

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165280	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/20/2024
NAME OF PROVIDER OR SUPPLIER  Bettendorf Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2730 Crow Creek Road Bettendorf, IA 52722	

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 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22506</b></p> <p>Based on clinical record review, policy review and staff interview the facility failed to ensure a resident received their ordered medications and not someone else for 1 of 5 residents reviewed (Resident #1). On 6/3/24 as the nurse and Certified Medication Aide (CMA) passed the medication to the residents, the CMA delivered the wrong medications to Resident #1. Following the error, the CMA reported the incident to the nurse who notified the appropriate people. After receiving notification, the provider gave the nurse an order to send Resident #1 to the emergency room (ER) for further evaluation. During her stay in the ER, Resident #1 had a change in condition due to the accidental overdose, that resulted in the need to have tube placed down her throat to assist her with breathing (intubated). Due to the severity in her change in condition, the provider admitted her to the intensive care unit (ICU). This resulted in an immediate jeopardy (IJ) situation. The facility reported census of 60.</p> <p>The Department notified the facility of the IJ on 6/18/24 at 8:45 AM. The facility corrected the deficient practice as of 6/4/24 by implementing the following:</p> <p>a. The facility sent Resident #1 to the hospital the night of 6/3/24 at around 10:45 PM and returned to the facility on 6/1 I/24. Resident #1 has since received all scheduled medication as ordered.</p> <p>b. The interview of Resident #5 on 6/4/24 and review of the Medication Administration Record (MAR) reflected she received scheduled medication as ordered since 6/4/24.</p> <p>c. The facility immediately suspended the two employees pending a full investigation of the incident on 6/4/24. The nursing leadership completed a whole house audit on 6/4/24 to ensure the MAR was correct.</p> <p>d. The facility conducted interviews on 6/4/24 of all interviewable residents that the staff involved were responsible for and there were no reports of any other missed medication administration.</p> <p>On 6/7/24 after the completion of the investigation, the facility terminated the employees.</p> <p>On 6/4/24 the facility immediately completed competencies, skills validation and education to all Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Certified Medication Technician (CMTs) regarding the policy of medication administration which includes:</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 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>i) Section 7.2 section A #4 on page 1 of 6 which states the five rights to medication administration.</p> <p>ii) Section 7.2 section B #7 on 4 page of 6 which states 'The person who prepares the dose, for administration is the person who administers the dose.</p> <p>iii) Section 7.2 B # 15 page 4 of 6 which states Medication supplied for one resident are never administered to another resident: All licensed nurses and CMTs who were in house, as well all other licensed nurses and CMTs completing competencies. skills validation and education before the start of their next shift by nursing leadership started on 6/4/2024. Any and all qualified persons will not administer medication before receiving the education provided, including new hires who will have the skills competencies completed before the start of their first shift. The facility will not schedule a RN, LPN, or CMT until they complete their education and skills competencies.</p> <p>Findings include:</p> <p>Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of hypertension, renal insufficiency, and a seizure disorder. The MDS listed Resident #1 received dialysis while a resident in the facility.</p> <p>The Medication Administration - Preparation and General Guidelines dated December 2017 instructed the facility have sufficient staff and medication distribution system to ensure safe administration of medications without unnecessary interruptions. In addition, the person who prepared the medication must be the person who administers the dose.</p> <p>On 6/13/24 at 12:45 PM Staff B, Certified Medication Aide, stated on 6/3/24, he worked the 6:00 PM to 6:00 AM shift and assisted with passing medications. At around 9:00 PM he finished passing his medications and moved to the East hall to help Staff A finish her medications. Staff A told him the medications in a medication cup sitting on the medication cart belonged to Resident #1, she instructed him to give them to her. Staff B stated he took the medications to Resident #1 and gave them to her. Upon returning to the medication cart, Staff A looked at the computer screen and realized the medications he just gave Resident #1, belonged to Resident #6. Staff B stated Staff A notified everyone and handled the medication error issue.</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 6/17/24 at 9:31 AM Staff A, Registered Nurse, stated on the evening of 6/3/24, she finished giving medications on the North and [NAME] halls, then moved to the East hall around 9:00 PM. She asked Staff B to assist with checking blood sugars. Staff A explained she set up Resident #5's and his roommate's medications in medication cups. She placed them on the medication cart. She had Resident #1 on her computer screen, while she searched in the medication cart, when Staff B came over and picked up Resident #5's medication cup, then walked away. Staff A reported she didn't pay attention and didn't recall saying anything at the time. Moments later, Staff B exited Resident #1's room. Staff A asked Staff B if he gave those medications to Resident #1 and he stated yes. Staff A stated she immediately informed Resident #1 that she had received another resident's medications. Staff A stated she checked Resident #1's vital signs which were stable and contacted her physician, leaving a message of the error. Staff A stated another resident fell and she was taking care of her. About 30 minutes later, the physician called and gave an order to have Resident #1 sent to the emergency room for evaluation. Staff A stated she made those arrangements and sent Resident #1 to the hospital. Staff A denied instructing Staff B to give the medications to Resident #1, but admitted she knew he picked up the cup of medications and didn't stop him.</p> <p>The Nurses Note dated 6/3/24 at 11:27 PM reflected Resident #1 received</p> <p>Cefadroxil (antibiotic) 500 milligrams, L-Arginine (supplement) 500 milligrams, Trazadone (antidepressant that improve sleep) 50 milligrams, Tamsulosin (used to treat enlarged prostates in men) 0.4 milligrams (Flomax), Baclofen (muscle relaxant) 20 milligrams and Melatonin (supplements that assists with sleep) 10 milligrams in error. The nurse notified the physician who gave orders to send her to the emergency room (ER) for further evaluation. The nurse notified the resident and the medics.</p> <p>Resident #5's June 2024 Medication Administration Record (MAR) reflected the evening medications Resident #1 received as:</p> <ol style="list-style-type: none"> <li>a. Tamsulosin HCL Oral Capsule 0.4 milligrams. Give 2 capsules by mouth at bedtime for urinary retention.</li> <li>b. Trazodone HCL tablet 50 milligrams. Give 1 tablet by mouth at bedtime related to depression to promote sleep.</li> <li>c. Cefadroxil oral capsule 500 milligrams. Give 1 capsule by mouth two times a day for bacterial infection prophylactic (preventive).</li> <li>d. L-Arginine oral tablet. Give 500 milligrams by mouth three times a day for promotion of wound healing.</li> <li>e. Baclofen oral tablet 10 milligrams. Give 2 tablets by mouth 4 times a day related to other muscle spasms.</li> <li>f. Melatonin oral tablet 10 milligrams. Give 1 tablet by mouth at bedtime to promote sleep.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or get specialized rehabilitative services as required for a resident.</p> <p>22506</p> <p>Based on clinical record review and staff interview, the facility failed to provide rehabilitation services in accordance with physician orders for 1 of 3 residents reviewed (Resident #3). The facility reported census was 60.</p> <p>Findings include:</p> <p>The Order Summary Report dated 12/29/23 listed an order for a physical therapy evaluation and treatment as needed.</p> <p>The Physical Therapy (PT) Evaluation and Plan of Treatment report with a certification period of 1/2/24 - 2/1/24 signed by the Physical Therapist and Resident #3's primary care physician (PCP) directed Resident #3's PT frequency as five times a week.</p> <p>On 6/19/24 at 10:40 AM, Staff J, Physical Therapy Assistant (PTA), reported Resident #3 should have had physical therapy services five times per week. Staff J stated he didn't recall Resident #3 refusing therapy and noted she made good progress towards the end of her stay.</p> <p>The Physical Therapy Treatment Encounter Note(s) reflected Resident #3 had PT services one time during the week of January 7 13 and 14 20, then only twice during the week of February 11 17. During that same time, Resident #3 received Occupational Therapy four times during the week of January 7 13, six times during the week of January 14 20 and four times during the week of February 11 17.</p>