STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	09/03/2020

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

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

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F 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to notify family members/responsible party's of a change in resident condition for 1 out of 3 residents reviewed (Resident #6). The facility reported a census of 61 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE] for Resident #6 shown [DIAGNOSES REDACTED]. The MDS indicated Resident #6 scored a 8 out of 15 on the Brief Interview for Mental Status (BIMS), indicating the resident with severe cognitive impairment. The assessment revealed the resident had verbal behaviors toward others at least daily. The MDS indicated the resident needed extensive assist of 2 staff with transfers, dressing and personal hygiene. Record review of the Nurse Progress Notes from 4/5/20 at 10:30 a.m., reveal Resident #6 became increasingly agitated with combative behaviors and required antipsychotic medications. The medications were not effective and paramedics were called to transport the resident to the emergency room (ER). It took 6 paramedics to transfer onto gurney due to physically aggressive behaviors. The resident was treated at the ER and returned to the facility. The Care Plan with a revision date of 2/14/19 states Resident #6 has problems with mood. The interventions direct staff to educate family/caregivers regarding expectations of treatment, concerns with side effects and potential adverse effects, evaluation, and maintenance. Review of the Nurse Progress Notes for the month of April 2020 failed to document any notification to the family or power of attorney for Resident #6 of the incident on 4/5/20. During an interview 9/1/20 at 12:30 p.m., with the Assistant Director of Nursing states family was not notified of the incident with behaviors on 4/5/20 or the visit to the hospital ER. During an interview 9/2/20 at 4:20 p.m., the Director of Nursing stated she would expect family to be notified of incidents with having to send the resident to the ER.
F 0606 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Not hire anyone with a finding of abuse, neglect, exploitation, or theft.** Based on record review and staff interviews the facility failed to check staff backgrounds prior to allowing staff work on the floor with residents for one of eleven staff reviewed (Staff A), failed to have newly hired staff complete required Mandatory Reporter Training within 6 months of hire and failed to have reference checks for eight out of the eleven staff reviewed. Findings include: 1. According to Staff A's personal file, the facility hired him/her on 7/23/2020. Review of the time clock records revealed Staff A worked as a Licensed Practical Nurse (LPN) on 7/23, 7/24, 7/25, 7/26. 7/27. 7/28, 7/29, 7/30/2020. Review of the Single Contact Repository (SING) Background Check revealed the facility completed the check on 7/30/2020, seven days after hired. The report revealed an active LPN license and no child or dependent adult abuse history. The report required further research of the Criminal History. The facility failed to submit DHS (Department of Human Services) evaluation. On 9/2/2020 at 11:30 a.m. Staff F, Director of Nursing(DON) revealed Staff A would have had patient contact from 7/23 - 7/30/2020. 2. Review of Employee Records shown the following: a. 8 of the 11 staff records reviewed revealed no documentation of completion of the Mandatory Reporter Training within 6 months of hire date. b. 8 of the 11 staff records reviewed failed to contain verification of reference checks. Review of the facility policy: Number WM 2.0, Background Screening, Evaluation and Investigations directed to ensure that the company maintains a background screening, evaluation, and investigation policy for new and current staff in accordance with state and federal laws included: a. The Company will perform background investigations on new hires, reassigned and promoted employees and Associates to prevent the employment of any individual who has been convicted of a criminal offense related to health care or who has been debarred, excluded, or held to be otherwise ineligible for participation in federal or state programs. b. Background check/initial screening - Includes an initial screening/review and documentation of requisite eligibility to work requirements such as verification of professional licenses, certifications as required, driver's license if indicated, reference checks, eligibility to work in the US, conducted prior to an offer of employment being made. c. The company will conduct screening and background investigations in accordance with state and federal law and standards of practice as part of the pre-employment screening procedures for prospective employees. On 9/1/2020 at 2:10 p.m., Staff E, Administrator reported the facility planned to have an all staff in-service for Mandatory Reporter Training. The facility also initiated an audit of all staff files to ensure they meet the requirements. Staff F (DON) revealed the former Administrator kept a binder in his/her office and currently they could not locate the binder.
F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interviews the facility failed to provide appropriate medication administration per Physician order [REDACTED].#6), and failed to follow Physician order [REDACTED].#17). The facility reported a census of 61 residents. Findings include: 1. During an observation on 9/1/20 at 7:45 a.m. Staff G, Certified Medication Aide (CMA) administered to Resident # 6 [MEDICATION NAME] Inhaler 90 micrograms (mcg) one puff. She also administered Potassium Chloride liquid 20 milliequivalents (MEQ) per 15 milliliter (mL) and she gave 20 milliliter. The Physician order [REDACTED]. Give alternating Dose of 25 mg/ml\0.5 mg/ml by mouth two times a day for wheezing. The Physician order [REDACTED].#6 during the AM medication pass. During an interview on 9/1/20 at 3:55 p.m., the Assistant Director of Nursing verified Resident # 6 should receive 15 mL of Potassium Chloride Liquid and not 20 mL per the Physician Orders. She also was not sure why there is a discrepancy for the [MEDICATION NAME] inhaler she will clarify with the Physician and Pharmacy. The facility provided a policy titled Administering Oral Medications revised October 2010 which stated the purpose of this procedure is to provide guidelines for the safe administration of oral medications. The procedure directed staff to check the medication dose. Re-check to confirm the proper dose. 2. According to the Minimum Data Set (MDS) assessment dated [DATE] for Resident # 17 shown [DIAGNOSES REDACTED]. The MDS indicated Resident #17 scored a 6 out of 15 on the Brief Interview for Mental Status (BIMS), indicating the resident with severe cognitive impairment. The MDS indicated the resident needed extensive assist of 1-2 staff with transfers, dressing and personal hygiene. Review of physician progress notes [REDACTED]. On 3/19/20 states will refer to [MEDICATION NAME] if needed. b. On 4/3/20 documents possible due to [MEDICAL CONDITION], blood transfusion and [MEDICATION NAME] consult. c. On 5/13/20 states resident was supposed to see [MEDICATION NAME] a month ago but follow up never made. Suggestion and consultation made again, Assistant Director of Nursing informed regarding the need of consult. Review of the residents Medical Record failed to reveal any documentation of a [MEDICATION NAME] consult being completed until the Medication Review Report reveals an order dated 5/18/20 to administer Suprep Bowel prep kit for colonoscopy 5/19/20 at 1:00 p.m. The colonoscopy report dated 5/19/20 listed the findings in the proximal ascending colon, a partially obstructing, malignant appearing, ulcerated, circumferential mass was seen. During an interview with the Assistant Director of Nursing (ADON) 9/2/20 at 10:44 a.m., reported not sure why the [MEDICATION NAME] consult not done initially. The current ADON stated there was another ADON at

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.

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F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) the time who was responsible for setting up the consult. During an interview with the Director of Nursing (DON) on 9/2/20 at 4:15 p.m., states she would expect staff to follow physician orders [REDACTED]. The staff should have taken care of the [MEDICATION NAME] consult immediately.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and staff interviews the facility failed to provide adequate supervision to prevent falls for 1 out of 3 residents reviewed (Resident #7). The facility reported a census of 61 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE] for Resident #7 shown [DIAGNOSES REDACTED]. The MDS dated [DATE] indicated Resident #7 scored a 5 out of 15 on the Brief Interview for Mental Status (BIMS), indicating the resident with severe cognitive impairment. The MDS indicated the resident needed extensive to total assist of 1-2 staff with bed mobility, transfers, and locomotion. The MDS revealed the resident has a history of falls. The Care Plan with an initiation date of 6/3/20 states the resident is at risk for falls related to gait/balance problems, paralysis, unaware of safety needs. The Care Plan intervention initiated 6/8/20 direct staff to have mattress on floor beside bed whenever resident is in bed. There is also intervention dated 6/19/20 which directs staff do not leave resident up in chair in room alone. Review of the Incident Report dated 6/3/20 revealed Resident #7 was found lying on the floor next to the bed. Another Incident Report dated 6/19/20 indicated the resident was found on the floor after physical therapy had left him in wheelchair beside bed. The following issues noted during random observations of Resident #7 : a. On 8/25/20 at 2:44 p.m., he was lying in bed in low position with no matt on the floor next to the bed. Remained in bed until 4:31 P.M. with no fall mattress in place next to the bed. b. On 8/26/20 at 8:30 a.m., Resident #7 was sitting up in his wheelchair in his room alone. No staff present and did not have a fall matt in the room. c. On 8/26/20 at 12:55 p.m., Resident #7 was in bed with no fall mattress in place. d. On 8/27/20 at 10:45 a.m., Resident #7 was in bed with no fall mattress in place. During an interview on 9/2/20 at 1:30 p.m., Staff H, Certified Nursing Assistant (CNA) stated staff would be informed of fall interventions by staff from the shift before them and should be able to look at at the Care Plan to know what the fall interventions are for a resident. During an interview on 9/2/20 at 3:45 p.m., the Assistant Director of Nursing stated fall interventions are on residents' Care Plans and if it is on the Care Plan it should be done. During an interview on 9/2/20 at 4:15 p.m., the Director of Nursing (DON) stated Resident #7 should have the fall mattress on the floor and she would expect staff to follow the Care Plan. The DON also explains the staff have a Care Card on each resident to follow in a binder. The facility provided a Falls and Fall Risk Policy from Policy and Procedure Manual for long-Term Care with no date which directs staff on the Treatment/Management of falls 1.) Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observations, document/policy review and staff interview the facility staff failed to store and serve food under sanitary conditions, maintain the kitchen in a clean and sanitary manner to reduce the risk of contamination to food and food-borne illness. The facility identified a census of 61 residents. Findings include: During a tour of the kitchen on 9/1/20 at 11:30 a.m. the following noted: a. The perimeter of the kitchen, in the areas where the floor and wall met, especially behind and underneath equipment had a buildup of food debris and grime. The floor under the dishwasher had scattered debris. The entire kitchen floor had scattered food debris, dirt and grime. b. The three door True refrigerator had a large amount of visible grime and food debris on the exterior surface. c. The McCall freezer had a large amount of visible grime on the exterior and food debris on interior base. d. The True meat freezer had a large amount of visible grime and food debris on the exterior. e. Four of four kitchen carts used to transport supplies and food had a heavy amount of grime and food debris splattered throughout. f. One of three flour bins had 5 bowls of dry cereal on top of it without covers. g. A large 48 ounce jar of grape jelly, with approximately 25% remaining, sat on a kitchen shelf near the peanut butter. The label had instructions including refrigerate after opening. Staff C indicated the night shift left it out. Staff B indicated they currently had two staff in the kitchen; the previous dietary manager quit the week prior. On 9/2/20 at 11:00 a.m , Staff D, District Manager with the Housekeeping and Dietary Services Provider submitted a cleaning schedule for August 23-29. Staff D submitted no cleaning schedule for 8/30-9/5/20. The Kitchen Duties for the Dietary Aides cleaning schedule included daily items to be cleaned: a. Clean steam-table, stove top, prep tables, dish table, dish machine, robot coup, toaster. b. Wipe down walls, cooler doors, freezer door, front of oven. c. Sweep, mop, check dates in cooler, check thawing food in cooler, wipe out microwave and wipe out sink. On 9/2/20 at 11:55 a.m., Staff D submitted a new and revised cleaning schedule and the staff responsible. Staff D also indicated staff were currently deep cleaning the kitchen.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** Based on observation, staff interview and record review the facility staff failed to follow the Center for Disease Control (CDC) recommendations in regards to utilizing proper Personal Protection Equipment (PPE) and hand washing/sanitizing procedures while working in a facility to reduce the spread of the COVID-19 Virus. The facility reported a census of 61 residents. Findings include: 1. During an observation on 8/25/20 at 10:30 a.m., noted Staff K, Housekeeping while cleaning a resident room was wearing a cloth face mask over chin when Staff K saw surveyor she pulled the cloth mask up over her mouth and nose. Staff K failed to wash hands or use alcohol based hand sanitizer after touching mask and face. 2. During an observation on 8/25/20 at 12:25 p.m., Staff J, Certified Nursing Assistant (CNA) noted passing noon meal trays to rooms she was wearing a cloth mask down below nose, she put the cloth mask back up over nose using hands. Staff J delivered food tray to room A 14 the cloth face mask slid down again and she pulled up the cloth face mask again and failed to wash hands or use alcohol based hand sanitizer at any time while passing the room trays and touching mask and face. 3. During an observation on 8/26/20 at 11:35 a.m., Staff I, CNA noted ambulating a resident with a cloth mask on herself but no mask at all on the resident. 4. During an observation on 8/26/20 at 11:54 a.m., a Maintenance Worker in the B-Wing hall noted wearing a cloth mask. Per the Center for Disease Control (CDC) Website - a Health Care Provider (HCP) should wear a facemask at all times while they are in the facility. When available, facemasks are generally preferred over cloth face coverings for health care provider (HCP) as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others. Guidance on extended use and reuse of facemasks is available. Cloth face coverings should NOT be worn by HCP instead of a respirator or facemask if Personal Protection Equipment (PPE) is required. During an interview with the Director of Nursing (DON) on 8/26/20 at 4:30 p.m. states some staff are wearing cloth masks but understood they were able to wear them and was not aware of the CDC recommendations. They do have the required face masks available for staff. During interview with the DON on 9/2/20 at 4:17 p.m., stated she would expect staff to wash their hands if they touch their face mask. 2. During an observation on 8/25/20 at 11:48 a.m.,. Staff L, Certified Nurse Aide (CNA) and Staff M, CNA went into room R-6, R-7 and R-10 with noon meal trays and drinks. Staff L or Staff M did not don any Personal Protective Equipment (PPE) when going in or out of the three rooms. Staff left the rooms and did not wash hands or use any alcohol based hand sanitizer when going between the rooms. Each room had an isolation cart outside the room with PPE supplies available. Signs were posted on the door with standard precautions noted. During an interview with Staff H, CNA on 9/2/20 at 3:30 p.m., states if going into an isolation room, staff should wear gloves, gown and mask and when leave the room staff should wash hands. During an interview on 9/2/20 at 4:00 p.m., the Assistant Director of Nursing states when standard precautions signs are posted on resident doors the staff should follow the signs on the door. Staff should wear gown, gloves and mask when entering isolation rooms and dispose of them properly and wash hands when leaving the room. During an interview on 9/2/20 at 4:17 p.m., the Director of Nursing stated would expect staff to wear mask, gown and gloves when entering isolation rooms. She also would expect staff to wash or sanitize hands when going from room to room. Rooms R-6,7 and 10 are isolation rooms and staff should wear appropriate PPE. The facility provided a Isolation- Initiating Transmission - Based Precautions Revised August 2019 which states Transmission - based

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) precautions are utilized when a resident meets the criteria for a transmissible infection and the resident has risk factors that increase the likelihood of transmission. These may include (but are not limited to): 3. e.) Ensures that protective equipment (i.e., gloves, gowns, masks, etc.) is maintained outside the resident's room so that anyone entering the room can apply the appropriate equipment. The facility provided a policy titled Handwashing/Hand Hygiene revised August 2014 which directed all personnel shall follow the handwashing/hand hygiene procedure to help prevent the spread of infections to other personnel, residents and visitors. The policy directed staff to use alcohol based hand rub before and after entering isolation precaution settings. Hand hygiene is the final step after removing and disposing of Personal Protective Equipment.