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 09/13/2023

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: 5 Number of tenants with cognitive impairment: 13 Total census: 18 The following regulatory insufficiencies were cited during the investigation of Complaint #112734-C and the initial certification visit conducted to determine compliance with certification of a Dedicated Dementia Specific Assisted Living Program:	A 000		
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to follow established policies and procedures related to medication administration and blood glucose testing. This pertained to 4 of 5 current tenants reviewed (Tenants #1, #3, #4 and #5) and 2 of 3 tenants observed on the medication pass (Tenants #7 and #8). Findings follow: 1. Review of Tenant #1's file on 9/12/23 revealed the August and September medication administration records (MARs) reflected over 15 entries when it was noted medications could not	A 150	The Plan of Correction is attached	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A 150	Continued From page 1	A 150		

be administered due to not being available and that pharmacy was notified.

2. Review of Tenant #3's file on 9/13/23 revealed the August 2023 MARs reflected omissions on 8/7/23, 8/14/23, 8/15/23 and 8/26/23 for 8:00 a.m. and 8:00 p.m. medications. There was also an entry on 8/1/23 when it was noted a medication was not available to administer and pharmacy was notified.

3. Review of Tenant 4's file on 9/13/23 revealed the August 2023 MARs reflected omissions on 8/7/23, 8/14/23, 8/15/23 and 8/26/23 for 8:00 a.m. and 8:00 p.m. medications. There were also over five entries were it was noted medications could not be administered due to not being available and that pharmacy was notified.

4. Review of Tenant #5's file on 9/13/23 revealed the August 2023 MARs reflected omissions on 8/7/23, 8/14/23, 8/15/23 and 8/20/23 for the 8:00 a.m. and 8:00 p.m. medications. There was also one entry on 8/1/23 were it noted medications could be administered due to not being available and that pharmacy was notified.

5. When observed on 9/12/23 at 1:09 p.m. Staff C administered medications to three tenants (Tenant #6, #7 and #8). She administered medications to Tenant #6 and then to Tenant #7. No hand hygiene was observed before administering medications to Tenant #7. After administering medications to Tenant #7 she completed hand hygiene (per verbal report) and administered Tenant #8's oral medication in the common area. She then assisted Tenant #8 to her apartment by pushing her in her wheelchair. When in the apartment Staff C donned gloves and completed Tenant #8's blood glucose check;

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A 150	Continued From page 2 however, no hand hygiene was observed after assisting Tenant #8 to her apartment by pushing her wheelchair and prior to donning gloves for the blood glucose check. 6. Review of the Program's Medication, Treatment and Therapy Assistance policy and procedure indicated medications and treatments would be administered per orders. Staff would provide medication and treatments consistent with the MAR. The Blood Glucose Testing policy indicated for staff to gather supplies, wash hands and don gloves. The Medication Administration policy indicated to perform hand hygiene prior to the administration of medications. 7. When interviewed on 9/13/23 at 3:35 p.m. the Clinical Director confirmed she would expect hand hygiene to be completed in between tenants on the medication pass and before donning gloves. She said it could be an alcohol rub or hand washing. She also confirmed all MARs and orders were provided for the tenants listed above.	A 150		
A 345	481-67.9(4)b Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: b. Within 30 days of beginning employment, all program staff shall receive training by the program's registered nurse(s). This REQUIREMENT is not met as evidenced	A 345		

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A 345	Continued From page 3 by: Based on interview and record review the Program failed to provide nurse delegated training within 30 days of employment for 2 of 3 staff (direct care staff) reviewed hired in 2023 (Staff A and Staff B). Findings follow: 1. Review of Staff A's training documents on 9/7/23 and 9/12/23 revealed a hire date of 7/10/23. A certificate dated 8/16/23 reflected Staff A had completed a New Hire Competency Skills Checklist. The evaluator of Staff A's competency was Staff F, a licensed practical nurse (LPN) and not a registered nurse (RN). Staff A's nurse delegated training dated 8/16/23 was not completed within 30 days of her employment date and was not completed by an RN. 2. Review of Staff B's training documents on 9/7/23 and 9/12/23 revealed a hire date of 6/27/23. Staff B had nurse delegated training completed on 7/28/23, which was greater than 30 days from her employment date. 3. When interviewed on 9/13/23 at 3:35 p.m. the Clinical Director confirmed all nurse delegated training for the staff listed above was provided.	A 345		
A 135	481-69.22(1) Evaluation of Tenant 69.22(1) Evaluation prior to occupancy. A program shall evaluate each prospective tenant's functional, cognitive and health status prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit in order to determine the tenant's eligibility for the program, including whether the services needed are available. The cognitive evaluation shall utilize a	A 135		

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A 135	Continued From page 4 scored, objective tool. When the score from the cognitive evaluation indicates moderate cognitive decline and risk, the Global Deterioration Scale (GDS) shall be used at all subsequent intervals, if applicable. If the tenant subsequently returns to the tenant's mildly cognitively impaired state, the program may discontinue the GDS and revert to a scored cognitive screening tool. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete cognitive evaluations prior to taking occupancy for two of five current tenants reviewed (Tenants #1 and #5) and 1 of 2 discharged tenants reviewed (Tenant C2). Findings follow: 1. Review of Tenant #1's file on 9/12/23 revealed an admission date of 5/12/23. A cognitive evaluation was not completed prior to taking occupancy. 2. Review of Tenant #4's file on 9/13/23 revealed an admission date of 7/24/23. A cognitive evaluation was not completed prior to taking occupancy. 3. Review Tenant C2's file on 9/13/23 revealed an admission date of 6/23/23. A cognitive evaluation was not completed prior to taking occupancy. 4. When interviewed on 9/13/23 at 3:35 p.m. the Clinical Director confirmed all evaluations for the tenants listed above were provided.	A 135		
A 145	481-69.22(3) Evaluation of Tenant	A 145		

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A 145	Continued From page 5 69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete an evaluation for 1 of 1 tenants reviewed who experienced significant changes (Tenant #2). Findings follow: 1. Review of Tenant #2's file on 9/12/23 revealed Progress Notes indicated the following: a. On 6/15/23 Tenant #2 had a choking episode and became unresponsive when she was eating a sandwich. Tenant #2 turned blue in color and lost consciousness. The Heimlich Maneuver was performed and compressions were also performed. Staff called 911 and Tenant #2 was taken to the hospital for evaluation. b. It was noted on 6/16/23 (late entry) that on 6/15/23 Tenant #2 had left the building. Dining staff observed her leaving and alerted nursing staff. Nursing staff responded and brought Tenant #2 back into the building. c. On 7/21/23 Tenant #2 had aggressive behavior with another tenant's spouse and left the	A 145		

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A 145	Continued From page 6 unit out of the door. Staff redirected Tenant #2 back into the unit. d. On 7/22/23 Tenant #2 complained of foot pain when she was ambulating. The right foot and toes were swollen. There was a red area and lump noted on the outside of her foot. Tenant #2 was taken to urgent care for evaluation. There was a nondisplaced transverse right foot fracture at the base of her 5th metatarsal. Tenant #2 was placed in a boot was to follow up with orthopedics. f. On 7/26/23 Tenant #2 returned from the orthopedics clinic and was in a short leg walking cast. g. On 8/28/23 Tenant #2 returned from an orthopedics appointment. The cast was removed and a boot was placed to be worn for one week. 2. An orthopedic note dated 8/2/23 reflected Tenant #2 was in a wheelchair with a cast. Further record review revealed PT services were ordered by the primary care provider on 7/13/23. 3. Continued record review revealed evaluations were completed on 7/5/23 for a 30 day review; however, evaluations were not completed with significant change with the choking episode, leaving the unit and building, aggressive behavior, the foot fracture with cast and boot, wheelchair use and PT. 4. When interviewed on 9/13/23 at 3:35 p.m. the Clinical Director confirmed all evaluations were provided for the tenant listed above.	A 145		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted	A 350		

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A 350	Continued From page 7	A 350		

in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review the Program failed to update service plans to reflect the service needs of 5 of 5 current tenants reviewed (Tenants #1, #2, #3, #4 and #5) and 2 of 2 discharged tenants reviewed (Tenant C1 and Tenant C2). Findings follow:

1. Review of Tenant #1's file on 9/12/23 revealed the AL Nursing Assessment dated 8/27/23 reflected Tenant #1 had a history of clostridium difficile colitis.

Continued record review revealed Progress Notes reflected the following:
a. On 5/15/23 an order was received to crush medications and put into applesauce.
b. On 6/9/23 it was noted Tenant #1 received physical therapy (PT), occupational therapy (OT) and speech therapy (ST). It also noted Tenant #1 was recently treated for clostridium difficile with antibiotics which was resolved on 5/22/23.

Further record review revealed the Clinical Director provided an email with the following discharge dates for therapy: PT on 7/25/23, OT on 8/24/23 and ST on 8/14/23.

The tenant's service plan last updated on 8/27/23 service plan did not reflect Tenant #1's history of

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A 350	Continued From page 8	A 350		

clostridium difficile, or to crush medications and put into applesauce. The service plan also did not the initiation and discontinuation of therapy services.

2. Review of Tenant #2's file on 9/12/23 revealed Progress Notes indicated the following:
a. On 6/15/23 Tenant #2 had a choking episode and became unresponsive when she was eating a sandwich. Tenant #2 turned blue in color and lost consciousness. The Heimlich Maneuver was performed and compressions were also performed. Staff called 911 and Tenant #2 was taken to the hospital for evaluation.
b. It was noted on 6/16/23 (late entry) that on 6/15/23 Tenant #2 had left the building. Dining staff observed her leaving and alerted nursing staff. Nursing staff responded and brought Tenant #2 back into the building.
c. On 7/21/23 Tenant #2 had aggressive behavior with another tenant's spouse and left the unit out of the door. Staff redirected Tenant #2 back into the unit.
d. On 7/22/23 Tenant #2 complained of foot pain when she was ambulating. The right foot and toes were swollen. There was a red area and lump noted on the outside of her foot. Tenant #2 was taken to urgent care for evaluation. There was a nondisplaced transverse right foot fracture at the base of her 5th metatarsal. Tenant #2 was placed in a boot was to follow up with orthopedics.
f. On 7/26/23 Tenant #2 returned from the orthopedics clinic and was in a short leg walking cast.
g. On 8/28/23 Tenant #2 returned from an orthopedics appointment. The cast was removed and a boot was placed to be worn for one week.

An orthopedic note dated 8/2/23 reflected Tenant #2 was in a wheelchair with a cast.

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A 350	Continued From page 9 Further record review revealed PT services were ordered by the primary care provider on 7/13/23. Continued record review revealed the service plan was updated on 7/10/23 for a 30 day review; however, evaluations were not completed with significant change with the choking episode, leaving the unit and building, aggressive behavior, the foot fracture with cast and boot, wheelchair use and PT. 3. Review of Tenant #3's file on 9/13/23 revealed the AL Nursing Assessment dated 8/28/23 reflected Tenant #3 at times attached herself to male tenants, developed relations and made advances. When interviewed on 9/12/23 Staff C said Tenant #3 had shared a companionship with a tenant who had passed away. The tenants tried to kiss but were redirected. Both families were made aware and were agreeable with their friendship. On 9/12/23 at 1:48 p.m. Staff D said Tenant #3 and Tenant C1 had a relationship/companionship in the past. She said there was not anything physical between them. They were encouraged to be in the common areas and both families were aware. When interviewed on 9/13/23 at 2:25 p.m. Staff E said Tenant #3 and Tenant C1 were close, held hands and every once in awhile would kiss. Tenant #3 considered Tenant C1 her boyfriend. When they went into each other's apartments, staff would redirect them. Both families were made aware. When interviewed on 9/13/23 at 3:35 p.m. the	A 350		

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Clinical Director said Tenant #3 and Tenant C1 had a friendship that developed, they held hands and ate meals together. They also kissed and cuddled on the couch. It was reported Tenant C1 touched Tenant #3 on the outside of her clothing.

Review of the May, June and July 2023 24 hour Resident Communication Log reflected entries regarding Tenant #3 and Tenant C1 spending time together, holding hands, kissing, "making out/touching," trying to "sneak off" and sometimes very "handsy" with each other.

Tenant #3's service plan dated 5/30/23 was not updated to reflect the behavior as indicated in the communication logs and needed interventions related to her relationship with Tenant C1. The current service plan dated 8/28/23 did not reflect Tenant #3 attached herself to male tenants and needed interventions.

In addition, Tenant C1's service plan had not been updated to reflect the behaviors with Tenant #3 as indicated in the communication logs and interviews.

4. Review of Tenant #4's file on 9/13/23 revealed a Progress Note dated 8/23/23 indicating Tenant #4 continued to exit seek throughout the unit and tried to open any door. The note also indicated Tenant #4 damaged property and put items down her sink, shower drains and in the toilet.

Tenant #4's service plan dated 8/23/23 (30 day review) reflected behaviors on the service plan; however, the effective date related to the behaviors on the service plan was 9/4/23. The service plan was not updated when the evaluations were completed or when the behaviors with Tenant #4 were noted.

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A 350	Continued From page 11 5. When interviewed on 9/12/23 at 1:48 p.m. Staff D said Tenant #5 displayed exit seeking behavior every other day. When interviewed on 9/12/23 Staff C said Tenant #5 displayed exit seeking behavior after lunch. Record review revealed the ALP Monitoring Entrance Form identified Tenant #5 as one of the tenants who wandered throughout the Program. Tenant #5's service plan dated 7/7/23 did not reflect wandering or exit seeking behavior and interventions. 6. Review of Tenant C2's file on 9/13/23 revealed a Behavior Log documenting behaviors from June and July that included head butting staff, removing her clothing, being combative towards family, bending staff's fingers, yelling, removing her protective undergarment, digging her nails into staff, putting feces in her mouth, swatting at staff and squeezing staff's hands. The tenant's service plan dated 6/23/23 did not reflect Tenant C2's behavior. The service plan was updated on 7/17/23 and reflected behaviors; however, it was not updated when the behaviors were noted. 7. When interviewed on 9/13/23 at 3:35 p.m. the Clinical Director confirmed all service plans were provided for the tenants listed above.	A 350		
A 385	481-69.26(3)d 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	A 385		

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A 385	Continued From page 12 and as needed with significant change, but not less than annually. d. The service plan updated within 30 days of the tenant's occupancy shall be signed and dated by all parties. This REQUIREMENT is not met as evidenced by: Based on interview and record reivew the Program failed to obtained signed service plans within 30 days of taking occupancy for 1 of 5 current tenants reviewed (Tenant #2). Findings follow: 1. Review of Tenant #2's file on 9/12/23 revealed an admission date of 6/5/23. A service plan was dated 7/10/23; however, it was not signed by a health or human service professional or Tenant #2 or her legal representative. 2. When interviewed on 9/13/23 at 3:35 p.m. the Clinical Director confirmed all signed service plans were provided.	A 385		

Quartet
A SENIOR LIVING VILLAGE

Quartet Plan of Correction: Memory Care

1. Programs Policies and Procedures
67.2(3) The program shall follow the policies and procedures established by the program.

Elements detailing how the Program will correct each regulatory insufficiency, including at the system level.
Tenant #1 MAR was reviewed with Right Dose to verify accuracy of ordering and delivery.
Tenant #3 MAR was reviewed with Right Dose to verify accuracy of ordering and delivery. It was identified on the dates of 8/7/2023, 8/14/2023, 8/15/2023, and 8/26/2023 that medications were administered however the MAR was not synced which created omissions.
Tenant #4 MAR was reviewed with Right Dose to verify accuracy of ordering and delivery. It was identified on the dates of 8/7/2023, 8/14/2023, 8/15/2023, and 8/26/2023 that medications were administered however the MAR was not synced which created omissions.
Tenant #5 MAR was reviewed with Right Dose to verify accuracy of ordering and delivery. It was identified on the dates of 8/7/2023, 8/14/2023, and 8/15/2023 medications were administered however the MAR was not synced which created omissions.
Infection control education which will include handwashing will be provided in person on 11/16/23. Infection Control Relias module assigned to all team members on 11/9/2023.

Measures taken to ensure the problem does not reoccur/How the Program plans to monitor performance and ensure compliance.
A daily medication dashboard audit was initiated 11/2/2023. Right Dose instructed to review all residents MARs to ensure all medications are cycled if applicable. Initiated and educated team members on 11/1/2023 with an internal ordering process which includes a set order form for all team members to utilize when ordering medications for each specific pharmacy. This process also includes reconciliation on medications received at community. On 11/2/2023, educated all licensed nurses to complete orders timely. Initiated a daily end of the day audit on 11/2/2023 to ensure orders are entered and supplies are available. It was identified that not accurately syncing the MAR created omissions in our documentation. Education provided to all direct caregivers on

11/2/2023 to include education of correct MAR procedures. Education will be reinforced at direct caregiver meeting on 11/16/2023.
The date by which the regulatory insufficiency will be corrected.
11/30/2023

2. Staffing
67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: b. Within 30 days of beginning employment, all program staff shall receive training by the program's registered nurse(s)

Elements detailing how the Program will correct each regulatory insufficiency, including at the system level.
All direct caregivers will have delegations and competency skills check completed within 30 days of employment. ED completed an audit of all team members on 11/3/2023 to ensure all delegations and competency skills check lists were completed within 30 days of hire. It was identified on 11/3/2023 that Relias has a software glitch and will date certificates on the date the skills were documented and not actually completed. Going forward, the certificates will reference to use the skills checklist.

Measures taken to ensure the problem does not recur/How the Program plans to monitor performance and ensure compliance.
Weekly auditing of new hire delegations and skills competency review to be completed by Clinical Director or designee. This was initiated on 11/3/2023. Delegation and skills competency to be completed by Clinical Director or designee and scheduled by Resident Service Coordinator.
The date by which the regulatory insufficiency will be corrected.
11/30/2023

3.Evaluation of Tenant
69.22(1) Evaluation prior to occupancy. A program shall evaluate each prospective tenant's functional, cognitive and health status prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit in order to determine the tenant's eligibility for the program, including whether the services needed are available. The cognitive evaluation shall utilize a scored, objective tool. When the score from the cognitive evaluation indicates moderate cognitive decline and risk, the Global Deterioration Scale (GDS) shall be used at all subsequent intervals, if applicable. If the tenant subsequently returns to the tenant's mildly cognitively impaired state, the program may discontinue the GDS and revert to a scored cognitive screening tool.

Elements detailing how the Program will correct each regulatory insufficiency; including at the system level.
Cognitive evaluations were completed on Tenant #1 and Tenant #4.

Clinical Director or designee will complete a new assessment by 11/30/2023 with Tenant #2 to identify any service plan changes.

Measures taken to ensure the problem does not recur/How the Program plans to monitor performance and ensure compliance.
Clinical Director educated by Regional Nurse on AL regulations and completing cognitive evaluations prior to taking occupancy.
Clinical Director or Designee will complete cognitive assessment prior to admission. An audit will be completed after each admission to ensure compliance.
The Clinical Director or designee will round with all direct caregivers daily, review communication logs, follow assessment schedules, meet with BlueStone therapy weekly, and complete shift hand off with other licensed nurses to identify any changes of conditions. Change of condition education will be provided to all direct caregivers on 11/16/2023. RN notification guidelines will be presented and educated to all direct caregivers on 11/16/2023.
The date by which the regulatory insufficiency will be corrected.
11/30/2023

4.Service Plans
69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed.

Elements detailing how the Program will correct each regulatory insufficiency, including at the system level.
Tenant #1 passed away on 11/10/2023.
Clinical Director or Designee will complete a new assessment for Tenant #2 by 11/30/2023 and update service plan to include if applicable-a behavioral management plan, therapy services, and or assisted devices. The service plan will be sent to POA for review and signature.
Clinical Director or Designee will complete a new assessment for Tenant #3 by 11/30/2023 and update service plan if indicated to include behavioral interventions. The service plan will be sent to POA for review and signature.
Clinical Director or Designee will complete a new assessment for Tenant #4 by 11/30/2023 and update service plan if indicated to reflect updated behavioral interventions. The service plan will be sent to POA for review and signature.
Clinical Director or Designee will complete a new assessment for Tenant #5 by 11/30/2023 and update service plan if indicated to reflect wandering or exit seeking behaviors in a behavioral management plan if indicated. The service plan will be sent to POA for review and signature.

Measures taken to ensure the problem does not recur/How the Program plans to monitor performance and ensure compliance.

The Clinical Director or designee will round with all direct caregivers daily, review communication logs, follow assessment schedules, meet with BlueStone therapy weekly, and complete shift hand off with other licensed nurses to identify any changes of conditions. Change of condition education will be provided to all direct caregivers on 11/16/2023. RN notification guidelines will be presented and educated to all direct caregivers on 11/16/2023.

The date by which the regulatory insufficiency will be corrected.

11/30/2023

5.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.

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

Tenant #2 has a signed service plan by all parties.

Measures taken to ensure the problem does not recur/How the Program plans to monitor performance to ensure compliance.

Clinical Director or Designee and resident or representative will sign a service agreement within 30 days of taking occupancy. All service plans will be reviewed and signed with any changes.

The date by which the regulatory insufficiency will be corrected.

11/30/2023

ok