DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0466	A. BUILDING: _____ B. WING _____	C 09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUARTET SENIOR LIVING MC	3150 GLENBROOK CIRCLE SOUTH BETTENDORF, IA 52722

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 3 Number of tenants with cognitive impairment: 18 Total census: 21 The following regulatory insufficiencies were cited during the investigation into Complaint #121670-C.	A 000	The POC is attached	
A 160	481-69.23(1)c(1) Criteria for Admission / Retention of Tenants 69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who: c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who: (1) Despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program retained 1 of 1 discharged tenants who displayed verbal and physical aggression (Tenant C1). Findings include: Record review of progress notes for Tenant C1 revealed the following entries: - on 3/25/24, Tenant C1 was transferred to a	A 160		

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A 160	Continued From page 1	A 160		

hospital emergency room for an evaluation due to aggressive behaviors. She was swinging and yelling at staff and tenants as well as chasing staff. Tenant C1 was sent back with no new medication orders.
- on 5/16/24, Tenant C1 was attempting to hit other tenants. She was pacing around the hallway with an angry look on her face. Later in the day, Tenant C1 hit a resident assistant three times. Tenant C1 also hit a nurse in the left arm and threw a ball at her. The nurse decided Tenant C1 needed 1:1 supervision as the other tenants were afraid of the tenant. Eventually staff called the police and medics to transport Tenant C1 to the emergency room where she was treated and released.
- on 5/17/24, Tenant C1 swung her arm near another tenant but did not make contact with him.
- on 5/31/24, Tenant C1 had an incident of combativeness and wandering. She told a staff member she was tired and wanted to die. Staff increased supervision of Tenant C1. They notified her primary care provider and power of attorney of the incident.
- on 6/1/24, Tenant C1 was walking in the hallway when she came across Tenant #1. Tenant C1 grabbed the shoulders of Tenant #1 and shook her back and forth. Tenant #1 lost her footing, fell and hit her head on a wheeled walker and the floor. Tenant #1 reported her neck and the right side of her head hurt. Tenant #1 was transferred to the hospital. A CT of her head showed no evidence of an intracranial bleed. A CT of her spine and x-ray of the sacrum and coccyx showed no acute findings.

Tenant C1 went to her room after the incident on 6/1/24 where she hit at the door. A police officer and fireman arrived and Tenant #1 became combative with them and tried to kick and bite

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A 160	Continued From page 2 them. They restrained Tenant #1 and placed handcuffs on her. Tenant C1 was then transported to the hospital. The program provided Tenant C1 with a 30-day written notice of breach and termination of the occupancy agreement on 6/3/24 due to being dangerous to self or other tenants or staff. Tenant C1 had a service plan dated 2/20/24. It included a behavior management plan which was implemented on 11/15/23 to address instances when Tenant C1 became agitated with staff or paced anxiously in the unit. Tenant C1 had interventions in her service plan back to 11/15/23 to address her aggression. She had further incidents of aggression toward staff and/or tenants on 3/25/24, 5/16/24, 5/17/24 and 5/31/24. The program did not provide Tenant C1 with notice until 6/1/24, when she grabbed and shook Tenant #1 resulting in the need for emergency medical treatment. The program should not have retained Tenant C1 when they were aware of her earlier acts of aggression. These findings were confirmed by the Regional Director of Operations on 9/9/24 at 11:00 AM.	A 160		
A 355	481-69.26(2) Service Plans 69.26(2) Prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit, a preliminary service plan shall be developed by a health care professional or human service professional in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative.	A 355		

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A 355	Continued From page 3 All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to ensure a preliminary service plan was developed and signed prior to the signing of an occupancy agreement for 1 of 3 tenants reviewed (Tenant #3). Findings follow: Based on observation, interview and record review, the program allowed 1 of 3 current tenants reviewed to move into an apartment prior to signing the occupancy agreement (Tenant #3). Findings follow: Record review on 9/4/24 revealed progress notes for Tenant #3 (who previously resided in the Assisted Living program) dated 8/19/24 identifying she was spending time in the Memory Care program on a trial basis and was noted to have mostly positive experiences over the weekend. She had some periods of agitation about not knowing where things were or where to go but was easily redirected by staff. The Assistant Director of Nursing updated Tenant #3's daughter (the tenant's power-of-attorney) and was awaiting the go ahead to make the switch to Memory Care. On 8/23/24 at 4:45 PM, it was documented Tenant #3's daughter spoke with the Life Enrichment Director and Marketing Director and received verbal agreement for Tenant #3 to temporarily stay in the Memory Care program due to safety concerns. They coordinated a time for Tenant #3's power of attorney (daughter) to sign the paperwork to make the move to the Memory Care permanent.	A 355		

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A 355	Continued From page 4 A tour of the Memory Care program on 8/28/24 at 3:30 PM with the Assistant Director revealed an apartment with Tenant #3's name on the outside of the door. The apartment was empty. The Assistant Director reported Tenant #3 was staying in the program's model apartment. Tenant #3 was sleeping on the bed inside of the apartment. Personal items were scattered throughout the apartment. Tenant #3 had been residing in the Memory Care program for a couple of weeks due to concerns with her safety, according to the Assistant Director. Tenant #3 had a service plan with a date of 8/26/24, however the service plan was not signed or dated by either the daughter or a representative of the program until 9/4/24. Tenant #3's representative signed an occupancy agreement for her move from the Assisted Living program to the Memory Care program on 8/28/24 at 6:30 PM, at least 9 days after she began sleeping in an apartment in the Memory Care program. The Regional Director of Operations confirmed this finding on 9/9/24 at 11:00 AM.	A 355		

Quartet Senior Living
Plan of Correction

Facility Name: Quartet Senior Living, Bettendorf, IA

Survey Date: September 4, 2024

Violation/Deficiency: A 160 481-69.23(1)c(1) Criteria for Admission / Retention of Tenants

1. **Elements detailing how the Program will correct each regulatory insufficiency, including at the system level.**

   C1 discharged from the community on 7/5/2024

2. **Measures taken to ensure the problem does not recur.**

   The Regional Director of Operations educated the leadership and the community associates on the process and requirements for ensuring that communication is provided on new aggression and ensuring interventions are placed and monitored. Resident Services Director (RSD) and designee were trained on use of shift-to-shift report to ensure any resident aggression with potential risk for harm to self or others is evaluated immediately. The discharge process and providing a discharge notice was also reviewed. A new communication tool (shift to shift) was implemented to ensure that the Resident Aides (RAs) are communicating with the nurses each shift, team is documenting and notifying of new aggression or changes.

3. **How the Program plans to monitor performance to ensure compliance.**

   The leadership team is reviewing the communication tool (Shift to Shift) and discussing at the morning stand up meeting to monitor and ensure that interventions are complete. The Resident Service Director (RSD) is monitoring and auditing weekly and will continue for one quarter and report findings to the QAPI committee. The QAPI committee will review and will make recommendations as needed. The committee will decide if continued weekly monitoring needs to take place or if the community is maintaining compliance after the quarter is complete.

4. **The date by which the regulatory insufficiency will be corrected.**

   October 30st, 2024

Quartet Senior Living
Plan of Correction

Violation/Deficiency: A 355 481-69.26(2) Service Plans

1. **Elements detailing how the Program will correct each regulatory insufficiency, including at the system level.**

A new service plan and agreement was signed on September 4, 2024 with the family of Tenant 3.

2. **Measures taken to ensure the problem does not recur.**

Education was provided to the leadership team regarding not moving a resident internally without an updated service plan. As well as, not admitting a resident without a service plan signed prior to agreement and admission.

3. **How the Program plans to monitor performance to ensure compliance.**

An audit tool was developed to ensure that the community is monitoring the service plans, reviewing them with resident & responsible party, and timely signing. The tool is being updated as new residents come to the community and will be used if resident moves from one program to the other. This tool will be reviewed weekly by the Executive Director or designee weekly for one quarter. After the quarter, the QAPI committee will make recommendations to continue or cease if compliant.

4. **The date by which the regulatory insufficiency will be corrected.**

October 30st, 2024

Quartet Senior Living
Plan of Correction

Violation/Deficiency: A 150 481-67.2(3) Program Policies and Procedures- Notification to POA/Families

1. **Elements detailing how the Program will correct each regulatory insufficiency, including at the system level.**

   For the resident found to have been affected with this deficient practice, community called the family and notified of incidents and ensured they were update on resident's clinical status. Family was also informed that going forward, community will continue to update them for incidents and any other clinical changes along with hospice communication. Resident Service Director (RSD) and designee conducted a thorough audit of fall incidents. RSD provided in-service/ training sessions for nurses and clinical staff, using procedure for Incident & Accident Management, focusing on the importance of timely notification of resident representatives regarding incidents.

2. **Measures taken to ensure the problem does not recur**

An audit tool has been implemented and is being reviewed by the RSD or designee each week. The Resident Service Director or designee to ensure that there is timely notification of incidents to resident representative.

3. **How the Program plans to monitor performance to ensure compliance?**

Results of the audit will be reviewed at the community QAPI meeting. The team will review the audits and update as needed. These audits will be conducted for three months to ensure that the community stays within compliance. After the quarter, the QAPI committee will make recommendations to continue or cease if being done appropriately and maintaining compliance.

4. **The date by which the regulatory insufficiency will be corrected.**

October 30st, 2024