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 07/08/2025

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: 14 Number of tenants with cognitive impairment: 1 Total census: 15 The following regulatory insufficiencies were cited during the investigation of Incident #127969-C.	A 000	See attached POC 8/7/25	
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 interview and record review, the program failed to follow their policies/procedures regarding medication errors for 1 of 3 tenants reviewed (Tenant #1). Findings follow: On 7/07/25 record review revealed Tenant #1 returned to the program from a hospitalization on 4/11/25. A nursing progress note dated 4/11/25 at 4:34 p.m. indicated Tenant #1 returned from the hospital, accompanied by her son. Discharge paperwork was received and sent to the pharmacy. Tenant #1's hospital discharge report dated 4/11/25 indicated she was hospitalized on 4/08/25 for congestive heart failure exacerbation, wheezing, acute hypoxia respiratory failure and	A 150		

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A 150	Continued From page 1	A 150		

pneumonia. The discharge summary provided a list of current medications upon discharge. Tenant #1 was prescribed multiple routine medications, as well as PRN (as needed) medications.

According to Tenant #1's April 2025 Medication Administration Record (MAR), she did not receive the majority of her medication from the afternoon/evening of 4/11/25 through the morning of 4/13/25. The medications resumed on the afternoon of 4/13/25. The MAR indicated the medications were on hold from 4/09/25 to 4/13/25. The program failed to provide Tenant #1 the following prescribed medications:
Aspirin 81 mg, one tab at 6:00 a.m., not given on 4/12 and 4/13/25.
Doxazosin 4 mg, one tab at 6:00 a.m., not given on 4/12 and 4/13/25.
Gabepentin 100 mg, one tab three times per day, 6:00 a.m. dose not given on 4/12 or 4/13/25, noon dose not given on 4/11 or 4/12/25, 4:00 p.m. dose not given on 4/11 or 4/12/25.
Levothyroxine 112 mcg, one tab at 6:00 a.m., not given on 4/12 or 4/13/25.
Mucus Relief 600 mg, one tab twice per day, not given at 6:00 a.m. on 4/12 or 4/13/25 or at 4:00 p.m. on 4/11 or 4/12/25.
Senna Plus, one tablet twice per day, not given at 6:00 a.m. on 4/12 or 4/13/25 or 4:00 p.m. on 4/11 or 4/12/25.

No explanation or documentation regarding the medication error could be located in Tenant #1's record, including review of the MAR, progress notes and incident reports. Documentation of notification to the primary care provider (PCP) regarding the missed medications could not be located.

Review of the program's "Assisted Living

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A 150	Continued From page 2 Medication Procedure" revealed the physician should be notified of medication errors and the error should be documented in the tenant's record, along with any action taken. When interviewed on 7/08/25 at 8:50 a.m. the Assisted Living Director/Registered Nurse (ALD/RN) confirmed the program failed to provide Tenant #1 with her medication for approximately two days after she returned from the hospital on 4/11/15. She said the medications were put on hold while the tenant was hospitalized and mistakenly remained on hold after Tenant #1 returned. The ALD/RN verified the lack of documentation regarding the medication error and PCP notification.	A 150		
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 program failed to administer medications as prescribed for 1 of 3 tenants reviewed (Tenant #1). Findings follow:	A 285		

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A 285	Continued From page 3	A 285		

On 7/07/25 record review revealed Tenant #1 returned to the program from a hospitalization on 4/11/25. A nursing progress dated 4/11/25 at 4:34 p.m. indicated Tenant #1 returned from the hospital, accompanied by her son. Discharge paperwork was received and sent to the pharmacy.

Tenant #1's hospital discharge report dated 4/11/25 indicated she was hospitalized on 4/08/25 for congestive heart failure exacerbation, wheezing, acute hypoxia respiratory failure and pneumonia. The discharge summary provided a list of current medications upon discharge. Tenant #1 was prescribed multiple routine medications, as well as PRN (as needed) medications.

According to Tenant #1's April 2025 Medication Administration Record (MAR), she did not receive the majority of her medication from the afternoon/evening of 4/11/25 through the morning of 4/13/25. The medications resumed on the afternoon of 4/13/25. The MAR indicated the medications were on hold from 4/09/25 to 4/13/25. The program failed to provide Tenant #1 the following prescribed medications:
Aspirin 81 mg, one tab at 6:00 a.m., not given on 4/12 and 4/13/25.
Doxazosin 4 mg, one tab at 6:00 a.m., not given on 4/12 and 4/13/25.
Gabepentin 100 mg, one tab three times per day, 6:00 a.m. dose not given on 4/12 or 4/13/25, noon dose not given on 4/11 or 4/12/25, 4:00 p.m. dose not given on 4/11 or 4/12/25.
Levothyroxine 112 mcg, one tab at 6:00 a.m., not given on 4/12 or 4/13/25.
Mucus Relief 600 mg, one tab twice per day, not given at 6:00 a.m. on 4/12 or 4/13/25 or at 4:00 p.m. on 4/11 or 4/12/25.
Senna Plus, one tablet twice per day, not given at

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A 285	Continued From page 4 6:00 a.m. on 4/12 or 4/13/25 or 4:00 p.m. on 4/11 or 4/12/25. No explanation for the missed medication could be located in Tenant #1's record, including review of the MAR, progress notes and incident reports. Review of the program's "Assisted Living Medication Procedure" revealed the rights of medication administration, which included the right tenant, right medication, right dose and right time. When interviewed on 7/08/25 at 8:50 a.m. the Assisted Living Director/Registered Nurse (ALD/RN) confirmed the program failed to provide Tenant #1 with her medication for approximately two days after she returned from the hospital on 4/11/15. She said the medications were put on hold while the tenant was hospitalized and mistakenly remained on hold after Tenant #1 returned.	A 285		
A 145	481-69.22(3) Evaluation of Tenant 69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change.	A 145		

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A 145	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed provide thorough evaluations based on change of condition for one of three tenants reviewed (Tenant #1). Finding follows: Record review on 7/07/25 revealed Tenant #1 was 94 years old with a diagnosis including essential hypertension, anemia, edema of lower extremity, chronic kidney disease stage 3, Type 2 diabetes, congestive heart failure and urge incontinence. Tenant #1's most recent functional, cognitive and health assessment was dated 3/17/25. A nursing progress note dated 6/03/25 indicated Tenant #1 went to the emergency room (ER) for shortness of breath. She was admitted to the hospital. According to a nursing progress note dated 6/05/25, Tenant #1 returned from the hospital. She was admitted to the hospital for shortness of breath and DVT (deep venous thrombosis) in right leg. Tenant #1 was also treated for GI (gastrointestinal) bleed in the hospital. The nurse noted staff would encourage Tenant #1 to report risk for returning complications of the GI bleed and DVT, and listed possible complications/symptoms. The nurse noted Tenant #1 otherwise continued to be at her baseline functional and cognitive status. No health or functional assessment or additional nursing assessments were located in the record related to Tenant #1's return to the program. The hospital discharge report dated 6/05/25	A 145		

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A 145	Continued From page 6	A 145		

indicated Tenant #1 was just diagnosed with DVT in the emergency room. She was admitted for a GI bleed and acute on chronic blood loss anemia. The discharge report noted, "monitor closely, she is at extremely high risk for readmission given her age and comorbidities."

A nursing progress note dated 6/07/25 indicated Tenant #1 was having trouble breathing and went to the emergency room. A progress note on 6/11/25 indicated Tenant #1 returned from the hospital to the skilled unit (at The Summit of Bettendorf). According to a nursing progress note on 6/19/25, Tenant #1 was expected to return to the AL program the following day. The note indicated the tenant had returned to baseline and needed no changes to supports or services. Tenant #1 declined to continue occupational and physical therapy upon her return. No additional assessments could be located in the record regarding the tenant's return to the AL program. No assessments or meeting notes from the skilled care facility could be located in the record.

When interviewed on 7/08/25 at 2:20 p.m. the Assisted Living Director/Registered Nurse (ALD/RN) verified the two hospitalizations for Tenant #1 in June, with a short term transfer to skilled nursing care after the second hospitalization. The ALD/RN confirmed Tenant #1 returned to the ALP on 6//05/25 with new diagnoses/medical conditions discovered at the hospital: a GI bleed and DVT in right leg. The ALD/RN stated she sent a communication memo to staff regarding possible complications/symptoms of the new medical issues.

Tenant #1 returned to the ALP on 6/20/25 after being absent since 6/07/25 at the hospital and

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A 145	Continued From page 7 then skilled nursing care. When asked why assessments were not completed due to the change in Tenant #1's condition, the ALD/RN indicated Tenant #1 returned to the ALP at her baseline. She noted The Summit (the skilled nursing facility) held weekly meetings to review the tenant's status, which were attended by the ALD/RN. The ALD/RN indicated there was no need to complete new assessments since Tenant #1 returned at baseline. However, there was very little documentation to indicate Tenant #1's status upon return, other than a brief nursing progress note.	A 145		
A 360	481-69.26(3) Service Plans 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to update service plans as needed, for change of condition for one of three tenants reviewed (Tenant #1). Finding follows: Record review on 7/07/25 revealed Tenant #1 was 94 years old with a diagnosis including essential hypertension, anemia, edema of lower extremity, chronic kidney disease stage 3, Type 2 diabetes, congestive heart failure and urge incontinence. Tenant #1's most recent functional,	A 360		

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A 360	Continued From page 8	A 360		

cognitive and health assessment was dated 3/17/25 and service plan was dated 3/25/25.

A nursing progress note dated 6/03/25 indicated Tenant #1 went to the emergency room (ER) for shortness of breath. She was admitted to the hospital. According to a nursing progress note dated 6/05/25, Tenant #1 returned from the hospital. She was admitted to the hospital for shortness of breath and DVT (deep venous thrombosis) in right leg. Tenant #1 was also treated for GI (gastrointestinal) bleed in the hospital. The nurse noted staff would encourage Tenant #1 to report risk for returning complications of the GI bleed and DVT, and listed possible complications/symptoms. The nurse noted Tenant #1 otherwise continued to be at her baseline functional and cognitive status. No health or functional assessment or additional nursing assessments were located in the record related to Tenant #1's return to the program.

The hospital discharge report dated 6/05/25 indicated Tenant #1 was just diagnosed with DVT in the emergency room. She was admitted for a GI bleed and acute on chronic blood loss anemia. The discharge report noted, "monitor closely, she is at extremely high risk for readmission given her age and comorbidities."

A nursing progress note dated 6/07/25 indicated Tenant #1 was having trouble breathing and went to the emergency room. A progress note on 6/11/25 indicated Tenant #1 returned from the hospital to the skilled unit (at The Summit of Bettendorf). According to a nursing progress note on 6/19/25, Tenant #1 was expected to return to the AL program the following day. The note indicated the tenant had returned to baseline and needed no changes to supports or services.

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A 360	Continued From page 9 Tenant #1 declined to continue occupational and physical therapy upon her return. No additional assessments could be located in the record regarding the tenant's return to the AL program. No assessments or meeting notes from the skilled care facility could be located in the record. When interviewed on 7/08/25 at 2:20 p.m. the Assisted Living Director/Registered Nurse (ALD/RN) verified the two hospitalizations for Tenant #1 in June, with a short term transfer to skilled nursing care after the second hospitalization. The ALD/RN confirmed Tenant #1 returned to the ALP on 6//05/25 with new diagnoses/medical conditions discovered at the hospital: a GI bleed and DVT in right leg. The ALD/RN stated she sent a communication memo to staff regarding possible complications/symptoms of the new medical issues. Tenant #1 returned to the ALP on 6/20/25 after being absent since 6/07/25 at the hospital and then skilled nursing care. When asked why assessments were not completed due to the change in Tenant #1's condition, the ALD/RN indicated Tenant #1 returned to the ALP at her baseline. She noted The Summit the skilled nursing facility held weekly meetings to review the tenant's status, which were attended by the ALD/RN. The ALD/RN indicated there was no need to complete new assessments or update the service plan since Tenant #1 returned at baseline. Howerver, there was very little documentation to indicate Tenant #1's status upon return, other than a brief nursing progress note.	A 360		

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A 395	Continued From page 10	A 395		
A 395	481-69.26(4)a Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the program failed to develop a service plan in accordance with the tenant's needs and preferences for 1 of 3 tenants reviewed (Tenant #1). Finding follows: Observation on 7/08/24 at 7:25 a.m. revealed the medication manager set up Tenant #1's medications in a medication cup and put the cup on a table. The medication manager and Tenant #1 stated the tenant took the medications on her own after staff set them up. Staff did not need to watch the tenant take the medications. The medication manager left the room while the medications were in the cup on the table. When interviewed on 7/08/25 at 7:40 a.m. Tenant #1 noted the staff person who had assisted with her bathing and dressing the evening before had not assisted her with donning an incontinence brief. Tenant #1 said she didn't notice this until she had a toileting accident later in the evening. During a follow up interview on 7/08/25 at 3:00 p.m. Tenant #1 stated she had been allowed to take her medications on her own, without observation of staff, since she moved to the program. Tenant #1 moved the assisted living	A 395		

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A 395	Continued From page 11 program in May 2024. Review of Tenant #1's most recent Functional, Cognitive and Health Assessment dated 3/17/25 revealed she occasionally needed toileting assistance. Her most recent service plan dated 3/25/25 provided no information regarding toileting. The assessment and service plan both indicated the program provided medication management services and staff should remain with Tenant #1 while she took her medication. Tenant #1's Global Deterioration Scale (GDS) dated 3/17/25 revealed a score of 2, which indicated very mild cognitive decline. When interviewed on 7/08/25 at 2:20 p.m. the Assisted Living Director/Registered Nurse (ALD/RN) and the Executive Director (ED) confirmed Tenant #1's current service plan failed to address toileting needs. They also indicated Tenant #1's assessment and service plan should be reviewed regarding whether staff needed to observe her take her medication. The ED noted with a GDS score of 2, Tenant #1 probably could take the medications on her own.	A 395		

ok
8/8/25

PLAN OF CORRECTION
This plan of correction does not constitute an admission or agreement by The Summit of Bettendorf Assisted Living program to the accuracy of the facts alleged or conclusions set forth in the statement of insufficiencies. 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.

<u>Insufficiencies</u>

A150 – Program Policies and Procedures
A285 - Medications
Corrective actions will be accomplished for those tenants found to have been affected by the identified insufficiency.

- **Outline the elements of how the Assisted Living Program will correct each regulatory insufficiency; including at the system level.**

  Education provided to Clinical Leadership on 07/11/2025 regarding medication error and incident reporting expectations.

  Educated team on 07/11/2025 regarding return-from-hospital and requirements to notify on call of any tenant returns.

  Educated Clinical Leadership on 07/11/2025 regarding return-from-hospital tenants and requirement to confirm medication orders and present, accurate, and active.

  Additional educational/team meeting held 08/07/2025 to review all of above.

- **Measures taken to ensure the problem does not recur**

  Will audit all returns-from-hospital monthly x3 months to ensure meds are administered as directed.

  Completed audit for July: no variances identified.

- **How the Program plans to monitor performance to ensure compliance.**

  Will audit all returns-from-hospital monthly x3 months to ensure meds are administered as directed.

Administration will review audits to ensure accuracy and correction

- **The date by which the regulatory insufficiency will be corrected.**
  Immediately; insufficiency has been corrected.

A145 – Evaluation of Tenant
Corrective actions will be accomplished for those tenants found to have been affected by the identified insufficiency.

- **Outline the elements of how the Assisted Living Program will correct each regulatory insufficiency; including at the system level.**

  Change in condition assessment completed on tenant on 07/14/2025.
  Education provided at time of survey exit to Director of Assisted Living regarding expectation to document assessment findings at time of assessment, even if resident is at baseline.

- **Measures taken to ensure the problem does not recur**

  Will audit all re-admissions from hospitalizations/skilled nursing stays monthly x3 months to ensure change of condition assessment is completed if necessary.

  Completed audit for July: no variances identified.

- **How the Program plans to monitor performance to ensure compliance.**

  Will audit all re-admissions from hospitalizations/skilled nursing stays monthly x 3 months to ensure change of condition assessment is completed if necessary.
  Administration will review audits to ensure accuracy and correction.

  Completed audit for July: no variances identified.

- **The date by which the regulatory insufficiency will be corrected.**
  Immediately; insufficiency has been corrected.

A360 – Service Plans
Corrective actions will be accomplished for those tenants found to have been affected by the identified insufficiency.

- **Outline the elements of how the Assisted Living Program will correct each regulatory insufficiency; including at the system level.**

  Service plan for tenant reviewed/updated on 07/14/2025.

- **Measures taken to ensure the problem does not recur**
  Education provided to Assisted Living Director responsible for service plans at time of survey exit to ensure service plan reviews/updates are completed within 30 days of occupancy and as needed with significant change, but not less than annually.

- **How the Program plans to monitor performance to ensure compliance.**
  Will audit all changes in condition assessments monthly x3 months to ensure service plan(s) are updated per requirements.
  Administration will review audits to ensure accuracy and correction.

  Completed audit for July: no variances identified.

- **The date by which the regulatory insufficiency will be corrected.**
  Immediately; insufficiency has been corrected.

A395 – Service Plans
Corrective action will be taken for those tenants found to have been affected by the identified insufficiency.

- **Outline the elements of how the Assisted Living Program will correct each regulatory insufficiency; including at the system level.**

  Service plan for tenant reviewed/updated on 07/14/2025 to reflect wishes for medication administration.

- **Measures taken to ensure the problem does not recur**
  Education provided to Assisted Living Director responsible for service plans at time of survey exit to ensure service plans reflect needs/wishes.

  Education provided to team on 07/11/2025 to ensure service plan matches residents needs/wishes and actual service delivery.

  Additional educational/team meeting held 08/07/2025 to review all of above.

- **How the Program plans to monitor performance to ensure compliance.**
  Will audit all service plans to ensure needs/preferences are reflected for all tenants monthly x 3 months.

- **The date by which the regulatory insufficiency will be corrected.**

Immediately, insufficiency was corrected.