STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165510	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Davenport Lutheran Home	1130 W 53rd Street Davenport, IA 52806

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48452 Based on clinical record review, policy review, and staff interview the facility failed to maintain accurate Advance Directive records based on resident preference for 1 of 18 residents reviewed (Resident #42). The facility reported a census of 71. Findings include: The Minimum Data Set (MDS) for Resident #42, dated [DATE], revealed diagnoses of renal disease, encephalopathy, and hypertension. The MDS documented the resident scored 15 out of 15 on a Brief Interview for Mental Status exam, indicating intact cognition. A review of Physician Orders revealed a Full Code, order date [DATE]. A review of Care Plan, Date Initiated: [DATE], Revision on: [DATE] included a Focus area to address Advanced Care Planning - Full Code. Interventions included, in part; Staff will attempt cardiac resuscitation in the event [name redacted] is found without a [NAME] or breathing. [Name redacted] and her family have decided they would like medical treatment cardiac monitors oral/IV fluids and/or medications but do NOT want intubation or mechanical ventilation or artificial nutrition by tube. Less invasive airway support such as BIPAP (bilevel positive airway pressure - a noninvasive breathing machine that helps people breathe with they're having trouble) or CPAP (continuous positive airway pressure - a machine that uses mild air pressure to keep breathing airways open while sleeping) may be considered. [Name redacted] wants transferred to the hospital if indicated but she or her family should be consulted before deciding on critical care. During an interview on [DATE] at 11:12 AM, Resident #42 stated her code status was for CPR (cardiopulmonary resuscitation). A review Resident #42 electronic health record Admission Record on [DATE] at 2:44 PM, revealed a Code Status: (Advanced Directives) Full Code. During an interview on [DATE] at 03:26 PM, Staff H, LPN (Licensed Practical Nurse)stated if someone went into cardiac arrest they would look in the paper chart or the computer for code status. She was not aware there was a difference in this resident's record. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 03:37 PM the Assistant Director of Nursing stated they (staff) can look at the paper chart or on the computer. She was not aware there was a discrepancy in Resident #42's record and stated they would fix it right away. A facility policy, Reviewed: [DATE], titled CPR Emergency Treatment/Life Support Measures Procedures section included, in part; Upon admission, the facility's CPR Emergency Treatment/Life Support Measures policy will be explained to the resident/resident representative. The resident/resident representative's wishes regarding CPR will be verified and documented in the medical record.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48452 Based on observation, resident interview, and staff interview the facility failed to maintain a sanitary, orderly, and comfortable interior in the facility dining room during 4 of 4 dining observations. The facility reported a census of 71 residents. Findings include: An observation in the main dining room on 10/28/24 at 12:14 PM, revealed, on the east side of the room, approximately 12-foot section of the bottom of a ceiling beam wrapped in plastic. The beam had approximately seven pieces of tan tape, on each side, to secure the plastic. The plastic contained clumps of a white, dark brown and black material. On the east side of the beam, the paint area above the taped section bubbled off the wall. The tape on west side pulled away from the beam, leaving approximately six feet of the plastic detached. This area of the beam hung above the floor, wall and door connecting the kitchen to the dining area. A white and tan stain measuring approximately 1 foot by 1-foot, and up seven bricks from the floor covered a portion of the wall and kitchen door. Staff used the door to set up the dining area, and service residents' meals. A beverage cart, with milk, juice, pop, water, and thickened liquids sat underneath the plastic covered beam, outside the kitchen door. During the observation at 12:31 PM, one resident stood under the plastic to get drinks for himself, with four other residents seated at a table three to four feet away. During an observation on 10/29/24 at 07:42 AM, staff in the dining room prepared drinks under the plastic to serve to residents. The tape and plastic on the beam remained as observed before. Visible chunks of material were missing along the bottom of the beam, and exposed unfinished ceiling area. Two residents were seated at a table 3-4 feet away. During an interview on 10/29/24 at 11:48 AM, the Dining Services Director stated he thought the ceiling damage was due to a roof leak that caused water damage. He was not aware when it would be repaired. During an observation on 10/29/24 at 12:35 PM, the plastic continued to sag at the lunch meal with 3 residents 3-4 feet away. A resident observed going to a cart sitting under the exposed area to get pop. During on observation on 10/29/24 at 3:22 PM, four food service carts sat under covered beam. One cart contained empty storage containers used to wash dishes in the dishwasher. The second held straws, hand wipes, and tissues. A third had a cut birthday cake exposed to air and a piece on a plate with a fork in it. The last one held napkins, cups, silverware, a plate, and a pitcher with a couple of inches of liquid in the bottom. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 10/29/24 at 3:46 PM, the Administrator stated the area was damaged from a [NAME] storm last year and they were appealing an insurance denial. The plastic was their fix while they waited. She recognized the plastic was hanging down and carts were under them.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 37072 Based on clinical record review, staff interviews and facility policy review the facility failed to report an allegation of abuse to the state agency for 1 out of 1 allegation of abuse reviewed (Resident #75). The facility reported a census of 71 residents. Findings include: The Minimum Data Set(MDS) assessment tool, dated 7/25/24, listed diagnoses for Resident #75 included anemia, hypertension, renal insufficiency, osteoporosis, and Alzheimer's disease. The MDS indicated the resident required moderate assistance from staff for toileting hygiene, showering, dressing, personal hygiene, and transferring. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 4 out of 15, indicating impaired cognition. Review of the clinical record for Resident #75 failed to reveal any documentation regarding an incident between staff and Resident #75. During an interview on 10/30/24 at 12:26 PM Staff H, Licensed Practical Nurse (LPN) stated Resident #75 reported to Staff I, Certified Nursing Assistant (CNA) another CNA [Staff J] had given her a shower earlier and performed cares aggressively. She spoke with Resident #75 and the resident told her she did not want her [Staff J] to give her a shower any more because she performed perineal and anal cares aggressively. Staff H called her managers the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) and informed both of them. The Director of Nursing directed her to send Staff J home. Staff H stated the reason I did not chart anything on the incident was because it was the end of my shift and I was in the middle of giving report when it all happened, and I did not even send Staff J home. The nurse who I reported off to sent her home. I would do an incident report I guess if the situation called for it. During an interview on 10/30/24 at 12:49 PM Staff I, CNA stated Resident # 75 and her were ambulating back from the dining room and she kept asking me about a girl and she kept saying she was the weird one. Resident #75 told me she got a shower from her and it was very aggressive. The resident specifically said her bottom area was a very aggressive wash up. It was in the back area of her buttocks. Staff I stated she went and reported it to the nurse right away. No one from management ever came and talked to me about it. The DON, ADON or administrator never talked to me about it. The main thing I was told to report to the charge nurse. I went straight to the nurse. We then wait for follow up from the administration. The staff member was sent home right after it happened and since it happened I have not seen her since. During an interview on 10/31/24 at 10:14 AM the Director of Nursing (DON) stated she was aware of the incident with Resident #75 and Staff J, CNA. The policy on abuse is that we would report it immediately. We would investigate the incident. The person responsible for reporting the abuse would be me and I would notify the administrator and Chief Executive Officer (CEO) immediately. Typically now I consult with the CEO and I would submit it to the state agency. I did call the CEO and we spoke about it because the nurse stated it wasn't intentional and she wasn't being harmed in any way we chose not to report it. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/31/24 at 11:27 AM the Administrator stated there was a situation between Resident #75 and a staff member. Staff notified me by phone when the incident occurred and the CNA [Staff J] involved was sent home. Regarding reporting abuse I have to go look into it, I would have to refer to our policy I am not sure when it should be reported. The facility policy, Reviewed: 3/15/24, titled Abuse, Neglect, Mistreatment and Misappropriation of Resident Property and Reporting Guidelines PROCEDURES section: G. REPORTING AND RESPONSE declared, in part; It is the policy of this facility that abuse allegations (abuse including resident-to-resident abuse, neglect, exploitations, or mistreatment, including injuries of unknown source and misappropriation of resident property) are reported per Federal and State Laws to the Department of Inspections and Appeals Health Facilities Division. The Procedure, External Reporting section declared Initial Report: All allegations of Resident Abuse shall be reported to Iowa DIA not later than two (2) hours after the allegation is made.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 37072 Based on record review, staff interview and facility policy review the facility failed to investigate an allegation of abuse for 1 out of 1 residents reviewed (Resident #75). The facility reported a census of 71 residents. Findings include: The Minimum Data Set(MDS) assessment tool, dated 7/25/24, listed diagnoses for Resident #75 included anemia, hypertension, renal insufficiency, osteoporosis, and Alzheimer's disease. The MDS stated the resident required moderate assistance from staff for toileting hygiene, showering, dressing, personal hygiene, and transferring. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 4 out of 15, indicating impaired cognition. Review of the medical record for Resident #75 failed to reveal any documentation regarding an incident between staff and resident. During an interview on 10/30/24 at 12:26 PM Staff H, Licensed Practical Nurse (LPN) stated Staff I, Certified Nursing Assistant informed her Resident #75 stated another CNA [Staff J, CNA] had given her a shower earlier and performed cares aggressively. Staff H called her managers the Director of Nursing and the Assistant Director of Nursing and informed both of them. During an interview on 10/31/24 at 10:14 AM the Director of Nursing stated she was aware of the incident with Resident #75 and Staff J. She stated she talked to Staff H, LPN about the incident when she reported it. She stated she did not talk to the resident or investigate it after she spoke with the nurse who reported it to her. During an interview on 10/31/24 at 11:27 AM the Administrator stated there was a situation between Resident #75 and a staff member. Staff notified me by phone when the incident occurred and the CNA involved was sent home. I thought an investigation was completed after the incident took place, it was determined it was a thorough washing and it was not well received. I would expect there to be an investigation. There should be documentation or an incident report if something happened. The facility policy, Reviewed: 3/15/24, titled Abuse, Neglect, Mistreatment and Misappropriation of Resident Property and Reporting Guidelines PROCEDURES section: D. INVESTIGATION declared It is the policy of this facility that reports of abuse (mistreatment, neglect, or abuse, including injuries of unknown source, resident-to-resident abuse, exploitation and misappropriation of property) are promptly and thoroughly investigated. The Procedure for the section included: The investigation process is used to try to determine what happened and designated facility personnel will begin and investigation immediately. The information gathered is given to the Administrator/designee. 1. Abuse: When an incident or suspected incident of Abuse is reported, the Administrator/designee will investigate the incident with the assistance of appropriate personnel. The investigation will include: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. A review of documentation to determine who was involved. b. Resident's statements: - Resident interviews will be conducted and documented by two members of the management as designated by the Administrator/designee two different times within 24 hours following the incident. - For non-verbal residents, cognitively impaired residents or resident who refuse to be interviewed, attempt to interview residents first. If unable, observe resident, complete an evaluation of resident behavior, affect and response to interaction, and document findings. c. Resident's roommate statements (if applicable) d. Involved staff and witness statement of events e. A description of the resident's behavior and environment at the time of the incident. f. Injuries present including a resident assessment. The charge nurse on duty will immediately complete a body assessment for injuries and document finding on a body drawing g. Observation of resident and staff behaviors during the investigation h. Environmental considerations.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 48452 Based on observation, facility policy review and staff interview, the facility failed to maintain a proper safe and appetizing food temperatures during a noon meal. The facility reported a census of 71 residents. Findings include: During an observation on 10/29/24 at 11:53 AM, Staff G, Dietary took food temperatures, with the following results: Turkey tetrazzini 177 F (degrees Fahrenheit) Peas 200 F Mashed potatoes 190 F Mixed vegetables 190 F Swedish meatballs 180 F Green beans 195 F Turkey tetrazzini pureed 200 F Peas pureed 200 F Gravy 200 F At 12:10 PM kitchen staff started the noon meal service to the residents in the dining room. The Dining Services Director stated room meals went out after dining room services was completed. He reported they use Styrofoam containers due to the increased number of room trays because it help temperatures longer. The last room tray was completed at 12:42 PM and sent out for delivery. Seven trays were delivered to resident rooms, and an additional one set aside for a resident who was sleeping. The last room tray was delivered at 12:59 PM and the test tray temperatures taken by the Dining Services Director. The turkey tetrazzini registered at 130 degrees and the peas at 148.9 degrees. After multiple attempts, he stated the tetrazzini was not going to meet the required temperature. He expected the turkey tetrazzini temperature at 140 or higher and said that was something they had to work on. The facility policy, reviewed on 3/3/24, titled Food Temperatures Procedures included, in part: 1. Hot foods shall be kept at 140 degrees. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. If at any time the food temperature is below 140 degrees for hot food .the food shall be reheated in the microwave oven to 165 degrees. 5. A monitor shall be kept monitoring the food temperatures . 6. The food temperature monitor shall be reviewed by the Dining Services Director to assure the monitor is being completed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25855 Based on observation, record review and staff interview the facility failed to utilize Enhanced Barrier Precautions while providing high contact care for 1 of 3 residents with a indwelling medical device (Resident #52), and maintain a foley catheter collection bag and tubing off the floor for 1 of 2 residents (Resident #125). The facility reported a census of 71 residents. Findings include: 1. The Minimum Data Set (MDS), dated [DATE], identified Resident #2 as cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 01 out of 15. The MDS listed diagnoses included: osteoporosis, seizure disorder and chronic obstructive pulmonary disease. The MDS assessed the resident required substantial/maximal assistance with most activities of daily living (dressing, bathing, using the toilet, etc). The MDS identified Resident #2 used the nutritional approach of a feeding a tube while a resident. A review of the Physician Order Summary with active orders as of 10/29/24, revealed an order for Enhanced Barrier Precautions (EBP, the infection control intervention designed to reduce transmission of multidrug-resident organisms that employs targeted gown and glove use during high contact resident care) - Staff to don gown and gloves prior to high-contact resident care activities, such as; Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, urinary catheter care, feeding tube care, Wound care including any skin opening requiring a dressing Face protection may also be needed if performing activity with risk of splash or spray. Order date: 4/1/24. The Care Plan, Date Initiated: 4/1/24, included a Focus area to address Resident requires enhanced barrier precautions due to G-tube. Interventions included, in part; Staff to don gown and gloves prior to high-contact resident care activities, such as: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, urinary catheter care, feeding tub cares, Wound care including any skin opening requiring a dressing During an observation on 10/29/24 at 9:57 AM, the door to Resident #52's room noted to have a Enhanced Barrier Precautions sign posted in a visible area. Staff A, Licensed Practical Nurse (LPN) entered the room to administer a morning GT feed. Staff A washed her hands, removed a carton of Jevity 1.5 cal formula and placed it on top of the over the bed table. Staff A then donned gloves and proceeded with preparing and administering the formula. Staff A did not wear a gown during this task. During an interview on 10/29/24 at 2:13 PM, Staff A LPN stated prior to a nurse providing any cares on a GT they should don gloves and check the GT site. She stated Resident #52 has EBP and she should have put on a gown and gloves before she administered the formula. During an interview on 10/30/24 at 12:47 PM, the Assistant Director of Nursing (ADON, and facility Infection Preventionist stated residents with GTs should be placed on EBP and nurses should don gloves and a gown prior to providing any cares with the GT. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy, Reviewed: 4/19/24, titled Enhanced Barrier Precautions directed targeted gown and glove use during high contact resident care activities known as Enhanced Barrier Precautions (EBP) are infection control intervention designed to reduce transmission of MDRO's (mulidrug-resident organisms). EBP must be used in conjunction with standard precautions to reduce the potential for transfer to MDRO's to staff hands and clothing. The policy listed examples of indwelling medical devices included feeding tubes, and declared high-contact resident care activities included device care or use. The Procedure section #2 directed Perform hand hygiene and don PPE (personal protective equipment) prior to high contact cares, Do NOT wear the same gown and gloves for care of more than one resident. 2. The MDS, dated [DATE], identified Resident #125 as cognitively intact with a BIMS score of 13 out of 15. The MDS listed diagnoses included: atrial fibrillation (an abnormal heart rhythm), coronary artery disease and urinary tract infection. The MDS assessed the resident required substantial/maximal assistance with most activities of daily living and had an indwelling urinary catheter. A review of the Physician Order Summary with active orders as of 10/29/24, revealed the following orders: a. Change catheter bag/tubing twice monthly per facility protocol .Order Date: 8/22/24 b. Foley Catheter (per Dr.'s order). 16 FR (catheter size) with 10 ml (milliliters) bulb filled with 10 ml sterile water and connected to straight drainage, Change Once Monthly and PRN (as needed) .Order Date: 9/3/24 The Care Plan, Date Initiated: 9/3/24 included a Focus area to address Resident requires an indwelling catheter related to urinary retention. Interventions included, in part; Position bag below level of bladder. Assure the catheter bag does not touch the floor. Store collection bag inside a protective dignity pouch. During an observation on 10/29/24 at 11:50 AM, Resident #125 sat in his wheelchair while in the main dining room. The urine collection bag was out of the dignity cover and drug on the floor while he self propelled himself approximately 50 feet out of the dining area. At 11:56 AM, Staff B, Certified Nursing Assistant (CNA) assisted another resident to dining room table near Resident #125. Staff B did not change the position of Resident #125's collection bag. The collection bag remained out of the dignity cover on the floor. At 12:06 PM, Staff A, LPN administered medications to Resident #125 Staff A did not change the position of the collection bag. At 12:21 PM, Staff D, CNA adjusted the clothing protector of a resident at the same table with Resident #125. Staff D did not change the position of Resident #125 collection bag. At 12:26 PM, the Nurse Consultant walked past Resident #125 and did not change the position of Resident #125 collection bag. At 12:48 PM, Resident #125 continued to sit at the dining room table, the position of the catheter collection bag remained out of the dignity cover, on the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 1:00 PM, Staff E, LPN pulled up Resident #125 collection bag and placed it in the dignity cover. A review of the Facility Policy titled: Catheter Care and dated as last reviewed 2/2/24 had documentation of the following: the tubing or the drainage bag should not touch the floor.