

| | | | |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165436 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/15/2024 |
| NAME OF PROVIDER OR SUPPLIER Ivy at Davenport | | STREET ADDRESS, CITY, STATE, ZIP CODE 800 East Rusholme Street 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 (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|--|---|
| <p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>26529</p> <p>Based on observation, clinical record review, and staff and physician interviews, the facility failed to follow physician orders directing treatment for pressure ulcers for 2 of 3 resident's reviewed for pressure ulcers (Resident's #1 and #2), and failed to follow standard infection control practices during wound care for 1 of 1 residents reviewed. (Resident #1.) The facility reported a census of 57 residents.</p> <p>Findings include</p> <p>1. The Minimum Data Set (MDS) Assessment, dated 7/6/24, revealed Resident #1 diagnoses included multiple sclerosis, diabetes and cerebrovascular accident (a stroke). The resident's Brief Interview for Mental Status (BIMS) score of score 15 out of 15 indicated intact cognition. The MDS indicated Resident #1 required extensive staff support to reposition in bed, transfer to and from bed and chair, and for dressing, toileting and bathing. The assessment revealed the presence of a Stage 3 (a full-thickness ulcer that extends through the skin and into deeper tissue and fat, but does not reach muscle, tendon, or bone) pressure ulcer present on admission to the facility.</p> <p>A wound care Physician Progress note, dated 8/5/24, revealed the resident had a Stage 4 (full-thickness tissue loss that exposes bone, tendon, or muscle) pressure ulcer on the sacrum (tailbone) that measured 4.5 centimeters (cm) long by 2.1 cm wide by 0.4 cm deep.</p> <p>Physician orders dated 7/8/24 directed staff to cleanse the sacral wound with wound cleanser, apply medi honey to wound bed and cover with ABD pad (type of absorbent pad used to manage drainage from a wound) secured with tape. Mix a 1:1 ratio of house antifungal powder and zinc cream for peri wound area daily and as needed (PRN).</p> <p>Review of the resident's August, 2024 Treatment Administration Record revealed Staff C, Registered Nurse (RN) documented she changed the resident's sacral dressing on 8/9/24.</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.

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

| | | | |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165436 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/15/2024 |
| NAME OF PROVIDER OR SUPPLIER Ivy at Davenport | | STREET ADDRESS, CITY, STATE, ZIP CODE 800 East Rusholme Street 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 (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an observation on 8/10/24, started at 10:11 a.m., Staff A, RN stood at the treatment cart positioned in the hall outside the resident's room, squirted zinc oxide paste into a 1 ounce sized medication cup, added an approximate equal amount of antifungal powder and mixed with a wooden spoon. Staff A applied gloves, and carried wound care supplies into the room as Staff B, Certified Nursing Assistant (CNA) cleared an over the bed table in the resident's room. Without sanitizing the surface of the table or applying a barrier, Staff A placed the wound supplies directly on the table. Staff A moved the over the bed table to the resident's bedside, removed the resident's covers, Staff A and Staff B rolled the resident to her left side, Staff A rolled the resident's incontinence brief up and pulled it out from under the resident. Staff A removed her gloves, went to the isolation cart outside of the room for more gloves, returned with 4 gloves and said staff would bring more to the room. Staff A applied gloves, removed an approximate 4 inch by 4 inch foam island type of dressing from the sacrum that was dated 8/9, with Staff C, RN's initials on it. The dressing was approximately 70 percent saturated with red serosanguinous drainage. Staff A, without a change of gloves or hand hygiene continued with care. Staff A sprayed non-sterile gauze squares with wound cleanser, and wiped the left buttocks area near the wound 3 times without changing the surface of the gauze, folded the gauze and wiped over the wound bed two times without changing the surface, sprayed wound cleanser on another non-sterile gauze and wiped the wound, folded the cloth and continued to wipe the left buttocks near the wound without changing the surface of the gauze. Staff A, without a change of gloves or hand hygiene, positioned a medi-honey strip inside the wound, opened the package of the ABD gauze, removed the gauze, unfolded it, applied to the sacral area, Staff B held the gauze in place as Staff A obtained pieces of tape to secure the dressing. Staff A changed gloves, used cleansing wipes, positioned behind the resident and wiped from front to back over the resident's right groin and vaginal area, used a new cleansing cloth and wiped over the resident's vaginal and rectal area, folded the cloth and wiped the left groin area two times without changing the surface of the cloth. Staff A, without a change of gloves or hand hygiene, applied the zinc paste and antifungal mixture to the resident's groin area and stated there was a doctor's order to apply it to her peri area. Staff A did not apply the mixture to the area around the wound as directed by the doctor.</p> <p>During an interview on 8/12/24 at 4:13 p.m., the resident's Wound Care Physician stated staff were directed to apply the zinc oxide with antifungal powder mixture to the skin immediately next to the wound, and that what was meant by the peri-wound description.</p> <p>2. The MDS Assessment tool dated 7/18/24 revealed Resident #2 had diagnoses that included paraplegia (paralysis of the lower half of the body), morbid obesity and encephalopathy. The residents BIMS score of 13 out of 15 indicated intact cognition. The MDS indicated the resident required extensive staff support to reposition in bed, transfer to and from bed and chair, dressing, toileting and bathing.</p> <p>A Wound Physician Progress note dated 8/5/24 revealed the resident had a Stage 4 pressure sore on the sacrum that measured 10.8 cm long by 15.6 cm wide by 1 cm deep, and had heavy sero-sanguinous drainage (yellow mixed with red colored).</p> <p>The Wound Physician transcribed orders on 8/5/24 Progress Note included:</p> <p>1. Apply calcium alginate once daily and as needed. ABD pad apply once daily and as needed. Tape (retention) apply once daily and as needed.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165436 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/15/2024 |
| NAME OF PROVIDER OR SUPPLIER Ivy at Davenport | | STREET ADDRESS, CITY, STATE, ZIP CODE 800 East Rusholme Street 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 (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>2. Antibiotic choice: linezolid (an antibiotic) 600 mg PO (per mouth) BID (twice daily) for 6 weeks.</p> <p>3. ID (Infectious Disease) consult.</p> <p>A review of the August 2024 MAR on 8/12/24 revealed the lack of a twice daily scheduled linezolid 600 mg, per the 8/5/24 physician order.</p> <p>A Wound Physician Progress note dated 8/12/24 revealed the resident's sacral wound measured 10 cm long by 15 cm wide by 1 cm deep, with heavy purulent drainage (pus mixed with blood), wound progress exacerbated due to infection, and the physician directed the resident's transfer to the hospital for antibiotics administered intravenously due to the wound infection.</p> <p>During an interview on 8/12/24 at 4:14 p.m., the Wound Physician stated staff had not contacted her with questions about the antibiotic ordered, and she was extremely concerned for the resident's condition if staff had not implemented the antibiotic order.</p> <p>During an interview 8/12/24 at 2:24 p.m., the Director of Nursing (DON) stated the Assistant Director of Nursing (ADON) rounds with the wound physician, and she would check with her about the antibiotic order.</p> <p>During an interview on 8/12/24 at 4:26 p.m. the DON stated the ADON did make the referral to the Infectious Disease doctor, but missed the antibiotic order, and the DON contacted the pharmacy and sent the order for the linezolid, it would be delivered that evening.</p> | | |