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 _____	R-C 04/24/2025

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 impairment: 0 Number of tenants with cognitive impairment: 16 Total census: 16 There were no regulatory insufficiencies identified related to the investigation of Complaint ##125118-C. The following regulatory insufficiencies were cited related the investigation of Complaints #124468-C and #127787-C and Incident #125841-I.	A 000		
A 115	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. This REQUIREMENT is not met as evidenced by:	A 115	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 115	Continued From page 1	A 115		

Based on interview and record review the Program failed to have a policy and procedure that had all required information, including the documentation of an incident on an incident report form. This pertained to 2 of 4 current tenants reviewed (Tenant #3 and Tenant #4) and 1 of 2 discharged tenants reviewed (Tenant C2). Findings follow:

1. Review of Tenant #3's file between 4/17/25 and 4/24/25 revealed Progress Notes indicating the following:
- On 4/11/25 at 7:16 a.m. Tenant #3 was found on the floor in her apartment. She was assisted off of the floor and her vital signs were taken.
- On 4/11/26 at 7:25 a.m. Tenant #3 was being violent and aggressive towards the staff.
- On 4/11/25 at 7:40 a.m. when staff was walking to the kitchen staff saw Tenant #3 fall to the ground.

Incident reports could not be located related to the incidents noted above for Tenant #3.

2. Review of Tenant #4's file from 4/17/25 to 4/24/25 revealed Progress Notes indicating the following:
- On 3/14/25 Tenant #4 was extremely agitated at dinner and wanted to see her spouse. She was upset, screaming and threw her plate across the room with her food on it.
- On 3/23/25 Tenant #4 was inconsolable, anxious, yelled, threatened others, screamed for her spouse and staff were not able to redirect. She was up all night and had vivid hallucinations.
- On 3/25/25 Tenant #4 was extremely agitated and screamed at the top of her lungs, yelled that she wanted to die, said staff were trying to kill her and to get her out of there. Redirection was effective for about 15 minutes, then she returned

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A 115	Continued From page 2	A 115		

to screaming. It was noted her behaviors of screaming and yelling obscenities was increasing and it was was upsetting to the other tenants.
- On 4/4/25 Tenant #4 screamed that she wanted to die and asked where her spouse was and to get her out of there. Staff were not able to redirect Tenant #4.
- On 4/4/25 Tenant #4 was back in the common area and was inconsolable. All PRN (as needed) medications were given without relief. Multiple staff attempted to redirect her without success. Other tenants yelled at her to get out of there, which escalated the behaviors. Tenant #4 was removed from the situation and returned to her apartment where she screamed for 15 minutes. Hospice was made aware of the behaviors and that it might be needed to send her out for evaluation if the behaviors continued. Hospice said not to send her out and for the nurse to control her. It was discussed with the management company that Tenant #4 needed a higher level of care. Tenant #4 was transported to the hospital via non-emergent transported.

Incident reports could not be located related to the incidents noted above for Tenant #4.

3. Review of Tenant C2's file between 4/17/25 and 4/24/25 revealed Progress Notes indicating the following:
- On 3/25/25 Tenant C2 had been physically aggressive towards staff. The aggression had increased the last couple of days as her pain increased. Staff reported she was hitting, punching and spitting out medications.
- On 3/30/25 Tenant C2 had become more resistant to cares, especially on the overnight shift. She was hitting and pinching nurses in inappropriate places and resisted repositioning. She also yelled profanities at staff and had made

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A 115	Continued From page 3 some racial comments to staff. An incident report dated 3/25/25 indicated Tenant C2 did not want to be touched, especially her legs. She was embarrassed to use the protective undergarment and asked to go to the bathroom. She could not move and was aggressive when staff tried to touch her. She swung at staff and told staff to get out or she was going to shoot them. The incident report completed on 3/25/25 did not reflect all of the behaviors noted in the progress notes on that date. An incident report could not be located related to Tenant C2's behavior on 3/30/25. 4. Review of the Program's Incident Management and Reporting Policy indicated all incidents regardless of severity must be documented. It indicated there were minor incidents, major incidents and critical incidents. Staff were to report any incident that impacted health, safety or rights to their supervisor. All incidents would be documented in the tenant's electronic health records (EHR) or on the incident report form. The policy did not indicate an incident report form would be utilized for every incident. and that it needed to completed in detail. 5. When interviewed on 4/21/25 at 12:00 p.m. the Regional Director of Operations confirmed all incident report policies and procedures were provided. She confirmed the policies and procedures would be updated and would reflected all required information.	A 115		
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and	A 150		

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A 150	Continued From page 4 procedures established by the program. This REQUIREMENT is not met as evidenced by: Observation, interview and record review revealed the Program failed to follow policies and procedures regarding head injuries (affecting 1 of 1 tenants reviewed with a head injury #1), service documentation (affecting 4 of 4 current and 2 of 2 former tenants reviewed #1, #2, #3, #4, C1, C2), and dining services (potentially affecting all 16 tenants). Findings follow: 1. Review of Tenant #1's file from 4/9/25 to 4/23/25 revealed the following: - an Incident Report dated 1/2/25 indicating staff was on the phone with the Health and Wellness Director (HWD) and heard a noise, went to the common area and found Tenant #1 on the floor with blood around her head. It indicated the HWD told staff to call 911 and she left by ambulance. The emergency department (ED) notes dated 1/2/25 indicated she was admitted and discharged on 1/2/25. It was noted Tenant #1 had dementia and would not sit still regarding the scalp repair. Five staples were placed, one staple had to be removed due to her moving. - a Progress Note dated 1/8/25 documented staff was on the phone with the HWD regarding another tenant and she heard a loud noise and found Tenant #1 on the floor. Staff noticed Tenant #1 was bleeding from the back of her head. It was charted on 1/8/25 and the incident occurred on 1/2/25. The note regarding the incident was completed six days after the occurrence. - a hospice document dated 1/10/25 indicated six staples were removed and steri-strips were applied. The laceration was scabbed with no	A 150		

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A 150	Continued From page 5	A 150		

drainage.

The Head Injuries policy and procedure indicated the incident and all subsequent actions would be thoroughly documented in the tenant's file. Documentation would include the initial assessment, any medical evaluation notifications made and follow up actions.

The policy and procedure related to head injuries was not followed for Tenant #1 related to the event on 1/2/25 as the incident was not thoroughly documented in her file. Tenant #1's fall with head injury occurred on 1/2/25. It was not documented in nurse's notes until 1/8/25. Tenant #1 returned on 1/2/25 after placement of staples in her head. There was no follow up documentation when Tenant #1 returned from the ED. The After Visit Summary was not available when requested for review. ED notes were provided; however, had a fax date of 4/9/25 (incident occurred on 1/2/25). Hospice documentation indicated the staples were removed on 1/10/25. There was no documentation in Tenant #1's file by the Program related to the removal of the staples.

2. Review of Tenant #1's file between 4/9/25 and 4/23/25 revealed Monthly Task Logs from January 2025 to April 2025 showed tasks not documented as completed for services including bed making, garbage removal, housekeeping, assistance with ambulation/mobility, bathing, dressing, toileting, hygiene/grooming and visual checks.

Review of Tenant #3's file between 4/17/25 and 4/23/25 revealed Monthly Task Logs from February to April 2025 showed tasks not documented as completed for services including

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A 150	Continued From page 6	A 150		

bathing, hygiene/grooming, dressing assistance, meal consumption and visual checks.

Review of Tenant #4's file between 4/17/25 and 4/24/25 revealed Monthly Task Logs from February to April 2025 showed tasks not documented as completed for services including escorts, toileting, meal consumption, visual checks, laundry, hygiene/grooming, and transfers.

Review of Tenant #5's file between 4/12/25 and 4/23/25 revealed a Monthly Task Log for April 2025 showed tasks not documented as completed for services including housekeeping and safety checks.

Review of Tenant C1's file between 4/21/25 and 4/24/25 revealed Monthly Task Logs for January and February 2025 showed tasks not documented as completed for services including visual checks, garbage removal, hygiene/grooming and dressing assistance.

Review of Tenant C2's file between 4/17/25 and 4/23/25 revealed Monthly Task Logs from February and March 2025 showed tasks not documented as completed for services including hygiene/grooming, dressing assistance, visual checks and housekeeping.

The Program's policy and procedure related to Documentation of Services/Medication revealed documentation was required for all services provided to tenants in the building. It indicated documentation would occur shortly after services were provided to the tenant. All documentation would be completed before the end of each shift including both completed and declined services. Documentation would be provided in the medical

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A 150	Continued From page 7 health record. When interviewed on 4/24/25 at 9:21 a.m. the Health and Wellness Director said if the documentation of tasks was not charted within two hours of when it was to be completed, the area disappeared and could not be charted on. When interviewed on 4/22/25 at 3:15 p.m. the Executive Director confirmed all task logs were provided for the tenants reviewed. 3. When observed on 4/17/25 during lunch at approximately 12:00 p.m. dietary staff delivered the food to the memory care unit. The dietary staff obtained food temperatures for the meatballs and french fries. Staff was not observed obtaining a temperature for the pasta salad (cold food item) that was served to tenants. Tenants had Styrofoam cups and were provided plastic beverages carafes containing water which they poured themselves. No other beverages were provided to the tenants. Staff E told the Executive Director there was not time to make lemonade before the meal. Staff E donned gloves and served the food. Staff E had on gloves but touched several contaminated surfaces including tongs, plates and plastic wrapping and then served french fries by picking them up with gloved hands. No utensils were observed when Staff E plated and served french fries to the tenants. The floor of the serving area and kitchen area was very sticky and did not appear to be clean. A garbage can in the kitchen area had a foot pedal to open; however, it was broken and had to be opened by hand. The refrigerator/freezer in the memory care unit was observed. The handles appeared to be visibly soiled. Inside the	A 150		

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A 150	Continued From page 8	A 150		

refrigerator there were items that were not marked or dated including a meat and cheese tray, fruit tray, and a pie. There was loosely wrapped sliced cheese that had a discard date of 4/7/25 that was still in the refrigerator (on 4/17/25) and it was not properly secured. There was also a large undated tray with no bake cookies in individual muffin/cupcake liners that was not covered. Additionally, there was a stack of no bake cookies in a large coffee filter uncovered dated 4/16/25. The no bake cookies were not secured or covered and several fell when items were moved in the refrigerator. These were discarded by the Executive Director as was the sliced cheese noted above. There was also an orange juice concentrate container that was not dated.

Record review revealed a Temp Log for the refrigerator and freezer. It was started on 4/18/25 and there were readings recorded on 4/18/25 and 4/22/25 in both the a.m. and p.m. Although two additional months of refrigerator/freezer temps were requested, none were provided.

When interviewed on 4/22/25 at 3:15 p.m. the Executive Director said the expectation was that nothing should be put in the refrigerator unless it was brought by the main kitchen. It should all be labeled when opened and have a discard date. Regarding the refrigerator/freezer temperatures requested, she stated they were thrown away because they were being not being tracked and were sporadic and terrible. New sheets were put into place and it should be completed twice daily, once in the a.m. and once in the p.m. She confirmed tongs should have been used for serving french fries and it had been addressed. She stated food temperatures were to be taken at every meal and should include hot and cold

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A 150	Continued From page 9 foods. When interviewed on 4/22/25 at 9:42 a.m. the Chef/Culinary Coordinator said three meals and snacks were provided daily. The temperature of the food was checked at the kitchen and then prior to serving in the memory care unit. The refrigerator and freezer temperatures should be taken at least twice per day, a.m. and p.m. Hot foods should be 135/140 degrees and cold foods ideally 35 to 40 degrees. He said staff were not taking food temperatures for cold foods previously. Foods should be labeled or marked when opened and have a discard date. Review of the Program's policy and procedure related to Nutrition and Food Service indicated the Program would ensure all food was prepared, stored and served in a safe and sanitary manner. It included following food handling and hygiene practices, regularly cleaning and sanitizing food preparation areas and equipment, providing a clean and comfortable dining area, and documentation of all nutrition and food service policies. The Program's policy and procedure related to Food Safety indicated all food would be handled and prepared in a manner that prevented contamination and ensured safety. It included using clean and sanitized utensils and equipment, cooking foods to appropriate temperatures, storing perishable foods at the appropriate temperatures, labeling and dating all food items and maintaining documentation of all food safety practices. In summary, the Program failed to follow policies and procedures related to Nutrition and Food Service and Food Safety including cleanliness of	A 150		

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A 150	Continued From page 10	A 150		

serving areas, labeling and storing food, maintenance of refrigerator and freezer temperature logs, serving of food with appropriate utensils and maintaining food temperature logs.

4. When observed on 4/17/25 during lunch at approximately 12:00 p.m. dietary staff delivered the food to the memory care unit. Tenants had Styrofoam cups and were provided plastic beverages carafes containing water which they poured themselves. No other beverages were provided to the tenants. Staff E told the Executive Director there was not time to make lemonade before the meal. Tenants were served meatballs on a bun, french fries, pasta salad (from a container) and applesauce in individual single serve containers.

Record review revealed the weekly menu provided listed salad bar, soup of the day (neither observed provided), meatball sub, pasta salad and french fries. There were no beverages or desserts listed on the menu. In review of the menu there were french fries served 4 of 7 days at lunch. There was coleslaw served 3 of 7 days at lunch. Nutritional menus were requested that were provided from the food supplier. These menus reflected the name of the management company at the top and provided four weeks of menus with portion sizes for fall winter 2024/2025. The menus listed all planned menus items including desserts, entrees, side items and beverages. The initial menus provided by the Program did not match the menus provided by the food supplier. The meal observed on 4/17/25 was not on the food supplier menus provided.

When interviewed on 4/22/25 at 9:25 a.m. and 3:15 p.m. the Executive Director said the weekly menus (initially provided) had changes made

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A 150	Continued From page 11	A 150		

from the nutritional menus provided by the food supplier. She said the changes were made in house by the Chef/Culinary Coordinator. The registered dietician did not review the changes made. Currently the Chef/Culinary Coordinator was making changes based on a couple of factors. There would be a new menu starting on 5/5/25 and going forward changes would be the exception and not the standard. They just received the menu substitution form and it would be used on the new menu cycle.

When interviewed on 4/22/25 at 9:42 a.m. the Chef/Culinary Coordinator said changes of menu were made for products not available and preferences of the tenants. He confirmed the registered dietician did not approve the changes of the menu.

Review of the Menu Substitution policy and procedure indicated "on occasion" items planned might need to be substituted due to the original product not being available, staff shortages, equipment malfunction, use of another product before it expires for cost control, use of leftovers for cost control and a holiday, theme or special menu. When substitutions needed to be made the Food Service Director would be consulted to determine a food equivalent. The registered dietitian would sign off that substitutions were approved with menu planning policies. Menu substitutions made for one of those reasons would be documented in the Menu Substitution Log.

In summary, the Program had menus provided by the food supplier that provided items to be served and serving size. The weekly menus provided did not match the nutritional menus by the food supplier. There were many changes made

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A 150	Continued From page 12 without completion of the substitution form and approval by the Registered Dietician.	A 150		
A 275	481-67.5(2)f(2) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (2) Medications shall be kept in a locked place or container that is not accessible to persons other than employees responsible for the administration or storage of such medications. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to keep physician ordered nutritional supplements in a locked place inacessible to others outside of staff for 2 of 2 tenants who had such supplements (Tenant #6 and Tenant #7). Findings follow: 1. On 4/17/25 at 12:44 p.m. the refrigerator in the memory care unit was observed. There were nutritional supplement drinks (two types). The refrigerator was not locked. 2. Review of Tenant #6's file on 4/24/25 reflected a doctor's order for one protein supplement daily to help with nutrition. It indicated he may also have another supplement as needed per Tenant #6's request or for meal replacement. The tenant's April 2025 medication administration	A 275		

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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 275	Continued From page 13 record (MAR) reflected an order for a protein shake, twice daily at 8:00 a.m. and 5:00 p.m. Staff documented the administration of the protein shake. 3. Review of Tenant #7's file on 4/24/25 reflected a doctor's order for Ensure Nutrition Shake, one bottle everyday at 10:00 a.m. and 2:00 p.m. The tenant's April 2025 MAR reflected an order for Ensure Nutrition Shake two times per day at 10:00 a.m. and 2:00 p.m. Staff documented the administration of the nutrition shake. 4. When interviewed on 4/24/25 at 9:21 a.m. the Health and Wellness Director said prior there were two tenants that had nutritional supplements in the refrigerator in the kitchen. She did not think the refrigerator was locked all the time. She confirmed the supplements were both now secured in a cupboard in the kitchen. The medication aide had keys to the cupboard.	A 275		
A 285	481-67.5(2)f(4) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. This REQUIREMENT is not met as evidenced	A 285		

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 _____	R-C 04/24/2025

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 285	Continued From page 14 by: Based on interview and record review the Program failed to administer medications as ordered. This pertained to 3 of 3 current tenants (Tenants #1, #3 and #4) and 2 of 2 discharged tenants (Tenant #C1 and Tenant C2) reviewed who received staff assistance with medication administration. Findings follow: 1. Review of Tenant #1's file between 4/9/25 and 4/23/25 revealed staff administered Tenant #1's medications. The February to April 2025 medication administration records (MARs) reflected medications that were ordered were not documented as administered (no initials or notations made on the MAR; omissions). It included the following orders: - Famotidine 20 milligram (mg) tablet, 1 tablet by mouth twice daily was not documented as administered 4 times in February, 2 times in March and 1 time in April (through a.m. 4/9/25). - Melatonin 3 mg tablet, two tablets, by mouth at bedtime was not documented as administered 2 times in February. - Nystatin powder to groin folds twice daily was not documented as administered 4 times in February, 2 times in March and 1 time in April (through a.m. 4/9/25). - Probiotic capsule, 1 capsule by mouth daily was not documented as administered 2 times in February, 2 times in March and 1 time in April (through a.m. 4/9/25). - Sertraline 100 mg tablet, 1.5 tablets, by mouth daily was not documented as administered 2 times in February, 2 times in March and 1 time in April. - Zinc Oxide ointment 20%, to buttocks area three times daily was not documented over 10 times in February, over 10 times in March and 4 times in April (through a.m. on 4/9/25).	A 285		

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 _____	R-C 04/24/2025

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 285	Continued From page 15 2. Review of Tenant #3's file between 4/17/25 and 4/24/25 revealed staff administered Tenant #3's medications. The February to April 2025 MARs reflected medications that were ordered and not documented as administered (no initials or notations made on the MAR; omissions). It included the following orders: - Ammonium Lac Lotion 12%, to body twice daily was not documented as administered 5 times in February, 1 time in March and 1 time in April. - Cetirizine 5 mg tablet, 1 tablet, by mouth at bedtime was not documented as administered 2 times in February. - Citalopram 20 mg, 1 tablet by mouth daily was not documented as administered 3 times in February, 1 time in March and 1 time in April. - Melatonin 10 mg tablet, 1 tablet by mouth at bedtime was not documented as administered 2 times in February and 1 time in April. - Propranolol 40 mg tablet, 1 tablet by mouth daily was not documented as administered 3 times in February, 1 time in March and 1 time in April. - Trazodone 50 mg tablet, 1/2 tablet by mouth daily (changed to twice daily on 3/8/25) was not documented as administered 5 times in February, 1 time in March and 1 time in April. - Vitamin D3 2 tablets, by mouth twice daily was not documented as administered 5 times in February, 1 time in March and 1 time in April. 3. Review of Tenant #4's file between 4/17/25 and 4/24/25 revealed staff administered Tenant #4's medications. The February to April 2025 MARs reflected medications that were ordered and not documented as administered (no initials or notations made on the MAR; omissions). It included the following orders: - Prevent Silicone Cream, twice daily was not	A 285		

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 _____	R-C 04/24/2025

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 285	Continued From page 16	A 285		

documented as administered 3 times in February and 1 time in March.
- Acetaminophen 325 mg, 2 tablets by mouth four times daily was not documented as administered 6 times in February, 3 times in March and 1 time in April.
- Divalproex 500 mg tablet, 1 tablet by mouth twice daily was not documented as administered 2 times in February and 1 time in March.
- Famotidine 20 mg tablet, 1 tablet by mouth twice daily was not documented as administered 2 times in February and 2 times in March.
- Mirtazapine 7.5 mg tablet, 1 tablet by mouth at bedtime was not documented as administered 2 times in February and 1 time in April.
- Quetiapine 50 mg tablet, 1 tablet by mouth three times daily was not documented as administered 8 times in February and 4 times in March.
- Valporic Acid Solution 250 mg/5 milliliters (ml), 5 ml by mouth four times daily was not documented as administered 5 times in February, 4 times in March and 1 time in April.

4. Review of Tenant C1's file between 4/21/25 and 4/24/25 revealed staff administered her medications. Tenant C1 was discharged on 2/11/25. The February 2025 MARs reflected medications that were ordered and not documented as administered (no initials or notations made on the MAR; omissions). It included the following orders:
- Donepezil 5 mg tablet, 1 tablet by mouth for 7 days was not documented as administered 1 time in February.
- Levothyroxin 150 microgram (mcg), 1 tablet by mouth once daily was not not documented as administered 2 times in February.
- Melatonin 5 mg tablet, 1 tablet by mouth at bedtime was not documented as administered 1

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 _____	R-C 04/24/2025

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 285	Continued From page 17	A 285		

time in February.
- Risperidone Solution 1 mg/ml take 0.5 ml by mouth three times daily was not documented as administered 2 times in February.
- Sertraline 100 mg tablet, 1 tablet by mouth was not documented as administered 1 times in February.
- Telfa non-adherent pad, cover open/bleeding lesions on legs daily was not documented as administered 2 times in February.

5. Review of Tenant C2's file between 4/17/25 and 4/24/25 revealed staff administered her medications. The February and March 2025 MARs reflected medications that were ordered and not documented as administered (no initials or notations made on the MAR; omissions). It included the following orders:
- Tubigrips, twice daily was not documented as completed 8 times in February.
- Acetaminophen ER tablet 650 mg, 1 tablet by mouth twice daily was not documented as administered 8 times in February.
- Aspirin low dose tablet 81 mg EC 1 tablet by mouth every morning was not documented as administered 4 times in February and 4 times in March.
- Hydrochlorothiazide 25 mg tablet, 1 tablet by mouth every morning was not documented as administered 4 times in February and 4 times in March.
- Melatonin 5 mg tablet, 1 tablet by mouth at bedtime was not documented as administered 2 times in February and 1 time in March.

Tenant C2's Progress Notes revealed the following:
- On 3/10/25 had an unwitnessed fall and had knee pain and a skin tear on her arm. She was transferred to the hospital for evaluation. The

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 _____	R-C 04/24/2025

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 285	Continued From page 18	A 285		

hospital called and reported Tenant C2 had a dislocated knee, it was reduced back into place and she would be discharged back to the program.
- On 3/10/25 Provider #1 wrote an order for Tramadol 50 mg, by mouth every 8 hours as needed for pain.
- On 3/11/25 hospice would order ABH cream for anxiety and agitation.
- On 3/13/25 the Program's preferred pharmacy could not fill the cream and hospice was notified.
- On 3/17/25 it was noted the ABH gel was received from another pharmacy.
- On 3/21/25 Tenant C2 had increased pain and was crying. Her left knee was hurting and she refused to let staff touch her.
- On 3/21/25 hospice was at bedside and called the doctor for orders for pain medications.
- On 3/21/25 hospice orders included ABH gel 1/12.5/2 mg give 1 ml, apply to hairless area every 4 hours as needed for anxiety/agitation, Tramadol 50 mg tablet, give two tablets (100 mg) by mouth now and every 6 hours as needed for pain, Dilaudid 2 mg tablets, give 1/2 tablet every 1 hour for anxiety/restlessness.
- On 3/22/25 Provider #1 had been notified of Tenant C2's condition and would monitor. She was aware hospice was visiting and writing orders for pain and anxiety.
- On 3/24/25 new orders were received from Provider #1 to add Dilaudid 2 mg every 8 hours as needed (keep as needed dose), add lorazepam 0.5 mg every 8 hours scheduled (keep as needed dose), discontinue Melatonin and Tramadol.
- On 3/27/25 it was noted the ABH gel was delivered from the other pharmacy and the dose was clarified with hospice prior to administration. The pharmacy order indicated ABH gel 1/12.5/2 mg 0.1 ml dose. Hospice indicated the order was

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 _____	R-C 04/24/2025

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 285	Continued From page 19	A 285		

for 1 ml of gel at each dose. The MAR indicated to give 0.01 Hospice was going to fax the order again and the on-call pharmacist for the other pharmacy believed it was supposed to be 0.1 ml. The order needed further clarification. The medication aide would administer 0.1 ml for scheduled and as needed doses until they received further clarification.
- On 3/28/25 it was noted the preferred pharmacy called to clarify scheduled and as needed orders for lorazepam and hydromorphone. The orders were from two different providers.
- On 3/29/25 it was noted all old orders were removed from hospice and all medication orders were verified with hospice.

Further review of physician and hospice orders and the March 2025 MAR indicated medications were not administered as ordered for Tenant C2 including ABH gel, Tramadol, lorazepam and hydromorphone. The MARs and orders indicated the following:

ABH gel orders and MAR
- (order) ABH gel 1/12.5/2, apply 0.5 ml to the inner wrist, three times per day as needed was ordered. No date was provided on the order (nurse's notes indicated 3/17/25). It was ordered by Provider #1.

The MAR reflected an order for ABH Gel, 1/12.5/2 apply 0.1 ml onto the skin as needed three times daily. It was documented as administered six times from 3/21/25 to 3/28/25. It was reflected as starting on 3/17/25 and was not discontinued despite a new order received from hospice (see below). It was ordered to apply 0.5 ml and the MAR reflected the medication administered was 0.1 ml. It was not administered as ordered.

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 _____	R-C 04/24/2025

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 285	Continued From page 20 - (order) ABH Gel 1/12.5/2 mg, give 1 ml, apply to inner wrist or hairless area every four hours as needed for anxiety and agitation. Ordered by hospice on 3/21/25. The MAR did not reflect the order for ABH gel, give 1 ml every 4 hours as needed ordered on 3/21/25. It was not administered as ordered. - (order) ABH gel 1/12.5/2, apply 1 ml topically to inner wrist or hairless area every four hours for anxiety and restlessness. Ordered by hospice on 3/25/25. The MAR reflected an order for ABH gel 1/12.5/2 apply 0.01 ml onto the skin every four hours. It was documented as administered six times from 3/27/25 to 3/29/25. It reflected as starting on 3/27/25 and was discontinued on 3/29/25. The order reflected to administer 1 ml and the MAR reflected the medication administered was 0.01 ml. The medication was not administered as ordered. The MAR then reflected an order for ABH gel 1/12.5/2 apply 0.1 mg onto the skin every four hours. It was documented as administered seven times from 3/29/25 to 3/31/25. It was reflected as starting on 3/29/25. The order reflected to administer 1 ml and the MAR reflected the medication administered was 0.1 mg. The medication was not administered as ordered. Hydromorphone (Dilaudid) orders and MAR - (order) Dilaudid 2 mg tablets, give half tablet by mouth every hour as needed for moderate to severe pain. Ordered by hospice on 3/21/25. The MAR reflected the order for the half tablet by	A 285		

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 _____	R-C 04/24/2025

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 285	Continued From page 21	A 285		

mouth every hour as needed. It was started on 3/22/25 and ended on 3/29/25. It was again added on 3/29/25 with a new order date of 3/29/25.

The MAR reflected an order for hydromorphone 2 mg tablet, take a half tablet by mouth every six hours as needed for pain. It was reflected as starting on 3/28/25 and was discontinued on 3/29/25. An order was not provided for hydromorphone every 6 six hours as needed. No doses were documented as administered.

- (order) hydromorphone 2 mg tablet, give 0.5 tablet every six hours for pain (scheduled). It was ordered on 3/25/25 by hospice.

The MAR did not reflect the order for hydromorphone 2 mg tablet scheduled every six hours when it was ordered. It was listed on the MAR after a clarification was received on 3/28/25 (see below). The medication was not administered as ordered.

The MAR reflected an order for hydromorphone 2 mg tablet, 1 tablet by mouth every 8 hours. It was ordered by Provider #1 on 3/25/25. It was not discontinued when new orders were received for hydromorphone from hospice on 3/25/25. It was documented as given 1 time from 3/25/25 to 3/29/25. It was discontinued on 3/29/25 after the clarification of orders was received (see below).

- (order) Clarification of orders for hydromorphone 0.5 tablet, give every 6 hours scheduled and 0.5 tablet every hour as needed. It also indicated to disregard the orders from Provider #1.

The MAR reflected an order for hydromorphone

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 _____	R-C 04/24/2025

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 285	Continued From page 22 tablet 2 mg, take a half tablet (1 mg) by mouth every six hours. It was reflected as starting on 3/29/25. It was started on the MAR until 3/29/25 despite being ordered on 3/25/25. Two doses were documented as administered on 3/29/25. The medication was not administered as ordered. The MAR also reflected to take half tablet hydromorphone every 1 hour as needed. It was added again dated 3/29/25 with a new order date of 3/29/25. Lorazepam order and MAR - (order) lorazepam 1 mg tablet, give a half tablet by mouth every one hours as needed for anxiety/restlessness. Ordered by hospice on 3/21/25. - (order) It was ordered to discontinue the current lorazepam order (give half tablet every 1 hour as needed). It was ordered on 3/25/25 by hospice. The MAR reflected the order for lorazepam 0.5 mg take 1 tablet by mouth every 1 hour as needed. It was reflected as starting on 3/22/25. It was not discontinued until 3/28/25 despite being discontinued on 3/25/25 by hospice. Doses were administered from 3/23/25 to 3/27/25. - (order) lorazepam 0.5 mg tablet, 1 tablet by mouth every 8 hours. It was ordered by Provider #1 on 3/25/25. The MAR reflected the order for lorazepam 0.5 mg, 1 tablet every 8 hours starting on 3/25/25. The order was discontinued on 3/29/25. It was not discontinued when the other lorazepam orders were received from hospice on 3/26/25. Doses were administered twice from 3/26/25 to 3/28/25.	A 285		

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 _____	R-C 04/24/2025

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 285	Continued From page 23 - (order) lorazepam 0.5 mg, give 1 tablet, by mouth hourly as needed until the ABH gel is available from pharmacy. It was ordered by hospice on 3/26/25. The MAR reflected the prior order for lorazepam 0.5 mg 1 tablet every hour as needed (which was discontinued on 3/25/25). The MAR did not reflect the new order on 3/26/25 for lorazepam 0.5 mg, 1 tablet by mouth hourly until the ABH gel was available. 6. When interviewed on 4/22/25 at 10:42 a.m. and 9:21 on 4/24/25 the Health and Wellness Director said Provider #1 ordered the ABH gel and the preferred pharmacy would not cover it and it would have to paid out of pocket. Hospice wrote the order and it was sent to another pharmacy to compound it. Hospice ordered 1 ml but the pharmacy filled it at 0.1 ml. That was the standard dose for the pharmacy. Hospice sent another order for the 1 ml and 0.01 ml was sent back and there were conflicting orders. Regarding Tenant C2's other medications, there were two people writing orders making the situation confusing.	A 285		
A 361	481-67.9(4)f 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: f. Services shall be provided to tenants in accordance with the training provided.	A 361		

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 _____	R-C 04/24/2025

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 361	Continued From page 24 This STANDARD is not met as evidenced by: Based on interview and record review the Program failed to ensure staff provided services in accordance with dementia training provided. This pertained to 1 of 2 staff reviewed related to dementia education (Staff C). Findings follow: 1. Review of Tenant #3's file on 4/17/25 revealed a Progress Notes dated 1/9/25 indicating all tenants had finished dinner. Tenant #3 was upset and said she had not eaten. Staff C told Tenant #3 she had just eaten and the two continued to argue. Tenant #3 threatened to get physically aggressive towards staff and Staff C was overhead telling Tenant #3 if she touched her she have her arrested. The Health and Wellness Director (HWD) overheard the altercation and came out to intervene. Staff C continued to argue that Tenant #3 had already eaten. The HWD warmed up food and sat with Tenant #3 while she ate dinner. Tenant #3 was very pleasant with the HWD. Continued record review revealed Tenant #3 was staged at at five on the Global Deterioration Scale, which indicated moderately severe cognitive decline. Tenant #3's service plan indicated she had frequent behavior issues and occasionally acted out towards staff and other tenants. Redirection was required to diffuse the situation. 2. When interviewed on 4/21/25 at 2:08 p.m. Staff C said Tenant #3 was on a rampage and was being aggressive. Tenant #3 said she was going to call the police and Staff C said the police would get her because she was being mean. Staff C said it was said in joking manner.	A 361		

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 _____	R-C 04/24/2025

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 361	Continued From page 25 When interviewed on 4/24/25 at 9:21 a.m. the HWD said she could hear the exchange from her office. Tenant #3 said she had not eaten and Staff C said she had. Tenant #3 said she was going to call the police and Staff C said she would call the police on her. The HWD said the expectation was staff would offer Tenant #3 food. She said there was a discussion and reeducation with Staff C. 3. Review of Staff C's file revealed dementia training had been completed. Staff had training completed related to dementia education; however, she did not provide services in accordance with that training related to the incident above.	A 361		
A 145	481-69.22(3) Evaluation of Tenant 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	A 145		

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 _____	R-C 04/24/2025

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 145	Continued From page 26 Program failed to complete evaluations as needed. This pertained to 1 of 4 current tenants (Tenants #1) and 2 of 2 discharged tenants reviewed (Tenant C1 and Tenant C2). Findings follow: 1. Review of Tenant #1's file between 4/9/25 and 4/23/25 revealed an Incident Report dated 1/2/25 indicated staff was on the phone with the Health and Wellness Director and heard a noise, went to the common area and found her on the floor with blood around her head. It indicated the Health and Wellness Director told staff to call 911 and she left by ambulance. The tenant's emergency department (ED) notes dated 1/2/25 indicated she was admitted and discharged on 1/2/25. It was noted Tenant #1 had dementia and would not sit still regarding the scalp repair. Five staples were placed, one staple had to be removed due to her moving and the staple going into one side of the laceration. A hospice document dated 1/10/25 indicated six staples were removed and steri-strips were applied. The laceration was scabbed with no drainage. Continued review revealed evaluations could not be located following the tenant's return from the ED. 2. Review of Tenant C1's file from 4/21/25 to 4/23/25 revealed Progress Notes indicating the following: - On 1/6/25 Tenant C1 was evaluated at the hospital for re-admission to the Program and would return on hospice services. - On 1/22/25 Tenant C1 had mottling noted on her bilateral lower extremities. She was	A 145		

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 _____	R-C 04/24/2025

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 145	Continued From page 27	A 145		

ambulating with an assist of her walker. The ulcer on her right foot was reddened and moist.
- On 2/9/25 the hospice nurse called and provided a new order for crushed medications. Tenant C1 was declining in her condition and had difficulty with swallowing.
- On 2/11/25 staff reported Tenant C1 declined in condition. Family and hospice were notified.
- On 2/11/25 staff called and reported Tenant C1 had died. Hospice and family was notified.

The tenant's most most recent evaluations were dated 1/6/25. Evaluations could not be located with a decline in Tenant C1's condition as noted above.

3. Review of Tenant C2's file between 4/9/25 and 4/24/25 revealed Progress Notes indicating the following:
- On 3/22/25 it was noted a change of condition was completed related to increased assistance with ambulation, toileting and repositioning. Assistance was needed with grooming and bathing but she refused all cares, all of the time. She had become more resistant to repositioning but was more cooperative with family at bedside. Hospice would order a hospital bed for easier repositioning. Tenant C2 was not wanting to move as much due to the suspected blood clot in her leg. Hospice ordered a bedside commode and she was placed on daily visits.
- On 3/24/25 a hospital bed and bedside commode arrived. The tenant refused any pain medications and told staff to get out of her apartment.
- On 3/25/25 the tenant had been physically aggressive towards staff. It had increased the last couple of days as her pain had increased. She refused medications at times. She had been hitting, punching and spitting out medications.

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 _____	R-C 04/24/2025

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 145	Continued From page 28 - On 3/27/25 the need for a higher level of care for Tenant C2 was discussed with hospice and program staff. - On 3/30/25 it was noted Tenant C2 had become more resistant to cares, especially on overnight shifts. She had been hitting, pinching staff in inappropriate places, resisted repositioning, yelled profanities and had made some racial comments to staff. - On 4/2/25 Tenant C2 was discharged to another facility due to needing a higher level of care. Continued review revealed evaluations dated 3/21/25 and 3/30/25. Evaluations were not completed between those dates when Tenant C2's behaviors increased, her pain increased and she refused medications. It also was not completed with the addition of a hospital bed and bedside commode. 4. When interviewed on 4/22/25 at 3:15 p.m. the Executive Director confirmed all evaluations were provided for the tenants reviewed.	A 145		
A 290	481-69.25(1)i Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception This REQUIREMENT is not met as evidenced	A 290		

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 _____	R-C 04/24/2025

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 290	Continued From page 29	A 290		

by:
Based on interview and record review the Program failed to document nurse's notes by exception. This pertained to 3 of 4 current tenants reviewed (Tenants #1, #3, and #5). Findings follow:

1. Review of Tenant #1's file between 4/9/25 and 4/23/25 revealed an Incident Report dated 1/2/25 indicated staff was on the phone with the Health and Wellness Director and heard a noise, went to the common area and found Tenant #1 on the floor with blood around her head. It indicated the Health and Wellness Director told staff to call 911 and she left by ambulance.

Further record review revealed emergency department (ED) notes dated 1/2/25 indicated she was admitted and discharged on 1/2/25. It was noted Tenant #1 had dementia and would not sit still regarding the scalp repair. Five staples were placed, one staple had to be removed due to her moving.

A hospice document dated 1/10/25 indicated six staples were removed and steri-strips were applied. The laceration was scabbed with no drainage.

A nurse's note was not completed when Tenant #1 returned from the ED or when the staples were removed.

2. Review of Tenant #3's file between 4/9/25 and 4/24/25 revealed Progress Notes indicating the following:
- On 2/19/25 an order was received for a urinalysis (UA) due to increased agitation, behaviors and not sleeping for 48 hours.
- On 4/10/25 urine was sent out for a UA due to

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 _____	R-C 04/24/2025

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 290	Continued From page 30 increased restlessness and mild behaviors. Nurse's notes were not documented by exception related to follow up for the UA on 2/19/25 and when the order was received and follow up on 4/10/25. 3. Review of Tenant #5's file from 4/21/25 to 4/23/25 revealed an incident report dated 4/5/25 indicating Tenant #5 was found on the floor in her apartment. Staff told the medication manager she had fallen and when the medication manager went to the apartment her body went limp, and her eyes rolled into the back of her head. Her breathing was different. Staff called her name without response. Staff called 911 and the nurse. Paramedics evaluated her and staff reported it might be behavioral since she moved to memory care recently. It was noted she remained in the building. A Progress Note dated 4/8/25 indicated staff found Tenant #5 on the floor and assisted her into the seat on her walker. Staff checked on her and found her body was limp, her eyes were rolled and her breathing was different. Staff called her name several times without response. Staff called 911 and notified the nurse. (This appeared to be related to the Incident Report dated 4/5/25). Further review revealed a nurses note indicating what occurred following the incident on 4/5/25 was not documented. 4. When interviewed on 4/22/25 at 3:15 p.m. the Executive Director confirmed all nurse's notes were provided for the tenants reviewed.	A 290		

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 _____	R-C 04/24/2025

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 295	Continued From page 31	A 295		
A 295	481-69.25(1)j Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: j. Medication lists, which shall be maintained in conformance with 481-paragraph 67.5(2)"d"; This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to obtain a medication list for medication administration. This pertained to 1 of 1 current tenant reviewed admitted in 2025 (Tenant #5). Findings follow: 1. Review of Tenant #5's file on 4/21/25 and 4/22/25 revealed Progress Notes indicating the following: - On 4/4/25 Tenant #5 moved from independent living (in the same building) to the Program. - On 4/8/25 a medication list was requested from the tenant's primary care provider. She had boxes of pill packs from an online pharmacy and vitamins that were hidden in her belongings. She said she had been administering her own medications. It was noted there were loose pills in the box and packets were from January and February of 2025. Tenant #5 did not know what medications she took. It was noted they would wait for medication list to verify. - On 4/14/25 a request was sent for a clarification of the medication list sent. A signed medication list for Tenant #5 was requested for the pharmacy. - On 4/17/25 an email was sent to Tenant #5's family member requesting an updated medication list from the doctor that was signed. Tenant #5 had been using an online pharmacy in the past but had not been taking any medications in the	A 295		

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 _____	R-C 04/24/2025

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 295	Continued From page 32	A 295		

past couple of months.
- On 4/18/25 a voicemail was left for Tenant #5's doctor requesting a signed medication list. It was noted Tenant #5 had not been taking her medications for some time, boxes of pill packets and supplements were found that were not opened. A fax was also sent to the doctor's office requesting a list.

2. Continued record review revealed a service plan dated 3/30/25 reflected Tenant #5 had a Global Deterioration Scale of four (moderate cognitive decline). It also indicated Tenant #5 required total assistance related to medication administration. Staff administered and re-ordered her medications. The medications were stored in her apartment. Staff administered her medications three times daily.

3. Further record review revealed a Fax Cover Sheet dated 4/18/25 was sent to Tenant #5's doctor and indicated to send a signed medication list to the Health and Wellness Director (HWD). It was noted she had moved to the memory care and they needed to get her medications sent to the pharmacy. The medication list was returned and signed 4/22/25.

4. When interviewed on 4/21/25 at 10:34 a.m. Staff A said Tenant #5 had been in memory care for about two weeks and she had moved from independent living. Staff had not been giving her medications as there had not been any orders on the MAR.

When interviewed on 4/21/25 at 11:00 a.m. Staff B said Tenant #5's medications were in the medication room. The medications were available but there was no orders on the MAR.

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 _____	R-C 04/24/2025

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 295	Continued From page 33 When interviewed on 4/22/25 at 10:42 a.m. the HWD said there was one tenant, Tenant #5, they had trouble getting a medication list for. Another provider sent a medication list; however, the provider was not the prescribing provider and was not comfortable giving a signed medication list. The HWD said staff were not administering her medications yet. She had left two voicemail messages and sent a fax to the doctor. She said Tenant #5 had previously lived in the independent living and had been in the assisted living for about two weeks. In summary, Tenant #5 moved from the independent living to the assisted living on 4/4/25. A signed medication list had not been obtained prior to to her moving into the Program. It then took over 2 weeks to get a signed list in order for the tenant to receive the medications she was prescribed.	A 295		
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 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	A 350		

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 _____	R-C 04/24/2025

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 350	Continued From page 34 Program failed to update service plans as to reflect the service needs of the tenants. This pertained to 3 of 4 current tenants reviewed (Tenants #1,#4 and #5) and 2 of 2 discharged tenants reviewed (Tenant C1 and Tenant C2). Findings follow: 1. Review of Tenant #1's file between 4/9/25 and 4/23/25 revealed an Incident Report dated 1/2/25 indicated staff was on the phone with the Health and Wellness Director (HWD) and heard a noise, went to the common area and found Tenant #1 on the floor with blood around her head. It indicated the HWD told staff to call 911 and she left by ambulance. The emergency department (ED) notes dated 1/2/25 indicated she was admitted and discharged on 1/2/25. It was noted Tenant #1 had dementia and would not sit still regarding the scalp repair. Five staples were placed, one staple had to be removed due to her moving. A hospice document dated 1/10/25 indicated six staples were removed and steri-strips were applied. The laceration was scabbed with no drainage. Tenant #1's service plan was not updated following Tenant #1's unwittnessed fall with injury, following the incident. 2. Review of Tenant #4's file from 4/17/25 to 4/24/25 revealed Progress Notes indicated the following: - On 3/14/25 Tenant #4 was extremely agitated at dinner and wanted to see her spouse. She was upset, screaming and threw her plate across the room with her food on it. - On 3/23/25 Tenant #4 was inconsolable,	A 350		

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 _____	R-C 04/24/2025

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 350	Continued From page 35	A 350		

anxious, yelled, threatened others, screamed for her spouse and staff were not able to redirect. She was up all night and had vivid hallucinations.
- On 3/25/25 Tenant #4 was extremely agitated and screamed at the top of her lungs, yelled that she wanted to die, said staff were trying to kill her and to get her out of there. Redirection was effective for about 15 minutes, then she returned to screaming. It was noted her behaviors of screaming and yelling obscenities was increasing and it was was upsetting to the other tenants.
- On 4/4/25 Tenant #4 screamed that she wanted to die and asked where her spouse was and to get her out of there. Staff were not able to redirect Tenant #4.
- On 4/4/25 Tenant #4 was back in the common area and was inconsolable. All PRN (as needed) medications were given without relief. Multiple staff attempted to redirect her without success. Other tenants yelled at her to get out of there, which escalated the behaviors. Tenant #4 was removed from the situation and returned to her apartment where she screamed for 15 minutes. Hospice was made aware of the behaviors and that it might be needed to send her out for evaluation if the behaviors continued. Hospice said not to send her out and for the nurse to control her. It was discussed with the management company that Tenant #4 needed a higher level of care. Tenant #4 was transported to the hospital via non-emergent transported.

Tenant #4's February, March and April 2025 medication administration records (MARs) reflected an order for Ensure Nutritional Drink, as needed once per day. Ordered on 1/4/25.

Further review revealed an order was received for Calmoseptine barrier cream to be applied to buttocks twice daily.

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 _____	R-C 04/24/2025

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 350	Continued From page 36	A 350		

The tenant's service plan most recently updated on 4/14/25 reflected a list of Tenant #4's medication orders. The list included Ensure Nutritional Drink and Calmoseptine (as noted above). The service plan did not identify the areas of concerns related to those orders including if there was weight loss or skin breakdown. Additionally, the service plan reflected Tenant #4 had behaviors and yelled out and staff education had been provided by hospice and the nurse. It indicated the behavior might require professional consultation or staff training. It indicated to report concerns to nursing. The service plan identified Tenant #4's behavior however, did not provide any interventions. Additionally, the service plan did not reflect Tenant #4 voiced at times that she wanted to die and interventions related to the behavior.

3. Review of Tenant #5's file on 4/21/25 and 4/22/25 revealed Progress Notes indicating the following:
- On 4/4/25 Tenant #5 moved from independent living (in the same building) to the Program.
- On 4/8/25 a medication list was requested from the tenant's primary care provider. The tenant had boxes of pill packs from an online pharmacy and vitamins that were hidden in her belongings. She said she had been administering her own medications. It was noted there were loose pills in the box and packets were from January and February of 2025.Tenant #5 did not know what medications she took. It was noted they would wait for medication list to verify.
- On 4/14/25 a request was sent for a clarification of the medication list sent. A signed medication list for Tenant #5 was requested for the pharmacy.
- On 4/17/25 an email was sent to Tenant #5's

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 _____	R-C 04/24/2025

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 350	Continued From page 37	A 350		

family member requesting an updated medication list from the doctor that was signed. Tenant #5 had been using an online pharmacy in the past but had been taking any medications in the past couple of months.
- On 4/18/25 a voicemail was left for Tenant #5's doctor requesting a signed medication list. It was noted Tenant #5 had not been taking her medications for some time, boxes of pill packets and supplements were found that were not opened. A fax was also sent to the doctor's office requesting a list.

A service plan dated 3/30/25 reflected Tenant #5 had a Global Deterioration Scale of four (moderate cognitive decline). It also indicated Tenant #5 required total assistance related to medication administration. Staff administered and re-ordered her medications. The medications were stored in her apartment. Staff administered her medications three times daily.

Further review revealed Tenant #5's service plan was not updated to reflect Tenant #5's medications were not available to administer due to not having a current signed medication list.

4. Review of Tenant C1's file from 4/21/25 to 4/23/25 revealed Progress Notes indicating the following:
- On 1/6/25 Tenant C1 was evaluated at the hospital for re-admission to the Program and would return on hospice services.
- On 1/22/25 Tenant C1 had mottling noted on her bilateral lower extremities. She was ambulating with an assist of her walker. The ulcer on her right foot was reddened and moist.
- On 2/9/25 the hospice nurse called and provided a new order for crushed medications. Tenant C1 was declining in her condition and had

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 _____	R-C 04/24/2025

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 350	Continued From page 38	A 350		

difficulty with swallowing.
- On 2/11/25 staff reported Tenant C1 declined in condition. Family and hospice were notified.
- On 2/11/25 staff called and reported Tenant C1 had died. Hospice and family was notified.

Tenant C1's service plan was dated 1/6/25. The service plan was not updated with a decline in Tenant C1's condition as noted above.

5. Review of Tenant C2's file between 4/9/25 and 4/24/25 revealed Progress Notes indicating the following:
- On 3/22/25 a change of condition was completed related to increased assistance with ambulation, toileting and repositioning. Assistance was needed with grooming and bathing but she refused all cares, all of the time. She had become more resistant to repositioning but was more cooperative with family at bedside. Hospice would order a hospital bed for easier repositioning. Tenant C2 was not wanting to move as much due to the suspected blood clot in her leg. Hospice ordered a bedside commode and she was placed on daily visits.
- On 3/24/25 a hospital bed and bedside commode arrived. The tenant refused any pain medications and told staff to get out of her apartment.
- On 3/25/25 the tenant had been physically aggressive towards staff. It had increased the last couple of days as her pain had increased. She refused medications at times. She had been hitting, punching and spitting out medications.
- On 3/27/25 the need for a higher level of care for Tenant C2 was discussed with hospice and program staff.
- On 3/30/25 it was noted Tenant C2 had become more resistant to cares, especially on overnight shifts. She had been hitting, pinching

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 _____	R-C 04/24/2025

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 350	Continued From page 39 staff in inappropriate places, resisted repositioning, yelled profanities and had made some racial comments to staff. - On 4/2/25 Tenant C2 was discharged to another facility due to needing a higher level of care. The tenant's most recent service plans were dated 3/22/25 and 3/31/25. The service plan was not updated between those dates when Tenant C2's behaviors increased, her pain increased and she refused medications. It also was not completed with the addition of a hospital bed and bedside commode. 6. When interviewed on 4/22/25 at 3:15 p.m. the Executive Director confirmed all service plans were provided for tenants reviewed.	A 350		
A 465	481-69.28(5) Food Service 69.28(5) Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide an orientation on sanitation and safe food handling prior to handling food. This pertained to 6 of 8 dietary staff reviewed (Staff H, I, K, L, M, and N). Findings follow: Review of staff files between 4/9/25 and 4/17/25	A 465		

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 _____	R-C 04/24/2025

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BROWN DEER PLACE	1500 1ST AVE N CORALVILLE, IA 52241

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A 465	Continued From page 40 revealed the following: - Staff H's date of hire was 5/4/22. Staff H was listed a server (kitchen) on the staff list provided. There was no food safety and sanitation training provided for Staff H. - Staff I's date of hire was 3/15/23. Staff I was listed a server (kitchen) on the staff list provided. There was no food safety and sanitation training provided for Staff I. - Staff K's date of hire was 9/30/24. Staff K was listed a server (kitchen) on the staff list provided. There was no food safety and sanitation training provided for Staff K. - Staff L's date of hire was 2/14/25. Staff L was listed a server (kitchen) on the staff list provided. There was no food safety and sanitation training provided for Staff L. - Staff M's date of hire was 2/21/25. Staff M was listed a server (kitchen) on the staff list provided. There was no food safety and sanitation training provided for Staff M. - Staff N's date of hire was 3/24/25. Staff N was listed a server (kitchen) on the staff list provided. There was no food safety and sanitation training provided for Staff N. When interviewed on 4/24/25 at 9:59 a.m. the Executive Director confirmed all dietary staff either prepared or served food.	A 465		
A 510	481-69.28(8) Food Service 69.28(8) All perishable or potentially hazardous food shall be cooked to recommended temperatures and held at safe temperatures of 41°F (5°C) or below, or 135°F (57°C) or above. This REQUIREMENT is not met as evidenced by:	A 510		

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 _____	R-C 04/24/2025

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 510	Continued From page 41 Based on interview and record review the Program failed to ensure potentially hazardous foods were cooked and served at safe temperatures potentially affecting all 16 tenants. Findings include: Review of the Daily Food Temperature Log from 4/9/25 to 4/21/25 reflected hot food items were not served at 135 degrees Fahrenheit or above on the following days: - on 4/11/25 the chicken breasts were served at 123 degrees - on 4/14/25 french fries were served at 131 degrees - on 4/16/25 and 4/17/25 sausage/bacon was served at 126 degrees - on 4/18/25 taco meat was served at 134 degrees. When interviewed on 4/22/25 at 9:42 a.m. the Chef/Culinary Coordinator said hot foods should be served at 135/140 degrees Fahrenheit.	A 510		

PLAN OF CORRECTION

Community Name: BROWN DEER PLACE

Plan of Correction Date: 4/29/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	PROVIDER INDENTIFICATION NUMBER/LICENSE NUMBER: S0111	DATE SURVEY COMPLETED/TYPE OF SURVEY: 4/24/2025 Revisits, Complaints, Self-Report

ID PREFIX 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
A 115	*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.	A 115	Policy implemented and sent out on 5/21/25 Instant in-service on incident report documentation and Incident Report Checklist given to staff members.	All incident reports to be completed in EHR system.	Implementation Date: 5/5/2025 Completion Date: 5/14/2025 Responsible Party: HWD
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.	A 150	Policy and Procedure manual placed in Nurse's station and front desk of Independent Living. All staff members educated on Policy and Procedure manual as well as location for future reference.	Upon hire, staff are to be aware of Policy and Procedures binder.	Implementation Date: 4/29/2025 Completion Date: 5/15/2025 Responsible Party: ED/HWD
A 275	*481-67.5(2)f(2) Medications* 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (2) Medications shall be kept in a locked place or container that is not accessible to persons other than employees responsible	A 275	Cupboard in MC kitchen with new lock placed for supplement drinks to be stored.	Any item with a physician's order will be kept in a locked area.	Implementation Date: 4/15/2025 Completion Date: 4/15/2025 Responsible Party: Maintenance

	for the administration or storage of such medications.				
A 285	*481-67.5(2)f(4) Medications* 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant.	A 285	Instant In-service provided to staff on documentation regarding medication administration.	HWD to perform audits of EHR dashboard to monitor medication administration.	Implementation Date: 5/5/2025 Completion Date: 5/16/2025 Responsible Party: HWD
A 361	*481-67.9(4)f 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: f. Services shall be provided to tenants in accordance with the training provided.	A 361	HWD completed new delegations with all staff members on 2/24/2025.	HWD to monitor staff competencies in providing services and re-educate as needed.	Implementation Date: 2/24/2025 Completion Date: 3/25/25 Responsible Party: HWD
A 145	*481-69.22(3) Evaluation of Tenant* 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.	A 145	Education provided to HWD on change of condition indicators to ensure change of conditions are completed in a timely manner.	Change of conditions will be completed in a timely manner.	Implementation Date: 5/23/2025 Completion Date:05/23/2025 Responsible Party: HWD

A 290	*481-69.25(1)i Tenant Documents* 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception	A 290	Education provided to Health and Wellness Director in regards to tenant documents as well as charting by exception.	Health and Wellness Director to document any updates or changes to residents' in EHR system.	Implementation Date: 5/5/2025 Completion Date: 5/14/2025 Responsible Party: HWD
A 295	*481-69.25(1)j Tenant Documents* 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: j. Medication lists, which shall be maintained in conformance with 481-paragraph 67.5(2)"d"	A 295	All residents requiring medication management by the community to have a signed medication list.	All new admissions to the community will have a signed medication list prior to admission or transfer.	Implementation Date: 5/5/2025 Completion Date: 5/14/2025 Responsible Party: HWD
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 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.	A 350	Education provided to Health and Wellness Director regarding service plans in relation to Policy 1.03 Service Plans.	The service plans shall be updated to ensure they are individualized to meet resident's needs.	Implementation Date: 5/23/25 Completion Date:5/23/2025 Responsible Party: HWD
A 465	*481-69.28(5) Food Service* 69.28(5) Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection.	A 465	All staff to have appropriate safe food handling training completed by 6/6/2025	Director to ensure training on safe food handling prior to staff prepping or serving food.	Implementation Date: 5/5/2025 Completion Date:6/6/2025 Responsible Party: ED
A 510	*481-69.28(8) Food Service*	A 510	All staff to have appropriate safe food handling training completed by	Director to ensure training on safe food handling prior to staff prepping	Implementation Date: 5/5/2025

	69.28(8) All perishable or potentially hazardous food shall be cooked to recommended temperatures and held at safe temperatures of 41°F (5°C) or below, or 135°F (57°C) or above.		6/6/2025. Temperature logs will be completed and maintained.	or serving food. Director to monitor temperature logs.	Completion Date:6/6/2025 Responsible Party: ED