Iowa Department of Inspections, Appeals, and Licensing
Health & Safety Division
Adult Services Civil Penalty Citation

Date: August 11, 2026
Program Name: Fountains Assisted Living
Address: 3752 Thunder Ridge Road, Bettendorf, IA 52722
Type of Action: Recertification Visit & Investigations #131269-I, #131679-I, #131374-C, #131824-C, #131968-C
Date(s) of Action: 7/1/26 – 7/6/26
Citation #11213

State Rule #		Amount of Civil Penalty
Iowa Administrative Code 481 Chapter 67.2(2)	**67.2 Program Policies and Procedures** **67.2(2) The program shall follow the policies and procedures established by the program.** Based on interview and record review the Program failed to follow established policy and procedure for an Alarmed Door on the Locked Memory Unit for 1 of 6 current tenants reviewed (Tenant #1) and 1 of 5 discharged tenants reviewed (Tenant C1). Findings follow: 1. Record review on 7/1/26 of a Care Plan for Tenant C1, dated 11/24/25, identified he had a history of Alzheimer's disease, tachycardia and congestive heart failure. He received services through Hospice. Tenant C1 had a history of falls and required standby/contact guard assistance of one person when ambulating. He had a history of getting up on his own. Record review on 7/1/26 revealed an incident report dated 1/6/26 noted Tenant C1 exited the Northwest door of the Assisted Living unit at approximately 2:00 PM while tenants were being escorted to music in the Assisted Living Unit. He walked around the side of the building outside of the Cascade North Door. He was fully clothed in sweat pants, sweatshirt, rubber-soled shoes and his 4-wheeled walker was present. Tenant C1 was laying supine on the ground without any injuries. His range of motion and cognition were at baseline. Staff and the Assistant Director of Nursing (ADON) helped him back to the Cascades community at 2:05 PM (the memory care unit where Tenant C1 resided). A head to toe assessment was completed and no external injuries were found.	**$2000.00**

	When interviewed on 7/2/26 at 10:12 AM Staff A explained every Tuesday she led an activity on the Memory Care unit at 1:00 PM. She would then escort interested tenants to the Assisted Living portion of the building for a music event at 2:00 PM. Staff A invited tenants to the music event, including Tenant C1. He indicated he did not want to attend but must have changed his mind. Staff A assisted four tenants through two sets of doors to leave the secured memory care unit. As the second door was spring loaded and she had to help two tenants who used a walker and one with a wheelchair, Staff A propped the door open. She doesn't think the door closed after she left with the last tenant which was when Tenant C1 left the unit without her knowledge. 2. Record review of Tenant #1's Care Plan (dated 2/26/26) identified a history of Alzheimer's dementia, wandering, and exit-seeking tendencies. An incident report dated 2/28/26 documented Tenant #1 exited the NW memory care door and was discovered by staff in the Independent Living building at 8:37 AM. The door failed to trigger an alarm upon his exit. When interviewed on 7/2/26 at 8:40 AM Staff B stated she worked the morning of 2/28/26. Employees were to complete checks of the exit doors at the beginning of their shifts to ensure they were locked and alarmed but she does not think this was completed on 2/28/26. She did not realize Tenant #1 was missing until she received a call notifying her he was in the independent living building. Upon her return she checked the exit doors and found the NW memory care door unlocked. During an interview on 7/2/26 at 9:15 AM, Staff D stated she began her shift at 3:00 AM on 2/28/26. Staff D signed the door check form for the 6:00 AM - 2:00 PM shift without physically verifying the door status, relying instead on verbal confirmation from the previous staff member that the doors were locked. She completed an assessment of Tenant #1 upon his return and he was fine. 3. The Program had a Policy (revised 6/2025) addressing how staff should manage the Alarmed Door in the Locked Memory Unit to ensure the safety of each tenant. As part of the security system in the locked memory unit, all doors leading to the outside were alarmed/coded doors. The proper way to exit the building through the doors was to enter the correct code into the keypad or use the key fob system located near the door. This would	

	unlock the door and allow a person to proceed through it. When the door closed it would once again lock. 4. The Executive Director confirmed staff failed to follow the Alarmed Door in the Locked Memory Unit policy during an exit meeting held on 7/6/26 at 4:45 PM.	