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	06/24/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48888 Based on staff interview, clinical record review, and facility policy review, the facility failed to clarify and ensure a current copy of a resident's advance directive was in the medical record for 2 of 3 residents (Resident #253 and Resident #15) reviewed for advanced directives. The facility reported a census of 60 residents. Findings include: 1. The Order Summary for Resident #253, dated [DATE], revealed both an active Physician order for full code/cardiopulmonary resuscitation (CPR) with the start date of [DATE] and an active Physician order for Do Not Resuscitate (DNR) with the start date of [DATE]. The Electronic Health Records (EHR) lacked documentation of Iowa Physician Orders for Scope Of Treatment (IPOST). The EHR and Nursing Progress Notes additionally lacked documentation the facility offered or assisted with completion of advanced directives. The Care Plan, initiated [DATE] and revised [DATE], revealed Resident #253 had advanced directives on record with the goal that if the resident's heart stops or if resident stops breathing, CPR will not be initiated in honor on Resident's #253's wishes. 2. The Order Summary for Resident #15, dated [DATE], revealed both an active physician order for Full Code/Cardiopulmonary Resuscitation (CPR) with the start date of [DATE] and an active physician order for Do Not Resuscitate (DNR) with the start date of [DATE]. The Iowa Physician Order for Scope of Treatment (IPOST), dated [DATE], signed by Resident #15's Power of Attorney (POA) and Physician revealed the resident's preference for DNR status with comfort measures only. The Care Plan, initiated [DATE], revealed Resident #15 had advanced directives on record with a goal that if Resident #15's heart stops or if they stop breathing, CPR will be initiated in honor of Resident #15's full code wishes. On [DATE] at 08:37 AM, Staff F, Licensed Practical Nurse (LPN), revealed that advanced directives would be found in each resident's physician orders, located in the EHR, which informed staff of resident's preference for life saving measures. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 01:17 PM, Director of Nursing (DON) informed that until facility had advanced directives in place, new residents would receive full code/CPR life saving measures. DON revealed that Social Services Worker also assisted residents and families with IPOST and advanced directive which caused both CPR and DNR orders to be in place. DON planned to increase interdisciplinary communication and audit medical records to ensure appropriate advanced directives were in place. The facility policy titled, Advanced Directives, revised [DATE], revealed the expectation that the plan of care be consistent with the resident's documented treatment preferences and/or advanced directives and if resident had not established advanced directives, the facility staff would offer assistance to establish advanced directives and instructed nursing staff to document in the medical record the offer to assist with the resident's decision to accept or decline. The policy additionally revealed responsibility of the Director of Nursing or designee to notify the Attending Physician of advance directives so that appropriate orders could be documented in the resident's medical record and plan of care.

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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 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. 49976 Based on record review, policy review, and staff interview the facility failed to have staff complete the Dependent Adult Abuse training within 6 months of hire for 1 of 6 employees reviewed, and to complete the Single Contact License & Background prior to the start date of a nursing staff for 1 of 6 employees reviewed. The facility reported a census of 60 residents. Findings include: 1. During employee file record reviews on 6/20/24 at 9:34 AM Staff C, Certified Nursing Assistant (CNA) was found to be hired on 3/30/23. The Dependent Adult Abuse (DAA) training certificate was absent from her employee file. On 6/20/24 at 11:30 AM, request made to facility administrative staff for documentation of DAA training completion for Staff C, A second request made at 1:36 PM. During an interview on 6/20/24 at 1:44 PM, the Director of Clinical services stated the facility did not have a DAA training certificate for Staff C. 2. During employee personnel file reviews on 6/20/24 at 9:34 AM Staff J, Licensed Practical Nurse (LPN) found to be hired on 5/23/24. A Single Contact License & Background (SING) background check found for Staff J with a completion date of 6/07/24. A review of time card records revealed Staff J worked directly with residents for 12 hour shifts, clocking in at 5:45 AM on 5/28/24, 5/30/24, 6/01/24, 6/02/24, 6/03/24, 6/04/24, and 6/05/24. During an interview on 6/20/24 at 12:56 PM Staff J confirmed she was hired on 5/23/24 and began working on the floor at the end of May. She was hired to work three 12-hour days per week. During an interview on 6/20/24 at 3:08 PM the Director of Clinical Services explained the DAA training must be completed prior to reaching the sixth month of employment. The SING for a new hire must be completed and reviewed prior to an employee's start date. These are per Iowa requirements. The facility lacked a policy regarding timelines for DAA training and SING completion.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49976 Based on observation, record review, policy review, and staff interview the facility failed to identify, assess and treat a skin tear in a timely manner (Res# 304). The facility reported a census of 60 residents. Findings include: The Minimum Data Set (MDS), dated [DATE], documented Resident #304 had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, indicating severely impaired cognition. The MDS included diagnoses: stroke, non-Alzheimer's dementia, and hemiparesis (inability to move one half of the body). The Care Plan updated 5/14/24 included goals to maintain or develop clean or intact skin. Interventions instructed staff to follow facility protocols for treatment of injury, monitor/document location, size and treatment of skin injury, and conduct weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. The Physician Order dated 6/05/24 instructed staff to complete a weekly skin evaluation every 7 days. A review of the weekly skin notes, dated 6/13/24, revealed no documentation of a skin tear on the resident's left arm. During an observation on 6/17/24 at 2:40 PM, Resident #304 was sitting in her wheelchair with her left arm contracted toward her chest. There was a large dark brown scabbed area on the top of the forearm. In an interview on 6/18/24 at 3:20 PM Staff D, Registered Nurse (RN) reported the facility does not have skin sheets, wound sheets, or incident sheets. They chart in the Electronic Health Record (EHR). She looked and could not find any documentation for the resident's skin tear. In an interview on 6/19/24 at 8:10 AM Staff E, RN checked the EHR and could not find any documentation for the resident's skin tear. In an interview on 6/19/24 at 8:15 AM the Director of Nursing (DON) explained the facility didn't know the resident had a skin tear. She was just made aware of it last night. The nurses didn't know it had happened or how it happened. During an interview on 6/19/24 at 3:55 PM the DON explained the nurses are supposed to do a skin assessment upon falls and any new open areas. The facility policy titled Skin Assessment, updated 9/2023 instructed staff to: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure injury. 2. Documentation of skin assessment: a. Include date and time of the assessment, your name, and position title. b. Document observations (e.g. skin conditions, how the resident tolerated the procedure, etc.). c. Document type of wound. d. Describe wound (measurements, color, type of tissue in wound bed, drainage, odor, pain). e. Document if resident refused assessment and why. f. Document other information as indicated or appropriate.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37072 Based on record review, staff interview and policy review the facility failed to provide adequate assessment and intervention to prevent deterioration of a pressure wound for 1 out of 4 residents reviewed with a pressure sore. (Resident # 153). The facility reported a census of 60 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] identified Resident #153 as mildly cognitively impaired with a BIMS (Brief Interview for Mental Status) score of 11 out of 15. The MDS listed the following diagnoses anemia, coronary artery disease, peripheral vascular disease, renal insufficiency and diabetes. It also identified Resident #153 required extensive staff assistance to total dependence of staff with bed mobility, transfers and toileting. The MDS indicated the resident received dialysis. The MDS indicated resident had a Stage 2 and a Stage 3 pressure ulcer. The Care Plan dated 1/23/24 indicated Resident #153 had a pressure ulcer upon admission. The Care Plan directed staff to provide wound cares as ordered by physician and treatment record. Staff to monitor dressing every shift to ensure it is intact and adhering. Report lose dressing to the treatment nurse. Staff to complete weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. The nurse is to assess/record/monitor wound healing at least weekly. Measure length, width and depth where possible. Report declines and/or signs and symptoms of infection to MD Review of the Nursing Admission assessment dated [DATE] revealed Resident #153 had a Stage 3 pressure ulcer on the sacrum measured 6 centimeter(cm) length by 4 cm width with a 4 cm depth. The Braden Scale for Predicting Pressure Ulcer Risk dated 1/22/24 revealed a score of 12 which indicates Resident #153 was high risk. The Nursing Admission assessment dated [DATE] revealed Resident #153 had a wound on his coccyx measured 7 cm length by 7 cm width. There was no depth documented and the documentation failed to reveal a Stage of the pressure ulcer. The Braden Scale for Predicting Pressure Ulcer Risk dated 1/22/24 revealed a score of 14 which indicates Resident #153 was moderate risk. The Weekly Skin Observation tool dated 3/20/24 noted a wound on the sacrum but failed to reveal measurements or the stage of the wound. The record revealed it was non pressure. The Braden Scale for Predicting Pressure Ulcer Risk dated 3/20/24 revealed a score of 07 which indicates Resident #153 was very high risk. The Wound Evaluation document dated 3/27/24 revealed a pressure type wound on the sacrum with a length of 12 cm. The evaluation lacked documentation of the width or depth of the wound. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of January 2024 Order Summary Report revealed the following order with a start date of 1/23/24: Dakins (1/4 strength) External Solution 0.125% (Sodium Hypochlorite) Apply to coccyx topically two times a day for wound cleanse with saline, pack with quarter strength dakins moistened 4 x 4's or kerlix, cover with aquacel sacral, change BID (twice daily) & as needed if loose or soiled. Review of February 2024 Order Summary Report revaled the following order with a start date of 2/7/24: Dakins (1/4 strength) External Solution 0.125% (Sodium Hypochlorite) Apply to coccyx topically two times a day for wound cleanse with saline, pack with Dakins moisten kerlix - being sure to pack into undermining from 12 o'clock to 12 o'clock, cover with silicone foam, change BID. Review of the January 2024 and February 2024 Treatment Administration Records lacked documentation of treatments completed for Resident #153 sacrum pressure sore. Review of the facility Progress Notes revealed a lack of documentation on any descriptions of the wound or condition report to physician to notify of the decline in the wound. The Physician Notes from an emergency department document on 4/12/24 at 9:41 AM revealed Resident #153 there with worsening hip/low back pain in addition to concerns for worsening sacral decubitus ulcer. Wound VAC found not to be working so was removed and replaced with wet-to-dry dressing. Patient not meeting septic criteria on presentation but his work-up showed significantly elevated inflammatory markers. Computed Topography scan (CT) concerning for new osteomyelitis (bone infection). Resident started on broad-spectrum antibiotics and admitted to hospital with infectious disease for consult. Results of CT from hospital on 4/12/24 revealed new osseous (relating to bone) findings and increased soft tissue loss overlying the sacrum compatible with infection and osteomyelitis. Chronic changes seen in both hips and lower lumbar spine. Wound care nursing note from hospital admitted d 4/12/24 revealed pressure wound to sacrum Stage 4 measured 11.5 cm length by 10.5 cm width, The depth of the wound 4 cm with undermining at 6-10 o'clock with max of 4 cm depth. On 06/20/24 at 12:19 PM Staff H, Licensed Practical Nurse (LPN) stated when there is a pressure ulcer the nurse should provide treatments per the physician order. The wound measurements are done by the wound physician if there was something new I would do the measurement myself. The wound physician does a measurement every week. If someone had a wound vac the nurse should be checking every shift to make sure there is no beeping and there is a good seal and if the canister is full. I also would provide the dressing change for it as ordered. If there was an issue I would reach out to supervisors and let them know. There has been issues getting supplies for wound vac in the past. It has taken about a week to get the proper supplies. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 06/20/24 01:00 PM Staff D, Registered Nurse (RN) stated the nurse should measure wounds on admission and then every time you change the dressing. Follow the physician order for treatment and if no treatment contact the physician to get an order. If there is a wound vac the nurse should be change the dressing every 3 days and if the canister is full it will alarm. The nurse should be looking at them in between time to make sure still intact. I remember Resident #153 he had a wound on his coccyx it would come up often we would change it 2-3 x day due to the spot it was in. I believe he had the wound vac but he also at times had a wet to dry dressing. We document the dressing changes on the treatment administration record. On 06/20/24 at 3:41 PM the Assistant Director of Nursing (ADON) stated the expectation is for pressure wounds to be documented and measured weekly and they are dressing changes done weekly. There were wound treatment orders for Resident # 153. On 6/20/24 at 3:41 PM the Director of Clinical Services stated if their is a change in condition with a wound they should be notify the family and the physician and if needed their is appropriate referral made to the wound clinic to be seen by a physician. The end goal is for the wound to heal. On 06/20/24 04:05 PM reviewed the wound sheets with the ADON and she stated there was no documentation for the wound after the initial admission documentation. She states the expectation is to have wound measurements completed on admission, readmission and then weekly. The nurse completing the readmission should have measured the wound and notified the physician of changes in the wound. The facility provided a policy titled Pressure Injury Prevention and Management with revision date of December 2022 which stated the facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate. The policy directed licensed nurses to conduct a full body skin assessment on all residents upon admission/re-admission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record. The policy revealed assessments of pressure injuries will be performed by a licensed nurse and documented. The staging of pressure injuries will be clearly identified to ensure correct coding on the MDS. Nursing assistants will inspect skin during bath and will report any concerns to the resident ' s nurse immediately after the task. Training in the completion of the pressure injury risk assessment, full body skin assessment, and pressure injury assessment will be provided as needed.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45775 Based on observations, clinical record review, facility policy review, resident and staff interviews the facility failed to identify and respond to an elopement in a timely manner for 1 of 1 residents (Resident #474). Resident #474 eloped from the facility on 6/8/24 at approximately 2:55 PM and was found 5.6 miles from the facility by a bystander at approximately 6:38 PM. Facility staff initially identified the resident was missing at 4:00 PM, notified management at 6:00 PM and called 911 at 6:03 PM. The facility failed to utilize equipment for resident safety for 2 of 2 residents (Resident #19 and Resident #48) during assistance with mobility/transfers. The facility reported a census of 60 residents. The State Agency informed the facility of the Immediate Jeopardy (IJ) on 6/12/24 at 5:47 PM. The IJ began on 6/8/24. Facility staff removed the Immediate Jeopardy on 6/14/24. The facility staff removed the Immediate Jeopardy by implementing the following actions: 1. Complete visual headcount of every resident at Ivy at [NAME] to ensure all were present and safe. 6/8/24 2. Residents residing in the community were re-evaluated for elopement 6/8/24. 3. 1:1 supervision placed on (Resident #474) 6/8/24 upon return to the facility until front door code can be changed and all systems for elopement in place 4. The weekend receptionist was given education on 6/9/24 when she returned to work. 5. An order was placed in Tels for the front door to be assessed for recording. 6. All staff education initiated on 6/8/24 on the facility protocol for elopement and the requirement to validate with Nurse or Management who an individual is, if unsure, before helping them exit the facility. Education will be ongoing until all staff have been educated. Facility staff, new hires, and contract staff will not be allowed to work until education is completed. 7. New Admissions will have wandering/elopement risk assessments completed and when/if identified at risk for elopement will be placed in the elopement risk binders. For admissions after normal business hours the admitting nurse will utilize the instant camera in R hallway medication cart to immediately place photo and demographic sheet in the binders accessible to staff at receptionist desk and other nursing elopement binders. The other two books will be updated next business day. The elopement books will contain a face sheet with photo of residents residing in the facility. The Admissions Director/Designee will provide communication to non-clinical staff of new admissions or anticipated new admission either during the week during normal business hours and during after -hour and weekends. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	8. Staff education was completed in regard to after hours admission or weekends for residents identified at risk for elopement will have instant camera photo taken as well as the Resident identified book at the reception area to communicate non-clinical staff of current residents as well as any new admits and/or potential after hours of weekend admissions, Began on 6/13/24 with completion on 6/14/24. The scope was lowered from a J to a D at the time of the survey after ensuring the facility implemented education. Findings include: 1. A review of the Electronic Health Record (EHR) revealed Resident #474 admitted to the facility on [DATE] after a hospitalization . The diagnoses documented in the EHR included: Unspecified sequelae of cerebral infarction (stroke); unspecified dementia, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety; and type 2 diabetes mellitus. The Baseline Care Plan, dated 6/7/24, indicated the resident at risk for falls, cognitively impaired, required one person physical assistance for transfers and walking in room and corridor, and utilizes a manual wheelchair and walker. A Progress Note, dated 6/8/24 at 1:17 PM, documented the resident is A&Ox2 (alert and oriented times two - aware of who they are and where they are at), resident has been wandering throughout the day from her room to the dining room. Resident is pleasant and orient[ed] call light. Resident ate meals today in the dining room. Resident denies pain or discomfort at this time. BP (blood pressure) 120/81, P (pulse) 80, RR (resting respirations) 18, T (temperature) 98.0, O (oxygen saturation) 98%. A Progress Note, dated 6/8/24 at 9:40 PM, documented family notified of elopement, no concerns at this time and they are grateful and stated these things happen, she has run away before she was in a nursing home, and she's very quick and sneaky. family coming from [redacted] to meet resident at ER (emergency room) and are bringing her back OT (Occupational Therapy) the facility after the evaluation. A document titled, Initial Federal Report, dated 6/8/24, revealed on 6/8/24 at approximately 5:50 PM the Administrator and ADON (Assistant Director of Nursing) were notified by Nurse [redacted] who reports that resident [name redacted (Resident #474)] could not be found in the facility. Facility Nursing Staff report searching the entire facility and not able to find her. The Director of Clinical Services was notified. The Administrator was notified and immediately called 911 to report the facility had been unable to find this resident. The Initial Federal Report revealed when the ADON notified the family of the incident, the family member said she was not surprised and reported that she [the resident] ran away before while living in her apartment. When asked if the family had mentioned anything about her [the resident] running away prior to admission when they completed her admission documentation, the Social Services Director stated they did not say anything. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Initial Federal Report continued, stating the resident was found by local police at/near the police station on [NAME] Street at approximately 6:45 PM. The Initial Federal Report documented after being found the resident transferred to a local emergency room for evaluation. Then transported back to the facility following treatment for UTI (urinary tract infection), minor scarp to her upper lip and chin. Hospital ED (emergency department) records show she didn ' t ' need sutures and scans were negative for major injury including fractures. Upon return, the resident was placed on 1:1 supervision by staff. During an interview on 6/12/24 at 12:53 PM, the Administrator stated the front door of the facility is armed with an alarm. The Administrator demonstrated the alarm will sound if a code is not entered. The door is equipped with a two inch 15 second delayed egress. Meaning the door will open approximately two inches and stop. The alarm will sound, building in intensity, until a staff answers the alarm. The system also announces the location of the open door. The door will remain stopped at two inches unless the alarm is not answered after 15 seconds, when it will open all of the way. An observation on 6/12/24 at 1:01 PM, found Resident #474 in her room, in bed with the covers over her head. Staff Q, Certified Nursing Assistant (CNA) sat outside in the hallway outside of the residents room During an interview on 6/12/24 at 1:02 PM, Staff Q stated Resident #474 is receiving 1:1 supervision after having eloped on 6/8/24. Staff Q stated she is covering the 10:00 AM to 2:00 PM shift. Staff Q stated she did not know when the 1:1 supervision started. During an interview on 6/12/24 at 1:15 PM, Staff M stated she worked the morning of 6/8/24. She stated someone entered the code to the front door, and Resident #474 left the facility. Staff M stated she did not know who entered the alarm. Staff M stated she Resident #474 was found at a local park, approximately a mile from the facility. During an interview on 6/12/24 at 1:44 PM, Staff O, Receptionist stated there have been a lot of discharges and new admissions lately. Staff O stated there is an Elopement book at the front desk. Staff O stated the book includes residents who need supervision. A sheet for each resident includes their name and a picture. A description of height, weight and color of hair is also listed. Staff O stated the book was last a few days ago. Staff O stated she did not know if Resident #474 had been added to the book prior to 6/8/24. An observation on 6/12/24 at 2:15 PM, found Resident #474 in her room, in bed sleeping. The resident noted to have abrasions on her upper lip, and the left side of her chin. (continued on next page)

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	165436	A. Building B. Wing	06/24/2024

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	During an interview on 6/12/24 at 3:08 PM, Staff N, LPN stated on 6/8/24 at approximately 4:15 PM a staff informed her Resident #474 could not be found. Staff N stated she checked her assigned hallway and after not being able to find the resident called a Code Silver. Staff N explained a Code Silver means everyone needs to stop doing what they are doing and do a headcount of the residents on each hallway. Staff N stated she did not know the last time the resident had been seen. Staff N stated after the headcount, all nurses met in the center hallway and reported the headcount results. Staff N stated only Resident #474 could not be accounted for. The team decided to check all empty rooms and connected bathrooms and meet again in the center hall. Staff N stated after the nurses reconvened and confirmed they could not find Resident #474, she called the ADON. Staff N stated she was unsure of the time. But knows she text the height and weight of Resident #474 to the ADON at 4:51 PM During an interview on 6/12/24 at 3:34 PM, when queried about reviewing the facility investigation notes, the Administrator stated all notes are found in the EHR. The Administrator stated he did not complete staff interviews. The Administrator added during his investigation he reviewed camera footage of the front door area of the facility. He stated the footage revealed on 6/8/24 at 2:55 PM Resident #474 walked to the front door, wearing a red and black fleece coat, carrying a white plastic shopping bag. The Administrator stated the weekend receptionist, entered the alarm code to the front door, and Resident #474 exited the building. The Administrator stated staff started looking for the resident at 5:30 PM, and he called 911 at 6:03 PM upon being informed the resident could not be found. The Administrator stated he was notified at 7:31 PM, the resident was found by local police. When queried as to where the resident had been found the Administrator stated he believed the resident to have been found at the police station on [NAME] Street, approximately 2.2 miles from the facility. During an interview on 6/13/24 at 8:55 AM, a local police department officer stated they received a call on 6/8/24 at 6:03 PM from the facility regarding a missing resident. When queried on the location the resident was found, the police officer stated the missing persons report remains open as the department had not found the resident, or been informed the resident has been found. During an interview on 6/13/24 at 9:06 AM, a local emergency department confirmed Resident #474 was brought to the hospital on 6/8/24 at approximately 7:38 PM. The ED staff stated they have no information as to where the resident had been found. The staff stated the resident came to the hospital by ambulance. The local hospital document, titled ED Provider notes, dated 6/8/24, revealed Resident #474 presented to the ED by ambulance for AMS (altered mental status). Initial patient evaluation time 7:38 PM. Patient found on the side of the road by EMS (Emergency Medical Services). She has abrasions to her face likely from a fall today. Clinical Impressions included: At high risk for elopement; abrasion of chin; abrasion of lip, fall, and cystitis (urinary tract infection). During an interview on 6/13/24 at 9:13 AM, a dispatch staff from the local EMS provider stated Resident #474 was found at the side of the road at the intersection of [NAME] and [NAME] Drive. The dispatch stated a bystander saw Resident #474 on the side of the road, became concerned, pulled over help her and called 911. The bystander assisted the resident into their car until the ambulance arrived. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Emergency Medical Service provider report titled, A Patient Care Report - Final, dated 6/8/24 revealed: a. A call received at 6:38 PM b. Dispatched at 6:39 PM c. At scene at 6:49 PM d. At destination (local emergency room) at 7:29 PM. Per a global positioning system, the [NAME] and [NAME] Drive intersection, depending on the route taken, is 5.5 to 5.8 miles from the facility. During an interview on 6/13/24 at 12:50 PM, Staff P, Receptionist stated on 6/8/24 she worked from 8:00 AM to 3:00 PM. She stated she did not know she had opened the door for Resident #474 until 6/9/24, when the Administrator showed her the video. Staff P stated she opened the door for the resident and let her out before the end of her shift. Staff P stated she thought that was around 2:50 PM. Staff P stated she was trained by the full time receptionist. She stated she was trained to ask people who they are before letting them in or out of the facility. Staff P stated she had never met Resident #474 prior to the incident. Staff P stated after watching the video she remembered the resident, and assumed she was a family member visiting a resident. Staff P stated she finds out who is a new resident by word of mouth, or from the full time receptionist. She stated there was an Elopement book at the front desk, but it has not been updated with Resident #474 picture/information. Staff P stated the book is now updated. During an interview on 6/13/24 at 4:20 PM, the Director of Clinical Services stated the facility waited too long to contact 911 after realizing Resident #474 was not in the building. She stated after the initial headcount, and the resident identified as missing administration should have been notified and 911 called immediately. When queried as to where the resident was found, the Director of Clinical Services stated she did not know the exact location where the police found Resident #474. On 6/13/24 at 5:00 PM, a drive from the facility to the intersection of [NAME] and [NAME] Drive revealed: a. [NAME] to [NAME] Street is heavily trafficked with cars and semi-trucks. b. The speed limit varies between 25 to 35 miles per hour depending on school zones. c. The pedestrian sidewalk ends at the intersection of [NAME] and Wisconsin Avenue. d. The intersection of [NAME] and Wisconsin Avenue is 0.6 miles from the [NAME] Drive intersection. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	e. The speed limit at Wisconsin Avenue increases to 45 miles per hour. f. After Wisconsin Avenue, the side of the road is paved with gravel. A facility policy, revised date of 3/2024, titled Elopements and Wandering Residents documented the facility ensures that residents who exhibit wandering behavior and/or at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person centered plan of care addressing the unique factors contributing to wandering or elopement risk. Policy Guidelines included: 5. Procedure for Locating Missing Resident a. Any staff members becoming aware of a missing resident will alert personnel using facility approved protocol b. The designed facility will look for the resident. c. If the resident is not located in the building or on the grounds, administrator or designee will notify the police department and serve as the designated liaison between the facility and the policy department. The administrator or designee should also notify the company ' s corporate office. d. DON (Director of Nursing) or designee shall notify the physician and family member or legal representative. e. Policy will be given a description and information about the resident; include any photos. f. All parties will be notified of the outcome once the resident is located. g. Appropriate reporting requirements to the State Survey agency will be conducted. 34821 4. The MDS for Resident #19 dated 5/24/24, listed diagnoses of cerebrovascular accident (CVA), hypertension (high blood pressure) and diabetes mellitus (DM). The BIMS reflected a score of 4 out of 15, indicating severely impaired cognition. The MDS assessed Resident #19 required substantial staff assist for transfers. The Care Plan for Resident #19 dated 12/4/23, directed he required assist of 1 and gait belt for all transfers. The Care Area Assessment (CAA) dated 5/24/24, revealed Resident #19's needed max to dependent assist of staff with most activities of daily (ADL's) for task completion due to impaired mobility and weakness. Resident is at risk for falls due to impaired mobility and weakness. He required max to dependent assist of staff with transfers. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation on 06/17/24 at 10:54 AM, Staff C, CNA took Resident#19 from under his arm as he stood on the one leg and turned him (stand pivot transfer) from his bed to his scooter. Staff C failed to use a gait belt with the transfer. During an interview on 06/20/24 at 9:58 AM Staff G, CNA described her transfer of Resident # 19, she sat him up on the side of the bed applied a gait belt, made sure his foot is on the pivot disk before she helped him stand and turned him to the scooter. During an interview on on 6/20/24 at 1:05 PM, Staff F Licensed Practical Nurse (LPN) reported R#19 required assist of 1, and a gait belt for a transfer out of bed. The policy titled Safe Resident Handling/Transfers revised 10/4/23 identified, it is the policy of this 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. Guidelines of the policy included: a. The interdisciplinary team or designee will evaluate and assess each resident's individual mobility needs, taking into account other factors as well, such as weight and cognitive status. b. Handling aids may include gait belts, transfer boards, and other devices. c. Staff members are expected to maintain compliance with safe handling/transfer practices. Failure to maintain compliance may lead to disciplinary action up to and including termination of employment. d. Resident lifting and transferring will be performed according to the resident's individual plan of care. 48888 5. The MDS dated [DATE], revealed a BIMS score of 5 out of 15, indicating severely impaired cognition. Resident #48 utilized wheelchair for mobility and dependent on staff assistance to transfer to and from chair. Once sat in wheelchair, Resident #48 able to self propel wheelchair 150 feet independently. Diagnoses included encephalopathy and difficulty in walking. Resident #48 had 2 or more falls without injury since prior assessment. The Care Plan, initiated 02/27/24, revealed Resident #48 had an impaired ability to independently move or navigate wheelchair. An intervention, initiated 02/27/24, instructed staff that Resident #48 does some of the work to move or navigate the wheelchair, but usually required assistance of a helper to provide more than half the effort in moving the wheelchair from one place to another. During an observation on 06/18/24 at 12:32 PM, Staff M, Certified Nursing Assistant (CNA), pushed Resident #48 from the main C hallway into north dining room, no foot pedals in place on wheelchair, Resident #48 held his feet up approximately 1 to 2 inches from the floor during transportation. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/20/24 at 01:17 PM, Staff M, CNA, revealed that foot pedals must always be used when a resident is pushed in wheelchair and stated if she saw a resident pushed in wheelchair without pedals, she would stop. Staff M indicated transportation of residents in wheelchair without foot pedals may result in fall or injury to the resident. During an interview on 06/20/24 at 01:17 PM, Director of Nursing (DON) stated she would expect foot pedals are applied to wheelchairs before staff assist a resident with wheelchair transportation. The DON confirmed Resident #48 required occasional staff assistance with wheelchair transportation. During an interview on 06/20/24 at 01:20 PM, the Director of Clinical Services, revealed that many residents who self propel in wheelchair had pedal bags added to the back for foot pedal storage.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49976 Based on clinical record review, policy review, and staff interview the facility failed to have a physician conduct the first resident assessment within 30 days of admission for three of five residents reviewed (Res #47, Res #5, Res #304). The facility reported a census of 60 residents. Findings include: 1. The Minimum Data Set (MDS) report dated 5/07/24 for Resident #47 documented a Brief Interview for Mental Status (BIMS) score of 9 out of 5 indicating moderately impaired cognition. The MDS diagnoses included: stroke, seizure disorder, and metabolic encephalopathy (chemical imbalance that damages the brain). The Electronic Health Record (EHR) indicated Resident #47 admitted to the facility on [DATE]. A review of the Physician Progress Note dated 2/19/24 at 10:36 AM revealed a new resident initial visit was conducted by a Nurse Practitioner (ARNP). 2. The MDS dated [DATE] for Resident #50 documented a BIMS score of 9 out of 15 indicating moderately impaired cognition. The MDS diagnoses included: fractures and other multiple trauma, renal insufficiency (kidney failure), and GERD (gastroesophageal reflux disease). The EHR indicated Resident #50 admitted to the facility on [DATE]. A review of the Physician Progress Note dated 4/26/24 at 1:23 PM revealed a new resident initial visit was conducted by an ARNP. 3. The MDS report for Resident #304 documented a BIMS score of 3 out of 15, indicating severely impaired cognition. The MDS diagnoses included: stroke, non-Alzheimer's dementia, and hemiparesis (inability to move one half of the body). The EHR indicated Resident #304 admitted to the facility on [DATE]. A review of the Physician Progress Note dated 4/03/24 at 4:31 PM revealed a new resident initial visit was conducted by a ARNP. In an interview on 6/20/24 at 3:08 PM the Director of Clinical Services explained she expected each resident to be seen by a physician within the first 30 days and then they can be seen by an ancillary provider. The facility policy titled Physician Visits and Physician Delegation, reviewed 12/22 instructed the physician to see the resident within 30 days of initial admission to the facility. At the option of the physician, required visits in Skilled Nursing Facilities, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist that is acting within scope of practice defined by State law and under the supervision of the physician.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 49976 Based on clinical record review, staff interview, and policy review the facility failed to ensure Certified Nursing Assistants (CNA) were provided routine competency evaluations for two of three employees reviewed. The facility reported a census of 60 residents. Findings include: 1. A review of the employee personnel files on 6/20/24 at 10:05 AM revealed Staff C, CNA did not receive routine competency evaluations. The employee was hired on 3/30/23. 2. A review of the employee education files on 6/20/24 at 10:45 AM revealed Staff K, CNA did not receive routine competency evaluations. Staff K was hired on 4/01/20. On 6/20/24 at 11:30 AM documentation of CNA competency evaluations requested. A second request made at 1:36 PM . On 6/24/24 the Director of Clinical Services reported she could not find a performance evaluation for Staff K. During an interview on 6/20/24 03:08 PM, the Director of Clinical Services explained she expected all staff to complete their core competency requirements for education, including the 12 hours of yearly education and the yearly competency evaluations. The facility knew they were behind. The facility policy titled Competency Evaluation, revised 3/23 instructed the facility to complete subsequent and/or annual competency evaluated at a frequency determined by the facility assessment, evaluation of the training program, and/or job performance evaluations. Checklists must be used to document training and competency evaluations. Employee competency forms must be maintained in the Staff Development Coordinator's office for current training year, then forwarded to the Human Resources Director for placing into the employee's personnel file.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48888 Based on observations, interviews, facility document review and facility policy review, the facility failed to maintain sanitary conditions for the storage, preparation and handling of beverage cups during 1 of 1 meal services observed; and failed to maintain appropriate temperatures for frozen food stored in 1 of 3 freezers. The facility reported a census of 60 residents. Findings include: On 06/17/24 at 10:10 AM, during an initial tour of the main kitchen, the stand alone freezer thermometer indicated a temperature of 30 degrees Fahrenheit. The kitchen stove top appeared to be coated with a black substance and grease. During an observation of the noon meal on 6/17/24 from 12:15 PM to 12:38 PM Staff A, Dietary Aide served 10 glasses to 9 residents with bare fingers touching the drinking rim surface of the glass. On 06/18/24 at 11:00 AM, throughout lunch preparation the floor in kitchen noted to be heavily flooded around the dishwasher, continuing towards the front of the kitchen near the preparation sink, in front of the steam table, and in front of the food preparation counter. The water on the floor contained food particles, wrappers, dirt, and debris. [NAME] towels placed on the floor in the areas with the water appeared to be heavily saturated, and brown and black in color. The stove top appeared to have a thick yellow crusted substance, pushed towards the back of the stove. A collection of heavy dust visible under the center of a set of three connected refrigerator units. Areas of dust noted on the ceiling above the dishwasher and food preparation areas. On 06/18/24 at 11:30 AM, the stand alone freezer thermometer continued to read 30 degrees Fahrenheit. Freezer contained: 2 rolls of ground beef, box of hamburger patties, 2 packages of pre-made soup, a bag of French toast sticks, and a bag of sweet potato fries. The shelves of freezer felt slightly cool, but not cold. Noted French toast sticks soft to touch and one of the two rolls of ground beef had softened. Dietary Manager confirmed temperature read 30 degrees Fahrenheit, informed staff recently cleaned freezer, which resulted in higher temperature reading. On 06/18/24 at 12:25 PM, following lunch service, stand alone freezer thermometer continued to read 30 degrees Fahrenheit, Dietary Manager indicated thermometer may not be functioning appropriately and planned to change the thermometer. On 06/18/24 at 02:56 PM, a new thermometer placed in stand alone freezer, temperature read 10 degrees Fahrenheit, Dietary Manger revealed freezer not functioning appropriately and planned to notify maintenance staff. On 06/20/24 at 11:38 AM, Dietary Manager revealed the expectation that main kitchen is cleaned daily and for dietary staff to sign off checklist when cleaning tasks are completed. Dietary Manager additionally revealed the expectation of dietary staff to handle resident's drinking glasses in a way that prevents contamination to rim of glass. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility document titled Freezer Temperature Log, dated June 2024, revealed the following freezer temperature entries: 1. June 6th at 07:00 PM= 20 degrees Fahrenheit 2. June 9th at 07:00 PM= 20 degrees Fahrenheit 3. June 11th at 07:00 PM= 20 degrees Fahrenheit 4. June 12th at 07:00 PM= 40 degrees Fahrenheit 5. June 13th at 07:00 AM= 20 degrees Fahrenheit 6. June 17th at 07:00 PM= 30 degrees Fahrenheit The facility provided dietary staff assignment checklist, not dated, revealed a daily expectation of the cook assigned to record refrigerator and freezer temperatures, clean grill or stove if used, and sweep the floor. The assignment checklist revealed a daily expectation of dietary aides to mop kitchen floor. The facility policy, titled Food Safety Requirements, revised November 2022, instructed staff to monitor food temperatures and functioning of refrigeration equipment daily and at routine intervals during all hours of operation. Policy revealed that all equipment used in the handling of food shall be cleaned and sanitized and handled in a manner to prevent contamination. This policy additionally revealed expectation of staff to adhere to safe hygienic practices to prevent contamination of foods from hands or physical objects.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. 48888 Based on staff interview, review of CMS-2567 reports, and facility policy review, the facility failed to ensure an effective QAPI (Quality Assurance Performance Improvement) process to address previously identified quality deficiencies, resulting in multiple repeat deficiencies identified on the facility's current recertification and complaint survey previously identified during surveys completed in the last twelve months. The facility reported a census of 60 residents. Findings include: 1. Review of the facility's CMS-2567 form from a recertification survey which occurred 04/11/23 to 06/05/23 revealed the facility received immediate jeopardy level and harm level citations related to the following areas: a. Free of accidents, hazards, supervision, and devices b. Food procurement, storage/preparation/service and kitchen sanitation. c. Treatment and services to prevent or heal pressure ulcers The facility's plan of correction for this survey revealed documentation present at the end of the CMS-2567 form included the following: a.) Free of accidents and hazards: Residents were reviewed for elopement risk, interventions placed as appropriate with updated binders located at nurses station and front desk. Facility conducted environmental review of egress doors to ensure functionality and reviewed kitchen serving area to ensure keypad entry locks were in place and functioning. Staff were educated on elopement risk assessments, resident trigger identification, interventions, supervision, response procedures, routine mock drills, behavior alert and communication, and functionality of egress doors. Director of Nursing (DON), or designee, responsible for audits of resident elopement risk assessments and to ensure elopement binder kept up to date. Maintenance Director responsible for review of egress doors to ensure functionality. Administrator responsible for elopement drill documentation to ensure staff participation. b.) Food Procurement, store/prepare/serve-sanitary: Facility reported kitchen surfaces, refrigerator units, drawers, equipment, and floor were cleaned and added ceiling air return vents and AC vents to the routine cleaning schedule. Dietary staff completed food safety training. Dietary and Maintenance staff were educated on routine cleaning and disinfection standards, safe resident environment, personal hygiene, hand hygiene, hair nets, pest control program, and preventative maintenance. Dietary staff were educated on food safety, food handling, routine dietary duties, menus, and communication related to broken equipment. Facility Administrator responsible for conduction of audits to ensure food safety practices demonstrated, routine dietary duties carried out, and menus followed. Quality Assurance/Performance Improvement Committee recommended ongoing quarterly monitoring. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c.) Services to prevent or heal pressure ulcers: Licensed staff were educated on the regulation with emphasis on prevention of the development and transmission of infection, clean dressing change process, and interventions to prevent development of pressure ulcers. Director of Nursing (DON), or designee, to conduct licensed staff audits of clean dressing change competency and audits of residents at risk for pressure ulcers to ensure preventative interventions in place. 2. The CMS-2567 form from a complaint survey dated 09/19/23 to 10/12/23 revealed the facility again issued a harm level deficient practice for free of accidents, hazards, supervision, and devices during this specific survey. 3. The facility's current recertification survey, entrance date 06/17/24, resulted in an Immediate Jeopardy level deficient practice for free of accidents and hazards and a harm level deficient practice for services to prevent or heal pressure ulcers. Additionally, the current recertification survey resulted in a deficient practice for food procurement, storage/preparation/service and kitchen sanitation. On 06/24/24 at 09:30 AM, Facility Administrator revealed that kitchen sanitation is an ongoing project in collaboration with Dietary Manager to provide staff education and re-education, and ensure that cleaning lists and temperature logs are completed. Administrator revealed ongoing collaboration with nursing department to determine residents at risk for elopement, and put interventions in place. Administrator stated an elopement drill, code silver, occurred once in past 2 months and had been successful. Administrator revealed that in light of recent elopement all staff educated on immediate communication to leadership if a resident is missing and felt current Quality Assurance Committee is headed in the right direction to resolve repeat deficiencies. The Facility provided documentation of QAPI sign in sheets from the following dates: 02/22/24, 02/28/24, 04/30/24, and 05/30/24. Facility unable to provide additional documentation of sign in sheets prior to the 02/22/24. The facility policy titled, Quality Assurance and Performance Improvement (QAPI), revised 07/17/23, revealed expectation of the Quality Assessment and Assurance (QAA) Committee to meet at least quarterly and as needed, develop and implement appropriate plans of actions to correct identified quality deficiencies, regularly review and analyze data, and act on available data to make improvements. The policy additionally instructs the facility to take action at performance improvement as documented in QAA Committee meeting minutes and action plans with success of the actions to be monitored and documented in subsequent QAA Committee meetings.

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	06/24/2024

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34821 Based on observations, clinical record review, staff interviews and facility policy review the facility failed to implement Enhanced Barrier Precautions (EBP) for 2 of 2 resident reviewed for EBP (Resident #9, #25). The facility failed to handle laundry with Personal Protective Equipment (PPE) for 2 out of 2 observations. The facility reported a census of 60 residents. Findings include: 1. The MDS for Resident #9 dated 5/1/24, listed diagnoses of venous insufficiency and diabetes mellitus. The MDS reflected she scored 11 out of 15 on the Brief Interview for Mental Statues (BIMS), indicating moderately impaired cognition. The MDS reflected 2 venous ulcers. The Diagnoses Sheet for Resident #9 dated 6/20/24, listed diagnoses resistant to multiple antimicrobiales drugs (MDRO), venous insufficiency and diabetes mellitus. The Care Plan for Resident #9 revised on 5/20/24, lack her MDRO diagnosis and lack intervention related to EBP. The facility Matrix dated 6/12/24, listed Resident #9 with a stage 4 pressure ulcer (a deep tissue injury that involves full-thickness skin loss and exposure of bone, tendon, or muscle). The Order Summary Report for Resident#9 dated 6/17/24, failed to direct EBP. The Wound Evaluation & Management Summary dated 6/3/24, described a Stage 4 pressure wound of the right heel full thickness 1.2 centimeters (cm) by 1.2 by 0.1 cm. Surface 1.44 cm. Thick black necrotic tissue 100%. wound improved decreased surface size. Apply Betadine once daily for 30 days. On 6/17/24 at 11:50 AM, Resident# 9's room door held (PPE) personal protective equipment that included gowns. On 6/19/24 10:22 AM Staff F Licensed Practical Nurse (LPN) used alcohol based hand sanitizer and applied gloves. Staff F completed treatments to Resident #9's left great toe, left shin and her left heel wound. Staff F failed to apply a gown while she completed the wound care. On 6/20/24 at 09:54 AM Staff F reported Resident # 9 room door held the PPE because of Carbapenem-resistant Acinetobacter baumannii (CRAB) in the urine. On 6/20/24 at 1:16 PM, the Infection Preventionist (IP) reported she expected staff to use the EBP with tube feedings, wounds, catheter, and IV (intravenous). She said she's put a system in place for the staff to know when to use EBP. She reported the doors need a sign and the PPE hung. She stated she's done some education on the PPE needed. On 6/20/24 at 1:24 PM, the IP at R#9's room confirmed the facility failed to indicate the needed for EBP. She reported she has the signs on order and has the PPE needed for EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility provided a policy titled Enhanced Barrier Precautions dated 10/4/23, directed it is the policy of this facility to implement enhanced barrier precautions for preventing transmission of novel or targeted multidrug-resistant organisms (MDROs). Enhanced barrier precautions refer to the use of gown and gloves for certain residents during specific high-contact resident care activities that have been found to increase risk for transmission of multidrug-resistant organisms. Novel or targeted MDROs are organisms that are resistant to all or most antibiotics tested , are uncommon in a geographic area, or have special genes that allow them to spread their resistance to other germs. An order for enhanced barrier precautions will be obtained for residents with any of the following: Wounds and/or indwelling medical devices (e.g., central line, urinary catheter, feeding tube, tracheotomy/ventilator) regardless of MDRO colonization status. 2. On 6/20/24 at 9:33 AM, Staff B Housekeeping/Laundry delivered clothes on the A wing hall with the hung laundry cart open on the side to remove the hung clothes by A16. The hung laundry cart remained open as staff moved the cart to the other end of the hall as she delivered clothes. Nursing staff passed by as they picked up meal trays from resident's rooms. At 09:53 AM Staff B by room A3 covered the cart. On 6/20/24 at 1:16 PM, the Infection Preventionist (IP) reported she expected the linen covered in the hall while transported. 06/20/24 12:15 PM the policy titled Infection Prevention and Control Program revised 7/1/23, reflected; This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. The policy failed to address the Enhanced Barrier Precautions (EBP). The Linens section of the policy included: a. Laundry and direct care staff should handle, store, process, and transport linens to prevent the spread of infection. b. Clean linen shall be separated from soiled linen. c. Clean linen shall be delivered to resident care units on covered linen carts with covers down. d. Linen shall be stored on all resident care units on covered carts, shelves, in bins, drawers, or linen closets. e. Soiled linen shall be collected at the bedside and placed in a linen bag. When the task is complete, the bag shall be closed securely and placed in the soiled utility room. Soiled linen shall not be kept in the resident's room or bathroom. f. Environmental services staff shall not handle soiled linen unless it is properly bagged. 48888 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. The Minimum Data Set (MDS), dated [DATE], for Resident #25 revealed severe cognitive impairment. Diagnoses included cerebral palsy and dysphagia (difficulty swallowing) The Care Plan, revised 07/12/23, revealed Resident #25 required feeding tube related to dysphagia and instructed staff to provide local care to Gastronomy Tube (G-Tube) site as ordered and monitor for signs and symptoms of infection. Care Plan lacked instruction for Enhanced Barrier Precautions or additional Personal Protective Equipment (PPE) to prevent the spread of infection related to chronic internal device. The Medication Administration Record (MAR) revealed current orders for Nothing Per Oral route (NPO), and administration of 45 milliliters (mL) Jevity Liquid Supplement via G-Tube one time a day for dependence on enteral feed with a total run time of 16 hours each day. MAR orders instructed staff to check G-Tube residual and placement and flush with 30 mL of water before and after medication administration. On 06/19/24 at 08:37 AM, Staff F, Licensed Practical Nurse (LPN) prepared, crushed, and mixed with water, Resident #25's morning medications, following Physician orders. Staff F entered Resident #25's room applied hand sanitizer and donned gloves, no additional PPE (i.e. gown) applied prior to medication administration via Gastronomy Tube. No additional signage, staff instruction, or PPE observed upon entrance to Resident #25's room. She paused, clamped, and removed tubing for continuous Jevity feeding from G-Tube site. Staff F flushed G-Tube with water, administered crushed medication mixture, then flushed tube again with water prior to restarting the Jevity tube feeding. She removed gloves and applied hand sanitizer. 49976 4. In an observation on 6/19/24 at 9:02 AM Staff B, Housekeeper noted resident clothes and linens are in a plastic bag upon pickup. She explained staff wore gloves to separate and place the soiled laundry into the washing machines. She further explained staff are not required to wear any other protective equipment when handling soiled laundry. They are to transport all items in a clean, covered bin. A pile of linens were directly on the floor by the dryer. During an observation on 6/19/24 at 11:55 AM Staff B failed to wear a gown and wore only gloves, opened a resident linen bag, and placed towels, linens, and pads in the washer. She placed a personal item on a pile on the floor. She then grabbed linens from a second resident's bag and placed them in the washer. Soiled laundry came into direct contact with Staff B's clothing. In an interview on 6/19/24 at 4:01 PM, the Director of Maintenance explained there's really nothing set in place for what staff are expected to wear when handling soiled laundry. The facility policy titled Handling Soiled Linen, updated 12/05/23 directed staff to: 1. Linen can become contaminated with pathogens from contact with intact skin, body substances, or from environmental contaminants. Transmission of pathogens can occur through direct contact with linens or aerosols generated from sorting and handling contaminated linen. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. All used linen should be handled using standard precautions (i.e., gloves) and treated as potentially contaminated. Other protective equipment may be required. 3. Linen should not be allowed to touch the uniform or floor and should be handled as little as possible, with minimum agitation to avoid contamination of air, surfaces, and persons.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49976 Based on observation, policy review, and resident and staff interviews the facility failed to keep the facility free from vermin. The facility reported a census of 60 residents. Findings include: 1. During an observation on 6/17/24 at 2:40 PM a hole in the outside soffit (underside of roof overhang) measuring roughly 2 feet by 2 feet on the right side of the entrance was found. In an interview on 6/18/24 at 11:59 AM Staff D, Registered Nurse (RN) remarked she had heard things in the ceiling and assumed they were raccoons. In an interview on 6/18/24 at 12:31 PM Staff I, Occupational Therapist noted she had heard residents complain about raccoons in the ceiling. She reported there is a crawl space attic above the front of the building. In an interview on 6/18/24 at 1:30 PM the Director of Maintenance stated he started working at the facility about three months ago. At that time, he put all the soffit back up that had fallen down. He reported there were raccoons in the facility before he started. He was just made aware of the hole on the right side of the entrance yesterday. He thought it was probably squirrels this time. He stated the pest control service did come yesterday to set and move mouse traps in the building. In an interview on 6/20/24 at 10:07 AM the vermin control professional reported there were two holes in the outside soffit. He noted there was an actual raccoon entrance hole on the [NAME] of the front entrance. He explained the only thing that makes holes like that are raccoons and reported the facility definitely had raccoons going up there. In an interview on 6/20/24 at 12:42 PM the Director of Maintenance explained the pest control company had been there every month, twice this month putting mouse traps out and moving them around the building. He noted mice have been in the building since he started in March. 37072 2. The MDS dated [DATE] for Resident #20 revealed a BIMS score of 15 out of 15, indicating intact cognition. On 06/17/24 at 11:20 AM Resident #20 stated I have seen mice. I saw them down where we go out to smoke in the dining room going under a heater vent. I think it is because people drop their food on the floor. 2. The MDS dated [DATE] for Resident #154 revealed a BIMS score of 15 out of 15 indicating intact cognition. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 06/17/24 at 11:46 AM Resident #154 stated there are mice in the building and I see them everyday. He pointed out a mouse trap in the corner of his room in the corner. There is a hole by the front door. You can hear the raccoons up in the room. Mice run out in front of you at night. On 06/20/24 12:09 PM Staff L, Certified Nursing Assistant (CNA) stated I saw a mouse in the women's bathroom on L hall just on Saturday. They have had the problem a while, I have seen exterminator in the building and there also one down in a residents room. I seen a mouse on L hall and also on C hall. On 06/20/24 12:17 PM Staff H, Registered Nurse (RN) stated I saw a mouse one about a week ago on A hall. I reported it to the Administrator I haven't seen anything being done that I am aware of but only here two days a week. The facility provided a policy titled Pest Control with a revision date of 4/5/21 revealed staff facility- wide pest-control strategies are developed emphasizing kitchens, cafeterias, laundries, central sterile supply areas, loading docks, construction activities, and other regions prone to pest infestations. Guidelines included: 1. On-going measures are taken to prevent, contain, and eradicate common household pests such as roaches, ants, mosquitoes, flies, mice, and rats. 2. General measures to decrease pests include the elimination of cracks and crevices, proper lighting and ventilation, use of screens on windows and doors, and use of self-closing doors. 3. Monitor for breaks in screens and doors on a routine basis. 4. Food stored in the dietary area is kept in a designated area in securely covered containers, is off the floor and away from the walls. 5. Any food items kept in residents ' rooms stored in covered containers or sealed bags, except uncut fruits such as bananas or oranges. Review resident plan of care for non-compliance with food storage and provide education as needed. 6. Maintain garbage storage area(s) in a sanitary condition to prevent the harborage and feeding of pests. 7. A contract with a pest control company may be elected to assure regular inspection and application of chemical pesticides. 8. The facility will contract for routine pest control service by a credentialed pest-control specialist. The pest control contractor shall have knowledge of pest control treatment methods for healthcare facilities. 9. Facility employees shall not handle or apply pesticides. (continued on next page)

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	165436	A. Building B. Wing	06/24/2024

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	10. Regular inspections by the local and county sanitation departments are part of the pest control program. 11. The facility will follow applicable state and local regulations on regular pest control. 12. Maintenance Director or designee will maintain records of pest control program and applicable contracts with pest control services, including applicable SDS (Safety Data Sheets) for pesticides applied. 13. The facility shall maintain a method for staff to notify the Maintenance department when pests are identified.

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. 49976 Based on personnel file review, staff interview, and policy review the facility failed to ensure staff members were provided mandatory education on the rights of residents and the responsibilities of the facility for 5 of 6 employees reviewed. The facility reported a census of 60 residents. Findings include: A review of the employee education files on 6/20/24 at 9:42 AM revealed the following staff did not have record of resident rights and facility responsibilities education: a. Staff H, Licensed Practical Nurse (LPN) b. Staff C, Certified Nursing Assistant (CNA) c. Staff K, CNA d. Staff A, Dietary Aide e. Staff J, LPN On 6/20/24 at 11:30 AM a request made to facility clinical administrative staff to provide documentation of the required education. A second request made at 1:36 PM. In an interview on 6/20/24 03:08 PM the Director of Clinical Service explained she expected all staff to complete their core competency requirements for education, including the 12 hours of yearly education and the yearly competency evaluations. The facility policy titled Orientation, revised 10/01/22 instructed the facility to create a general orientation plan that reflected the onboarding process for all newly hired employees, and reflected content that is applicable to all staff. It noted general orientation must be completed prior to the employee's formal contact with facility residents. Checklists must be used to document training and competency evaluations conducted during the orientation process. It required all documentation to support completion of the orientation process to be maintained in the employee's personnel file. The facility policy titled Required Training, Certification, and Continuing Education of Nurse Aides, revised 10/01/22 instructed the facility to provide education including resident rights and facility responsibilities.

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F 0944 Level of Harm - Potential for minimal harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 49976 Based on record review, staff interview, and policy review the facility failed to ensure staff members were educated on the mandatory quality assurance and performance improvement (QAPI) program for five of six employees reviewed. The facility reported a census of 60 residents. Findings include: 1. A review of the employee education files on 6/20/24 from 9:42 AM to 10:56 AM revealed the following staff did not have a record of completed education on QAPI: a. Staff H, Licensed Practical Nurse (LPN) b. Staff C, Certified Nursing Assistant (CNA) c. Staff K, CNA d. Staff A, Dietary Aide e. Staff J, Licensed Practical Nurse (LPN) A review of the General Orientation Plan, dated 2022 revealed the absence of QAPI training. On 6/20/24 at 11:30 AM. a request made to facility clinical administrative staff to provide documentation QAPI education. A second request made at 1:36 PM. In an interview on 6/20/24 03:08 PM the Director of Clinical Service explained she expected all staff to complete their core competency requirements for education, including the 12 hours of yearly education and the yearly competency evaluations. The facility policy titled Orientation, revised 10/01/22 instructed the facility to create a general orientation plan that reflected the onboarding process for all newly hired employees, and reflected content that is applicable to all staff. It noted general orientation must be completed prior to the employee's formal contact with facility residents. Checklists must be used to document training and competency evaluations conducted during the orientation process. It required all documentation to support completion of the orientation process to be maintained in the employee's personnel file. The facility policy titled Required Training, Certification, and Continuing Education of Nurse Aides, revised 10/01/22 instructed the facility to provide education including elements and goals of the facility's QAPI program.

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	165436	A. Building B. Wing	06/24/2024

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 49976 Based on record review, staff interview, and policy review the facility failed to ensure Certified Nursing Assistants were provided the required minimum of 12 hours of in-service education yearly for one of three employees reviewed. The facility reported a census of 60 residents. Findings Include: A review of the employee education files including online training transcripts and in-service sign in sheets on 6/20/24 at 10:05 AM revealed Staff C, CNA did not have 12 hours of in-service education yearly. The employee was hired on 3/30/23. On 6/20/24 at 11:30 AM, a request made to the facility clinical administrative staff to provide documentation of the required education. A second request made at 1:36 PM. In an interview on 6/20/24 03:08 PM the Director of Clinical Service explained she expected all staff to complete their core competency requirements for education, including the 12 hours of yearly education and the yearly competency evaluations. The facility policy titled Required Training, Certification, and Continuing Education of Nurse Aides, revised 10/01/22 instructed the facility to provide at least 12 hours of in-service training annually, based on the employment date, not calendar year. Documentation of in-services must be forwarded to the HR Director and maintained in the employee's personnel file.