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
	S0454	A. BUILDING: _____ B. WING _____	C 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUMMIT OF BETTENDORF	4699 53RD AVENUE 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 are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 15 Number of tenants with cognitive impairment: 3 Total census: 18 The following regulatory insufficiencies were cited during the investigation of Complaint #123511-C and the recertification visit conducted to determine compliance with certification of an Assisted Living Program.	A 000		
A 160	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to provide adequate care and services for 1 of 4 tenants reviewed (Tenant #2). Finding follows: Record review on 9/25/24 revealed Tenant #2's incident reports for falls for 8/03/24, 8/07/24, 8/08/24, 8/12/24, 8/25/24, 9/02/24, 9/03/24 and	A 160	The POC is attached	

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A 160	Continued From page 1 9/07/24. The nursing assessment for 8/12/24 incident report noted, "Staff to monitor and check on more frequently." Documentation of increased checks after 8/12/24 could not be located in Tenant #2's record. Tenant #2's service plan, last updated 8/08/24, made no mention of increased checks. On 9/26/24 at 12:55 p.m. the Senior Clinical Quality Specialist confirmed she could not find any documentation of increased monitoring/checks for Tenant #2 related to the nursing note from the fall on 8/12/24.	A 160		
A 285	481-67.5(2)f(4) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to administer medications as prescribed for 2 of 4 tenants reviewed (Tenant #1 and Tenant #3). Finding follows: 1. Record review and interview from 9/19/24 to 9/30/24 revealed the program failed to provide adequate nursing oversight for ordering, managing and administering Tenant #1's	A 285		

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Pregabalin medication, given for pain control.

Tenant #1's August Medication Administration Record (MAR) indicated she was on Pregabalin (generic Lyrica) 25 mg twice per day prior to 8/21/24, for chronic pain. The medication was increased to three times per day on 8/21/24. According to progress notes, Tenant #1 saw her Primary Care Provider (PCP) on 8/22/24 for ongoing pain concerns. The PCP increased the Pregabalin to a 75 mg capsule three times per day, in addition to increasing other pain medication. The program failed to consistently provide Tenant #1 with the Pregabalin.

A. Tenant #1's August MAR included an entry for Pregabalin 75 mg capsule, three times per day, with a start date of 8/22/24 and discontinued date of 8/23/24. A new order for Pregabalin 25 mg, three capsules, three times per day, started 8/23/24.

Review of Tenant #1's August MAR and August Controlled Drug Record for Pregabalin 25 mg revealed the program failed to administer the medication as prescribed:
- 8/23/24: Staff documented on the MAR they administered the medication as prescribed, three 25 mg tabs of Pregabalin three times per day. However, staff documented on the Controlled Drug Record they removed only one 25 mg capsule for each dose.
- 8/24/24: Staff documented on the MAR they administered the medication as prescribed, but documented on the Controlled Drug Record they removed only one 25 mg capsule for each dose.
- 8/25/24: Staff documented on the MAR they administered the medication as prescribed for the morning and noon doses. The Controlled Drug Record indicated three 25 mg capsules were

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removed for the morning dose, leaving one capsule remaining. The one remaining capsule was given for the noon dose. The afternoon dose was documented on the MAR as not given.
- 8/26/24: No documentation on the MAR indicated Pregabalin was given.
- 8/27/24: No documentation on the MAR indicated Pregabalin was given.
From 8/23/24 to 8/27/24, Tenant #1 received the correct dosage of Pregabalin 75 mg one time which was the morning dose on 8/25/24.

Progress notes reviewed from 8/22/24 to 8/27/24 provided no explanation regarding medication errors or problems obtaining the Pregabalin. A nursing note on 8/26/24 noted Tenant #1 complained of pain related to shingles, but made no mention of the tenant not receiving the Pregabalin as ordered.

The August MAR had an order with a start date of 8/26/24 for Pregabalin 75 mg capsule, three times per day. The pharmacy Proof of Delivery document indicated the medication arrived at the program on 8/27/24 at 7:30 p.m. According to the August MAR and the Controlled Drug Record for Pregabalin 75 mg, Tenant #1 first received a dose of the Pregabalin 75 mg capsule on the morning of 8/28/24.

On 9/25/24 at 3:35 p.m. the Senior Clinical Quality Specialist (SCQS) said the PCP initially ordered Pregabalin 75 mg capsules on 8/22/24, but the insurance/pharmacy would not fill the prescription since Tenant #1 had 25 mg tablets on hand. The PCP changed the order on 8/23/24 to Pregabalin three 25 mg tablets, three times per day. The SCQS reviewed the August MAR and Drug Control Record for Pregabalin 25 mg and confirmed Tenant #1 did not receive Pregabalin

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as ordered between 8/23/24 and 8/27/24. The Drug Control Record indicated staff gave only one 25 mg tablet per dose, with the exception of the morning dose on 8/25/24, when they correctly administered three tablets. The last 25 mg tablet was given at the noon dose on 8/25/24, with no tablets remaining.

B. Tenant #1's September MAR included an entry for Pregabalin 50 mg capsule three times per day for shingles pain for 14 days, with a start date of 8/30/24. This order replaced the prior order for Pregabalin 75 mg capsule three times per day. Tenant #1 received the Pregabalin 50 mg through the evening of 9/12/24. According to the MAR, the Pregabalin 50 mg three times per day started again on 9/17/24 (first given on 9/18/24).

Progress notes between 8/30/24 and 9/17/24 made no mention of the Pregabalin, or of contact with Tenant #1's family or PCP office regarding the medication. The SCQS made entries on the morning of 9/18/24 regarding contact with family, PCP office and pharmacy related to refill/new order for the Pregabalin 50 mg.

On 9/25/24 at 3:35 p.m. the SCQS stated the Pregabalin 50 mg order was written for only 14 days. She noted Tenant #1 also received other pain medication. The SCQS said she wasn't aware Tenant #1 complained of pain after the Pregabalin ended on 9/12/24 until she had a message from an on-call nurse later in the day on 9/17/24. The nurse indicated she contacted the PCP regarding a refill for the Pregabalin, but there was a problem with the order. The medication was delivered to the program on the evening of 9/17/24, but a family member had obtained their own prescription by that time and gave Tenant #1 a dose of the medication. The

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A 285	Continued From page 5 SCQS said when she contacted the PCP office on 9/18/24, they indicated this was their error for not ordering a refill. On 9/26/24 at 2:05 p.m. the Medical Assistant (MA) at the PCP office said she consulted with the office nurse practitioner who was involved with this situation. The MA stated Tenant #1 had been on Pregabalin for pain control for quite a while. The program should not have assumed the medication was discontinued when the 14 day supply ran out. She said Pregabalin should not be suddenly stopped. It should be tapered off if discontinued. The program should have contacted the PCP's office. The MA said she did not tell anyone at the program the PCP office was at fault for not ordering a refill. The MA said Tenant #1's daughter contacted the office on 9/17/24 and told them her mother hadn't received Pregabalin for 3-4 days. The MA contacted the program and was told they thought it was discontinued. The PCP office re-ordered the medication on 9/17/24, but the daughter called back and said there was a problem getting it at the program, so the PCP office ordered a small dose at a local pharmacy for the daughter to pick up and give to her mother on 9/17/24. On 10/01/24 in email contact, Tenant #1's daughter indicated family members visited Tenant #1 regularly and noticed increased pain, crying, fatigue, sweating and poor appetite as of 9/13/24. Family members discovered on 9/17/24 Tenant #1's Pregabalin was discontinued on 9/12/24. A family member contacted the PCP office to restart the medication on 9/17/24. The daughter indicated the family members didn't realize the Pregabalin was discontinued. It had been prescribed for quite some time for chronic pain, but was increased in late August after Tenant #1	A 285		

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A 285	Continued From page 6 was diagnosed with shingles. 2. Record review on 9/26/24 revealed Tenant #3's progress notes indicated she was hospitalized from 7/22/24 to 7/26/24, with a diagnosis of metabolic encephalopathy, pneumonia and possible urinary tract infection. The nursing assessment completed upon return indicated "orders noted," with no mention of new orders. Tenant #3 had a diagnosis of Type 2 Diabetes prior to the hospitalization. Tenant #3's July MAR listed Tradjenta 5 mg one tablet daily, with a start date of 7/26/24. Tradjenta is a medication used to help control blood sugar for people with Type 2 Diabetes. According to the MAR, staff administered the medication from 7/27/24 to 7/31/24. Tenant #3's August MAR revealed multiple missed doses of Tradjenta between 8/01/24 and 8/20/24. Staff documented they administered the Tradjenta on 8/01, 8/03, 8/04, 8/07/8/08, 8/13 and 8/14. They documented the medication as unavailable/not given on 8/02, 8/04, 8/05, 8/06, 8/09, 8/10, 8/11, 8/12, 8/15, 8/16, 8/17, 8/18, 8/19 and 8/20. Progress notes from 8/01/24 to 8/20/24 had multiple entries regarding the Tradjenta being unavailable, but no information regarding why it was unavailable or efforts made to obtain the medication. Progress notes after 8/20/24 provided no additional information regarding the Tradjenta, although the MAR indicated it was consistently given as of 8/21/24. Tenant #3's quarterly Functional, Cognitive, Health Assessment dated 8/08/24 noted the hospitalization and the start of Tradjenta on	A 285		

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A 285	Continued From page 7 7/26/24. The assessment provided no information provided regarding problems with obtaining or administering the medication. On 9/26/24 at 2:30 p.m. the SCQS indicated she didn't know why Tenant #3 did not receive the Tradjenta for multiple days in August. On 10/02/24 the SCQS provided pharmacy documentation, which revealed 6 tablets of Tradjenta were delivered to the program for Tenant #3 on the evening of 7/26/24. The next documented delivery of Tradjenta for Tenant #3 was on the evening of 8/20/24. The SCQS verified via email there was no documentation of attempts to obtain additional Tradjenta prior to 8/20/24. She confirmed the program did not notify Tenant #3's PCP of the dates the medication was not given. The SCQS declined to confirm staff must have mistakenly documented the administration of the Tradjenta on 8/03, 8/04, 8/07, 8/08, 8/13 and 8/14/24. 3. According to the program Medication Procedure, all medications should be managed according to the five "R's", which includes the right tenant, right medication, right dose and right documentation.	A 285		

The Summit of Bettendorf ALP
4699 53rd Ave
Bettendorf, Iowa

PLAN OF CORRECTION

This plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation or that corrective action was necessary.

A160

The Summit Ridge ALP provides adequate care and services to all tenants.

1. The program corrected the system using the following elements.
    a. Education
    b. Auditing
2. Measures taken to ensure that the problem doesn't recur.
    a. Team Members responsible for review of Incident Reports and supportive interventions received education on placement of fall interventions on the service plan on 10/17/24.
3. The program will monitor performance to ensure compliance.
    a. Program RN or designee will conduct auditing of incident report and safety interventions to ensure that compliance is maintained weekly x 4 weeks and monthly x 2 quarters.
4. Date of Compliance
    11/9/24

A285

The Summit of Bettendorf ALP administered medications as directed by the physician.

1. The program corrected the system using the following elements.
    a. Process Change
    b. Education
    c. Auditing
2. Measures taken to ensure that the problem doesn't recur.
    a. Team Members responsible for administration of medication received education on 9/27/24 related to medication administration per order.
    b. Team Members received education on process change related to coding medication administration as "not available and process related to notifications of program RN related to medications not being available for administration and required follow up on 10/1/24 and 10/29/24.

3. The program will monitor performance to ensure compliance.
    a. Program RN or designee will complete auditing weekly x 4 weeks and monthly x 2 quarters of medication regimen administrations to ensure compliance.

4. Date of Compliance
    11/9/2024