

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165436	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2025
NAME OF PROVIDER OR SUPPLIER Ivy at Davenport		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, Food and Drug Administration Drug Labeling resource, resident responsible party and staff interviews, the facility failed to ensure prescribed psychotropic's where adequately clinically indicated and necessary to treat a specific condition for 4 of 4 residents (Resident #1, Resident #4, Resident #5, and Resident #6). The facility failed to coordinate services between the psychiatric provider and primary care provider to prevent the potential of administering unnecessary medications for 1 of 4 residents (Resident #1) in the sample. The facility reported a census of 64 residents.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS) Assessment tool dated 4/20/25 revealed a list of diagnoses for Resident #1 which included cerebrovascular accident (a stroke), anxiety, and depression. A Brief Interview for Mental Status (BIMS) score of 11 out of 15 indicated moderately impaired cognition. The Behavior section indicated no hallucinations, delusions, or physical or verbal behavioral symptoms towards others in the last 7 days. The MDS documented Resident #1 utilized a feeding tube since 8/5/24. The MDS indicated Resident #1 admitted to the facility on [DATE].</p> <p>Review of the electronic health record (EHR) Medical Diagnosis list dated 6/2/25, indicated the following diagnoses related to mental health:</p> <p>a. Anxiety disorder, unspecified. Date: 11/27/24. Classification: Acquired during stay.</p> <p>b. Depression, unspecified. Date: 7/5/24. Classification: admission [prior].</p> <p>Review of the Care Plan, Date Initiated: 10/13/24 revealed a Focus area to address The resident uses ANTI-ANXIETY medication r/t anxiety. Interventions included, in part:</p> <p>a. Administer ANTI-ANXIETY medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT. Date Initiated: 10/13/24.</p> <p>Review of the electronic health record (EHR) revealed a Telemed Psych Note encounter entered on 10/14/24 at 3:05 PM by [name redacted, Staff D, Psychiatric Advanced Nurse Practitioner]. The note indicated:</p> <p>a. Chief Complaint: Psychiatric evaluation and psychotropic medication management.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. History of Present Illness: [Name redacted] .seen for psychiatric evaluation and medication management. She has a psychiatric history of depression. Staff reports she was admitted at the hospital but returned to the facility confused. It is difficult to have a conversation with her sometimes, during today's assessment she kept saying No', she is seen in bed she said she is angry and wants to go home .she doesn't sleep at night, occasional agitation needed.</p> <p>c. Psychiatric OBSERVATION: MOOD: IRRITABLE .HALLUCINATION: NONE SUICIDALITY: NONE DELUSION: NONE BEHAVIOR: AGITATED .</p> <p>d. Psych/GDR (gradual dose reduction) Visit NP/PA/MD (nurse practitioner/physician assistant/medical doctor)</p> <p>1. Major depressive disorder, single episode, moderate, Generalized anxiety disorder. Current Medication: Increase Trazodone (antidepressant) to 50 mg (milligrams) daily via tube feed; Start Hydroxyzine HCL (antihistamine used for antianxiety effect) 25 mg daily via tube feed; Alprazolam (antianxiety) 0.5 mg every 12 hr (hour) as needed for anxiety; Paroxetine (antidepressant) 20 mg by mouth daily for depression; Hydroxyzine HCL 25 mg every 6 hours as needed for anxiety.</p> <p>2. Continue supportive non-pharmacological interventions: Assess for pain during periods of agitation; Reorient as needed; Gentle redirection as needed; Maintain daily routine as much as possible; Communicate simply about aspects of care/ activities/changes; Keep familiar or favorite objects/pictures around; Behavior monitoring and documentation; Notify writer if there are any concerns related to changes in mood or behavior.</p> <p>Review of the EHR revealed the following Physician Orders from the primary care provider:</p> <p>a. Seroquel (antipsychotic) Oral Tablet 25 mg .Give 25 mg orally three times a day for anxiety/behaviors related to UNSPECIFIED SEQUELAE OF CEREBRAL INFARCTION; ANXIETY DISORDER, UNSPECIFIED. Start Date: 12/21/24.</p> <p>b. Haloperidol Lactate (antipsychotic) Injection Solution 5 MG/ML (milligrams/milliliter) 5 mg IM (intramuscular injection) Q8 hours PRN (every 8 hours as needed) - AGITATION/ANXIETY/RESTLESSNESS. Start Date: 12/30/24 with D/C (discontinue) 2/17/25. Start Date: 2/26/25 with D/C: 4/7/25. Start Date: 4/8/25 with D/C: 4/9/25. Start Date: 4/16/25 with D/C: 4/17/25. Start Date: 4/17/25 with D/C: 5/1/25.</p> <p>c. Bupropion (antidepressant, brand name Wellbutrin) Extended Release (ER) (antidepressant) 150 mg administered oral daily. Start Date: 2/27/25 with D/C 4/17/25.</p> <p>Review of the Care Plan, Date Initiated: 12/22/24 revealed Focus area to address The resident uses PSYCHOTROPIC medications r/t (related to) anxiety. Interventions included, in part:</p> <p>a. Administer PSYCHOTROPIC medications as ordered by physician. Monitor for side effective and effectiveness Q-SHIFT (every shift). Date Initiated: 12/22/24.</p> <p>(continued on next page)</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. Monitor/record occurrence of for target behavior symptoms pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others, etc and document per facility protocol. Date Initiated: 12/22/24.</p> <p>Review of the Telemed Psych Note encounter notes entered on 1/27/25, 3/24/25, and 3/31/25 entered by Staff D, Psychiatric Advanced Practice Nurse revealed:</p> <p>a. Chief Complaints for each encounter: Follow up</p> <p>b. History of Present Illness: [per encounter]</p> <p>1. Today, 1/27/25, she is seen for follow up visit. She is in bed. States she is doing ok. States she gets a bit depressed because she is in here. Reports her dad died and she fell 2 days ago. Mood and appetite are stable. Will continue to monitor.</p> <p>2. Today, 3/24/2025, she is seen for follow up visit. She is seen in her bed. States it is not a good day for her because she has gas and it is bothering her. Staff is aware. Mood and appetite are stable. will continue to monitor.</p> <p>3. Today, 3/31/25, she is seen for follow up visit. She is in bed. States she is doing ok. States she gets a bit depressed because she is in here. Reports her dad died and she fell 2 days ago. Mood and appetite are stable. Will continue to monitor.</p> <p>c. Psychiatric OBSERVATION for each encounter, in part: MOOD: IRRITABLE; HALLUCINATION: NONE; SUICIDALITY: NONE; DELUSION: NONE; and BEHAVIOR: AGITATED.</p> <p>d. Psych/GDR (gradual dose reduction) Visit NP/PA/MD (nurse practitioner/physician assistant/medical doctor) for each encounter:</p> <p>1. Major depressive disorder, single episode, moderate, Generalized anxiety disorder Current medication. Trazodone to 50mg daily via tube feed. Hydroxyzine HCL 25mg daily via tube feed. Alprazolam 0.5mg every 12c hours as needed for anxiety. Paroxetine 20mg by mouth daily for depression. Hydroxyzine HCL 25mg every 6 hours as needed</p> <p>for anxiety. The note for the encounter on 3/31/25 included Discontinue Wellbutrin 150 mg by mouth daily.</p> <p>2. Continue supportive non-pharmacological interventions: Assess for pain during periods of agitation; Reorient as needed; Gentle redirection as needed; Maintain daily routine as much as possible; Communicate simply about aspects of care/ activities/changes;Keep familiar or favorite objects/pictures around; Behavior monitoring and</p> <p>documentation. Notify writer if there are any concerns related to changes in mood or behavior.</p> <p>e. Additional Notes for each encounter included, in part: Patient was seen for a telemedicine visit. Patient seen and in stable condition. Education provided to nursing. Nursing concerns addressed. Anxiety addressed. GDR addressed.</p> <p>(continued on next page)</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Telemed Psych Notes encounter entries on 1/27/25, 3/24/25 and 3/31/25 lacked documentation of the primary care physician orders for Seroquel and Haloperidol 5 mg IM Q8 hours PRN</p> <p>Review of the Drugs@FDA (Food and Drug Administration) - Approved Drugs site (https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm) revealed the following indicated uses:</p> <p>a. Seroquel 25 mg: Labeling-Packet insert 1/22/25: Indications and Usage: Schizophrenia, Bipolar I disorder manic episodes, and Bipolar disorder, depressive episodes</p> <p>b. Haloperidol IM 5 mg/ml: Labeling-Packet insert 11/17/20: Indications and Usage: Schizophrenia.</p> <p>During an interview on 6/5/25 at 11:02 AM, Staff A, Licensed Practical Nurse (LPN), stated Resident #1 had frequent symptoms of anxiety that included restlessness and calling out, sometimes relieved by staff reassurance or 1 to 1 activity. Staff A stated sometimes it didn't matter what was attempted, the resident remained extremely anxious. Staff A stated she had administered the haloperidol injection, and notified the facility physician when the resident had increased anxiety. Staff A stated she had not notified the Psychiatric Nurse Practitioner as she had not worked when the resident had telemed psych appointments.</p> <p>During an interview 6/5/25 at 4:10 PM, Staff C, LPN, stated she administered Haldol to the resident when she had increased anxiety and restlessness, would try to calm the resident by talking to her, administered analgesics and Alprazolam when needed, repositioned the resident and offered snacks/beverages, but sometimes it didn't matter what was attempted, the resident would remain anxious, would call out for help, but when she was asked what she needed the resident couldn't say what she needed. The resident would ask for the Haldol, and Staff C stated sometimes when she administered the medication it didn't seem like it had any effect on the resident as she remained anxious. Staff C stated she had not notified the Psychiatric Nurse Practitioner of the resident's increased anxiety or use of Haldol, and communicated with the primary care physician when needed for the resident.</p> <p>During an interview 6/4/25 at 10:49 AM, Staff F, the Interim Director of Nursing (DON) and Corporate Nurse stated she could not locate documentation that staff communicated with Staff D about the resident's anxiety or administration of Haldol. The DON explained Staff D was no longer a provider with the contracted company, and could not contact her. The DON provided contact information for the current Psychiatric Nurse Practitioner. Staff E. The DON was not aware that staff had administered Haldol and agreed the matter should have been addressed with the Psychiatric Nurse Practitioner. The DON stated staff should have communicated the resident's symptoms with the Psychiatric Nurse Practitioner and in the process of providing that education to the nursing staff. The DON stated she had recently assumed her position, after the resident's physician prescribed Seroquel and Haldol, and would also address the matter with the physician, their Medical Director.</p> <p>During an interview 6/4/25 at 4:40 PM, Staff E, Psychiatric Advanced Practice Nurse Practitioner stated she had not received any communication from the facility staff about the resident having increased anxiety or the need to administer Haldol IM. Staff E stated if the resident had increased or unmanageable anxiety, they should communicate that with her so she could provide appropriate services and direction to staff. Staff E stated it is not appropriate to use Haldol for resident as it is to be used when there is extreme agitation/aggression with the risk of harm to the resident or others, an emergent situation, and not indicated for anxiety with restlessness.</p> <p>(continued on next page)</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/2/25 at 5:48 PM, the resident's responsible party/Power of Attorney (POA) stated the resident had anxiety and needed frequent reassurance. The POA stated the resident received too many medications and questioned if the medications were actually making the resident more anxious for the resident.</p> <p>2. The MDS Assessment tool dated 4/14/25 revealed a list of diagnoses for Resident #4 which included acute respiratory failure with hypoxia, anoxic brain damage, anxiety and depression. A BIMS score of 5 out of 15 points indicated severely impaired cognition. The Behavior section indicated no hallucinations, delusions, or physical or verbal behavioral symptoms towards others in the last 7 days. The MDS indicated an admission date of 10/16/24, with a readmission date of 12/18/24.</p> <p>Review of the EHR Medical Diagnosis list, date 6/5/25 revealed the following diagnoses:</p> <ul style="list-style-type: none"> a. Delirium due to unknown physiological condition. Date: 12/18/24. Classification: Admission b. Depression, unspecified. Date: 12/18/24. Classification: Admission. c. Anxiety disorder, unspecified. Date: 12/13/24. Classification: Acquired during stay. <p>Review of the Care Plan, Date Initiated: 12/8/24 revealed a Focus area to address The resident uses PSYCHOTROPIC medications r/t anxiety, hallucinations. Interventions included, in part:</p> <ul style="list-style-type: none"> a. Administer PSYCHOTROPIC medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT. Date Initiated: 12/8/24. b. Discuss with MD, family re ongoing need for use of medication. Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy. Date Initiated: 12/8/24. c. Monitor/record occurrence of for target behavior symptoms (pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others, etc) and document per facility protocol. Date Initiated: 12/08/24. <p>Review of the Care Plan, Date Initiated: 4/15/25 revealed a Focus area to address The resident uses ANTIDEPRESSANT medication r/t (related to) depression. Interventions included, in part:</p> <ul style="list-style-type: none"> a. Administer Antidepressant medications as ordered by physician. Monitor/document side effects and effectiveness Q-SHIFT. Date Initiated: 4/15/25. <p>Review of the Care Plan. Date Initiated: 12/23/24 revealed a Focus area to address The resident has a behavior problem r/t episodes of calling out, verbal and physical aggression towards staff, pulling at g tube (tube that goes into the abdomen to meet hydration and nutrition needs when unable to safely eat and or drink by mouth), has episodes of yelling, spitting, awake all night. Interventions included:</p> <ul style="list-style-type: none"> a. Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 12/23/24. <p>(continued on next page)</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. Anticipate and meet the residents needs</p> <p>c. Explain all procedures to the resident before starting and allow the resident to adjust to changes</p> <p>d. If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and /or under unacceptable to the resident</p> <p>e. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed</p> <p>f. Monitoring of behavior episodes and attempt to determine underlying causes. Consider location, time of day, persons involved, and situations. Document behavior and potential causes.</p> <p>Review of Physician Orders revealed the following orders:</p> <p>a. ALPRAZolam Oral Tablet 0.5 MG .Give 1 tablet by mouth at bedtime related to ANXIETY DISORDER, UNSPECIFIED. Start Date: 12/18/24.</p> <p>b. ALPRAZolam Oral Tablet 0.5 MG .Give 1 tablet by mouth as needed for anxiety related to o ANXIETY DISORDER, UNSPECIFIED. Start Date: 12/18/24.</p> <p>c. OLANZapine (brand name Zeprexa, an atypical antipsychotic) Oral Tablet 5 MG .Give 2 tablets by mouth two times a day for agitation. Start Date: 12/19/24. End Date: 4/7/25.</p> <p>d. SEROquel Oral Tablet 25 mg .Give 1 tablet by mouth three times a day for agitation/anoxic brain injury related to DEPRESSION, UNSPECIFIED. Start Date: 1/29/25.</p> <p>Review of EHR revealed a Physician Progress Note entered on 1/29/25 at 1:33 PM .Reason for Visit: staff reports he is having increased behaviors, he is hitting, and yelling profanity at staff. Subjective: resting in chair, Smiling. He is pleasant, no complaints today. Denies having behaviors .Assessment and Plan; discussed with staff that I do not feel comfortable with prescribing medication for his behaviors due to his history of anoxic brain injury. I recommended that they notify [provider name redacted] for further guidance.</p> <p>An Order Note entered on 1/29/25 at 2;15 PM revealed Note Text: The order you have entered Seroquel Oral Tablet 25 MG .Give 1 tablet by mouth three times a day for agitation/anoxic brain injury .</p> <p>Review of the Drugs@FDA (Food and Drug Administration) - Approved Drugs site (https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm) revealed the following indicated uses:</p> <p>a. Olanzapine 5 mg: Labeling-Packet insert 1/22/25: Indications and Usage: Schizophrenia, Acute Treatment of manic or mixed episodes associated with bipolar I disorder and maintenance treatment of bipolar I disorder, Medication therapy for pediatric patients .Adjunct to valproate or lithium in the treatment of manic or mixed episodes associated with bipolar I disorder</p> <p>b. Seroquel 25 mg: Labeling-Packet insert 1/22/25: Indications and Usage: Schizophrenia, Bipolar I disorder manic episodes, and Bipolar disorder, depressive episodes</p> <p>(continued on next page)</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Progress Notes revealed a lack of documentation regarding:</p> <p>a. The Care Plan Intervention to Discuss with MD, family re ongoing need for use of medication. Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy.</p> <p>b. Monitoring of behavior episodes and attempt to determine underlying causes. Consider location, time of day, persons involved, and situations. Document behavior and potential causes.</p> <p>3. The Minimum Data Set (MDS) Assessment tool dated 5/14/25 revealed a list of diagnoses for Resident #5 which included cerebrovascular accident (a stroke), and hemiplegia (paralysis on one side of the body). The BIMS score of 3 out of 15 indicated severely impaired cognition. The Behavior Assessment section indicated no hallucinations, delusions, or physical or verbal behavioral symptoms towards others in the last 7 days. The MDS indicated Resident #1 admitted to the facility on [DATE], with a readmission date of 5/7/25.</p> <p>Review of the EHR Medical Diagnosis list, date 6/5/25 revealed a lack of a mental health diagnosis upon admission on [DATE] or after admission.</p> <p>Review of Physician Orders revealed an order for Seroquel 25 mg .Give 25 mg via G-tube three times a day for anxiety. Start Date: 5/14/25.</p> <p>Review of the Care Plan, Date Initiated: 5/15/25 revealed a Focus area to address The resident uses PSYCHOTROPIC medication r/t anxiety. Interventions included, in part:</p> <p>a. Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness every shift. Date Initiated: 5/15/25.</p> <p>b. Discuss with MD, family re ongoing need for use of medication. Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy Date Initiated: 5/15/25.</p> <p>c. Monitor/record occurrence of for target behavior symptoms (pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others. etc.) and document per facility protocol. Date Initiated: 5/15/25.</p> <p>Review of the Drugs@FDA (Food and Drug Administration) - Approved Drugs site (https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm) revealed the following indicated uses:</p> <p>a. Seroquel 25 mg: Labeling-Packet insert 1/22/25: Indications and Usage: Schizophrenia, Bipolar I disorder manic episodes, and Bipolar disorder, depressive episodes</p> <p>4. The MDS Assessment tool dated 4/24/25 revealed Resident #6 list of diagnoses included paraplegia (paralysis of the lower part of the body), anxiety and depression. A BIMS score of 15 out of 15 indicated intact cognition. The Behavior section indicated no hallucinations, delusions, or physical or verbal behavioral symptoms towards others in the last 7 days. The MDS indicated an admission date of 4/17/25.</p> <p>(continued on next page)</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the EHR Medical Diagnosis List, dated 6/5/25 revealed:</p> <p>a. Insomnia, Unspecified. Date: 4/17/25. Classification: Admission.</p> <p>Review of the Care Plan, Date Initiated: 4/18/25 revealed a Focus are to address The resident uses PSYCHOTROPIC medications r/t insomnia. Interventions included, in part:</p> <p>a. Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness every shift. Date Initiated: 4/18/25.</p> <p>b. Monitor/record occurrence of for target behavior symptoms (pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others. etc.) and document per facility protocol. Date Initiated: 4/18/25.</p> <p>Review of Physician Orders revealed an order for Quetiapine (generic Seroquel) 50 mg .Give 1 tablet by mouth every 24 hours as needed for insomnia once nightly.</p> <p>Review of the Drugs@FDA (Food and Drug Administration) - Approved Drugs site (https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm) revealed the following indicated uses:</p> <p>a. Seroquel 50 mg: Labeling-Packet insert 1/22/25: Indications and Usage: Schizophrenia, Bipolar I disorder manic episodes, and Bipolar disorder, depressive episodes</p> <p>During an interview on 6/5/25 at 4:50 PM, Staff F, DON, agreed that insomnia was not an appropriate indication for Seroquel. The DON stated she has been compiling a list of all residents who are prescribed psychotropic medications to ensure the appropriateness of the medication and planned to seek physician orders as indicated.</p>