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 _____	06/11/2020

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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility document review and staff and resident interviews, the facility failed to prevent a non-qualified staff member from providing medications and treatments to residents which required the knowledge of a licensed or registered nurse for 5 of 7 residents reviewed (Residents #1, #4, #5 #6 and #7). On 5/18/20, Staff A (Certified Medication Aide or CMA) administered insulin injections, gastric tube feedings and medications and inserted a urinary catheter to the affected residents. The facility identified a census of 52 current residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #1 had [DIAGNOSES REDACTED]. The assessment documented a Brief Interview for Mental Status (BIMS) score of 13, indicating intact memory and cognition. Resident #1's Care Plan, updated on 3/24/20, documented she had a nutritional problem related (in part) to Type 2 diabetes mellitus. The Care Plan instructed staff to administer the resident's medications as ordered and to monitor/document for side effects and effectiveness. The Order Summary Report dated 5/18/20 instructed staff to administer Detemir insulin subcutaneously (SQ, a shallow injection) 15 units (u) in the morning and Humalog insulin 14 u before meals for diabetes. The Medication Administration Report (MAR) for 5/2020 documented that on 5/18/20 Staff A injected Resident #1 with insulin at 7:00 a.m., 8:00 a.m. and 11:00 a.m. 2. The MDS dated [DATE] documented Resident #4 had [DIAGNOSES REDACTED]. The assessment documented a BIMS score of 13 and that she required intermittent urinary catheterization. Resident #4's Care Plan, updated on 5/26/20, documented she had a suprapubic catheter with an intervention to educate her on risk vs: benefits for nursing to do catheter care, as she has in the past been responsible. The resident's Order Summary Report dated 5/18/20 instructed staff to insert a straight urinary catheter every 4 hours. The MAR for 5/2020 did not contain documentation of catheter insertion on 5/18/20 at 2:00 p.m. During a phone interview on 6/9/20 at 10:30 a.m., Resident #4 stated the nurses usually do her urinary straight catheters, but remembered that once Staff A did it. She did not remember the exact date, but it occurred after lunch. The resident stated she did not think Staff A should have done the catheterization because the resident learned later learned that Staff A is not a nurse. 3. The MDS dated [DATE] documented Resident #5 had [DIAGNOSES REDACTED]. The MDS documented Resident #5 had a BIMS score of 6, indicating severely impaired memory and cognition. Resident #5's Care Plan, updated on 3/24/20, documented she had the [DIAGNOSES REDACTED]. The resident's Order Summary Report dated 5/18/20 instructed staff to administer Humalog insulin 5 u before meals, additional Humalog if needed based on blood sugar measurement and via a sliding scale and Levimir insulin 35 u twice a day. The MAR for 5/2020 recorded Staff A administered Resident #5's insulin doses on 5/18/20 at 7:00 a.m. and 11:00 a.m. 4. The MDS dated [DATE] documented Resident #6 had a [DIAGNOSES REDACTED].#6 had impaired short and long-term memory and severely impaired cognitive skills for daily decision-making. The assessment also documented the resident required a feeding tube (G tube) and she received 51% or more of her calories through the tube. Resident #6's Care Plan, updated on 3/24/20, documented she had a nutritional problem related to receiving nothing by mouth and dependency on [DEVICE] feedings for nutrition. The Care Plan instructed staff to monitor for intolerance to the feedings, like residual (undigested) feeding solution, bloating, gas, diarrhea or vomiting. The Care Plan also directed to provide [DEVICE] feedings as ordered. The resident's Order Summary Report dated 5/18/20 instructed staff to provide an enteral ([DEVICE]) feeding of [MEDICATION NAME] 1.2 and 90 milliliters (ml) flush during and 125 ml water flushes before and after every tube feeding bolus 4 times per day beginning 3/9/20. The Order Summary report also recorded she received nothing by mouth and received medications via the [DEVICE]. The MAR for 5/2020 recorded Staff A administered Resident #6's [DEVICE] feedings at 10:00 a.m. and 2:00 p.m. and her morning medications via [DEVICE] on 5/18/20. 5. The MDS dated [DATE] documented Resident #7 had the [DIAGNOSES REDACTED]. Resident #7 had a BIMS score of 13. Resident #7's Care Plan, updated on 3/24/20, documented she had the [DIAGNOSES REDACTED]. The resident's Order Summary Report dated 5/18/20 instructed staff to administer Humalog insulin 15 u before meals, additional Humalog if needed based on blood sugar measurement and via a sliding scale and Levimir insulin 50 u every morning. The MAR for 5/2020 recorded Staff A administered Resident #7's insulin doses on 5/18/20 at 7:30 a.m., 8:00 a.m. and 11:30 a.m. During a phone interview on 6/9/20 at 11:07 a.m., Resident #7 stated she remembered the day Staff A gave her insulin injection and that 5/18/20 sounded right. The resident stated she had never had a CMA do an insulin injection either before or since that day. The resident recalled that Staff A talked about how she was almost done with Nursing School, so she did not question her doing the injection. During interview at the facility on 5/28/20 at 8:15 a.m., the Administrator/Director of Nursing (Admin/DON) stated the facility recently discharged Staff A from employment. Staff A worked as a CMA, but had graduated Nursing school in 2013, did not pass Boards, but planned to re-test. The Admin/DON stated Staff A took it upon herself to do gastric (G) tube medications and feeding, insert a suprapubic urinary catheter and administer residents' insulin. The facility learned of Staff A's actions on 5/18/20 when she relayed giving insulin to the CMA (Staff B) on the oncoming shift. After asking Staff A about her actions, the Admin/DON stated Staff A admitted to doing nursing procedures and argued that she was a nurse. Staff A was suspended by the facility left and then came back briefly to tell the Admin/DON the facility's ADON (Assistant Director of Nursing) instructed her to do the procedures. On 6/3/20 at 10:00 a.m., the facility's Human Resources (HR) staff member verified that on 5/18/20 around 2:45 p.m., Staff B reported concerns about Staff A's actions during first shift that day. After learning of the concern, she informed the Admin/DON of the situation. Facility staff conducted an internal investigation and reported the incident to the Department of Inspections and Appeals (DIA) on 5/29/20, documenting allegations of resident rights and unqualified personnel. Review of the facility's Nursing schedule revealed the following assignments on 5/18/20 day shift: a. Staff A, CMA on B hall. b. Staff C, CMA on A hall. c. Staff D, Licensed Practical Nurse(LPN) on L & R Hall. A phone interview with Staff C, CMA on 6/3/20 at 3:37 p.m. revealed about 1 - 2 weeks ago (she could not remember the exact date), she saw Staff A draw up insulin and enter a resident's room (she also could not recall which resident). She stated seeing this concerned her, since Staff A was a CMA. Staff C stated she did not report her observation to anyone, stating the ADON was in the area and Staff C thought she might have seen it. During a telephone interview on 6/3/20 at 3:57 p.m., Staff B, CMA stated that on 5/18/20 about 2:55 p.m., he had just received report from the off going nurse and stood at the nursing station with Staff A and Staff C. Staff C told him that Staff A was being a nurse that day and gave insulin injections. Staff B stated Staff A admitted to giving insulin injections right then, saying she went to school for that and knew how. Staff B stated he asked Staff A if she was joking, Staff A replied no and that Staff C looked uneasy during the conversation. Staff B then reported the exchange to HR, who took it to the Admin/ADON. Staff B stated he was shocked, as CMA's are not supposed to inject insulin. His Nursing Instructor was specific about what CMA's can and cannot do. During additional phone interview with Staff C on 6/4/20 at 8:15 a.m., she remembered the conversation on 5/18/20 at the A Hall nursing station as related by Staff B. Staff C remembered Staff A said she gave resident insulin injections on A Hall. Staff C stated she was actually confused about

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

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F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) Staff A's title as Staff A worked 12-hour shifts and nurses only did those; Staff A also talked about graduating Nursing School and wore her name badge turned around. Staff C concluded 5/18/20 was the second time she had worked with Staff A. During a phone interview on 6/4/20 at 9:42 a.m., Staff D, LPN stated she arrived late the morning of 5/18/20 and was running behind. Staff D stated she first started passing resident medications on R & L halls and that Staff A and Staff C worked passing medications on A & B halls. Staff A came to R & L hall about 7:30 a.m. or 7:45 a.m. and reported she gave resident insulin injections that morning. Staff D stated she knew Staff A had graduated Nursing School and she planned to take Boards in 30 days. Staff A also informed Staff D the ADON knew she gave insulin injections and was okay with this as Boards were coming up. Staff D stated she continued passing medications on R & L halls. Then, about 9:30 a.m. or 9:45 a.m., Staff A informed her that she had done Resident #6's [DEVICE] feeding and the ADON told her to. Staff D continued that about 3:00 p.m. or 3:30 p.m., the Admin/DON asked her who gave resident insulin injections and she reported that Staff A did. On 5/19/20, Staff D spoke with the ADON who told her she never approved Staff A to do insulin injections or [DEVICE] medications. Staff D stated she graduated Nursing school [AGE] years ago and at that time; you worked under your DON's license until you got Board passage results. She thought that is what Staff A was doing. Staff D stated that she also believed Staff A when she reported doing these things with ADON approval. She remembered that 5/18/20 was the second time she had worked with Staff A and the first time, Staff D did all insulin injections, [DEVICE] medications and catheterizations. During telephone interview on 6/4/20 at 10:30 a.m., when asked about events on 5/18/20, Staff A stated she had no idea why she was being asked about that and she did not want to talk about it. Staff A then stated she gave insulin injections that morning, added [DEVICE] feeding solution to a freshly hung bag for Resident #6 and inserted a straight catheter into Resident #4 that shift. She stated the ADON asked her to do all these things and that Staff D had approved her giving insulin injections beforehand (Staff D stated she learned of the injections after they were given). Staff A stated the ADON was lying as she did not want to lose her license and Staff A told the truth and does not retaliate. Staff A stated she graduated Nursing School and planned to take Boards again soon. During an interview at the facility on 6/8/20 at 10:40 a.m., Staff E, CMA (working as Medical Records staff at that time) stated that mid-morning on 5/18/20, Staff A came to her and asked where the facility kept the tube feeding supplies for Resident #6. Staff E asked Staff A why she wanted them and Staff A told her to give Resident #6's medications. Staff E told Staff A she was not supposed to do [DEVICE] medications and Staff A informed Staff E it was okay because the ADON told her it was, as Staff A had passed Nursing School and would take Boards soon. Staff E stated the morning meeting was going on at the time and she told HR about it later. During an interview on 6/8/20 at 11:20 a.m., the ADON recalled that on 5/18/20 at 6:40 a.m., Staff E called her and informed her that Staff D had not arrived and she asked what to do. The ADON asked Staff E to ask Staff F, LPN who worked the previous night to do the morning insulin injections and for Staff E to pass medications. When the ADON arrived, she learned Staff E arrived about 7:00 a.m. The ADON did not see Staff F, so she assumed the morning insulins given. After 10:00 a.m., Resident #4 came and asked her to do her morning urinary catheterization; she did that and completed Resident #6's 10:00 a.m. [DEVICE] feeding. The ADON remembered asking Resident #4 to get her for the 2:00 p.m. straight catheterization and heard nothing else, so she thought Staff D had done it. On her way home, HR called and asked if she knew about Staff A doing Resident #4's 10:00 a.m. catheter and Resident #6's tube feeding. Staff A had stated she performed the procedures at the ADON's instruction. The ADON said that Staff A must have lied as she did Resident #4's 10:00 a.m. urinary catheter. The ADON also relayed that she asked Staff F to give the insulins. The ADON concluded she knew Staff A had graduated from Nursing school in 2013 and failed Boards and she would have never given Staff A permission to do catheters, tube feedings and insulin injections. During additional phone interview on 6/8/20 at 1:30 p.m., Staff E remembered talking with the ADON the morning of 5/18/20. Staff E stated that Staff D was running late and the ADON asked her to start medication pass from the cart and to ask Staff F to do morning insulins. Staff E stated she passed the request onto Staff F, who was at the nurse's station, and started medication pass. About 7:15, Staff D arrived and she did not see Staff F after that as she did medication pass. On 6/9/20 at 10 a.m., Staff F stated she remembered that Staff D ran late on 5/18/20, but arrived between 6:30 and 7:00 a.m. Staff F did not remember Staff E's call to the ADON or being asked to do insulin injections. Since Staff D arrived by 7:00 a.m., Staff F did not need to do blood sugar measurements or insulin injections. During a phone interview on 6/10/20 at 10:45 a.m., Staff G, CMA stated she worked often with Staff A. Staff G stated that Staff A was a good CMA, but was stuck on when she would become a nurse. Staff G stated she heard about that every time they worked together. Individual Employee Time Cards documented that on 5/18/20, Staff D began her shift at 7:00 a.m. and Staff F ended her shift at 8:30 a.m. Review of Staff A's Personnel File revealed a hire date of 4/16/20 as a CMA. The file contained a certificate of successful completion Medication Aide testing on 1/8/18. Staff A's resume documented she completed training as an LPN in 2013. Staff A's SING (single contact repository) check of 4/13/20 did not record she had a license to practice as a nurse in Iowa. The file also contained a Disciplinary Action Form dated 5/19/20 documenting the facility terminated Staff A's employment on 5/19/20 for [MEDICATION NAME] outside of her scope by giving insulin injections, tube feedings a catheterization. The course information for CMA from the community college that issued Staff A's CMA certification documented she received training to safely administer [MEDICATION NAME] medications in nursing facilities and related areas. [MEDICATION NAME] medications would include oral, topical, rectal and sublingual medications. The Job Description for a CMA dated 12/18 documented the CMA would administer medications as ordered by the attending physician, under the direction of the charge nurse and the DON. The administration of medications shall be in accordance with established nursing standards, the policies, procedures and practices of this facility and the requirements of the state. The description documented specifically the CMA would accurately and safely prepare, administer and document the oral and/or topical medications that are commonly used in this facility and may be ordered for resident use. The Job Description for a Charge Nurse (LPN or Registered Nurse) dated 12/11 instructed the nurse would administer professional services such as catheterization and tube feedings, among other duties. The facility's policy on Insulin Administration, revised 9/14, instructed only appropriately licensed or certified personnel shall draw and administer insulin. The facility's policy on Enteral Tube Feeding, revised 11/18, instructed staff to assess and report complications and the negative consequences of tube feeding. The facility's policy on Intermittent Female Resident Catheterization, revised 10/10, identified it to be a sterile procedure and directed staff to collect assessment data during the procedure. The Suprapubic Catheter Replacement policy, revised 10/10, also identified sterility during the procedure and verification of placement. The incident detailed above resulted in determination of Immediate Jeopardy for the facility and notified of such on 6/10/20. The Facility staff abated the Immediate Jeopardy situation on 6/10/20 through the following actions: a. On 5/18/20 - Verbal training to all nurses and CMA's regarding scope of practice. b. On 5/18/20 - Suspension of staff A with termination on 5/19/20. c. On 5/18/20 and 6/10/20 - Verbal and written education on scope of practice to Staff D. d. On 5/29/20 - Formal written training to all nurses and CMA's on scope of practice. e. On 6/10/20 - Education towards reporting for Staff C and initiation of addition training to all staff regarding immediate reporting of anything unusual, suspicious or inappropriate. If administrative staff could not immediately educate staff, they would receive the training prior to beginning their next shift.