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	06/04/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, facility policy review, and staff interviews, the facility failed to implement individualized interventions related to positioning in bed for a dependent resident at high risk for falls for 1 of 4 (Resident #1) residents reviewed for safety. The facility reported a census of 62 residents.Findings include:Review of Resident #1's Minimum Data Set (MDS) admission assessment dated [DATE], revealed no score for the Brief Interview for Mental Status. The list of diagnoses included seizure disorder, anoxic brain damage not elsewhere classified, cognitive communication deficit and severe cognitive impairment. The MDS indicated Resident #1 dependent for all activities of daily living (ADL's), and due to medical condition did not attempt rolling left and right, sit to lying, lying to sitting on side of bed, sit to stand, and chair/bed-to-chair transfer. The MDS dated [DATE] indicated Resident #1 dependent for rolling left and right, chair/bed-to-chair transfer. The MDS documented Resident #1 had No Falls Since Admission.Review of Resident #1's electronic health record (EHR) revealed an admission packet from a previous long term care facility. The Care Plan included an undated Focus area to address Resident is at risk of falls r/t (related to) needs assist of 2 and Hoyer Lift (a brand of mechanical lift) for all transfers; with a Goal dated 12/11/25, to Minimize risk for falls throughout next review. Undated Interventions included, in part: Assist resident with transfers as needed, she needs assist of 2 and Hoyer lift for transfers; Bed is in low position, when she is in it; and Positioning Device to reposition approx. (approximately) Q (every) 2 hrs and PRN (as needed).Review of the Baseline Care Plan dated 10/30/25 revealed, in part:a. Section G. SAFETY & SKIN Risks.Is the resident at risk for falls: Yes.Fall Care Plan: Focus: Resident is at risk for falls.Interventions:1. Anticipate and meet the resident's needs.2. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance.3. Ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair.4. Maintain safe environment for resident: floors free of clutter/spills, working/reachable call light, bed in low position, personal items in reach.Review of Fall Risk Assessments in the EHR revealed:a. On 10/30/25 a score of 50, which per the scale indicated high risk for falls.b. On 2/6/26 a score of 30, which indicated a moderate risk for falls.c. On 5/30/26 a score of 55, which indicated a high risk for falls.Review of Resident #1's Care Plan revealed the following Focus area's:a. Initiated on 11/05/25: Advanced Directives.b. Initiated on 11/25/25: GERD (gastroesophageal reflux disease, often called heart burn); Risk of pressure ulcers; Bowel incontinence; Indwelling catheter; Risk of constipation; Seizure disorder; Communication problem; Impaired cognitive functioning; Hypertension; Dependent on staff to complete ADL care.c. Initiated on 1/21/26: Allergic to certain medication: Erythromycin.d. Initiated on 2/9/26: Independent and formal group activities.e. Initiated on 3/20/26: Impaired ability to transfer independently.f. Initiated on 3/21/26: Impaired ability to bathe/shower.g. Initiated on 4/9/26: Impaired ability to eat independently; Impaired ability to complete oral and/or personal hygiene; Impaired ability to dress self; Impaired ability to independently toilet; Impaired bed mobility; Impaired ability to bathe/shower.h. Initiated on 4/13/26: Enteral Nutrition (feeding through a tube inserted through the abdominal wall (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	into the stomach); Remain in facility.i. Initiated on 4/30/26: Impaired Ability to complete oral and/or personal hygiene tasks.j. Initiated on 6/1/26: Risk for falls.Review of the EHR revealed the following:a. A General Note entered on 5/30/26 at 4:22 PM: Approximately 1548 [3:48 PM], I was notified the resident was on the floor by staff. I proceeded to find Resident on the right side of her bed face down. I felt for her pulse, she was breathing and responsive. Nursing staff as well as two aids assisted with safely turning her on her back, disconnecting her tube feeding to help prevent aspiration from her feeding. Vitals obtained, BP 97/64, pulse 92, temp 97.0, O2% 96. No open wounds were visualized. No blood noted. Ambulance called, Report given to [Name of hospital redacted]. Left message with [provider name redacted] Hoyer assisted by staff to place the patient on the stretcher with [Name of emergency services redacted] ambulance staff. Resident's POA notified.b. A General Note entered on 5/30/26 at 4:53 PM: Prior to being notified of the resident on floor, I rounded 30 minutes befor and seen resident in her bed. Entered by facility nursing staff.c. A General Note entered on 5/30/26 at 11:43 PM: Resident admitted to the [name of hospital redacted].d. A Change of Condition note entered on 6/1/26 at 11:05 AM:Resident observed on floor adjacent to bed following an unwitnessed fall from bed. Resident is a quadriplegic with significant mobility limitations and is dependent on staff for all transfers, positioning, and activities of daily living. Resident receives nutrition via G-tube and has multiple comorbidities contributing to elevated risk for injury and complications.Upon assessment, resident was awake and responsive to baseline level of cognition. Head-to-toe assessment completed immediately. No visible injuries noted. No bruising, swelling, lacerations, deformities, or bleeding observed. Range of motion unchanged from baseline limitations. Skin assessment completed with no new areas of concern identified. Vital signs obtained and documented. Neurological assessment completed with findings consistent with resident's baseline status. Resident denied pain/discomfort (or unable to verbalize pain; assessed utilizing facility-approved pain scale).Physician notified of incident. Responsible party/family notified. Neurological monitoring initiated per facility protocol. Resident transferred from floor utilizing appropriate mechanical lift and staff assistance with EMS. Resident monitored closely for delayed signs or symptoms of injury.Following further medical evaluation, resident was transferred to the hospital for assessment and treatment of acute medical conditions including urinary tract infection, hypothermia, and aspiration pneumonia. At the time of transfer, there were no identified injuries related to the fall event. Clinical presentation and transfer were related to acute medical concerns requiring hospital evaluation and treatment.Resident remains at high risk for falls and injury due to quadriplegia, inability to independently reposition, dependence for mobility, and complex medical status. Care plan reviewed and updated. Interdisciplinary team notified for follow-up and ongoing monitoring.e. A Risk Meeting Note entered on 6/1/26 at 11:06 AM: Post-Fall Interventions:1. Maintain bed in lowest position at all times unless direct care is being provided.2. Place bilateral floor mats at bedside when resident is in bed.3. Continue Q2-hour rounds for safety, positioning, comfort, toileting needs, and environmental assessment.4. Continue scheduled repositioning at minimum every 2 hours and as needed 5. Ensure call light and personal items remain within reach when resident is able to utilize them.6. Utilize pressure-relieving mattress, or perimeter mattress and positioning devices (wedges) to maintain proper alignment and reduce migration within bed.7. Evaluate need for wedge cushions, positioning bolsters, or specialty equipment to reduce risk of rolling or sliding from bed.8. Educate staff regarding resident-specific transfer, positioning, and safety precautions.9. Review Kardex and care plan with direct care staff.10. Complete post-fall neurological assessments per facility protocol.11. Monitor for delayed signs/symptoms of injury, pain, altered mental status, skin changes, or decline in condition. 12. Continue G-tube safety precautions and aspiration precautions as ordered.13. Interdisciplinary review of fall event including nursing, therapy, provider, and risk management as indicated.14. Review hospital findings upon return and revise care plan based on any new recommendations.f. A Risk Meeting Note entered on 6/1/26 at 11:30 AM: Resident reviewed in risk meeting for follow up of fall on 5/30/26. She had no injury from fall. Interventions were to make (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sure bed is to floor and fall mat. Care plan reviewed, updated and currently meets resident needs. Resident receiving PT/OT services at time of fall. Resident sent to ER for post fall evaluation.g. A General Note entered on 6/2/26 at 10:35 PM: Resident arrived back to the facility via medical transport 1800. 16 F foley in place, patent and draining.Review of a Hospital Discharge summary dated [DATE], revealed, in part.assessed in the Emergency Department on 5/30/26 after a fall at the nursing home, no injuries were identified related to the fall. During an observation on 6/3/26 at 8:50 AM, Resident #1 in bed and covered with a blanket. The resident is positioned on her back leaning towards her right side with the head of bed elevated, and the bed in a low position. Fall mats placed on the floor, on both sides of the bed. The residents head positioned on a pillow, protective boots on her feet, and the call light positioned on resident's chest.During an observation on 6/4/26 at 8:40 AM, Resident #1 in bed, with her eyes closed, covered with a blanket and positioned on her back. The call light positioned on the resident's chest, with fall mats positioned on floor on both sides of the bed. The resident's bed in the low position, with the head of the bed elevated. Four (4) green wedges in place for positioning support on both arms and legs. During an interview on 6/2/26 at 3:38 PM, Staff A, Registered Nurse (RN), stated was on duty and assigned to the resident's hall on the 6 AM to 6 PM shift on 5/30/26. Staff A explained Resident #1 is non-verbal, she had a traumatic brain injury (TBI) and was total care. She added the resident might move her arms towards her during stimulus, her legs might quiver if she was uncomfortable. Staff A stated she had last seen the resident on her back in bed with the head of the bed up 10 to 15 minutes before she was found on the floor. Staff A stated the height of Resident #1's bed had not been changed and the top of her mattress was at the nurse's waist level, she stated she was 5'2 tall. She assessed her for injury did not identify any physical injuries and she did not have seizure activity. She carefully rolled her to her back with staff assistance, no physical injuries were found. She called the provider for orders and called 911. She didn't know how she fell and the staff on duty didn't know how she fell.During an interview on 6/3/26 at 11:54 AM, Staff B, Certified Nursing Assistant (CNA), stated if Resident #1 was on her back in bed she could move towards her right, or would end up in that direction, she sort of leaned that way. She checked on the resident often, every time she walked past the room, and they check/change her/repositioned Resident #1 at least every 2 hours. If positioned correctly she thought the resident would be okay. Staff B reported on 5/30/26, she saw Resident #1 between 2 and 3 PM. She described Resident #1 having been in bed, on her back with the head of the bed up. Staff B stated the resident's bed had been kept bed at waist height to her [Staff B] and she was 5'7 tall. She stated the bed was not in the low position. Staff B explained when she went past the resident's room around 3:30 PM, she saw the resident was not in bed. Staff B stated she found the resident face down on the floor with the blanket under her [Resident #1]. During an interview on 6/3/26 at 12:18 PM, Staff C, CNA, stated she worked on the resident's hall on the 6 AM. to 2 PM shift on 5/30/26. Lately it seemed like the resident moved more, and her eyes moved more. Staff C stated when the resident was in bed, she would stay in the position left in. Staff C stated the resident didn't move her head off the pillow until 5/30/26. Staff C stated Resident #1 moved her head more that day and she told the nurse. Staff C explained when she moved her head her shoulders and upper torso did not move. Staff C stated the resident's bed was kept at her waist level, and she reported stood 5'3 tall. Staff C stated she last checked on the resident at 2 PM on 5/30/26, recalled the resident positioned her on her back, with her head of the bed up. The resident's door had been kept open and Staff C stated she always looked in the room when she went by. Staff C stated it seemed like she moved more but she never thought she would fall off the bed, she was very surprised by that. Staff C added positioning wedges were now in the residents room, and staff were supposed to use them to establish a boundary for the sides of the bed.During another interview on 6/4/26 at 8:58 AM, Staff C, CNA, stated she was on duty the evening of 6/2/26 when the resident came back from the hospital, and how she knew they were supposed to use the wedges to position her. Staff C explained since Resident #1 returned from the hospital they were supposed to keep her bed low, fall mats on both sides of the bed and use the (continued on next page)

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