STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. Building B. Wing	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ivy at Davenport	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, payroll record review, facility policy review, resident and staff interviews the facility failed to prevent neglect which resulted in a fall, and verbal abuse which caused a resident to feel bad about them self for 1 of 7 (Resident #1) residents reviewed for abuse. The facility reported a census of 66 residents. Findings include:Review of the Minimum Data Set (MDS) assessment tool dated 4/2/25 revealed a list of diagnoses for Resident #1 which included hypertension (high blood pressure), depression, generalized weakness and difficulty walking. The Brief Interview for Mental Status (BIMS) score of 14 out of 15 points, indicated intact cognition. The assessment indicated Resident #1 always able to make herself understood, understood others and had no symptoms of delirium. The assessment revealed the resident required maximal staff assistance to reposition in bed, transfer to and from bed or chair, toileting, toileting hygiene, dressing the lower body and the resident unable to ambulate.Review of the Care Plan, initiated date of 4/3/25, revealed a Focus area to address The resident is at risk for falls. Interventions included:a. Keep call light within reach and encourage the resident to use it, if not cognitively impaired, for assistance as needed. Date initiated 4/3/25.b. Anticipate and meet the resident's needs. Date initiated 4/3/25. A Focus area, initiated date of 4/3/25 addressed Resident is at risk or has actual IMPAIRED ABILITY TO TRANSFER INDEPENDENTLY. The Intervention directed:a. TRANSFER: The resident is DEPENDENT for transfers and requires a Sara lift (a brand name for mechanical stand lift) with 2 helpers for transfers. Date, initiated 4/3/25. Review of the facility self-reported incident revealed on 6/6/25, the Administrator [former] was notified by the resident [name redacted, Resident #1] that employee [name redacted, Staff A, Certified Nursing Assistant (CNA)] is always angry with her, yells at her and says you're not doing things for yourself and makes her feel bad. Says it happened a couple of days ago on Wed evening [June 4, 2025].Employee [name redacted, Staff A, CNA] was immediately suspended pending the results of the investigation.Review of the facility investigation documentation revealed a hand-written note transcribed by the administrator [former] during the investigation. The statements on the note, written out in bullet like format, included: , in part:6/6/25[Name redacted, Resident #1]a. Consistent problem with ladyb. Always anger with mec. Yells at herd. Under impression that she can do [NAME]. Says your not doing things for yourself'f. Made her stand and walk to toilet *fell - then got mad that she fell. Day before yest. (yesterday) Wed. 6/4.g. Doesn't want her as a caregiver anymoreh. Makes me feel bad i. Directing anger at mej. Throw clothes at mek. Says I'm not going to wheel you downl. Used lift by self. Hit back of head on fallm. Everyone else has been wonderfuln. Feels it was a verbal and physical. Review of facility payroll records revealed Staff A worked on the 2 p.m. to 10 p.m. evening shift on 6/2/25, 6/3/25 and 6/5/25. Review of electronic resident care records, revealed an electronic signature by the CNA staff assigned to Resident #1 on 6/2/25 and 6/3/25. Staff A, CNA electronic signature present on the care records for 6/2/25 and 6/3/25.During an interview on 6/26/25 at 10:20 a.m., Resident #1 stated Staff A would berate her, say you have to get up to go to the bathroom. I can't lift you. Staff A had taken care of her on several days, thought Staff A was under the impression that she could walk, and was angry when she spoke to her, she threw her clothes at her. Resident #1 stated she reported her concerns to the Administrator and had not seen Staff A since then. During an interview on 7/9/26 at 7:54 a.m., Resident #1 stated she was transferred by 1 or 2 staff, sometimes they use a gait belt but they usually did not, they used to transfer her with a stand lift machine, but they had not used that for about a month. When asked if she had fallen when Staff A had taken care of her, the resident stated yes, Staff A transferred her by herself, out of bed and into the wheelchair, she never used a gait belt. Staff A told her she could walk and needed to walk to the toilet, and pushed her in the wheelchair up to the bathroom doorway. The wheelchair wouldn't fit through the door, Staff A told her she needed to walk to the toilet and threw the walker in front of her. The resident stated she hit her head when she stood up and fell to the floor. Staff A was angry with her because she fell, picked her up off the floor by herself, she put the belt under her and pulled her up with the Stand Lift machine. She did not get the nurse and the nurse did not assess her for injuries after the fall. This happened on the last evening that Staff A took care of her and the resident reported the fall to the Administrator when she talked to him about it.During an interview on 6/25/25 at 10:36 a.m., the interim Administrator stated staff are expected to treat residents with dignity and respect, and to report any concerns about resident mistreatment immediately to the Administrator or manager in charge.During an interview on 7/2/25 at 3:03 p.m. the former Administrator stated when he spoke to Resident #1, she reported Staff A was rude to her

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and staff interviews, the facility failed to ensure resident freedom from potential abuse by permitting an alleged preparator to return to work prior to the initiation and completion of an investigation by the State Agency for 1 of 2 allegation of resident abuse reviewed. The facility reported a census of 66 residents. Findings include:Review of the Minimum Data Set (MDS) assessment tool dated 5/9/25 revealed a list of diagnoses for Resident #2 which included schizophrenia, non-Alzheimer's dementia, and anxiety. The Brief Interview for Mental Status (BIMS) score of 8 out of 15 points indicated a severe cognitive impairment. The MDS revealed Resident #2 presented with history of delirium, which included disorganized thoughts and unable to focus attention. The MDS assessed Resident #2 required substantial staff assistance to transfer on and off the toilet and toilet hygiene. Review of a facility self-reported incident revealed, in part,.On 6/13/25, HR Manager [name redacted] reported to the administrator that Resident [name redacted, Resident #2] told her that the night shift C.N.A (Certified Nursing Assistant) [Name redacted, Staff D, CNA] did not help her get dressed or use the bathroom on the night shift last night. Resident [name redacted, Resident #2] describes the C.N.A who fits the description of employee [name redacted, C.N.A, Staff D, CNA]. Immediate Actions: - Family and physician were notified. - Night shift C.N.A [name redacted, Staff D, CNA] was immediately suspended.Review of a document titled Initial Federal Report revealed an Incident Information section, which in part documented A. Allegation, Abuse. B. Date and Time: 6/13/25. C. Name of Resident(s): [name redacted Resident #2]. D. Name(s) of Alleged Perpetrator(s): [name redacted, Staff D, CNA].Final Report Findings section, Investigation Summary:.After record review, staff interview and resident interview, the facility found the following: The employee [name redacted, Staff D, CNA] was suspended due to alleged abuse/neglect to resident [name redacted, Resident #2]. On the same day, 6/13/25 it was found that employee [name redacted, Staff D, CNA] was indeed NOT the individual who resident [name reacted, Resident #2] who accused of alleged abuse neglect.Upon discovery of this, C.N.A [name redacted, Staff D, CNA] was reinstated/brought back to work and resumed her shifts as normal. Review of the document titled Documentation Survey Report v2 for June 2025 and July 2025 revealed Staff D, CNA initiated having provided various care tasks to Resident #2 during third shift (10 p.m. to 6 a.m.) on 6/13/25, 6/16/25, 6/21/25, 6/26/25, 6/27/25, 7/8/25 and 7/10/25.The State Agency entered the facility on 6/25/25 to initiate the investigation regarding the allegation of abuse regarding Staff D, CNA made by Resident #2 on 6/13/25. During an interview on 7/1/25 at 10:59 a.m., Staff C, Corporate Nurse, stated they brought Staff D back to work because the resident's description of the perpetrator had changed, the resident knew Staff D and liked her.During an interview on 7/2/25 at 3:03 p.m., the former facility Administrator stated when he spoke to the resident she provided a physical description that matched Staff D, who had worked the night before. Later in the day the resident changed her description of the staff member, said she knew who Staff D was, liked her and she took good care of her. They didn't think they could go by the resident's description of the responsible staff member because she had changed it 3 times and they returned Staff D to work status that same day. Review of the facility policy titled Abuse, Neglect and Exploitation policy, last reviewed on 3/25/25, revealed a Policy statement which declared It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.VI. Protection of Resident section directed: The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to:A. Responding immediately to protect the alleged victim and integrity of the investigation;B. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; C. Increased supervision of the alleged victim and residents;D. Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator; E. Protection from retaliation; F. Providing emotional support and counseling to the resident during and after the investigation, as needed;G. Revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse.

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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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, clinical record review, facility policy review, resident and staff interviews, the the facility failed to ensure staff followed transfer precautions identified on the resident's care plan that resulted in a fall (Resident #1) for 1 of 3 residents reviewed for transfer techniques, and failed to ensure that nursing staff utilized gait belts during resident transfers as required. The facility reported a census of 66 residents. Findings include:Review of the Minimum Data Set (MDS) assessment tool dated 4/2/25 revealed a list of diagnoses for Resident #1 which included hypertension (high blood pressure), depression, generalized weakness and difficulty walking. The Brief Interview for Mental Status (BIMS) score of 14 out of 15 points, indicated intact cognition. The assessment indicated Resident #1 always able to make herself understood, understood others and had no symptoms of delirium. The assessment revealed the resident required maximal staff assistance to reposition in bed, transfer to and from bed or chair, toileting, toileting hygiene, dressing the lower body and the resident unable to ambulate.Review of the Care Plan, initiated date of 4/3/25, revealed a Focus area to address The resident is at risk for falls. Interventions included:a. Keep call light within reach and encourage the resident to use it, if not cognitively impaired, for assistance as needed. Date initiated 4/3/25.b. Anticipate and meet the resident's needs. Date initiated 4/3/25.A Focus area, initiated date of 4/3/25 addressed Resident is at risk or has actual IMPAIRED ABILITY TO TRANSFER INDEPENDENTLY. The Intervention directed:a. TRANSFER: The resident is DEPENDENT for transfers and requires a Sara lift (a brand name for mechanical stand lift) with 2 helpers for transfers. Date, initiated 4/3/25. During an interview on 7/9/26 at 7:54 a.m., Resident #1 stated she was transferred by 1 or 2 staff, sometimes they used a gait belt but they usually did not, they used to transfer her with a stand lift machine, but they had not used that for about a month. The resident described on 6/3/25 Staff A, CNA transferred her by herself, out of bed and into the wheelchair, she never used a gait belt. Staff A told her she could walk and needed to walk to the toilet, and pushed her in the wheelchair up to the bathroom doorway. The wheelchair wouldn't fit through the door, Staff A told her she needed to walk to the toilet and threw the walker in front of her. The resident stated she hit her head when she stood up and fell to the floor. Staff A picked her up off the floor by herself, she put the belt for the Stand Lift under her and pulled her up with the Stand Lift machine. She did not get the nurse and the nurse did not assess her for injuries after the fall. Review of the investigation for a facility reported incident revealed a hand-written note transcribed by the former administrator. The note documented Resident #1 reporting Staff A, Certified Nursing Assistant (CNA) was under the impression the resident could do more, said you are not doing things for yourself. Resident #1 reported Staff A made her stand and walk to toilet, *fell - then got mad that she fell.the resident reported Staff A used the lift by self. Hit back of head on fall.Review of Resident #2's electronic health record did not reveal the alleged fall, and the facility could not provide documentation related to the alleged fall. he resident's electronic health record did not reveal, and the facility could not provide documentation related to the resident's alleged fall. During an interview on 7/2/25 at 3:41 p.m. Staff A, CNA, stated the resident was supposed to be a 1:1 transfer, but she wouldn't try so she was a 2:1 transfer with a lot of support by staff. Staff A explained on the last evening that she worked with the resident she got her up by herself. She positioned the wheelchair right next to the bed, the resident was seated on the side of the bed. Staff A stated she did use a gait belt and as the resident put her feet on the floor she wouldn't pick her feet up to turn. Staff A stated she had to use all her strength to pull and turn the resident towards the wheelchair, she had a hold of the waistband of her pants because she didn't have a gait belt. She was able to get her into the wheelchair without incident. During an interview on 7/8/25 at 3:28 p.m., the DON stated she was not aware the resident had a fall at the facility and would look for documentation related to the fall; if a resident fell, the staff should notify the nurse, not move the resident until the resident was assessed for injuries, and document all issues related to the fall.During an interview on 7/10/25 at 1:27 p.m., Staff B, Physical Therapist, stated there were days when Resident #1 could take 5 to 10 steps with maximal support by therapy staff in the therapy room, but more often than not she couldn't lift her feet from the floor or ambulate with maximal therapy staff support. The resident had always been care planned as a Stand Lift transfer for nursing staff because she was not safe to transfer by a manual 1 to 1 or 2 to 1 staff pivot method. During a 2nd interview on 7/16/25 at 10:30 a.m., Staff A, CNA, stated the resident [Resident #2] used to be a 2:1 transfer with walker. The last day she worked with the resident, physical therapy staff told her she was a 1:1 transfer with walker. They had been transferring her with a Stand Lift to put her to bed to change her, but otherwise they never used the