STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165172	A. Building B. Wing	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarwood Healthcare Center	605 Greenwood Drive Iowa City, IA 52246

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, facility policy review, and staff interviews the facility failed to implement fall interventions per Care Plan for 2 of 4 residents (Resident #3 and Resident #4) reviewed for falls. The facility reported a census of 54 residents. Findings include:1. Review of Resident #3's Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated a severe cognitive impairment. The list of diagnoses included traumatic brain injury and depression. Per the assessment, Resident #3 used a walker, and required partial/moderate assistance for chair/bed to chair transfers.Review of Resident #3's Care Plan revealed the following Focus areas:a. Dated 4/6/24, [name redacted, Resident #3] is high risk for falls r/t (related to) gait/balance problems. Unaware of safety needs. b. Dated 4/13/24, [name redacted, Resident #3] has had an actual fall with no injury d/t unsteady gait. Interventions included, in part:1. 03/19/2026 Fall Intervention: Do not leave unattended in wheelchair in room.2. 03/21/2026 Fall Intervention: Keep Wheelchair in the hallway when in recliner3. 03/24/2026 Fall Intervention: Education done with staff to not leave resident unattended in his wheelchair in his room. Review of Resident #3's electronic health record (EHR) revealed the following Incident Reports:a. #1022 - Witnessed Fall. Date: 3/19/26 at 4:30 PM. Resident: [name redacted, Resident #3]. Incident Location: Resident's Room. Incident Description: Nursing Description - CNA (Certified Nursing Assistant) was walking past resident's room, resident was leaning forward in his wheelchair and dropped to his knees. No injuries resident did not hit his head, range of motion intact, denies pain, he was wearing his tennis shoes, alarm sounded.Resident Description: resident stated he was trying to adjust himself in the wheelchair and fell forward.Immediate Action Taken: Description: Fall Intervention - Do not leave unattended in wheelchair in room.b. #1024 - Unwitnessed Fall. Date: 3/21/26 at 9:40 AM. Resident: [name redacted, Resident #3]. Incident Location: Resident's Room. Incident Description: Nursing Description - Resident had an unwitnessed fall in his room. Staff reports that res (resident) is in his room on the floor. Upon entering the room res was observed sitting in an upright position on the floor in front of his recliner chair. Res encouraged to utilize call light for assistance. Resident Description: When asked what happened, res reports that he was trying to get from his wheelchair to the recliner chair. Immediate Action Taken Description: Upon assessment vitals. No injuries or bruising noted. Res then assisted up from the floor to his recliner chair with assist X3 and gait belt. Neuro flow sheet initiated per protocol. Fall Intervention: Keep Wheelchair in the hallway when in recliner. c. #1025 - Unwitnessed Fall. Date: 3/24/26 at 4:22 PM. Resident: [name redacted, Resident #3]. Incident Location: Resident's Room. Incident Description: Nursing Description - Resident was in his wheelchair when he leaned forward and tried to pick something up off the floor. 2 envelopes were on the floor. Resident Description: Resident attempted to transfer without help, and fell in his room. Immediate Action Taken Description: Vitals and assessment completed. Resident denies pain. Resident educated to call for help to transfer. Fail Intervention: Education done with staff to not leave resident unattended in his wheelchair in his room.During an interview on 6/10/26 at 11:36 AM, Staff A, CNA queried if Resident #3 could be in his wheelchair in his room and Staff A stated Resident #3 (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	could be in his wheelchair in his room because he had a chair alarm on it. During an interview on 6/10/26 at 2:41 PM, Staff F, CNA queried if Resident #3 could be in his wheelchair in his room and Staff F stated she thought Resident #3 could be in his room in his wheelchair unsupervised for a little while. During an interview 6/10/26 at 3:51 PM, the Director of Nursing (DON) asked about the falls for Resident #3 on 3/19/26, 3/21/26, and 3/24/26 and the DON spoke of the interventions the facility tried with Resident #3. The DON stated the resident would self-propel into his room and no one would know Resident #3 in his room. The DON stated the staff needed to follow through with the interventions put in place. 2. Review of Resident #4's MDS assessment dated [DATE], revealed a BIMS score of 14 out of 15, which indicated intact cognition. The list of diagnoses stroke, diabetes mellitus, and depression. Per the assessment, Resident #4 required supervision/touching assistance with chair/bed to chair transfer and walking. The MDS documented an admission date of 4/22/26.Review of Resident #4's Baseline Care Plan dated 4/22/26 indicated Resident #4 an assist of 1 with transfer, walking, and toileting; and used a front wheeled walker.Review of Resident #4's Care Plan revealed the following Focus areas:a. Dated 5/13/26, [name redacted, Resident #4] is at risk for falling r/t hx (history) of fall with fx (fracture), high risk medications.b. Dated 5/13/26, [name redacted, Resident #4] has an actual fall with no injury. Interventions, in part:1. 05/01/2026 Fall Intervention: Reminder sign to call for assistance2. 05/02/2026 Fall Intervention: Education with staff to hold onto gait belt. [Name redacted, Resident #4] is assistance x 1 with a gait belt.3. 05/05/2026 1st fall - Fall Intervention: Education with staff to leave walker within reach.4. 05/26/2026 Fall Intervention: 1:1 with new CNA that took did not leave walker in reach education on keeping walker near [Name redacted, Resident #4].Review of Resident #4's EHR revealed the following Incident Reports:a. #1049 - Unwitnessed Fall. Date: 5/1/26 at 9:00 PM. Resident: [Name redacted, Resident #4]. Incident Location: Resident's Room. Incident Description: Nursing Description - No, resident found sitting on the floor in front of her tv. Resident Description: Resident said she was in front of her tv and tried to reach for her walker and lose her balance and fell. Immediate Action Taken Description: Assessed resident, no injuries noted. Resident denies hitting her head. Fall Intervention: Reminder sign to call for assistanceb. #1051 - Witnessed Fall. Date: 5/2/26 at 8:45 PM. Resident: [Name redacted, Resident #4]. Incident Location: Resident's Room. Incident Description: Nursing Description - Yes, Resident walking in her room trying to get her pajamas, try to turn around and started falling, CNA was with her in her room. Resident Description: Resident said she was trying to get he[r] pajamas and turned and started to fall. Immediate Action Taken Description: Assessed resident, CNA said she did not hit her head, no injuries noted, able to move all extremities without difficulty, eyes/pupils round and reactive to light bilaterally. Assisted resident on her feet, able to walk using her walker with assist x1 and GB. Denies any pain or discomfort. Fall Intervention: Education with staff to hold onto gait belt. Resident is assistance x 1 with a gait belt.c. #1055 - Unwitnessed Fall. Date: 5/6/26 at 4:25 PM. Resident: [Name redacted, Resident #4]. Incident Location: Resident's Room. Incident Description: Nursing Description - Resident was found on the floor next to her bed. Resident Description: Resident said she was trying to reach for her walker and just fell. Immediate Action Taken x Description: Assessed resident, no injuries noted. Fall Intervention: Education with staff to leave walker within reach.d. #1065 - Witnessed Fall. Date: 5/26/26 at 5:00 PM. Resident: [Name redacted, Resident #4]. Incident Location: Resident's Room. Incident Description: Nursing Description - Yes, CNA and nurse heard the chair alarm at resident's room, started to run at her room but was too late. CNA saw resident lost her balance reaching for her walker and fell. Resident Description: Resident said she was trying to reach for her walker and fell, and said she hit her head. Immediate Action Taken Description: Assessed resident, small bruise noted on her right elbow.Fall Intervention: 1:1 with new CNA that took did not leave walker in reach education on keeping walker near resident.During an observation on 6/9/26 at 1:23 PM, Resident #4 sat in her recliner and her walker positioned approximately 3 feet away against the closet doors. During an interview on 6/10/26 at 12:49 PM, Staff B, CNA queried where Resident #4 walker needed to be located and Staff B stated (continued on next page)

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