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	12/16/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations, staff interview, and facility policy review, the facility failed to ensure residents had a safe, homelike environment. Observations of the facility revealed the floor heating vent covers bent, broken, or falling off showing the internal metal heating elements in resident rooms for 1 of 3 hallways and in 1 of 1 resident common area. The facility reported a census of 66 residents. Findings include: During an observation on 12/15/25 at 11:30 AM, room B4 had a baseboard heater that ran along the bottom length of one wall. The metal cover on the heater appeared bent away from the wall and exposed a large area of the internal heating element. The internal heating element contained metal plates that felt warm when touched. The resident's bed, in room B4, placed approximately 2 feet away and parallel to the baseboard heater. On 12/15/25 at 2:48 PM, the metal cover in room B4 appeared straightened and replaced. The baseboard heater no longer exposed the heating elements. During an observation on 12/16/25 at 9:26 AM, room B1 had a baseboard heater that ran along the bottom length of one wall. The resident's bed was positioned perpendicular, with the head of the bed along the wall in the location of the heater. The metal cover on the heater had 2 pieces, the piece behind the head of the bed fell off and exposed the heating elements, while the piece away from the bed remained in place. During an observation on 12/16/25 at 9:30 AM, room B3 had a baseboard heater that ran along the bottom length of one wall. The resident's bed was positioned perpendicular, with the head of the bed along the wall in the location of the heater. The metal cover on the heater had 2 pieces, the piece behind the head of the bed fell off and exposed the heating elements, while the piece away from the bed remained in place. The 2 pieces didn't meet together, leaving approximately 3-4 inches of exposed heating elements without a cover. During an observation on 12/16/25 at 9:35 AM, the residents' common area, used both as a main dining room and activities area, had a baseboard heater that ran along the bottom length of one wall. The room had a table positioned along the wall in the location of the heater. The metal cover on the heater appeared bent away from the wall and exposed a large area of the internal heating element. During an interview on 12/16/25 at 10:25 AM, the facility Maintenance Director reported they normally go through the facility once a week and if they had heater covers falling off or bent, they would be put back on or straighten the covers and replace. The Maintenance Director stated they noted the heater cover in room B4 bent on 12/15/25. They took it to the shop and straightened it before replacing. During an interview on 12/16/25 at 1:30 PM, the Director of Nursing (DON) reported the baseboard heater covers frequently get knocked off or bent when beds get moved or by wheelchairs. The DON stated she requested the maintenance staff to go through the facility weekly to check the heater covers. The DON notified the facility was looking at getting new heater covers because current covers have been beat up for so long. Review of the facility policy titled, Safe and Homelike Environment, revised 7/22/25, indicated in accordance with residents' rights, the facility would provide a safe, clean, comfortable and homelike environment. This includes ensuring the resident can receive care and services safely. The physical layout of the facility, both inside and outside, maximizes resident independence and does not pose a safety risk.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. (continued on next page)

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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 0606 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 staff interview, employee personnel record review, and facility policy review, the facility failed to ensure a background check was completed on staff, prior to working with dependent adults, for 1 of 5 staff personnel files reviewed. The facility reported a census of 66 residents. Findings include: Review of the facility provided document, titled New Hire Orientation Schedule, revealed Staff A, Certified Nursing Assistant (CNA), completed new hire orientation on 11/20/25 Review of the facility provided document, titled Background Screening Report, ordered 11/19/25, listed the results as pending for a national criminal and sex offender search. Review of the facility requested Single Contact License and Background Check for Staff A, dated 11/19/25, revealed that Staff A's criminal history required further research. Review of the facility provided document, titled Iowa Criminal History Record Check Request SING form S, dated 11/20/25, revealed Staff A had simple and serious misdemeanor convictions. Review of Staff A's employee personnel file lacked an approval notice for Staff A to work in the facility following identification of criminal history records. Staff A's background check records remained in a pending results status. During an interview on 12/16/25 at 11:30 AM, Staff E, Scheduler, started employment on 7/28/25. Staff E stated they must check the following before a new hire can work with residents: background check, identity verification, and onboarding process. Staff E identified the Administrator as the person responsible for ordering the background check. The Administrator would notify Staff E when the pending background checks cleared. Staff E stated that there must have been a miscommunication between herself and the Administrator when she believed a sticky note on the front of Staff A's file indicated that Staff A was good to go, so Staff E began scheduling Staff A to work shifts as a CNA. During an interview on 12/16/25 at 1:30 PM, the Director of Nursing (DON), reported Staff A, worked at the facility for approximately 2 weeks and worked independently on B hallway on 12/8/25 from 2:00 PM to 10:00 PM. The DON denied personally checking in with Staff A to see how she performed as a new hire. Review of the facility policy, titled Background Investigations, revised 8/27/25, directed job reference checks, drug screenings, license verifications, and criminal conviction record checks are conducted on all personnel providing an application for employment with the facility. The Section A. Policy Explanation and Compliance Guidelines, directed the following, in part: The Human Resource department will conduct all applicable background investigations on each individual making application for employment with this company and on any current employee if such background investigation is appropriate for the position for which the individual has applied.For all applicants applying for a position as a certified nurse aide, the Human Resources department will contact the nurse aide registry of the state in which the individual is certified and/or previously employed to verify that the applicant's certification is in good standing. Persons applying for employment and current employees will be informed of this policy. The company will not conduct a background investigation without an applicant's or employee's advance consent. Applicants or employees who do not consent to background investigation will, however, not be considered for positions that the company has determined to require the completion of a background investigation.If the background investigation(s) disclose any material misrepresentation or omissions by the applicant or employee on the application form or reveal information indicating that the individual may not be appropriate for hire, the company will investigate the matter further. Upon completion of such investigation, if the company determines that the applicant's or employee's background makes him/her unsuitable for the position he/she is seeking, the applicant will not be employed or, if already employed, will be terminated.The facility will not employ individuals who:Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law.Have had a finding entered into the state nurse aide [NAME] try concerning abuse, neglect, exploitation, mistreatment of residents, or misappropriation of resident property.Have a disciplinary action in effect against his or her professional license in a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of resident, or misappropriation or resident property.All inquiries regarding background investigations should be directed toward the Human Resource Director or Administrator.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation of Video evidence, staff interview, clinical record review, and facility policy review, the facility failed to provide adequate supervision and assistance to 1 of 3 residents (Resident #1) reviewed for nursing supervision. Resident #1 had cognitive impairment, known to wander, and had multiple attempted elopements. The video evidence showed on 12/8/25 at 9:25 PM, the facility staff (Certified Nursing Assistant, CNA), responsible for Resident #1's care, entered the front door code and let them outside the building and then exited behind them. The CNA re-entered the facility at 9:27 PM without Resident #1 and didn't report to other staff that Resident #1 went outside. The staff at the facility became aware of Resident #1 missing on 12/9/25 at 6:12 AM, by a facility staff member, driving to work. The staff member found Resident #1 approximately 1.7 miles from the facility (approximately a 38-minute walk) near a busy road with 2 lanes of traffic in each direction, wearing a jacket and light weight shoes, no gloves or hat, with the weather reported as below freezing with snow on the ground and wind chill values ranging between 8-17 degrees Fahrenheit. The staff described Resident #1's hands as freezing cold. Upon their return to the facility, an assessment of Resident #1 found them with a decrease in oxygen saturation and wheezing. After an assessment by Resident #1's provider, they ordered to send her to the Emergency Department for a potential pulmonary embolism (blood clot in the lung).The State Agency informed the facility of the Immediate Jeopardy (IJ) situation on 12/11/25 at 11:35 AM. The IJ began on 12/8/25, and on 12/11/25 at 3:21 PM the SA confirmed the immediacy removed on 12/09/25 by the facility staff by implementing the following actions: The facility initiated an investigation of the elopement on 12/9/25 and placed Resident #1 on one-on-one supervision with staff until they had all systems for elopement risks place. The facility updated Resident #1's Care Plan and notified the physician and responsible party of the incident. The facility completed a visual head count of every resident to ensure all were present and safe. The Director of Nursing (DON)/Designee assessed every resident on 12/9/25 for wandering and elopement risk, then updated 3 of 3 elopement books. The facility educated all staff on the elopement policy and procedures, the elopement book, elopement response plans, and not allowing resident/visitors out of the front door until verified by a nurse or manager on 12/9/25. The facility implemented resident rounding sheets for frequent monitoring and rounding sheets to be reviewed on a daily basis. The facility completed a Performance Improvement Project (PIP) and discussed the incident in a Quality Assurance and Performance Improvement (QAPI) meeting with the Medical Director on 12/9/25. The scope was lowered from J to G at the time of the survey. The facility reported a census of 66 residents. Findings include: Resident #1's Minimum Data Set (MDS) assessment, dated 10/8/25, identified a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment. Resident #1 had inattention, and disorganized thinking came and went, or fluctuated in severity. The MDS included diagnoses of non-Alzheimer's dementia, chronic obstructive pulmonary disease (COPD), asthma, and cognitive communication deficit. The MDS identified Resident #1 could transfer and ambulate more than 150 feet independently without the use of an assistive device. The Care Plan Focus, initiated 7/3/25, indicated Resident #1 had a high risk for an elopement due to wandering. The goal reflected Resident #1 would not leave the facility unattended. The Interventions dated 7/3/25 instructed the following: Assess Resident #1 for fall risk. Identify the pattern of wandering: Is wandering purposeful, aimless, or escapist? Is the resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate. Monitor for fatigue and weight loss. The Care Plan Focus, initiated 7/2/25, listed Resident #1 had a risk for falls related to wandering behavior. An intervention, initiated 10/20/25, instructed staff to be aware of their location and for signs of fatigue, increasing fall risk. Resident #1's Progress Notes from 7/2/25 and 12/8/25, reflected their attempted elopements. The entries included, in part: On 7/2/25 at 6:00 PM, as a visitor came in the front door, Resident #1 headed for the front door with her coat on and witnessed walking out the door. Resident #1 would not stop walking and stated she was going to a man's house. The note documented that redirection was ineffective, the nurse notified administration, the police, and emergency services. Resident #1 agreed to go back into the facility and staff members walked with her back to the facility. On 7/7/25 at 4:22 PM, Resident #1 attempted to leave the facility by trying to open exit doors. The note informed staff needed to de-escalate and redirect the resident. On 7/17/25 at 6:01 PM, a nurse witnessed Resident #1 push open the front door and walk out. The nurse remained with Resident #1 and attempted to redirect her. Resident #1 stated she didn't live at the facility and would not tell the nurse where she was going. The nurse noted