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 |
|---|---|---|---|
| | S0111 | A. BUILDING: _____ B. WING _____ | C 04/16/2024 |

| 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<br><br>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.<br><br>Number of tenants without cognitive impairment: 5<br>Number of tenants with cognitive impairment: 12<br>Total census: 17<br><br>No regulatory insufficiencies were cited during the investigation into Complaint #116587-C, Incident #117795-I, Complaint #117824-C or Complaint #118690-C.<br><br>The following regulatory insufficiencies were cited during the investigation into Complaint #115147-C and Complaint #116487-C. | A 000 | The Plan of Correction is attached | |
| A 115 | 481-67.2(1)b Program Policies and Procedures<br><br>67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following:<br><br>b. An incident report shall be in detail and shall be provided on an incident report form.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the program failed to produce detailed incident reports involving 2 of 6 discharged tenants | A 115 | | |

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Director | (X6) DATE 8/9/2024

DEPARTMENT OF INSPECTIONS AND APPEALS

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| A 115 | Continued From page 1<br>reviewed (Tenant C1 and Tenant C2). Findings include:<br><br>1) Record review on 4/17/24 revealed an incident report dated 8/24/23 at 7:01 am indicating Tenant C1 became physically and verbally aggressive with staff as they assisted her with morning cares. As staff backed away to de-escalate the situation, Tenant C1 started to pursue them and fell. Tenant C1 clutched her left upper arm and stated she had pain. She was taken to the emergency room for further evaluation.<br><br>The program completed an internal investigation on 8/25/23 into Tenant C1's 8/24/23 fall. The summary of investigative findings noted Tenant C1 was upset Staff A and Staff B were trying to remove Tenant #4 from her room. Staff A left the apartment with Tenant #4. Tenant C1 tried to hit Staff B and lost her balance, falling to the ground. Tenant C1 fell and broke her elbow due to agitation. Staff A and Staff B did all they could to diffuse the situation and keep Tenant #4 safe.<br><br>On 4/18/24 at 11:15 AM Staff B reported Staff A was trying to get Tenant #4 out of Tenant C1's bed. Tenant #4 was in the bed wearing underwear and Tenant C1 had her outside clothes on. They tried several times to get him out of the room. When she arrived, Tenant C1 was upset and swinging at Staff A. Staff B tried to keep Tenant C1 from swinging at Staff A so Staff A could get Tenant #4 out of the apartment. Tenant C1 became increasingly physical, tried to chase them and fell as she took took a swing.<br><br>On 4/18/24 at 11:35 AM Staff A reported Tenant C1 fell around shift change. They went down the hall and found Tenant #4 in bed with Tenant C1. The tenants were sleeping soundly. Tenant C1's | A 115 | | |

DEPARTMENT OF INSPECTIONS AND APPEALS

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| A 115 | Continued From page 2<br>family was strict and didn't want them together. Staff A tried to get Tenant #4 out of the apartment. Tenant #4 didn't have a problem with putting on his clothes and getting out. Tenant C1 kicked and hit at Staff A. Staff A got Tenant #4 to the hallway when she heard someone yell "ow!" Staff A pivoted back and saw Tenant C1 on the ground toward her side.<br><br>The incident report completed by a former nurse contained inaccurate information as to the cause of the tenant's behaviors and made no mention of another tenant being present in the apartment.<br><br>2) An incident report for Tenant C2 dated 10/23/23 at 16:30 (4:30 PM) identified he was found in resident's room complaining of pain in his side. He had a bruise and a scrape. The cause was unknown. There were no witnesses to the event listed. The time family was notified was documented as 16:40 (4:40 PM)<br><br>The program completed an internal investigation into Tenant C2's injury on 10/23/23 beginning at 9:00 AM. The date and time of the incident were listed as 10/23/23 at 5:30 AM. It was noted Tenant C2 was sleeping in another tenant's bed. Staff C went to tell Staff D about the situation. When Staff D went to get Tenant C2 out of the other tenant's bed, she found him on the floor. Staff D was able to get Tenant C2 up and he walked back to his room. Due to the bruise on his left rib cage, he was sent to the ER where imaging showed the tenant had a fractured rib.<br><br>Review of a statement written by Staff D on 10/24/23 revealed she went to pass medication to tenants around 5:30 AM on 10/23/23. Staff C told her Tenant C2 was asleep in another tenant's bed and she could not get him to go to his room. Staff | A 115 | | |

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| A 115 | Continued From page 3<br>D went to the other tenant's room and found Tenant C2 sitting on the floor. The tenant asked Staff D to help him stand up. She assisted him up and back to his apartment. She helped Tenant C2 change his incontinence undergarment as it was soaking wet. He did not appear to be in pain.<br><br>3) The program had an incident report policy. It noted when an incident report was written, it should be factual and to the point. Witnesses of the incident should also provide a factual statement.<br><br>On 4/22/24 at 10:30 AM, the Regional Nurse Specialist confirmed the above findings and agreed the incident reports were not written in detail. | A 115 | | |
| A 350 | 481-69.26(1) Service Plans<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the program failed to ensure service plans addressed the needs of 1 of 4 current (Tenant #4) and 2 of 5 discharged (Tenant C1, Tenant C2) tenants | A 350 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| A 350 | Continued From page 4<br>reviewed. Findings include:<br><br>1) Record review on 4/17/24 revealed the program completed an internal investigation into a fall Tenant C1 experienced on 8/24/23. The summary of investigative findings noted Tenant C1 was upset Staff A and Staff B were trying to remove Tenant #4 from her room. Staff A left the apartment with Tenant #4. Tenant C1 tried to hit Staff B and lost her balance, falling to the ground. Tenant C1 fell and broke her elbow due to agitation. Staff A and Staff B did all they could to diffuse the situation and keep Tenant #4 safe.<br><br>On 4/18/24 at 11:15 AM, Staff B reported on 10/23/23 Staff A was trying to get Tenant #4 out of Tenant C1's bed. Tenant #4 was in the bed wearing underwear and Tenant C1 had her outside clothes on. They tried several times to get Tenant #4 out of the room. When she arrived, Tenant C1 was upset and swinging at Staff A. Staff B tried to keep Tenant C1 from swinging at Staff A so Staff A could get Tenant #4 out of the apartment. Tenant C1 became increasingly physical, tried to chase them and fell as she took a swing.<br><br>On 4/18/24 at 11:35 AM Staff A reported Tenant C1 fell around shift change. They went down the hall and found Tenant #4 in bed with Tenant C1. The tenants were sleeping soundly. Tenant C1's family was strict and didn't want them together. Staff A tried to get Tenant #4 out of the apartment. Tenant #4 didn't have a problem with putting on his clothes and getting out. Tenant C1 kicked and hit at Staff A. Staff A got Tenant #4 to the hallway when she heard someone yell "ow!" Staff A pivoted back and saw Tenant C1 on the ground toward her side. Staff A recalled Tenant #4 and Tenant C1 often stayed in each other's rooms. | A 350 | | |

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| A 350 | Continued From page 5<br>She believed Tenant C1's daughter was strict about not wanting Tenant #4 in her mother's room. The daughter had communicated to management Tenant #4 should not be in the room after the daughter found a man's clothing in her mother's apartment. Staff A remembered she either received a note or verbal instructions from management to keep the tenants apart.<br><br>On 4/18/24 at 10:35 AM, the current memory care coordinator reported Tenant #4 often entered Tenant C1's apartment. Staff were instructed to keep the apartment door open when Tenant #4 was present. Tenant C1 was very territorial toward Tenant #4 and said Tenant #4 was her husband.<br><br>On 4/22/24 at 2:15 PM the former memory care coordinator stated Tenant C1 thought Tenant #4 was her husband. There were times Tenant C1 was very possessive over Tenant #4 and things/people she believed were hers. Tenant C1 could become aggressive if people took things she thought were hers. At times Tenant #4 slept in Tenant C1's apartment. When Tenant #4 slept in the apartment it set Tenant C1 off when staff tried to remove him. Tenant C1's daughter was usually accepting of the situation because she knew if they intervened it threw her mom into a tailspin.<br><br>Tenant C1's service plan at the time of the incident, dated 6/13/23, did not include any information regarding what type of relationship existed between the tenant and Tenant #4. There were no directives for staff to follow regarding where and when they could spend time together.<br><br>Tenant #4's service plan at the time of the incident, dated 2/20/23, did not include any | A 350 | | |

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| A 350 | Continued From page 6<br>information regarding what type of relationship existed between the tenant and Tenant C1. There were no directives for staff to follow regarding where and when they could spend time together.<br><br>2) An incident report for Tenant C2 dated 10/23/23 identified he was found in resident's room complaining of pain in his side. He had a bruise and a scrape. The program completed an internal investigation into Tenant C1's injury on 10/23/23. The description of the incident noted Tenant C2 was sleeping in another tenant's bed. Staff C went to tell Staff D about the situation. When Staff D went to get Tenant C2 out of the other tenant's bed, Staff D found him on the floor. Staff D was able to get Tenant C2 up and he walked back to his room. Due to the bruise on his left rib cage, he was sent to the ER where imaging showed the tenant had a fractured rib.<br><br>On 4/18/24 at 11:35 AM Staff A reported Tenant C2 had entered other tenants' apartments and slept in their beds.<br><br>On 4/18/24 at 10:35 AM, the current memory care coordinator reported Tenant C2 had slept in other tenants' beds.<br><br>Tenant C2 service plan at the time of the incident, dated 8/31/23, identified he wandered. It did not identify Tenant C2 was known to sleep in others' beds or interventions on how to prevent this behavior from occurring.<br><br>3) On 4/22/24 at 3:47 PM, the Regional Nurse Specialist confirmed the service plans did not address the tenants' needs. | A 350 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | PROVIDER/SUPPLIER/CLIA INDENTIFICATION NUMBER: S0111 | DATE SURVEY COMPLETED: 4/19/24 |
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| Tag # | SUMMARY STATEMENT OF DEFICIENTCIES (EACH DEFICIENCY SHOULD BE PRECEDE BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY | Identify what changes to the provider's systems and practices were made to ensure compliance with the specific statute(s). Include information about how the provider will maintain compliance in the future. | COMPLETION DATE |
|---|---|---|---|---|---|
| **Tag #1** | **Regulation and Reg Number**<br>481-67.2(1)b Program Policies and Procedures 67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following: b. An incident report shall be in detail and shall be provided on an incident report form.<br><br>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to produce detailed incident reports involving 2 of 6 discharged tenants reviewed (Tenant C1 and Tenant C2). | **Tag #**<br>A 115 | **What initial correction was made?**<br><br>Current staff training will be completed by 9/1/2024 on incident reporting policies and procedures and the importance of accurate information being provided.<br><br>The previous nurse is no longer employed by the community as of: 12/8/2023<br><br>Tenant C1 discharged on: 9-30-2023<br><br>Tenant C2 discharged on: 12-3-2023 | **How will we ensure and maintain compliance going forward?**<br>Upon hire, education will be provided to the nurse and direct care staff on incident reporting policies and procedures and the importance of accurate information being provided.<br><br>Upon hire, the new nurse will be trained in service plans to include: Resident preference specification, updating and reviewing of service plans, and incident reporting.<br><br>An audit will be completed for incident reporting daily, weekly, monthly, as needed as determined by the Director or designee. | **Implementation Date:** 6/7/2024<br><br>**Completion Date:** Ongoing<br><br>**Responsible Party:** Director or Designee |
| **Tag #2** | **Regulation and Reg Number**<br>481-69.26(1) Service Plans<br>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 | **Tag #**<br>A 350 | **What initial correction was made?**<br>Current staff education on service plans, policies and procedures, and the importance of accurate information.<br><br>Tenant C1 discharged on: 9-30-2023 | **How will we ensure and maintain compliance going forward?**<br>Upon hire, the new nurse will be trained in service plans to include Resident preference specification, updating and | **Implementation Date:** 6/7/2024<br><br>**Completion Date:** Ongoing |

*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 regulatory insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state law.*

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| | 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.<br><br>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to ensure service plans addressed the needs of 1 of 4 current (Tenant #4) and 2 of 5 discharged (Tenant C1, Tenant C2) tenants | | Tenant C2 discharged on: 12-3-2023<br><br>The previous nurse is no longer employed by the community as of: 12/8/2023 | reviewing of service plans, and incident reporting.<br><br>The importance of accurate documentation of incident reporting and interventions will be reviewed during initial training with the new nurse.<br><br>An audit will be completed of service plans daily, weekly, monthly, as needed, as determined by the Director or designee. | **Responsible Party:** Director or Designee |

Compliance Date: 9/7/2024

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