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
	S0236	A. BUILDING: _____ B. WING _____	C 07/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAINS ASSISTED LIVING	3752 THUNDER RIDGE ROAD 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: 55 Tenants with cognitive impairment: 16 Total census: 71 No regulatory insufficiencies were cited during the investigation of Complaint #131374-C, Complaint #131824-C, Complaint #131968-C or the recertification visit conducted to determine compliance with certification rules for an Assisted Living Program for People with Dementia. The following regulatory insufficiency was cited during the investigation of Incident #131269-I and Incident #131679-I.	A 000	**See Attached** **POC 9/1/26**	
A 116	481-67.2(2) Program Policies and Procedures 67.2(2) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: 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	A 116		

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A 116	Continued From page 1	A 116		

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.

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.

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A 116	Continued From page 2 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	A 116		

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A 116	Continued From page 3 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.	A 116		

Plan of Correction for The Fountains Senior Living
In Response to
Recertification Visit & Investigations #131269-I, #131679-I, #131374-C, #131824-C, & #131968-C
Survey Date: 7/1/26-7/6/26

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state law.

Regulatory Insufficiency: Program Policies and Procedures 67.2(2)

67.2(2) – The program shall follow the policies and procedures established by the program.

1. **Elements detailing how the program will correct the insufficiency.**
    a. All nursing staff re-educated on the alarmed door policy.
    b. All nursing staff re-educated on checking the alarmed doors once per shift.
2. **What measures will be taken to ensure the problem does not recur.**
    a. Nursing staff to complete door alarm checks once per shift to ensure doors are locked and alarmed appropriately.
    b. ED, AED, and Maintenance Director are the only staff that have the ability to de-alarm an egress door.
3. **How the program plans to monitor performance to ensure compliance.**
    a. The ED, DON, ADON or designee will complete random checks of alarmed doors to ensure they are locked and alarmed appropriately.
    b. Regional Nurse and/or designee will complete random checks of alarmed doors when on site to ensure they are locked and alarmed appropriately.
4. **The date by which the regulatory insufficiency will be corrected.**
    a. The regulatory insufficiency was corrected by 9/1/2026.

Sincerely,

CJ Ward, Executive Director