

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

Printed: 07/30/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165436	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/25/2026
NAME OF PROVIDER OR SUPPLIER Ivy at Davenport		STREET ADDRESS, CITY, STATE, ZIP CODE 800 East Rusholme Street Davenport, IA 52803	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, facility policy review, lift manufacturer safety instructions, local fire department personnel interviews, and resident and staff interviews, the facility failed to provide staff education on how to select the right size body sling for residents dependent on the use of a mechanical lift, failed to identify a hospital slide sheet as unsafe for use with a mechanical lift, and failed to have correct mechanical lift sling sizes available to meet the needs of a bariatric resident for 2 of 12 residents (Resident #8 and Resident #39) reviewed for mechanical lift transfer. Nursing staff failed to safely transfer Resident #8 when they placed a hospital slide sheet with handles under the resident, attached the handles to the mechanical lift, and engaged the lift. The handles tore from the slide sheet and the resident had to be emergently lowered to a recliner. Resident #8 repeatedly voiced fear of falling. Nursing staff were unable to transfer the resident out of the recliner and called the local fire department for assistance. The fire department personnel attempted to manually transfer Resident #8 with the slide sheet, which again tore. A second unit from the local fire department was called to assist. The State Agency (SA) informed the facility of the Immediate Jeopardy (IJ) on 3/20/26 at 10:12 AM. The IJ began on 2/26/26, when staff used a hospital slide sheet as a mechanical lift body sling, engaged the lift and the sheet tore from the lift hooks. On 3/23/26, the SA confirmed the immediacy removed effective 3/21/26, through the following actions: 1. The Director of Nursing (DON) and designee(s) trained all nurses and nurse aides on the use of mechanical lift and sit to stand lift. All staff will be trained prior to their next shift. 2. The DON and designee(s) reviewed the care plan for each resident who require the use of a mechanical lift or sit to stand lift to ensure resident specific interventions were present. Proper sling size and fit for each resident was added as an intervention, pulling to Kardex (care guide) and care profile. 3. The DON and designee(s) re-assessed residents requiring mechanical lifts for transfers via the Mechanical Lift and Sling Size Risk Evaluation. 4. The DON and designee(s) trained nursing staff on the location of the sling size and type of mechanical lift or sit to stand lift to utilize for residents requiring lifts for transfers via the Kardex in the POC portion of PCC. This training includes reviewing of Kardex prior to transferring residents as assessments can change based on resident condition changes. 5. All facility specific policies and procedures regarding mechanical lifts were reviewed/revised to ensure compliance with manufacturer's recommendations and guidelines. Nursing staff were re-educated on 3/20/26, remaining nursing staff will be educated prior to their next shift. 6. The Administrator purchased two slings on 3/5/2026 that will accommodate weight up to 1000 pounds. The scope lowered from J to D at the time of the survey after ensuring the facility implemented staff education and procedures. The facility reported a census of 59 residents. Findings include: 1. Review of the Minimum Data Set (MDS) for Resident #8, dated 2/17/26 revealed diagnoses which included morbid obesity, anxiety, depression, and acute and chronic respiratory failure with hypoxia (low oxygen levels in body). The MDS identified Resident #8 did not attempt sitting to lying, lying to sitting on the side of bed, sit to stand, or chair/bed-to-chair transfer due to medical concerns or safety concerns. The Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicated intact cognition. The MDS listed a height of (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	69 inches, and weight of 535 pounds. Review of Resident 8's Care Plan revealed Focus areas to address: a. Resident is at risk or has actual IMPAIRED ABILITY TO TRANSFER INDEPENDENTLY. Date Initiated: 7/31/25. Goal: Resident will FREE FROM COMPLICATIONS related to impaired transfer ability through next review date. Target Date: 4/30/26. Interventions included TRANSFER: The resident is dependent for transfers and requires MECHANICAL LIFT total body lift with 2 HELPERS for transfers. Date Initiated: 7/31/25.b. Resident has a HISTORY OF POTENTIALLY TRAUMATIC EVENTS and is at risk for re-traumatization and/or experiencing a traumatic stress response. Initiated: 8/26/25. Goal: Resident will feel safe and comfortable in direct care situations. Target Date: 4/30/26. Interventions included, in part: Help Resident IDENTIFY TRIGGERS that prompt anxiety or symptoms and evaluate the outcome of these reactions. Date Initiated: 8/26/25. During an interview on 3/15/26 at 11:45 AM, Resident #8 stated it could take 2-3 hours in the evenings before her call light got answered. Resident #8 explained the staff told her they needed to get someone to help and would be back, and then after an hour she would have to activate her call light again. When the staff returned, she would be told the same thing. Resident #8 stated she had called her niece, who then called the facility. Staff would tell her they were about to respond and the nurse was aware. The interview interrupted due to resident care needs. Resident #8 asked for the SA to return to finish the interview. However, later on 3/15/26, the Resident hospitalized and did not return prior to the exit. A review of the electronic health record (EHR) revealed the following:a. A Mechanical Lift & Sling Size Risk Evaluation, dated 2/18/26 revealed: LIFT EVAL: What can the resident do to assist with transfer: Dependent. Sling Size: Most Recent height: 69.0 inches as of 7/25/25. Most Recent Weight: 534.5 Lbs (pounds) as of 2/3/26. Scale: Bariatric Lift. What weight range does the resident fall in: 350-600 lbs Extra Extra (XXL). Which sling size should be used: Extra Extra (XXL)b. A Progress Note, dated 2/26/26 at 11:01PM, entered by Staff Q, Licensed Practical Nurse (LPN) documented Resident #8 complained of indigestion/heartburn and requested to be assisted into her recliner. CNAs hoisted (transferred via mechanical lift) resident to recliner and during the process the hoist sling straps started to snap resident was lowered into the chair safely, after an hour resident wanted to get back into bed. This nurse had to call the fire department to help assist resident safely back to bed. It took 8 firemen to transfer resident back to bed. c. A General Note entered on 2/27/26 at 9:00 AM revealed Resident #8 reported her right 5th toenail was snagged last night when she was placed in bed. The nurse evaluated and clipped the toenail that was sharp then bacitracin and bandage was applied.d. A General Note entered on 2/27/26 at 9:05 AM, entered by Staff F, LPN Wound Nurse documented Late documentation - Floor nurse and CNA reported to this nurse that during attempt to transfer resident from her recliner to bed, residents sling began to rip. Resident was immediately lowered back into her chair. EMT's (emergency medical team) called to help assist staff to get resident into bed. 3 EMT's arrived and assessed situation. In front of resident EMT's claimed that there was insufficient equipment in the facility to transfer the resident. Of note, Hoyer (full body mechanical lift) sling broke immediately before they were called and prior to this her hoist sling has been sufficient. These EMT's called fire department in order to get resident into her bed. 6 EMT's voiced to this nurse that they were going to move resident bed in front of her recliner and transfer into her bed manually. EMT's reported that this was successful. As floor nurse in charge of resident was unable to document in progress note, this nurse is documenting today. Will continue to monitor. e. A Nutrition/Dietary Note, dated 3/16/26: RD (Registered Dietician) SIG (significant CHANGE ASSESSMENT: CBW (Current body weight): 574.5 # (pounds)Review of a Grievance/Concern Report, dated 3/2/26, revealed, in part: Resident: [Name redacted, Resident #8] .Description of grievance/concern: (Removing red and yellow? Agree with this) .States Hoyer (a brand name of a type of mechanical lift, often used to describe all brands of mechanical lifts) lift was recently used and it tore so the medics (Fire Department) came to assist.Describe actions taken to resolve the grievance/complaint: Education on Hoyer operation/new sling ordered.Was grievance/complaint resolved: Yes, [name redacted, Resident #8] was happy - new slings arrived. During an interview on 3/17/2026 at 4:25 PM, (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Staff N, Certified Nursing Assistant (CNA) queried about the mechanical lift sling used to transfer Resident #8. Staff N opened up a closet in the B hallway which contained three shelves of lift slings. Staff N pulled out slings until she located a sling with a blue ribbon and identified it as the sling used for Resident #8. Staff N stated the sling crisscrossed between Resident #8's legs. Staff N stated the sling was an X-large identified by ribbon color. Upon inspection, the tag appeared worn/torn and the size and weight limit were unable to be identified. During an interview on 3/17/2026 at 4:27 PM, Staff O, CNA stated she was hired on 2/11/26. Staff O stated she was educated to get the slings from the closet in the B hallway, and most residents have special instructions in the EHR [brand name of EHR redacted]. Staff O stated the blue-ribbon mechanical lift slings were X-large and green ribboned slings were large. Staff O stated during her shift from 2-10 pm on 2/26/26, Staff M, CNA, and Staff AA, CNA asked her to assist with transferring Resident #8 from bed to a recliner due to complaints of heart burn. Staff O stated the sling used for the transfer was one she had never used before at the facility. She explained it was not netted or cloth, rather it looked like a transfer sling, silver on one side, blue on the other and multiple loops on each of the long sides. Staff O stated the only other sling available was a medium, purple ribboned sling that would not work for Resident #8. Staff O stated this was the first time she had assisted to transfer Resident #8. Staff O stated they put the silver/blue sling with the multiple loops under Resident #8, and attached the second loop from the top and the second loop from the bottom on each side of the sling to the Hoyer. Staff O further explained started to elevate the lift. As Staff O moved the Hoyer away from the bed, she heard the sling rip. Staff O explained the resident said she heard the rip, and she was scared of falling. Staff O stated she had the right side of the sling and the lift controller in her hands. Staff M, CNA stood behind the recliner, pushed it underneath the resident, and grabbed the top of the sling. Staff O stated Staff AA, CNA stood on the left side. Per Staff O, they held on until Resident #8 was lowered into the recliner. Staff O stated it was very scary. Staff O explained the sling then ripped on the bottom of the right side, and the loops pulled away from the sling. Staff O informed Staff Q, LPN of the situation and Staff Q called the DON. The DON directed me to call the fire department for assistance. Staff O further explained three firemen men responded, and Staff O described Resident #8 as looking scared with her arms crossed. The resident did not talk. Staff O stated the fireman suggested they attempted to lift Resident #8 with the lift by attaching the sling on the third loops from the bottom to raise her enough to place the purple sling under the torn sling. Staff O stated when that was attempted, the loops on the left side ripped from the lining. They lowered the resident down to the chair. Staff O explained Resident #8 repeatedly said How are you going to get me back to bed?. The firefighters called the department for additional assistance. When the additional personnel arrived, they took the headboard off the bed, and lowered the bed to the level of the foot of the recliner. The firefighters curled the sides of the torn sling and pulled Resident #8 into bed. Staff O stated Resident #8 reported she was in pain as her toe was run over by the Hoyer. During an interview on 3/17/2026 at 5:05 PM, Staff M, CNA stated the facility did not provide training for the Hoyer or for sling use. Staff M explained there were multiple slings in the chaotic closet. Staff M stated the facility did not provide the equipment for a resident that weighed as much as Resident #8, and they did not have an appropriate sling. Per Staff M, there were not enough staff to provide transfer assistance so Resident #8 did not get up in the evening. Staff M added the resident had been to the hospital several times and was transferred by the fire department with EMT's (emergency medical technicians). Staff M stated on 2/26/26, Staff Q, LPN directed her to transfer Resident #8 from the bed to a recliner. Staff M stated she told Staff Q that she did not feel good about it since there were only three CNAs and a sling that came from the hospital. Staff M described the hospital sling as blue on one side and grey on the other side. Staff M explained she was not familiar with the sling. Per Staff M, Staff Q said she wanted Resident #8 in the recliner so Staff M? had Staff AA and Staff O assist. Staff M stated they placed the sling under Resident #8 and moved her away from the bed. Staff M stated, My heart almost came out, I have never heard a sling tear before. Staff M stated she pushed the recliner under Resident #8 and felt if (continued on next page)		

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

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The Lieutenant stated there was a Hoyer sling on a counter with a label for 500 pounds and he did not know why the staff did not use it. The Lieutenant stated he did not know what the facility had for slings, but during a different dispatch staff weighed Resident #8 at 600 pounds. The Lieutenant wanted safety for the resident and the fire crew. He stated the facility had low staffing on the evenings but that was their patient, and (facility) should not be calling the fire department. The Lieutenant stated on 2/26/26 the first attempt to transfer Resident #8 involved wedging the recliner against the wall. The facility staff lifted her again with the Hoyer, using the lift sheet, so the other sling could be placed under Resident #8. The Lieutenant stated the lift sheet started ripping again, one handle after the other right down the side. Resident #8 was lowered back down in the recliner. The Lieutenant explained he called for three more firefighters to assist. When the additional crew arrived, they lowered the bed, took the head board off, and put the bed at the foot of the recliner. He explained it took all six of the crew to slide Resident #8 into the bed using the torn lift sheet. The Lieutenant stated his crew recognized the torn sheet. Per the Lieutenant, it was a slide sheet/transfer sheet from the hospital and not a Hoyer sling. The Lieutenant stated, This was the most unsafe situation. During an interview on 3/23/26 at 10:25 AM, Staff BB, CNA stated she provided training for new CNAs. Staff BB stated 5 days ago [March 18, 2026], the DON, ADON and the Administrator completed a mechanical lift demonstration and filled out validation forms. Staff BB stated the staff were directed if there was no tag on the sling to identify a maximum weight due to being washed off, staff were not to use it and were to turn it in. Staff BB stated she did not remember all the colored ribbon around the slings to identify the sling size, and management had her organize the closet that contained the slings. During an interview on 3/23/26 at 11:12 AM, Staff AA, CNA stated on 2/26/26, she assisted Staff M, CNA to transfer Resident #8 from her bed to the recliner. Staff AA stated Staff M expressed her concerns about the transfer sling which was blue and grey in color. Staff AA stated it was not like the regular slings and the facility did not have any slings like it. Staff AA described the sling had 6 loop handles on each side. Staff AA explained the bariatric lift was designed for 4 loops. Staff AA stated it was the only sling available. Staff AA stated another CNA [Staff O, CNA] assisted to move Resident #8 away from the bed and the sling began to pop, tearing on the right side at the bottom. Staff AA explained the material tore from the loops and the recliner was away from the bed. Staff AA stated they had to get Resident #8 into the recliner that was not big enough for her, and explained she was squished in. Staff AA notified Staff Q, LPN the predicament she put them in could have hurt everyone involved. Staff AA stated Resident #8 said don't drop me as she was fearful. Staff AA explained if Resident #8 would have fallen, it would have been catastrophic as she was very heavy. Per Staff AA, staff could not turn Resident #8 to place another sling under her, Staff AA explained Staff Q, LPN and Staff F, LPN/Wound Nurse did not enter the room to assist. Staff AA stated she was so irritated as this should not be happening. Staff AA stated the fire department responded, called in back up with 3 [persons] on each side and utilized the torn sheet. Staff AA reported the fire crew identified the sheet as a slide sheet. Staff AA stated the slide sheet was not appropriate to support Resident #8. Per Staff AA, Resident #8 appeared to be nervous, scared and irritated. She just wanted to get to where she was safe. Staff AA did not understand why Staff Q did not assess the resident in bed related to the resident's chest pain. Staff AA stated she felt if facility staff had to call the fire department every time Resident #8 needed to be transferred, then she (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	was not in the right facility to provide the care she needed. On 3/23/26 at 11:16 AM, Staff CC, LPN stated she was worked in a different part of the facility on 2/26/26 and was not asked to assist with Resident #8. Staff CC stated the staff often would call the fire department to assist with Resident #8 transfers to either go to the hospital or to appointments. Staff CC stated staff called the fire department due to safety as Resident #8 was very big. On 3/23/26 at 4:52 PM, Staff Q, LPN stated on 2/26/26, Resident #8 complained of chest pain after she ate supper while lying flat in bed. Staff Q directed the three CNAs on duty to transfer Resident #8 to the recliner. Staff Q stated one CNA reported that they couldn't assist Resident #8 back to bed the same way they got her out of bed. Staff Q stated she was told that they heard a snap and the strap of the sling started to fray. Staff Q stated the sling utilized for the transfer was grey and blue with loops on the bottom. It was not torn through but it was frayed on the right bottom side, where the loop attached to the sling. Staff Q stated Resident #8 could not tolerate the upright position for very long as her legs got tired. Staff Q notified the DON who told her she needed time to think about that. Staff Q stated the DON called back and directed her to call for the medics. The fire department responded and told her they were going to lift Resident #8 up just enough to put another sling under her. Staff Q stated staff tried to lift Resident #8 using the frayed sling with the mechanical lift and had not even moved her off the recliner when they heard it fraying again. Staff Q stated Resident #8 was very scared as she was afraid, they would drop her. Per Staff Q the firefighters did not know what to do so they called for more crew members. Staff Q explained the facility didn't have enough staff on duty, only 3-4 aides and the wound nurse. Staff Q stated she left the room due to more firefighters responding. She explained the fire crew dismantled the bed, placed it at the foot of the recliner and slipped Resident #8 onto the bed. Staff Q stated the Administrator was informed the sling was not completely broken, but was frayed on the right bottom corner. Staff Q stated she was directed not to use that sling again. Staff Q stated she did not want to think about if it gave away. Staff Q stated staff had used that sling to transfer Resident #8 before, when she was sent out to the hospital. 2. The MDS dated [DATE] identified Resident #39 as cognitively intact with a BIMS score of 13 out of 15. The resident had the following diagnoses: multiple sclerosis, paraplegia (paralysis of half of the body) and renal insufficiency (kidney failure). The MDS also identified Resident #39 had an impairment to both legs, and was dependent on staff for assistance with transfers. During an observation on 3/17/2026 at 12:22 PM, Resident #39 was in his electric wheelchair and sat on a mechanical lift sling with a purple-colored ribbon. The identifying tag listed size medium. The rest of the tag was worn too thin to identify the maximum weight limit for the sling. A document titled Mechanical Lift & Sling Size Risk Evaluation dated 1/5/26 revealed Resident #39 was dependent and recommended the total body lift. Resident #39 weighed 248 pounds and required a large size sling. The manufacturer safety instructions for the [Brand Redacted] True Bariatric Lift directed, DO NOT lift a patient if you are not trained and competent to do so. In addition, it directed to ALWAYS check the sling is suitable for the particular patient and is of the correct size and capacity.		

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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. Based on observations, kitchen record review, facility policy review and staff interviews, the facility failed to safety store opened food items, maintain temperature logs for the dishwasher, refrigerators, freezers, and for two days of meals, and failed to maintain the cleanliness of the equipment and flooring during two separate observations at varying times. The facility reported a census of 59 residents. Findings include: 1. The initial kitchen observation on 03/15/2026 from 9:58 AM - 10:32 AM revealed the following: a. Review of dishwasher temperature logs, revealed from 03/01/2026 through 03/03/2026 temperature checks were completed and the results of the chemical checks were not present. From 03/04/26 through 03/15/2026 temperature and chemical checks results were not indicated. b. Review of three refrigerator temperature logs revealed from 03/10/2026 through 03/15/2026 temperature results not indicated. c. Review of two freezer temperature logs revealed from 03/10/2026 through 03/15/2026 temperature results not indicated. d. Review of food temperature logs revealed on 03/12/2026 and 03/13/2026 no results recorded. e. A freezer contained an open plastic bag of boxed sausages open with 8 sausages exposed. One half of the sausages light brown, the other half darker brown. Multiple sausages had visible ice crystals on them. f. An undated bag of elbow noodles sat open on the top of a dry storage shelf with the contents exposed to air. A cellphone and a half full glass of a pink liquid sat on the shelf below. The baseboards opposite the shelf were covered in a film of grey dust. g. The stove had a thick, black, bumpy substance caked on the burners. The front left burner had a 1-inch by 2-inch orange substance cooked onto its surface. The middle burner had a 3 inch by 1 inch red and yellow chunky substance on the right side. The front right burner had splashes of dried on yellow and off-white substances dried to the top of the black substance. h. Under the door of the Refrigerator #1, a dried, peeling yellow substance approximately 2 inches by 4 inches found on the floor. The vent at the bottom of the refrigerator covered with a greasy substance with bits of food stuck in another sticky substances. Freezer #2 had crushed up yellow and white particles under the door on the floor. The floor under the two sink basins and by the milk refrigerator had light colored particles stuck to the floor. The floor between the sink and the coffee machine had a visible clear tacky substance. During an interview on 3/15/26 at 10:27 am, Staff E, [NAME] after having been asked for a cleaning schedule, and dishwasher temperatures logs stated she could not present them. 2. Observations of the kitchen/dining area on 3/18/26 at 11:04 am, revealed the following concerns: a. Staff U, Dietary Aide had long, artificial-looking painted nails. Staff U passed drinks and fruit cups to residents. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Ivy at Davenport		STREET ADDRESS, CITY, STATE, ZIP CODE 800 East Rusholme Street Davenport, IA 52803	
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. The vent above the open steam table covered with a thick layer of dust. c. The racks above a prep table which held spoons covered with a thick layer of dust. d. A fire suppression system spigot on the ceiling near the coffee machine covered with a thick layer of dust. e. Four fire suppression system spigots over the stove covered with dust particles. One of the spigots had a clump of a dirt-like substance clinging to it. f. Metal shelving which held pans face down covered with dust particles. g. The ceiling, back wall, right side wall, and light vent of the microwave covered with food debris. h. The top of a drawer handle covered with a long, thick layer of black grime. The drawer contained multiple scoops and spatulas. Multiple scoops contained crumbs. i. The outside of the ice machine in the dining room covered with a thick layer of brown and white build-up. The inside ceiling of the machine had a section covered with a yellow substance. Water dripped from this area into the ice. The Dietary Manager wiped off the substance. When queried regarding the water which dripped down into the ice, he stated he would empty the machine out and clean it. He stated he thought maintenance cleaned the ice machine on a monthly basis. On 3/18/26 at 2:35 p.m. the Dietary Manager stated staffing had been tough but they were getting there. He stated he expected the kitchen to be clean and sanitary. He stated he would talk about the ceiling and stated staff should not have false nails as they can hold bacteria. The March 2026 Daily Cleaning Tasks AM [NAME] schedule included the following areas to clean: microwave and all shelves. The March 2026 Daily Cleaning Log AM Aides schedule included the following areas to clean: ice machine. The March 2026 Daily Cleaning Tasks PM [NAME] schedule included the following areas to clean: microwave and shelves. The facility policy Sanitation Inspection revised 3/26/25, stated the facility would ensure food service areas were clean, sanitary, and in compliance with applicable state and federal guidelines. The facility policies Dietary Employee Personal Hygiene, dated 3/26/25, stated staff should keep fingernails short and artificial nails were not permitted. The facility policy Kitchen Hood Inspection and Cleaning revised 4/2/25, stated the facility would clean and maintain the kitchen hood exhaust system to foster a safe and healthful environment.		

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

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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** Based on clinical record review, facility policy review, and staff interviews, the facility failed to maintain accurate and accessible Advance Directive decisions for 2 of 24 residents reviewed (Residents #22 and #27). The facility reported a census of 59 residents. Findings include: 1. Review of the Minimum Data Set (MDS) for Resident #27, dated [DATE] included a list of diagnoses, which included: hypertension, non-Alzheimer's dementia, and anemia. The Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicated intact cognition. Review of the electronic health record (EHR) revealed two Physician Orders for Scope of Treatment forms (commonly referred to as an IPOST. An IPOST is a document used to indicate Advanced Directive choices and signed by the resident or a representative and a physician) dated [DATE], signed by the Resident #27 and the physician. a. The first IPOST, dated [DATE] indicated Resident #27 chose: Cardiopulmonary Resuscitation (CPR) - CPR/Attempt Resuscitation; Medical Interventions - Full Treatment; Artificially Administered Nutrition - Long-term artificial nutrition by tube. Medical Decision Maker - Patient. b. The second IPOST, dated [DATE] indicated Resident #27 chose: Cardiopulmonary Resuscitation (CPR) - DNR/Do Not Attempt Resuscitation; Medical Interventions - Comfort Measures Only; Artificially Administered Nutrition - No artificial nutrition by tube. Medical Decision Maker - Patient. Review of the electronic health record (EHR) Physician Orders section revealed an order, dated [DATE], for Full Code/CPR with full treatment and long-term artificial nutrition by tube. The EHR for Resident #27 also included a Code Status area in the banner, which listed the resident as a Full Code/CPR with full treatment and long-term use of artificial nutrition by tube. Review of Resident #27's Care Plan, dated [DATE] revealed a Focus area to address Resident HAS ADVANCED DIRECTIVES on record, with the Intervention: Resident is a DNR. 2. Review of the MDS for Resident #22 dated [DATE] revealed a list of diagnoses which included: schizophrenia, chronic obstructive pulmonary disease (a condition involving constriction of the airways and difficulty or discomfort breathing), and myelodysplastic syndrome (a type of blood cancer that occurs in bone marrow). The BIMS score of 14 out of 15 indicated intact cognition. Review of the IPOST document signed by a Nurse Practitioner and Resident #22 on [DATE] IPOST, revealed a Code status of Cardiopulmonary Resuscitation (CPR) - DNR/Do Not Attempt Resuscitation; Medical Interventions - Comfort Measures Only; Artificially Administered Nutrition - No artificial nutrition by tube. Review of the EHR Physician Orders section revealed no order to indicate Resident #22's Advanced Directive decision. The EHR lacked a Code Status area in the banner. Review of Resident #22 Baseline Care Plan, dated [DATE] revealed a Focus area to address Resident/Resident Representative has chosen DO NOT Resuscitate (DNR), with an Intervention For DNR Status: Verify presence of physician's order for DNR. During an interview on [DATE] at 3:52 PM, Staff A, Licensed Practical Nurse (LPN) stated a resident's Code Status could be found in the EHR banner area for each resident. When asked for Resident #22's current status, Staff A looked in the Residents EHR. Staff A stated Resident #22's EHR did not have a Code Status area in the banner. Staff A stated without the Code Status listed in the resident's banner of the EHR it is not immediately apparent the Advanced Directive wishes of the resident. Staff A located Resident #22's IPOST within the Documents tab of the EHR. During the same interview, when asked for the Code Status for Resident #27, Staff A stated the Code Status in the EHR indicated the resident is a Full Code. Staff A checked Resident #27 most recent IPOST in the Documents tab of the EHR and stated the IPOST, dated [DATE] had a Code Status of DNR/Do Not Attempt Resuscitation. Staff A, LPN explained the Administrator uploaded the initial IPOST upon a resident's admission. Staff A stated at the time of admission, Resident #27 had an IPOST, dated [DATE] which had CPR checked. Staff A stated the Social Worker uploaded a new IPOST when changes were made. Staff A stated when the updated IPOST is uploaded there should be an update in the Code Status section of a resident's EHR (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	banner. During an interview on [DATE] at 4:02 PM, Staff B, Social Services Director explained the usual practice is to update the Code Status in the EHR banner immediately after an IPOST has been received or changed. Staff B stated this had not been done for when Resident #27 changed her IPOST. Staff B stated she could not explain why Code Status section of the EHR banner had not been added for Resident #22. Staff B stated the Code Status area of the EHR banner is where staff checked for the Code Status of a resident. Review of the policy titled Cardiopulmonary Resuscitation (CPR), dated [DATE] revealed a Policy statement which declared it is the policy of this facility to adhere to residents' rights to formulate advance directives. In accordance to these rights, this facility will implement guidelines regarding cardiopulmonary resuscitation (CPR). The Policy Explanation and Compliance Guidelines section included, in part: If a resident experiences a cardiac arrest, facility staff will provide basic life support, including CPR, prior to the arrival of emergency medical services and: a. In accordance with the resident's advance directives. B. In the absence of advance directives or a Do Not Resuscitate order.		

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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** Based on clinical record review, facility policy review, and staff interview, the facility failed to notify the provider of a significant weight gain for 1 of 2 residents (Resident #8) reviewed for nutrition. The facility reported a census of 59 residents. Findings include: The Minimum Data Set (MDS) assessment tool, dated 2/17/26, listed diagnoses for Resident #8 which included morbid obesity, heart failure, and diabetes (a disease which caused abnormal blood sugars). The MDS listed her Brief Interview for Mental Status (BIMS) score as 14 out of 15, indicating intact cognition. Care Plan entries, dated 7/19/25, stated the resident had altered cardiovascular status related to congestive heart failure and directed staff to monitor and report changes in weight. Review of the Weight Summary for Resident #8 revealed the following weights: 2/3/26 535.4 lbs (pounds) 3/11/26 574.5 lbs. The resident's weight change from 2/3/26 to 3/11/26 resulted in a 7.3% gain. A hospital Medication Administered Report, dated 3/18/26, stated the resident admitted to the hospital on [DATE]. The facility lacked documentation of provider notification of the resident's weight gain from 3/11/26 to 3/16/26. During a phone interview on 3/25/26 at 8:04 a.m., the Director of Clinical Services stated she expected staff to notify the provider of a significant weight gain. She stated she was aware that staff did not report Resident #8's weight gain. The facility policy Notification of Changes, revised 12/2/25, stated the facility would promptly inform the resident's physician when there was a change in condition. The facility policy Weight Monitoring, dated 12/2/25, stated a 5% change in weight in 1 month would be considered a significant change.		

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Printed: 07/30/2026
Form Approved OMB
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, and resident representative/staff interviews, the facility failed to exercise reasonable care for the protection of a resident's cell phone from loss for 1 of 1 residents reviewed for missing items (Resident #67). The facility reported a census of 59 residents. Findings include: The Minimum Data Set (MDS) assessment tool, dated [DATE], listed diagnoses for Resident #67 which included heart failure, depression, and anxiety. The Brief Interview for Mental Status (BIMS) score as 4 out of 15, indicated a severe cognitive impairment. Review of the electronic health record (EHR) revealed Resident #67 passed away on [DATE]. The facility lacked documentation of the belongings of Resident #67 that were packed up by staff after her death on [DATE]. The Resident Representative reported the family picked up the belonging within 48 hours. On [DATE] at 10:35 a.m., via phone, the RR stated she sent the resident a cell phone and it went missing after one week. On [DATE] at 9:22 a.m., Staff V, Receptionist stated Resident #67 had a cell phone delivered to her, and the resident spoke to her daughter on the phone. Staff V stated she was not aware that the cell phone was missing. She stated if residents did not have a phone, staff would bring the resident up to the nursing station to utilize the phone. She stated the facility did not have a cordless phone. On [DATE] at 12:51 p.m., Staff A, Licensed Practical Nurse (LPN) stated Resident #67 had a phone but she wasn't aware that it was missing. On [DATE] at 5:16 p.m., the Administrator stated she did not have a list of items Resident #67's family received upon discharge. She stated there were items remaining including clothing and stuffed animals. She stated she did not recall a phone being one of the items. On [DATE] at 8:29 a.m., the Administrator stated she did not remember that Resident #67 had a phone. She stated she would develop a system to document items residents had in their possession. The facility policy Resident Personal Belongings, revised [DATE], stated the facility would ensure that personal belongings were rightfully returned to the resident's representative in the event of the resident's death. The policy stated possessions brought in during the duration of the resident's stay would be added to the resident's inventory listing.		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on personnel file review, facility policy review, and staff interviews, the facility failed to complete a background check prior to 1 of 3 newly hired staff starting their employment. The facility reported a census of 59 residents. Findings include: The facility New Hire Reporting report listed a start date for Staff L, Certified Nursing Assistant (CNA) as 6/5/25. Review of Staff L, CNA personnel file revealed the most current background checks on file as: a. Single Contract License and Background Check (SING) completed 9/22/21. The Criminal History Background Check Results read: Further research is required. Please await DCI (Division of Criminal Investigations') final response for criminal history. An Approval Notice dated 9/28/21 read, in part .The Iowa Department of Human Services has completed a Record Check Evaluation on the criminal or abuse history of the applicant and the result of the evaluation is that the applicant MAY WORK for your agency .b. Iowa Record Check Request completed on 9/27/21 confirmed a Waiver Signature on File for Staff L, CNA. c. Iowa Criminal History background check completed on 9/27/21. The personnel file lacked documentation of background checks completed after 2021, and prior to Staff L, CNA hire date of 6/5/25. On 3/25/26 at 8:29 a.m., the Administrator stated the facility should complete background checks prior to the staff member's start date. She stated the facility completed this with Staff L but she could not locate the documentation. The facility policy Abuse, Neglect, and Exploitation, revised 4/22/25, stated the facility would provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibited abuse. The policy stated the facility would complete a background check on potential employees and maintain documentation of the screening.		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165436	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/25/2026
NAME OF PROVIDER OR SUPPLIER Ivy at Davenport		STREET ADDRESS, CITY, STATE, ZIP CODE 800 East Rusholme Street Davenport, IA 52803	
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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	him. The Administrator stated she was not certain of the whereabouts of Resident #40. A document titled [NAME] County Iowa Sheriff's Office Inmate Listing Resident #40 revealed:a. [NAME] police department booking date 3/13/26 at 2:20 pm.b. Description Trespass Case # [number redacted]c. Release date 3/14/26 at 9:34 am court ordered, self-custody duration 19 hours, 14 minutes.Multiple attempts made to contact Resident #40 on 3/16/26 via cell phone, messages left without a return call.During an interview on 3/16/2026 at 4:47 PM, the Administrator stated she gave the involuntary 30-day Discharge Notice with the right to appeal in February 2026. The Administrator stated Resident #40 refused to sign the discharge and this is the reason she did not notify the State Agency or the Ombudsman. The Administrator explained on 3/13/26 it was an emergent discharge. She stated she did not notify the State Agency or Ombudsman office and she did not know why. The Administrator stated her expectation was that nursing would notify the physician. The Administrator stated she was unsure what a recapitulation of stay entailed but stated there was an incident summary in the computer.Review of the facility policy titled Transfer and Discharge, dated 7/17/23 revealed:a. It is the policy of this facility to permit each resident to remain in the facility and not transfer or discharge the resident from the facility, except in limited circumstances.b. Generally, the notice must be provided at least 30 days prior to a transfer or discharge of the resident. Exceptions to the 30-day requirement apply when the transfer or discharge is affected because:a. The health and/or safety of individuals in the facility would be endangered due to the clinical or behavioral status of the resident;b. The resident's health improves sufficiently to allow a more immediate transfer or discharge;c. An immediate transfer or discharge is required by the resident's urgent medical needs; ord. A resident has not resided in the facility for 30 days.e. In these exceptional cases, the notice must be provided to the resident, resident's representative if appropriate, and LTC ombudsman as soon as practicable before the transfer or discharge.f. The facility will maintain evidence that the notice was sent to the Ombudsman.g. In situations where the facility determines a resident's clinical or behavioral status endangers the safety or health of individuals in the facility, documentation regarding reason for the transfer or discharge will be provided by a physician, but not necessarily the resident's attending physician.h. Discharge to the Community: Facility will obtain a physician's order for transfer or discharge and instructions or precautions for ongoing care. A member of the interdisciplinary team will complete relevant sections of the Discharge Summary. The nurse caring for the resident at the time of discharge is responsible for ensuring the Discharge Summary is complete and includes, but not limited to, the following:i. A recap of the resident's stay that includes diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology and consultation results.ii. A final summary of the resident's status.iii. Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over the counter).iv. A post discharge plan of care that is developed with the participation of the resident, and the resident's representative(s) which will assist the resident to adjust to his or her new living environment.		

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

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

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

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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** Based on clinical record review, policy review, and staff interview, the facility failed to ensure Care Plans are revised to reflect changes in the care needs and the monitoring needs for 3 of 18 residents (Resident #39, Resident #50, and Resident #65) reviewed. The facility reported a census of 59 residents. Findings include: 1. The Minimum Data Set (MDS) assessment tool, dated 1/3/26, listed the following diagnoses for Resident #50 insomnia, obesity, and depression. The MDS listed a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated intact cognition. A 2/1/26 Administration Note stated staff found a bottle of sleep aids on the resident's night stand that was open with pills on the nightstand, floor, and bedside table. The staff member educated the resident with regard to self-medicating and notified the provider. A 2/3/26 Physician Progress Notes stated the resident should not utilize OTC (over the counter) medications without approval of the provider. The note stated if staff located OTC sleep aids again, the provider would discontinue Resident #50's order for Ambien (a prescription sleep aid) because the resident should not take the OTC and Ambien at once. A 2/14/26 General Note stated staff found two bottles of aspirin (a non-narcotic pain medication which also prevented blood clot formation) and 2 bottles of a sleep aid. The resident had bright red clots in her stool and the facility sent her to the ER (emergency room). A 3/11/26 Physician Progress Note stated the resident had a gastrointestinal bleed from taking OTC medications. Staff also found the resident with sleep aids on more than one occasion. The resident's Care Plan did not address the resident's history of taking OTC medications and did not provide direction for staff to monitor this in the future. 2. The MDS assessment tool, dated 3/10/26, list of diagnoses for Resident #65 included malnutrition, weakness, and heart failure. The MDS listed a BIMS score of 10 out of 15, which indicated a moderate cognitive impairment. A 3/7/26 Daily Skilled note stated the resident was nothing by mouth (NPO) status. A 3/9/26 Care Plan entry stated the resident was NPO. An Order Summary Report listed a 3/19/26 order for a regular diet with regular texture, nectar thick consistency with food cut up into bite sized pieces. A 3/20/26 General Note stated the resident reported he was confused because one person told him he could eat and another said that he couldn't and he didn't know what to believe. The facility failed to update the Care Plan to reflect the resident's current diet order. On 3/25/26 at 8:04 a.m., via phone, the Director of Clinical Services stated Care Plans should include a resident's correct diet and should also address if a resident had a history of taking unprescribed OTC medication. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. The Minimum Data Set (MDS) dated [DATE] identified Resident #39 as cognitively intact with a BIMS (Brief Interview for Mental Status) score of 13 and had the following diagnoses: multiple sclerosis, paraplegia (paralysis of half of the body) and renal insufficiency (kidney failure). The MDS also identified Resident #39 had an impairment to both legs, was totally dependent on staff for assistance with transfers, lower body dressing, putting on and removing footwear and required substantial/maximal assistance with showers and personal hygiene. The MDS identified Resident #39 utilized an indwelling catheter. Review of the electronic health record (EHR) revealed: a. On 3/10/26, Resident #39 diagnosed with a multi-drug-resistant infection (MRSA) only susceptible to intravenous (IV) antibiotics (ATB). b. On 3/11/26, Resident #39 is needing a PICC (peripherally inserted central catheter line, a type of IV that can be in place for several weeks to months) c. A 3/12/26 Physician Order for 7 days IV ATB for urinary tract infection, Meropenem 1 gram IV, 1st dose at infusion center. Review of the Care Plan, dated 11/17/23 revealed a Focus area to address the use of an indwelling foley catheter. The Care Plan lacked Interventions to address the UTI with a MRSA and the use of a IV antibiotic and associated care. The facility policy Care Plan Revisions Upon Status Change, dated 9/29/25, stated the facility would revise the comprehensive care plan when the resident experienced a status change.		

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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. Based on observations, clinical record review, resident and staff interviews, the facility failed to assist 1 of 1 residents (Resident #59) to wash her hair in a preferred manner in an attempt to lessen the physical discomfort the task caused the resident. The facility reported a census of 59 residents. Findings include: The Minimum Data Set (MDS) for Resident #59 dated 02/02/2026 included diagnoses of other forms of scoliosis lumbar region, hypercalcemia (calcium too high), and need for assistance with personal care. The Brief Interview for Mental Status (BIMS) assessment revealed a score of 14/15 which indicated intact cognition. The MDS indicated Resident #59 required partial/moderate assistance with shower/bathe self, and set up or clean up assistance with personal hygiene. Review of the electronic health record (EHR) Diagnosis List revealed a Need for Assistance with Personal Care added as an Additional Diagnosis on 12/23/25. The Care Plan for Resident #59 included a Focus area, dated 11/20/25, to address The Resident has an ADL (activities of daily living) self-care performance deficit r/t (related to) AKA (above knee amputation), scoliosis, cognition impairment AEB BIMS score. Interventions included, in part; a. BATHING/SHOWERING: Provide sponge bath when a full bath or shower cannot be tolerated. Dated Initiated: 11/20/25. b. BATHING/SHOWERING: The resident requires substantial/maximal assistance. Date Initiated: 11/20/25. c. a. Resident prefers to have hair washed in a trash bag in the recliner. Date initiated: 3/19/26. During an observation on 03/15/2026 at 1:38 PM, Resident #59's hair appeared greasy. During an interview, Resident #59 stated she gave herself a bath with wipes the day before [Saturday, March 14, 2026] because staff refused to help her find a way to wash her hair with water instead of using a rinse-free shampoo cap. The resident stated she told Certified Nursing Assistants (CNA's) and nurses her back hurt when they tried to give her a sponge bath in her bed. Resident #59 explained the CNA refused to wash her hair while she sat in her recliner. She stated her back was often in pain and laying in the recliner was her most comfortable position. During an observation on 03/18/2026 at 8:57 AM, Resident #59's hair appeared greasy, slicked back with strands of hair clumped together. The resident stated she was supposed to get her shower that day [Wednesday]. Resident #59 stated she wanted her hair washed but staff again refused to accommodate her back pain and do it from her chair. Resident #59 stated she refused showers sometimes because she wanted to be in her recliner when bathed, and staff would not let her do this. She stated she found that frustrating. On 3/16/26 at 2:41 PM Staff W, CNA stated staff used bathing sheets located in a binder to document if residents received a bath/shower. She explained the staff looked at the sheets to plan which residents needed a bath. Staff W looked at Resident #59 bathing sheets and stated the resident's scheduled bath days are Wednesdays and Saturdays. During an interview on 03/18/2026 at 9:37 AM, Staff L, CNA stated she was at the facility when the resident refused her shower on Saturday [March 14, 2026]. She said they tried to get her to go to the shower room or have a bed bath, offered a chair with a cushion, and have offered shower caps for her hair. Staff L stated they did not wash her hair with water in her recliner. During an interview on 3/18/26 at 9:39 AM Staff X, CNA stated the resident [Resident #59] would not get a shower that day [Wednesday, March 18, 2026] in spite of being told the resident wanted her scheduled bath. Staff X stated the resident was not due (scheduled) for bathing until Saturday. Staff X stated she would not give the resident a bath that day [Wednesday, March 18, 2026] and she wasn't going to give her a bath or wash her hair in that chair. During an interview on 03/18/2026 at 12:05 PM, the Assistant Director of Nursing (ADON) stated it was a problem that CNAs refused to wash the resident's hair. She expected staff to make accommodations for her back pain and resident preferences. During an interview on 03/18/2026 at 3:14 PM, the Administrator stated they were looking into Resident #59 bathing/hair washing concerns. The Administrator stated that when they spoke to the CNAs regarding the resident's bathing they were given a variety of responses regarding how it should or could be done. She acknowledged it was not acceptable to deny bathing and stated the CNAs should make accommodations for this resident.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, and staff interview, the facility failed to monitor resident weights per physician orders for 1 of 2 residents (Resident #65) reviewed for nutrition. The facility reported a census of 59 residents. Findings include: The Minimum Data Set(MDS) assessment tool for Resident #65, dated 3/10/26, list of diagnoses included malnutrition, weakness, and heart failure. The MDS listed the resident's Brief Interview for Mental Status Score (BIMS) score as 10 out of 15, indicating moderately impaired cognition. A 3/7/26 Daily Skilled note stated the resident admitted to the facility on [DATE], received tube feedings, and was nothing by mouth(NPO) status. On Order Summary Report listed a 3/6/26 order for daily weights x 3 days, weekly weights x 4 weeks followed by monthly weights. The March 2026 Treatment Administration Record (TAR) listed a 3/6/26 order for daily weights x 3 days, weekly weights x 4 weeks followed by monthly weights. The 3/6/26 and 3/9/26 entries for daily weights were blank. The 3/16/26 entry for a weekly weight documented 9 which was the code for See Progress Notes. The Progress Notes for 3/16/26 did not include information regarding why staff did not obtain a weight. On 3/25/26 at 8:04 a.m., via phone, the Director of Clinical Services stated she expected staff to carry out weights per the order unless the resident refused. The facility policy Weight Monitoring, dated 12/2/25, stated the facility would develop a weight monitoring schedule upon admission for all residents.		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on personnel file review, facility policy review, and staff interviews, the facility failed to ensure 2 of 3 Certified Nursing Assistants (CNAs) received performance evaluations every 12 months. The facility reported a census of 59 residents. Findings include: 1. An untitled employee profile report, dated 3/25/26, listed Staff S CNA's hire date as 7/11/23. The facility lacked documentation of a completed performance evaluation for Staff S in the last 12 months. 2. An untitled employee profile report, dated 3/25/26, listed Staff T CNA's hire date as 9/30/20. The facility lacked documentation of a completed performance evaluation for Staff T in the last 12 months. On 3/25/26 at 8:04 a.m., via phone, the Director of Clinical Services stated the facility should carry out yearly performance evaluations for CNA's. The facility policy Evaluation Process, revised 8/27/25, stated the facility would review the work performance of employees with a formal written evaluation. The policy did not specify how often the facility completed the evaluations.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165436	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/25/2026
NAME OF PROVIDER OR SUPPLIER Ivy at Davenport		STREET ADDRESS, CITY, STATE, ZIP CODE 800 East Rusholme Street Davenport, IA 52803	
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, clinical record review, policy review, and staff interview, the facility failed to ensure the medication error rate did not exceed 5% for 2 of 4 residents observed during medication administration (Residents #6 and #65). The facility's medication error rate calculated as 7.69%. The facility reported a census of 59 residents. Findings included: 1. The Minimum Data Set (MDS) assessment tool, dated 3/3/26, list of diagnoses for Resident #6 included diabetes (a disease which caused fluctuations in blood sugar), heart failure, and anxiety disorder. The MDS stated the resident received insulin (an injectable medication used to lower blood sugar) and listed the resident's Brief Interview for Mental Status (BIMS) score as 13 out of 15, indicating intact cognition. The March 2026 Medication Administration Record (MAR) listed an order for insulin glargine (a long-acting insulin with a brand name of Lantus) 30 units every 12 hours. On 3/18/26 at 8:15 a.m., Staff F, Licensed Practical Nurse (LPN) retrieved Resident #6's Lantus pen from the medication cart and stated she received 30 units. Staff F then went into the resident's room and dialed up the dosage to 40 units. When queried on whether the correct dose was 30 units or 40 units, Staff F stated she would check. Staff F left the room and came back and said that the correct dose was 30 units. Staff F then administered 30 units of Lantus to the resident. 2. The MDS assessment tool, dated 3/10/26, list of diagnoses for Resident #65 included malnutrition, weakness, and heart failure. The MDS listed the resident's BIMS score as 10 out of 15, indicating moderately impaired cognition. The March 2026 Medication Administration Record (MAR) listed the following medications with direction to administer from 6:00 a.m. to 9:00 a.m. via gastrostomy tube(g-tube, a tube surgically inserted into the stomach throughout the abdominal wall, used to instill nutrition, hydration and medications): a. Empagliflozin (treated heart failure)10 milligrams (mg)b. Eplerenone (treated high blood pressure) 25 mgc. Multivitamin tabletd. Omeprazole (treated heartburn and indigestion) 20 mge. Apixaban (used to prevent blood clots) 2.5 mgf. Calcium carbonate 600 mgg. Carvedilol (treated high blood pressure) 6.25 mgOn 3/18/26 at 9:13 a.m., Staff K Registered Nurse (RN) crushed the following medications for Resident #65 and poured them into a medication cup:a. Empagliflozin 10 mgb. Eplerenone 25 mgc. Multivitamin tabletd. Omeprazole 20 mge. Apixaban 2.5 mgf. Calcium carbonate 600 mgg. Carvedilol 6.25 mgStaff K then took a spoon and retrieved a few larger pieces of one of the medications and placed them in a separate medication cup. When queried Staff K stated those were the large pieces of omeprazole and they didn't instill well through the resident's g-tube. Staff K then instilled the resident's medications into his g-tube and did not include the pieces of omeprazole. On 3/18/26 at 3:25 p.m., the Assistant Director of Nursing (ADON) stated prior to giving a medication, nurses should check the MAR and the medication card, and then check the MAR again. She stated Staff F, LPN should have prepared the insulin at the cart. With regard to crushed medications for g-tube administration, she stated staff should not discard large pieces of medications as the water can dilute this. The facility policy Medication Administration revised 4/9/25, stated staff would administer medications as ordered by the physician and in accordance with professional standards. The policy directed staff to ensure they administered the right dose.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, facility policy review, and staff interviews, the facility failed to ensure 2 of 8 residents (Residents #6 and #39) reviewed for medications were free of a significant medication error. The State Agency intervened prior to a nurse giving Resident #6 the incorrect dose of insulin; and Resident #39 missed a dose of an intravenous antibiotic. The facility reported a census of 59 residents. Findings include: 1. The Minimum Data Set (MDS) assessment tool, dated 3/3/26, list diagnoses for Resident #6 included diabetes (a disease which caused fluctuations in blood sugar), heart failure, and anxiety disorder. The MDS stated the resident received insulin (an injectable medication used to lower blood sugar) and listed the resident's Brief Interview for Mental Status (BIMS) score as 13 out of 15, which indicated intact cognition. The March 2026 Medication Administration Record (MAR) listed an order for insulin glargine (a long-acting insulin with a brand name of Lantus) 30 units every 12 hours. During an observation on 3/18/26 at 8:15 am, Staff F, Licensed Practical Nurse (LPN) retrieved Resident #6's Lantus pen from the medication cart and stated she received 30 units. Staff F then went into the resident's room and dialed up the dosage to 40 units. When queried on whether the correct dose was 30 units or 40 units, Staff F stated she would check. Staff F left the room and came back and said that the correct dose was 30 units. Staff F then administered 30 units of Lantus to the resident. On 3/18/26 at 3:25 pm, the Assistant Director of Nursing (ADON) stated prior to giving a medication, nurses should check the MAR and the medication card, and then check the MAR again. She stated Staff F should have prepared the insulin at the cart. 2. The MDS, dated [DATE] identified Resident #39 as cognitively intact with a BIMS score of 13 out of 15. The MDS list of diagnoses included multiple sclerosis, paraplegia (paralysis of half of the body) and renal insufficiency (kidney failure). The MDS identified Resident #39 with an indwelling catheter. Review of the electronic health record (EHR) revealed: a. On 3/10/26, Resident #39 diagnosed with a multi-drug-resistant infection (MRSA) only susceptible to intravenous (IV) antibiotics (ATB). b. On 3/11/26, Resident #39 is needing a PICC (peripherally inserted central catheter line, a type of IV that can be in place for several weeks to months) c. A 3/12/26 Physician Order for 7 days IV ATB for urinary tract infection, Meropenem 1 gram IV, 1st dose at infusion center. Review of the March 2026 MAR for Resident #39 revealed meropenem 1 gram IV two times a day (6am & 6pm) for 7 days was initiated on 3/13/26 at 6am. On 3/16/26 the 6am dose documentation 9 initialed by Staff Q, Licensed Practical Nurse (LPN). A Progress note dated 3/13/26 at 3:59 pm for Resident #39 revealed the IV ATB therapy ordered for 3/13/26 to 3/20/26 and it was ok to receive the first dose after the PICC was inserted. (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/24/26 at 3:52 pm, Staff Q, LPN stated she documented a 9 on 3/16/26 in the March 2026 MAR for Resident #39's Meropenem IV ATB am dose. Staff Q explained a 9 directed the reader to refer to the progress notes. Staff Q stated the RN failed to document the administration for the ATB and the MAR prompted for a response. Staff Q stated she was unable to recall if the RN administered the dose and did not notify the RN or the physician. Staff Q stated she could not administer the ATB as it was via the PICC line and that was not in an LPN's scope of practice. Review the electronic health record revealed a lack of documentation related to the 9 documented on the March 2026 MAR for the 3/16/26 6 am dose of meropenem. During an interview on 3/25/2026 at 8:52 am, the Administer stated she was unaware of the missed dose of ATB for Resident #39 and it was her expectation that the LPN would not document for the RN and the physician should be notified. The facility policy Medication Administration revised 4/9/25, stated staff would administer medications as ordered by the physician and in accordance with professional standards. The policy directed staff to ensure that the six rights of medication administration are followed: Right resident, right drug, right dosage, right route, right time and right documentation.		

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview 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 on the current survey which had been previously identified in 2025. The facility reported a census of 59 residents. Findings include: Review of the CMS 2567 form dated 3/6/25 revealed, in part, deficiencies had been identified with notification of changes, care planning, assistance with activities of daily living, accidents and hazards, and kitchen sanitation. Concerns with the above areas were identified during the facility's current recertification and complaint survey completed 3/25/26. Review of the CMS 2567 form dated 7/16/25 revealed, in part, deficiencies identified with accidents and hazards. Concerns with the above area was identified during the facility's current recertification and complaint survey, completed 3/25/26. Review of the CMS 2567 form dated 12/16/25 revealed, in part, deficiencies identified with accidents and hazards. Concerns with the above area was identified during the facility's current recertification and complaint survey, completed 3/25/26. QAPI Meeting Attendance and Agenda Sign-in Sheets documented meetings held on 2/23/25 and 2/26/26. Undated Root Cause Analysis Performance Improvement Plan (PIP) Framework for Nursing Home QAPI documents, provided by the Administrator on 3/25/26, included PIPs such as fall prevention. The documents did not contain further PIPs related to accidents and hazards or dietary sanitation. The facility lacked documentation of QAPI activities carried out during the survey year period between 3/15/25 and 3/25/26. On 3/25/26 at 8:29 a.m., the Administrator stated the QAPI program was a mess. She stated they were aware of this after they had an Immediate Jeopardy deficiency in December 2025. She stated since then they worked diligently on this and completed a QA meeting in February. The policy QAPI, dated 2/5/25, stated the facility would develop a data-driven QAPI program that focused on indicators of the outcomes of care and quality of life and addresses all the care and unique services the facility provided. The plan stated the QA team would meet quarterly and would focus, in part on survey outcomes.		