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	06/04/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review and staff interviews, the facility failed to ensure a resident only received medications prescribed to them for 3 of 3 residents reviewed (Resident #19, Resident #1, and Resident #3) for medication errors. The facility reported a census of 70 residents.Findings include:1. Resident #19's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. The MDS documented he had diagnoses of hypertension, renal insufficiency, and diabetes.Review of the Medication Error Incident Report for Resident #19 documented on 02/03/26 morning medication administration, he received another resident's medication. The medication given were: aspirin 81 mg (milligrams), Caltrate (calcium and vitamin D supplement) 600mg+D3 20MCG (micrograms), carvedilol (beta- blocker works by slowing the heart rate and relaxing blood vessels)12.5 mg, ferrous sulfate (iron supplement) 325 mg, furosemide (diuretic, often called a water pill) 40 mg , hydrochlorothiazide (diuretic) 25mg and a Multivitamin tablet.Review of the February 2026 Medication Administration Record (MAR) revealed Resident #19 had not been prescribed to take: Caltrate, carvedilol, furosemide, hydrochlorothiazide or a multivitamin on 02/03/26.During an interview on 6/4/26 at 9:30 AM, the Director of Nursing (DON) explained on 2/3/26 the nurse became distracted when pulled away from the cart. When the nurse returned to the cart she failed to identify the resident prior to giving the medication. The DON reported she expected staff to do the 6 rights of medication administration and staff are to always identify the resident by asking the resident to confirm.2. Resident #1's MDS assessment date 5/20/26 identified a BIMS score of 9 of out 15, indicating moderate cognitive impairment. The MDS documented he had diagnoses of congestive heart failure, dementia, and renal insufficiency.Review of the Medication Error Incident Report for Resident #1 documented on 5/4/26 morning medication administration, he [Resident #1] received another resident's medication. The medications given were: amlodipine besylate (antihypertensive) 5mg - 2 tabs, carbamazepine ER (extended release anticonvulsant) 2 capsules, lacosamide (anticonvulsant) 200mg, Macrobid (antibiotic) 100 mg, potassium chloride ER (extended release) 20mg, and vitamin C 500mg.Review of the May 2026 MAR revealed Resident #1 had not been prescribed to take: carbamazepine, lacosamide, Macrobid, potassium chloride or Vitamin C on 05/04/26.During an interview on 6/3/26 at 2:53 PM Staff G, Certified Medication Aide (CMA) reported that on the day of the medication error she had put Resident #1's medications in a med cup and got called away to help another staff with a transfer. Staff G explained she put the med cup in the cart to go help. When she came back, she then started getting Resident #20's medications ready and got called away so put that cup in the cart. When she got back to the cart, she gave Resident #1 his medication from one of the med cups in the cart. Staff G stated realized she gave Resident #20's medications to Resident #1. She stated she reported it right away to the nurse and notified the family and physician right away too. 3. Resident #3 MDS assessment dated [DATE] identified a BIMS score of 3 of out 15, indicating severe cognitive impairment. The MDS documented diagnoses of hypertension, seizure disorder and cerebrovascular accident (stroke), transient ischemic attack, or stroke.Review of the Medication Error Incident Report for Resident #3 documented on 05/22/26 morning medication administration, he received another (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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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's medication. The medication given were: amiodarone HCL(medication used to treat a heart arrhythmia) 200 mg, apixaban (anticoagulant, or blood thinner) 5 mg, carvedilol 12.5 mg, clopidogrel bisulfate (antiplatelet) 75 mg, doxazosin mesylate (antihypertensive) 4 mg, empagliflozin (medication used to expel excess blood sugar) 10 mg, Gabapentin (anticonvulsant) 100 mg, pantoprazole sodium (used to treat acid reflux) delayed release, paroxetine HCL (antidepressant) 40 mg, senna plus (stool softener) 8.6-50 mg, spironolactone (diuretic) 50 mg, and torsemide (diuretic) 20 mg.Review of the May 2026 MAR revealed Resident #3 not prescribed amiodarone, apixaban, carvedilol, clopidogrel, doxazosin, empagliflozin, pantoprazole, paroxetine, senna, spironolactone or torsemide on 05/22/26. During an interview on 6/4/26 at 8:18 AM Staff H, CMA reported she was getting Resident #2's medications ready while talking to Resident #3, and then got side track and gave Resident #3 the medications for Resident #2. Staff H stated got a nurse right away and the nurse assessed him and called the doctor and family right away too.Review of the undated facility policy titled Medication Errors revealed, in part: Medication Errors include H. Wrong Person. A document titled Medication Administration listed the 6 Rights of Med Admin(stration), which included: the right patient, the right med, right time, right route, right dose and right documentation. The document listed Common Medication Errors which included, Wrong.Client.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, facility policy review and staff interviews, the facility failed to label, date and store food in accordance with professional standards in an effort to prevent cross contamination and food borne illness. The facility reported a census of 70 residents.Findings include:During an observation on On 6/2/26 at 11:17 AM, the resident refrigerator in the Rehab hallway noted to have sticky substances on the door and on the interior shelves. The refrigerator contained the following unlabeled an undated resident food items: a. Grapes in a sandwich sized bag with no name or date indicated. b. A opened tea drink with no name or open date indicated, and an expiration date of 4/26/26.c. 3 - individual sour cream packets with an expiration date of 11/20/25.d. 8 - individual undated coffee creamers.e. 1 - patterned face mask located in the bottom drawer with no name indicated.f. Mustard container with an expiration date of 5/13/25g. A drink in a to go container with lid and straw with no name or date indicated.The freezer contained 1 blue and black bio mask with the indicated use for migraines. A visible hair noted in the velcro strap of the mask. On the top of the refrigerator sat two containers of a protein supplement with an expiration date of 4/27/26. The protein supplement containers had a cream-colored liquid noted at the base of each container. During on observation on 6/2/26 at 11:17 AM, a refrigerator on the second floor noted to have food particles on inside of the unit. The following food items found in the refrigerator: a. 7- individual Italian dressing packets with an expiration date of 04/04/26.b. 1- yogurt container with an expiration date of 5/23/26.c. An open container of chocolate milk with no name or opened date indicated.d. An apple juice container with an expiration date of 04/16/25.e. 2 -sandwiches wrapped in plastic film with no name indicated, and dated 5/27/26.f. Mexican food in a to go container with no name or date indicated. g. Grapes stored in a sandwich sized bag with no name or date indicated.During an interview on 6/02/26 11:27 AM, Staff B. Licensed Practical Nurse (LPN) stated third shift are to clean the refrigerator and check for expired and unmarked items.During an interview on 6/3/26 11:00 AM, the Administrator stated she expected that the refrigerators are cleaned, all food dated, labeled and expired food thrown out.Review of the facility policy titled Food Safety Requirements dated 12/29/25 revealed, a Guideline section, which directed, in part: All foods stored in the refrigerator or freezer shall be covered, labeled and dated.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on employee file review, staff interviews, and facility policy review the facility failed to ensure staff completed the required Dependent Adult Abuse training within 6 months of hire and that staff completed renewal training within 3 years of previous training for 3 of 9 staff reviewed (Staff C and Staff D, Certified Nurses Aide and Staff E, Cook). The facility reported a census of 70 residents. Findings include:1. Review of Staff C, Certified Nurses Aide (CNA)'s employee file documented a hired date of 3/27/25. A Dependent Adult Abuse (DAA) certificate to indicate the training completed within 6 months of hire not found in the file. 2. Review of Staff D, CNA's employee file revealed documentation DAA training completed on 5/16/23. The file did not have documentation the renewal training had been completed within the required 3 years. 3. Review of Staff E, [NAME] employee file revealed documentation DAA training completed on 10/22/22. The file did not have documentation the renewal training had been completed within the required 3 years. During an interview on 6/3/26 at 10:00 AM, the Human Resources (HR) Director stated Staff C, CNA had not completed the DAA training. She added Staff D, CNA had not completed the three year reviewal of DAA training, and Staff E, [NAME] never completed the right renewal DAA training. During an interview on 6/03/26 10:17 AM, Administrator stated DAA should be completed within 6 months of hire and renewed every 3 years. Review of the undated facility policy titled Abuse Prevention Program revealed the program has mandated training on abuse prevention, identification and reporting. That the training is for new hires and existing staff members as required by Centers for Medicare and Medicaid Services (CMS).