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 04/07/2026

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: 0 Tenants with cognitive impairment: 24 Total census: 24 The following regulatory insufficiency was cited during the investigation of Incident #130946-I.	A 000	see attached POC 5/23/26	
A 285	481-69.26(4)a Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and indicate: a. The tenant's identified needs and preferences for assistance; This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to include a tenant's specific needs on the service plan to prevent falls for 1 of 1 tenants reviewed (Tenant #1). Findings follow: Record review on 3/30/26 revealed the following information related to Tenant #1 from incident reports and progress notes: - An incident report dated 9/2/25 noted staff was called into her room on 9/2/25 by family. Tenant #1 was on the floor in between the bed and lift chair. Her lift chair was all the way up in the air. She complained of pain to her bottom. Redness was noted on the upper right side of her back. An	A 285		

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A 285	Continued From page 1	A 285		

incident note dated 9/3/25 identified the root cause of the fall was raising her lift chair too high and slipping out. The fall intervention was the family looking at fixing the chair so it would not lift as high.

- An incident note dated 9/4/25 documented staff entered Tenant #1's room for a safety check and found her on the floor next to the lift chair on the right side. Her footrest was all the way reclined up. It appeared she tried to get out of the chair without putting the footrest down and slid out. Tenant #1 had a purple bruise on her posterior forearm and rear shoulder blade. A progress note on 9/5/25 listed the root cause analysis of the fall as Tenant #1 attempting to take herself to the toilet and the intervention would be staff providing her with toileting assistance more frequently.

- On 9/11/25 an incident report noted Tenant #1 was found on her right side on the floor in front of her recliner with her blankets on the floor beside her. No injuries were noted but she complained of generalized pain. An incident note from 9/15/25 listed the cause of the fall to be increased restlessness. An intervention was listed to bring Tenant #1 to more activities.

- Staff did not see Tenant #1 in her apartment when looking through the window on 9/18/25. When the employee went into the apartment she was found on the floor. Tenant #1 complained of pain when breathing or moving her left side. The root cause of the analysis of the fall was self ambulation, based on a 9/22/25 incident note. A meeting was scheduled with Tenant #1's daughter with a plan to get her a fall watch.

A final report following an 11/16/25 unwitnessed

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A 285	Continued From page 2	A 285		

fall with fracture noted Tenant #1 was a 95-year-old female with a diagnosis of Parkinson's disease and osteoarthritis. She scored a five on the Global Deterioration Scale, indicating a moderately severe cognitive decline. Tenant #1 had an unwitnessed fall from her electric recliner in her apartment on 11/16/25 at 9:36 p.m. She was transported to the emergency department (ED). An incident note from 11/17/25 identified the root cause of the fall on 11/16/25 was the electric recliner. The intervention was to ask the family to replace the electric recliner with a manual recliner.

Tenant #1's service plan, dated 9/26/25, included dates on which interventions were added to the plan. She had four safety checks a shift. Tenant #1's service plan included the following:

-Toileting: Tenant #1 had a goal to toilet safely with an intervention of needing assistance (6/18/25). No intervention was added for staff providing her with toileting assistance more frequently from the 9/4/25 incident.

-Transferring: Tenant #1 wanted to be able to transfer safely and get in and out of a bed, chair, car, etc. (2/28/25). No intervention was added for the lift chair after the 9/2/25 incident.

-Mobility: She had a history of falls which put her at risk if she ambulated without assistance (7/2/25).

-Falls: Staff could help her to prevent falls by minimizing clutter in the apartment (6/18/25). No interventions were noted for 9/11/25 for activities. No fall watch was added after the incident on 9/18/25.

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Interventions failed to be added to the service plan until 11/17/25 after the unwitnessed fall with a fracture on 11/16/25.

The ED Physician Notes detailed Tenant #1 presented following a fall with left shoulder pain, hip pain, facial pain and headache after a mechanical fall. She was found on the ground by staff members after a suspected fall out of her recliner. The daughter suspected the patient was using her remote to raise her chair to the standing position which caused her to fall. An x-ray of Tenant #1's shoulder showed an acute left humeral neck fracture. Other x-rays were negative. Following her time in the hospital, tenant #1 was transferred to a skilled nursing facility. She returned to the Program on 1/9/26.

When interviewed on 4/01/26 at 4:00 p.m. Staff C recalled entering Tenant #1's apartment on 11/16/25 and finding the lift chair up and at a 90 degree angle. Tenant #1 was laying face first on the floor. When staff attempted to touch her she was saying, "ow, ow". The staff contacted the on-call nurse and Tenant #1's daughter, who transported her to the ED. Staff C believed toileting was an issue related to Tenant #1's falls. When the tenant was constipated, staff needed to check on her more frequently as she would get up and down, wanting to go to the bathroom. Her balance was an issue. Tenant #1 liked to fiddle with things. She would lose her remote, take her pendant off and then press it. Her vision was impaired, which led to her confusing the pendant for the remote.

When interviewed on 3/31/26 at 11:55 a.m. Staff A explained she told the nurse several times Tenant #1 pressed the remote on her lift chair, thinking it was her pendant. The tenant's son

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A 285	Continued From page 4 was at the Program a few times trying to replace the remote because it was hot. During an interview on 3/31/26 at 12:30 p.m. Staff B recalled entering Tenant #1's apartment and finding her in the lift chair with her feet in the air and the chair completely reclined. Other times Tenant #1 would be stuck all the way up in her chair. Staff B believed her chair should have been removed long before the tenant's fall on 11/16/25. During an exit interview on 4/7/26 at 2:40 p.m. the Wellness Director confirmed the Program did not include information about Tenant #1's specific needs on her service plan.	A 285		

Plan of Correction

StoryPoint Bettendorf

Previously known as Quartet Senior Living – MC

3150 Glenbrook Circle South

Bettendorf, IA 52722

Cited Deficiency: A 285 481-69.26a - Service Plans

- **The Corrective Actions which were accomplished for those residents who were found to have been affected by the deficient practice:**
  - Tenant #1 electric recliner was removed from her apartment after 11/16/2025 fall.
- **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**
  - All residents that had a fall with the intervention not completed have the potential to be affected.
  - No other residents were identified during the post investigation.
- **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur:**
  - The Wellness Director or her designee will review the Incident Reports in PCC as well as the 24-hour report at the Clinical Stand-Up meeting, to review falls, identify interventions, and ensure tasks and service plans are updated.
  - The Wellness Director or her designee complete routine rounds to ensure there are no electric recliners in Memory Care.
  - The Wellness Director or her designee will inform new residents that electric recliners are not allowed in Memory Care.
- **How the corrective actions will be monitored to ensure the deficient practice will not reoccur:**
  - An ad-hoc quality meeting was held with all Wellness leaders to discuss the deficient practice.
  - Any deficiencies noted in internal audits will be addressed at the Clinical Stand-Up meeting.
- **The date by which the regulatory insufficiency will be corrected: 5/23/2026**