STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction Date: _____ A Focused COVID-19 Infection Control Survey and an investigation of Complaints #94037, #94275, #94316, #94404, #94410, #94458, #94518, #94623, #94624, #94714, #94777, and #94800 was conducted on 12/10/20 through 1/5/21 by the Department of Inspections and Appeals. The facility was found to be in non-compliance with CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. All the Complaints noted with areas of Substantiation. The following deficiencies relates to the investigation. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C) Total residents: 56	F 000		
F 569 SS=D	Notice and Conveyance of Personal Funds CFR(s): 483.10(f)(10)(iv)(v) §483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or death.	F 569		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 569	Continued From page 1	F 569		

Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is not met as evidenced by:

Based on record review, and staff and responsible party interviews, the facility failed to return funds from the resident's trust fund account within 30 days of the resident's death for Resident #9 as per regulations. The facility reported a census of 56 residents.

Findings include:

The 11/9/20 Minimum Data Set (MDS) Assessment tool revealed Resident #9 had diagnoses that included non-Alzheimer's dementia, cerebrovascular accident (a stroke) and COVID-19 virus, severe cognitive impairment with symptoms of delirium present, and required extensive assistance of at least 1 staff to reposition in bed, transfer to and from bed and chair, dressing, eating, toileting, bathing and personal hygiene, and unable to stand or ambulate.

Facility records revealed the resident died at the facility on 11/10/20, and a Resident Trust Fund Statement dated 12/15/20 revealed a balance of $243.29 remained in the resident's account.

During an interview on 12/14/20 at 10:16 a.m., the resident's responsible party (RP) stated they had made multiple calls to the facility since the resident's death and as of that date had not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 569	Continued From page 2 received the remainder of funds from the resident's trust fund account. During an interview on 12/30/20 at 1:52 p.m., the Business Office Manager stated a check for the balance in the resident's trust fund account was prepared for the RP and she would send it via mail that day.	F 569		
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any,	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 3	F 580		

when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on observation, resident, family/Responsible Party (RP), staff interviews and record review, the facility failed to notify family of changes in the residents' condition for five of sixteen residents reviewed, four of who had been discharged. (Residents #2, #3, #6, #9 and #14) The facility reported a census of 56 residents.

Findings include:

1. Resident #2's Minimum Data Set 5 Day Assessment completed 11/12/20 documented the following diagnoses: medically complex conditions, COVID-19 and pneumonia. It also identified the resident as cognitively impaired with a Brief Interview for Mental Status (BIMS) score

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 4	F 580		

of 4 out of 15, also required assistance of one person for transfers, dressing, toileting and bathing.

The Care Plan with the last revision date of 12/1/20 identified the resident with the problem of PASRR - referral to the office of substitute decision maker and identified a resident's family member as his Power of Attorney (POA) for health care and financial.

The Care Plan also identified the resident with the problem of an unplanned/unexpected weight loss related to decreased food intake and did not direct staff to notify family of any significant weight loss.

A review of the Progress Notes revealed the following entries:
a. On 11/6/2020 at 1:17 p.m., the resident was sent out via medic at 6:45 am. With complaint of hip pain. Upon assessment of resident femur bone appeared to be protruding. Medics were called and patient was sent out.
The entry did not include documentation to show the family had been notified of the transfer.
b. On 12/4/20 at 12:18 p.m., his weight is 138 pounds, has lost 6 pounds in 30 days and lost 12 pounds (7.9%) in 90 days.
The entry did not include documentation to show the family had been notified of the significant weight loss.
c. On 12/10/20 at 11:35 a.m., the resident's current weight is 136.1 pounds, has lost 7.5 pounds (5.2%) in one month.
The entry did not include documentation to show the family had been notified of the significant weight loss.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 5	F 580		

A review of the resident's weight in the electronic medical record revealed the following:
a. On 12/7/20 weight 133.3 pounds.
b. On 11/24/20 weight 138.2 pounds.
c. On 11/17/20 weight 143.6 pounds.
d. On 10/6/20 weight 149.2 pounds.

During an interview on 12/14/20 at 11:58 a.m., a resident's family member and second POA reported when the resident was sent to the hospital on 11/6/20, the facility did not call her or the first POA. A family friend who is employed at the facility called the resident's first POA to let her know that the resident was sent to the hospital. The nurse from the hospital reported the facility did not provide any information about the resident's medication or next of kin. No information had been sent with the ambulance.

In an interview on 12/14/20 at 11:23 a.m., the resident's first POA reported the facility did not inform her when he had been sent to the emergency room on 11/6/20, that she had been informed by a friend that worked at the facility. She also reported the facility did not call her with updates on his condition that she always has to call them. After COVID came, she had only one conference call regarding her father. She also reported she had not been informed of his weight loss in December 2020.

During an interview on 12/22/20 at 9:59 a.m., Staff F, Licensed Practical Nurse (LPN) reported family should be notified when the resident is admitted to the hospital, that a Medication List, Face Sheet and Transfer Summary should accompany the resident.

In an interview on 12/28/20 at 9:12 a.m., the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 6	F 580		

Director of Nursing reported nurses should notify family with any significant weight loss, any incident that is concerning, admissions to the hospital. This should be documented in the Progress Notes in the computer. She also reported when a resident is transferred to the hospital, forms that should accompany the resident should include the Face Sheet, Code Status, Bed-Hold Policy, Insurance Card copy, SBARs, Physician Orders for medications, etc.

A review of the facility policy with last revision date of May 2017 titled: Change in a Resident's Condition or Status had documentation of the following:
Unless otherwise instructed by the resident, a nurse will notify the resident's representative when:
a. The resident is involved in any accident or incident that results in an injury including injuries of an unknown source.
b. There is a significant change in the resident's physical, mental, or psychosocial status.
c. There is a need to change the resident's room assignment.
d. A decision has been made to discharge the resident from the facility; and/or
e. It is necessary to transfer the resident to a hospital/treatment center.

2. The 11/14/20 Minimum Data Set (MDS) Assessment Tool revealed Resident #3 with diagnoses that included anxiety, thyroid disorder, other fracture and positive COVID-19 virus, scored 10 out of 15 points possible on the Brief Interview for Mental Status (BIMS) cognitive assessment without symptoms of delirium present, and required extensive assistance of at least 1 staff to reposition in bed, transfer to and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 7	F 580		

from bed and chair, dressing, toileting, bathing and personal hygiene.

Facility documents revealed the resident admitted from the hospital on 11/12/20 and died at the facility on 11/30/20. A Physician Order transcribed 11/25/20 directed staff to administer Ceftriaxone (a very strong antibiotic) 1 Gram injected via intramuscular injection (a shot) 1 time daily for 3 days for cellulitis (infection of the skin and underlying tissue). The record lacked documentation the Responsible Party (RP) was notified of the change of condition or treatment plan.

During an interview 12/15/20 at 9:07 a.m., the resident's RP stated communication from the facility about the resident's condition was poor, they made repeated unsuccessful attempts to contact the facility for updates, then went to the facility and rang the doorbell in attempts to obtain information about the resident's condition and facility staff said if they didn't have paperwork to drop off they should leave. The day before the resident died the facility called, notified them of an alternate contact phone number due to a phone outage and informed them the resident was doing well, then the next day they called and said the resident was dead. The RP was unaware of the resident's cellulitis.

3. The 10/12/20 Minimum Data Set (MDS) Assessment Tool revealed Resident #6 admitted to the facility on 10/3/20 with diagnoses that included anemia, anxiety, thyroid disorder and respiratory failure, scored 12 out of 15 points possible on the Brief Interview for Mental Status (BIMS) cognitive assessment, without symptoms

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 8	F 580		

of delirium, and required extensive assistance of at least 1 staff to reposition in bed, transfer to and from bed and chair, dressing, toileting, bathing and personal hygiene, and unable to stand or ambulate.

During an interview on 12/15/20 at 9:44 a.m., the resident's RP stated they had not received appropriate notifications from the facility about changes in the resident's condition, attempted to address the matter with staff but unsuccessful, and made arrangements for the resident's transfer to another facility on 10/15/20 due to concerns about the resident's care that included the lack of communication from the facility.

4. The 11/9/20 Minimum Data Set (MDS) Assessment Tool revealed Resident #9 with diagnoses that included non-Alzheimer's dementia, cerebrovascular accident (a stroke) and COVID-19 virus, severe cognitive impairment with symptoms of delirium present, and required extensive assistance of at least 1 staff to reposition in bed, transfer to and from bed and chair, dressing, eating, toileting, bathing and personal hygiene, and unable to stand or ambulate. The resident died at the facility on 11/10/20.

During an interview 12/14/20 at 10:16 a.m., the resident's RP stated the facility rarely notified them of any changes, other residents at the facility that had called and notified them the resident had declined so they contacted the facility and informed then of the resident's positive COVID status. The RP stated the physician's nurse called and informed them they had increased the resident's Morphine to keep her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 9	F 580		

comfortable, the RP was unaware the facility had started her on the medication prior to the call.
5. The MDS Assessment dated 11/19/20 for Resident #14 shown diagnoses include Anemia, Gastroesophageal Reflux Disorder, Diabetes, Hyperlipidemia, Thyroid Disorder and Parkinson's. The MDS indicated Resident #14 scored a 5 out of 15 on the Brief Interview for Mental Status (BIMS), indicating the resident severe cognitive impairment. The MDS indicated the resident needed extensive assist to total dependence of 1-2 staff with transfers, dressing and personal hygiene. The MDS indicated the resident is high risk for skin damage and has moisture associated skin damage.

The Progress Notes dated 12/13/20 revealed the resident with multiple pressure areas on the inside of the Left thigh. Unable to measure at this time. All areas open and Director of Nursing, Assistant Director of Nursing and Administrator aware of wounds.

The Weekly Pressure Wound Observation Tool dated 12/13/20 failed to reveal documentation of family/Power of Attorney notification.

Review of the Nurse Progress Notes from 12/13/20 through 12/20/20 revealed the facility failed to notify the resident's representative of the pressure ulcer discovered on 12/13/20.

During an interview 12 /21/20 at 3:15 p.m., the Director of Nursing states she would expect family or resident representative to be notified of pressure ulcers the same day the pressure ulcer was discovered.

F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 10 CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 11	F 584		

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident and staff interviews the facility failed to provide a clean shower room for 1 out of 1 reviewed and maintain a home like environment for 1 out of 3 rooms observed. The facility reported a census of 56 residents.

Findings include:

During an observation of the A wing shower room on 12/14/20 at 11:15 a.m., the surveyor observed black scuff marks on the tiles of the floor in the shower room. The south wall of the A wing shower room had a large broken corner of particle board in the corner with large amount of black material built up behind and around the base board. The particle board had black bubbling areas for the 5 feet length of where the baseboard meets the particle board on the wall. There was dirt and debris around the and a thick black substance. The A wing shower room had two lights and observed debris in both light covers.

During an observation on 12/15/20 at 11:45 a.m. the floor in room A-6 bed 2 had 3 missing tiles on the floor below the window. The tiles along the row next to the window were loose and coming up revealing a black substance below the tiles.

During and interview on 12/21/20 10:30 a.m., Staff X, Housekeeping stated the shower rooms are cleaned daily and tries to scrub the walls if look dirty but have not noticed anything lately in A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 12 wing hall shower room During an interview 12/21/20 11:00 a.m., the Account Manager for Housekeeping states the shower rooms should be cleaned daily. The black should not be on the walls or baseboard in the A wing shower room. During an interview 12/21/20 at 2:38 p.m., the Interim Administrator states the black debris should not be in the A wing shower room and the South wall does need to be replaced. She was not aware of the missing and loose tiles in room A-6 but will add to list of repairs to be completed.	F 584		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 13 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, staff and a resident's responsible party (RP) interviews, the facility failed to investigate an allegation of misappropriation of resident property, failed to report the allegation as required to the Iowa Department of Inspections and Appeals (DIA), and failed to report reasonable suspicion of a crime to local law enforcement as required, for 1 record reviewed with an allegation of misappropriation of property (Resident #3). The facility reported a census of 56 residents. Findings include: The 11/14/20 Minimum Data Set (MDS) Assessment tool revealed Resident #3 with diagnoses that included anxiety, thyroid disorder, other fracture and positive COVID-19 Virus, scored 10 out of 15 points possible on the Brief Interview for Mental Status (BIMS) cognitive assessment without symptoms of delirium present, and required extensive assistance of at least 1 staff to reposition in bed, transfer to and from bed and chair, dressing, toileting, bathing and personal hygiene. Facility documents revealed the resident admitted from the hospital on 11/12/20 and died at the facility on 11/30/20.	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 14 During an interview 12/15/20 at 9:07 a.m., the resident's RP stated they spoke with the resident via telephone the day after she was admitted to the facility, she was very upset and said her gold crucifix necklace was gone. The RP stated they contacted staff at the facility and reported it right away, the facility was supposed to look into the matter and get back to them about it, and they made additional attempts to contact the facility about the issue without success. The resident's record lacked any documentation of the event. During an interview 12/21/20 at 1:40 p.m., the facility's Interim Administrator stated she spoke to staff, looked through files, contacted the Corporate Office and there were no records of the resident's missing necklace or investigation of the matter. The facility's undated Abuse Prohibition and Elder Justice Act Policy directed employees: 1. Misappropriation of resident property was financial exploitation and abuse. 2. All allegations of abuse must be followed up and looked into. 3. All allegations of abuse must be reported to the state within 24 hours. 4. Results of the investigation must be sent to the state within 5 days.	F 609		
F 620 SS=D	Admissions Policy CFR(s): 483.15(a)(1)-(7) §483.15(a) Admissions policy. §483.15(a)(1) The facility must establish and implement an admissions policy. §483.15(a)(2) The facility must- (i) Not request or require residents or potential	F 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 620	Continued From page 15	F 620		

residents to waive their rights as set forth in this subpart and in applicable state, federal or local licensing or certification laws, including but not limited to their rights to Medicare or Medicaid; and
(ii) Not request or require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.
(iii) Not request or require residents or potential residents to waive potential facility liability for losses of personal property.

§483.15(a)(3) The facility must not request or require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may request and require a resident representative who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

§483.15(a)(4) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However,-
(i) A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 620	Continued From page 16	F 620		

cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of such additional services; and
(ii) A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid eligible resident.

§483.15(a)(5) States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid.

§483.15(a)(6) A nursing facility must disclose and provide to a resident or potential resident prior to time of admission, notice of special characteristics or service limitations of the facility.

§483.15(a)(7) A nursing facility that is a composite distinct part as defined in §483.5 must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under paragraph (c)(9) of this section.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff and a resident's responsible party (RP) interviews, the facility required payments as a condition of admission and continued stay, a violation of Medicare regulations for skilled care recipients, for 1 of 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 620	Continued From page 17	F 620		

resident records reviewed (Resident #3). The facility reported a census of 56 residents.

Findings include:

The 11/14/20 Minimum Data Set (MDS) Assessment tool revealed Resident #3 admitted to the facility on 11/12/20, with diagnoses that included anxiety, thyroid disorder, other fracture and positive COVID-19 Virus, scored 10 out of 15 points possible on the Brief Interview for Mental Status (BIMS) cognitive assessment without symptoms of delirium present, required extensive assistance of at least 1 staff to reposition in bed, transfer to and from bed and chair, dressing, toileting, bathing and personal hygiene, and physical therapy services initiated 11/13/20.

Physician Orders transcribed 11/12/20 directed the resident's admission to the facility at a skilled level of care.

An 11/13/20 Physician Order directed the provision of skilled physical therapy services 5 times a week for 4 weeks for therapeutic exercise, neuromuscular reeducation, gait training, wheelchair management and manual therapy.

Documentation revealed the resident died at the facility on 11/30/20.

Facility documents revealed a $6300 charge to a credit card.

A statement dated 11/20/20, addressed to the RP requested $5280 payment by 12/1/20.

During an interview 12/15/20 at 9:07 a.m., the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 620	Continued From page 18 resident's RP stated they had paid the facility upon the resident's admission, and then again on 11/30/20, and later found out that her care was covered by Medicare and they wouldn't have had to pay. During an interview on 12/21/20 at 11:17 a.m., the Interim Administrator stated if a resident was admitted skilled under Medicare A, the resident should not be billed or have to pay anything up front, the Business Office Manager was new and didn't know that she wasn't supposed to bill the resident or RP for services when they were covered by Medicare. She acknowledged the RP had paid the bill and she contacted the Corporate Office to send a reimbursement check to the RP. At the time of survey exit, the facility failed to provide the requested billing policies and procedures.	F 620		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 19	F 657		

An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and record review, the facility failed to update residents' Care Plans for three out of twelve residents reviewed in the standard sample (Residents #4,#12 and #14). Resident #4's Care Plan did not address ambulatory status after she fractured her hip, Resident #14's Care Plan did not address newly developed pressure ulcers which developed 2 weeks prior, Resident #12's care plan did not address her transfer, weight bearing status after she fractured her pelvis. The facility reported a census of 56 residents.

Findings Include:

1. Resident #4's Minimum Data Set (MDS) Significant Change Assessment completed 11/28/20 documented the following diagnoses: debility, cardiorespiratory conditions, displaced intertroachanteric fracture left femur, atrial fibrillation (an abnormal heart rhythm). It also identified the resident as cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13 out of 15, required extensive staff assistance with most activities of daily living.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 20	F 657		

The Care Plan with last revision date of 12/7/20, identified the resident with the problem of an Activities of Daily Living (ADL) self-care performance deficit related to disease process, impaired balance, limited Range of Motion (ROM) related to a fractured femur. Interventions related to transfer documented the resident required limited assistance by staff to move between surfaces as necessary. Does not like to wait for assist and will refuse. Educate her to wait for assist.

The Care Plan did not address the need for assistive devices or weight bearing status.

During an interview on 12/21/20 10:10 a.m., Staff A, Occupational Therapy Assistant, reported the resident did not have orders to ambulate at that time and had orders for toe touch weight bearing.

In an interview on 12/22/20 at 8:10 a.m., the MDS Coordinator reported Care Plans are to be updated every 3 months or whenever there is a change in their condition.

2. Resident #12's MDS 5 Day Assessment completed 11/27/20 documented the following diagnoses: progressive neuro conditions, COVID-19, heart failure and pneumonia. It also identified the resident as cognitively impaired with a BIMS score of 6 out of 15 and required limited staff assistance with most activities of daily living.

The Care Plan did not identify the resident as having had a fall resulting in fracture on 12/10/20 and again on 12/20/20 as of 12/21/20.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 21	F 657		

A review of the Nurse's Notes revealed the following:
a. On 12/11/20 at 10:14 a.m. post fall on 12/10/20 and increased complaint of pain to the left hip/femur area, unable to bear weight or walk this morning. Noted anatomical difference from the left to the right.
b. On 12/11/20 at 10:43 a.m. resident sent out to the emergency room for further evaluation and treatment post fall on 12/10/20. The notes had no documentation of an assessment of the fall on 12/10/20.
c. On 12/20/20 at 5:32 p.m. resident fell on 12/19, x-ray ordered for right hand. Results called to the doctor.

During an interview on 12/22/20 at 9:59 a.m., Staff F, Licensed Practical Nurse (LPN) reported the MDS nurse and Director of Nursing (DON) had the responsibility to update the Care Plans daily to weekly, depending on issues identified with each resident. The nurses had the responsibility to report changes to the MDS Coordinator and/or DON. The nurses on the floor can add to the Care Plan if this is approved.

In an interview on 12/28/20 at 9:12 a.m., the DON reported Care Plans are to be updated anytime there is a change in the resident's condition. Prior to her hire date on 11/5/20, clinical meetings to discuss problems had not been conducted. Currently all department heads attend standup meetings daily and are responsible for taking notes on issues in their department and follow-up.

A review of the undated facility policy titled: Comprehensive Care Plans documented the following:
a. The Comprehensive Care Plan will be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 22	F 657		

reviewed and revised by the interdisciplinary team after each Comprehensive and Quarterly MDS Assessment.
b. Qualified staff responsible for carrying out interventions specified in the Care Plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.

A review of the facility policy with the last revision date of August 2006 and titled: Using the Care Plan documented the following:
a. Completed Care Plans are kept in the electronic medical record for review as needed.
b. The nurse supervisor uses the Care Plan to complete the Certified Nurse Aide's daily/weekly work assignment sheets and/or flow sheets
c. CNAs are responsible for reporting to the nurse supervisor any change in the resident's condition and Care Plan goals and objectives that have been met or expected outcomes that have not been achieved.
d. Other facility staff noting a change in the resident's condition must also report those changes to the nurse supervisor and/or the MDS assessment coordinator.
e. Changes in the resident's condition must be reported to the MDS Assessment Coordinator so that a review of the resident's assessment and Care Plan can be made.
f. Documentation must be consistent with the resident's Care Plan.

3. The Significant Change Minimum Data Set (MDS) Assessment dated 11/19/20 for Resident #14 shown diagnoses include Anemia, Gastroesophageal Reflux Disorder (GERD), Diabetes, Hyperlipidemia, Thyroid Disorder and Parkinson's. The MDS documented Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 23 #14 scored a 5 out of 15 on the Brief Interview for Mental Status (BIMS) test, indicating the resident with severe cognitive impairment. The MDS indicated the resident needed extensive assist to total dependence of 1-2 staff with transfers, dressing, personal hygiene and also a high risk for skin damage and has moisture associated skin damage. The Progress Notes dated 12/13/20 revealed the resident with multiple pressure areas on the inside of the Left thigh. Unable to measure at this time. All areas open and the Director of Nursing, Assistant Director of Nursing and Administrator aware of wounds. Review of the Care Plan with revision date of 12/3/20 revealed Resident #14 has potential impairment to skin integrity related to fragile skin. The Care Plan failed to address the pressure ulcers found on 12/13/20 with any new interventions.	F 657		
F 661 SS=E	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's	F 661		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 24	F 661		

representative.
(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, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.
This REQUIREMENT is not met as evidenced by:
Based on record review, and staff interviews, the facility failed to document the disposition of medications upon the resident's discharge from the facility or death for 5 of 5 closed records reviewed (Resident's #3, #6, #7, #9 and #13). The facility reported a census of 56 residents.

Findings Include:

1. The 11/14/20 Minimum Data Set (MDS) Assessment Tool revealed Resident #3 admitted to the facility on 11/12/20 with diagnoses that included anxiety, thyroid disorder and positive COVID-19 virus, and required extensive assistance of at least 1 staff to reposition in bed, transfer to and from bed and chair, dressing, toileting, bathing and personal hygiene. The resident died at the facility on 11/30/20, disposition of the resident's medications upon discharge was not documented as required in the record, and the facility could not provide the documentation upon request.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 25	F 661		

2. The 10/12/20 MDS revealed Resident #6 admitted to the facility on 10/3/20 with diagnoses that included anemia, anxiety, thyroid disorder and respiratory failure, and required extensive assistance of at least 1 staff to reposition in bed, transfer to and from bed and chair, dressing, toileting, bathing and personal hygiene. The resident discharged from the facility on 10/15/20, disposition of the resident's medications upon discharge was not documented as required in the record, and the facility could not provide the documentation upon request.

3. The 11/9/20 MDS revealed Resident #9 with diagnoses that included non-Alzheimer's dementia, cerebrovascular accident (a stroke) and COVID-19 virus, required extensive assistance of at least 1 staff to reposition in bed, transfer to and from bed and chair, dressing, eating, toileting, bathing and personal hygiene, and unable to stand or ambulate. The resident died at the facility on 11/10/20, disposition of the resident's medications upon discharge was not documented as required in the record, and the facility could not provide the documentation upon request.

4. The 11/30/20 MDS revealed Resident #13 admitted to the facility on 11/23/20 with diagnoses that included hypertension (high blood pressure), pneumonia, thyroid disorder and positive COVID-19 virus, and required minimal staff assistance to reposition in bed, dressing, personal hygiene and toileting. The resident discharged from the facility on 12/7/20, disposition of the resident's medications upon discharge was not documented as required in the record, and the facility could not provide the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 26 documentation upon request. During an interview 12/22/20 at 10:05 a.m., Staff F, Licensed Practical Nurse (LPN), stated staff were supposed to destroy resident medications when they were discharged but didn't know how it was documented, and recently found out they could return unopened medications to the pharmacy. Requests made on 12/21/20 for the facility's medication reconciliation and discontinued medication orders policies were undelivered at the time of survey exit on 1/05/21. 5. Review of Resident #7's Face Sheet revealed she had been admitted to the facility on 11/25/20 and discharged 11/27/20. A review of the Progress Notes revealed no documentation of the disposition of her medications after discharge.	F 661		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident, family, and staff interviews and record review, the facility failed to document that baths/showers had been provided for five of twelve residents reviewed (Residents #2, #5, #8, #10, #12) and failed to provide proper incontinence care for one of four residents observed in the standard sample (Resident #4). The facility reported a census of 56 residents.	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 27	F 677		

Findings include:

1. Resident #2's Minimum Data Set (MDS) 5 Day Assessment completed 11/12/20 had documented the following diagnoses: medically complex conditions, COVID-19 and pneumonia. It also identified the resident as cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 4 out of 15, required assistance of one person for transfers, dressing, toileting and bathing.

A review of the Care Plan identified the resident with the problem of activities of daily living self-care performance deficit related to cognitive loss and directed staff to provide sponge baths when a full bath or shower can not be tolerated.

A review of the Bath/Shower Sheets revealed no showers/baths were given from Nov 12 through Dec 1 a total of 18 days, and again after Dec 11 onward till 12/21/20 (10 days).

2. Resident #4's MDS completed 11/28/20 documented the following diagnoses: debility, cardiorespiratory conditions, displaced intertroachanteric fracture left femur, atrial fibrillation (an abnormal heart rhythm). It also identified the resident as cognitively intact with a BIMS score of 13 out of 15, and required extensive staff assistance with most activities of daily living.

The Care Plan with a due to be reviewed date of 12/23/20 identified the resident with the problem of an Activities of Daily Living (ADL) self-care performance deficit related to disease process,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 28	F 677		

impaired balance, limited Range of Motion (ROM) related to a surgical repair - open reduction internal fixation (ORIF) of left leg. Interventions directed staff to provide limited assistance of one to toilet the resident.

During an observation on 12/14/20 at 11:39 a.m., Staff C, Certified Nurse Aide (CNA) and Staff T, Personal Care Assistant (PCA, a non-certified Nurse Aide) entered the room to provide incontinence care. Staff T placed a washbasin with water on top of the bedside table without placing a barrier underneath. After cleansing the perineal area, Staff C repositioned the resident to lie on her left side, Staff T then cleansed the resident's rectal crease from the coccyx area toward the perineal area. Staff C repositioned the resident to lie on her right side then Staff T cleansed the resident's rectal crease from the coccyx area toward the perineal area. After both secured the new incontinent brief into place, Staff T then emptied the washbasin in the sink instead of the toilet.

In an interview on 12/22/20 at 8:38 a.m., Staff B, CNA, reported when providing incontinence care, she would fill a basin with water, put it on a clean towel, wash her hands, put on clean gloves, wash from the top of the stomach down toward the thigh, change the side of the cloth , wash the other thigh, get another towel, dry, remove her gloves, wash her hands, wash from top of private area and work my way down to the rectal area. Then she would change her gloves, turn the resident to the side, wash from the bottom and up toward the back. She would put these in bag, remove gloves, wash hands, put on new gloves, turn the resident to the other side and repeat washing front to back. She would remove her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 29	F 677		

gloves, wash hands, don new gloves then empty the basin in the toilet.

During an interview on 12/21/20 at 8:46 a.m., Staff Y, CNA, reported when providing incontinence care, she would wash her hands, put on gloves, place the washbasin on a towel on top of the table, clean from under the stomach and down the inner thigh, change gloves, wash hands, put on new gloves, turn the resident on the side, cleanse from the upper hip and wash down toward the thigh, repeat to the other side. Then she would empty the washbasin into the toilet.

During an interview on 12/22/20 at 9:19 a.m., Staff K, PCA, reported when providing incontinence care, she would wash from front to back, place the washbasin on a towel and empty the basin into the sink. She had received training from a CNA who is no longer employed at the facility and completed training in 3 days.

In an interview on 12/22/20 at 9:45 a.m., Staff T, PCA, reported when providing incontinence care, she would place a clean towel on the table, put the basin with water on top of the towel, remove gloves, wash hands, put on new gloves, then cleanse from the outer hip area, wash from top to bottom toward the groin, remove gloves, wash hands, new gloves, use new cloth, wash the other side. Then she would remove gloves, wash hands, new gloves, have the resident to side, wash from front to back, get a new wash cloth and then wash the outer hip and thigh, remove gloves, wash hands, new gloves, tuck the soiled brief under the resident, turn to other side, repeat. She would empty the wash basin into the toilet, remove gloves and wash her hands.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 30	F 677		

During an interview on 12/28/20 at 9:12 a.m., the Director of nursing (DON) reported when providing incontinence care, she would expect staff to place a barrier under the wash basin, wash from front to back, and empty the basin into the toilet when finished.

A review of the facility policy dated as last revised February 2018 and titled: Perineal Care had documentation of the following for a female resident:
a. Wash and dry your hands thoroughly.
b. Fill the wash basin one half full of warm water, place on the bedside stand within easy reach.
c. Put on gloves.
d. Wash perineal area, wiping from front to back.
e. Continue to wash the perineum moving from the inside outward to the thighs. Rinse perineum thoroughly in the same direction, using fresh water and a clean washcloth.
f. Gently dry perineum.
g. Ask the resident to turn on her side with top leg slightly bent.
h. Rinse wash cloth and apply soap or skin cleansing agent.
i. Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks (front to back motion).
j. Rinse and dry thoroughly.
k. Remove gloves and discard into designated container.
l. Wash and dry your hands thoroughly.

3. Resident #5's MDS Five Day Assessment completed 11/12/20 documented the following diagnoses: other neurological conditions, COVID-19, other fracture and alcoholic hepatitis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 31	F 677		

It also identified the resident to be cognitively intact with a BIMS score of 15 out of 15 and required extensive staff assistance with most activities of daily living.

A review of the Care Plan with the target date of 1/21/20 identified the resident with the problem of ADL self-care performance deficit related to limited mobility, limited ROM (range of motion), musculoskeletal impairment and directed staff to:
a. Provide a full sponge bath when a shower or bath cannot be tolerated.
b. Provide extensive staff assistance with showering and safety awareness.

A review of the bath/shower sheets revealed no documentation of showers completed on November 18 and 20 and from December 2 through 11, 2020.

During an interview on 12/10/20 at 11:42 a.m., the resident reported during the month of October, she had not received showers or assistance with bed baths.

4. Resident #8's MDS Quarterly Assessment completed 10/21/20 documented the following diagnoses: debility cardiorespiratory conditions, acute ischemic heart disease and diabetes mellitus. It also identified the resident required extensive staff assistance with most activities of daily living. He had not been assessed for cognitive status, however, the facility identified the resident as interviewable.

The Care Plan with the target date of 1/19/21 identified the resident with the problem of ADL (activities of daily living) self-care performance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 32	F 677		

deficit related to activity intolerance/amputation and directed staff to provide moderate assistance of one staff with bathing/showering and as necessary and provide a sponge bath when a full bath or shower cannot be tolerated.

A review of the bath/shower sheets revealed the resident did not have documentation that a shower had been given on November 23 and 30 and December 14.

In an interview on 12/14/20 at 9:37 a.m., the resident reported 12/11/20 he had been scheduled to have a shower, but the staff wanted to do it during an activity, so he did not get one. He also did not receive showers on the 7th and 10th as scheduled.

5. Resident #10's MDS Admission Assessment completed 11/21/20 documented the following diagnoses: debility: cardiorespiratory conditions, COVID-19 and atrial fibrillation (an abnormal heart rhythm). It also identified the resident to be cognitively intact with a BIMS score of 13 out of 15 and required limited staff assistance with most activities of daily living and identified the resident at risk for developing pressure ulcers.

The Care Plan with the target date of 12/23/20 identified the resident with the problem of an ADL self-care performance deficit related to weakness and fear of falling and directed staff to provide extensive assistance by one staff with bathing/showering and as needed and to provide sponge bath when a full bath or shower cannot be tolerated.

A review of the bath/shower sheets on 12/21/20 revealed the resident did not have documentation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 33 of a bath or shower given for 11 days. 6. Resident #12's MDS 5 Day Assessment completed 11/27/20 documented the following diagnoses: progressive neuro conditions, COVID-19, heart failure and pneumonia. It also identified the resident as cognitively impaired with a BIMS score of 6 out of 15 and required limited staff assistance with most activities of daily living. The Care Plan with the last revision date of 12/22/20 identified the resident with the problem of ADL self-care performance deficit related to dementia, fatigue, impaired balance directed staff to: provide extensive assistance by one staff with bathing/showering and as needed and provide sponge bath when a full bath or shower cannot be tolerated. A review of the bath/shower sheets on 12/21/20 revealed the resident did not have documentation of a bath or shower for 14 days. During an interview on 12/28/20 9:12 a.m., the DON reported if a bath/shower could not be completed on the scheduled shift, the next shift should attempt to complete it. A review of the undated facility policy titled: Bathing a Resident, did not address what to do if a resident refuses or where to document that the bath/shower had been completed.	F 677		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 34	F 684		

applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident, family and staff interviews and record review, the facility failed to document adequate assessments for six of twelve residents reviewed in the standard sample (Residents #2, #4, #7, #8, #12 and #18). The facility reported a census of 56 residents.

Findings Include:

1. Resident #2's Minimum Data Set (MDS) 5 Day Assessment completed 11/12/20 documented the following diagnoses: medically complex conditions, COVID-19 and pneumonia. It also identified the resident as cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 4 out of 15, required assistance of one person for transfers, dressing, toileting and bathing.

A review of the Care Plan with the last review date of 12/1/20 identified the resident with the problem of limited physical mobility related to history of old hip and pelvic fractures and directed staff to monitor/document/report as needed any signs/symptoms of immobility: contractures forming or worsening, thrombus formation, skin breakdown, fall related injury.

A review of the nurse's notes revealed the following:
On 11/6/2020 1:17 p.m.: Resident was send out

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 35	F 684		

via medic at 6.45 a.m. with a complaint of hip pain. Upon assessment of resident, the femur bone appeared to be protruding. Medics were called and patient was sent out.
The entry had no documentation as to what occurred prior to his transfer to the hospital. The notes did not have documentation of an assessment of the resident upon readmission to the facility on 11/10/20. The next entry had been dated 11/13/20.

2. Resident #4's MDS Significant Change Assessment completed 11/28/20 documented the following diagnoses: debility, cardiorespiratory conditions, displaced intertroachanteric fracture left femur, atrial fibrillation (an abnormal heart rhythm). It also identified the resident as cognitively intact with a BIMS score of 13 out of 15, required extensive staff assistance with most activities of daily living.

The Care Plan with a start date of 11/11/20 and dated as last reviewed 11/27/20, identified the resident with the problem of Activities of Daily Living (ADL) self-care performance deficit related to disease process impaired balance and limited Range of Motion (ROM) related to history of bilateral fractured arms and directed staff to provide limited assistance to move between surfaces and as necessary. It did not address the need to use a gait belt or any assistive devices.

The Care Plan with a target date of 11/15/20 identified the resident with the problem of being at risk for falls related to gait/balance problems and directed staff to:
a. Anticipate and meet the resident's needs.
b. Be sure the call light is within reach and remind her to use it for assistance and wait for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 36	F 684		

staff to come for her own safety.
c. Educate her about safety reminders and what to do if a fall occurs.
d. Encourage her to participate in activities that promote exercise physical activity for strengthening and improved mobility.
e. Physical Therapy (PT) to evaluate and treat as ordered or as needed.

The Care Plan dated as last revised 12/7/20 identified the resident with the problem of an alteration in musculoskeletal status related to a new fracture of the femur and directed staff to:
a. Encourage/supervise/assist with the use of supportive devices.
b. Anticipate and meet needs, be sure call light is within reach and respond promptly to all requests for assistance.
c. Give analgesics as ordered, monitor and document for side effects and effectiveness.
d. Monitor/document/report as needed signs/symptoms of complications related to arthritis.

A review of the nurse's notes revealed the following:
a. On 11/21/2020 at 5:00 p.m., X-Ray tech states did 2 views of front unable to turn res in to much pain view does show fracture front of formal neck. After physician notified, received new orders to send to Emergency Room (ER) for evaluation and treatment.
b. On 11/21/20 at 5:20 p.m., Medic here to transport resident to the ER, appropriate paperwork given to the medics.
c. On 11/26/20 9:09 p.m. per report at change of shift, resident hydrocodone order requires prescription in order to be filled by pharmacy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 37	F 684		

The notes did not have documentation of an assessment of the resident after returning from the hospital after having surgery to repair the femur fracture on 11/26/20.

A review of the Hospital Discharge Summary dated 11/26/20 had documentation of the following:
Admission diagnosis: left hip pain secondary to left intertroachanteric femur fracture status post fall. Acute on chronic hypercapnic respiratory failure secondary to COPD exacerbation, COVID-19 pneumonia. On 11/24/20, patient complained of left-sided chest pain and noted to have AFIb with RVR (atrial fibrillation with rapid ventricular response) and started with Amiodarone drip. Later she had been transitioned to Amiodarone 400 mg orally twice daily. She will be discharged home with Amiodarone 400 mg twice daily for 5 more days followed by 200 mg daily.

In an interview on 12/14/20 at 10:20 a.m., Staff S, Licensed Practical Nurse (LPN) reported after a resident fall, the nurse should assess the resident, get a set of vitals, find out if call light was in reach, did she have head injuries, then use the hoyer lift and transfer the resident back to the bed. Then she should call the hospital, physician, family, Administrator and Director of Nursing (DON). The nurse should chart what happened, vitals, doctor notified, family notification. Resident's condition, physical assessment, should be taken every 15 minutes for the 1st hour, every 30 minutes for the next hour then hourly for the next 4 hours then every 8 hours. This should be documented on fall assessments in Electronic Medical Record (EMR).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 38	F 684		

During an interview on 12/14/20 at 2:24 p.m., Staff D, LPN reported after a resident fall, the nurse should assess the resident head to toe, look for any injuries, obtain a set of vital signs, ask the resident if having any pain, notify the physician, family and DON then complete an incident report.

In an interview on 12/15/20 at 1:17 p.m., Staff F, LPN reported after a resident fall, the nurse should
assess the resident, and if there is a fracture, should call 911 and call the doctor later and explain what happened. Fill out the SBAR form under falls which provides directions on what needs to be documented. She reported she would document a progress note as to what happened and what had been found. If the resident is sent to the hospital, the nurse would need to document the transfer summary what happened, why they went, if there were orders given, etc, calling family, calling the doctor.

During an interview on 12/22/20 at 4:20 p.m., Staff V, Registered Nurse (RN) reported when a resident is admitted/re-admitted to the facility, the nurse should chart vital signs, appearance of incision, pain, edema, breathing, head to toe assessment. This should be charted in the progress notes. An admission assessment and skin assessment should be found under the assessments tab. All should be charted before the shift ends.

In an interview on 12/22/21 at 4:41 p.m., Staff M, LPN reported when a resident is admitted/re-admitted to the facility, the nurse should complete a head to toe assessment. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 39	F 684		

also reported she had never been trained on what the facility expected. She would complete a skin assessment, check the incision, how she arrived at the facility, assess for fall risk, after ortho surgery, check for redness, swelling heat, infection. This should be documented in the nurse's notes before the shift ends.

In an interview on 12/28/20 at 9:12 a.m., the DON reported she would expect the nurse to document in the incident report, which guides them what to document and document on the progress notes, document the head to toe assessment, anything new, describe what happened, should be assessed at least every 15 minutes four times, every 30 minutes twice and hourly four times and once a shift for the next 72 hours.

3. Resident #7's MDS Admission Assessment completed 11/26/20 documented the following diagnoses: fracture and other multiple trauma, heart failure and arthritis. It also identified the resident required extensive staff assistance with all activities of daily living and had not been assessed for cognitive status.

A review of the EMR revealed the following:
a. The resident had been admitted to the facility on 11/25/20.
b. No documentation of a Care Plan.
c. No documentation of an assessment of the resident until 11/27/20 when she expired.

4. Resident #8's MDS Quarterly Assessment completed 10/21/20 had documentation of the following diagnoses: debility cardiorespiratory conditions, acute ischemic heart disease and diabetes mellitus. It also identified the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 40	F 684		

required extensive staff assistance with most activities of daily living. He had not been assessed for cognitive status, however, the facility identified the resident as interviewable.

The Care Plan with the target date of 1/19/21 identified the resident with the problem of limited physical mobility related to amputations and directed staff to monitor/report as needed any signs/symptoms of immobility; contractures forming or worsening thrombus formation, skin-breakdown, fall related injury

A review of the nurse's notes revealed the following entries:
a. On 11/22/20 11:28 p.m., lung sounds clear; no coughing, sneezing. Sore throat or shortness of breath noted. Will continue to monitor.
b. On 11/25/20 at 00:56 a.m., Resident has complained of right hand pain, swelling is noted. He states he had a fall on 11/22/20 during the evening. An as needed (PRN) dose of hydrocodone was given. Dr. was called and ordered a 2 view X-ray of his hand to be performed in the morning.

The notes showed no documentation to show the resident fell or an assessment post fall on 11/22/20

During an interview on 12/28/20 at 9:12 a.m., the DON reported she would expect the nurses to report results of any radiology reports to the physician that show whether or not there had been a fracture identified.

The Care Plan with the target date of 1/19/21 identified the resident with a diabetic ulcer to both legs related to diabetes and directed staff to put

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 41	F 684		

on shoes only when he is up and to have wound care to see.

It also identified the resident with the problem of potential for and actual impairment to skin integrity related to cellulitis, edema, fragile skin and directed staff to monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs/symptoms of infection, maceration, etc to physician.

A review of the weekly skin observation tool completed 10/16/20 identified the resident with two stage III pressure ulcers to:
a. Bottom of left foot identified as pressure ulcer with the length of 1 cm (centimeter), width of 0.7 cm and depth of 0.2 cm
b. Bottom of right foot identified as pressure ulcer with the length of 0.5 cm, width of 0.7 cm and depth of 0.3 cm

The notes showed no documentation of weekly assessments or measurements completed after 10/16/20.

During an interview on 12/28/20 at 9:12 a.m., the DON reported the resident's wounds had been identified as diabetic ulcers and not pressure ulcers. The nurses should document anything pertinent to the wound, measurements and that the form will direct staff on what needs to be documented. There is also a spot they can add any additional progress notes.

5. Resident #12's MDS 5 Day Assessment completed 11/27/20 documented the following diagnoses: progressive neuro conditions, COVID-19, heart failure and pneumonia. It also

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 42	F 684		

identified the resident as cognitively impaired with a BIMS score of 6 out of 15 and required limited staff assistance with most activities of daily living.

The Care Plan with the last revision date of 12/22/20 identified the resident with the problem of an alteration in musculoskeletal status related to fracture of the pelvis and hand and directed staff to monitor/document/report as needed the signs/symptoms or complications related to arthritis.

A review of the nurse's notes revealed the following:
a. On 12/11/20 at 10:14 a.m., post fall on 12/10/20 and increased complaint of pain to the left hip/femur area, unable to bear weight or walk this morning. Noted anatomical difference from the left to the right.
b. On 12/11/20 at 10:43 a.m., resident sent out to the emergency room for further evaluation and treatment post fall on 12/10/20. The notes did not have documentation of an assessment of the fall on 12/10/20.
c. On 12/20/20 at 5:32 p.m. resident fell on 12/19, x-ray ordered for right hand. Results called to the doctor.
The notes did not have documentation of whether or not the resident sustained a fracture to the right hand.

In an interview on 12/14/20 at 10:20 a.m., Staff S, LPN reported when a resident is admitted or re-admitted to the facility, the nurse should document an assessment, where the resident came from, their diagnosis, what their baseline assessment is and this should be completed before the shift ends.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 43	F 684		

During an interview on 12/14/20 at 2:24 p.m., Staff D, LPN reported when a resident is re-admitted, the nurse should document an admission note which should include a set of vitals, an assessment, a list of their medications. The nurse's note should include: the report from the hospital and use that as an admission note, describe the resident, age, how they got here, who accompanied them, a history of why they are being admitted, orientation, mood. The nurse should document all this before she leaves for the day.

In an interview on 12/15/20 1:17 p.m., Staff F, LPN reported , she only received one day of training and had not been informed of the protocol of how a resident's readmission to the facility should be done. When a resident is re-admitted, she would write an admission assessment note which should include where they came from, allergies, code status, what they are being admitted for, a full head to toe assessment and should be completed within the first hour of admission. This should be documented in the progress notes and in the admission assessment form.

During an interview on 12/28/20 9:12 a.m., the DON reported when a resident is re-admitted, she would expect the nurse to:
a. Upon return from a hospitalization: document Skin assessment, set of vitals, assessment of what has changed with medications or treatments, acquired any wounds in the hospital, any changes in diet.
b. Returns from hospital after fall with fx at the facility: document CMST, color, capillary refill, etc.
c. Has a fall at the facility: the initial assessment, assess the resident before moving the resident by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 44	F 684		

the nurse, head to toe assessment, any displacement or rotation, pain at the site, any portable x-rays done.
d. Has an x-ray report called to the physician: document whether or not there was a fracture. This should be documented in the progress notes or in the risk management forms which all the nurses have access to.

A review of the facility policy with last revision date of May 2017 titled: Change in a Resident's Condition or Status had documentation of the following:
a. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact Situation, Background, Assessment, Recommendation (SBAR) Communication Form.
b. Except in medical emergencies, notification will be made within twenty-four hours of a change occurring in the resident's medical/mental condition or status.
c. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.

A review of the facility policy with the last revision date of February 2014 titled: Resident Examination and Assessment had documentation of the following:
The assessment information should be recorded in the resident's electronic medical record:
Notify the physician of any abnormalities such as, but not limited to:
a. Abnormal vital signs.
b. Labored breathing, breath sounds that are not clear; or cough, productive or nonproductive.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 45	F 684		

c. Change in cognitive, behavioral or neurological status from baseline.
d. Distended, hard abdomen or absence of bowel sounds,
e. Wounds or rashes on the resident's skin; and
f. Worsening pain, as reported by the resident.
5. According to the MDS Assessment dated 6/1/20 for Resident #18 shown diagnoses include Hypertension, Thyroid Disorder, Non-Alzheimer's Dementia and Glaucoma. The MDS indicated Resident #18 scored a 13 out of 15 on the BIMS, indicating the resident intact cognitive status. The MDS indicated the resident needed limited assist of 1 staff with dressing and personal hygiene, resident is independent with transfers.

During an observation on 12/15/20 at 8:30 a.m. Resident #18 is in bed and complains of itching and burning eyes. Eyes appear red and irritated. Resident states they have been like this for three weeks and staff have not done nothing about it.

During an observation on 12/16/20 at 10:45 a.m. Resident #18 is lying in bed and both eyes remain red and irritated.

During an observation on 12/17/20 at 1:45 p.m.. Resident #18 continues to have red eyes and residents complaints of dry and itchiness.

Review of Resident #18's Progress Note reveal an entry on 11/29/20 states redness around eyes and complaint of burning. Wet wash cloth applied to help soothe, Spoke with Advanced Registered Nurse Practitioner (ARNP) who is ordering artificial tears and cool compresses.

Review of the residents electronic health record (EHR) failed to reveal any further assessment or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 46	F 684		

documentation of redness or eye irritation until an entry dated 12/20/20. Resident asking for ointment for eyes nurses assessed resident and located some Vaseline for eyes. Resident refused to have eye drops instilled into eyes. Nurse educated resident regarding need for eye drops and resident stated feeling better after nurse left.

The Order Summary Report reveals a physician order dated 11/29/20 for cool compresses to eyes four times a day as needed for 20 minutes for eye irritation. Artificial Tears solution 1%. Instill 2 drops in both eyes as needed for eye irritation.

Review of the Medication and Treatment Administration Records for November and December of 2020 lists the order for cool compresses and Artificial Tears. The staff failed to administer the cool compresses or Artificial Tears since the order was received on 11/29/20.

Review of the Care Plan with a target date of 2/4/21 revealed the Care Plan failed to address any eye problems.

An interview with Staff F, LPN on 12/17/20 at 2:00 p.m., states resident #18 did complain of eye problems yesterday and she did get the eye drops. She keeps wanting an ointment but not sure what she is talking about.

During an interview on 12/21/20 at 3:15 p.m. with the DON, she states she would expect staff to notify the nurse right away of resident complaining of red itchy eyes and for the nurse to contact the physician for telehealth to be seen if needed. If the nurse receive orders, it should be followed up and administered as soon as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 47 possible.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, resident, family and staff interviews and record review, the facility failed to prevent facility acquired pressure ulcers forming and failed to document assessments/measurements weekly on two of two residents reviewed with pressure ulcers. (Residents #10 and #14) The facility reported a census of 56 residents. Findings Include: 1. Resident #10's Minimum Data Set (MDS) Admission Assessment completed 11/21/20 documented the following diagnoses: debility: cardiorespiratory conditions, COVID-19 and atrial fibrillation (an abnormal heart rhythm). It also identified the resident to be cognitively intact with a Brief Interview for Mental Status (BIMS) score	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 48	F 686		

of 13 out of 15 and required limited staff assistance with most activities of daily living and identified the resident at risk for developing pressure ulcers.

The Care Plan with the target date of 12/23/20 identified the resident with potential impairment to skin integrity and actual pressure area related to decreased mobility and directed staff to provide weekly treatment documentation to include the measurement of each area of skin breakdown to include there width, length, depth, type of tissue and exudate and any other notable changes or observations.

A review of the daily skin assessment completed 11/18/20 at 2:47 p.m. revealed the resident's skin intact with no pressure ulcers, only with bruising to the skin.

A review of the Nurse's Notes revealed the following entry on 12/12/20 at 3:35 p.m. patient complained of burning to the sacral/coccyx area, the nurse assessed the area and found an open pressure sore measuring 4 by 3 by ¾ stage 1 (dimensions had not been labeled as to which were length, width or depth) New order from the Nurse Practitioner to apply Mepilex to the area and for wound care to see.

A review of the Weekly Pressure Wound Observation Tool completed 12/12/20 at 3:49 p.m. revealed the following:
a. Documented as Stage 1 which tool identified as Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 49	F 686		

b. Measurements of Length: 4 cm Width: 3 and ¾ cm Depth: 0.1 cm.
c. Description - Epithelial tissue present, granulation tissue present, no drainage, skin surrounding wound pink and intact, well defined skin edges

No further documentation of assessments or measurements of the wound found.

During an observation of wound care/dressing change revealed the following beginning 12/15/20 at 9:29 a.m. with
Staff K, Personal Care Aide (PCA) and Staff F, Licensed Practical Nurse (LPN) providing incontinence care. Staff F removed the dressing and cleansed rectal crease using correct technique, one wipe per swipe. An open area noted to the coccyx missing a top layer of skin, wound bed appears pink, no drainage, covered with white cream which Staff F reported had been barrier cream and the only treatment had been a Mepilex dressing. Staff F then applied Phytophex barrier cream using the same gloves that she cleansed the resident's rectal crease and wound with, applied from outward edges of wound inward to middle of wound and did not change gloves before applying Mepliex dressing to wound. Staff F did not change gloves before she began cleansing the resident's peri area, before removing a tube of Triad ointment from drawer and applied to peri area or before repositioning the resident in bed using the soaker pad.

In an interview on 12/15/20 12:49 p.m., Staff K, PCA reported the resident did not have a pressure relieving mattress on her bed or cushion in her recliner or wheelchair. She had been off a few days and when she returned, the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 50	F 686		

had an open area which she did not know what caused it. The only intervention she had been aware of had been to remind the resident to turn from side to side.

During an interview on 12/15/20 at 1:17 p.m., Staff F, LPN reported when she had first been informed by the aide of the pressure sore, she measured it, cleaned it up. Prior to the wound opening, the intervention she had was barrier cream and the area had been caused by pressure as the resident is non-compliant with repositioning. Staff F reported she assessed the wound every shift she worked and that the nurse is responsible for documenting measurements and assessments on the Weekly Wound Care Assessment Form and she also documented in the Progress Notes. When asked how she would perform wound care on Resident #10, she reported she would clean the wound with the wipes, reapply the barrier then apply the Mepilex dressing, should change gloves when finished and admitted she should have removed her gloves, washed her hands and put new gloves on before she applied the barrier and dressing.

In an interview on 12/28/20 9:12 a.m., the Director of Nursing (DON) reported the Assistant DON (ADON) is responsible for documenting on wounds. She expected nurses to address each time the wound is observed and document on the Weekly Skin Assessment Forms. They should be documenting anything pertinent to the wound, measurements - the form pretty much drives what needs to be documented. There is also a spot they can add any additional Progress Notes. While completing wound care, she would expect the nurse to change gloves any time from dirty to clean areas or from one part of the body to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 51	F 686		

next, or after cleaning the wound and before putting on any new treatments or dressings.

A review of the undated facility policy titled: Prevention of Pressure ulcers/injuries had documentation of the following:
Risk assessment
a. Assess the resident on admission (within 8 hours) for existing pressure ulcer/injury risk factors.
Repeat the risk assessment weekly and upon any changes in condition.
b. Conduct a comprehensive skin assessment upon admission including:
Skin integrity - any evidence of existing or developing pressure ulcers or injuries.
Tissue tolerance - the ability of the skin (and supporting structures to endure the effects of pressure and
Areas of impaired circulation due to pressure from positioning or medical devices.
c. Use a screening tool to determine if a resident is at risk for under-nutrition or malnutrition.
d. Inspect the skin on a daily basis when performing or assisting with personal cares or Activites of Daily Living (ADL's).
Identify any signs of developing pressure injuries (ie: non-blanchable erythema) For darkly pigmented skin, inspect for changes in skin tone, temperature and consistency.
Inspect pressure points (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter, etc.).
Wash the skin after an episodes of incontinence, using pH balanced skin cleanser.
Moisturize dry skin daily.
Reposition resident as indicated on the Care Plan.

Mobility/Repositioning:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 52	F 686		

a. Choose a frequency for repositioning based on the resident's mobility, the support surface in use, skin condition and tolerance and the resident's stated preferences.
b. At least every hour, reposition residents who are chair-bound or bed-bound with the head of the bed elevated 30 degrees or more.
c. At least every 2 hours, reposition residents who are reclining and dependent on staff for repositioning.
d. Reposition more frequently as needed, based on the condition of the skin and the resident's comfort.
e. Teach residents who can change positions independently the importance of repositioning. Provide support devices and assistance as needed. Remind and encourage residents to change positions.
Support surfaces and pressure redistribution:
Select appropriate support surfaces based on the resident's mobility, continence, skin moisture and perfusion, body size, weight and overall risk factors
Monitoring:
a. Evaluate, report and document potential changes in the skin.
b. Review the interventions and strategies for effectiveness on an ongoing basis.

A review of the facility policy with the last revision date of July 2017 titled: Pressure Ulcers/Injuries Overview had documentation of the following:
Avoidable:
Avoidable means that the resident developed a pressure ulcer/injury and that the one or more of the following was not completed:
a. Evaluation of the resident's clinical condition and risk factors.
b. Definition or implementation of interventions

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 53	F 686		

that are consistent with resident needs, resident goals, and professional standards of practice.
c. Monitoring or evaluation of the impact of the interventions: or
d. Revision of the interventions as appropriate.

Stage 2 Pressure Ulcer: partial-thickness skin loss with exposed dermis:
a. The Stage 2 pressure ulcer appears as partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer.
b. The wound bed is viable, pink or red, moist and may also present as an intact or open/ruptured blister
c. Adipose (fat) tissue is not visible and deeper tissues are not visible
d. Granulation tissue, slough and eschar are not present
e. This stage should not be used to describe moisture associated skin damage including incontinence associated dermatitis, intertriginous dermatitis (inflammation of skin folds), medical adhesive related skin injury, or traumatic wounds (skin tears, burns, abrasions).

Stage 3 Pressure Ulcer: Full-thickness skin loss
a. The Stage 3 pressure ulcer appears as full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present.
b. Slough and/or eschar may be visible but does not obscure the depth of tissue loss
c. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds.
d. Undermining and tunneling may occur.
e. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 54 f. If slough or eschar obscures the wound bed, it is an unstageable pressure ulcer/pressure injury A review of the facility policy with the last revision date of September 2013 and titled: Dressings, Dry/Clean had documentation of the following procedure: a. Clean bedside stand. Establish a clean field. b. Wash and dry your hands thoroughly. c. Put on clean gloves. Loosen tape and remove soiled dressing. d. Pull glove over dressing and discard into plastic or biohazard bag. e. Wash and dry your hands thoroughly. f. Open dry, clean dressings(s) by pulling corners of the exterior wrapping outward, touching only the exterior surface. g. Label tape or dressing with date, time and initials. Place on clean field. h. Using clean technique, open other products. i. Wash and dry your hands thoroughly. Put on clean gloves. j. Assess the wound and surrounding skin for edema, redness, drainage, tissue healing progress and wound stage. k. Cleanse the wound with ordered cleanser. If using gauze, use clean gauze for each cleansing stroke from the least contaminated area to the most contaminated area (usually from the center outward). l. Use dry gauze to pat the wound dry. m. Apply the ordered dressing and secure with tape or bordered dressing per order. Label with date and initials to top of dressing. n. Discard disposable items into the designated container. o. Remove disposable gloves and discard into designated container. Wash and dry your hands thoroughly.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 55	F 686		

p. Reposition the bed covers. Make the resident comfortable.
q. Place the call light within easy reach of the resident.
r. Clean the bedside stand.
s. Wash and dry your hands thoroughly.
2. The MDS Assessment dated 11/19/20 for Resident #14 shown diagnoses include Anemia, Gastroesophageal Reflux Disorder, Diabetes, Hyperlipidemia, Thyroid Disorder and Parkinson's. The MDS indicated Resident #14 scored a 5 out of 15 on the BIMS, indicating the resident with severe cognitive impairment. The MDS indicated the resident needed extensive assist to total dependence of 1-2 staff with transfers, bed mobility, dressing and personal hygiene. The MDS indicated the resident is high risk for skin damage and has moisture associated skin damage.

During an observation on 12/15/20 Staff B, Certified Nursing Assistant (CNA) and Staff C, CNA were providing incontinent cares to Resident #14 during which 2 open areas approximately dime sized with red wound base were noticed to right gluteal fold. Staff A, CNA stated she had notified the nurse of this over the weekend. They told Staff E, Personal Care Assistant (PCA) to go get the nurse. Staff D, Licensed Practical Nurse (LPN) came into the room and then left again, she returned with a hydrocolloid dressing and applied this to the wound, She did not measure the area or cleanse. Staff D, LPN stated they have standing orders for the dressing. Staff B, CNA and Staff C, CNA transferred resident into her wheelchair and the wheelchair had no cushion in the seat.

During an observation on 12/16/20 at 10:30 a.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 56	F 686		

the resident is sitting in wheelchair at table in the main dining room hoyer sling underneath resident and no cushion in wheelchair.

During an observation on 12/16/20 at 12:30 p.m. the resident remains in wheelchair in the main dining room with no cushion in the wheelchair and sitting on the hoyer sling.

Review of the residents Braden scale dated 11/10/20 revealed a score of 14 which indicates the resident is at moderate risk for skin breakdown.

Review of the standing orders for the facility dated 11/30/20 failed to reveal an order for Hydrocolloid dressing. The standing orders for a new onset wound directed staff to 1.) Measure wound, chart 2.) Clean, dress, and off load per facility protocol 3.) Start weekly wound observation tool 4.) Implement pressure relief measures 5.) Reposition per facility protocol (every 2 hours in bed or every 1 hour in chair) 6.) Notify nursing supervisor and provider.

Review of the Treatment Administration Record (TAR) and Resident #14 Physician Orders failed to reveal a treatment for the wound to the right gluteal area.

Review of Resident #14's Care Plan dated 12/3/20 directed staff to provide pressure relieving/reducing pad to protect the skin while up in chair. Provide weekly documentation to include areas of skin breakdown, redness and any other notable changes or observations.

The Administrator provided a sheet titled Admission Skin Review dated 12/11/20 which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 57	F 686		

stated resident #14 had a blister at site 39 which is the right popliteal area which measured 1 centimeter by 0.2 centimeter.

The Progress Notes for Resident #14 dated 12/13/20 states resident noted with multiple pressure areas on the inside of the right thigh. No complaint of pain noted to the area, and cleaned with normal saline and calazime cream applied to the area. Resident was placed in wheelchair after crawling out of bed onto the floor on her fall matt and unable to measure at this time. All areas open and the DON, ADON and Administrator aware of wounds.

The Weekly Wound Documentation Tool in the Electronic Health Record (EHR) dated 12/13/20 was initiated but incomplete.

Review of the resident's medical record failed to reveal any further documentation on the wound until the surveyor asked the Administrator for further information. Interview with Interim Administrator on 12/21/20 at 12:30 p.m. states typically they would complete a Risk Management Tool for Skin and do weekly measurements. The nurse should notify the Medical Doctor and the Power of Attorney (POA) when the pressure ulcer is discovered.

During an interview with the DON on 12/21/20 at 3:15 p.m., stated she would expect the CNA to notify the nurse if an open area is noted. The nurse should clean, dress, position off the area and notify the Medical Doctor on the same day to obtain orders for treatment.

During an interview on 12/21/20 at 4:00 p.m., Staff F, LPN stated the wound sheet was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 58 filled out originally after initiated on 12/13/20 because it was change of shift and she asked the next shift to complete and it was never done. She was unable to obtain measurements today either because Resident #14 has been up in her wheelchair all day. Staff F, LPN did speak to the Nurse Practitioner today and she did not recall being notified of the pressure ulcer either.	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, family and staff interviews and record review, the facility failed to prevent falls resulting in fractures for two residents (Residents #4 and #12) and failed to prevent a fall out of the wheelchair for one (Resident #14) of six residents reviewed in the standard sample. The facility reported a census of 56 residents. Findings Include: 1. Resident #4's Minimum Data Set (MDS) Significant Change assessment completed 11/28/20 documented the following diagnoses: debility, cardiorespiratory conditions, displaced intertrochanteric fracture left femur, atrial fibrillation (an abnormal heart rhythm). It also identified the resident as cognitively intact with a	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 59	F 689		

Brief Interview for Mental Status (BIMS) score of 13 out of 15, required extensive staff assistance with most activities of daily living.

The Care Plan dated with the target date of 11/15/20 identified the resident with the problem of an Activities of Daily Living (ADL) self-care performance deficit related to Disease Process , Impaired balance, limited range of motion related to history of bilateral fractured humerus. Interventions included to transfer: resident requires limited assistance by staff to move between surfaces and as necessary.

A review of the Risk Management Report identified the resident fell on 11/21/20 at 12:00 p.m. and had documentation of the following: This nurse was informed by staff resident had fallen, entered the room, observed resident sitting on buttock bilateral lower extremities extended straight out, resident had gown on and non-skid slipper socks. Certified Nurse Aide (CNA) stated she assisted the resident to get changed,the resident stood up, the CNA pulled up the resident's incontinent brief when resident lost her balance and the resident fell back. No injuries observed at time of incident.
The report did not include documentation to show the Personal Care Aide (PCA a non-certified Nurse Aide) did not place a gait belt on the resident which she had reported to this nurse and to the surveyor.

A review of the Nurse Practitioner (NP) Notes revealed on 11/21/20 at 3:30 p.m., the NP asked to see the resident to evaluate after falling and possible injury to the left leg. The NP asked to assess patient after a fall on the left side of the body, NP assessed patient via webcam and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 60	F 689		

patient is complaining of new onset of left hip pain. X-ray of the left femur status post fall and complaint of pain to left leg. NP explained to patient if the x-ray shows a fracture she will be sent to the hospital.

A review of the facility nurse's notes revealed the following:
a. On 11/21/2020 at 5:00 p.m., X-Ray tech stated 2 views of front, unable to turn the resident as she had too much pain. View does show a fracture of the front formal neck. Called on call physician and received orders to send to the emergency room to evaluate and treat.
b. On 11/21/20 5:20 p.m. Medic here to transport the resident to the emergency room, appropriate paperwork given to medics.
c. On 11/22/20 10:53 a.m. called hospital to follow up on resident, nurse reported resident had surgery this morning for fractured femur
d. On 11/26/20 9:09 p.m. per report at shift change, resident hydrocodone order requires prescription in order to be filled by pharmacy

A review of the timeline provided by the Director of Nursing (DON) revealed the resident returned from the hospital post-surgical repair of a hip fracture on 11/26/20.

In an interview on 12/14/20 at 10:20 a.m., Staff S, LPN reported she did not work the day the resident fell and had been informed of the resident's fall the day after when she returned to work. Staff E reported to her that she did not put a gait belt on the resident before she fell. The resident was not independent prior to this fall, she had to have the assist of one using a gait belt.

During an interview on 12/14/20 at 2:24 p.m.,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 61	F 689		

Staff D, Licensed Practical Nurse (LPN) reported on the day the resident fell and fractured her femur, Staff E, PCA (non-certified nurse aide) had helped the resident who had already been standing without a walker, when Staff E attempted to change the resident's incontinent brief, the room was so cluttered, the resident lost her balance and fell on her bottom. After the aides informed her, Staff D went to the resident's room and found her sitting on the floor with Staff E beside her. Staff E did report that she did not place a gait belt on the resident before the resident fell. The resident did not have any outward rotation of either leg. She did complain of pain to the left leg. The aides used a gait belt to assist the resident up to the chair. After she notified the Nurse Practitioner and physician of the fractured femoral head, she received orders to send her to the hospital.

In an interview on 12/14/20 at 3:18 p.m., Staff H, Certified Medication Aide (CMA), reported prior to the fall on 11/21/20, the resident had been Care Planned to pivot transfer with assist of two using a gait belt. The resident was not independent prior to this fall, she had to have the assist of two to transfer.

During an interview on 12/15/20 at 11:37 a.m., Staff E, PCA, reported she had been informed that the resident had been independent. She was kneeling on the floor helping the resident pull up her incontinent briefs, the resident decided to stand up then fell sideways. She did not place a gait belt on her. The resident fell on her left side, no bleeding and she complained of left hip pain. Staff E pulled the emergency call light then Staff D, LPN entered the room and helped Staff E transfer the resident back to the wheelchair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 62	F 689		

In an interview on 12/15/20 at 11:53 a.m., Staff I, PCA, reported Resident #4 should have a gait belt around her and use a walker when the aides transfer her. She did not always cooperate and would try to get up on her own.

During an interview on 12/15/20 at 12:29 p.m., Staff J, PCA reported the resident should not get up by herself and that staff should use the gait belt to help her up.

In an interview on 12/28/20 at 9:12 a.m., the DON reported if the aide had not been sure of how the resident had been care planned to transfer, she would expect the aide to place a gait belt around the resident before transfer.

2. Resident #12's MDS 5 Day Assessment completed 11/27/20 documented the following diagnoses: progressive neuro conditions, COVID-19, heart failure and pneumonia. It also identified the resident as cognitively impaired with a BIMS score of 6 out of 15 and required limited staff assistance with most activities of daily living.

The Care Plan with the last revision date of 12/22/20 identified the resident with the problem of an alteration in musculoskeletal status related to fracture of the pelvis and hand and directed staff to monitor/document/report as needed the signs/symptoms or complications related to arthritis.

A review of the nurse's notes revealed the following:
a. On 12/11/20 at 10:14 a.m., post fall on 12/10/20 and increased complaint of pain to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 63	F 689		

left hip/femur area, unable to bear weight or walk this morning. Noted anatomical difference from the left to the right.
b. On 12/11/20 at 10:43 a.m., resident sent out to the emergency room for further evaluation and treatment post fall on 12/10/20. The notes did not have documentation of an assessment of the fall on 12/10/20.
c. On 12/20/20 at 5:32 p.m., resident fell on 12/19/20, x-ray ordered for right hand. Results called to the doctor.
The notes did not have documentation of whether or not the resident sustained a fracture to the right hand.

An observation on 12/15/20 beginning at 9:53 a.m. revealed Staff K, PCA and Staff F, LPN entered the resident's room as the resident had been standing in the middle of the room, both assisted the resident to ambulate to the bathroom, holding her under each arm and did not place the gait belt (which was observed in the resident's closet) around the resident. Staff F reported the resident had a fall last week which resulted in a pelvic fracture. After both assisted the resident to sit on the toilet, Staff K then placed a gait belt around the resident's waist.

In an interview on 12/22/20 at 9:59 a.m., Staff F, LPN reported she had not been working when the resident fell on 12/20/20. She repeatedly informed the CNAs that there always needs to be someone in the hallway to keep an eye on the resident as she constantly got up on her own and did not understand to call for help. The resident had a fracture to her right hand, and prior to that fall had not been independent, she should have had assist of one staff with the gait belt. She also reported there should be documentation in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 64	F 689		

Nurse's Notes if a fracture had been identified.

During an interview on 12/28/20 9:12 a.m., the DON reported she would expect the nurses to document after a resident fell on the Incident Report which guides them what to document. The nurse should document on the Progress Notes and document the head to toe assessment, anything new, describe what happened, should be assessed at least every 15 minutes four times, every 30 minutes twice and hourly four times then once a shift for 72 hours. She also reported she would expect the nurse to report to the physician whether or not the x-rays showed a fracture. She then reported if the staff had any doubts on how to transfer the resident, would expect them to use a gait belt.

A review of the undated facility policy titled: Fall Prevention Program had documentation of the following:
High Risk Protocols
a. The resident will be placed on the facility's Fall Prevention Program.
b. Indicate fall risk on the care plan.
c. Place Fall Prevention Indicator on the name plate to the resident's room.
d. Place Fall Prevention indicator on resident's wheelchair.
e. Implement interventions from low/moderate risk protocols.
f. Provide interventions that address unique risk factors measured by the risk assessment tool: medications, psychological, cognitive status or recent change in functional status.
g. Provide additional interventions as directed by the resident's assessment.
h. When any resident experiences a fall, the facility will:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 65	F 689		

1. Assess the resident.
2. Complete a post-fall assessment.
3. Complete an incident report.
4. Notify physician and family.
5. Review the resident's care plan and update as indicated.
6. Document all assessments and actions.
7. Obtain witness statements in the case of injury.

A review of the policy with the last revision date of March 2018 and titled: Falls and Fall Risk, Managing had documentation of the following:
- Resident-Centered Approaches to Managing Falls and Fall Risk
a. The staff with the input of the attending physician will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls.
b. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions.
c. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant.
d. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable.
e. In conjunction with the attending physician, staff will identify and implement relevant interventions to try to minimize serious consequences of falling.

- Monitoring Subsequent Falls and Fall Risk
a. The staff will monitor and document each

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 66	F 689		

resident's response to interventions intended to reduce falling or the risks of falling.
b. If interventions have been successful in preventing falling, staff will continue the interventions or re-consider whether these measures are still needed if a problem that required the intervention.
c. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified.
d. The staff and/or physician will document the basis for conclusions that specific irreversible risk factors exist that continue to present a risk for falling or injury due to falls.
3. The MDS Assessment dated 11/19/20 for Resident #14 shown diagnoses include Anemia, Gastroesophageal Reflux Disorder, Diabetes, Hyperlipidemia, Thyroid Disorder and Parkinson's. The MDS indicated Resident #14 scored a 5 out of 15 on the BIMS, indicating the resident severe cognitive impairment. The MDS indicated the resident needed extensive assist to total dependence of 1-2 staff with transfers, bed mobility, dressing and personal hygiene. The MDS indicated the resident is high risk for skin damage and has moisture associated skin damage.

During observations of the resident #14 on 12/14/20 the following noted:
a. At 12/14/20 at 11:30 p.m., sitting in wheelchair at a table in the main dining area with head down on table and eyes closed. Resident remained at the table at 12:00 p.m.
b. At 2:30 p.m., sitting at a table in activity in the main dining area slumped forward in her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 67	F 689		

wheelchair with head down on the table.
c. At 3:30 p.m., laying face forward on the ground in front of wheelchair in the main dining area. Staff D, LPN assessed the resident and directed CNA's to get resident back into wheelchair and then to bed.

Review of the Resident's Morse Fall Scale Form noted the following entries:
a. On 12/1/20 revealed Resident #14 was found lying in front of her wheelchair. Resident states she was reaching for item on cabinet that is sitting in hallway when slid out of the chair.
b. On 12/4/20 reveals the Resident #14 fell out of wheelchair onto the floor in the main dining room the nurse observed her on her stomach.
c. On 12/8/20 revealed the resident was found on the floor next to her bed.
d. On 12/14/20 revealed Resident #14 was observed laying in prone position with bilateral feet under her wheelchair. Resident had on pants, shirts, gripper socks incontinent of urine. Resident unable to give description.

The Care Plan for Resident #14 with a revision date of 12/3/20 indicated she is at moderate risk for falls related to gait and balance problems. The Care Plan fails to reveal any interventions regarding falls out of wheelchair or positioning interventions.

During an interview with Staff A, Certified Occupational Therapy Assistant (COTA) states they have not seen the resident for wheelchair positioning related to falls. They did provide treatment for Resident #14 for wheelchair mobility and upper extremity strength but she was discharged on 11/20/20.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 68 During an interview on 12/21/20 at 3:15 p.m. the DON stated after a resident falls, the nurse should do a head to toe assessment for injury and figure out what caused the fall. The staff should have follow up and assess the need for new interventions to prevent falls.	F 689		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record reviews, the facility failed to follow physician orders for three out of twelve residents reviewed (Residents #4, #7, and #8). The facility reported a census of 56 residents. Findings Include: 1. Resident #4's Minimum Data Set (MDS) Significant Change Assessment completed 11/28/20 documented the following diagnoses: debility, cardiorespiratory conditions, displaced intertrochanteric fracture left femur, atrial fibrillation (an abnormal heart rhythm). It also identified the resident as cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13 out of 15, required extensive staff assistance with most activities of daily living. APIXABAN/ELIQUIS (a medication used as a blood thinner): The Care Plan dated as last revised 12/21/20 for admission date of 12/12/20 identified the resident with the problem of the resident on anticoagulant	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 69	F 760		

therapy and directed staff to administer anticoagulant medications as ordered by the physician. Monitor for side effects and effectiveness each shift.

A review of the facility Nurse's Notes revealed the following:
a. On 11/21/2020 at 5:00 p.m., X-Ray tech stated 2 views of front, unable to turn the resident as she had too much pain. View does show a fracture of the front formal neck. Called on call physician and received orders to send to the emergency room to evaluate and treat.
b. On 11/21/20 5:20 p.m., Medic here to transport the resident to the emergency room, appropriate paperwork given to medics.
c. On 11/22/20 10:53 a.m., called hospital to follow up on resident, nurse reported resident had surgery this morning for fractured femur.

Review of the Discharge Summary from the hospital for Resident #4 dated 11/26/20 showed the resident admitted 11/21/20 and discharged on 11/26/20 back to the facility. Admission diagnoses included left hip pain secondary to a left intertrochanteric femur fracture status post fall, respiratory failure secondary to Chronic Obstructive Pulmonary Disorder (COPD) exacerbation and COVID pneumonia. On 11/22/20 the resident underwent Open Reduction Internal Fixation (ORIF - surgical repair) of the left hip. On 11/24/20, rapid response was called after the resident complained of left-sided chest pain. The resident identified with AFib (atrial fibrillation an abnormal heart rhythm) with RVR (rapid ventricular response) and started with an Amiodarone (medication to control heart rhythm) IV drip and later transitioned to oral Amiodarone. When discharged back to the facility the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 70	F 760		

prescribed Amiodarone 400 milligrams (mg) by mouth (po) twice a day to continue 5 more days, followed by 200 mg daily and continue on her regular dose of Apixaban/Eliquis, which on discharge orders noted to be 5 mg by mouth, twice a day.

A review of the November 2020 Medication Administration Record (MAR) revealed the following order:
Eliquis (Apixaban) 5 mg one tablet two times a day related to PE (pulmonary embolus) - no start date had been documented. A hold date from 11/21/20 at 7:12 p.m. to 11/28/20 at 1:31 p.m., no doses signed out as given during this week. No notation of the Eliquis restarting once the resident returned from the hospital on 11/26/20, per Hospital Discharge Orders and was not given the rest of the month of November.

A review of the timeline provided by the Director of Nursing (DON) revealed the resident returned from the hospital post-surgical repair of a hip fracture on 11/26/20 and re-admitted to the hospital on 12/6/20.

A review of the hospital Physician's History and Physical dated 12/6/20 at 10:55 p.m. had documentation the patient recently admitted to the hospital from 11/21/20 through 11/26/20 with a left femoral fracture and underwent Open Reduction Internal Fixation (ORIF - surgical repair) on 11/22/20. During her hospital stay, also had AFib (atrial fibrillation an abnormal heart rhythm) with RVR (rapid ventricular response) which was controlled with Amiodarone. Discharged back to the facility with Amiodarone and was supposed to follow up with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 71	F 760		

cardiologist, but she did not follow through. CT scan of the chest was obtained which was suspicious for scattered pulmonary emboli. Started with IV heparin drip for possible pulmonary embolism. Patient is already on Eliquis at nursing home for paroxysmal A Fib.

A review of the December 2020 MARs revealed the following order:
a. Apixaban tablet 5 mg by mouth two times a day related to PE - no start date documented.
b. No order transcribed to MAR from 12/1/20 through 12/14/20.
c. The first dose of Apixaban not documented as given till 12/14/20 at 8:00 p.m.

A review of the Physician Orders documented on the hospital transfer form dated 12/12/20 had orders for Apixaban (Eliquis/blood thinner) 5 mg (milligrams) by mouth twice daily.

AMIODARONE HCL (an medication affecting the rhythm of the heart)::
A review of the Care Plan revealed it failed to address the resident with cardiac history and the need to administer Amiodarone and potential side effects to monitor for.

A review of the Nurse's Notes had documentation of the following:
On 12/18/20 1:03 p.m., clarification on Amiodarone order completed by the DON.
The resident returned from the hospital with conflicting Amiodarone orders, needs to be clarified with the cardiologist prior to being filled.

A review of the Physician Orders on the transfer document dated 12/12/20 had documentation of the following orders:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 72	F 760		

Amiodarone 200 mg (milligrams) tablet - one tab daily for 30 days. Amiodarone 400 mg orally twice daily for 5 days followed by 200 mg orally daily afterward.

A review of the December 2020 MAR revealed the following orders:
a. Amiodarone HCL tablet 200 mg give one tablet by mouth two times a day for 30 days - signed out as given at 8:00 a.m. on December 13, 14, 15, 16, 17, 18 and at 8:00 p.m. on December 12, 13, 14, 15, 16, 17
b. Amiodarone tablet 200 mg give 2 tablets twice a day for 5 days - discontinue date 12/18/20 - no doses signed out as given

The resident received the wrong dose from 12/12/20 through 12/18/20 and should have received 200 mg two tablets for 5 days then 200 mg one tablet daily afterward.

During an interview on 12/14/20 at 2:24 p.m., Staff D, Licensed Practical Nurse (LPN), reported it is the nurse's job to enter the Admission Note, the Assistant DON or DON will then enter the orders into the computer, then the floor nurse can fax the orders to the pharmacy. The medications need to be entered into the computer in order for the pharmacy to process the medications.

In an interview on 12/15/20 at 1:17 p.m., Staff F, LPN, reported the admitting nurse is responsible for entering the orders into the electronic medical record and sends to the pharmacy. The facility did not have a double check system. She reported she would always go back and review everything twice.

During an interview on 12/22/21 at 4:41 p.m.,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 73	F 760		

Staff M, LPN, reported she thought she entered the orders into the computer, however, there had been 3 residents admitted that same day. The nurse who admitted the resident is responsible for entering the orders into the computer. She also reported she had never been trained at the facility. She could not recall the orders for Apixaban and Amiodarone as she took care of 49 residents.

In an interview on 12/22/20 at 4:20 p.m., Staff V, Registered Nurse (RN), reported the nurse who admitted the resident should enter the orders into the computer and fax them to the pharmacy. She took care of the resident the day after she returned from the hospital on 11/27/20. The nurses should double check the orders, however, this does not always happen. Once the orders have been entered and checked, they are placed into a basket that is kept in a cupboard behind the Nurse's Station. There is no system to show that the orders have been double checked when looking at the MARs on the computer. It can take weeks after the actual order is written and scanned into the computer. She could not recall the orders for Resident #4 for Apixaban and Amiodarone.

During an interview on 12/28/20 at 9:12 a.m., the DON reported the nurse on duty would be responsible for entering the orders into the computer and did not think the nurses were double checking the orders. She verified the resident should have received Eliquis 2.5 mg two tablets twice daily. The admitting nurse forgot to add it to the list of the medications. Regarding the order for the Amiodarone, the DON found the order was a significant change from what she had prior to being hospitalized. The resident should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 74	F 760		

have received 200 mg one tab BID (twice daily). This was another order that was missed. The order when she came back from the hospital was 200 mg one tablet once daily for 30 days, then it also says 400 mg (200 mg x 2 tabs) by mouth twice daily for 5 days followed by 200 one tab mg by mouth once daily. On 12/17/20, she had the floor nurse call the medical director, who later directed us to hold the Amiodarone until the order had been clarified with the cardiologist. When the resident came returned from the hospital, the cardiologist wanted her to have 200 mg one tablet once a day. The orders should have been clarified as soon as she returned from the hospital. She verified Amiodarone 200 mg one tab one dose had been given on 12/13/20 She did not receive any doses after that. The orders were not discontinued from the computer that should have been discontinued.

2. Resident #7's MDS Admission Assessment completed 11/26/20 documented the following diagnoses: fracture and other multiple trauma, heart failure and arthritis. It also identified the resident required extensive staff assistance with all activities of daily living and had not been assessed for cognitive status.

The resident noted admitted to the facility 11/25/20 and did not have a Care Plan documented prior to her death on 11/27/20.

A review of the Physician Orders on the Order Summary Report dated 11/01/20 to 11/30/20 revealed the following orders dated 11/26/20:
a. Budenoside-formoterol fumerate aerosol 160-4.5 mcg/act 2 puff inhale orally two times a day.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 75	F 760		

b. Ferrous sulfate 325 mg (milligrams) one tablet every morning.
c. Furosemide 40 mg one tablet one time a day.
d. Gabapentin 300 mg one capsule two times a day for 14 days.
e. Lidocaine patch 5% apply to back topically at bedtime for 30 days, apply 3 patches.
f. Montelukast Sodium tab 10 mg one tab at bedtime for asthma for 30 days.
g. Pantoprazole sodium 40 mg one tablet two times daily.
h. Paroxetine Hcl 30 mg 2 tabs daily for depression for 30 days.
i. Potassium chloride ER (extended release) tablet 20 meQ (milliequivelents) give two tablets two times a day.

Review of the November 2020 MAR revealed no medications had been signed out as administered for Resident #7.

During an interview on 12/28/20 at 9:12 a.m., the DON reported the resident had been admitted during the evening shift, the pharmacy did not send the medications prior to her expiring at the facility, and unsure why. The expectation would be for the nurse to notify the DON, look for medications in the Ebox or call the pharmacy again if the medications are not in the facility within 2 hours. She also verified after reviewing the November 2020 medication administration records that none of the medications ordered had been signed out as administered.

In an interview on 12/28/20 at 12:24 p.m., the Consultant Pharmacist reported there are orders that had been entered on 11/27/20 and the pharmacy had been closed for the holiday. The facility should have called the pharmacy on call

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 76	F 760		

number and it does not appear that they called the on call service which is available 24 hours. There is no record that they called before the 11/27/20. The orders were waiting to be filled when the pharmacy staff returned to work on Friday 11/27/20. They never received notification that this resident had been admitted. It showed an admission date of 11/26/20, which is when electronic orders came over. The Consultant Pharmacist stated were closed that day and we filled the orders on 12/27/20. If orders are called after hours, our Regional Pharmacy is in Des Plaines, Illinois. There also is a 24 hour Pharmacy near the facility that could have sent a 3 day supply. He also reported there had been a time they had a difficult time contacting the facility as the phones had not been working.

3. Resident #8's MDS Quarterly Assessment completed 10/21/20 documented the following diagnoses: debility cardiorespiratory conditions, acute ischemic heart disease and diabetes mellitus. It also identified the resident required extensive staff assistance with most activities of daily living. He had not been assessed for cognitive status, however, the facility identified the resident as interviewable.

The Care Plan with the target date of 1/19/21 identified the resident with a diabetic ulcer to both legs related to diabetes and directed staff to put on shoes only when he is up and to have wound care to see.

The Care Plan also identified the resident with the problem of potential for and actual impairment to skin integrity related to cellulitis, edema, fragile skin and directed staff to monitor/document

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 77	F 760		

location, size and treatment of skin injury. Report abnormalities, failure to heal, signs/symptoms of infection, maceration, etc to physician.

A review of the physician orders revealed the following:
a. On 10/2/20 Right lateral foot: cleanse with normal saline, apply hydrofera blue slightly moistened cover with Vaseline gauze, 4 x 4, roll gauze, tape. Change dressing 3 times per week- every other day and as needed.
b. Surgical shoe to right leg.
c. On 10/2/20 Left lateral foot: Left Lateral foot cleanse with normal saline apply hydrofera blue slightly moistened cover with Vaseline gauze, 4 x 4, roll gauze, tape. Change dressing 3 times per week- every other day and as needed surgical shoe to left leg.

Review of the November 2020 treatment administration record (TAR) revealed the following:
a. An order for Left lateral foot: Left Lateral foot cleanse with normal saline apply hydrofera blue slightly moistened cover with Vaseline gauze, 4 x 4, roll gauze, tape. Change dressing 3 times per week- every other day and as needed.
b. Surgical shoe to the left leg one time a day every other day for wound care.
c. The treatments not signed out as completed on November 2, 4, 10, 18, 20, and 22.
d. Order for Right lateral foot: cleanse with normal saline apply hydrofera blue slightly moistened cover with Vaseline gauze, 4 x 4, roll gauze, tape. Change dressing 3 times per week every other day and as needed.
e. Surgical shoe to Right Lower Extremity (RLE).
f. One time a day every other day for wound care.
f. Treatments had not been signed out as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 78	F 760		

completed on November 2, 4, 10, 18, 20, and 22.

A review of the December 2020 TAR revealed the following:
a. Order for Left lateral foot: Left Lateral foot cleanse with normal saline apply hydrofera blue slightly moistened cover with Vaseline gauze, 4 x 4, roll gauze, tape. Change dressing 3 times per week- every other day and as needed (PRN).
b. Surgical shoe to left leg one time a day every other day for wound care.
c. Treatments had not been signed out as completed on December 6, 10 and 12.
d. Order for Right lateral foot: cleanse with NS apply hydrofera blue slightly moistened cover with Vaseline gauze, 4 x 4, roll gauze, tape. Change dressing 3 times per week- every other day and as needed.
e. Surgical shoe to right leg. one time a day every other day for wound care.
f. Treatments not signed out as completed on December 6, 10 and 12.

During an interview on 12/10/20 12:06 p.m., the resident reported he went to the Wound Clinic and they say the dressings need to be changed every day. He would need to hunt down the nurse to change the dressings. The nurses are not changing the dressings for at least 3 days. When he had first arrived to the facility, he developed an infection to the wounds, they would begin to heal but later became infected as the nurses were not changing the dressings. He reported 4 days would go by before the dressings would be changed.

In an interview on 12/14/20 at 9:37 a.m., the resident reported the nurses did not change his dressings on 12/13/20. Usually most of them will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 79	F 760		

do it, but they get so busy, they end up not doing it which is how the wounds got infected the second time, they didn't change the bandages, his socks used to get wet. The wounds would heal, then the dressings would not get changed and the wounds would get infected again since he is diabetic.

In an interview on 12/14/20 at 2:24 p.m., Staff D, LPN reported the resident's dressings had been ordered to be changed every other day and should be signed out on the treatment administration record when completed.

A review of the undated facility policy titled: Medication Administration had documentation of the following:
a. Review MAR (medication administration record) to identify medication to be administered.
b. Administer medication as ordered in accordance with manufacturer specifications.
c. Sign the MAR after administered. For those medications requiring vital signs, record the vital signs onto the MAR.

A review of the facility policy with the last revision date of April 2007 and titled: Medication Orders and Receipt Record had documentation of the following:
a. The charge nurse will maintain medication order and receipt records.
b. The medication order/receipt record shall contain:
aa. The prescription number;
bb. The resident's name;
cc. Name, quantity ordered, and strength of the drug;
dd. Order date;
ee. Name and title of person placing the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 80 order; ff. Name of the dispensing pharmacy; gg. The date and quantity received; and hh. Name and title of the person receiving the order. c. The Director of Nursing services will designate individuals to be responsible for completing medication order/receipt forms. d. Medications should be ordered in advance, based on the dispensing pharmacy's required lead time. e. Emergency medications ordered/received shall also be entered onto the medication order and receipt record. f. The receiving nurse shall record medication orders received on the receipt record. The receiving nurse shall verify each delivered medication and check off the order form. Controlled substances shall be verified in the presence of the person delivering the drug order. g. Noted discrepancies shall be reported to the dispensing pharmacy. h. The facility shall retain medication order/receipt records for at least one year or as otherwise required by applicable law and regulations.	F 760		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and responsible party (RP) interviews, the facility	F 835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 835	Continued From page 81	F 835		

failed to be administered in a manner that enabled an effective and efficient use of resources to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, evidenced by disruption of telephone service due to unpaid bills, and disregard of required Medicare billing practices customary for long-term care facilities, cited elsewhere in this document. The facility reported a census of 56 residents.

Findings Include:

Review of Facility telephone invoices revealed:
a. A Billing End Date of 7/31/20, $989.18 due before 8/30/20, with $469.41 paid on 8/30/20.
b. A Billing End Date of 8/31/20, $930.26 due before 9/30/20, with $410.49 paid on 9/30/20.
c. A Billing End Date of 9/30/20, $796.54 due before 10/31/20, with $485.65 paid on 10/19/20, and $310.89 paid on 10/30/20. The bill reflected that there was no phone service at the facility from 10/16/20 until after 5:00 p.m. on 10/21/20.
d. A Billing End Date of 10/31/20, $299.16 due before 11/30/20, with a total of $796.54 received by 10/31/20.
e. A Billing End Date of 11/30/20, $293.76 due before 12/30/20, with $299.16 paid on 11/3020.

On 12/10/20, when the surveyor attempted to enter the facility in the morning and dialed the phone number posted at the entrance (the facility's phone number) an error message alerted the surveyor it was a non-working telephone number at that time.

During an interview 12/10/20 at 9:58 a.m., the Long-Term Care Ombudsman stated on 10/19/20, she received a phone call from a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 835	Continued From page 82	F 835		

resident's family member that said the phones at the facility had not worked for several days, there was no communication from the facility about the matter, or provision for another method of contact. The Ombudsman called the facility Administrator on 10/19/20, who acknowledged the phones had been out over the weekend, and she advised the Administrator that an alternate phone number for communication would have to be provided for resident family members.

During an interview 12/14/20 15 10:16 a.m., Resident #9's RP stated they were very frustrated by the difficulty they had experienced when they tried to contact the facility. They made repeated calls, at different times, on different days, the phone rang and rang and went unanswered, and the facility had not notified them of an alternate phone number due to a phone outage.

During an interview on 12/21/20 at 1:50 p.m., the Director of Nursing (DON) stated when she was a staff nurse, the phones were out for a while, they had a cell phone they used at the time, she'd heard it was because the bill wasn't paid but not sure of the accuracy as it was before she was in administration.

During an interview on 12/10/19 at 12:17 p.m., Staff DD, Licensed Practical Nurse (LPN), stated the facility phones didn't work for 2 weeks in October because the bill wasn't paid. The facility paid the bill, and it was a couple more days before the phone company turned them back on, staff used cell phones during that time and the facility posted the cell phone number on their Facebook page. Staff DD stated there had been times since then the phones hadn't worked due to mechanical issues, most recently on 12/7/20.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 835	Continued From page 83 During an interview on 1/4/21 at 11:03 a.m. a Customer Account Representative at the facility's telephone service provider stated the facility had received alerts on their statements in July, August and September, 2020 statements. The alerts on the statements were due to an unpaid balance, the account was subject to service disruption and telephone service was disconnected from 10/16/20 until 10/21/20 due to non-payment. On 10/21/20, the facility's previous Administrator contacted the telephone service provider, reported the phones were still disconnected and requested the service restored.	F 835		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 84 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 85	F 880		

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident, family and staff interviews and record reviews, the facility failed to follow proper infection control practices for four of four residents reviewed in the standard sample (Residents #2, #4 and #12) and failed to comply with the proper screening process for those who entered the facility. Residents #2 and #4 had not been placed in proper quarantine after they had returned from a hospitalization. Resident #12 received incontinence care after having a bowel movement without the staff changing gloves until just prior to leaving the room. The facility reported a census of 56 residents.

Findings include:

1. Resident #2's Minimum Data Set (MDS) 5 Day Assessment completed 11/12/20 documents the following diagnoses: medically complex conditions, COVID-19 and pneumonia. It also identified the resident as cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 4 out of 15, required assistance of one person for transfers, dressing, toileting and bathing.

A review of the Care Plan with the last revision date of 12/1/20 identified the resident with the problem of being at risk for depression/behavior changes related to COVID-19 quarantine and did not direct staff to place the resident in the L hall (designated as the quarantine area for new admits/re-admits) for 14 days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 86	F 880		

A review of the resident's electronic record revealed he had been hospitalized 11/6/20 and returned to his room in the B hall on 11/11/20.

Review of the Nurse's Notes revealed on 11/6/2020 at 1:17 p.m., the Resident was sent out via medic at 6.45 a.m. with complaint of hip pain. Upon assessment of resident femur bone appeared to be protruding. Medics were called and patient was sent out. The notes had no documentation on 11/11/20 upon his return from the hospital.

During an interview on 12/15/20 at 1:17 p.m., Staff F, Licensed Practical Nurse (LPN) reported when the resident returned from the hospital last month, he had not been quarantined and sent back to his original room in the B hall and had not been placed in droplet or airborne isolation.

2. Resident #4's MDS Significant Change Assessment completed 11/28/20 documented the following diagnoses: debility, cardiorespiratory conditions, displaced intertroachanteric fracture left femur, atrial fibrillation (an abnormal heart rhythm). It also identified the resident as cognitively intact with a BIMS score of 13 out of 15, and required extensive staff assistance with most activities of daily living.

A review of the Care Plan with a start date of 11/26/20 and completion date of 12/24/20 identified the resident with the problem of at risk for depression/behavior changes related to COVID-19 quarantine (initiated on 7/21/20) and had a target date of 2/9/21. It directed staff to:
a. Arrange for psych consult, follow up as indicated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 87	F 880		

b. Discuss any concerns, fears, issues regarding health or other subjects.
c. Monitor/document/report as needed any signs/symptoms of depression.
The above Care Plan also identified the resident with the problem of COVID-19 symptoms and directed staff to follow CDC guidelines and physician order per facility protocol.

A review of the electronic medical record revealed when the resident had been re-admitted from the hospital on 12/2/20 she had been admitted to her original room in the A hall.

A review of the Nurse's Notes on 11/26/20 revealed no documentation by nursing of which room the resident had been re-admitted to post hospitalization for a repaired fractured femur or if resident had been placed in isolation.

During an interview on 12/15/20 at 1:17 p.m., Staff F, LPN reported when the resident returned from the hospital on 11/26/20 after her hip surgery, she went back to her original room in the A hall and not placed in droplet or airborne isolation.

In an interview on 12/28/20 at 9:12 a.m., the Director of Nursing (DON) reported when residents are admitted or re-admitted from the hospital, they are supposed to be quarantined to the L hall for 14 days.

Review of the undated facility policy titled: COVID-19 Staff Education Plan (Policy for what to do with COVID) revealed the following:
Quarantine Unit: Quarantine is not a COVID positive unit. This unit is for those residents who:
a. Have admitted/readmitted from an outside

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 88	F 880		

facility and need to be observed for 13 days for signs or symptoms of COVID.
b. Have signs/symptoms of COVID but do not have a positive COVID test.
c. Have been in a room with a person who has tested positive for COVID< but they have tested negative.
d. Possible exposure to a COVID positive staff member/family member.

3. Resident #12's MDS 5 Day Assessment completed 11/27/20 documented the following diagnoses: progressive neuro conditions, COVID-19, heart failure and pneumonia. It also identified the resident as cognitively impaired with a BIMS score of 6 out of 15 and required limited staff assistance with most activities of daily living.

The Care Plan with the last revision date of 12/22/20 identified the resident with the problem of an Activities of Daily Living (ADL) self-care performance deficit related to dementia, fatigue, impaired balance and directed staff to provide extensive assistance by one staff for toileting and personal hygiene.

During an observation on 12/15/20 9:53 a.m., Staff K, Personal Care Aide (PCA, non-certified Nurse Aide) and Staff F, LPN assisted the resident to remove her incontinent brief which had a moderate amount of soft stool which transferred to the toilet seat. Both staff wore gloves before assisting the resident to sit on the toilet, Staff K used the correct technique to cleanse the resident's perineal and rectal crease front to back and did not change her gloves before holding the resident's hand to assist the resident to stand up. Both then held on to each

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 89	F 880		

side of the gait belt and Staff K did not change her gloves after she cleansed off the bowel movement from the resident and before she held on to the resident's right hand. Both staff held the resident under her arms without changing their gloves first.

During an interview on 12/28/20 at 9:12 a.m., the DON reported during incontinence care, she would expect staff to change gloves after cleaning off a bowel movement.

A review of the facility policy dated as last revised February 2018 and titled: Perineal Care had documentation of the following for a female resident:
a. Wash and dry your hands thoroughly.
b. Fill the wash basin one half full of warm water, place on the bedside stand within easy reach.
c. Put on gloves.
d. Wash perineal area, wiping from front to back.
e. Continue to wash the perineum moving from the inside outward to the thighs. Rinse perineum thoroughly in the same direction, using fresh water and a clean washcloth.
f. Gently dry perineum.
g. Ask the resident to turn on her side with top leg slightly bent.
h. Rinse wash cloth and apply soap or skin cleansing agent.
i. Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks.
j. Rinse and dry thoroughly.
k. Remove gloves and discard into designated container.
l. Wash and dry your hands thoroughly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 90	F 880		

4. The following observations related to failure to comply with the proper screening process for COVID-19, by failure to check the surveyors' temperature or complete the screening questions for upon entrance to the facility by the following staff:
a. On 12/14/20 at 7:08 a.m. Staff R, Certified Nurse Aide (CNA).
b. On 12/15/20 at 6:20 a.m. Staff R, CNA.
c. On 12/16/27 at 6:15 a.m. Staff BB, PCA
d. On 12/17/20 at 6:05 a.m. Staff CC, CNA.
e. On 12/21/20 at 6:30 a.m. Staff R, CNA.
f. On 12/22/20 at 6:00 a.m. Staff R, CNA.
g. On 12/28/20 at 7:15 a.m. Staff D, LPN.

A review of the undated facility policy titled: Emergency Plan for Pandemic Policy revealed the following:
a. Manage Visitor Access and Movement Within the Facility
b. Passively screen visitors for symptoms of acute respiratory illness before entering the Health Care Facility.
5. The surveyor entered the front door of the building on 12/14/20 at 9:00 a.m. Staff R, Certified Nurse Aide (CNA) opened the front door. Allowed surveyor to enter and did not offer to take temperature or provide screening for signs or symptoms of COVID-19.

The surveyor entered the front door of the building on 12/15/20 at 7:00 a.m. Staff R, CNA opened the door which was locked and allowed surveyor to enter and did not provide screening questions or body temperature.

The surveyor entered the front door of the facility on 12/16/20 at 7:08 a.m. Staff R, CNA allowed surveyor to enter the building without providing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 91	F 880		

screening or taking temperature.

During an interview on 12/16/20 with the DON stated the CNA at the front door should be providing screening to anyone who enters the front door of the building regarding COVID-19.

The facility provided a policy titled COVID-19 Policy/Plan for facilities last updated 9/30/20 which directed if a vendor or provider be permitted into the building they will sign in and out, temperature screen and use hand hygiene at entrance and exit. Visitors will be screened using the visitor log and taking the visitor's temperature, the visitor will be instructed in proper hand hygiene.

6. Observations by 3 nurse surveyors, present in the facility between 12/10/20 and 12/22/20 revealed facility staff did not consistently screened the surveyors for COVID-19 related symptoms prior to entry and exit at the facility, sometimes not screened at all, a thermometer was not consistently available at the screening station and a thermometer when available revealed sub-normal body temperature readings when used.

The list of COVID-19 symptoms identified in the Facility's Visitor Log did not represent a comprehensive list of symptoms, and the surveyors were not instructed to perform hand hygiene or report any symptoms of illness to the facility that occurred within 14 days after the visit.

On 12/22/20 at 10:00 a.m., Staff R, CNA used the thermometer and recorded the surveyor's temperature at 93.1 degrees Fahrenheit (normal body temperature 98.6 degrees Fahrenheit), did not attempt to obtain another reading, or different thermometer, or check with nursing staff for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 92	F 880		

further direction.

The facility's COVID-19 policy last updated 9/30/20 directed that visitors that were allowed entrance to the facility would be screened for symptoms of COVID-19 with temperature taken and a visitor's log used, and instructed on hand hygiene and to avoid contact with surfaces. The policy instructed that all visitors were to sign in and out, to use hand sanitizer upon entrance to the facility, and instruct the visitor to notify the facility if they become sick within 14 days of visiting the facility.

The following employee personnel files reviewed on 12/22/20 did not reveal documentation of basic infection control education that included hand-hygiene, or completion of a basic skills competency check list that ensured infection control practices followed when the specific skill was demonstrated:
a. For Staff E, patient care assistant (PCA, a non-certified nurse aide), hired 10/30/20.
b. For Staff I, PCA, hired 10/12/20 and terminated 12/19/20.
c. For Staff K, PCA, hired 5/20/20.
d. For Staff N, PCA, hired 11/19/20.
e. For Staff O, PCA, hired 11/19/20.
f. For Staff T, PCA, hired 8/31/20.

An In-Service Education form entitled "Infection Control" dated 10/26/20 and 10/27/20 revealed 31 employee signatures that included Staff K and Staff T.

An In-Service Education form entitled "PPE" (personal protective equipment) dated 11/16/20 revealed 25 employee signatures that included Staff K.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 93 Employee interviews revealed: a. On 12/22/20 at 10:47 a.m., Staff R, CNA, stated while she was on a light duty assignment at the present time, she was supposed to answer the front door and ensure that visitors signed in and answered the questions, and to stop the visitor from entry if they had a temperature, and her scheduled work hours were 6:00 a.m. to 2:30 p.m. b. On 12/22/20 at 8:46 a.m., Staff Y, CNA stated the new PCA's were not trained on infection control, 2 days prior she spoke to 1 of them about how to apply gloves and the employee said she had never heard that. When the PCA's were hired they were assigned to a CNA and it was up to that CNA to train them, and felt the CNA supervisor or DON should follow-up on that. c. On 12/21/20 at 12:34 p.m., Staff C, CNA supervisor stated she completed the CNA skills check lists and training sheets for the new CNA's and placed those sheets in a 3 ring binder. d. On 12/21/20 at 3:43 p.m., the Interim Administrator stated employees were on their honor to answer the COVID-19 screening questions and take their temperature before they punched in for work, there was no system to ensure that employees completed the activity, and she could not provide a report of the employee answers to the screening questions to ensure that all employees had completed the activity every day they worked. She stated that if the employee answered that they have a positive symptom, that action would generate an e-mail that is delivered to their marketing staff person who was required to follow up on the report. She also stated orientation packets for new employees had not been utilized and starting on that day and going forward, they would be	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 94 initiated until all employees were caught up. The facility had contracted with Relias a few weeks ago, a computer based employee education program, but had not implemented it's use as of that date, and she could not ensure that new employees had infection control training prior to direct care activities with the residents.	F 880		
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.	F 886		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 95	F 886		

§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;

§483.80 (h)((3) For each instance of testing:
(i) Document that testing was completed and the results of each staff test; and
(ii) Document in the resident records that testing was offered, completed (as appropriate
to the resident's testing status), and the results of each test.

§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms
consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.

§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.

§483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state
and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and staff interviews, the facility failed to test 5 of 5 facility staff sampled for COVID-19 twice weekly as required based on parameters set forth by the Department of Health and Human Services (HHS), and failed to prevent a nursing staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 96	F 886		

member from resident contact once the staff was identified as positive for the COVID-19 Corona virus. The facility reported a census of 56 residents.

Findings include:

The QSO-20-38-NH document (Center for Clinical Standards and Quality/Quality, Safety & Oversight Group from HHS and the Centers for Medicare & Medicaid Services) that mandates infection control practices related to the COVID-19 Corona virus in all long-term care facilities directed facilities to test staff for the virus twice weekly when the county positivity rate was greater than 10 percent.

The Scott County, Iowa COVID-19 positivity rate reported on "https://iowacovid19tracker.org/scott-county/" revealed positivity rates of:
23.0 percent on 11/11/20, 25.3 percent on 11/21/20, 12.1 percent on 11/30/20 and 16.7 percent on 12/16/20.

Employee COVID test records revealed:

Staff L, Certified Nurse Aide (CNA), tested 11/9/20, 11/12/20, 11/16/20, 11/21/20, 11/30/20, 12/3/20, 12/7/20, 12/10/20 12/14/20, 12/17/20.

Staff M, Licensed Practical Nurse (LPN), tested 11/5/20, 11/10/20, 11/12/20, 11/16/20, 11/19/20, 11/23/20, 11/27/20, 12/11/20.

Staff BB, Patient Care Aide (PCA), tested 11/9/20, 11/16/20, 11/19/20, 11/23/20, 11/30/20, 12/3/20.

Staff P, Housekeeper, tested 11/10/20.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 97 Staff Q, Dietary Aide (DA), tested 11/5/20, 11/9/20, 11/12/20, 11/16/20, 11/23/20, 11/30/20, 12/7/20, 12/14/20. Staff F, LPN, tested positive for the virus on 11/2/20. The clock-in and clock out report for Staff F revealed she worked from 6:00 a.m. to 4:30 p.m. on 11/2/20. The facility's COVID-19 policy dated last updated 9/30/20 directed that staff would be tested as required based on county prevalence numbers and was mandatory for employees Staff interviews revealed: a. On 12/22/20 at 10:05 a.m., Staff F, LPN, stated she was scheduled to work as a staff nurse from 6:00 a.m. to 6:00 p.m. on 11/2/20, she had her rapid COVID test at the facility that morning around 10:00 a.m. and it was positive, she was not sent home until around 5:00 p.m. due to lack of replacement staff and continued to provide direct care to residents that day. b. On 12/21/20 at 1:50 p.m., the Director of Nursing (DON), stated both she and the assistant DON (ADON) completed employee COVID testing twice weekly on Mondays and Thursdays, and no system in place that ensured that all employees were tested twice weekly as required. c. On 12/17/20 at 8:41 a.m., the Interim Administrator stated they have not tested any residents since the facility was declared "a COVID facility", and at that time there were 4 residents that were negative for the virus.	F 886		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4)	F 925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 925	Continued From page 98	F 925		

§483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, resident and staff interviews the facility failed to control rodents and exterminate them in a timely manner. The facility reported a census of 56 residents.

Findings include:

1. The Minimum Data Set (MDS) for Resident #19 dated 9/9/20, indicated the resident had a Basic Interview for Mental Status (BIMS) of 14 out of 15 indicating cognitive status is intact.

During an observation on 12/15/20 at 11:45 a.m. Resident #19 alerted the surveyor he would like her to look at something. The bed in his room A 6 -2 was perpendicular to the window in the room about a foot of space was between the bed and the window and directly below the bottom of the bed was a sticky trap with two dead mice on it. Resident asked a Housekeeper to dispose of the mice. Staff P, Housekeeper entered the room during the conversation with resident and removed the mice.

2. The MDS for Resident #19 dated 11/10/20 indicated the resident had a BIMS of 13 out of 15 indicating cognitive status is intact.

During an interview on 12/15/20 at 2:00 p.m., resident #19 stated she just picked up a mouse from under her bed and flushed it down the toilet. The mouse was in a trap the Maintenance Man had placed under her bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 925	Continued From page 99 During an interview on 12/15/20 at 2:30 p.m. Staff P, Housekeeper states she is aware of the mouse problem in the facility. They have had 5 of them in the Housekeepers office. The Maintenance Department was putting out traps but does not think anything else was ever done to prevent them. During an interview on 12/15/20 at 2:30 p.m. the Account Manager for Housekeeping states the previous Maintenance Supervisor, Administrator, Director of Nursing and the Assistant Director of Nursing were aware of the rodent problem. She is not aware of any exterminators being used to get rid of the mice. During an interview on 12/21/20 the Administrator stated she was looking for pest control information she thought there was some from EcoLab. During an interview on 12/21/20 at 2:38 p.m. the Interim Administrator states she has been unable to find anything on pest control but she is still looking. The facility provided a policy titled Pest Control revised May 2008. The policy statement declared our facility shall maintain an effective pest control program. Policy interpretation and implementation 1.) The facility maintains an on-going pest control program to ensure the building is kept free of insects and rodents. 3. Upon entering the facility conference room on 12/21/20 at 6:30 a.m., the surveyor observed a dead mouse on the floor by the table.	F 925		