STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ivy at Davenport	**800 East Rusholme Street , Davenport, Iowa, 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
F0000	INITIAL COMMENTS Correction date: _____ The following deficiencies resulted from investigation of complaint #2689091-C and facility reported incident #2688655-I, conducted December 10, 2025 - December 16, 2025. Complaint #2689091-C resulted in a deficiency. Facility reported incident #2688655-I resulted in a deficiency. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F0000		
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment 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.	F0584		

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ivy at Davenport	**800 East Rusholme Street , Davenport, Iowa, 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
F0584 SS = D	Continued from page 1 §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 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observations, staff interview, and facility policy review, the facility failed to ensure residents had a safe, homelike environment. Observations of the facility revealed the floor heating vent covers bent, broken, or falling off showing the internal metal heating elements in resident rooms for 1 of 3 hallways and in 1 of 1 resident common area. The facility reported a census of 66 residents. Findings include: During an observation on 12/15/25 at 11:30 AM, room B4 had a baseboard heater that ran along the bottom length of one wall. The metal cover on the heater appeared bent away from the wall and exposed a large area of the internal heating element. The internal heating element contained metal plates that felt warm when touched. The resident's bed, in room B4, placed approximately 2 feet away and parallel to the baseboard heater. On 12/15/25 at 2:48 PM, the metal cover in room B4 appeared straightened and replaced. The baseboard heater no longer exposed the heating elements. During an observation on 12/16/25 at 9:26 AM, room B1 had a baseboard heater that ran along the bottom length of one wall. The resident's bed was positioned perpendicular, with the head of the bed along the wall	F0584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ivy at Davenport	**800 East Rusholme Street , Davenport, Iowa, 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
F0584 SS = D	Continued from page 2 in the location of the heater. The metal cover on the heater had 2 pieces, the piece behind the head of the bed fell off and exposed the heating elements, while the piece away from the bed remained in place. During an observation on 12/16/25 at 9:30 AM, room B3 had a baseboard heater that ran along the bottom length of one wall. The resident's bed was positioned perpendicular, with the head of the bed along the wall in the location of the heater. The metal cover on the heater had 2 pieces, the piece behind the head of the bed fell off and exposed the heating elements, while the piece away from the bed remained in place. The 2 pieces didn't meet together, leaving approximately 3-4 inches of exposed heating elements without a cover. During an observation on 12/16/25 at 9:35 AM, the residents' common area, used both as a main dining room and activities area, had a baseboard heater that ran along the bottom length of one wall. The room had a table positioned along the wall in the location of the heater. The metal cover on the heater appeared bent away from the wall and exposed a large area of the internal heating element. During an interview on 12/16/25 at 10:25 AM, the facility Maintenance Director reported they normally go through the facility once a week and if they had heater covers falling off or bent, they would be put back on or straighten the covers and replace. The Maintenance Director stated they noted the heater cover in room B4 bent on 12/15/25. They took it to the shop and straightened it before replacing. During an interview on 12/16/25 at 1:30 PM, the Director of Nursing (DON) reported the baseboard heater covers frequently get knocked off or bent when beds get moved or by wheelchairs. The DON stated she requested the maintenance staff to go through the facility weekly to check the heater covers. The DON notified the facility was looking at getting new heater covers because current covers have been beat up for so long. Review of the facility policy titled, Safe and Homelike Environment, revised 7/22/25, indicated in accordance with residents' rights, the facility would provide a safe, clean, comfortable and homelike environment. This includes ensuring the resident can receive care and services safely. The physical layout of the facility, both inside and outside, maximizes resident independence and does not pose a safety risk.	F0584		
F0606 SS = D	Not Employ/Engage Staff w/ Adverse Actions CFR(s): 483.12(a)(3)(4) §483.12(a) The facility must- §483.12(a)(3) Not employ or otherwise engage	F0606		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ivy at Davenport	**800 East Rusholme Street , Davenport, Iowa, 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
F0606 SS = D	Continued from page 3 individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. §483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. This REQUIREMENT is NOT MET as evidenced by: Based on staff interview, employee personnel record review, and facility policy review, the facility failed to ensure a background check was completed on staff, prior to working with dependent adults, for 1 of 5 staff personnel files reviewed. The facility reported a census of 66 residents. Findings include: Review of the facility provided document, titled New Hire Orientation Schedule, revealed Staff A, Certified Nursing Assistant (CNA), completed new hire orientation on 11/20/25 Review of the facility provided document, titled Background Screening Report, ordered 11/19/25, listed the results as pending for a national criminal and sex offender search. Review of the facility requested Single Contact License and Background Check for Staff A, dated 11/19/25, revealed that Staff A's criminal history required further research.	F0606		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ivy at Davenport	**800 East Rusholme Street , Davenport, Iowa, 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
F0606 SS = D	Continued from page 4 Review of the facility provided document, titled Iowa Criminal History Record Check Request SING form S, dated 11/20/25, revealed Staff A had simple and serious misdemeanor convictions. Review of Staff A's employee personnel file lacked an approval notice for Staff A to work in the facility following identification of criminal history records. Staff A's background check records remained in a pending results status. During an interview on 12/16/25 at 11:30 AM, Staff E, Scheduler, started employment on 7/28/25. Staff E stated they must check the following before a new hire can work with residents: background check, identity verification, and onboarding process. Staff E identified the Administrator as the person responsible for ordering the background check. The Administrator would notify Staff E when the pending background checks cleared. Staff E stated that there must have been a miscommunication between herself and the Administrator when she believed a sticky note on the front of Staff A's file indicated that Staff A was good to go, so Staff E began scheduling Staff A to work shifts as a CNA. During an interview on 12/16/25 at 1:30 PM, the Director of Nursing (DON), reported Staff A, worked at the facility for approximately 2 weeks and worked independently on B hallway on 12/8/25 from 2:00 PM to 10:00 PM. The DON denied personally checking in with Staff A to see how she performed as a new hire. Review of the facility policy, titled Background Investigations, revised 8/27/25, directed job reference checks, drug screenings, license verifications, and criminal conviction record checks are conducted on all personnel providing an application for employment with the facility. The Section A. Policy Explanation and Compliance Guidelines, directed the following, in part: The Human Resource department will conduct all applicable background investigations on each individual making application for employment with this company and on any current employee if such background investigation is appropriate for the position for which the individual has applied.For all applicants applying for a position as a certified nurse aide, the Human Resources	F0606		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ivy at Davenport	**800 East Rusholme Street , Davenport, Iowa, 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
F0606 SS = D	Continued from page 5 department will contact the nurse aide registry of the state in which the individual is certified and/or previously employed to verify that the applicant's certification is in good standing. Persons applying for employment and current employees will be informed of this policy. The company will not conduct a background investigation without an applicant's or employee's advance consent. Applicants or employees who do not consent to background investigation will, however, not be considered for positions that the company has determined to require the completion of a background investigation.If the background investigation(s) disclose any material misrepresentation or omissions by the applicant or employee on the application form or reveal information indicating that the individual may not be appropriate for hire, the company will investigate the matter further. Upon completion of such investigation, if the company determines that the applicant's or employee's background makes him/her unsuitable for the position he/she is seeking, the applicant will not be employed or, if already employed, will be terminated.The facility will not employ individuals who:Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law.Have had a finding entered into the state nurse aide regis try concerning abuse, neglect, exploitation, mistreatment of residents, or misappropriation of resident property.Have a disciplinary action in effect against his or her professional license in a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of resident, or misappropriation or resident property.All inquiries regarding background investigations should be directed toward the Human Resource Director or Administrator.	F0606		
F0689 SS = SQC-J	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:	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ivy at Davenport	**800 East Rusholme Street , Davenport, Iowa, 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
F0689 SS = SQC-J	Continued from page 6 Based on observation of Video evidence, staff interview, clinical record review, and facility policy review, the facility failed to provide adequate supervision and assistance to 1 of 3 residents (Resident #1) reviewed for nursing supervision. Resident #1 had cognitive impairment, known to wander, and had multiple attempted elopements. The video evidence showed on 12/8/25 at 9:25 PM, the facility staff (Certified Nursing Assistant, "CNA"), responsible for Resident #1's care, entered the front door code and let them outside the building and then exited behind them. The CNA re-entered the facility at 9:27 PM without Resident #1 and didn't report to other staff that Resident #1 went outside. The staff at the facility became aware of Resident #1 missing on 12/9/25 at 6:12 AM, by a facility staff member, driving to work. The staff member found Resident #1 approximately 1.7 miles from the facility (approximately a 38-minute walk) near a busy road with 2 lanes of traffic in each direction, wearing a jacket and light weight shoes, no gloves or hat, with the weather reported as below freezing with snow on the ground and wind chill values ranging between 8-17 degrees Fahrenheit. The staff described Resident #1's hands as "freezing cold." Upon their return to the facility, an assessment of Resident #1 found them with a decrease in oxygen saturation and wheezing. After an assessment by Resident #1's provider, they ordered to send her to the Emergency Department for a potential pulmonary embolism (blood clot in the lung). The State Agency informed the facility of the Immediate Jeopardy (IJ) situation on 12/11/25 at 11:35 AM. The IJ began on 12/8/25 and the facility staff removed the IJ on 12/11/25 at 3:21 PM by implementing the following actions: The facility initiated an investigation of the elopement on 12/9/25 and placed Resident #1 on one-on-one supervision with staff until they had all systems for elopement risks place. The facility updated Resident #1's Care Plan and notified the physician and responsible party of the incident. The facility completed a visual head count of every resident to ensure all were present and safe. The Director of Nursing (DON)/Designee assessed every resident on 12/9/25 for wandering and elopement risk, then updated 3 of 3 elopement books. The facility educated all staff on the elopement policy and procedures, the elopement book, elopement response plans, and not allowing resident/visitors out of the front door until verified by a nurse or manager on 12/9/25. The facility implemented resident rounding sheets for frequent monitoring and rounding sheets to be reviewed on a daily basis. The facility completed a Performance Improvement Project (PIP) and discussed the incident in	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ivy at Davenport	**800 East Rusholme Street , Davenport, Iowa, 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
F0689 SS = SQC-J	Continued from page 7 a Quality Assurance and Performance Improvement (QAPI) meeting with the Medical Director on 12/9/25. The scope was lowered from “J” to “G” at the time of the survey. The facility reported a census of 66 residents. Findings include: Resident #1's Minimum Data Set (MDS) assessment, dated 10/8/25, identified a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment. Resident #1 had inattention, and disorganized thinking came and went, or fluctuated in severity. The MDS included diagnoses of non-Alzheimer’s dementia, chronic obstructive pulmonary disease (COPD), asthma, and cognitive communication deficit. The MDS identified Resident #1 could transfer and ambulate more than 150 feet independently without the use of an assistive device. The Care Plan Focus, initiated 7/3/25, indicated Resident #1 had a high risk for an elopement due to wandering. The goal reflected Resident #1 would not leave the facility unattended. The Interventions dated 7/3/25 instructed the following: Assess Resident #1 for fall risk. Identify the pattern of wandering: Is wandering purposeful, aimless, or escapist? Is the resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate. Monitor for fatigue and weight loss. The Care Plan Focus, initiated 7/2/25, listed Resident #1 had a risk for falls related to wandering behavior. An intervention, initiated 10/20/25, instructed staff to be aware of their location and for signs of fatigue, increasing fall risk. Resident #1's Progress Notes from 7/2/25 and 12/8/25, reflected their attempted elopements. The entries included, in part: On 7/2/25 at 6:00 PM, as a visitor came in the front door, Resident #1 headed for the front door with her coat on and witnessed walking out the door. Resident #1 would not stop walking and stated she was going to a man’s house. The note documented that redirection was ineffective, the nurse notified administration, the police, and emergency services. Resident #1 agreed to go back into the facility and staff members walked with her back to the facility. On 7/7/25 at 4:22 PM, Resident #1 attempted to leave the facility by trying to open exit doors. The note informed staff needed to de-escalate and redirect the resident. On 7/17/25 at 6:01 PM, a nurse witnessed Resident #1 push open the front door and walk out. The nurse remained with Resident #1 and attempted to redirect her. Resident #1 stated she didn't live at the facility and would not tell the nurse where she was going. The nurse noted Resident #1 rapidly walk through neighborhoods and across a busy street. She became	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ivy at Davenport	**800 East Rusholme Street , Davenport, Iowa, 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
F0689 SS = SQC-J	Continued from page 8 angry when addressed by the nurse. The staff notified the Administrative Staff of the situation, police, and emergency services. The facility got Resident #1 into the ambulance and transported her to the hospital. At 8:25 PM Resident #1 found stable and returned to the facility from the hospital. On 7/20/25 at 3:26 PM, someone witnessed Resident #1 telling another resident, she'd see them tomorrow, as she walked towards the front door with a bag and drink cup in hand. Resident #1 had a pattern of waiting until a visitor left and opened the door. A Nurse and Certified Nurse Aide (CNA) blocked the door as Resident #1 became combative and hit the nurse. Resident #1 stated you better get out of my way right now and tried to push past the staff out the door. Resident #1 turned and walked away, yelling profanities. The nurse documented they advised the nursing staff to monitor Resident #1 for attempts to exit the facility. On 10/10/25 at 1:23 AM, someone observed Resident #1 wandering with episodes of restlessness and approaching the exit doors. Resident #1 had moderate exit seeking behavior. Resident #1's Admission Record, dated 12/10/25, revealed she resided in room B8-2. The Daily Nursing Schedule dated 12/8/25, listed Staff A, CNA, as responsible for the residents on the B hallway from 2:00 PM until 10:00 PM. The schedule reflected Staff B, CNA, as responsible for the residents on B hallway from 10:00 PM on 12/8/25 until 6:00 AM on 12/9/25. Review of the facility provided Video evidence revealed the following timestamped camera observations: On 12/8/25 at 9:21 PM, Resident #1 walked out of a room and down the B hallway towards the dining room.On 12/8/25 at 9:24 PM, Resident #1 walked up the C hallway (connects the back of the facility to the front of the facility) towards the front door. One staff member observed walking out of a room on the C hallway, pushing a linen cart and going in the opposite direction of Resident #1. Resident #1 observed wearing a blue/purple colored jacket, legging-type pants, white socks, shoes, no gloves, no hat, hair up in a ponytail, and holding a black purse in her left hand. On 12/8/25 at 9:24:57 PM, Resident #1 walked to the front door, then touched the keypad on the wall, next to the front door. On 12/8/25 at 9:25:38 PM, Staff A walked to the front door. Staff A entered a code into the keypad and Resident #1 pushed open the front door. Staff A followed directly behind Resident #1 out the front door. On 12/8/25 at 9:25:55 PM, a staff member walked to the front door, looked out the window next to the front door, and at 9:26:55 PM, they walked away from the front door. On 12/8/25 at 9:27:38 PM, Staff A observed walking back into the facility through the front door. The video didn't include Resident #1 returning to the facility. On 12/8/25 at 9:28:06 PM, Staff A observed walking alone down C hallway towards	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ivy at Davenport	**800 East Rusholme Street , Davenport, Iowa, 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
F0689 SS = SQC-J	Continued from page 9 the back of the facility.On 12/8/25 at 9:29:29 PM, Staff A observed walking down B hallway, past Resident #1's room. Review of nursing progress notes, dated 12/9/25, documented the following entries:On 12/9/25 at 5:30 AM: the facility received a phone call that morning of Resident #1 not in the building. Educated staff to call code silver and check the entire building, then proceed outside if Resident #1 is still not found. The staff notified the Director of Nursing (DON) notified immediately and Administrator. On 12/9/25 at 6:23 AM: The nurse completed a head-to-toe assessment Resident #1 following the incident. Resident #1's vitals assessed in normal range, except for pulse oximeter level of 89% on room air (RA) ("normal" oxygen level are 90% and above), pulse 68, blood pressure 120/76, 18 respirations, temperature 97.1 temporal (forehead scan). Resident #1's lung sounded abnormal with audible wheezing (loud high-pitched noise made when breathing). The nurse would request orders from provider for STAT (immediate) chest x-ray and albuterol nebulizer treatments as needed. When inquired if Resident #1 would like to go to the hospital, she declined and explained she was just tired now and didn't want to go now. The provider would be in facility at approximately 8:30 AM - 9:00 AM and would evaluate her at that time. The nurse completed Resident #1's skin assessment as normal, noting no discoloration at the time to her feet, toes, hands, fingers, lips, ears, or nose. She had a good capillary refill (measure of hydration status by pinching the skin looking at how quickly the skin returns to before it got pinched, the quicker the better). The nurse planned to monitor her as the day progressed. Resident #1 reported her feet didn't hurt and showed good sensation as well. Resident #1 reported no pain anywhere. The nurse provided a nebulizer treatment and portable x-ray company contacted for STAT chest x-ray 2 views. No other concerns at that time. On 12/9/25 at 11:45 AM: the nurse notified the hospital they sent Resident #1 over for possible PE (Pulmonary Embolism). Resident #1's x-ray returned with right lower lobe infiltrates (abnormal material in the lung) and diminished (hard to hear) lung sounds. The Emergency Room (ER) staff knew Resident #1 as a long-term resident at the facility and would need discharged back to the facility. On 12/10/25 at 3:50 AM: Resident #1 returned to the facility via ambulance following treatment for sarcoidosis (a buildup of cells in the body, noted in the lungs for Resident #1 that can affect breathing). Resident #1 had a follow-up appointment with pulmonology (physician who specializes in the lungs) in one week. In addition, Resident #1 had a follow-up appointment with her provider in 1 to 2 days. Review of an Incident Report, dated 12/9/25, completed by the Director of Nursing	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ivy at Davenport	**800 East Rusholme Street , Davenport, Iowa, 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
F0689 SS = SQC-J	Continued from page 10 (DON), indicated on 12/9/25 at 5:30 AM, the staff called the DON to report Resident #1 not in the building. The Incident Report documented the immediate action taken included the DON educating the nurse to call a “code silver” (elopement protocol) and search the entire building. Then search for Resident #1 outside the building. The Incident Report indicated at approximately 6:10 AM the facility called reporting they found Resident #1. Upon return to the facility, the nurse conducted a head-to-toe assessment Resident #1 with no apparent injuries. The Incident Report listed Resident #1’s oxygen saturation as 89%, temperature 96.9 degrees Fahrenheit (normal range 97.5 F- 99.5 F), Resident #1 had audible wheezing, and diminished lung sounds. The facility received an order from the provider to obtain a chest x-ray. Results of the chest x-ray showed infiltrates to the right (lung) lower lobe and the provider advised the facility to send Resident #1 to the hospital for possible pulmonary embolism (PE). The Incident Report noted upon return to the facility from the hospital, Resident #1 had no new orders, except to follow up with a Pulmonologist in one week. Review of the Emergency Department (ED) notes, dated 12/9/25, revealed Resident #1 presented for an abnormal x-ray. The hospital performed a Computed Tomography (CT) scan which showed an occlusion (blockage) of the left (lung) lower lobe segmental pulmonary artery (a blood vessel used to send blood to specific areas of the lungs) and left hilar adenopathy (swelling of lymph nodes located in the lungs where the bronchi and vessels enter/exit) related to Resident #1’s history of sarcoidosis. The ED notes reflected the hospital cleared Resident #1 to discharge back to the facility on 12/9/25 and follow-up as an outpatient with her Pulmonologist. Review of a Global Positioning System (GPS), online mapping, revealed the location staff found Resident #1 as approximately 1.7 miles, or about a 38-minute walk from the facility. The GPS street view, for the location the staff reported they found Resident #1 noted to have one busy road with 2 lanes of traffic in each direction, perpendicular (two lines that meet) to a residential street. Review of a Climatology report, dated from 12/8/25 at 9:25 PM and 12/9/25 at 5:24 AM, indicated the temperatures ranged from 22 degrees Fahrenheit (F) to 28 degrees F with wind speeds reported between 7 miles per hour (mph) and 17 mph. The wind chill values ranged between 8 degrees F and 17 degrees F. Review of an Online Police Department Incident Report, dated 12/9/25 at 12:28 PM, revealed that the facility administrator reported they couldn't locate a resident in the building. The facility administrator received notification at 5:35 AM. They found Resident #1 at 6:09 AM by a facility employee. During an interview on 12/16/25 at 9:15 AM,	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ivy at Davenport	**800 East Rusholme Street , Davenport, Iowa, 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
F0689 SS = SQC-J	Continued from page 11 Staff A, stated that she worked as a CNA for about 10 years and worked at the facility for approximately 2 weeks. Staff A reported not being familiar with the residents but worked on the B hallway before. She worked independently on B hallway 12/8/25 from 2:00 PM to 10:00 PM. Staff A stated she saw Resident #1 in the facility but didn't know she was a resident. Staff A reported on 12/8/25 around 9:25 PM, as she went outside to her car, she saw Resident #1 at the front door trying to enter the code. Staff A entered the code and let her out. Staff A reported that Resident #1 said she was going to visit her daughter and then started walking. Staff A stated that she didn't know who she was and didn't know she let out a resident. When queried about how Staff A found out which residents she was responsible for, Staff A reported she would learn the resident's faces. Staff A denied asking other staff about Resident #1 when she wasn't sure. She denied telling anyone about letting someone out of the front door when unsure who it was. Staff A denied having new hire training or education on residents with a risk for elopement. During an interview on 12/16/25 at 10:05 AM, Staff B reported they worked at the facility for almost 2 years, confirmed working the overnight shift from 10:00 PM on 12/8/25 until 6:00 AM on 12/9/25 on the B hallway. Staff B reported she didn't receive any report or communication from the previous shift when she took over the B hallway at 10:00 PM. Staff B stated during her first set of rounds, which included checking on residents and providing cares as needed, she saw Resident #1's bathroom door was shut with the bathroom light on. Staff B stated she assumed Resident #1 was in the bathroom at that time, because Resident #1 was able to take herself to the bathroom without staff assistance. Staff B recalled that at approximately 5:25 AM Resident #1's roommate called for assistance and Staff B identified that Resident #1 wasn't in her bed or the bathroom. When they asked the roommate if she saw Resident #1, the roommate told Staff B she hadn't seen Resident #1 all night. Staff B informed that she immediately notified the charge nurse about Resident #1 not being in her room and the staff began to search for Resident #1 throughout the facility and followed the search outside of the facility. During an interview on 12/15/25 at 1:00 PM, Staff C, CNA, worked at the facility since Sept. 2025. She confirmed she worked 12/9/25 at 6:00 AM and stated that during her drive to work she saw a woman walking on the sidewalk who appeared to be Resident #1. Staff C reported she called the facility and asked if Resident #1 was in her bed. The staff told Staff C about Resident #1 missing from the facility, so she drove around the block, parked on a busy road, put the car's hazard lights on, and approached Resident #1. Staff C stated she asked	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ivy at Davenport	**800 East Rusholme Street , Davenport, Iowa, 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
F0689 SS = SQC-J	Continued from page 12 Resident #1 how long she walked and Resident #1 responded that she did not know. Staff C asked Resident #1 to get in her car, Resident #1 agreed and Staff C assisted her to step over a snowbank and sit in Staff C's car. Staff C recalled when she found Resident #1 the morning of 12/9/25, it was still dark outside with snow on the ground and an average amount of traffic on the street she walked next to. Staff C reported Resident #1 had on a jacket, didn't wear a hat or gloves, and had been shivering. Staff C reported when she helped Resident #1 over the snowbank, by holding her hands, Staff C noticed that the resident's hands were freezing cold. Staff C reported that when she assisted Resident #1 back into the facility from her car, Resident #1 could barely walk. Staff C said that Resident #1 had on mesh sneakers with a Velcro strap over top and stated Resident #1's socks were wet and freezing cold. The staff removed the socks and shoes right away. Staff C reported that Resident #1 recognized some peers and staff faces but was not oriented to time of day or surroundings and had been known to wander in the facility. During an interview on 12/15/25 at 11:45 AM, Staff D, Licensed Practical Nurse (LPN), confirmed she worked as Resident #1's nurse on the morning of 12/9/25. Staff D reported they completed a skin assessment on Resident #1 when she returned to the facility without discoloration or injury noted. Staff D stated they noted Resident #1's oxygen saturation level as low, between 84-89% on room air and a low body temperature, when they took her vitals. Staff D reported Resident #1 had a lot of expiratory wheezing and nasal drainage. Staff D stated she asked the DON about sending Resident #1 to the hospital when she returned to the facility but, the DON told her they would get a chest x-ray and start nebulizer treatments instead. Staff D recalled they obtained a chest x-ray at approximately 10:00 AM and the provider visited the facility at about 10:30 AM to assess Resident #1. Staff D reported due to the results from the chest x-ray the provider ordered to have Resident #1 seen in the ED. During an interview on 12/16/25 at 1:30 PM, the DON, explained they expected the staff to check the elopement book for residents at risk of elopement before letting any resident outside. In addition, they expected the staff to ask when they didn't know if someone was a resident or visitor. The DON stated Staff A worked at the facility for approximately 2 weeks, had worked on B hallway 3 or 4 times prior to 12/8/25 shift, and should have known that Resident #1 was not a visitor. The DON denied personally checking with Staff A to see how she performed as a new hire. Review of the facility policy, titled Elopements and Wandering Residents, revised 7/1/25, listed the policy purpose statement as to ensure residents who exhibit wandering	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ivy at Davenport	**800 East Rusholme Street , Davenport, Iowa, 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
F0689 SS = SQC-J	Continued from page 13 behavior and/or are at risk for elopement received adequate supervision to prevent accidents. In addition, they received care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Section A.: Policy Explanation and Compliance Guidelines directed the following: The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary.Monitoring and Managing Residents at Risk for Elopement or Unsafe WanderingResidents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team.The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan.Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff.Adequate supervision will be provided to help prevent accidents or elopements.Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly.The effectiveness of interventions will be evaluated, and changes will be made as needed. Any changes or new interventions will be communicated to relevant staff.Review of the facility policy, titled Walking Rounds Shift Report, implemented 12/9/25, defined the policy purpose statement as to use walking round shift reporting to promote successful transfer of information between nursing staff at shift change in an effort to prevent adverse events, medication errors, and medical mishaps. Section A. Policy Explanation and Compliance Guidelines directed the following:Walking rounds shift report will be used for a 24-hour period to ensure continuity of care. The night shift nurse will enter the necessary information on the shift report for the following day. The walking rounds shift report may only be altered by the DON if there are changes that need to be made. All staff will be in-serviced on the use of walking rounds shift report prior to implementation as well as upon hire and as needed.	F0689		