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 12/02/2025

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. Tenants without cognitive impairment: 1 Tenants with cognitive impairment: 17 Total census: 18 The following regulatory insufficiencies were cited related to the recertification visit conducted to determine compliance with certification a Dedicated Dementia Specific Assisted Living Program:	A 000		
A 125	481-67.2(1)d Program Policies and Procedures 67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following: d. The incident report shall include statements from individuals, if any, who witnessed the incident. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program's incident report policy and procedures failed to have all required information, including witness statements requirements. This potentially affected all tenants (census of 18). Finding follows: Record review on 12/02/25 revealed the	A 125		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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 12/02/2025

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 125	Continued From page 1 Program's policy incident reports, effective/revised date of 5/01/25 directed any incident occurrences related to tenants, visitors, staff or the building/grounds would be documented. The procedure indicated various steps including: staff completed the incident report immediately but not later than the end of the shift. The incident report would be factual. The policy and procedure lacked required information including the incident report would include statements from individuals who witnessed the incident. Additional policies and procedures related to incident reports were requested and a Head Injury policy and procedure was provided. Review of the Head Injury policy indicated no additional information found met the requirement for information required in the incident report policy and procedure. No additional policies and procedures were provided regarding incident reports. It should be noted in April 2025 (exit date of 4/24/25) the Program was cited for a similar regulatory insufficiency related to the incident report policy and procedure not having all required information. The rule cited at that visit was 67.2(1)(b) related to the policy and procedure not including the report would be in detail and provided on an incident report form. On 12/02/25 at the time of the exit interview the Vice President of Clinical Services did not confirm/deny the policy lacked the witness statement requirements.	A 125		
A 365	481-67.9(4)g Staffing	A 365		

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 12/02/2025

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 365	Continued From page 2 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: g. The program shall have in place a system by which certified or noncertified staff communicate in writing occurrences that differ from the tenant's normal health, functional and cognitive status. The program's registered nurse or designee shall train certified and noncertified staff on reporting to the program's registered nurse or designee and documenting occurrences that differ from the tenant's normal health, functional and cognitive status. The written communication required by this paragraph shall be retained by the program for a period of not less than three years, and shall be accessible to the department upon request. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to have non-certified and certified staff document in writing occurrences that differed from the tenant's normal health, functional and cognitive status. This pertained to 3 of 4 tenants reviewed (Tenants #1, #3, and #4). Findings follow: Record review on 12/01/25 of Tenant #1's Progress Notes entered by the Director of Nursing (DON) with documents from the Advanced Registered Nurse Practitioner (ARNP) revealed following entries: (all entries listed below were not completed by direct care staff):	A 365		

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 12/02/2025

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 365	Continued From page 3	A 365		

a. On 10/29/25, a visit note from the ARNP indicated he was seen for evaluation of a rash in his groin. The DON reported his behaviors included attempting to give female tenants back rubs. A new order was received for Baza AF cream, apply to groin twice daily.

b. On 11/04/25, the DON spoke with Tenant #1's family regarding him yelling out in his sleep and touching himself in front of staff and asking them to assist.

c. On 11/09/25, the DON documented the 30-day assessment was completed. In the note regarding the 30-day assessment there was no documentation regarding behaviors.

d. On 11/12/25, a visit note from the ARNP indicated "a lot of other inappropriate behaviors of yelling out at night, touching others, giving back rubs to other female residents, masturbating in front of people." A new order was received to start fluoxetine 10 milligrams (mg) daily. It noted to continue to monitor closely around others and redirect when his behavior was inappropriate.

e. On 11/17/25, the DON documented a change of condition assessment was completed related to discrepancies in the 30-day assessment. He recently dug stool out of his protective undergarment and left it on the floor in other tenants' apartments. It was also noted he took snacks from other tenants' apartments.

Record review of staff to nurse communication sheets since Tenant #1's admission (10/14/25) revealed one document provided that indicated to remind to change a medication time for Tenant #1. There were no staff to nurse communication sheets to reflect any occurrences of the changes

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 12/02/2025

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 365	Continued From page 4	A 365		

with Tenant #1 listed above especially regarding Tenant #1's behavior.

Further record review revealed Tenant #1's service plans dated 11/09/25 (30 day) and 11/17/25 (change of condition) reflected some of the behaviors indicated above; however, the behaviors started prior to the development of the service plans and would have been unusual occurrences.

2. When interviewed on 12/01/25 at 1:02 p.m. Tenant #3's family member reported Tenant #3 had difficulty swallowing. She explained they did not provide special diets and they were talking about staff cutting up her meat into small pieces. She indicated hospice was involved with her care too. Tenant #3 ate slowly.

When interviewed on 12/02/25 at 2:40 p.m. the Executive Director recalled a new hospice nurse was at the Program while Tenant #3 ate and the hospice nurse brought up swallowing difficulties. The Director of Nursing (DON) was not there that day. It was at breakfast, Tenant #3 did not choke, she coughed food up and spit food)out and cleared her throat. The hospice nurse indicated it appeared she had trouble swallowing textures or foods. She could clear her throat related to the incident observed. The hospice nurse would talk to Tenant #3's family about if the family wanted to do something about it. The hospice nurse wanted to know about interventions including expanding the esophagus and to be aware that she could aspirate. The Executive Director indicated she had not seen therapeutic diets at the Program and did not believe they were provided. Tenant #3's diet was currently lactose intolerant.

When interviewed on 12/02/25 at 2:00 p.m. 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 _____	C 12/02/2025

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 365	Continued From page 5	A 365		

DON said it had not reported to her by either hospice or staff that Tenant #3 had problems with swallowing Since then, she asked staff if Tenant #3 had problems and was told when hospice was there last week she choked at lunch; she was coughing. Staff told her about the incident she had not visited with hospice about the incident and was not aware of any other incidents. She said with Tenant #3 it was hit or miss, sometimes she coughed a lot. Tenant #3 had a general diet and the DON indicated there were no special diets provided. Tenant #3's family asked about thickened liquids and was told they did not provide special diets. The DON reported once in a while at breakfast Tenant #3 appeared to have swallowing difficulties, but she did not feel like Tenant #3 had not been able to consume her food. Sometimes staff sat at a table with her. The DON did not notice a lot of episodes or choking with her and it was discussed with hospice a couple months ago. The DON indicated sometimes staff cut her food, however she was not someone who needed to have her food cut up at every meal. She drank nutritional supplements with meals.

Record review on 12/02/25 of Tenant #3's file for staff to nurse communication sheets revealed no documentation completed for the past three months, including for the incident above.

3. Record review on 12/02/25 of Tenant #4's Progress Note dated 10/17/25 was entered by the DON and not by direct care staff. The note indicated staff reported Tenant #4's right foot and ankle were swollen. Staff was not sure of the cause of the swelling and had not reported an incident to the DON. Hospice visited and observed her ankle. Hospice and the ARNP were notified on 10/18/25 of the swelling. Tenant #4'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 _____	C 12/02/2025

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 365	Continued From page 6 family was aware and had visited on 10/17/25. Staff were instructed to keep her foot elevated to reduce swelling. Continued record review of staff to nurse communication sheets for the past three months for Tenant #4 revealed none were completed or provided, including when staff initially reported the swelling in Tenant #4's right foot and ankle on 10/17/25. When interviewed on 12/02/25 at 2:00 p.m. the DON confirmed staff to nurse sheets were not completed related to Tenant #1's behaviors, the incident with Tenant #3 or with Tenant #4's swollen lower extremity. She indicated staff called her regularly regarding incidents and she had several calls regarding Tenant #4's foot. The DON confirmed she was not aware of the incident with Tenant #3 until 12/02/25 (it occurred the week prior). When interviewed on 12/02/25 at 2:40 p.m. the Executive Director confirmed staff to nurse sheets were not completed related to Tenant #1's behaviors, the incident with Tenant #3 or with Tenant #4's swollen lower extremity.	A 365		
A 400	481-67.19(3) Record Checks 67.19(3) Requirements for employer prior to employing an individual. Prior to employment of a person in a program, the program shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state.	A 400		

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 12/02/2025

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 400	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete a background check that included a criminal history check and child and dependent adult abuse record checks prior to employment. This pertained to 1 of 4 staff hired in the last four months (Staff B). Finding follows: Record review on 11/25/25 of Staff B's file revealed a hire date of 8/12/25. A background check completed on 3/28/23 was initially provided related to Staff B's prior employment. A background check related to Staff B's current employment was requested. A Single Contact License and Background Check was provided dated 11/25/25 (date of review) indicated no records were found for the criminal history background check or abuse registry background check. Continued record review revealed Employee Timesheet records indicated Staff B first worked on 8/25/25. When interviewed on 11/25/25 at approximately 11:46 a.m. and on 12/2/25 at 2:40 p.m. the Executive Director said Staff B worked previously under the prior management company; however, her dates of prior employment were unknown. The Executive Director completed a new background check for Staff B on 11/25/25. The Executive Director confirmed a background check was not completed prior to 11/25/25 for Staff B's current employment.	A 400		
A 415	481-67.19(3)c Record Checks 67.19(3)c If a person considered for employment	A 415		

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 12/02/2025

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 415	Continued From page 8	A 415		

has been convicted of a crime. If a person being considered for employment in a program has been convicted of a crime under a law of any state, the department of public safety shall notify the program that upon the request of the program the department of human services will perform an evaluation to determine whether the crime warrants prohibition of the person's employment in the program.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review the Program failed to complete an evaluation determination to determine if employment was prohibited for a staff with a prior record. This pertained to 1 of 1 staff reviewed with a prior record (Staff A). Finding follows:

Record review on 11/25/25 and 12/01/25 of Staff A's file revealed a hire date of 11/05/25. The Single Contact License and Background Check was completed on 10/30/25 and no records were found for the child or dependent adult abuse registries. Further research was indicated related to the Criminal History Background Check. An Iowa Criminal History Record Check Request Sing form S indicated a criminal history record was found dated 11/03/25. An evaluation determination was not completed at the time of review on 11/25/25 related to the record indicated. An evaluation determination was provided dated 12/01/25 that indicated Staff A could work at the Program.

When interviewed on 11/25/25 at approximately 11:46 a.m. the Executive Director (ED) confirmed the evaluation determination was not completed. The ED indicated Staff A would be coming in 11/25/25 to fill out the paperwork. On 12/2/25 at

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 12/02/2025

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 415	Continued From page 9 2:40 p.m. the Executive Director confirmed the evaluation determination had not been completed (prior to 12/01/25) and it was an omission. She said Staff A had not worked on the floor.	A 415		
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 observation, interview and record review the Program failed to complete evaluations as needed with significant change. This pertained to 2 of 4 tenants reviewed (Tenant #3 and Tenant #4). Findings follow: 1. When interviewed on 12/01/25 at 1:02 p.m. Tenant #3's family member reported Tenant #3 had difficulty swallowing. She explained they did not provide special diets and they were talking about staff cutting up her meat into small pieces. She indicated hospice was involved with her care	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 _____	C 12/02/2025

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 10	A 145		

too. Tenant #3 ate slowly.

Observations on 12/01/25 at approximately 12:23 p.m. Staff C assisted several tenants with medications including Tenant #3. She administered lorazepam 0.5 milligram (mg) tablet, half tablet 0.25 mg to her. She placed the medication into a medication cup for her to take at the dining room table. Tenant #3 could not see the pill and Staff C touched the pill with a gloved hand and put it in her mouth.

When interviewed on 12/02/25 at 2:40 p.m. the Executive Director recalled a new hospice nurse was at the Program while Tenant #3 ate and the hospice nurse brought up swallowing difficulties. The Director of Nursing (DON) was not there that day. It was at breakfast, Tenant #3 did not choke, she coughed food up and spit food)out and cleared her throat. The hospice nurse indicated it appeared she had trouble swallowing textures or foods. She could clear her throat related to the incident observed. The hospice nurse would talk to Tenant #3's family about if the family wanted to do something about it. The hospice nurse wanted to know about interventions including expanding the esophagus and to be aware that she could aspirate. The Executive Director indicated she had not seen therapeutic diets at the Program and did not believe they were provided. Tenant #3's diet was currently lactose intolerant.

When interviewed on 12/02/25 at 2:00 p.m. the DON said it had not reported to her by either hospice or staff that Tenant #3 had problems with swallowing Since then, she asked staff if Tenant #3 had problems and was told when hospice was there last week she choked at lunch; she was coughing. Staff told her about the incident she had not visited with hospice about the incident

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 12/02/2025

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 11	A 145		

and was not aware of any other incidents. She said with Tenant #3 it was hit or miss, sometimes she coughed a lot. Tenant #3 had a general diet and the DON indicated there were no special diets provided. Tenant #3's family asked about thickened liquids and was told they did not provide special diets. The DON reported once in a while at breakfast Tenant #3 appeared to have swallowing difficulties, but she did not feel like Tenant #3 had not been able to consume her food. Sometimes staff sat at a table with her. The DON did not notice a lot of episodes or choking with her and it was discussed with hospice a couple months ago. The DON indicated sometimes staff cut her food, however she was not someone who needed to have her food cut up at every meal. She drank nutritional supplements with meals.

Record review on 12/02/25 of Tenant #3's file revealed she was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. Her most recent nurse's note,dated 11/03/25 indicated it was completed for a 90-day review. The entry indicated she was out for all meals and had a good appetite.

Continued record review revealed the most recent cognitive, health and functional evaluation was dated 5/28/25 and indicated Tenant #3 required cutting up of foods, opening cartons and packages. It indicated no issues with choking and no referral needed. For meal consumption enabling devices and methods it indicated none applied. The evaluation indicated a regular diet.

Further record review revealed Tenant #3's file lacked a change of condition evaluation completed related to the incident and to address interventions related to safe meal consumption

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 12/02/2025

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 12	A 145		

for Tenant #3.

The Program's policy and procedure indicated therapeutic diets prescribed by a healthcare provider would be provided.

2. Record review on 12/02/25 of Tenant #4's file revealed the Comprehensive Assessment dated 3/13/25 was Tenant #4's most recent cognitive, health and functional evaluations provided. The evaluation indicated Tenant #4 required the assistance of one person for transfers. Tenant #4 used a wheelchair and had no falls. For bathing Tenant #4 preferred showers twice per week. For meals she would determine her own food preferences. For meal consumption enabling devices and methods the evaluation indicated none applied.

When observed on 12/01/25 at the time of the lunch meal staff brought Tenant #4 to the dining room in a Broda chair. She was assisted to the dining room table and remained seated in the Broda chair throughout the meal observation. Staff D was observed seated at the table with Tenant #4 and fed her during the meal.

Continued record review revealed Progress Notes indicated the following:

a. On 9/10/25, Tenant #4 was wheelchair bound. She required the assistance of two people for transfers and was on hospice. It noted a waiver (waiver of administrative rule for level of care issued through the Department) had been received previously and they were waiting to hear back regarding a second waiver.

b. On 9/23/25, Tenant #4 continued on hospice services and the waiver from the Department 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 _____	C 12/02/2025

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 13	A 145		

not arrived.

Further record review revealed Tenant #4 had falls on 10/24/25 and 11/18/25 that resulted in skin tears.

Continued record review revealed the waiver application completed by the DON signed on 4/15/25 indicated Tenant #4 required the assistance of two people for transfers and cares. It indicated her care needs included transfers, dressing, bathing, toileting, medication administration, meal preparation and feeding assistance. It also indicated she was non-weight bearing. The waiver of administrative rule applied for was the assistance of two people for transfers. An approval notice was sent from the Department dated 9/09/25 indicated the waiver was granted for Tenant #4 and would be effective through 2/08/26.

When interviewed on 12/02/25 at 2:00 p.m. the DON reported Tenant #4 transferred with assistance of one to two people. Sometimes she ate on her own and some days staff assisted with eating. Most of the time she drank by herself. She explained hospice completed a bed bath. Tenant #4 sustained skin tears but healed. She had no pressure sores and could reposition herself.

Further record review of Tenant #4's file revealed evaluations were not completed as needed with significant change related to the use of two people at times for transfers, the Broda chair, feeding assistance, bed baths and falls with injuries.

When interviewed on 12/2/25 at 2:00 p.m. the DON confirmed she was not aware of the issue

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 12/02/2025

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 14 with Tenant #3 that occurred last week until 12/02/25. She indicated it was probably the most recent evaluations for Tenant #4 and 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 by: Based on interview and record review the Program failed to document nurse's notes by exception. This pertained to 2 of 4 tenants reviewed (Tenant #2 and Tenant #4). Findings follow: 1. Record review on 12/01/25 and 12/02/25 of Tenant #2's file revealed Progress Notes dated 10/06/25 indicated a new order was received for escitalopram five milligrams (mg), by mouth, daily for depression. Tenant #2's family was notified of the order. Continued record review revealed Order Forms indicated the following: a. Escitalopram five mg, by mouth once daily was ordered on 10/06/25. It was noted by the Director	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 _____	C 12/02/2025

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 15 of Nursing (DON) on 10/6/25. b. "It is ok to start the escitalopram on 10/29." It was noted by the DON on 10/29/25. Further record review revealed the October 2025 medication administration record (MAR) reflected escitalopram five mg, take one tablet by mouth daily with a start date of 10/29/25 and the first dose was administered on 10/30/25. When interviewed on 12/02/25 at 2:00 p.m. the DON said regarding the delay in the start of the initial order for the medication 10/06/25 to 10/29/25 was related to talking with Tenant #2's family about starting her on the new medication and then the provider wrote the order to give the medication. Continued record review of Tenant #2's nurse's notes did not indicate any further entries related to the reason for the delay of the start of the medication as ordered or when the order was received on 10/29/25 indicated it was approved to start the medication. 2. Record review on 12/02/25 of Tenant #4's file revealed Progress Notes indicated the following: a. On 9/10/25, Tenant #4 was wheelchair bound. She required the assistance of two people for transfers and was on hospice. It also noted a waiver (waiver of administrative rule for level of care issued through the Department) had been received previously and they were waiting to hear back regarding a second waiver. b. On 9/23/25, Tenant #4 continued on hospice services and the waiver from the Department had not arrived.	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 _____	C 12/02/2025

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 16 Continued record review revealed the Adult Services Monitoring Entrance Form completed by the Program dated 11/25/25 indicated there were no tenants approved for the level of care waiver through the Department. Further record review revealed an approval notice from the Department, dated 9/09/25 indicated the waiver was granted for Tenant #4 and it would be effective through 2/08/26. Continued record review revealed Tenant #4's nurse's notes did not reflect the receipt of the approval notice and the waiver had been granted for Tenant #4. When interviewed on 12/02/25 at 2:00 p.m. the DON confirmed all nurse's notes were provided for the tenants reviewed.	A 290		
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 observation, interview and record	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 _____	C 12/02/2025

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 17	A 350		

review the Program failed to update service plans as needed and ensure they reflected the service needs of the tenants. This pertained to 3 of 4 current tenants reviewed (Tenants #1, #3, and #4). Findings follow:

Record review on 12/01/25 of Tenant #1's Progress Notes entered by the Director of Nursing (DON) with documents from the Advanced Registered Nurse Practitioner (ARNP) revealed following entries: (all entries notes listed below were not completed by direct care staff):

a. On 10/29/25, a visit note from the ARNP indicated he was seen for evaluation of a rash in his groin. The DON reported his behaviors included attempting to give female tenants back rubs. A new order was received for Baza AF cream, apply to groin twice daily.

b. On 11/04/25, the DON spoke with Tenant #1's family regarding him yelling out in his sleep and touching himself in front of staff and asking them to assist.

c. On 11/09/25, the DON documented the 30-day assessment was completed. In the note regarding the 30-day assessment there was no documentation regarding behaviors.

d. On 11/17/25, the DON documented a change of condition assessment was completed related to discrepancies in the 30-day assessment. He recently dug stool out of his protective undergarment and left it on the floor in other tenants' apartments. It was also noted he took snacks from other tenants' apartments.

Further record review revealed Tenant #1's service plans were dated 11/09/25 (30 day) and

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 12/02/2025

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 18	A 350		

11/17/25 (change of condition). The service plan was not updated when the behaviors were first noted. It was documented in the ARNP visit note on 10/29/25 and 11/12/25. Additionally, the current service plan dated 11/17/25 reflected some of the behaviors above; however, did not reflect he attempted to give female tenants back rubs and touched others as indicated above.

2. When interviewed on 12/01/25 at 1:02 p.m. Tenant #3's family member reported Tenant #3 had difficulty swallowing. She explained they did not provide special diets and they were talking about staff cutting up her meat into small pieces. She indicated hospice was involved with her care too. Tenant #3 ate slowly.

Observations on 12/01/25 at approximately 12:23 p.m. Staff C assisted several tenants with medications including Tenant #3. She administered lorazepam 0.5 milligram (mg) tablet, half tablet 0.25 mg to her. She placed the medication into a medication cup for her to take at the dining room table. Tenant #3 could not see the pill and Staff C touched the pill with a gloved hand and put it in her mouth.

When interviewed on 12/02/25 at 2:40 p.m. the Executive Director recalled a new hospice nurse was at the Program while Tenant #3 ate and the hospice nurse brought up swallowing difficulties. The Director of Nursing (DON) was not there that day. It was at breakfast, Tenant #3 did not choke, she coughed food up and spit food)out and cleared her throat. The hospice nurse indicated it appeared she had trouble swallowing textures or foods. She could clear her throat related to the incident observed. The hospice nurse would talk to Tenant #3's family about if the family wanted to do something about it. The hospice nurse wanted

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 12/02/2025

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 19	A 350		

to know about interventions including expanding the esophagus and to be aware that she could aspirate. The Executive Director indicated she had not seen therapeutic diets at the Program and did not believe they were provided. Tenant #3's diet was currently lactose intolerant.

When interviewed on 12/02/25 at 2:00 p.m. the DON said it had not reported to her by either hospice or staff that Tenant #3 had problems with swallowing Since then, she asked staff if Tenant #3 had problems and was told when hospice was there last week she choked at lunch; she was coughing. Staff told her about the incident she had not visited with hospice about the incident and was not aware of any other incidents. She said with Tenant #3 it was hit or miss, sometimes she coughed a lot. Tenant #3 had a general diet and the DON indicated there were no special diets provided. Tenant #3's family asked about thickened liquids and was told they did not provide special diets. The DON reported once in a while at breakfast Tenant #3 appeared to have swallowing difficulties, but she did not feel like Tenant #3 had not been able to consume her food. Sometimes staff sat at a table with her. The DON did not notice a lot of episodes or choking with her and it was discussed with hospice a couple months ago. The DON indicated sometimes staff cut her food, however she was not someone who needed to have her food cut up at every meal. She drank nutritional supplements with meals.

Record review on 12/02/25 of Tenant #3's file revealed she was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. Her most recent nurse's note was dated 11/03/25. The note indicated it was completed for a 90-day review. The entry

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 12/02/2025

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 20	A 350		

indicated she was out for all meals and had a good appetite.

Continued record review revealed Tenant #3's most recent service plan, dated 5/29/25 indicated she required assistance at meals including opening packages, might need encouragement to select menu items and cutting up food. She had a regular diet.

Further record review revealed Tenant #3's file lacked any documentation related to the incident that occurred the week prior at breakfast as noted above. There were no nurse's notes, incident report or staff to nurse communication sheets completed related to the incident. After the incident occurred the service plan was not updated as needed related to the issue and did not address interventions related to safe meal consumption for Tenant #3.

The Program's policy and procedure indicated therapeutic diets prescribed by a healthcare provider would be provided.

3. Record review on 12/2/25 of Tenant #4's file revealed the service plan dated 3/15/25 was the most recent service plan provided. The service plan indicated Tenant #4 required the assistance of one person for transfers. It indicated she used a wheelchair. For bathing it indicated she preferred showers. For falls it indicated Tenant #4 would not sustain any injuries related to falls and to ensure she was wearing appropriate footwear. The service plan reflected Tenant #4 would be fed her meals.

When observed on 12/01/25 at the time of the lunch meal staff brought Tenant #4 to the dining room in a Broda chair. She was assisted to 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 _____	C 12/02/2025

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 21	A 350		

dining room table and remained seated in the Broda chair throughout the meal observation. Staff D was observed seated at the table with Tenant #4 and fed her during the meal.

Continued record review revealed Progress Notes indicated the following:

a. On 9/10/25,Tenant #4 was wheelchair bound. She required the assistance of two people for transfers and was on hospice. It noted a waiver (waiver of administrative rule for level of care issued through the Department) had been received previously and they were waiting to hear back regarding a second waiver.

b. On 9/23/25,Tenant #4 continued on hospice services and the waiver from the Department had not arrived.

Further record review revealed Tenant #4 fell on 10/24/25 and 11/18/25 that resulted in skin tears.

Continued record review revealed the waiver application completed the DON signed on 4/15/25 indicated Tenant #4 required the assistance of two people for transfers and cares. It indicated her care needs including transfers, dressing, bathing, toileting, medication administration, meal preparation and feeding assistance. It also indicated she was non-weight bearing. The waiver of administrative rule applied for was regarding the assistance of two people for transfers. An approval notice was sent from the Department dated 9/09/25 that indicated the waiver was granted for Tenant #4 and would be effective through 2/08/26.

When interviewed on 12/2/25 at 2:00 p.m. the DON explained Tenant #4 transferred with

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 12/02/2025

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 22	A 350		

assistance of one to two people. Sometimes she ate on her own and some days staff assisted with eating. Most of the time she drank by herself. She indicated hospice completed a bed bath. Tenant #4 sustained skin tears but it healed. She had no pressure sores and could reposition herself.

Further record review of Tenant #4's file revealed the service plan was not updated as needed related to the use of two people at times for transfers, the Broda chair, bed baths, falls with injuries and individualized interventions.

When interviewed on 12/2/25 at 2:00 p.m. the DON confirmed Tenant #1's service plan did not reflect he attempted to give female tenants back rubs. She was not made aware of the issue with Tenant #3 that occurred last week until 12/2/25. She also confirmed it was probably the most recent service plan for Tenant #4. The DON confirmed all service plans for the tenants reviewed were provided.