STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165280	A. Building B. Wing	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bettendorf Health Care Center	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)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews and policy review, the facility failed to attempt to educate a resident on potential discharge options prior to his leaving after having signed an Against Medical Advice form for 1 of 1 resident reviewed. The facility reported a census of 63 residents.Findings include: The Minimum Data Set (MDS) dated [DATE] identified Resident #1 as cognitively intact with a BIMS (Brief Interview for Mental Status) score of 15 and had the following diagnoses: heart failure, neurogenic bladder, diabetes mellitus and persistent mood disorders. The MDS identified Resident #1 required set up/cleanup assistance with eating, oral hygiene, toileting, showers, personal hygiene. The MDS identified the resident had physician orders for the following medications: anti-anxiety, hypnotics, anticoagulant, opioid, hypoglycemic (including insulin) and anticonvulsant.Review of the clinical record revealed Resident #1 had Physician Orders for:a. Jardiance (for Diabetes Mellitus) 10 milligram (mg) one tablet daily.b. Lorazepam (for anxiety) 1 mg tablet daily.c. Metoprolol (for high blood pressure) 25 mg one tablet daily.d. Apixaban (blood thinner for abnormal heart rhythms) 25 mg twice daily.e. Lorazepam 1.5 mg tablet twice daily. f. Glargine insulin (for Diabetes Mellitus) 18 units subcutaneously (injection) at bedtime.g. Lispro Insulin sliding scale four times daily based on blood sugars.The census tab in the electronic medical record revealed Resident #1 was admitted to the facility on [DATE], was hospitalized [DATE], returned to the facility 10/8/25 and discharged [DATE].The Initial Psychiatric assessment dated [DATE] identified Resident #1 had the primary treating diagnosis of generalized anxiety disorder, had the secondary treating diagnosis of Other stimulant abuse and had other specified persistent mood disorders. The Reason for Referral: Agitation, Hallucinations, Grief/Loss Issues, Alcohol or Substance Abuse, High Risk Behavior, Verbal Aggression, Medication Evaluation.The Discharge Planning Form dated 9/16/25 revealed the form was reviewed with the resident, the overall goal was to discharge to another facility and that the plan was to be discharged to a local mental health facility. The form was signed as completed by the facility Social Worker.A review of a Facility Incident Report dated 10/7/25 at 9:00 PM documented that a nurse observed Resident #1 push Resident #2. Resident #2 fell onto the floor and hit her head. Resident #1 reported he did not push Resident #2, that the door pushed her. The Abuse and Neglect Coordinator and Director of Nursing were called, notified 911 to summon police and ambulance. Notified provider and family. Both residents were taken to the hospital for evaluation and neither one had injuries.A review of the progress notes had documentation of the following:a. On10/8/25 at 2:23 AM Resident #1 returned from the hospital via taxi, was pleasant and cooperative.b. On 10/8/25 at 9:17 AM Resident #1 signed the AMA (Against Medical Advice) paperwork in the presence of the Business Office Manager (BOM) and DON (Director of Nursing).c. On 10/8/25 at 10:41 AM Resident #1 called himself a cab, packed some of his belongings and left the facility at this time. Provided medication list to the resident.Review of the clinical record did not reveal documentation to show other alternatives for discharge planning had been discussed with Resident #1 on 10/8/25.A review of the facility AMA (Against Medical Advice) Form had documentation that the resident released the facility of any further responsibility for the resident's care, safety or welfare. It was signed by the resident on 10/8/25 and witness signatures from the DON and the BOM.During an interview on 10/15/25 at 8:47 AM, Resident #1 reported an incident on 10/7/25 where Resident #2 kept trying to enter his room. He had called for the staff 5 different times to keep her away from his room and no one did anything. He reported the next morning the staff woke him up and told him to just sign the AMA (Against Medical Advice) paper. They told him it was because of the incident between him and Resident #2. He was still sleepy and did not really understand what the form was, other than it was to get him kicked out. He admitted he did have plans to eventually leave, but he felt he needed more time to learn how to do things on his own. The day he was discharged (10/8/25), he did not feel he could take care of himself. The staff did not inform him of plans to discharge him until he came back from the hospital (10/8/25) and told him he had to do this on his own and find a place to stay. He was sent to a homeless shelter, he did not have any medications with him and woke up the next morning with a blood sugar between 400 and 500 (a reading he obtained from an internal blood glucose monitor). He reported he did not have any insulin and an ambulance had to take him to the hospital. He did not feel safe in the homeless shelter. A friend of the family took him home from the hospital that day.During an interview on 10/13/25 at 10:25 AM, Staff C, Registered Nurse (RN) reported she did not feel Resident #1 fully understood the AMA form that they had him sign before he was discharged on 10/8/25. Staff C also reported Resident