

**Department of Inspections, Appeals, and Licensing
Health & Safety Division
Citation**

Citation Number #10882					Report date August 21, 2025
Facility name On With Life Long Term Care		Survey dates July 28, 2025 - August 5, 2025			
Facility address 1002 Washington Ave					
City Polk City		CP			
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date	
58.43(9)	481—58.43(135C) Resident abuse prohibited. Each resident shall receive kind and considerate care at all times and shall be free from mental, physical, sexual, and verbal abuse, exploitation, neglect, and physical injury. 58.43(9) Allegations of dependent adult abuse. Allegations of dependent adult abuse shall be reported and investigated pursuant to Iowa Code chapter 235E and 481—Chapter 52. (I, II, III) DESCRIPTION Based on record review, facility state self- report intake review, staff interviews, and policy review the facility failed to report to the state agency within the required time frame that a resident’s medication was missing and camera video footage showed the medication was removed by a staff member for 1 of 1 resident (Resident #1) reviewed. The facility reported a census of 38 residents. Findings include: The Admission Minimum Data Set (MDS) for Resident #1 dated 5/15/25 documented diagnoses of stroke and hemiplegia (paralysis of one side of the body) and was dependent on staff for all activities of daily living. The MDS documented a Brief Interview of Mental Status was unable to be	Class II	\$500.00	Upon Receipt	

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Facility Administrator

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	performed due to resident rarely/never understood. The Medication Administration Record, dated 4/1/25 – 4/30/25, for Resident #1 revealed a physician’s order for Dronabinol (a Schedule 3 controlled medication that is a form of the main psychotic active component of marijuana plants) four times a day for nausea. A picture of a pharmacy dispensed medication bubble pack card revealed prescription #C5670485 dated 3/13/25 for Resident #1 for Dronabinol 5 milligrams four times a day, with 4 pills remaining in the card. State agency Intake Information form, intake # 129523, documented the Administrator (ADM) submitted on 6/4/25 at 4:59 PM the following information: the ADM was notified by the Director of Nursing on 5/30/25 at 10:35 AM that a Dronabinol pill that had been prescribed for Resident #1 was missing and that the facility camera video footage on 5/28/25 at 2:14 AM showed Staff A, Registered Nurse (RN), agency staff, handling the packaging without cause. The camera video footage revealed Staff A enter the locked medication room, unlock the refrigerator and handle the Dronabinol medication card, when there was no need to. Staff A, RN then went straight to the breakroom, accessed a locker, sat in the nurses’ station for a couple of minutes before going outside			

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	on a break. On 5/30/25 the following were notified of the incident; the staffing agency Staff A was contracted through, the pharmacy, and the medical provider and a report was filed with the local police department and the state board of nursing. Interview on 7/28/25 at 3:15 PM, the ADM stated she was notified on 5/30/25 by the DON of the missing Dronabinol medication and the video footage. The ADM stated the Assistant Director of Nursing (ADON) was notified on 5/28/25 by a staff nurse that the controlled medication count for Dronabinol was not correct and the DON and ADON started the investigation on 5/29/25. Additionally, the ADM stated she did not report to the state agency until 6/4/25 as there was no current order for the medication, no resident was impacted by the missing medication, and the medication actually wasn't prescribed to any resident. The ADM did agree that the missing medication was prescribed for Resident #1 when it was dispensed from the pharmacy and Resident #1's name was on the medication card. Facility Self-Report document submitted by the ADM on 6/4/25 at 4:59 PM revealed the following: Criminal act occurred 5/28/25 2:15 AM, and date aware 5/30/25. ADM received notification from the DON at 10:35am on 5/30/2025 that we had one 5mg Dronabinol pill missing, and camera footage showed a night shift agency nurse handling the			

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	packaging without cause. The Dronabinol had been discontinued for the resident but had not been destroyed. The medication had been prescribed for Resident #1. Resident #1 was discharged to the hospital as after 12 days in the hospital it appeared that she would not return to the facility. Resident #1 was re-admitted to the facility 24 days after her discharge. When she re-admitted back to the facility she was no longer on the Dronabinol, and the order for it was discontinued. Reviewing the camera footage, at 2:14am on 5/28/25, Staff A was observed entering the locked medication room, unlocking the refrigerator and handling the Dronabinol card, when there was no need to, then going straight into the breakroom and accessing a locker. Staff A then sat in the nurses station for a couple of minutes, before going outside on a break. As this medication was not active for any resident at the time of the theft and no residents were impacted, we did not notify any resident/resident representative(s). Interview on 7/30/25 at 1:15 PM, the ADON stated Staff B, RN called her on 5/28/25 between 6 PM - 7PM and stated the Dronabinol was missing and unaccounted for. The ADON stated she told Staff B she would talk to the DON and look at it in the morning. The ADON stated the next day she worked on getting camera video footage, looked around for the medication, and concluded that 1 pill was			

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	missing from the Dronabinol, as should have been 5 pills and was only 4. The ADON stated the narcotic count sheet was signed as accurate on 5/27/25 at 6 PM so she and the DON reviewed the facility video footage for 5/27/25 6 PM – 5/28/25 6 PM for the camera above the refrigerator where the Dronabinol was stored, and during review of the video footage, Staff A was the only staff member that handled the Dronabinol medication card, which was the only medication card in the refrigerator at the time. Interview on 8/5/25 at 11AM, the DON stated the ADON reported to her on 5/29/25 that the ADON had received a call from an evening shift nurse regarding a medication discrepancy on 5/28/25. The DON stated on 5/29/25 she completed interviews with the nurses and was not able to come to a conclusion for the missing medication. The DON stated on 5/30/25 she received the camera video footage and reviewed all footage for 5/27/25 6 PM – 5/28/25 6 AM. The DON stated during review of the footage she observed Staff A go into the medication room, remove the dronabinol medication card from the refrigerator, appeared that Staff A put a pill from the card into a cup, covered the cup with a paper towel, removed the cup from the medication room, go into the break room and opened and reached into a locker. The DON notified the ADM on 5/30/25 of her				

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	findings after the video observations with her conclusion that she felt Staff A had taken the missing medication. The DON stated on 5/30/25 she reported her findings to the state board of nursing, police and the staffing agency Staff A worked through but did not file a report to the state agency. The facility Mistreatment of Person Served-Prevention and Reporting Policy revised 6/24 documented the facility prohibits abuse, exploitation, misappropriation of person property, and any other violation of rights (collectively "mistreatment") and all facility personnel are mandatory reporters for mistreatment and have an independent duty to report. The policy further documented all incidents of suspected mistreatment/crimes against person served shall be reported (and investigated) in accordance with applicable laws and regulations including reporting immediately to a supervisor and within 2 hours to local law enforcement and the state hotline number. FACILITY RESPONSE			

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