

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165436	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Ivy at Davenport		STREET ADDRESS, CITY, STATE, ZIP CODE 800 East Rusholme Street Davenport, IA 52803	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interview and policy review the facility staff failed to serve food under sanitary conditions to prevent cross contamination and potential food borne illness during 1 of 2 meals. The facility identified a census 59 residents. Findings include: During observation of the lunch meal service in the back dining area on 7/13/26 starting at 12:19 PM, the Dietary Manager (DM) gave instructions to Staff A, Dietary Cook, that he needed to use tongs when he served bread and he did not have to wear gloves unless he was preparing ready to eat foods. Staff A began plating food on plates as he wore gloves. Staff A placed a scoop of noodles on a plate and held his opposite hand to guard/guide noodles in place on the plate, then poured a white sauce over the noodles and placed a scoop of green beans and a chicken breast on the plate, touching the utensils with the same gloves. Staff A continued to wear gloves, lifted the lid over a pan of hotdogs, picked up a hotdog and placed the hotdog in a bun on the plate. Staff A held the sack with hotdog buns in his gloved hand, spun the bag around to close the bag and sat the bag of buns on the counter. During the meal service, Staff A continued to touch utensils and plate food including the same process of shielding noodles as he poured the noodles onto the plate wearing the same gloves. Staff A placed a hotdog bun on the plate with his gloved hand, lifted the lid on the pan of hotdogs and placed the hot dog in the bun on the plate. Staff A continued to wear the same gloves as he plated food for other residents. In an interview on 7/16/26 at 9:05 AM, the DM reported staff do not need to wear gloves when serving food unless touching or serving raw food. Staff should use tongs for serving bread. The DM reported she expected gloves removed and hands washed after food touched to prevent cross contamination. A Food Safety Requirements policy reviewed/revised 3/26/25 revealed food served in accordance with professional standards for food service safety and in ways to prevent foodborne illness. Gloves used when touched ready to eat foods. Staff shall exhibit appropriate use of gloves.		

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, facility policy review, resident and staff interviews, the facility failed to provide accommodate the need for a bariatric shower chair for 1 out 5 residents (Resident #2) reviewed for baths. The facility reported a census of 59 residents. Findings include: Resident #2's Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. The list of diagnoses morbid obesity, cerebrovascular accident (stroke) and hemiplegia (one sided paralysis). The MDS indicated Resident #2 independent with bathing and personal hygiene. Review Resident #2's Care Plan revealed a Focus area to address The resident is at risk for falls r/t medications that may cause dizziness, loss of balance, or impaired judgement, weakness, FUNCTIONAL IMPAIRMENTS which causes safety issues with transfers and/or walking. The Care Plan did not address activities of daily living such as bathing or personal hygiene. During an interview on 7/13/26 at 11:55 AM, Resident #2 stated the leg on a shower chair broke the last time he took a shower in the beginning of June. Resident #2 stated that time, staff have given him a bed bath or used wipes, and then a dry shampoo shower cap to wash his hair. He stated his wheelchair is new and facility staff wanted him to use it in to get into the shower. Resident #2 stated he refused to do that as he did not want the dirt from his body to rinse off onto the wheelchair. The resident stated facility staff have told him a shower chair is on order but it has yet to arrive. He added maintenance told him it will be here but it has never arrived. Resident #2 stated since Memorial Day I have only had 2 maybe 3 showers. He stated he gets frustrated because I really would prefer to have a shower than a bed bath or get cleaned with wipes. Upon request, the facility provided a purchase order dated 6/30/36. The purchase order initiated by the Maintenance Director, and approved by the Administrator the same day. The order status pending approval from the corporate office. On 7/15/26, the State Agency informed of a second purchase order for a bariatric shower chair. The maintenance director submitted the order on 7/15/26 at 12:09 PM, the Administrator approved it at 1:58 PM, and it is currently pending approval by the corporate office. During an interview on 7/16/26 at 10:01 AM, the Maintenance Director stated he became aware of the need for a bariatric shower chair the day after the leg broke off the previous chair. He stated he submitted a purchase order for it on 6/30/26 and it still has not been approved. He added he did resubmit the order again yesterday and it has not been approved. He explained anything that is over \$500 needs to be approved. The MD stated the Administrator approved the request, however the corporate office has yet to give approval. He stated there is no other bariatric shower chair in the facility. During an interview on 7/16/26 at 11:30 AM, the Director of Nursing (DON) stated she did not know anything about a bariatric shower chair. She explained the facility had a big long bed that is used for residents to take showers. She stated she is not aware of Resident #2 not getting his showers. The DON stated she has seen shower sheets for Resident #2 but was not aware he was not getting actual showers, and was not aware he preferred to get a shower over a bed bath. She stated that is not acceptable for staff to only offer bed baths and the staff should have let management know his preference. The DON added it can take some time to get things approved from corporate. During an interview on 7/16/26 at 11:57 AM, the Administrator stated she only became aware of the bariatric shower chair issue yesterday when the State Agency asked about a replacement chair. She stated she approved a purchase order right away and then maintenance submitted a request again. The Administrator explained when she found out about needing a new bariatric shower chair she reached out to the owner and they said they would approve immediately. The Administrator stated she did not know how (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	long it should take to get the approval, adding it should be as soon as possible for a need like that.Review of the facility policy titled Residents Rights dated of 3/4/25, revealed, in part: The resident has the right to a dignified existence, self-determination, and communication with and access to person and services inside and outside the facility.		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on personnel file review, facility policy review, and staff interview, the facility failed to ensure all employees had a criminal and abuse registry background checks completed prior to the start of employment for 1 of 7 employee files reviewed. The facility identified a census of 59 residents. Findings include: Review of a New Hire Date report dated 1/1/26 to 7/18/26 revealed Staff K, former Administrator had a hire date of 6/8/26. Review of Staff K's personnel file confirmed a hire date of 6/8/26, and found no documentation that a criminal and abuse registry background check had been completed. During an interview on 7/15/26 at 3:06 PM, Staff P, Human Resources (HR)/Corporate Compliance stated Staff K did not have a SING (Single Contact Repository) background check completed. Staff P stated she found out after Staff K's 6/8/26 start date that Iowa requires the SING, and it had not been done. Staff P stated she now understands the SING needs to be completed before an employee starts work. During an interview on 7/16/26 at 11:57 AM, the current Administrator stated the SING should be done before date of hire and start of employment for all employees. Review of the facility policy titled Abuse, Neglect and Exploitation Policy revised 4/22/25, included a Policy Explanation and Compliance Guidelines section which directed, in part: The components of the facility abuse prohibition plan are discussed herein: I. Screening: A. Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. 1. Background, reference and credentials' checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants. 2. Screenings may be conducted by the facility itself, third-party agency or academic institution. 3. The facility will maintain documentation of proof that the screening occurred.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, resident and staff interview the facility failed to safely transfer a resident when staff did not utilize the correct size sling for a sit to stand mechanical lift, and failed to ensure two nursing staff assisted a resident with a mechanical lift for 1 of 4 residents (Resident #3) reviewed for falls. The facility reported a census of 59 residents. Findings include: Review of Resident #3's Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #3 had diagnoses of right knee pain and obesity. A Brief Interview for Mental Status score of 15 out of 15 indicated intact cognition. The MDS documented Resident #2 dependent on staff for chair/bed-to-chair transfers, and had no falls. Review of Resident #3's Care Plan dated 5/6/26 revealed a Focus area to address the resident is at risk for falls d/t (due to) impaired mobility, non-ambulatory status and daily use of antidepressant medications. Interventions included, in part: a. 2 assist large sling, full body sit to stand lift for all transfers. Date Initiated: 6/16/26. b. Dycem (brand name for a non-slip material which provides grip and improves stability) to the edge of the bed. Date Initiated: 6/16/26. During an interview on 7/14/26 at 10:15 AM, Resident #3 reported she had a fall a couple of weeks ago. The resident explained she was in the sit to stand lift, the back strap (on the sling) was too big and she slipped through it. Resident #3 stated she did not incur any injuries from the fell. Review of the electronic health record revealed: a. A Post Fall Note entered on 6/15/26 at 2:14 PM: CNA (Certified Nursing Assistant) reported to nurse that the resident slid from the edge of the bed to the floor during a transfer with a [NAME] lift (sit to stand lift). A full skin assessment revealed no injuries or bruises noted. Resident denied pain. Neuro checks and range of motion WNL (within normal limits). A Dycem stay put non-slip material added to the mattress. CNA educated on proper positioning. b. A Post Fall Review Note entered on on 6/16/26 at 1:00 PM: A fall occurred on 6/15/26. The fall was witnessed. The resident sustained no injury related to the fall. Resident to be a Hoyer (brand name for a full body mechanical) lift at this time because of lack of strength to use a [NAME] lift. A physical therapy referral recommended. c. MDS Note entered on 6/16/2026 at 4:32 PM: Resident admitted to facility from the hospital on 3/26/25. Diagnosis included knee pain, weakness and obesity. Resident requires two assist sit to stand with large sling for all transfers. Resident was evaluated for fall risk on admission and care plan was initiated with interventions implemented. Resident had witnessed fall on 6/15/26. Resident states they were transferring her with a sit to stand lift to her bed and she slipped when being lowered to the bed. Resident reported she slid off of the mattress onto the floor. Resident reports no pain or injury as a result of this. Plan of care was updated to include a Dycem to the edge of mattress and the CNA was provided education on transfers and positioning. Review of an Incident Audit Report revealed, in part: At 6/15/26 at 3:47 PM: Nursing Description: CNA reported to nurse that during resident transfer with a [NAME]-lift to bed, the resident slid to the floor from the bed. Resident Description: Resident states she was sitting on her bed and started to slide to the floor. Resident states she is unsure how ti happened but slid to the floor. She reports no pain or injury. During an interview on 7/15/26 at 2:45 PM, Staff G, CNA, reported she had four days of orientation when she began to work at the facility. Staff G stated Resident #3 used the sit to stand lift for transfers, and had had one fall, which occurred when she assisted the resident. She explained the resident fell because the wrong sized sling was used and during the transfer Resident #3 slid out of the sling. Staff G stated an extra-large sling had been left on the sit to stand device and she thought that was the sling Resident #3 used. She stated Resident #3 uses a (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	large sized sling. Staff G stated she was the only staff who assisted Resident #3 during this transfer. During an interview on 7/16/26 at 8:50 AM, Staff G, CNA, reported she had worked at the facility for 1 year. She explained she looked at the Kardex (care plan) to know what a resident needed done or how the resident transferred. Her orientation entailed staff showed her around the facility, how to work the equipment, the location of supplies, and how things are done. She looked at the Kardex banner to see what size sling a resident needed. The tag on the sling had a hole punched next to the size, and that is how she knew the size of the sling. Staff G reported the facility had a lot of regular slings for lifts but not a lot of slings for the sit to stand. Staff G took the State Agency to the closet with the slings and showed the tags on the sling with a punch indicating the size of sling. Staff G reported only two residents used the sit to stand lift. Resident #3 used a large sling and a sit to stand lift. During an interview on 7/16/26 at 9:00 AM, the Director of Nursing (DON) reported she expected staff to follow the Kardex to know how a resident transferred and the size sling needed for transfers with a mechanical lift. She updated the Care Plans recently with the sling sizes for each resident. There were two slings for each resident. The DON reported she worked the floor on the day Resident #3 had a fall but was not involved in any follow up related to the resident's fall or the staff involved. During an interview on 7/16/26 at 10:45 AM, the DON reported that two staff were required for all transfers with a mechanical lift including a sit to stand lift. During an interview on 7/16/26 at 10:50 AM Staff H, CNA, reported she looked at the Kardex to know what size sling a resident used. Staff H stated she sized up the resident to ensure the sling fit properly. Staff H stated she tells by looking at the sling if it's the correct size and if the sling will fit the resident, adding it is just common sense when you see the size of the person and what size sling to use. Staff H explained the sling had a tag that indicated the size of the sling, and the facility provided training on the slings and mechanical lifts about 2 weeks ago. She explained there was a demonstration on making sure staff knew how to fit the resident for the sling, use of the mechanical lift machines, including the sit to stand lift, and where to place the strap on the resident. During an interview on 7/16/26 at 11:00 AM, Staff E, CNA, reported she looked at the Kardex to know if a resident needed to use a lift for transfers and what size sling to use for that resident. She stated she would also check with the ADON (Assistant Director of Nursing) if needed. Staff E explained the sling size is marked on the back of the sling, or there is a yellow dot on the tag of the sling to indicate if the sling was a medium, large or extra-large sling. She stated the facility provided education two weeks ago about how to use the stand lift and went over the proper sling sizes to use. During an interview on 7/16/26 at 11:30 AM, the DON reported she saw something related to education or counseling in the former DON's office for Staff G, CNA. She will look for it and provide to the State Agency. No documentation was provided to the State Agency. Review of a Sit to Stand Mechanical Lift Validation Checklist signed by Staff G, CNA on 3/20/26 revealed the following procedural steps: a. Review the resident's care plan. b. Gather needed supplies. Ensure the sling is the correct size and in good working condition. c. Ensure two staff members present. d. Position the resident on the appropriately sized sling according to the resident's care plan. e. Position the lift. f. Attach the sling straps to the lift. g. Gently raise the resident up and ensure the sling straps are secure. h. Transfer resident to surface and gently lower the resident. i. Remove the sling. Review of the facility policy titled A Safe Resident Handling and Transfer Policy reviewed/revised on 6/1/25 revealed: It is the policy of the facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. Mechanical lifts may include equipment such as a full body lift and a sit to stand lift. Staff will inspect the equipment prior to use to ensure (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	functionality. Residents measured correctly as per the manufacturer's instructions on the proper sling sizing. Resident lifting and transferring will be performed according to the resident's individual plan of care. Two staff members must be utilized whenever a resident transferred with a mechanical lift.		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observations, resident and staff interviews and policy review, the facility failed to ensure sufficient nursing staff were available to provide timely care and answer call within a 15-minutes of activation for 3 of 5 residents reviewed for sufficient staffing. The facility reported a census of 59 residents. Findings include: 1. During observation on 7/13/26 starting at 3:55 PM, two call lights noted to be activated on the A Hall. At the time, Resident #11 sat in a large broda chair in his room and reported he wanted to lay down. The resident reported his call light had been on for at least 10 minutes. He explained he had completed therapy and his bottom was getting a little sore from sitting. At 4:05 PM, a Certified Nursing Assistant (CNA) entered the resident's room, shut the call light off and walked down the hall to another resident's room. At 4:09 PM, Staff C, CAN and Staff D, CNA, entered another a resident room across from Resident #11's room to assist with a transfer from a motorized wheelchair to bed. At 4:16 PM, the call light above Resident #11's room re-activated back on. At 4:23 PM, Staff D entered Resident #11's room and shut the call light off. At 4:25 PM, Staff D took a pair of gloves from a box on the wall in the hallway, then entered Resident #11's room. At 4:27 PM, Staff C entered Resident #11's room. Staff C and Staff D connected a sling under Resident #11 to a mechanical lift and transferred the resident from the broda chair to the bed. A total of 32 minutes elapsed from time light initially activated until Staff C entered room to assist with the two person transfer. 2. During observation on 7/16/26 starting at 10:55 AM, two call lights observed on in A Hall. Staff F, Licensed Practical Nurse, heard telling another staff person that one CNA was in the shower and Staff B, CNA, was on break. At 11:00 AM, Resident #11 reported his call light had been on for at least 5 minutes. He reported his incontinence brief needed changed. At 11:19 PM, Staff E, CNA, entered Resident #11's room, shut the call light off, then left the room to go to another room. During confidential resident interviews on 7/14/26 starting at 10:15 AM to 12:51 PM, three out of five interviewable (based on a Brief Interview for Mental Status each had a score of at least 13 out of 15) residents reported lengthy call light response times. The residents reported they had to wait 20 to 45 minutes for staff to come whenever they put their call light on. Two of the three residents said that staff came in the room, shut the call light off and say they would be back but the staff did not always come back. The residents reported they turned their call light on again. One resident reported it depended on the staff person working and how many staff were scheduled to work. Some of the staff acted like they did not want to be at the facility and there had been times when a staff person just walked out. Sometimes the nurse came in and asked the resident what he needed but then the nurse turned the call light back on for the CNA to come to the room and do what was needed. One resident reported the shower aide got pulled to work on the floor when the facility was short-handed and then the resident did not get his scheduled shower. During an interview on 7/16/26 at 9:00 AM, the Director of Nursing (DON) reported she expected the resident call lights to be answered within 15 minutes. She expected the nurse to answer the call light if the CNA could not get to the call light during that time. The DON stated anyone from any of the departments could answer a call light to see what the resident needed. Review of the facility policy titled Call Light Accessibility and Timely Response reviewed/revised 6/1/25 revealed a Policy statement which declared: The purpose of this policy is to assure the facility is adequately equipped with a call light at each resident' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. The Policy Explanation and Compliance Guidelines sections directed, in part: a. All staff members who see or hear an activated (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	call light are responsible for responding.b. Process for responding to call lights:1. Listen to the resident's request and respond accordingly. Inform the resident if you cannot meet the need and assure him/her that you will notify the appropriate personnel.		

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. Based on personnel file review, facility policy review, and staff interview, the facility failed to assure all Certified Nursing Aides (CNA's) had a current, active certification prior to working in the facility for 1 of 7 employee's sampled. The facility identified a census of 59 residents. Findings include: Review of Staff L, Certified Nursing Aide (CNA) Iowa Single Contact Repository (SING) result summary dated 2/26/26, revealed: Professional Licensing. Final Result Date: 2/26/26. Final SING result: Record Not Found. This individual is current ineligible to work in Iowa. Based on the License Number and SSN (Social Security number) that was entered into SING, this individual was not found on the Iowa Nurse Aid Registry. You may verify this response through the Direct Care Worker registry at www.dia-hfd.iowa.gov professional licensing record not found. Review of the Iowa Nursing Aide Registry revealed: Certifications - Certified Nurses Aide: Status: No Employment. Currently Employed: No. Certification Date: 10/22/2020. Expiration Date: 10/22/22. Review of the facility provided report titled Active Employee Report (active as of 7/13/26) revealed Staff L listed as a full-time employee in the Nursing Department with the Position of CNA. The facility provided an offer of employment letter addressed to Staff L which indicated an anticipated first day of employment date of 2/27/26. Review of a document titled Timecard Detail Report revealed Staff L worked at the facility during the months of March, April, May, June and July 2026. During an interview on 7/15/26 at 3:06 PM, Staff P, Human Resources stated on 3/2/26 the facility completed on-boarding with Staff L, and gave her an offer letter on this date. Staff P stated the SING had already been ran which showed the CNA license was not valid. Staff P explained the facility expected Staff L to start on 2/27/26 and the skills checklist was done on 2/27/26 for a CNA position. Staff P stated Staff L did work after those dates as a CNA and is currently employed as a CNA at the facility. During an interview on 7/16/26 at 11:57 AM, the current Administrator explained in February 2026 she was not the Administrator, and the Administrator at the time was running license verifications. She stated she would expect all CNA's and nursing staff to have the current certifications or licenses while working at the facility.		

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, staff interview and policy review the facility failed to prepare medication in a sanitary manner to prevent cross contamination for 1 of 4 residents (Resident #10) observed during a medication pass. The facility reported a census of 59 residents. Findings include: During observation on 7/14/26 at 8:39 AM, Staff B, Certified Medication Aide (CMA), checked the computer and prepared medications for Resident #10. Staff B punched out the following medications: colchicine, aspirin, metoprolol, furosemide, gabapentin, and two tabs of metformin from the prepared bubble packs into his bare hand and placed the pills/capsules into a medication cup. Staff B then punched sertraline, oxybutynin and bupropion from the bubble packs directly into the medication cup. At 8:44 AM, Staff B took the cup of medications and gave them to Resident #10. During an interview on 7/16/26 at 10:55 AM, Staff F, Licensed Practical Nurse (LPN), reported the process of preparing medications for a resident: use hand sanitizer, check the computer, remove the medication card from the cart, hold the medication card over the medication cup and pop out the pill into the medication cup. Staff F stated it would not be ok for staff to punch out the pills into their bare hand and then place the medication into a cup because it was not sanitary. During an interview on 7/16/26 at 11:30 AM, the Director of Nursing (DON) reported staff should punch the pill out of the medication card into a medication cup. She added the pills should not be touched with bare hands or fingers. A Medication Administration policy reviewed/revised 4/9/25 revealed medications are administered in accordance with professional standards of practice and in a manner to prevent contamination or infection.		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, resident and staff interviews, pest control statements, pest control company interviews, and policy review the facility failed to ensure an effective process in place to deter and mitigate pests in resident rooms and common areas. The facility reported a census of 59 residents. Findings include: Observations revealed the following: a. On 7/13/26 at 11:55 AM, mouse glue traps were observed in various resident rooms on the floor in the bathroom and under the radiator/furnace vent and storage rooms on Hall A and Hall B. b. On 7/15/26 at 10:50 AM, a mouse sticky pads and bait box were located in Room B14. The bait box had a grayish colored object protruding from the side. c. On 7/16/26 at 10:55 AM, a metal cage/box for rodents placed on the floor under the cabinet by the back nurse's station. A white bait box placed under the vent at the end of Hall A. In an interview on 7/15/26 at 8:25 AM, Resident #13 reported she saw mouse droppings in the bathroom in her room. She had only resided in the room for two weeks and she had observed mouse droppings in her bathroom ever since she moved into the room. She also had seen a mouse drop out of the heat vent in the bathroom while she sat on the toilet. She told maintenance about it. Maintenance brought in glue traps. Resident #13 confirmed three mice had been caught so far. The resident reported she thought the mice traveled through the heating vents in the room and the building. In an interview on 7/14/26 at 9:55 AM, Staff J, Certified Nursing Assistant (CNA), stated she had seen rodents in the front and back dining rooms and in the resident rooms. Recently when she worked, she saw two mice in the front dining room (near the front door to the facility) running back and forth. In an interview on 7/14/26 at 3:40 PM, Staff I, CNA, reported she has seen mice at the facility. On the night shift, when staff sat in the back dining room between rounds, she saw mice run in and out of the heat vents in the dining room. Staff I reported the staff would leave the lights on to deter the mice from coming out. Staff I stated she had not seen any mice in the residents' rooms. A Pest Control Service Report dated 2/5/26 and 5/13/26 revealed services entailed the exterior structure perimeter was treated per scope. The product used was a mice and rat repellent to target mice. The report also revealed prior service dates on 9/17/25, 11/18/25 and 1/15/26. The Pest Control Service Report dated 5/13/26 revealed a recommendation to patch small holes due to observation of gaps, and placement of solid bait in common areas and bedrooms. A Statement from the facility's former Pest Control company dated 7/14/26 revealed a general pest control program for dates 11/1/25, 12/1/25, 1/1/26, 2/1/26, 3/1/26, 4/1/26 and 5/1/26. The statement revealed the account was 225 days past due and services may be placed on hold or cancelled due to non-payment. In an interview on 7/14/26 at 2:50 PM, the pest control technician confirmed he came to the facility to provide pest control services. He recently provided a bed bug treatment. A few months ago around March or April, an exterior rodent spray was added to their service. He had not seen activity of pests or rodents when he came to the facility. When he spoke with the Maintenance Director, the Maintenance Director told him he had not seen any activity of rodents either. In an interview on 7/14/26 at 4:00 PM, the former Pest Control Service reported they had done monthly service and performed exterior treatment such as a barrier for insects and spiders, rodent control and overall monthly inspections. He applied chemicals based upon inspections and the reports from staff. When he was at the facility, some of the kitchen areas were cleaned and serviced monthly but they relied on reports from the facility about any activity or citing of bugs or rodents on the units or in the resident rooms. A technician came to the facility but no technician was sent in to service the facility in the past couple of months due to nonpayment for services provided. The last time a technician was at the facility was 4/2026. Per the technician's report in 3/2026, mice were caught in the break room, mechanical room and the vending area. In (continued on next page)		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/2026, there were three mice caught on the outside (inside the bait boxes) and no mice caught on the inside. The feeding and exterior stations were heavy which meant the stations were doing their job outside. In an interview on 7/15/26 at 10:50 AM, the Maintenance Director reported he had worked at the facility for 11 months. The facility used a Pest Control services including spray and glue traps. He checked the glue traps and bait boxes throughout the facility daily. A Stick-em is placed under the baseboards, register and dark areas. The mice like to hide in the edges of the room. The pest control company sprayed outside and inside the facility once a month and whenever needed. The pest control company also checked the traps biweekly. The Maintenance Director reported the facility is strictly using the new pest control company since the facility had a change in Administration. In an interview 7/16/26 at 9:55 AM, the Administrator reported the Maintenance Director took care of pest control services. The Administrator reported they switched to a different pest control company because they did not feel the former pest control company were effective in dealing with the issues they had with pests. In an interview on 7/16/26 at 10:10 AM, the Maintenance Director reported the facility switched to a different pest control company because he did not feel the services they were getting were helping. The new pest control company came to the facility since 4/2026 and came to the facility every two weeks or whenever the facility called them. The surveyor inquired why the new pest control company was coming every two weeks. The Maintenance Director stated there had been more citing's of mice. The pest control company came to check the traps and also to treat the interior and exterior areas. In an interview on 7/16/25 at 12:40 PM, Staff P, Human Resources and Compliance Officer, reported none of the staff or maintenance went with or followed the former pest control company around the facility when they came to the facility to perform pest control treatments so the facility was not sure if the company performed the treatments or what areas were treated. The facility ended up switching to another pest control company because they had concerns that the former pest control company's services were not effective. Maintenance now went with the technician since the new pest control company started coming to the facility, and Maintenance shared concerns with what they were seeing at the facility. A Pest Control Program Policy reviewed/revised 4/2/25 revealed it is the facility's policy to maintain an effective pest control program that eradicates and contains common household pests and rodents. The facility will maintain a written agreement with a qualified outside pest service to provide comprehensive pest control services on a regular and scheduled basis. The facility will ensure that appropriate chemicals are used to control pests. The facility will also maintain a report system of issues that may arise in-between scheduled visits with the outside pest service, and treat pests as indicated.		

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on employee file review, staff interviews, and facility policy review the facility failed to ensure 1 of 5 staff members completed the Dependent Adult Abuse training every 3 years. The facility reported a census of 59 residents. Findings include: Review of Staff's M, Registered Nurse (RN) employee file found no documentation of a current Dependent Adult Abuse training. During an interview on 7/15/26 at 3:06 PM Staff P, Human Resources (HR) stated Staff M did have Dependent Adult Abuse training, and she had just sent Staff M a copy of the certificate. Staff P added she is not sure how often staff need to update the training but guessed it was annually. On 7/16/26 at 11:30 Am the Director of Nursing (DON) stated Dependent Adult Abuse education should be completed every 3 years. She stated the facility offers the training through a website and normally the DON or Human Resources would track when the training needs to be updated. During an interview on 7/16/26 11:57 AM, the Administrator confirmed dependent adult abuse education should be completed every 3 years for staff. On 7/16/26 at 12:25 PM Staff P, Human Resources informed the State Agency the facility did not have documentation that Staff M had current Dependent Adult Abuse training. The facility's policy titled Abuse, Neglect and Exploitation Policy revised date of 4/22/25, directed Employee Training, in part: a. New employees will be educated on abuse, neglect, exploitation and misappropriation of resident property during initial orientation. b. Existing staff will receive annual education through planned in-services and as needed.		