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 09/23/2025

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. Tenants without cognitive impairment: 1 Tenants with cognitive impairment: 27 Total census: 28 No regulatory insufficiencies were cited during the investigation of Incident #129627-I and Complaint #129504-C. The following regulatory insufficiencies were cited during the investigation of Complaint #130350-I and the recertification visit conducted to determine compliance with certification of an Assisted Living Program for People with Dementia.	A 000	see attached POC 12/24/25	
A 155	481-69.23(1)b 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: b. Requires routine, two-person assistance with standing, transfer or evacuation This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the Program retained 2 of 4 tenants reviewed who regularly required the assistance of two staff for transfers (Tenant #1 and Tenant #3). Findings follow: 1. Record review on 9/16/25 identified Tenant #1 was a 78 year old man diagnosed with	A 155		

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A 155	Continued From page 1	A 155		

Alzheimer's disease and Parkinson's disorder. He scored a six on the Global Deterioration Scale indicating a severe cognitive decline. Tenant #1's progress notes revealed on 8/27/25, staff entered Tenant #1's room and found him on the floor in front of his wheelchair next to his bed. He was lying on his left side with a small skin tear to the back of his head, a purple bruise to his left posterior forearm and two abrasions to his right posterior forearm. The Emergency Medical Services (EMS) were called and EMS transferred him to the hospital in the afternoon. Tenant #1 was diagnosed with a compression fracture of the T-12 (the twelfth thoracic vertebrae) and returned in the early morning hours of 8/28/25 with a TLSO (Thoracolumbosacral Orthosis) brace which he needed to wear at all times.

A review of the hospital discharge summary dated 8/28/25 revealed Tenant #1's daughter accompanied him to the Emergency Room (ER). The ER doctor talked with Tenant #1's daughter to ask if the Program would be able to care for him due to his generalized weakness and the fall. The daughter believed the Program would be able to do so. The doctor asked the ER nurse to contact Program staff to ensure he would be able to safely discharge there due to his weakness and the fracture rather than to a skilled nursing facility. The doctor spoke with the ER nurse following the call and she said the Program would take him back. He was to meet with an orthopedist on 8/28/25.

During an interview on 9/16/25 at 6:25 p.m.,Staff E reported she received the call from the ER nurse on 8/28/25. She recalled she replied yes to the ER nurse, who asked if staff were in the building and able to receive Tenant #1. The ER nurse asked if there was a nurse on duty and

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Staff E reported there was not. The ER nurse told her Tenant #1 had a broken vertebra and a back brace, but did not explain the care he needed. Staff E indicated when the medics and Tenant #1 returned from the ER and she set eyes on him, she questioned their ability to care for the tenant. She told the medics he needed 1:1 attention and they couldn't provide this. The individuals who transported him back to the building reportedly seemed concerned about Program staff's ability to keep him safe as he was unable to get out of bed without falling. She called the Navigate Manager who was on-call and asked if they could send him back to the ER due to concerns about his safety.

Tenant #1 and the Navigate Manager, a Registered Nurse, met with an orthopedist on 8/28/25. A report from the orthopedist confirmed the diagnosis of a fracture of the T12 and explained the tenant should wear the brace at all times. The orthopedist recommended Tenant #1 use a walker when ambulating. The tenant needed to be diligent about using the walker and wearing the brace. Tenant #1 and the Navigate Manager were advised he should rest, ice, compress, and modify his activities.

During an interview on 9/16/25 at 4:55 p.m. the Navigate Manager confirmed attending the orthopedic appointment with Tenant #1. The orthopedist made it clear Tenant #1 should not fall due to the seriousness of the injury to his spine. The Navigate Manager informed staff they needed to keep Tenant #1 within their line of sight at all times. The Navigate Manager said she was told by the orthopedist Tenant #1 could not fall again. The family arranged for a private caregiver for him during the overnight shift.

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A 155	Continued From page 3 Review of an incident report dated 8/29/25 revealed staff walked into the living area and found Tenant #1 on the floor. The recliner was elevated and the tenant was on his bottom. The staff member did not observe any injuries during the body assessment. His brace was intact and he complained of back pain, however it was not new back pain. Tenant #1 was unable to rate his pain. A predisposing factor to the fall was Tenant #1 was ambulating without assistance. The incident was not witnessed. Tenant #1 experienced an unwitnessed fall on 8/31/25 at 4:00 p.m.. He was found laying on the floor with his wheelchair behind him in the day room. Four staff assisted him off the floor and into his wheelchair. Tenant #1 experienced a second unwitnessed fall on 8/31/25 at 5:06 p.m. He sat in the recliner with his feet elevated and tipped the front of the chair over and slid out onto the floor with his back up against the footrest of the recliner. Staff attempted to do a full assessment, but due to the back brace and T12 fracture, they were unable to get him off the floor safely. The medics were called and Tenant #1 was transferred to the hospital. A review of Tenant #1's hospital records revealed he was admitted on 8/31/25 following two unwitnessed falls. A history and physical completed on 9/01/25 noted no change to the T12 fracture, but he was unable to ambulate safely and his pain was worse with activities. He had acute back pain. The physician recommended he be transferred to a skilled nursing facility and received physical therapy and occupational therapy. During an interview on 9/17/25 at 4:00 p.m., Staff D reported she was present for two of Tenant #1's falls after he returned from the hospital with his	A 155		

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fracture. He needed a two-person assist during this time period. He hallucinated. She recalled one night she was supposed to leave at 11:00 p.m. but could not due to the intensity of Tenant #1's hallucinations. He would not sit down because he was afraid of falling. It took two employees to get him ready for bed. She did not think it was safe for him to have returned to the program after his fracture.

During a further interview with Staff E she recalled after he returned from his T12 fracture, Tenant #1 would not stay still and kept trying to remove his brace. He tried to get out of chairs on his own. Tenant #1 was a constant two to one transfer. She felt there was no way to keep him safe.

During an interview on 9/16/25 at 2:50 p.m. Staff C reported following 8/27/25, Tenant #1 required two to three staff for transfers. He constantly tried to remove his brace as he did not understand why he needed to keep it on.

During an interview on 9/17/25 at 4:30 p.m. the Resident Services Director (RSD) and Navigate Manager reported they were hopeful the orthopedist would recommend surgery following the 8/28/25 appointment. When this was not the case, they did what they could to keep him safe but it was clearly not enough. Looking back, they should have done more.

2. Record review on 9/16/25 of Tenant #3's progress notes revealed on 7/28/25 the nurse met with her daughter regarding a change in status. Tenant #3 regularly transferred with the assistance of two staff. On 8/18/25, a significant change assessment was completed due to Tenant #3's decline in her mobility and ability to

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A 155	Continued From page 5 transfer. She pushed back when staff attempted to assist her to stand. Tenant #3 exhibited these behaviors since 7/01/25. During an interview on 9/16/25 at 2:05 p.m. Staff B reported Tenant #3 used a two-person transfer most of the time. She attributed this to Tenant #3's behaviors which included she locked her legs and refused to get up when prompted by staff. When interviewed on 9/17/25 at 4:00 p.m. Staff D indicated Tenant #3 displayed a number of behavioral issues requiring two staff to help her with transferring. She was able to do more for herself, but chose not to help staff with her care. When interviewed on 9/17/25 at 4:30 p.m. the RSD and Navigate Manager confirmed Tenant #3 required two staff to assist with transfers over half the time and exceeded the assisted living level of care.	A 155		
A 360	481-69.26(3) Service Plans 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the Program failed to update the service plan for 1 of	A 360		

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A 360	Continued From page 6 4 residents reviewed with a fractured spine (Tenant #1). Finding follows: Record review on 9/16/25 revealed Tenant #1's progress notes dated on 8/27/25, indicated staff entered his room and found him on the floor in front of his wheelchair next to his bed. He was lying on his left side with a small skin tear to the back of his head, a purple bruise to his left posterior forearm and two abrasions to his right posterior forearm. The Emergency Medical Services (EMS) were called and EMS transferred him to the hospital. Tenant #1 returned in the early morning on 8/28/25 after being diagnosed with a compression fracture of the T-12 (the twelfth thoracic vertebrae) and needed to wear a TLSO (Thoracolumbosacral Orthosis) brace at all times. He needed to follow up with an orthopedic clinic later in the morning. On 8/28/25, Tenant #1 and the Navigate Manager, a Registered Nurse, met with an orthopedist. The orthopedist confirmed the diagnosis of a fracture of the T12 and explained he should wear the brace at all times. The orthopedist recommended Tenant #1 use a walker when ambulating. The tenant needed to be diligent about using the walker and wearing the brace. The orthopedist explained to them Tenant #1 needed to rest, ice, compress, and modify his activities. During an interview on 9/16/25 at 4:55 p.m. the Navigate Manager confirmed attending the orthopedic appointment with Tenant #1. The orthopedist made it clear Tenant #1 should not fall due to the seriousness of the injury to his spine. The Navigate Manager informed staff they needed to keep Tenant #1 within their line of sight at all times. The family arranged for a private	A 360		

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A 360	Continued From page 7 caregiver for him during the overnight shift. Tenant #1 fell three times and on 8/30/25 went back to the emergency room. When interviewed on 9/16/25 at 2:05 p.m., Staff B recalled staff were told they needed to keep Tenant #1 within line of sight following his fall on 8/28/27. He kept trying to take his brace off and was in terrible pain. On 9/16/25 at 2:50 p.m. Staff C reported following on 8/27/25, Tenant #1 required two to three staff for transfers. He constantly tried to remove his brace as he did not understand why he needed to keep it on. A service plan and Iowa Assisted Living Assessment were developed on 8/20/25 when Tenant #1 experienced a change of condition. The Program failed to update his service plan following his fall on 8/28/25 to reflect the need to wear his TSLO brace, the need for staff to keep him within line of sight and his need for increased assistance with transfers when providing care. On 9/24/25 at 1:30 p.m. the Resident Service Director (RSD) and Navigate Manager confirmed these findings.	A 360		
A 395	481-69.26(4)a Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance	A 395		

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A 395	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the Program failed to ensure the service plans included the needs of 3 of 4 tenants reviewed (Tenant #2, Tenant #3 and Tenant #4). Findings follow: 1. Record review on 9/16/25 revealed Tenant #2's progress notes indicated on 6/11/25 Tenant #2 became verbally aggressive with staff over seating in the dining room with family. He approached staff in an aggressive manner, cursing at them. On 6/19/25, Tenant #2 approached two staff and ruffled their hair. Tenant #2 tightly grabbed another tenant's arm and walked with this person around the hall and would not let go. When asked to do so, he threw an item at the wall. He threatened staff and grabbed a staff member's wrist. Staff called 911 and he went to the emergency room due to agitation. On 7/03/25, Tenant #2 became agitated while sitting at the dining table. He picked up a fork and raised it to strike the table. He was asked to walk away due to safety reasons, which he did. He left the area but became agitated when another tenant came into sight. The Program nurse wrote a 90-day review on 8/27/25 which she observed Tenant #3 short tempered and frustrated with others then withdrew to his apartment. On 9/05/25, the note indicated Tenant #5 agitated off and on throughout the day. When interviewed on 9/16/25 at 1:34 p.m. Staff A indicated Tenant #2 threatened to punch the staff. He also charged at staff and cornered them. This happened each day she worked. She heard Tenant #2 whispering about the things he was thinking about doing to staff and tenants.	A 395		

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When interviewed on 9/16/25 at 2:05 p.m. Staff B reported it did not take much to set Tenant #2 off. He self-isolated and often hallucinated. The other night, Tenant #2 told an employee he would kill her. He often fixated on being abused

When interviewed on 9/16/25 at 2:50 p.m. Staff C reported Tenant #2 often lived in an altered state. He could be triggered by other tenants yelling at night. If staff gave him space, he de-escalated.

When interviewed on 9/16/25 at 6:25 p.m. Staff E indicated Tenant #2 tried to break through a door when he heard a female tenant yelling. The previous week he tried to get into another tenant's room to "get at" an employee.

Tenant #2's service plan noted he required frequent assistance with redirection. He moved about without purposeful direction and needed naps. If staff met resistance when helping him with activities of daily living they should stop and reapproach at a later time. The service plan failed to mention aggression, hallucinations, triggers by past abuse and others yelling.

2. Record review on 9/16/25 revealed Tenant #3's progress notes indicated Tenant #3 met with her physical therapist on 8/10/25 and ambulated 100 feet with encouragement. She was encouraged to participate in activities. On 8/13/25, Tenant #3 met with the physical therapist and walked 120 feet. Staff were asked to encourage her to participate in activities and to walk. The nurse documented she assessed Tenant #3 due to her decline in transfers and mobility. She was known to push back against staff when they attempted to assist her to stand, which was believed to be a behavior she exhibited since 7/01/25. On 9/01/25, she saw the physical therapist, he documented

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A 395	Continued From page 10 Tenant #3 refused gait training due to a fear of falling and right knee pain. During an interview on 9/16/25 at 2:05 p.m. Staff B reported Tenant #3 transferred with two people most of the time. She attributed this to the Tenant #3's behaviors which included she locked her legs and refused to get up when prompted by staff. When interviewed on 9/17/25 at 4:00 p.m. Staff D indicated Tenant #3 displayed a number of behavioral issues which led to her requiring two staff to complete transfers. She was able to do more on her own, but chose not to help staff with her care. A review of Tenant #3's service plan, last updated on 7/28/25, revealed she was able to get in and out of bed with an assist of two. The plan noted a need for staff to reorient her when she wandered. The plan indicated Tenant #3 would participate in activities. The section which identified what activities she liked, noted "likes/hobbies:___" with no entries. The activities section was last updated on 6/18/25 even though the physical therapist suggested Tenant #3 participated in activities. The plan failed to mention Tenant #3 received physical therapy, refused to help with her care or displayed behaviors. 3. Record review on 9/16/25 revealed Tenant #4's service plan dated 6/18/25 noted she transferred safely with assistance. She was not ambulatory. She required frequent assistance with redirection. When interviewed on 9/16/25 at 1:34 p.m. Staff A reported Tenant #4 required a two person assist with transfers and also required up to three staff to help her with showering. Tenant #4 yelled out	A 395		

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A 395	Continued From page 11 when she received incontinence care. When interviewed on 9/16/25 at 2:05 p.m. Staff B indicated Tenant #4 required two staff to provide transfers every day. She was known to yell out when she received toileting assistance. During an interview on 9/17/25 at 4:00 p.m. Staff D indicated there were days it took three to four staff to assist Tenant #4 with toileting assistance as she actively worked against them. Tenant #4's service plan failed to identify that she required the assistance of more than one person for transfers and activities of daily living. Her plan failed to mention she yelled out when she received incontinence care.	A 395		

Quartet Senior Living

Plan of Correction

Facility Name: Quartet Senior Living, Bettendorf, IA

Survey Date: 9/16/25

Violation/Deficiency: A 155 481-69.23(1)b Criteria for Admission/Retention of Tenants

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

Each readmission will continue to be screened by the registered nurse prior to accepting the resident back to the community. Any noted change of care level will be assessed by the registered nurse then discussed with IDT for discharge to higher level of care.

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

Immediate assessment of resident upon noted change in level of care.

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

Audit charting on level of assist of 6 residents for 90 days. Assess and review all therapy notes for new admissions for 90 days.

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

12/24/25

Quartet Senior Living

Plan of Correction

Facility Name: Quartet Senior Living, Bettendorf, IA

Survey Date: 9/16/25

Violation/Deficiency: A360 481-69.26(3) Service Plans

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

Each resident's service plan will continue to be reviewed and updated within 30 days of occupancy, annually, semiannually as required with assessments.

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

Service plans will be reviewed for all admissions, semiannually, annually, and with any significant change.

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

Will review 6 service plans weekly for 90 days.

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

12/24/25.

Quartet Senior Living

Plan of Correction

Facility Name: Quartet Senior Living, Bettendorf, IA

Survey Date: 9/16/25

Violation/Deficiency: A 395 481-69.26(4)a Service Plans

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

Memory Care resident's service plans will continue to be reviewed and updated as required with admission, annual, semi-annual, and significant change assessments to address the resident's behaviors, triggers and interventions to mitigate the behavior

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

Service plans for Memory Care residents will be reviewed for all admissions, semiannually, annually, and with any significant change.

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

Will review 6 service plans weekly for 90 days.

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

12/24/25.