facility reported a census of 98 residents.Findings include:1. Review Resident #43's Minimum Data Set (MDS) assessment, dated 12/19/25, revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated intact cognitive function. The MDS indicated Resident #43 utilized a walker and wheelchair for mobility, and required substantial/maximum staff assistance with activities of daily living related to toilet transfer and toilet/personal hygiene. The list of diagnoses included diabetes, hemiplegia (paralysis on one side of body), cerebral infarct (stroke), seizures and right shoulder pain. Review of Resident #43's Care Plan, last revised 11/26/25, revealed, in part, the resident an ADL self-care performance deficit related to left-sided hemiplegia and required 1:1 (assist of 1 staff) with the commode at shower wall or in the bathroom.During an interview on 1/26/26 at 12:59 PM, Resident #43 reported there had been a commode in the shower room on his hall (East 300 hall) with a faulty left leg. Resident #43 reported on a Saturday in December [2025], Staff G, Certified Nursing Assistant (CNA), assisted the resident to the commode in the shower room on his hall. The resident stated after he was safely seated the staff left and when he leaned to the left, the leg on the commode broke and he fell. The resident stated he landed on his left shoulder and hit his head. He stated he requested to go to the emergency room to be evaluated and returned later that night. The resident explained the leg on the commode had been faulty for about 2 weeks prior to the leg giving out on him, and he had informed staff of the faulty leg. Review of the facility's incident report, titled Resident Event, dated 12/6/25, revealed, in part, at 7:15 AM: Resident was being transferred to commode in shower room by staff. When resident sat on commode the leg buckled and resident fell to the floor. Call out to On-call doctor and received new order to send resident, per his request, to ED for eval and treat. Resident had no visible injuries. Complaints of pain to his right shoulder and left hip. Resident stated he had called his wife and updated her and requested this nurse not call his family and stated he would call them himself. Resident was given PRN pain med.Review of the progress note, titled Health Status, dated 12/6/25 at 11:55 AM, revealed Staff B, LPN documented the following: Res returned from the ED (emergency department) with no new orders. Scans done at ED were negative, no new injuries.During an interview on 1/28/26 at 8:05 AM, Staff D, CNA, reported being aware one of the legs being bent on the commode located in the 3300 hall (East 300 hall) shower room prior to Resident #43's fall. Staff D, CNA, reported the leg on the commode had been bent for some time before it was replaced but was unsure for how long. Staff D explained they had put commode in the maintenance book for repair. Staff D reported other residents had used the commode, as well. Staff D reported any of the residents on the East 300 hall would have used the commode when they were in the shower room. During an interview on 1/29/26 at 9:51 AM, the Maintenance Director reported they received information on items that needed repair through the written paper log maintained in each nursing station, through an electronic system, or through verbal requests made by staff. The Maintenance Director reported maintenance staff completed monthly checks on resident rooms and shower rooms to determine if repairs were needed. The Maintenance Director reported being unaware until yesterday (1/28/26) that there had been a problem with a commode chair in the East 300 hall shower room. During an interview on 1/29/26 at 11:03 AM, the Administrator reported staff replaced the commode the day of the accident happened. They had another commode available and did not have to order one.Review of the undated facility policy, titled Preventative Maintenance, revealed maintenance staff were to inspect and fix problems as they emerged, and repairs were to be fully documented.2. Review of Resident #6's MDS assessment, dated 12/3/25, revealed the resident had a BIMS score of 15 out of 15 which was indicative of intact cognitive function with minimal to no cognitive impairment. The MDS assessment (continued on next page)

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	165169	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan - Davenport	700 Waverly Road Davenport, IA 52804

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified the resident required substantial/maximum assistance for bed repositioning, was dependent on staff for transfers and independent in mobility with manual wheelchair use. The list of diagnoses included morbid obesity, right femur (upper leg bone) fracture, lymphedema (fluid buildup in the legs), muscle weakness and demyelinating disease of the central nervous system (disease that caused numbness, weakness and fatigue). Review Resident #6's Care Plan, last revised 12/10/25, revealed, in part, the resident used tobacco products. The Care Plan identified the resident used tobacco products independently and the resident was to smoke in the designated area: the courtyard.Review of the form, titled Tobacco Use Evaluation, dated 9/2/25, revealed the resident smoked/vaped 5 to 10 times per day, morning afternoon and evening. The form assessed the resident did not have any physical limitations that would interfere with her ability to get outside and get back in independently. The resident received education regarding smoking/vaping in designated area and acknowledged understanding. During an interview on 1/26/26 at 11:15 AM, Resident #6 reported being in bed all day for the last two weeks due to knee pain, swelling and cellulitis in the right leg. Resident #6 explained prior to the last two weeks, she had been out of bed all the time doing activities. During an interview on 1/27/26 at 10:00 AM, Resident #6 reported she both smoked cigarettes and vaped. Resident #6 explained when she vaped, she vaped in her room. She reported she had been just vaping the last couple weeks due to not being able to go out and smoke. Resident #6 reported she vaped in her room and staff were aware that she was vaping in her room.3. Review of Resident #11's MDS assessment, dated 12/24/25, revealed a BIMS score of 10 out of 15 which indicated a moderate cognitive impairment. The resident required substantial/maximum staff assistance for toileting, hygiene, transfers and upper body dressing. The resident was dependent on staff for lower body dressing. The resident was independent for mobility with manual wheelchair use. Diagnoses included stroke, dementia and schizophrenia (disorder that affects thinking, emotions and behaviors and characterized by delusions, hallucinations and cognitive difficulties). Review of Resident #11's Care Plan, last revised 12/30/25, revealed, in part, the resident had impaired cognitive function/dementia or impaired thought process, and poor recall. The Care Plan identified the resident had an ADL self-care performance deficit related to impaired mobility and cognition. The Care Plan identified the resident vaped inside in recliner, not in the designated smoking area and included interventions to educate and offer to take resident outside to the designated area; negotiate a time for vaping/smoking and return at the agreed upon time. Review of the form, titled Tobacco Use Evaluation, 12/22/25, revealed, in part, the resident currently used tobacco, there was no previous assessment, the resident smoked/vaped 5 to 10 times per day, morning, afternoon, evening, and night. The form assessed the resident did not have any physical limitations that would interfere with her ability to get outside and get back in independently. The form identified the resident was able to safely operate the e-cigarette device. The resident received education regarding smoking/vaping in designated area and acknowledged understanding. A review of the electronic health record revealed the following Progress Notes:a. A Communication with Resident/Family noted, dated 12/24/25, documented, in part social services staff spoke with the resident and her family regarding moving the resident. The resident's current roommate was complaining about the smoke from the vape.b. A Care Plan Review note, dated 12/24/25, documented, in part the resident would go outside to smoke every so often, but mainly stayed in her room vaping.During an interview on 1/26/26 at 11:05 AM, Resident #11 reported she could smoke any time she wanted and she could smoke by herself without staff. Resident #11 reported she was allowed to vape in her room. Resident #11 picked up her vape machine which had been sitting on her bedside table.During an interview on 1/28/26 at 7:46 AM, Staff B, LPN, reported she had not seen, but had heard that both Resident #6 and Resident #11 vaped in their room. Staff B reported if she caught them vaping in their room, she would redirect them to smoke outside. During an interview on 1/28/26 at 8:05 AM, Staff D, CNA reported she had witnessed both Resident #11 and Resident #6 vaping in their room. When asked if Staff D was supposed to do anything when resident seen vaping in their room, Staff D said no and that she had done nothing when she had witnessed the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents vaping. During an interview on 1/28/26 at 11:10 AM, the Director of Nursing (DON) explained that Resident #11 had a history of vaping, and needed to go outside if staff caught her smoking in her room. The DON reported the facility did not allow residents to smoke or vape in their room, because it was a fire safety hazard. The DON reported Resident #6 was not supposed to be vaping in the room either. If staff caught her, they were supposed to offer to take her outside or cue and remind her to take the vape outside to use. The DON reported both Resident #6 and Resident #11 were independent while smoking. During an interview on 1/29/26 at 9:35 AM, the Administrator reported residents who smoked/vaped had been educated today (1/29/26) on using vapes/cigarettes in the appropriate area. She had not done any staff education related to making sure staff redirected residents to smoke/vape outside, but planned to do education with staff. Review of the policy, titled Smoking and Tobacco Use, dated 12/15/25, revealed, in part, that smoking inside the building was not permitted .The electronic cigarette or e-cigarette is a battery-operated product that is intended as an alternative to cigarette smoking. This product may or may not deliver nicotine substances to the user in the form of a vapor. The vapor dissipates quickly; however regulators and health experts have not concluded this vapor is harmless when ingested or with skin contact. The facility will follow manufacturing guidelines for storage of the device and batteries. Although these devices are not considered smoking devices, they will not be permitted inside (facility-owned) buildings.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, clinical record review, facility policy review and staff interview, the facility failed to ensure nursing staff followed physician orders to flush a feeding tube before/after an enteral feeding and after the administration of medications for 1 of 2 residents (Resident #2) reviewed with feeding tubes. The facility reported a census of 98.Findings include: Review of Resident #2's Minimum Data Set (MDS) assessment, dated 12/19/25, revealed a Brief Interview for Mental Status (BIMS) score of 15 out 15 which indicated intact cognition. The list of diagnoses included cerebral vascular accident (stroke), diabetes, and hemiplegia. The MDS indicated Resident #2 received nutrition both through a gastric feeding tube (g-tube) and a mechanically altered diet. Review of Clinical Physician Orders in the electronic health record (EHR), revealed the following:a. An order, dated 6/18/25, for Isosource 1.5 Cal oral liquid, give 200 milliliters (ml) via g-tube four times per day for meals bolus feeding. Flush with 70 ml before and after each feeding. b. An order, dated 9/24/24, for Calcium 600 milligrams (mg) one tablet every day via g-tube. c. An order, dated 12/21/23, flush medication administration: Flush with 30 cc (cubic centimeters, 1 cc equal to 1 ml) patency of water before medications, may slurry and mix medications and give at at one mix, or utilize 5 cc water between medications administration with 30 cc after all medications given. During an observation on 1/27/26 at 12:50 PM, Staff B, Licensed Practical Nurse (LPN), crushed a Calcium 600 mg tablet and mixed in a medication cup with water making a slurry mix. Staff B took the medication to the bedside, and drew up 30 cc of water with a syringe from a graduated cylinder filled with water. Staff B flushed the G-tube with the 30 cc of water. Staff B then used a syringe to draw up the calcium slurry mix. Staff B inserted the syringe tip into the g-tube port and pushed the medication in. Without flushing the g tube after administering the slurry mix, Staff B washed the syringe and put the syringe back in the resident's supplies. Staff B left the room and then returned with Isosource 1.5 Cal oral liquid, 250 ml container. Staff B poured the Isosource into a graduated cylinder, removed the plunger from a syringe, connected the syringe to the g-tube feeding port, slowly poured 200 ml of the Isosource into the syringe, and then flushed with 70 cc of water after the feeding. Staff B did not flush the g-tube with 70 cc of water prior to the enteral feeding. During an interview on 1/29/26 at 11:11 AM, Staff J, LPN, reported that Resident #2 required the g-tube to be flushed with 30 cc of water flushed before and after medication administration and 70 cc of water before and after g-tube feeding. Staff J explained the importance of flushing with water before and after medication administration and enteral feeding was to keep the g-tube line from clogging. During an interview on 1/29/26 at 11:43 AM, the Director of Nursing (DON) reported the nurse managers reviewed orders for accuracy, completed clinical rounding on nursing staff and audits for quality assurance and compliance.Review of the facility policy, titled Medication: Tube Administration, dated 3/4/25, revealed, in part, . Water may be required for reconstitution of an enteral formula as well as to dilute medications, provide flushes and maintain hydration . Flush tube with 30 ml (cc) of water before and after administering each medication pass.