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	03/25/2026

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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on clinical record review, facility policy review, resident representative and staff interviews, the facility failed to ensure a resident had a private area to make telephone calls for 1 of 1 residents (Resident #57) reviewed. The facility reported a census of 59 residents. Findings include:The Minimum Data Set (MDS) assessment tool, dated 10/8/25, listed diagnoses for Resident #67 which included heart failure, depression, and anxiety. The MDS listed a Brief Interview for Mental Status (BIMS) score as 4 out of 15, indicating a severe cognitive impairment. On 3/16/26 at 10:35 a.m., via phone, the Resident's Representative (RR) stated she sent the resident a cell phone but it went missing after approximately a week. The RR stated the facility did not have a portable phone for residents to use so the cell phone was the only option. On 3/23/26 at 12:38 p.m., Staff F, Licensed Practical Nurse (LPN) stated residents could use the phone in the dining room or at the nursing station but it was not private. On 3/23/26 at 12:51 p.m., Staff A, LPN stated that there was a phone at the nursing station for residents to use but it was not private. She stated the facility's cordless phone was not connected. On 3/23/26 at 9:22 a.m., Staff V, Receptionist stated Resident #67 had a phone delivered that she used to speak with her daughter. Staff V stated she was not aware that the phone was missing. She stated if residents did not have a phone, they would bring them up to the nursing station to utilize the phone. She stated the facility did not have a cordless phone. On 3/25/26 at 8:29 a.m., the Administrator stated the facility had plans to get a new phone line in the conference room and residents would be able to come in and shut the door when they made calls. The facility policy Resident Right to Privacy in Communication, revised 3/7/25, stated the facility would provide residents with reasonable access to the use of a telephone in an area where calls were not overheard.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review and staff interviews, the facility failed to complete an updated assessment, notify the physician, and provide and document sufficient preparation and orientation to ensure a safe and orderly discharge for 1 of 3 residents (Resident #40) reviewed for transfer and discharge. The facility reported a census of 59 residents.Findings include:Review of the Minimum Data Set (MDS), dated [DATE], for Resident #40 revealed a list of diagnoses which included diabetes mellitus, heart disease, kidney insufficiency, malnutrition, anxiety disorder, depression, osteomyelitis, difficulty walking and the use of a manual wheelchair. The MDS indicated the resident used of opioid pain medication, antiplatelet medication, insulin and anticonvulsant medication. The Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicated intact cognition. The Behavior section of the MDS indicated no physical (hitting, kicking, pushing, etc.) behavioral symptoms directed toward others, no verbal (threatening others, screaming at others, cursing at others) behavioral symptoms directed toward others, and no other behavioral symptoms (hitting or scratching self, pacing, public sexual acts, disruptive sounds) not directed towards others. Review of a letter on facility letterhead, dated 2/17/26, addressed to Resident #40, revealed, in part: This notice is to serve as an immediate involuntary discharge pursuant to 42 C.F.R. 483.15(c)(1)(C) Iowa Administrative Code 481-58. A facility may involuntarily transfer or discharge a resident when: The safety of individuals in the facility is endangered .The effective date of this notice is February 17th, 2026. The expected date of transfer is March 17th, 2026. You will be discharged to: [name and address of homeless shelter redacted]. The discharge notice is unsigned. Review of a letter on facility letterhead, dated 3/13/26, addressed to Resident #40, revealed, in part: This notice is to serve as an immediate involuntary discharge pursuant to 42 C.F.R. 483.15(c)(1)(C) Iowa Administrative Code 481-58.The effective date of this notice is March 13, 2026. The expected date of transfer is March 13, 2026. You will be discharged to: [name and address of homeless shelter redacted (same shelter identified on the 2/17/26 discharge notice]. The discharge notice is unsigned. Review of the Resident 40's Care Plan, dated 10/29/25 revealed Focus areas to address:a. The resident has a diagnosis of depression and anxiety disorder. Interventions included, in part:1. Monitor/document/report PRN any risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness.2. Monitor/document/report PRN any s/sx (sign and symptoms) of depression, including: hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing, negative statements, repetitive anxious or health-related complaints, tearfulness.Review of the electronic health record (EHR) revealed a Transfer/Discharge Report dated 3/15/26. Chief Complaint (reason for transfer): Behavioral Symptoms (e.g. agitation, psychosis). Miscellaneous Information: Date of Transfer/discharge: [DATE] Time: 15:13 (3:13 PM). Transfer/discharged to: Hospital: [name redacted].Review of the EHR revealed a Progress Note, dated 3/13/26 entered at 2:25 PM which documented Approximately 7:20 AM a staff nurse [Staff A, Licensed Practical Nurse (LPN)] was attempting to give resident (Resident #40) his medications and ask if he wanted needed a pain pill. Resident became verbally aggressive yelling cursing and threatening the nurse and blocked her between him and the meal tray cart and med caret. Resident did eventually reverse in w/c (wheelchair) and nurse went to another room, and the nurse notified would nurse who notified Administrator who called the police to report resident behavior. Police came to the facility and talked with the resident and recommended that resident discharge from facility Gave resident time to pack his belongings. Approximately 1030 AM this nurse and social worker went down to resident room and gave discharge paperwork. Resident continues to yell at staff stating he was on (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the phone and didn't want to be bothered. Left paperwork with him. Gave resident time to get his belongings packed but refused to leave. Police were called again approximately 2pm. Social Worker and police went down to resident room. Resident being verbally aggressive to social worker and the police. Police escorted resident in hand cuffs and left facility via police car accompanied by police. During an interview on 3/16/2026 at 10:09 AM, the Ombudsman stated Resident #40 left phone messages for her stating the facility was kicking him out because he pushed a pregnant staff member, he denied the action, and reported the police was notified. The Ombudsman stated the facility had not reported the incident, police action or a discharge to the State Ombudsman office. The Ombudsman stated the facility reported an incident during the summer 2025 when Resident #40 illegally hit another resident.During an interview on 3/16/2026 at 2:05 PM, Staff F, LPN stated on 3/13/26 Staff A, LPN reported Resident #40's behavior and called the Administrator who immediately responded. Staff F stated she told Staff A that she would give the resident his medication. Staff F stated the Administrator called the police since Resident #40 did not stop cussing and told them he wanted him to leave. Staff F stated that this was not a normal discharge and she did not call the physician. Staff F stated Resident #40 had refused care from a psychologist on the telehealth. Staff F stated the Administrator offered Resident #40 a ride to the homeless center but he was not going to leave and the facility could not force him to leave. Staff F stated the police returned and arrested Resident #40. Staff F stated the facility conducted interdisciplinary meetings daily and had discussed Resident #40's noncompliance and the need to find somewhere else to transfer him.During an interview on 3/16/2026 at 2:34 PM, Staff B, Social Service Director stated she started her position in the fall of 2025, and had been working with Resident #40 to transfer out of the facility. Staff B stated Resident #40 had multiple denials for placement. She stated Resident #40 received an involuntary discharge notice in February 2026 and was attempting to locate safe housing for him. Staff B stated Resident #40 was in a shelter before his admission to the facility and obtained an infection in his foot that required a surgical removal of his leg. Staff B stated Resident #40 did not meet the level of care for another nursing home and several apartment complexes refused him based on a lack of adequate income. Staff B stated Resident #40 was rude to the Administrator on multiple occasions. Staff B stated when she arrived to work on 3/13/26 at 8:34 AM, police were talking to Resident #40. Staff B stated she had been instructed to give Resident #40 discharge papers to the homeless shelter. Staff B explained she attempted to give Resident #40 the discharge papers, which included the appeal paperwork but Resident #40 stated he did not want to be discharged and refused to sign the paperwork. Staff B stated the Administrator had called the police as Resident #40 was getting verbally aggressive. Staff B stated the aggressive behavior was why he needed to be discharged . Staff B stated the physician was not notified and she did not notify the State Ombudsman office. During an interview on 3/16/26 at 3:22 PM, the Administrator stated on 3/13/26 Staff A, LPN notified her Resident #40 blocked her and she was upset, trying to get around him. The Administrator stated Resident #40 displayed aggressive behavior 2 weeks prior, calling her a racist bitch, and she had to ask him to leave her office. The Administrator stated she responded and Resident #40 would not explain what happened. The Administrator stated Resident #40 was homeless prior to admit, the hospital had surgically removed his leg and she had tried to do everything to help him. The Administrator stated Resident #40 tried to shut the door in her face. The Administrator stated she notified the police and Resident #40 went outside to visit with them, then police came inside and stated he wanted to go to the homeless shelter and they would be back to give him a ride. The Administrator stated Staff B, Social Service Director attempted discharge paper work and he refused, cussed and screamed. The Administrator stated Resident #40 continued to be verbally aggressive so she notified the police were responded and removed him in hand cuffs. The Administrator stated she discharged Resident #40 due to potential for violence and the aggressive behaviors toward staff and residents. The Administrator stated she was made aware another resident's family member picked up Resident #40 after the police released him and took him to the hospital and then the hospital released (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	him. The Administrator stated she was not certain of the whereabouts of Resident #40. A document titled [NAME] County Iowa Sheriff's Office Inmate Listing Resident #40 revealed:a. [NAME] police department booking date 3/13/26 at 2:20 pm.b. Description Trespass Case # [number redacted]c. Release date 3/14/26 at 9:34 am court ordered, self-custody duration 19 hours, 14 minutes.Multiple attempts made to contact Resident #40 on 3/16/26 via cell phone, messages left without a return call.During an interview on 3/16/2026 at 4:47 PM, the Administrator stated she gave the involuntary 30-day Discharge Notice with the right to appeal in February 2026. The Administrator stated Resident #40 refused to sign the discharge and this is the reason she did not notify the State Agency or the Ombudsman. The Administrator explained on 3/13/26 it was an emergent discharge. She stated she did not notify the State Agency or Ombudsman office and she did not know why. The Administrator stated her expectation was that nursing would notify the physician. The Administrator stated she was unsure what a recapitulation of stay entailed but stated there was an incident summary in the computer.Review of the facility policy titled Transfer and Discharge, dated 7/17/23 revealed:a. It is the policy of this facility to permit each resident to remain in the facility and not transfer or discharge the resident from the facility, except in limited circumstances.b. Generally, the notice must be provided at least 30 days prior to a transfer or discharge of the resident. Exceptions to the 30-day requirement apply when the transfer or discharge is affected because:a. The health and/or safety of individuals in the facility would be endangered due to the clinical or behavioral status of the resident;b. The resident's health improves sufficiently to allow a more immediate transfer or discharge;c. An immediate transfer or discharge is required by the resident's urgent medical needs; ord. A resident has not resided in the facility for 30 days.e. In these exceptional cases, the notice must be provided to the resident, resident's representative if appropriate, and LTC ombudsman as soon as practicable before the transfer or discharge.f. The facility will maintain evidence that the notice was sent to the Ombudsman.g. In situations where the facility determines a resident's clinical or behavioral status endangers the safety or health of individuals in the facility, documentation regarding reason for the transfer or discharge will be provided by a physician, but not necessarily the resident's attending physician.h. Discharge to the Community: Facility will obtain a physician's order for transfer or discharge and instructions or precautions for ongoing care. A member of the interdisciplinary team will complete relevant sections of the Discharge Summary. The nurse caring for the resident at the time of discharge is responsible for ensuring the Discharge Summary is complete and includes, but not limited to, the following:i. A recap of the resident's stay that includes diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology and consultation results.ii. A final summary of the resident's status.iii. Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over the counter).iv. A post discharge plan of care that is developed with the participation of the resident, and the resident's representative(s) which will assist the resident to adjust to his or her new living environment.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, interviews, and policy review the facility failed to notify a resident and/or the resident's representative of the facility policy for bed hold, including reserve bed payment for 1 of 2 residents reviewed for hospitalizations (Resident #3). The facility also failed to provide a recapitulation of stay, to provide an appropriate plan of care for discharge to the community and failed to notify the long term care (LTC) Ombudsman before the discharge for 1 of 3 residents reviewed for transfer and discharge (Resident #40). The facility reported a census of 59 residents. Findings include:1. The Brief Interview for Mental Status (BIMS) assessment dated [DATE] documented Resident #3 scored 14/15, which indicated intact cognition. Review of the electronic health record (EHR) revealed Resident #3 had the following hospitalizations: a. admitted to the hospital on [DATE], returned to the facility on [DATE]. b. admitted to the hospital on [DATE], returned to the facility on [DATE]. The EHR lacked documentation of a bed hold issued to Resident #3 for either hospitalization. During an interview on 3/15/26 at 3:47 PM, Resident #3 stated he did not remember anyone talking to him about the bed hold policy at admission or when he went to the hospital. On 03/18/2026 at 12:23 PM, the Administrator asked to provide documentation of a bed hold for Resident #3 hospitalizations. At 12:41 PM, the Administrator sent an email to the State Agency which stated there were no bed holds issued to the resident. Review of the facility policy, titled Transfer and Discharge (including AMA) reviewed/revised 07/14/2025 documented in section 10.g. the facility would provide a notice of transfer and the facility's bed hold notice policy to the resident and representative as part of emergency transfers to acute care. 2. Review of the Minimum Data Set (MDS) dated [DATE] for Resident #40 revealed a list of diagnoses which included diabetes mellitus, heart disease, kidney insufficiency, malnutrition, anxiety disorder, depression, osteomyelitis, difficulty walking and the use of a manual wheelchair. The MDS indicated the use of opioid pain medication, antiplatelet, insulin and anticonvulsant. The BIMS score of 15 out of 15 indicated intact cognition. During an interview on 3/16/2026 at 10:09 AM, the Ombudsman stated Resident #40 left phone messages for her stating the facility was kicking him out because he pushed a pregnant staff member, he denied the action, and reported the police was notified. The Ombudsman stated the facility had not reported the incident, police action or a discharge. During an interview on 3/16/2026 at 2:34 pm, Staff B, Social Service Director stated she was hired in the fall of 2025 and began to find a facility in the community for Resident #40 to transfer and he was denied multiple times. Staff B stated Resident #40 had received discharge papers in February 2026 and she was attempting to locate safe housing for him. Staff B stated when she arrived to work on 3/13/26 at 8:34 am, police were talking to Resident #40. Staff B stated she was instructed to give (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #40 discharge papers to the homeless shelter and attempted to give him the discharge papers to include the appeal paperwork but Resident #40 stated he did not want to be discharged and refused to sign the paperwork. Staff B stated the aggressive behavior was why he needed to be discharged and the physician was not notified. Staff B stated she did not notify the LTC Ombudsman. Review of a letter on facility letterhead, dated 2/17/26, addressed to Resident #40, revealed, in part: This notice is to serve as an immediate involuntary discharge pursuant to 42 C.F.R. 483.15(c)(1)(C) Iowa Administrative Code 481-58. A facility may involuntarily transfer or discharge a resident when: The safety of individuals in the facility is endangered .The effective date of this notice is February 17th, 2026. The expected date of transfer is March 17th, 2026. You will be discharged to: [name and address of homeless shelter redacted] . Right to appeal information. The discharge notice is unsigned. Notice sent to physician and Ombudsman. Review of a letter on facility letterhead, dated 3/13/26, addressed to Resident #40, revealed, in part: This notice is to serve as an immediate involuntary discharge pursuant to 42 C.F.R. 483.15(c)(1)(C) Iowa Administrative Code 481-58.The effective date of this notice is March 13, 2026. The expected date of transfer is March 13, 2026. You will be discharged to: [name and address of homeless shelter redacted (same shelter identified on the 2/17/26 discharge notice] . Right to appeal information. The discharge notice is unsigned. Notice sent to physician and Ombudsman. During an interview on 3/16/26 at 3:22 pm, the Administrator stated on 3/13/26 she discharged Resident #40 due to potential for violence and the aggressive behaviors toward staff and residents .In a later interview at 4:47 pm, the Administrator stated she gave the involuntary 30 days right to appeal in February 2026 and Resident #40 refused to sign it and that is why she didn't notify the Department of Inspection, Appeals and Licensing (DIAL) and the LTC Ombudsman, then on 3/13/26, it was an emergent discharge and she did not notify and did not know why. The Administrator stated her expectation was that nursing would notify the physician. The Administrator stated she was unsure what a recapitulation of stay entailed but stated there was an incident summary in the computer. Review of a policy titled Transfer and discharge date d 7/17/23 revealed, in part: a. It is the policy of this facility to permit each resident to remain in the facility and not transfer or discharge the resident from the facility, except in limited circumstances. c. The health and/or safety of individuals in the facility would be endangered due to the clinical or behavioral status of the resident; g. In these exceptional cases, the notice must be provided to the resident, resident's representative if appropriate, and LTC ombudsman as soon as practicable before the transfer or discharge. h. The facility will maintain evidence that the notice was sent to the Ombudsman. i. In situations where the facility determines a resident's clinical or behavioral status endangers the safety or health of individuals in the facility, documentation regarding reason for the transfer or discharge will be provided by a physician, but not necessarily the resident's attending physician. j. Discharge to the Community: Facility will obtain a physician's order for transfer or discharge and instructions or precautions for ongoing care. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A member of the interdisciplinary team will complete relevant sections of the Discharge Summary. The nurse caring for the resident at the time of discharge is responsible for ensuring the Discharge Summary is complete and includes, but not limited to, the following: i. A recap of the resident's stay that includes diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology and consultation results. ii. A final summary of the resident's status. iii. Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over the counter). iv. A post discharge plan of care that is developed with the participation of the resident, and the resident's representative(s) which will assist the resident to adjust to his or her new living environment.

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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	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, facility policy review, lift manufacturer safety instructions, local fire department personnel interviews, and resident and staff interviews, the facility failed to provide staff education on how to select the right size body sling for residents dependent on the use of a mechanical lift, failed to identify a hospital slide sheet as unsafe for use with a mechanical lift, and failed to have correct mechanical lift sling sizes available to meet the needs of a bariatric resident for 2 of 12 residents (Resident #8 and Resident #39) reviewed for mechanical lift transfer. Nursing staff failed to safely transfer Resident #8 when they placed a hospital slide sheet with handles under the resident, attached the handles to the mechanical lift, and engaged the lift. The handles tore from the slide sheet and the resident had to be emergently lowered to a recliner. Resident #8 repeatedly voiced fear of falling. Nursing staff were unable to transfer the resident out of the recliner and called the local fire department for assistance. The fire department personnel attempted to manually transfer Resident #8 with the slide sheet, which again tore. A second unit from the local fire department was called to assist. The State Agency (SA) informed the facility of the Immediate Jeopardy (IJ) on 3/20/26 at 10:12 AM. The IJ began on 2/26/26, when staff used a hospital slide sheet as a mechanical lift body sling, engaged the lift and the sheet tore from the lift hooks. On 3/23/26, the SA confirmed the immediacy removed effective 3/21/26, through the following actions: 1. The Director of Nursing (DON) and designee(s) trained all nurses and nurse aides on the use of mechanical lift and sit to stand lift. All staff will be trained prior to their next shift.2. The DON and designee(s) reviewed the care plan for each resident who require the use of a mechanical lift or sit to stand lift to ensure resident specific interventions were present. Proper sling size and fit for each resident was added as an intervention, pulling to Kardex (care guide) and care profile.3. The DON and designee(s) re-assessed residents requiring mechanical lifts for transfers via the Mechanical Lift and Sling Size Risk Evaluation.4. The DON and designee(s) trained nursing staff on the location of the sling size and type of mechanical lift or sit to stand lift to utilize for residents requiring lifts for transfers via the Kardex in the POC portion of PCC. This training includes reviewing of Kardex prior to transferring residents as assessments can change based on resident condition changes.5. All facility specific policies and procedures regarding mechanical lifts were reviewed/revised to ensure compliance with manufacturer's recommendations and guidelines. Nursing staff were re-educated on 3/20/26, remaining nursing staff will be educated prior to their next shift.6. The Administrator purchased two slings on 3/5/2026 that will accommodate weight up to 1000 pounds.The scope lowered from J to D at the time of the survey after ensuring the facility implemented staff education and procedures.The facility reported a census of 59 residents. Findings include:1. Review of the Minimum Data Set (MDS) for Resident #8, dated 2/17/26 revealed diagnoses which included morbid obesity, anxiety, depression, and acute and chronic respiratory failure with hypoxia (low oxygen levels in body). The MDS identified Resident #8 did not attempt sitting to lying, lying to sitting on the side of bed, sit to stand, or chair/bed-to-chair transfer due to medical concerns or safety concerns. The Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicated intact cognition. The MDS listed a height of 69 inches, and weight of 535 pounds. Review of Resident 8's Care Plan revealed Focus areas to address: a. Resident is at risk or has actual IMPAIRED ABILITY TO TRANFER INDEPENDENTLY. Date Initiated: 7/31/25. Goal: Resident will FREE FROM COMPLICATIONS related to impaired transfer ability through next review date. Target Date: 4/30/26. Interventions included TRANSFER: The resident is dependent for transfers and requires MECHANICAL LIFT total body lift with 2 HELPERS for transfers. Date Initiated: 7/31/25.b. Resident has a HISTORY OF POTENTIALLY TRAUMATIC EVENTS and is at risk for re-traumatization and/or experiencing a traumatic stress response. Initiated: 8/26/25. Goal: Resident will feel safe and comfortable in direct care situations. Target Date: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4/30/26. Interventions included, in part: Help Resident IDENTIFY TRIGGERS that prompt anxiety or symptoms and evaluate the outcome of these reactions. Date Initiated: 8/26/25. During an interview on 3/15/26 at 11:45 AM, Resident #8 stated it could take 2-3 hours in the evenings before her call light got answered. Resident #8 explained the staff told her they needed to get someone to help and would be back, and then after an hour she would have to activate her call light again. When the staff returned, she would be told the same thing. Resident #8 stated she had called her niece, who then called the facility. Staff would tell her they were about to respond and the nurse was aware. The interview interrupted due to resident care needs. Resident #8 asked for the SA to return to finish the interview. However, later on 3/15/26, the Resident hospitalized and did not return prior to the exit. A review of the electronic health record (EHR) revealed the following:a. A Mechanical Lift & Sling Size Risk Evaluation, dated 2/18/26 revealed: LIFT EVAL: What can the resident do to assist with transfer: Dependent. Sling Size: Most Recent height: 69.0 inches as of 7/25/25. Most Recent Weight: 534.5 Lbs (pounds) as of 2/3/26. Scale: Bariatric Lift. What weight range does the resident fall in: 350-600 lbs Extra Extra (XXL). Which sling size should be used: Extra Extra (XXL)b. A Progress Note, dated 2/26/26 at 11:01PM, entered by Staff Q, Licensed Practical Nurse (LPN) documented Resident #8 complained of indigestion/heartburn and requested to be assisted into her recliner. CNAs hoyered (transferred via mechanical lift) resident to recliner and during the process the hoyer sling straps started to snap resident was lowered into the chair safely, after an hour resident wanted to get back into bed. This nurse had to call the fire department to help assist resident safely back to bed. It took 8 firemen to transfer resident back to bed. c. A General Note entered on 2/27/26 at 9:00 AM revealed Resident #8 reported her right 5th toenail was snagged last night when she was placed in bed. The nurse evaluated and clipped the toenail that was sharp then bacitracin and bandage was applied.d. A General Note entered on 2/27/26 at 9:05 AM, entered by Staff F, LPN Wound Nurse documented Late documentation - Floor nurse and CNA reported to this nurse that during attempt to transfer resident from her recliner to bed, residents sling began to rip. Resident was immediately lowered back into her chair. EMT's (emergency medical team) called to help assist staff to get resident into bed. 3 EMT's arrived and assessed situation. In front of resident EMT's claimed that there was insufficient equipment in the facility to transfer the resident. Of note, Hoyer (full body mechanical lift) sling broke immediately before they were called and prior to this her hoyer sling has been sufficient. These EMT's called fire department in order to get resident into her bed. 6 EMT's voiced to this nurse that they were going to move resident bed in front of her recliner and transfer into her bed manually. EMT's reported that this was successful. As floor nurse in charge of resident was unable to document in progress note, this nurse is documenting today. Will continue to monitor. e. A Nutrition/Dietary Note, dated 3/16/26: RD (Registered Dietician) SIG (significant CHANGE ASSESSMENT: CBW (Current body weight): 574.5 # (pounds)Review of a Grievance/Concern Report, dated 3/2/26, revealed, in part: Resident: [Name redacted, Resident #8] .Description of grievance/concern: (Removing red and yellow? Agree with this) .States Hoyer (a brand name of a type of mechanical lift, often used to describe all brands of mechanical lifts) lift was recently used and it tore so the medics (Fire Department) came to assist.Describe actions taken to resolve the grievance/complaint: Education on Hoyer operation/new sling ordered.Was grievance/complaint resolved: Yes, [name redacted, Resident #8] was happy - new slings arrived. During an interview on 3/17/2026 at 4:25 PM, Staff N, Certified Nursing Assistant (CNA) queried about the mechanical lift sling used to transfer Resident #8. Staff N opened up a closet in the B hallway which contained three shelves of lift slings. Staff N pulled out slings until she located a sling with a blue ribbon and identified it as the sling used for Resident #8. Staff N stated the sling crisscrossed between Resident #8's legs. Staff N stated the sling was an X-large identified by ribbon color. Upon inspection, the tag appeared worn/torn and the size and weight limit were unable to be identified. During an interview on 3/17/2026 at 4:27 PM, Staff O, CNA stated she was hired on 2/11/26. Staff O stated she was educated to get the slings from the closet in the B hallway, and most residents have special instructions in the EHR [brand name of EHR (continued on next page)

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	165436	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ivy at Davenport	800 East Rusholme Street Davenport, IA 52803

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	redacted]. Staff O stated the blue-ribbon mechanical lift slings were X-large and green ribboned slings were large. Staff O stated during her shift from 2-10 pm on 2/26/26, Staff M, CNA, and Staff AA, CNA asked her to assist with transferring Resident #8 from bed to a recliner due to complaints of heart burn. Staff O stated the sling used for the transfer was one she had never used before at the facility. She explained it was not netted or cloth, rather it looked like a transfer sling, silver on one side, blue on the other and multiple loops on each of the long sides. Staff O stated the only other sling available was a medium, purple ribboned sling that would not work for Resident #8. Staff O stated this was the first time she had assisted to transfer Resident #8. Staff O stated they put the silver/blue sling with the multiple loops under Resident #8, and attached the second loop from the top and the second loop from the bottom on each side of the sling to the Hoyer. Staff O further explained started to elevate the lift. As Staff O moved the Hoyer away from the bed, she heard the sling rip. Staff O explained the resident said she heard the rip, and she was scared of falling. Staff O stated she had the right side of the sling and the lift controller in her hands. Staff M, CNA stood behind the recliner, pushed it underneath the resident, and grabbed the top of the sling. Staff O stated Staff AA, CNA stood on the left side. Per Staff O, they held on until Resident #8 was lowered into the recliner. Staff O stated it was very scary. Staff O explained the sling then ripped on the bottom of the right side, and the loops pulled away from the sling. Staff O informed Staff Q, LPN of the situation and Staff Q called the DON. The DON directed me to call the fire department for assistance. Staff O further explained three firemen men responded, and Staff O described Resident #8 as looking scared with her arms crossed. The resident did not talk. Staff O stated the fireman suggested they attempted to lift Resident #8 with the lift by attaching the sling on the third loops from the bottom to raise her enough to place the purple sling under the torn sling. Staff O stated when that was attempted, the loops on the left side ripped from the lining. They lowered the resident down to the chair. Staff O explained Resident #8 repeatedly said How are you going to get me back to bed?. The firefighters called the department for additional assistance. When the additional personnel arrived, they took the headboard off the bed, and lowered the bed to the level of the foot of the recliner. The firefighters curled the sides of the torn sling and pulled Resident #8 into bed. Staff O stated Resident #8 reported she was in pain as her toe was run over by the Hoyer. During an interview on 3/17/2026 at 5:05 PM, Staff M, CNA stated the facility did not provide training for the Hoyer or for sling use. Staff M explained there were multiple slings in the chaotic closet. Staff M stated the facility did not provide the equipment for a resident that weighed as much as Resident #8, and they did not have an appropriate sling. Per Staff M, there were not enough staff to provide transfer assistance so Resident #8 did not get up in the evening. Staff M added the resident had been to the hospital several times and was transferred by the fire department with EMT's (emergency medical technicians). Staff M stated on 2/26/26, Staff Q, LPN directed her to transfer Resident #8 from the bed to a recliner. Staff M stated she told Staff Q that she did not feel good about it since there were only three CNAs and a sling that came from the hospital. Staff M described the hospital sling as blue on one side and grey on the other side. Staff M explained she was not familiar with the sling. Per Staff M, Staff Q said she wanted Resident #8 in the recliner so Staff M? had Staff AA and Staff O assist. Staff M stated they placed the sling under Resident #8 and moved her away from the bed. Staff M stated, My heart almost came out, I have never heard a sling tear before. Staff M stated she pushed the recliner under Resident #8 and felt if she would not have been there, Resident #8 would have been on the floor. Staff M stated she notified Staff Q that Resident #8 was stuck in the chair on a ripped sling and it required everyone in the building to turn her, 4 or more staff. Staff M stated she was not asked to assist when the firemen came. Staff M stated management purchased a sling to support 600 pounds to replace the torn sling. Staff M stated she did not think it was wide enough for the resident. During an interview on 3/18/2026 at 11:35 AM, the Fire Chief stated the fire department staff had been called for assistance to transfer Resident #8 from the nursing home to the hospital. The Fire Chief stated the facility did not have the appropriate sling for the resident's weight, and the facility staff asked the crew to run (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the mechanical lift. The Fire Chief stated he told his staff that facility staff needed to manage their own equipment. The Fire Chief stated he then notified the Administrator. The Administrator assured him that staff were trained on the use of the mechanical lift, the facility had the appropriate slings, and she would take care of it. On 2/26/26, the fire department was notified the nursing home needed assistance. The Fire Chief stated the facility staff used a lift sheet, not a mechanical lift sling, for Resident #8. He stated the sheet ripped during the lift which caused Resident #8 to be stuck in a recliner. The Fire Chief shared two emails regarding emergency services calls to the facility to assist transfers for Resident #8. Email received on 3/18/26 at 12:11 PM. An email dated 2/12/26 from the Fire Chief addressed to the facility Administrator read: This email is a follow up to a previous email sent out by [fire department personnel name redacted] and a conversation which was held by [fire department personal name redacted] and yourself [Administrator] in regards to the bariatric patient in [room number redacted, Resident #8] at the facility. I am requesting information on the actual procedure in which you would like us to follow for the safety of the patient and my crew. I would also like to limit the liability issues which could come about with not having a set procedure in place to handle this patient. The patient we are regularly going to at this facility is well over 500 pounds. The main issues are continually dealing with are split between the staff at the facility and EMS response to this patient. The staff at the facility do not seem to have a clear answer on the use of the Hoyer lift. When responding to these calls they come at different times of day and different staff members present. Each time we get conflicting information how we are to use their equipment and move the patient. I believe they have different styles of lifts and rating. Staff have also stated we are not to use any lifts and want us to manually move the patient. The following are questions for the facility:The Administrator responded to the questions below on 2/12/26 at 9:42 AM. The fire department relayed the answers to their staff on 2/12/26 at 11:06 AM. 1. Is the Hoyer lift they have on the site capable and rated to lift the patient safely? Administrator response: Rated for 1000# (pounds)2. Is the sling used rated and capable of lifting the resident safety? Administrator response Yes, it is specifically for that patient3. Are all employees trained in the use of and selection of the proper equipment in moving the resident? Administrator response: All employees are trained in the use of the lifts and the DON will refresh the employees as well after the conversation with the Administrator. 4. Are they to run the lift and not us? They have stepped away from the lift and stated they didn't know how to use it. Administrator response: They are to run the lift. If they say they don't know how to use it, let me [fire department supervisory staff] know immediately, try to get the name of the staff, and I [fire department supervisor staff] will get in touch with the administrator. During an interview on 3/18/26 at 3:43 PM, the Administrator stated she was unaware of a color coordination to the size of the mechanical lift sling and stated each resident had a mechanical lift sling with their name on it. Per the Administrator, the slings were not shared. The Administrator picked up a resident's sling. It lacked a name on it and the inside label was unreadable. The Administrator notified the DON on 3/18/26 at 4:03 p.m. per phone call, who stated all of the weights and sizes were listed inside of the sling on the label.During an interview on 3/19/26 at 8:29 AM, the Lieutenant of the local fire department stated the fire department staff had been dispatched to the facility multiple times to assist with Resident #8. The Lieutenant stated the time that concerned him the most was on 2/26/26. The Lieutenant stated he was the first to arrive. He found Resident #8 in a recliner with a torn slide sheet under her. The Lieutenant stated Resident #8 told him the slide sheet was torn and she was stuck in the recliner. The Lieutenant stated the staff nurse entered the room and stated she was told at shift change she was to call the fire department when the resident was ready to go back to bed. The staff nurse then left the room. The Lieutenant stated, that was their solution to their problem, that was their plan, to utilize the fire department. The Lieutenant stated two facility staff in the room reported that the slide sheet began to rip while Resident #8 was elevated during the transfer from the bed to the recliner. The Lieutenant stated if those handles would have completely ripped, Resident #8 would have been seriously hurt. Per the Lieutenant, that was his major concern. The (continued on next page)

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The Lieutenant explained he called for three more firefighters to assist. When the additional crew arrived, they lowered the bed, took the head board off, and put the bed at the foot of the recliner. He explained it took all six of the crew to slide Resident #8 into the bed using the torn lift sheet. The Lieutenant stated his crew recognized the torn sheet. Per the Lieutenant, it was a slide sheet/transfer sheet from the hospital and not a Hoyer sling. The Lieutenant stated, This was the most unsafe situation. During an interview on 3/23/26 at 10:25 AM, Staff BB, CNA stated she provided training for new CNAs. Staff BB stated 5 days ago [March 18, 2026], the DON, ADON and the Administrator completed a mechanical lift demonstration and filled out validation forms. Staff BB stated the staff were directed if there was no tag on the sling to identify a maximum weight due to being washed off, staff were not to use it and were to turn it in. Staff BB stated she did not remember all the colored ribbon around the slings to identify the sling size, and management had her organize the closet that contained the slings. During an interview on 3/23/26 at 11:12 AM, Staff AA, CNA stated on 2/26/26, she assisted Staff M, CNA to transfer Resident #8 from her bed to the recliner. Staff AA stated Staff M expressed her concerns about the transfer sling which was blue and grey in color. Staff AA stated it was not like the regular slings and the facility did not have any slings like it. Staff AA described the sling had 6 loop handles on each side. Staff AA explained the bariatric lift was designed for 4 loops. Staff AA stated it was the only sling available. Staff AA stated another CNA [Staff O, CNA] assisted to move Resident #8 away from the bed and the sling began to pop, tearing on the right side at the bottom. Staff AA explained the material tore from the loops and the recliner was away from the bed. Staff AA stated they had to get Resident #8 into the recliner that was not big enough for her, and explained she was squished in. Staff AA notified Staff Q, LPN the predicament she put them in could have hurt everyone involved. Staff AA stated Resident #8 said don't drop me as she was fearful. Staff AA explained if Resident #8 would have fallen, it would have been catastrophic as she was very heavy. Per Staff AA, staff could not turn Resident #8 to place another sling under her, Staff AA explained Staff Q, LPN and Staff F, LPN/Wound Nurse did not enter the room to assist. Staff AA stated she was so irritated as this should not be happening. Staff AA stated the fire department responded, called in back up with 3 [persons] on each side and utilized the torn sheet. Staff AA reported the fire crew identified the sheet as a slide sheet. Staff AA stated the slide sheet was not appropriate to support Resident #8. Per Staff AA, Resident #8 appeared to be nervous, scared and irritated. She just wanted to get to where she was safe. Staff AA did not understand why Staff Q did not assess the resident in bed related to the resident's chest pain. Staff AA stated she felt if facility staff had to call the fire department every time Resident #8 needed to be transferred, then she was not in the right facility to provide the care she needed. On 3/23/26 at 11:16 AM, Staff CC, LPN stated she was worked in a different part of the facility on 2/26/26 and was not asked to assist with Resident #8. Staff CC stated the staff often would call the fire department to assist with Resident #8 transfers to either go to the hospital or to appointments. Staff CC stated staff called the fire department due to safety as Resident #8 was very big. On 3/23/26 at 4:52 PM, Staff Q, LPN stated on 2/26/26, Resident #8 complained of chest pain after she ate supper while lying flat in bed. Staff Q directed the three CNAs on duty to transfer Resident #8 to the recliner. Staff Q stated one CNA reported that they couldn't assist Resident #8 back to bed the same way they got her out of bed. Staff (continued on next page)

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