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
	S0465	A. BUILDING: _____ B. WING _____	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUARTET SENIOR LIVING	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 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 interview and record review, the program failed to update the service plans for 4 of 9 tenants reviewed when they experienced a significant change of condition (Tenant #1, Tenant #2, Tenant #7 and Tenant #9). Findings follow: 1. Record review on 9/18/25 revealed Tenant #1 moved to the program on 8/22/25. An initial service plan was written on 7/25/25 and identified she was able to get in and out of bed with the assistance of one staff member. She was not ambulatory and needed staff to push her wheelchair. A review of Tenant #1's progress notes identified the following: On 9/03/25 she saw an outpatient provider for a re-assessment for physical therapy. Tenant #1 recertified to continue physical therapy to work on transferring, gait and lower bilateral extremity strengthening. On 9/05/25 the Executive Director and Resident Services Director (RSD) met with Tenant #1 for making excessive requests of staff to complete tasks such as putting her groceries away,	A 360	see attached POC 12/24/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0465	A. BUILDING: _____ B. WING _____	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUARTET SENIOR LIVING	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 360	Continued From page 1	A 360		

procuring items within her reach and scratching her lip. They let Tenant #1 know staff would no longer be able to provide these services but she could contract with a private duty caregiver to complete the tasks.

When interviewed on 9/16/25 at 1:34 p.m. Staff A reported Tenant #1 required two staff to assist her with all transfers. The tenant needed two staff to provide transfers in and out of bed, into her wheelchair and with toileting assistance.

During an interview on 9/16/25 at 2:50 p.m. Staff C indicated she heard from many staff members Tenant #1 required two staff to safely provide transfers.

When interviewed on 9/23/25 at 1:30 p.m. the RSD and Navigate Manager reported Tenant #1 was provided with a 30-day notice due to exceeding level of care as she required two staff for transfers. They confirmed her service plan was not promptly updated when the tenant required the need of two staff for transfers, received physical therapy or made unreasonable demands of staff for their services.

2. Record review on 9/18/25 revealed Tenant #2 moved to the program on 6/29/25. A service plan developed on 6/24/25 (and modified on 7/01/25) noted he required weight bearing assistance to get in and out of bed, the chair and car. Staff needed to provide 1:1 assistance with a gait belt and his front wheeled walker when walking with him. Tenant #2 had a history of falls which put him at risk if he ambulated unassisted due to generalized weakness and altered gait secondary to Parkinson's disease. Staff should minimize clutter in his apartment. He was unable to ambulate long distances and staff should push

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0465	A. BUILDING: _____ B. WING _____	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUARTET SENIOR LIVING	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 360	Continued From page 2	A 360		

him in a wheelchair if requested. No changes were made to the section of his service plan addressing mobility, falls or transferring after 7/01/25.

A review of Tenant #2's progress notes revealed the following:
On 6/30/25,Tenant #2 was found sitting in front of his recliner. He bent over to grab something and lost his balance. No injuries were noted.

On 7/03/25, he slid out on the left side of his bed. Tenant #2 was not wearing his emergency response pendant when he fell and was unable to call for help for a couple of hours. He crawled to the other side of his bed and got his pendant to call for help. He reported his right shoulder ached. Staff provided him with a pendant he could wear on his wrist. The Program arranged staff checked on Tenant #2 at 8:00 p.m. and 11:00 p.m. to ensure he had his pendant available as he experienced falls at night.

On 7/06/25 ,Tenant #2 fell when attempting to transfer from his recliner to the wheelchair. He denied any injuries at the time of the fall.

On 7/09/25 staff responded to an emergency page and found Tenant #2 sitting on the living room floor. He lost his balance when getting up. He denied pain.

On 7/11/25, he showered with staff assistance, Tenant #2 lost his balance and slipped onto his back. He had bruising to the posterior right shoulder, left scapula and right coccyx.

On 7/11/25, Tenant #2's went too fast and tipped his scooter in the kitchen. He denied pain from the accident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0465	A. BUILDING: _____ B. WING _____	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUARTET SENIOR LIVING	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 360	Continued From page 3 On 7/30/25, Tenant #2 lost his balance, fell to his knees and hit his head on the side of the bed. He had a small cut on the side of his head and knee. He refused emergency treatment. On 8/02/25, Tenant #2 fell when he was getting ready to sit in the wheelchair. He fell over onto his right side, his knee and his buttocks. Tenant #2 was encouraged to have at least one staff present when transferring. On 8/07/25, Tenant #2 self transferred from his recliner to a wheelchair when fell to his buttocks. He was educated to press his pendant for help. Tenant #2 later reported dizziness, nausea and an elevated blood pressure but refused to go to the emergency room. On 8/11/25, Tenant #2 was referred for physical therapy. On 8/14/25, he slid from his chair to the floor when he attempted to transfer from his recliner to the wheelchair. On 9/17/25, Tenant #2 lost his balance when he walked to the kitchen without his walker. He denied any injury. During an interview on 9/16/25 at 1:34 p.m. Staff A reported she was concerned about Tenant #2 due to his frequent falls. Staff often entered his apartment and found him on the floor. He wouldn't use his pendant to call for assistance or wait for staff to help him. When interviewed on 9/16/25 at 3:50 p.m. Staff C indicated Tenant #2 frequently required two staff to help him with transferring.	A 360		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0465	A. BUILDING: _____ B. WING _____	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUARTET SENIOR LIVING	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 360	Continued From page 4 During an interview on 9/23/25 at 1:30 p.m. the RSD confirmed the Program failed to update Tenant #2's service plan to address his frequent falls or increased visual checks. 3. Record review on 9/18/25 revealed Tenant #7 moved to the program on 8/05/25. A review of Tenant #7's progress notes revealed the following: On 8/18/25, Tenant #7 requested a transfer to the Emergency Department due to black emesis, neck pain and hives. She was treated in the hospital for an upper gastro-intestinal bleed and atrial fibrillation. Tenant #7 discharged from the hospital on 8/21/25 with orders for a physical therapy evaluation. On 8/22/25, Tenant #7 experienced two falls after feeling dizzy. She had a skin tear to her left knee. The Program increased her supervision checks. On 8/29/25, Tenant #7 paged staff to inform them she fell in her bathroom. She was not injured. On 8/30/25, Tenant #7 tripped over clutter on her apartment floor. On 9/04/25, she experienced increased confusion after urinating in the trash can during the night. Her daughter asked if her mother might have a urinary tract infection. The Program nurse contacted Tenant #7's primary care provider (PCP) to get an order for a urinalysis. She was prescribed an antibiotic for a urinary tract infection. On 9/04/25, Tenant #7 was admitted to physical therapy, occupational therapy and bath aide	A 360		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0465	A. BUILDING: _____ B. WING _____	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUARTET SENIOR LIVING	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 360	Continued From page 5 services. On 9/10/25, she fell attempting to open her apartment door. She landed on her buttocks and right elbow. She reported a pain of five and had bruising on her elbow. On 9/10/25, the nurse noted after her physical therapy visit, which the physical therapy assistant (PTA) suggested staff assisted Tenant #7 with getting up and moving daily with a gait belt. A review of Tenant #7's service plan, dated 7/17/25, revealed Tenant #7 transferred independently and was able to get in/out of bed, a chair, and car without staff assistance. She was independent with her mobility. Tenant #7 wanted to remain free of injury regarding falls. The plan noted Tenant #7 as continent and independent with toileting. She made safe judgements and functioned appropriately in social situations. There was no mention of her experiencing urinary tract infections which might lead to confusion or urinating in inappropriate places. The service plan failed to be updated 7/17/25. During an interview on 9/23/25 at 1:30 p.m. the RSD confirmed the Program failed to address Tenant #7's falls, need for transferring assistance, outside providers or confusion with urinary tract infections after she experienced these changes in condition. 4. Record review on 9/18/25 revealed Tenant #9 moved to the program on 7/24/25. A review of progress notes revealed the following: On 8/19/25, staff noted non-pitting edema to Tenant #9 ' s left lower extremity. Her daughter reported she would bring in the thrombo embolic	A 360		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0465	A. BUILDING: _____ B. WING _____	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUARTET SENIOR LIVING	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 360	Continued From page 6 deterrent (TED) hose. Tenant #9 wore them in the past but stopped as she was unable to put them on herself. They agreed this task would be added to the service plan. The program received an order from Tenant #9's PCP for staff to apply the compression stockings each morning and to assist her in removing them in the evening. A review of Tenant #9's service plan dated 8/22/25 revealed no entry addressing edema, dressing or the application of TED hose. The service plan failed to be updated when she experienced this change of condition. When interviewed on 9/23/25 at 1:30 p.m. the RSD confirmed this finding.	A 360		

ok

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.