DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0453	A. BUILDING: _____ B. WING _____	C 02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUMMIT OF BETTENDORF MC	4699 53RD AVE BETTENDORF, IA 52722

(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) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 2 Number of tenants with cognitive impairment: 13 Total census: 15 No regulatory insufficiencies were cited during the investigation of Incident #109130-I, Complaint #110110-C, Complaint #108135-C or Complaint 110650-C. The following regulatory insufficiencies were cited during the investigation of Complaint #109302-C and Complaint #110644-C.	A 000		
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews the Program failed to follow 3 out of 5 policies and procedures reviewed regarding medication administration, narcotics reconciliation, and staff accepting gifts. Findings include: 1. On 2/2/23 at 11:14 am during a medication administration observation, Staff B prepared and attempted to administer Tenant # 9's noon medication including one 500 mg tablet of Cephalexin which was to be given 4 times daily	A 150	The Plan of Correction is attached.	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A 150	Continued From page 1	A 150		

by the Program staff. Tenant # 9 refused the antibiotic and stated she had not taken her antibiotic from the morning medication pass either. Tenant #9 produced a medication cup to Staff B which contained two white pills that appeared to be at one time wet and a Cephalexin 500 mg tablet. Tenant # 9 stated she refused to take her antibiotic because it caused her to have hallucinations. Staff B took all of the tablets in the cup and placed them into the locked medication storage cabinet in Tenant # 9's apartment along with the noon dose of medication. Staff B told Tenant #9 she would inform the registered nurse (RN) of the tenant's wishes.

On 2/2/23 the Assisted Living Medication Procedure policy was reviewed. The policy indicated medications were to be initialed as given at the time of the medication management by the same person. Tenant refusals were to be documented as such by staff. The Program's "Medication Manager Certification for Assisted Living - Training Procedure" also revealed all medication managers would receive supervised clinical experience by the RN regarding medication administration.

Review of Tenant # 9's record revealed a physician's order dated 1/27/23 for the administration of Cephalexin 500 mg tablets to be given orally four times daily for 7 days for cellulitis of the foot. The tenant's February medication administration record (MAR) revealed Staff B had signed off as giving Tenant #9 the am doses of her medication including the Cephalexin 500 mg on the morning of 2/2/23. The service plan for Tenant # 9 dated 1/24/23 indicated the following regarding medication administration: "Resident requests staff members manage prescription medication by providing them the correct

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A 150	Continued From page 2	A 150		

medications at the correct time. After providing medications, staff remain with resident while they take their medications."

On 2/2/23 a review of Staff B's RN delegation packet revealed she received training on 11/11/22 regarding appropriate steps in medication supervision which included watching the tenant consume medication unless otherwise indicated in the service plan.

On 2/7/23 at 9:25 am, Staff B stated she had administered the am doses of Tenant # 9's medications and had not fully observed her ingest the pills. On 2/7/23 at 2:30 pm, the Director and RN confirmed Staff B had not followed the Program's written Assisted Living Medication Procedure policy.

2. On 2/6/23 during a review of Program policies, the Assisted Living Medication Procedure policy was reviewed. The policy revealed each WesleyLife Community developed its own procedure for counting and destroying controlled substances. The RN delegation training highlighted the following: "At the beginning of each shift, a resident associate (RA) from the outgoing and incoming shifts will count the narcotics together, verify and sign they agree with the count."

On 2/6/23 during a review of the January narcotic reconciliation records for "Sierra Group 1" (which included the narcotics of 4 tenants) it was noted the following days had gaps in the narcotic counting: January 1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, and 31. The January narcotic reconciliation records for "Sierra Group 2" (which included the narcotics of 4 tenants) had gaps in

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the narcotic counting for January 1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, and 31.

On 2/7/23 at 9:35 am, the RN stated she is aware of the gaps in the narcotic counting record. An inservice/training was just held with staff regarding the topic and the importance of the counting. The RN indicated she believed only med managers could or should conduct the narcotic counting between shifts. The Program's policy indicated RAs were able to also count narcotics. On 2/7/23 at 2:30 pm, the Director and RN confirmed staff had not followed the Program's policy which tied into the RN delegation for narcotics reconciliation.

3. On 2/1/23 at 3:35 pm, Staff C stated Tenant #6's husband visited his wife often. His visits made her (Staff C) feel uncomfortable. Staff C stated he would stare at her and ask other staff if she was working or where she was at. She told administration about her concerns. In November of 2022 she was standing outside in the cold with no coat on and Tenant #6 and her husband saw her when they left the premises to go on an outing. When they returned, Tenant #6's husband presented Staff C with a new Wal-Mart coat that cost approximately $20.00. Staff C accepted the gift but stated she had never accepted money from him.

On 2/6/23 during a review of Program policies, the Program's Gifts and Tips policy was reviewed. The policy revealed the following: "Due to the nature of the services we perform at the Program, you are not permitted to accept gifts or tips from clients, residents, or their families. If a gift or tip is offered to you, you should politely decline. If there is nothing you can do to avoid receiving a gift or

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A 150	Continued From page 4 tip, you should turn the gift over to your leader who may place it into a common fund that can be used for all team members or for future resident/client events." On 2/7/23 at 2:30 pm, the Director and RN confirmed Staff C had not followed the Program's policy on Gifts and Tips.	A 150		

This constitutes our credible allegation of compliance as of 05/04/23

481-67.2(3) Program Policies and Procedures
The program shall follow the policies and procedures established by the program.

Corrective active taken for each regulatory insufficiency:
RAs who failed to ensure all narcotics are counted per policy, and that medications are administered according to each individual's service plan received re-education and corrective action on 2/6/23 and 2/9/23.

The RA identified to have accepted a gift from a family member was immediately counseled on 2/1/2023 the policy which prevents this action, and the gift returned to the family member. This team member no longer works here.

Measure/system prevents re-occurrence:
To ensure the problem does not recur,
ALRN or Designee will monitor narcotic shift-count documentation to ensure that narcotics are counted as program policy indicates. Responsible RAs will be re-educated by 4/30/2023 on appropriate medication procedures and acceptance of gifts.

Monitor for permanent solutions:
As part of The Summits ongoing commitment to quality assurance, the ALRN/Designee will conduct audits 3x/week for 2 weeks. Then weekly for 3 weeks and prn after that. Results of the audits will be reviewed as part of our on-going quality assurance process and the frequency of the audits thereafter will be based on outcomes of the audits and subsequent recommendations.

Date of Compliance: May 4, 2023

✓ 4/17/23