STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAALP080	A. BUILDING _____ B. WING _____	11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWN DEER PLACE	1500 1ST AVE N CORALVILLE, IA 52241

(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 disorder: 2 Number of tenants with cognitive disorder: 16 TOTAL Census of Assisted Living Program for People with Dementia: 18 The following regulatory insufficiency was cited during the investigation of Incident #104684-I:	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 interview and record review the Program failed to follow established policy and procedure regarding completion of incident reports. This pertained to 1 of 1 discharged tenant reviewed who experienced an alleged theft (Tenant C1). Findings follow: Record review of the Program's narrative note (undated and untitled document) indicated on 5/4/22 Tenant C1's family reported to the Director a check was cashed on 4/25/22 from Tenant C1's account. Tenant C1's family checked his apartment and noted three other checks missing. It was reported to the local police department and the Program began an internal investigation. When interviewed on 11/10/22 at 11:50 a.m. the Director said Tenant C1's family called and reported a check was cashed from Tenant C1's	A 150		

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A 150	Continued From Page 1 account and family provided the name of the person the check was paid to the order of. The Director said he did not know the person. Shortly after the telephone call Tenant C1's family arrived to the Program and showed the Director the check (online). Tenant C1's family went to his apartment and reported there were three checks missing and one had been cashed. The police were called and took information from Tenant C1's family. The Program's investigation was also started. Continued record review on 11/10/22 and 11/14/22 of Tenant C1's file revealed Tenant C1 moved to the Program from independent living on 3/1/22. He was sent out to the hospital on 3/18/22 and returned to the Program post hospitalization and skilled nursing facility stay on 5/5/22. Tenant C1 died on 7/23/22. An incident report was not completed related to the alleged theft from Tenant C1. Further record review of the Program's Incident Report policy and procedure revealed staff would notify the nurse (or designated person) if a tenant had fallen or with the occurrence of unusual events. An incident report would be completed by the nurse (or designated person). The nurse (or designated person) would indicate a person in charge in their absence to complete the incident report. The incident report would be submitted to the nurse as soon as possible. The nurse was responsible to follow up with a review of the incident and enter the incident into the electronic records system. Handwritten incident reports were kept for three years and electronic incident reports were kept "indefinitely." 5. When interviewed on 11/10/22 at 11:50 a.m. the Director confirmed an incident report was not completed related to the incident with Tenant C1.	A 150		

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If deficiencies are cited, an approved plan of correction is requisite to continued program participation.