STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165553	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Vistas at Bettendorf	2500 Grant Street 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, clinical record review, document review and staff interview the facility failed to clean resident fingernails as part of grooming for 1 of 6 resident sampled (Resident #58). The facility identified a census of 70 residents.Finding include:The 6/11/25 Minimum Data Set (MDS) Assessment documented Resident #58 with severely impaired decision making and unable to recall the current season, location of own room, staff names and faces or that they are in a nursing home. Resident #58 exhibited inattention, disorganized thinking and altered level of consciousness continually present, without fluctuation. The MDS lacked documentation Resident #58 exhibited any physical or verbal behaviors. The MDS noted Resident #58 with impairment on both lower extremities (hip, knee, ankle, foot); utilized a wheelchair and was dependent upon staff for shower/bathing, toileting hygiene and personal hygiene. The MDS documented Resident #58 as always incontinent of bowel and bladder. The MDS listed diagnoses of Alzheimer's Disease, Non-Alzheimer's Dementia, anxiety, depression, end stage renal disease. The Activities of Daily Living (ADL) Self-Care Performance Deficit Care Plan revised 7/17/25 directed the staff under Bathing/Showering to check nail length and trim/clean on bath days and as necessary and to provide extensive assistance of two staff for bath/shower every Sunday morning as necessary. Observation on 8/12/25 at 3:45 PM Resident #58 lay in bed with her right middle finger, ring finger and pinky finger in her mouth licking her fingers. Resident #58 had a dried brown-black substance under her right middle, ring and pinky fingers. During an observation on 8/13/25 at 10:30 AM Staff D and E, Certified Nursing Assistants (CNAs) completed peri-cares for Resident #58 while lying in bed. Staff E asked Staff D to hand her a disposable wet wipe. Staff E lifted Resident #58 right hand and wiped her fingers and attempted to wipe under two fingernails, then placed her hand back down. Observation after cares revealed Resident #58 right forefinger, middle, ring, and pinky fingers with a brown-black substance under her fingernails. Interview on 8/13/25 10:40 AM Staff D explained morning cares include washing the resident's face, under arms, performing peri-cares, applying lotion to the arms/legs and setting the resident up or providing oral care for the resident. Staff D voiced second shift and activities complete nail care. Observation on 8/13/25 at 10:46 AM revealed Resident #58 lying in bed supine. The room smelled of bowel movement. Resident #58 had her right hand inside the front of her brief digging. Resident #58 brought her right hand out of her brief. Her right hand had dark brown/black substance under her forefinger, middle, ring, and pinky fingers. Interview completed on 8/13/25 at 10:45 AM Staff F, CNA verbalized morning cares consist of washing the residents face, brushing their teeth and completing peri-cares. Staff F said the aides usually try to set up to do fingernail care around 10 AM several days per week. She stated if the resident wants their nails done, they will do them then. When asked about residents that could not make that decision, she said they do their nail care if they have time. Staff F thought is was the same on both floors. Interview on 8/13/25 at 11:44 Staff G, CNA explained there is a lady that comes up on the floor that complete fingernail care. She is an environmental aide. She is not sure how often she comes to the floor, but she is on the floor often and she does the nail care. On 8/13/25 at 11:45 AM Staff H, Registered Nurse (RN) stated activities does nail painting and the restorative aides do nail care as an extra from time to time. He had never observed there is any routine nail care that the aides provide. An 8/14/25 review of Resident #58 Shower Sheets showed no nail care documented as completed for the following showers:a. 6/03/25b. 6/13/25c. 6/24/35d. 6/27/25e. 7/04/25f. 7/11/25g. 7/15/25h. 7/18/25Interview on 8/14/25 at 9:48 AM the Assistant Director of Nursing (ADON) reported she expects the CNAs to completed fingernail care with showers/baths and as needed. During an interview on 8/14/25 at 9:51 AM the Director of Nursing (DON) reported activities does a trim and nail polish activity, but it is the responsibility of the CNAs to trim and clean the fingernails with the showers/baths twice a week and as needed. The Undated Nail Care Policy provided by the facility documented a purpose to promote cleanliness, prevent the spread of infection and to prevent injury to the resident or others due to jagged, sharp edges. The Policy lacked direction to the staff on when nail care was to be provided.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 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, policy review and staff interview, the facility failed to monitor a change in condition which resulted in a hospitalization for 1 of 1 residents sampled (Resident #37). The facility reported a census of 70 residents.Findings include:Resident #37's Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 15/15 indicating intact cognition. Resident #37 had functional limitation in range of motion on one side of the upper and lower body, utilized a wheelchair and was dependent upon staff for toileting hygiene, bathing, lower body dressing and personal hygiene. The MDS noted Resident #37 was always incontinent of bowel and bladder. The MDS listed diagnoses of stroke, heart failure, end stage renal disease, diabetes mellitus, hemiplegia (paralysis on one side of the body)/hemiparesis (weakness on one side of the body), and morbid obesity. The Bladder Incontinence Care Plan, revised 3/11/25, directed to monitor/document for signs and symptoms of urinary tract infection (UTI): pain, burning, blood tinged urine, cloudiness, no output, deepening urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior and change in eating patterns. A 7/13/25 8:47 PM Health Status Progress Note documented Resident #37 with a temperature of 97 degrees Fahrenheit (F) and complaints of burning with urination. A facsimile (fax) sent to the Provider to update on the resident's condition and awaiting a return fax.A Fax dated 7/14/25 to the Provider documented Resident #37 had complained of burning with urination, was incontinent, used a bed pan and briefs. The Fax noted Resident #37 was afebrile and vital signs were within normal limits and asked for a physician order for a urinalysis and culture. The bottom of the Fax contained hand written documentation faxed 7/14 at 1:30 PM. The Fax included a Physician Order/Response of yes. There was no fax date/time posted on the document. A review of the Progress Notes and Vital Sign Records revealed no vital signs documented for 7/14/25. A 7/16/25 10:30 PM Nurse Progress Note detailed a clean catch urine sample had been collected and placed in the fridge for the laboratory to pick up in the AM. The urine was cloudy and dark yellow with a strong odor. A 7/17/25 5:30 AM Nurses Progress Note documented Resident #37 with an altered mental status, unable to answer most questions, imaking guttural sounds. Vital signs blood pressure 168/44, pulse 58 beats per minute, respirations 22 breaths per minute, temperature 102 degrees F, pulse oximeter 90-92 percent on room air. The Provider was notified and gave a verbal order to send to the emergency department (ED) for evaluation and treatment. A 7/17/25 1:57 PM Nurses Progress Note documented Resident #37 had been admitted to the hospital with urosepsis (a severe, life threatening condition where a UTI spread to the blood stream, causing a systemic inflammatory response known as sepsis. The progression can lead to organ damage and septic shock if not treated promptly). A 7/17/25 6:20 AM ED Form documented Resident #37 arrived by ambulance with a Chief Complaint of gargled speech, burning sensation with peeing and the facility sent a urinalysis (UA) with no results. Vitals and Sepsis Screening documented a temperature of 103 degrees F, blood pressure 123/90, pulse rate 82, respirations 26, pulse oximeter of 88% (low) and altered mental status. Visit reason: sepsis alert. A 7/17/25 ED Physician Note, Final Report documented Resident #37 with a past medical history of diastolic heart failure, hypertension, diabetes, hyperlipidemia, prior admission for urosepsis presented in the ED with fever and altered mental status. The Resident was found to have sepsis with a white count of 23 and a fever of 103.7. The Resident was given 1 liter of fluid due to diastolic heart failure, Zosyn after review of prior sensitivities, likely urinary source with positive nitrates, many bacteria, many white cells, moderate leukocyte esterase. The chest x-ray showed moderate pulmonary edema and resident admitted with internal medicine for further management. An 8/13/25 review of Resident #37 Electronic Health Record (EHR) revealed a 4/23/25 Emergency Department Final Report noting Resident #37 had been admitted to the hospital 4/22/25 with a diagnosis of acute hypoxic respiratory distress, fever, sepsis and acute UTI prior to the 7/17/25 ED visit. Further review of Resident #37 EHR (Progress Notes, Temperature Record, Blood Pressure Record, Pulse Record, Respiration Record, Pulse Oximeter (oxygen) Record, Assessment Tab) lacked documentation of any documented physical assessment/monitoring, or vital signs from 7/14/25 until the morning of 7/17/25 when Resident #37 was transferred out to the ED. Interview on 8/13/25 at 10:16 AM Staff H, Registered Nurse (RN) reported when a resident complains of UTI symptoms, the nurses writes up a communication form and fax it to the Provider. They also have access to an on-call physician if they need something immediately. The nurses have a form they use to communicate to each other on what has been done. Staff

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 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, document review and staff interview the facility failed to document completion of fifteen-minute checks to ensure appropriate supervision which resulted in a fall on 5/27/25 for 1 of 4 resident sampled for supervision (Resident #82). The facility identified a census of 70 residents. Findings include:Resident #82's Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 9/15 indicating a moderate cognitive loss. The resident was dependent upon staff for toileting hygiene, upper/lower body dressing, and partial/moderate assistance (helper does less than half the effort. The helper lifts, holds, supports trunk or limbs, but provides less than half the effort) with bed positioning (sit to lying position and lying to sitting on side of the bed). The MDS listed diagnoses of Alzheimer's Disease, Cerebrovascular Accident (stroke), other fracture, anxiety, depression, and a stress fracture of the hip, unspecified. The Activities of Daily Living (ADL) Care Plan revised 5/07/25 directed the following care:a. Resident #82 to be non-weight bearing to the right upper and lower extremity.b. Staff to assist with bed mobility and encourage to reposition every two hours. The High Risk for Falls Care Plan initiated 5/01/25 documented the following interventions:a. Ensure call light is within reach and encourage to use it. Initiated 5/01/25.b. Ensure resident is wearing non-skid socks. Initiated 5/10/25.c. Follow facility fall protocol. Initiated 5/01/25. d. Dusk to dawn night light placed by resident's sink in room. Initiated 5/23/25e. Low bed with floor mat. Hospice to provide wedges for bed boundaries. Initiated 5/28/25. The Care Plan lacked documentation of the initiation of 15-minute supervision checks on 5/04/25. A review of the May and June 2025 15-Minute Check Sheets from 5/04/25 to 6/07/25 revealed the following missing documentation indicating no checks had been completed:a. 5/06/25 6:00 AM to 1:45 PMb. 5/06/25 2:15 PM to 5:45 PM.c. 5/07/25 8:00 PM to 5:45 AMd. 5/08/25 6:00 AM to 9:45 PMe. 5/19/25 11:30 AM to 1:45 PMf. 5/20/25 6:00 AM to 1:45 PMg. 5/26/25 11:45 PM to 5:45 AMh. 5/27/25 2:15 PM to 8:45 AMA Progress Note dated 5/27/25 at 10:03 PM documented the nurse was alerted by staff that Resident #82 was on the floor observed sitting in an upright position resting against the bed. Resident #82's 5/27/25 10:36 PM Unwitnessed Fall Report prepared by Staff O, LPN documented the staff alerted Resident #82 was on the floor. The Fall Report documented Resident #82 had confusion, incontinence, recent changes in cognition, gait imbalance, impaired memory and a recent change in medication. The Fall Report lacked documentation of the last time a visual check had been completed on the resident. Resident #82 did not sustain an injury from the fall. Interview on 8/13/2025 at 2:14 PM Staff L, Licensed Practical Nurse (LPN) voiced she was not sure why Resident #82 had been placed on 15-minute checks. The resident had been trying to get up unassisted and she was supposed to be non-weight bearing. The resident liked to have her feet on the floor and would be positioned diagonally on the bed lwhen she was trying to get up unassisted. During an interview on 8/13/25 at approximately 2:50 PM Staff M, LPN reported Resident #82 had been placed on 15-minute checks for at least three days when she returned from the hospital but wasn't sure why she had been placed on the checks after that. Staff M explained the 15-minute checks are designated to the Certified Nursing Assistant (CNAs) and they document the 15-minute checks on a paper form. There are no staff specifically assigned to provide the 15-minute checks and no one is responsible to ensure the 15-minute documentation gets completed that she is aware of. They were checking that the resident's legs were in the bed as she would dangle her arm off the bed and put her feet on the floor. Interview completed on 8/13/2025 at 3:28 PM Staff N, LPN reported Resident #82 was on 15-minute checks when she returned from the hospital. The resident would forget that she couldn't get up and move on her own. They just wanted to monitor her more consistently. The CNA's would assist and encourage her to reposition if they found her laying across the bed with her legs on the floor. The CNA's should have documented the 15-minute checks. Staff N verbalized even if the checks were not signed off, she feels the staff probably did the 15-minute checks. Interview on 8/13/2025 at 3:59 PM Staff O reported she had filled out an incident report when Resident #82 fell on 5/27/25. She had been working with Staff P, CNA. Staff O explained she was not responsible for doing the 15-minute checks. It was the CNA's responsibility. Staff O could not recall the last time that Resident #82 had a 15-minute check completed prior to her fall on 5/27/25 at 10:03 PM. She did not document it in the incident report but she could check with the Director of Nursing (DON) to see if she had it documented. Staff O had only been alerted that Resident #82 was on the floor by the night shift. During an interview on 8/13/25 at 4:18 PM the Administrator reported she was not the Administrator when Resident #82 fell on 5/27/25

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview and facility policy review, the facility failed to ensure two residents took their medications and left the medications at the bedside (Residents #9 and #54) and failed to ensure Resident #42 swallowed his medications before Resident #20 took them. The facility reported a census of 70 residents. Findings include:1. The Minimum Data Set (MDS) dated [DATE] identified Resident #20 as cognitively intact with a BIMS (Brief Interview for Mental Status) score of 15 and had the following diagnoses: Non-Traumatic Brain Dysfunction, Non-Alzheimer’s Dementia and Peripheral Vascular Disease. The MDS also identified Resident #20 as independent with most activities of daily living. A review of an incident report completed by the ADON (Assistant Director of Nursing) dated 5/21/25 revealed the following: CNA reported to nurse that Resident #20 took another resident’s medication. The other resident brought down his medications with him to first floor so he could take it with dinner. This other resident went to this resident’s room and set his meds down and this resident took his meds. (the incident report did not identify the name of the other resident later identified as Resident #42) Medications included: Tegratol 400 mg (milligrams) and Keppra 750 mg. The Medical Director was notified, instructed staff that she would be very tired and shouldn’t walk around and to call pharmacy for medication interactions. Resident #20 verbalized feeling very tired and was educated not to walk around her room that night. Resident #20’s Care Plan failed to address the problem of the above incident where she took Resident #42’s medications. A review of Resident #20’s progress notes for entire month of May 2025 had no documentation of the above incident. 2. The MDS dated [DATE] identified Resident #42 as severely cognitively impaired with a BIMS of 04 and had the following diagnoses: Cerebrovascular Accident (stroke), Seizure Disorder and repeated falls. The MDS also identified Resident #42 as independent with most activities of daily living. A review of an incident report completed by the ADON (Assistant Director of Nursing) dated 5/21/25 revealed the following: CNA reported to nurse that Resident #20 took another resident’s medication. The other resident brought down his medications with him to first floor so he could take it with dinner. This other resident went to this resident’s room and set his meds down and this resident took his meds. (the incident report did not identify the name of the other resident later identified as Resident #42) (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medications included: Tegratol 400 mg (milligrams) and Keppra 750 mg. The Medical Director was notified, instructed staff that she would be very tired and shouldn’t walk around and to call pharmacy for medication interactions. Resident #20 verbalized feeling very tired and was educated not to walk around her room that night. On 6/28/24, the Care Plan identified Resident #42 with the problem of a Seizure Disorder and instructed staff to give him his seizure medication as ordered by doctor and to monitor/document side effects and effectiveness. The care plan failed to address the incident where he took his medications in for another resident and the need to have the nurse ensure she/he observed the resident actually swallowing the medications. A review of Resident #42’s progress notes for entire month of May 2025 had no documentation of the above incident. In an interview on 8/14/25 at 8:16 AM, the ADON (Assistant Director of Nursing) reported the following: a. When asked about the incident on 5/21/25 at 5:00 PM where one resident took another resident’s medications, she reported Staff B, LPN gave Resident #42 his medications which he took with him to Resident #20’s room. b. Resident #20 picked up Resident #42’s medications and took them. c. Resident #20 has a BIMS of 15, but is very forgetful and has short term memory. d. Resident #42 acted like he took his medications in front of Staff B, however he actually did not swallow the pills. He likes to take his medications with his meals. e. Staff B should have taken his medications to him at the dining room table. The DON (Director of Nursing) and ADON provided nursing staff with education. f. She was not sure if this should have been addressed on the residents’ Care Plans. In an interview on 8/14/25 at 8:57 AM, Staff C, RN reported the following a. When asked about the incident on 5/21/25 at 5:00 PM where one resident took another resident’s medications, she reported Resident #20 reported she took Resident #42’s medications. She was taking care of Resident #20 and did not know what medications Resident #42 had in the medication cup. b. She could not explain why Resident #42 had his medications with him when he went into Resident #20’s room and she ended up taking his medications. In an interview on 8/14/25 at 9:15 AM, the Director of Nursing reported the following: (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. When asked about the incident on 5/21/25 at 5:00 PM where one resident took another resident’s medications, she reported she received a phone call from the ADON who reported Resident #20 took Resident #42’s medications. b. Staff B, LPN thought she gave Resident #42 his medications upstairs before he went to visit Resident #20 downstairs. When he got to her room, he put the cup of his medications on her table and she picked them up and took them. She could not recall the names of the medications. c. Resident #42 usually likes taking his medications with his meals. d. She expected the nurse to actually watch him swallow his pills to prevent this error. e. Actions she took after this error occurred was she educated Staff B and the rest of the nursing staff on the importance of watching the resident actually swallow their medications. In an interview on 8/14/25 at 9:39 AM, Staff B, LPN reported the following: a. When asked about the incident on 5/21/25 at 5:00 PM where one resident took another resident’s medications, she reported she was up on 2nd floor and went to give Resident #42 his pills. She could not remember what they were. She handed them to him in the medication cup, he picked them up and put the cup by his mouth as if he actually took meds. She did not check his mouth to see if he actually swallowed them. In the past when she handed him his pills, he would say he wanted to take the pills down to the dining room with him. She would tell him no, she would give them later. That day, she did not ask if he wanted to take his pills then or with his meals. She actually thought he took them. b. She was not familiar with his routine and there was nothing on the MARs or care plan that would let her know he preferred to take the medications with his meals. He specifically said the doctors told him he needed to take his medications with food. She though it would be helpful if there were instructions on the MARs for incidents like this. c. When asked what could have been done to prevent the incident, she reported she could have stood there for another 30 seconds to make sure he swallowed his medications. Not ten minutes later, another resident wanted her to leave his medications there for him to take later with supper. d. When asked what was done to prevent this kind of error again, she reported all nurses were educated by notes left in their mailboxes. A review of the facility policy titled: Medication Administration with the last revision date of 6/21/21 had documentation of the following procedure: a. Identify the resident by picture and check the eMAR (Electronic Medication Administration Record). Each medication is to be verified for the right dose, right medication, right time as well as well as right route, by comparing the label on the medication container to the eMAR. b. Read the label three times before dispensing the medication into the med cup or pill pouch. c. Administer the medication. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. Observe the act of swallowing. e. Record the medication given on the eMAR after the medication is swallowed. 2. Resident #54’s MDS assessment dated [DATE] showed a BIMS score of 9/15 indicating a moderate cognitive loss. The MDS listed diagnoses of Non-Alzheimer’s Dementia, Chronic Obstructive Pulmonary Disease (COPD, a chronic lung disease that makes it hard to breath), bipolar disorder (a mental health condition characterized by extreme shifts in mood, energy, activity levels and cycling between high and low depression which can impact the ability to function in daily life, affecting thinking and behaviors) and mild cognitive impairment of uncertain/ unknown etiology. Resident #54's Medication Review Report (MRR) signed by the Provider on 7/08/25 listed an order for an Albuterol Sulfate Inhalation Aerosol Solution 108 (90 base) micrograms per actuation (MCG/ACT) give two inhales orally every six hours as needed for shortness of breath/COPD. The MRR lacked documentation Resident #54 could keep the medication at the bedside. During an observation on 8/13/2025 at 8:33 AM Resident #54 observed sitting in his chair with an Albuterol Sulfate Inhaler sitting within reach on his bedside table approximately 2 foot away. Resident #54 reported that he had COPD and when he takes the inhaler it helps him breath. Observation on 8/13/25 at 8:40 AM revealed the hallway outside of Resident #54 room with no medication cart or nurse in the hallway. Interview completed on 8/13/25 at 1:15 AM Staff H, RN stated medications cannot be left at the bedside unless the care plan specifies the resident can have their medications at the bedside. Usually that includes medications like inhalers and eye drops. Sometimes a resident will ask the nurse to leave medications at the bedside, but those are just over the counter medications. If a resident asks and the medication is an over the counter medication, he will leave the medication with the resident, otherwise certain residents get really upset. Resident #54 cannot have medications left at the bedside, but he does have an inhaler he keeps at the bedside. Staff H assumed Resident #54 has an order for the inhaler to be at the bedside. Resident #54 likes his independence so he has not pulled the inhaler out of the room. Resident #54 is a resident that is in between. He is alert, but is not totally 100% alert. He has good and bad times. Interview on 8/13/25 at 12:00 PM Staff I, RN explained the nurses are not to leave medications at the bedside. Interview on 8/13/25 at 1:35 Staff J, LPN voiced the nurses absolutely do not leave medications at the resident's bedside. Interview completed on 08/13/2025 at 2:00 PM Staff K, LPN stated resident medications are not to be left at the bedside. If a resident does not take their medication, the nurses are to take the medication with them. They lock the medication in the medication cart and re-approach the resident to take later. An 8/13/25 review of Resident #58 Electronic Health Record (EHR) Care Plan, Progress Notes, Assessments and Electronic Medication Administration Record (EMAR) August 2025 lacked documentation of a self-medication administration assessment for safety. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165553	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Vistas at Bettendorf	2500 Grant Street Bettendorf, IA 52722

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/14/25 at 7:21 AM Staff T, Housekeeping voiced he finds pills on the resident floors in their rooms all the time. During an interview on 8/14/25 at 9:44 PM the DON reported there are no residents that self-administer their medications at this time. They provided an education back in June 2025 specifically about not leaving medications in resident rooms. In order for a resident to have medications in their room, a self-medication administration assessment would be completed by herself, the Assistant Director of Nursing (ADON) or the charge nurse followed by an observation of the resident for medication safety. The resident or legal representative would have to sign a medication administration safety form. The DON reported there is no medication safety assessment for Resident #54 because he cannot self-administer his medications and the nurses should not have left any medication in the resident’s room. During an interview on 8/14/25 at 11:09 AM the DON explained they utilize the medication administration competency form for training new nurses. A charge nurse would be responsible for training and observing the new nurse complete medication administration for competency. Each year they do nurse medication competency where she or the ADON watch each nurse complete three resident medication passes. 3.) The Minimum Data Set (MDS) dated [DATE] identified Resident #9 as cognitively intact with a BIMS (Brief Interview for Mental Status) score of 14 and had the following diagnoses: Cerebral vascular accident (CVA) , depression and hemiplegia The MDS also identified Resident #9 as partial to moderate assist with most activities of daily living. On 08/12/2025 at 3:14 PM Resident #9 medications on overbed table next bed, 6 pills in a medication cup. She just woke up when entered the room and no staff present in the room. On 08/14/2025 at 11:04 AM Resident #9 Staff U, RN stated I did work Tuesday on the day shift. I did administer Resident #9 medications. I do not leave her medication in her room because sometimes she will not take her medications. She shouldn't have had them in her room she has been know to store them. Resident #9 takes them in front of me. She should not have medications sitting in her room. I have no idea why they would have been in her room. There were not any medications in the room when I was in the room. Staff U stated medications should not be left in a residents room. 08/14/2025 at 11:15 AM Assistant Director of Nursing (ADON) states medications should not be left at the bed side. Resident #9 would not be appropriate to take medications by herself independently or self administer. We did inservice in June at the nurses meeting about medication administrations. We did bring up to the nurses that medications should not be left at the bedside. Our policy is they should watch them take the medications and swallow the medications.