STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. Building B. Wing	03/06/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25855 Based on observation, family and staff interviews, the facility failed to notify the resident representative of a change in the medication regime for 1 of 2 residents (Resident #10) reviewed. The facility reported a census of 65 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] identified Resident #10 as cognitively intact with a BIMS (Brief Interview for Mental Status) of 12 out of 15. Diagnoses listed on the MDS included: depression, cognitive communication deficit, and dysphagia (difficulty swallowing). Review Resident #23 Care Plan, Date Initiated: 1/13/22 included a Focus area to address The resident has impaired cognitive function or impaired through processes r/t (related to) HX (history) of ETOH (alcohol) abuse. Interventions included, in part: a. Communicate with the resident/family/caregivers regarding his capabilities and needs. Date Initiated: 1/13/2022. b. The resident needs supervision/assistance with all decision making. Date Initiated: 1/22/22. During an interview on 3/3/25 at 8:27 AM, Resident #10's Power of Attorney (POA) stated he had not been informed of a new medication prescribed for the resident until he received the bill from the pharmacy. The POA stated the medication was depoprovera. Review of Physician's Orders revealed an order for Depo-Provera Intramuscular Suspension 150 Mg (milligrams)/Ml (milliliters) (Medroxyprogesterone Acetate (Contraceptive)) Inject 1 ml intramuscularly one time a day every Fri (Friday) for Hypersexuality. The order start date 12/6/24. During an interview on 3/5/25 at 10:48 AM, the Director of Nursing stated she would expect the family or resident representative to be notified whenever there is any change of condition, new medications, new appointments out of the facility, or any other related changes. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy Notification of Changes, last reviewed date of 11/8/23 Compliance Guidelines statement declared: The facility will inform the resident, consult with the resident ' s physician and/or notify the resident ' s family member or legal representative when there is a change requiring such notification. Circumstances requiring notification included, in part: #3. Circumstances that require a need to alter treatment. This may include: a. New treatment.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 25855 Based on observation, record review and staff interview, the facility failed to provide a homelike environment free of odors in 2 of 4 hallways, and failed to ensure the handrails of one of four hallways to be free of exposed sharp edges. The facility reported a census of 65 residents. Findings include: #1. During an interview on 2/24/25 at 10:59 AM, a resident representative for Resident #45 stated when she visited the facility the smell of urine was overpowering. She stated she could smell it as soon as she walked into the building. Observations of the A and B halls revealed the following: On 2/24/25 at 12:33 PM, the end piece to the handrails outside room B2 and B8 missing, exposed sharp edges noted. On 2/24/25 at 1:40 PM, hallway outside room B5 noted to have a strong odor of urine. On 2/25/25 at 8:00 AM, strong odor of urine noted in back dining room by A and B halls. During an interview on 3/4/25 at 11:00 AM, the Administrator reported the facility currently did not have a Maintenance Supervisor as the last one quit on 3/1/25. During an interview on 3/4/25 at 11:40 AM, Staff R, Certified Nursing Assistant (CNA) stated she is not sure what caused the odors in the A and B hallway, but thought it could be embedded in the flooring. During an interview on 3/4/25 at 12:50 PM, Staff I, Licensed Practical Nurse (LPN) reported she did not feel the odors in the A and B hallways and back dining room were caused by the linen bins and thought it could be caused by the flooring. During an interview on 3/4/25 at 12:28 PM, Staff J, Registered Nurse (RN) reported she felt the odors in the A and B hallways and back dining room were caused by flooring that should be replaced. 48374 #2. During an observation on 2/26/25 at 9:13 AM while in room B9 with the Director of Nursing (DON) and Staff F, RN for wound care a dried red substance was observed on the wall near the end of the bed. The red substance was smeared and ran down the wall. During an observation on 2/27/25 at 8:35 at AM, the red substance remained on the wall in room B9. During an interview on 2/27/25 at 8:40 AM Staff F, RN stated she had not seen the red substance on the wall. She stated if she would have seen it she would have had it cleaned off immediately. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/27/25 at 8:54 AM, the DON reported she had not seen the red substance on the wall. While in room B9, the DON stated she certainly had not seen this yesterday when in the room for wound care. During an interview on 03/04/25 at 11:00 AM the Administrator advised it is his expectation all staff members immediately clean up any visibly soiled surfaces when observed. It is his expectation that all resident rooms are cleaned and disinfected routinely A review of the Facility Policy titled: Routine Cleaning and Disinfection dated as last revised 6/25/24 had documentation of the following: a. Routine cleaning and disinfection of the frequently touched or visibly soiled surfaces will be performed in common areas, resident rooms and at the time of discharge. b. Routine cleaning and disinfection will be conducted with a detailed focus on visibly soiled surfaces. c. Cleaning of walls, blinds and window curtains will be conducted when visibly soiled.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 45338 Based on observation, interview, and clinical record review the facility failed to complete a significant change Minimum Data Set (MDS) assessment when the resident discontinued hospice services for one of one resident reviewed for hospice (Resident #53). The facility reported a census of 65 residents. Findings include: Review of the Quarterly Minimum Data Set (MDS) assessment for Resident #53 dated 1/24/25 revealed the resident scored 13 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated the resident was cognitively intact. The General Note dated 12/24/24 at 12:23 PM revealed, Resident expressed wanting to come off hospice, hospice RN (Registered Nurse) and social worked came and resident signed off services effective today. MD (Medical Doctor) notified. The Physician Progress Note dated 12/27/24 at 12:13 PM revealed, Reason for visit: staff reports resident is off hospice and wishes to pursue treatment for her cancer .States that she did not want hospice any longer when she was informed that they do not do chemo (chemotherapy) treatments .Assessment/plan: no longer receiving hospice care. Review of Resident #53's MDS history revealed the resident had a significant change MDS assessment completed 10/24/24, and next had a quarterly MDS assessment completed 1/24/25. On 2/24/25 at 2:01 PM, Resident #53 observed in wheelchair and used the telephone at the nursing station. On 2/27/25 at 11:36 AM, the MDS Coordinator explained the team would let her know needed significant change, she would open one up, and the IDT (interdisciplinary) team and the MDS Coordinator would work on completing the significant change. The MDS Coordinator explained she would needed communication that [resident] stopped hospice so that one could be opened. When queried for this instance if the facility let her know stopped hospice services, the MDS Coordinator responded not that she could remember, she would have opened one. The MDS Coordinator explained if wanted a MDS opened, needed to communicate so let MDS Coordinator know. On 3/5/25 at 11:13 AM, the Director of Nursing (DON) confirmed when get off of hospice, should have triggered significant change. Per the DON, didn't change payer in the system and got missed, and as soon as happened (payer source change), triggered significant change so everyone could go in and do/document assessments. On 3/4/25 at 2:36 PM, a Facility Policy for significant change MDS requested via email to the facility's Administrator. On 3/5/25 at 11:17 AM, the facility's Administrator explained via email the facility followed the RAI (Resident Assessment Instrument), and did not have a policy to address significant change.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25855 Based on observation, record review and staff interview, the facility failed to address smoking as a focus area for 2 of 3 residents reviewed for smoking (Residents #51 and #264). The facility reported a census of 65. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] identified Resident #264 as cognitively intact with a BIMS (Brief Interview for Mental Status) of 15 and had the following diagnoses: malnutrition, anxiety disorder and respiratory failure. The MDS identified Resident #264 dependent on staff for toileting, lower body dressing, putting on and taking off footwear. During an observation on 2/24/25 at 1:33 PM, Staff A, Certified Nursing Assistant (CNA) pushed Resident #264 in her wheelchair outside to the smoking area. Resident #264 proceeded to smoke a cigarette. Review of the Care Plan revealed a lack of a Focus area, Goal and Interventions to address Smoking. During an interview on 3/3/25 at 3:04 PM Staff B, Registered Nurse (RN) reported Resident #264 smoked and that should have been identified on her Care Plan. Staff B stated the MDS Coordinator completes the Care Plans. During an interview on 3/5/25 at 10:48 AM, the Director of Nursing (DON) stated if a resident smokes, this should be included on the Care Plan. She explained MDS Coordinator works remotely and is responsible for developing the initial Care Plan. When asked why Resident #264's Care Plan did not identify her as a smoker, the DON explained she reviewed Resident #264's smoking assessment and realized the nurse who completed the admission assessment may have failed to ask the question. A review of the facility policy titled Comprehensive Care Plans, last revised in March 2023, Policy Expectations and Compliance Guidelines directed, in part: #3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident ' s highest practicable physical, mental and psychosocial well-being. 48374 2. The MDS dated [DATE] revealed Resident #51 diagnoses list included:anxiety disorder, adult failure to thrive, and fracture of the right femur. Resident #51 BIMS score as 11 out of 15,indicated a moderate cognitive impairment. The MDS indicated the resident required substantial/maximal assistance for oral hygiene, and dependent on staff for upper and lower body dressing, putting on and taking off footwear, and personal hygiene. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 02/25/25 at 9:30 AM, Resident #51 outside smoking in designated smoking area, with facility staff present. Resident #51 noted to not be wearing a smoking apron for safety. During the observation, Staff D, CNA stated residents can go outside at designated smoking times four times per day, and can smoke up to two cigarettes each time. She stated a staff member is always outside with the residents during the designated smoking times and possesses the lighter. Staff D stated each resident's cigarettes are in individual baggies marked with their name and date. She stated residents can not have cigarettes or lighters in their position inside the facility. Staff D stated all cigarettes and lighters are kept in a locked room behind the nurses desk, and residents do not have access to the room. On 02/25/25 at 3:50 PM Resident #51 was observed lined up with other residents to go outside and smoke. At 4:00 PM the resident went outside with a staff member and was handed two cigarettes. Review of a quarterly Ivy Smoking Screen assessment, dated 2/20/25, identified Resident #51 as currently smoking, requires supervision when smoking, and the Care Plan is updated to reflect smoking status. Review of Resident #51 Care Plan revealed a lack of a Focus area with associated Goals and Interventions to address Smoking. During an interview on 3/4/25 at approximately 3:15 PM, the DON stated any resident who smokes should have it addressed on the Care Plan, and quarterly Smoking Screen assessments completed. She stated she was not aware Resident #51's Care Plan did not include smoking as a Focus area.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45338 Based on observation, interview, clinical record review, and facility policy review the facility failed to hold care conferences quarterly, failed to revise the care plan when the resident discontinued hospice services for four of twenty-two residents reviewed for care plans (Resident #18, Resident #52, Resident #53, Resident #54). The facility reported a census of 65 residents. Findings include: 1. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident scored 13 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated the resident was cognitively intact. On 2/26/25, review of Resident #53's Care Plan revealed, I am receiving Specialty Services such as Hospice with [Hospice Company Redacted]. The General Note dated 12/24/24 at 12:23 PM revealed, Resident expressed wanting to come off hospice, hospice RN (Registered Nurse) and social worked came and resident signed off services effective today. MD (Medical Doctor) notified. The Physician Progress Note dated 12/27/24 at 12:13 PM revealed, Reason for visit: staff reports resident is off hospice and wishes to pursue treatment for her cancer .States that she did not want hospice any longer when she was informed that they do not do chemo treatments .Assessment/plan: no longer receiving hospice care. On 3/5/25 at 11:14 AM, when queried about revision of the resident's care plan and how soon would occur, the facility's Director of Nursing explained normally [MDS Coordinator] would do the change when triggered the significant change, explained the [MDS Coordinator] was not always on the call when had meetings (when such information discussed), if the MDS Coordinator had known. The Facility Policy titled Comprehensive Care Plans dated 3/22 and revised 3/23 revealed, 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. 47336 2. The MDS assessment dated dated 1/23/25 revealed Resident #54 scored a 6 out 15 on the BIMS exam, which indicated cognition severely impaired. During an interview on 2/25/25 at 10:20 AM, Resident #54 wife stated she never attended a care conference for her husband. Resident #54 wife asked if she ever received a call or a letter requesting her attendance for the call conference and she stated no. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/26/25 at 3:13 PM, Social Services queried if residents or their families invited to the care conferences and she stated yes, she invited the resident and would call family and she documented who came in her care note in the progress notes. Social Services asked when Resident #54 last care conference was and she stated she didn't think they done with him in awhile. Social Services asked how often the facility completed care conferences and she stated quarterly and Resident #54 was overdue for a care conference and they should of completed one on him on 10/17//24. During an interview on 2/27/25 on 1:18 PM, the DON queried how often care conferences needed completed and she stated anytime the resident had concerns and she thought quarterly. The DON informed of Resident #54 care conference had not been completed and it was due on 10/17/24 and she stated Resident #54 needed a care conference completed by now unless he refused. 3. The MDS assessment dated [DATE] revealed Resident #18 scored a 15 out of 15 on the BIMS exam, which indicated cognition intact. The Care Plan Note dated 11/8/24 at 11:02 AM, revealed Meeting with Resident #18 and her mother to do a care plan meeting During an interview on 2/24/25 at 2:36 PM, Resident #18 stated she had not attended a care conference since the first month she admitted to the facility. During an interview on 2/26/25 at 3:16 PM, Social Services queried on care conferences with Resident #18 and she stated the last care conference they had was on 11/8/24 and Resident #18 and her mother attended. Social Services asked when Resident #18 next care conference scheduled and she stated she didn't believe they had one scheduled but they would have one pretty soon because Resident #18 going to discharge. Social Services confirmed Resident #18 should of had a care conference around 2/8/25. During an interview on 2/27/25 at 1:19 PM, the DON queried on Resident #18 last care conference on 11/8/24 and Resident #18 not having another scheduled and the DON stated she was pretty sure the care conferences needed completed quarterly. 4. The MDS assessment dated [DATE] revealed Resident #52 scored a 5 out of 15 on the BIMS exam, which indicated cognition severely impaired. The MDS revealed wandering behavior not exhibited in the 7 day look back. The MDS indicated the resident used a wheelchair and wheeled 150 feet once seated in a corridor or similar space independently. The MDS revealed diagnoses of metabolic encephalopathy; anxiety disorder, and depression. The Care Plan revealed a focus area dated 9/16/24 for behavior problem related to episodes of agitation, difficulty sleeping at times. The Care Plan did not address the resident behaviors for wandering into other resident's rooms. During an interview on 2/26/25 01:37 PM, Staff D, CNA (Certified Nurse Aide) queried if Resident #52 wandered into other resident's rooms and she stated yes, he attempted to go into other resident's room. Staff D stated one time he went into Resident #31 room and Resident #31 said it scared her. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/26/25 at 2:25 PM, Staff B, RN (Registered Nurse) queried if Resident #52 went into other resident's rooms and she stated yes and he tried to follow the nurse into rooms also. Staff B stated Resident #52 a busy body and strolled around in his wheelchair, but didn't exit seek. During an interview on 2/26/25 at 4:45 PM, Resident #31 queried if other resident ever came into her room and she stated yes, last night. Resident #31 stated she didn't know his name, but he was the resident at the front of the hall on the left (Resident #52 room) came into her room and said something to Resident #31. Resident #31 stated she told Resident #52 to get out in a harsh voice and Resident #52 left her room. Resident #31 stated it scared her when Resident #52 came into her room. During an interview on 2/27/25 at 2:02 PM, the DON queried on Resident #52 behavior of wandering in other resident's rooms and she stated she didn't know Resident #52 did that. The DON asked if the behaviors of wandering into other residents rooms needed care planned and she stated yes, it should be. The Facility Comprehensive Care Plan Policy dated March 2022 revealed the following: a. It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the residents comprehensive assessment. b. The comprehensive care plan will describe, at a minimum the following . 1. Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated. The Facility Care Planning- Resident Participation Policy dated 9/24 revealed the following: a. The facility will discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences, and allow them to see the care plan, initially, at routine intervals, and after significant changes. The facility will make an effort to schedule the conference at the best time of the day for the resident/resident's representative

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45338 Based on observation, interview, and clinical record review the facility failed to administer blood pressure medications and seizure medications per physician order for 2 of 4 residents reviewed for professional standards of practice (Resident #43, Resident #265). The facility also failed to complete weekly weights per physician order for 1 of 2 residents reviewed for nutrition (Resident #23). The facility reported a census of 65 residents. Findings include: 1. Review of the Minimum Data Set (MDS) assessment for Resident #43 dated 2/7/25 revealed the resident scored 13 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition. Review of the Care Plan for Resident #43 dated 8/25/24 revealed the following: The resident has altered cardiovascular status r/t (related to) HTN (hypertension), hypotension. The Physician Order dated 8/24/24 revealed, Midodrine HCl Oral Tablet 5 MG with instructions to give 1 tablet by mouth every 8 hours as needed for low <sic> blood pressure. Directions per order revealed, 1 TAB PER G -TUBE (gastrostomy tube) TID (three times a day) PRN (as needed) HYPOTENSION FOR SBP (systolic blood pressure) <90. Review of the resident's Medication Administration Record (MAR) dated February 2025 for the time period of 2/15/25 to 2/25/25 revealed following dates and resident blood pressures when the medication was not administered: a. 2/17/25 at 7:35 AM: blood pressure (bp) 85/72 b. 2/18/25 at 7:10 AM: bp 75/52 c. 2/18/25 at 4:33 PM: bp 80/64 d. 2/19/25 at 7:44 AM: bp 80/53 e. 2/19/25 at 4:25 PM: bp 81/60 The Physician Order dated 10/9/24 revealed, Metoprolol Tartrate Oral Tablet 25 MG (milligram) with instructions to give 1 tablet by mouth two times a day for htn hold if systolic bp (top reading of blood pressure) less than 120, hold if heart rate is less than 60 BPM (beats per minute). Review of the resident's Medication Administration Record (MAR) dated February 2025 revealed Metoprolol 25 MG administered to the resident for the 6AM to 9AM dose on the following dates when the resident's systolic bp was less than 120: a. 2/1/25: blood pressure (bp) 104/62 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. 2/2/25: bp 113/76 c. 2/3/25: bp 95/65 d. 2/7/25: bp 118/72 e. 2/8/25: bp 118/74 f. 2/11/25: bp 92/54 The medication was also administered to the resident for the 4PM to 7PM dose on the following dates when the resident's systolic blood pressure was less than 120: a. 2/13/25: bp 91/53 b. 2/19/25: 81/60 On 3/5/25 at 11:16 AM, the facility's Director of Nursing (DON) confirmed nursing staff should follow parameters as guidance to whether given medication or not. Review of the facility policy titled Medication Administration-General, implemented 5/30/23 and revised 9/19/23, revealed the following: Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters. 25855 2. The MDS dated [DATE] listed diagnoses for Resident #265 included: neurogenic bladder (lack of bladder control due to nerve damage) , urinary tract infection and epilepsy. The MDS indicated Resident #265 dependent on staff for assistance with toileting, showers, dressing, putting on and removing footwear and personal hygiene. The MDS identified Resident #265 with an indwelling catheter. Review of Resident #265's Care Plan, dated 12/18/24, revealed a Focus area to address The resident has a seizure disorder r/t (related to) epilepsy. Interventions included, in part: a. Give medications as ordered. Monitor/document for effectiveness and side effects. Date Initiated: 12/18/24. b. Give seizure medication as ordered by doctor. Monitor/document side effects and effectiveness. Date Initiated: 12/18/24. Review of the Order Summary Report, document dated 3/4/25, revealed a Physician's Order for Epidiolex Oral Solution 100 Mg (milligrams/Ml (milliliters)(Cannabidiol). Give 2.5 ml by mouth two times a day for partial epilepsy with impairment. Start date 12/17/24. A review of the December 2024 MAR revealed: a. On 12/17/24, a 9 documented for the evening dose of Epidiolex (continued on next page)

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	165436	A. Building B. Wing	03/06/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. On 12/18/24, a 9 documented for the morning and evening dose of Epidiolex. c. On 12/19/24, a 9 documented for the morning and evening dose of Epidiolex. d. On 12/20/24, a 9 documented for the morning dose of Epidiolex e. On 12/23/24, a 8 documented for the morning dose. Per the MAR Chart Codes, a 6 indicated resident hospitalized , a 8 indicated medication unavailable, and a 9 indicated Other/See Progress Notes. A review of the electronic health record revealed lack of documentation for the 9 indicated on the MAR for 12/17/24, 12/18/24, and 12/19/24. A General Note entered on 12/20/24 at 10:12 AM documented [Hospital name and department redacted] contacted to inform [provider name redacted] of our facility not able to obtain medication Epidiolex 2.5 ml dosage as ordered by [provider name redacted] upon admission. Voice message left for nurse to return call on proceeding with order. Upon getting clarification, Resident and her [redacted] POA will be updated as well as [provider and nurse Practioner name redacted]. A General Note entered on 12/20/24 at 5:19 PM documented [Hospital name and department redacted] contacted to notify that the medication Epidiolex was not able to be supplied by our facility pharmacy or specialty pharmacy per our pharmacy rep. [name redacted] due to DEA (Drug Enforcement Agency) issues. [Provider name redacted]contacted, and to call nursing back on cell number as it is after hours. Nursing will contact the facility upon receipt of updated order/s after he contacts the [provider name, hospital and department name redacted]. During an interview on 2/25/25 at 9:57 AM, Resident #265's representative and Power of Attorney (POA) stated Resident #265 had not gotten her seizure medications as scheduled, and the resident then had increased seizure activity. Review of a General Note entered on 12/23/24 at 11:01 AM revealed Residents family came to visit and as they were leaving they informed the receptionist that [name redacted] felt hot resident was assessed by this nurse and treatment nurse. residents vitals BP (blood pressure) 99/81 R (respirations) 14 and O2 (oxygen level) 93. Resident stated that she feels like she had a seizure. resident was lethargic. Per [provider name redacted] - sent to ER (emergency room) for evaluation. Report called to [name of hospital redacted]. Review of General Note entered on 12/24/25 at 1:13 PM documented .resident is still in ICU (Intensive Care Unit) at [name of hospital redacted]. 48374 3. Resident #23's MDS assessment dated [DATE], identified a BIMS score of 12, indicating moderately impaired cognition. The MDS included diagnosis of unspecified severe protein-calorie malnutrition. Review of Physician Orders revealed an order for weekly weights, start date of 2/11/25. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Clinic Weights and Vitals in the electronic health record (EHR) revealed a weight of 157.5 pounds on 2/14/25. No further documentation of weekly weights found in the EHR. During an interview on 3/5/25 at approximately 10:10 AM, the DON stated Resident #23 has an order to be weighed weekly and this is not being getting done. During an interview on 3/05/25 at 11:40 AM, the Consultant stated as the facility does not currently have a dietician she is one of two consultants covering for the position. She stated the last weight the facility documented for Resident #23 was on 2/14/25. The Consultant advised she would expect the facility to weigh a dialysis resident at least weekly. It is her expectation staff weigh the resident and not rely on the dialysis summary sheets.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45775 Based on observations, clinical record review, resident and staff interview, the facility failed to provide set up assistance for resident identified with an impaired ability to eat independently for 1 of 1 residents (Resident #23) in the sample. The facility reported a census of 65 residents. Findings include: 1. Review of Resident #23's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 12, which indicated a moderate cognitive impairment. The MDS included diagnoses of metabolic encephalopathy (brain function impairment), Crohn's disease, end stage renal disease and diabetes. Per the MDS, Resident #23 required set up or clean up assistance for eating. Review of the Care Plan, Date Initiated: 2/11/25 identified a Focus area to address Resident is at risk for or has actual IMPAIRED ABILITY TO EAT INDEPENDENTLY. The Intervention directed staff to EATING AND DRINKING: The resident usually requires a helper to provide SETUP ASSISTANCE prior to or following the eating activity (such as opening packages or cutting meat). Date Initiated: 2/11/25. During an interview on 02/25/25 at 12:35 PM, Resident #23 shared he has difficulty eating on his own and staff do not help him. He explained his hands are messed up and he can't cut up his food on his own. Resident #23 stated staff bring his plate to his room, set it down and then leave. During an interview on 2/26/25 at approximately 1:45 PM when queried about the assistance Resident #23 required to eat, Staff E, Certified Nurse Aide (CNA) stated sometimes he is assisted but not always. She explained sometimes staff help him cut up his food. Staff E stated on the days he has dialysis he doesn't usually eat very much. She stated the resident does not use special or adaptive silverware or plates. During an observation on 02/27/25 at 12:10 PM, Staff R, CNA delivered lunch to the resident's room, and left the room without offering or proving assistance. During an interview and observation on 02/27/25 at 12:30 PM, Resident #23 tray delivered to his room. The lunch meal consisted of ham and bean soup, green beans, and corn bread. The resident also had white milk and orange Kool-aid. The milk had been opened for him. The resident picked up the glass of juice and took a small drink. The resident spilled a spoonful of soup on his shirt. Resident #23 tried eating dessert with a fork which resulted in most bites falling back on to the plate. During an interview after the lunch meal on 2/27/25, Resident #23 stated staff dropped off his meal tray and left. He stated his hands are messed up and he can ' t eat like this. At approximately 12:50 PM Staff C, Registered Nurse (RN) entered the resident's room and asked the Resident if he was done. When he said yes she took the tray and left the room. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/27/25 at 12:52 PM when queried about the assistance Resident #23 required to eat, Staff C, RN stated he usually eats independently, and does not ask for assistance. Staff C stated she saw the resident did not eat much of the noon meal. She explained she did not ask if he needed assistance because she knew he ate a good breakfast. Staff C added she has occasionally assisted the resident depending on the meal. Staff C stated she was not sure if the resident's Care Plan had changed or been updated or if there is a physician's order to assist him. During an interview on 02/27/25 at 2:30 PM, the facility Director of Nursing (DON) stated she had only been at the facility for a couple of weeks and concerns about Resident #23 eating had not been brought to her attention. Review of a General Note in the electronic health record, dated 3/2/25 at 10:56 AM revealed CNA reports to this nurse she has noticed the resident doesn ' t eat very much of his tray. She reports concerns that he is unable to eat independently. Will pass concerns to NP (nurse practitioner). Review of Physician Orders revealed an order, start date of 3/3/25 to please get resident up with all meals and place in the dining room, will need to be fed as he is unable to feed self.

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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** 45338 Based on observation, staff interview, and clinical record review the facility failed to ensure wheelchair foot pedals utilized when residents assisted via wheelchair, and failed to ensure staff utilized a gait belt during transfer for 2 of 9 residents reviewed for accidents (Resident #12, #21). The facility reported a census of 65 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 scored 9 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated moderately impaired cognition. Per this assessment the resident used a walker and wheelchair. Review of Resident #12's Care Plan dated 10/18/23 revealed, Resident is at risk for or has actual IMPAIRED ABILITY TO INDEPENDENTLY MOVE/NAVIGATE WHEELCHAIR R/T (related to) Limited Mobility, Musculoskeletal impairment. The Intervention dated 10/25/23 revealed, Foot pedals when push assist is given for navigating in wheelchair. On 2/24/25 at 11:23 AM, Staff F, Certified Nursing Assistant (CNA) pushed Resident #12 in their wheelchair while the wheelchair did not have foot pedals applied. At 11:25 AM, Staff F again pushed the resident into another resident room while Resident #12 did not have foot pedals applied to resident's wheelchair. On 2/24/25 at 12:19 PM, Staff F pushed Resident #12 in their wheelchair while the resident did not have foot pedals on the wheelchair. On 3/3/25 at 3:20 PM, Staff B, Registered Nurse (RN) queried if should have foot pedals on when resident assisted in wheelchair, and responded, yeah. On 3/4/25 at 11:58 AM, Staff H, CNA explained, in part, for anybody pushed, the only way could push was foot pedals on wheelchair. On 3/5/25 at 11:18 AM, the facility's Director of Nursing (DON) acknowledged should have on at all times if push resident in wheelchair. 25855 2. The MDS dated [DATE] identified Resident #21 as cognitively impaired with a BIMS of 7. The MDS assessed Resident #21 required partial/moderate assistance to sit to stand and to transfer from chair/bed-to-chair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Plan, dated 10/19/23, revealed Resident #21 at risk for or has actual IMPAIRED ABILITY TO TRANSFER INDEPENDENTLY R/T Musculoskeletal impairment. The Intervention dated 12/6/24 revealed, TRANSFER: Resident requires assist of 1 staff using a GB (gait belt) et (and) walker for all functional transfers. During an observation on 2/25/25 at 11:02 AM, Staff D, CNA and Staff D, CNA assisted Resident #21 to stand and pivot to lie down in the bed without placing a gait belt around the resident. At 11:10 AM, both aides assisted resident to transfer from bed to wheelchair by holding resident underneath her arms and did not use a gait belt. Staff D reported the resident is usually one to one assist and usually independent. During an interview on 3/4/25 at 11:40 AM, Staff R, CNA reported Resident #21 was care planned to be transferred with the assist of one using a gait belt and walker. During an interview on 3/4/25 at 12:25 PM, Staff I, LPN reported Resident #45 was care planned to be transferred with the assist of two using the gait belt as she had a history of falls. A review of the facility policy titled: Safe Resident Handling/Transfers dated as last revised 12/17/24 had documentation of the following: Resident's lifting or transferring will be performed according to the resident's plan of care.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25855 Based on observation, record review and staff interviews, the facility failed secure the tubing for a urinary catheter in a position that prevented it from sitting on the floor for 1 of 2 residents reviewed for catheter care (Resident #45). The facility reported a census of 65 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] identified Resident #45 as cognitively impaired with a BIMS of 6 and had the following diagnoses: renal insufficiency (kidney failure), encephalopathy (a medical condition characterized by a general dysfunction of the brain) and malnutrition. The MDS also identified used an indwelling urinary catheter. On 12/23/22, the Care Plan identified Resident #45 with the problem of an Indwelling Catheter related to urinary retention, obstructive and reflux uropathy (a condition where urine flows backward from the bladder into the ureters). During an observation on 2/26/25, Resident #45 sat up in her wheelchair in the back dining room. The catheter tubing noted to be on the floor. Resident #45 self propelled her wheelchair with the tubing dragging on the floor. Resident #45 stepped on the tubing one time during this observation. During an interview on 3/4/25 at 11:40 AM, Staff R, Certified Nursing Assistant (CNA) stated if catheter tubing is on the floor it should be picked up and the nurse informed so the tubing can be changed. During an interview on 3/4/25 at 12:28 PM, Staff J, Registered Nurse reported if the CNA saw Resident #45's tubing on the floor, she would expect the aide to move the tubing up off the floor and let the nurse know about it. She would normally encourage the resident to wear a leg bag during the day and switch it out at night to the big bag. A review of the facility policy titled: Catheter Care and dated as last revised on 1/1/24 directed staff to ensure catheter tubing is secured to prevent touching the floor.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47336 Based on clinical record review, facility policy review, resident and staff interviews, the facility failed to coordinate communication with the dialysis center for 1 of 2 residents reviewed for dialysis (Resident #18). The facility reported a census of 65 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #18 scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact. The MDS indicated the resident received dialysis. The MDS revealed the medical diagnosis for renal insufficiency, renal failure, or end-stage renal disease (ESRD). The Care Plan revealed a Focus area dated 10/22/24 for hemodialysis related to ESRD. The Intervention dated 10/22/24 indicated encourage the resident to go for the scheduled dialysis appointments on Tuesday, Thursday, and Saturday every day shift at 9:30 . Review of the Physician Orders revealed the an order for Outpatient hemodialysis treatments: Day/s of the Week & Approximate Time: Tues (Tuesday)/Thur (Thursday)/Sat (Saturday) at 9:30 . Review of the clinical record revealed the most recent [Facility name redacted] Dialysis Communication Tool completed on 1/11/25 by the facility and the dialysis center. During an interview on 2/24/25 at 2:20 PM, Resident #18 stated she went to dialysis on Tuesday, Thursday and Saturday. Resident #18 stated she took a paper to dialysis and then the dialysis center faxed it back to the facility. During an interview on 2/26/25 at 2:28 PM, Staff B, RN (Registered Nurse) queried on Resident #18 communication with the dialysis center and she stated they sent a form printed off the computer and then the dialysis center should send back the form. Staff B stated the communication wasn't very good because Resident #18 would come back and tell Staff B, she had new orders and Staff B didn't get a call or fax. Staff B stated she thought it would work better if the dialysis center sent the paper back with the resident instead of waiting for a call or fax to come through. During an interview on 2/27/25 at 1:57 PM, the Director of Nursing (DON), queried on the communication between the dialysis center and the facility and she stated the staff filled out the initial portion and printed it out and sent the form to the dialysis center to fill out and send back to the facility. The DON stated it was a struggle to get the form back from the dialysis center. The DON informed the last form the facility provided for Resident #18 was dated 1/11/25 and her thoughts and she stated she knew the facility had them and it was just a matter of getting a copy of them and she could call the dialysis center for them. The DON asked how the facility knew if Resident #18 had changes in her care and she stated she didn't know, she only worked at the facility for a few weeks. The facility Hemodialysis Policy dated March 2022 directed: (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. The facility will assure that each resident receives care and services for the provision of hemodialysis and/or peritoneal dialysis consistent with professional standards of practice. This will include: 1. Ongoing assessment and oversight of the resident before, during, and after dialysis treatments . 2. Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 45338 Based on clinical record review, staff interview, and facility policy review the facility failed to ensure timely follow up for medication regimen review recommendations identified by the Pharmacist for 1 of 5 residents reviewed for unnecessary medications (Resident #47). The facility reported a census of 65 residents. Findings include: Review of the Minimum Data Set (MDS) assessment for Resident #47 dated 12/3/24 revealed the resident scored 15 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition. Per this assessment, the resident took antianxiety medication. The Pharmacist Review/Visit Progress Note dated 12/31/24 at 1:10 PM revealed, in part, Alprazolam PRN (as needed) and hydroxyzine PRN orders require stop dates - letter generated. The Pharmacist Review/Visit Progress Notes dated 1/28/25 and 2/24/25 stated the same recommendation and documented letters were generated/regenerated. On 3/4/25 at 2:40 PM, Resident #47's pharmacy recommendations and response communication requested for the following dates 12/31/24, 1/28/25, and 2/24/25. One Note to Attending Physician/Prescriber with print date 2/25/25 was provided by the facility for Resident #47. The form revealed the following: [Resident #47] currently has an order for Hydroxizine Hcl 50 MG (milligram) Q4HS (every 4 hours) PRN (as needed). Per regulatory guidelines, orders for psychotropic medications on a PRN basis must be limited to 14 days unless a stop date is noted. This order was implemented on 12/4/2024. This order needs to have a stop date of 12/18/2024 or a continuation duration noted to be in compliance with federal regulations. ***NURSING HAS REQUESTED THIS MEDICATION TO BE DISCONTINUE DUE TO NON-USE***. The following option had been selected on the form: Yes, extend the order with the following stop date (left blank). The Medication Regimen Review form was signed 3/4/25. On 3/5/25 at 10:50 AM, the facility's Director of Nursing (DON) explained they weren't done prior to DON getting to the facility, all she had were the original copies that wasn't sent to the Physician. On 3/5/25 at 11:12 AM, the DON acknowledged letters were not getting sent to the doctor, had received the February ones, and were waiting to get them back. Review of the Facility Policy titled Medication Regimen Review, dated 5/5/21 last revised 9/23, revealed the following: The drug regimen of each resident is reviewed at least once a month by a licensed pharmacist and includes a review of the resident's medical chart. The Facility Policy further revealed, Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities.

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	165436	A. Building B. Wing	03/06/2025

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25855 Based on observation, record review, resident and staff interviews, the facility failed to maintain a safe, palatable temperature of foods served at the noon meal on 2/25/25. The facility reported a census of 65 residents. Findings include: On 2/25/25 at 12:11 PM, the State Agency requested a test tray for the noon meal. At 12:17 PM, the Dietary Manager took food temperatures of the refried beans with a result of 134.2 degrees F (Fahrenheit); and of jello cake with whipped topping with a result of 69.2 degrees F. During an interview on 2/25/25 at 12:20 PM, the Dietary Manager reported he expected temperatures for hot food items be at least 135 degrees F, and cold food items be under 41 degrees F. 47336 2. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #47 scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact. The MDS indicated the resident required supervision or touching assistance with eating. During an interview on 2/24/25 at 11:44 AM, Resident #47 stated she ate in her room and the food being hot was a hit or miss and all of last week the food was cold. During an interview on 2/24/25 at 11:58 AM, Resident #47 food delivered to his room and he commented the fries were ice cold. 3. The MDS assessment dated [DATE] revealed Resident #31 scored a 12 out of 15 on the BIMS exam, which indicated cognition moderately impaired. The MDS indicated the resident needed set up or clean up assistance with eating. During an interview on 2/24/25 at 1:21 PM, Resident #31 stated the food tasted okay, but usually cold. A review of the facility policy titled: Food Safety Requirements, last revised April 2024 directed the following: a. When preparing food, staff shall take precautions in critical control points in the food preparation process to prevent, reduce, or eliminate potential hazards. b. Cooking - foods shall be prepared as directed until recommended temperatures for the specific foods are reached. Staff shall refer to the current FDA Food Code and facility policy for food temperatures needed. (continued on next page)

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	165436	A. Building B. Wing	03/06/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. Holding - staff shall monitor food temperatures while holding for delivery to ensure proper hot and cold holding temperatures are maintained. Staff shall refer to the current FDA Food Code and facility policy for food temperatures needed.

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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. 47336 Based on observation, staff interviews, and the facility policy, the facility failed to ensure 1 of 5 dietary staff covered their hair while in the kitchen. The facility reported a census for 65 residents. Findings include: During a kitchen observation on 2/25/25 at 11:00 AM, Staff G, Dietary Aide hairnet covered part of her hair. Staff G had multiple long braids of hair not covered by the hairnet and braids hung down her back. During an interview on 2/26/25 at 11:52 AM, Staff G only had part of her hair covered with 2 hairnets. Staff G had part of her braids hang down her back not in the hairnet. Staff G asked about wearing hairnets in the kitchen and Staff G stated they needed to wear them and she had 2 of them on. Staff G queried if all her hair needed to be in the hairnet and she stated yes, all of her needed covered. Staff G informed part of her hair not covered by the hairnet and she tried to put her hair in the hairnet and was unsuccessful and commented she had a lot of hair and had a hard time getting all of it in her hairnet. During an interview on 2/27/25 at 9:41 AM, the Dietary Manager queried about hairnet use and he stated the staff needed to all wear them in the kitchen and in the kitchenette in the back dining room. The Dietary Manager queried if all their hair needed covered by the hairnets and he stated yes and confirmed he had one staff member with weaves they had trouble with her hair not all being in the hairnet. The Facility Kitchen Personnel Hygiene-Attire Policy dated 11/14.24 revealed the following: a. Personal Hygiene-Proper Attire for food handlers should include hair covering (hair nets or caps) .Food employees shall wear hair restraints such as hats, hair coverings or nets .

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 48374 Based on staff interview, review of CMS-2567 reports, and facility policy review, the facility failed to ensure an effective Quality Assurance Performance Improvement (QAPI) process to address previously identified quality deficiencies, resulting in multiple repeat deficiencies on the current survey previously identified in 2023 and 2024. The facility reported a census of 65 residents. Findings include: Review of the Department of Inspections, Appeals and Licensing (DIAL) website under the facility's visit history revealed deficient practices identified during the Recertification and Complaint Survey ending on 3/6/25 also cited during the following survey's: a. F689 cited during Recertification Surveys ending on 6/5/23 and 6/24/24, and a Complaint Survey on 10/21/23. b. F812 cited during Recertification Surveys ending on 6/5/23, and 6/24/24. c. F865 cited during Recertification Survey ending on 6/24/24. During an interview on 3/5/25 at 12:20 PM the Administrator reported awareness of repeated deficiencies cited during the past survey and the current survey. The Administrator revealed the kitchen processes is an ongoing project in collaboration with the Dietary Manager to provide staff education, re-education and staff retention. The Administrator revealed the facility continues to work on more efficient communication between floor staff and leadership and continue to implement new QAPI projects until proven successful. Facility management meet informally every month and officially every quarter. The facility policy titled, Quality Assurance and Performance Improvement (QAPI), revised 7/17/23, revealed expectation of the Quality Assessment and Assurance (QAA) Committee to meet at least quarterly and as needed, develop and implement, and maintain an effective, comprehensive, data driven QAPI program that focuses on indicators of the outcomes of care and quality of life and addresses all the care and unique services the facility provides.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45338 Based on observation, interview, clinical record record review, and facility policy review the facility failed to ensure enhanced barrier precautions (EBP) utilized for incontinence care, wound care, and gastrostomy tube site care for one of two residents reviewed for EBP, and failed to ensure appropriate infection control practices during medication administration for one of ten residents observed during medication administration (Resident #16) when a barrier was not utilized for the glucometer. The facility also failed to ensure the infection control policies were reviewed annually by the facility's Medical Director. The facility reported a census of 65 residents. Findings include: 1. On 2/27/25 at approximately 8:16 AM during an observation conducted for medication administration, Staff L, Registered Nurse (RN) had the glucometer directly on Resident #16's over the bed table. Staff L checked the resident's blood sugar and set the glucometer back on the table. At 8:19 AM, Staff L set the glucometer by the sink in the resident's room. At 8:20 AM, the glucometer was on the medication cart without a barrier present. At 8:29 AM, the glucometer was on the medication cart. Staff L queried when she cleaned the glucometer, and explained did so at the top and bottom of her shift. On 3/3/25 at 3:20 PM, Staff B, RN queried when glucometer cleaned, and responded between residents. When queried if barrier used if going to set glucometer down, and responded supposed to, yes. On 3/5/25 at 11:19 AM, the DON queried if barrier should be used for glucometer, acknowledged it should be, and acknowledged staff should be sanitizing the glucometer in between use. Review of the Facility Policy titled Infection Prevention and Control dated 7/1/24 revealed, This facility has established and maintains an infection 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. 25855 2. The Minimum Data Set (MDS) dated [DATE] identified Resident #58 as cognitively impaired and did not have a BIMS score completed. The MDS also identified Resident #58 with the following diagnoses: stroke, renal insufficiency (kidney failure) and pneumonia and dependent on staff assistance for all activities of daily living. The MDS also identified Resident #58 had a feeding tube through which he received all his total calories. A review of the Physician Orders revealed the following: 1/3/25 may crush and mix medications for administration into GT 2/25/25 G-tube site- cleanse area with NS or wound cleaner, apply t-sponge dressing secure with tape every day shift for wound care and PRN (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/28/25 wound care to left buttock: cleanse with wound cleanser, apply Triad twice daily and as needed During an observation on 2/25/25 at 8:54 AM, Staff C, RN wound nurse, Staff B, RN and Staff A, Certified Nursing Assistant (CNA) entered the room, washed their hands and donned gloves. The nursing staff proceeded to complete wound care, GT (gastric tube) site care and incontinence cares. The staff did not don protective gowns during this observation. During on observation on 2/25/25 9:15 AM, Resident #58 door noted to have a sign for Enhanced Barrier Precautions with bin of Personal Protective Equipment well stocked with isolation gown and gloves outside the room. During an interview on 3/3/25 at 2:39 PM, Staff C, RN stated when providing cares to a resident in Enhanced Barrier Precautions, staff should wear a gown and gloves. She stated when providing care for Resident #58 on 2/25/25 she and the other two staff forgot to put on the isolation gowns. During an interview on interview on 3/4/25 at 9:59 AM, the DON/Infection Preventionist stated when staff provide cares for residents in Enhanced Barrier Precautions, they should don an isolation gown and gloves and mask if needed. A review of the facility policy titled: Enhanced Barrier Precautions dated as implemented 7/1/24 directed: Initiation of Enhanced Barrier Precautions: An order for Enhanced Barrier Precautions will be obtained for residents with any of the following: Wounds (e.g. chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds or chronic venous stasis ulcers) and/or indwelling medical devices (e.g. central lines, urinary catheters, feeding tubes, etc). Implementation of Enhanced Barrier Precautions: a. Make gown and gloves available immediately near or outside the resident's room b. PPE (Personal Protective Equipment) is only necessary when performing high-contact care activities c. High contact resident care activities include: aa. Changing briefs or assisting with toileting bb. Device care or use for feeding tubes cc. Wound care: any skin opening requiring a dressing

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 25855 Based on record review, staff interview and policy review, the facility failed to provide immunizations to 3 of 5 residents reviewed. (Residents #23, #50 and #58). The facility reported a census of 65 residents. Findings include: A review of the immunization records revealed the following: Residents #23 and #48 did not have documentation of the pneumococcal vaccine given. Residents #23 and #50 did not have documentation of the influenza vaccine given in 2024. During on interview on 3/4/25 at 9:59 AM, the Director of Nursing/Infection Preventionist stated she had not had a chance to look at immunization status related to flu and pneumvax since she started at the facility a month ago. She stated currently, there is no one assigned to enter the immunization data when residents are admitted . A review of the facility policy titled: Influenza Vaccination dated as last revised 7/1/24 had documentation of the following: 1. Influenza vaccinations will be routinely offered annually from October 1st through March 31st unless such immunization is medically contraindicated, the individual has already been immunized during this time period or the resident refuses to receive the vaccine. 2. The resident's medical record will include documentation that the resident and/or resident's representative was provided education regarding the benefits and potential side effects of immunization and that the resident received or did not receive the immunization due to medical contradiction or refusal. A review of the facility policy titled: Pneumococcal Vaccine (Series) dated as last revised 12/9/24 had documentation of the following: 1. Each resident will be assessed for pneumococcal immunization. 2. Each resident will be offered a pneumococcal immunization unless it is medically contraindicated or the resident has already been immunized. Following assessment for any medical contraindications, the immunization may be administered in accordance with physician-approved standing orders.