STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165322	A. Building B. Wing	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cottage Grove Place	2115 First Avenue SE Cedar Rapids, IA 52402

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 clinical record review, staff interview, observation, fire department and police reports, ambulance reports, employee file review, and facility record review, the facility failed to utilize a lap and shoulder seatbelt restraint prior to transporting a resident in a facility van for 1 of 3 residents reviewed (Resident #1). On [DATE], during transport from a doctor's appointment, the facility van driver failed to secure a lap and shoulder seatbelt restraint for Resident #1, who was seated in a secured wheelchair in the back of a transport van. As a result, Resident #1 flew forward out of the wheelchair over a folded middle row seat when the driver swerved and braked to avoid another vehicle. Resident #1 landed face down on the folded second row seat, with her head near the floor between the second-row seating and back side of the driver's seat. Blood was present from Resident #1's nose. Resident #1 was unresponsive, did not appear to be breathing, was pulseless, and cyanotic (bluish or purplish discoloration of the skin) to the face from the neck up. This constituted an Immediate Jeopardy (IJ) to resident health and safety. The facility reported a census of 49 residents.The State Agency informed the facility of the Immediate Jeopardy (IJ) on [DATE] at 11:00 AM. The IJ began on [DATE], the day Resident #1 was transported in a facility van without the use of a lap and shoulder restraint.Facility staff removed the Immediate Jeopardy on [DATE] through the following actions:-The facility halted van transportation services and utilized external transportation services. The scope lowered from J to D at the time of the survey after ensuring the facility utilized external transportation services. Findings include:Resident #1's Minimum Data Set (MDS) assessment dated [DATE] documented an admission date of [DATE]. The MDS assessment revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating intact cognition. The MDS revealed the resident used a wheelchair for mobility, the resident had no impairment for upper extremities (shoulder, elbow, wrist, hand), and had impairment on one side for lower extremity (hip, knee, ankle, foot). The MDS revealed Resident #1 was dependent (Helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers are required for the resident to complete the activity) to move from sit to lying, lying to sitting on the side of the bed, and for chair/bed-to-chair transfers The MDS listed diagnoses of atrial fibrillation (rapid, irregular, and uncoordinated heart rhythm), heart failure (progressive condition where the heart cannot pump enough blood to meet the body's needs), Cerebrovascular Accident (when blood flow to part of the brain is blocked or a blood vessel ruptures, causing brain cells to die), and hemiplegia (paralysis on one side of the body). Per the MDS, the resident received anticoagulant medication (used for the prevention of blood clots from forming) and antiplatelet medication (used to prevent blood cells called platelets from sticking together) during the look back period.The Care Plan Report initiated on [DATE], for Resident #1 identified the following Focus areas:1. Resident #1 received antiplatelet medication. Interventions included, in part, to use extra caution with manually transferring or positioning (intervention initiated [DATE]). 2. Resident #1 received anticoagulant medication. Interventions directed staff to:-Report skin abnormalities to the nurse-Resident/family/caregiver teaching to include: avoid activities that could result in injury, and take precautions to avoid falls. -Use extra (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	caution with manually transferring or positioning. 3. Resident #1 received skilled nursing facility level of care. Interventions dated [DATE] revealed the resident required transfer assist with 2 people using Hoyer (full body mechanical lift) lift using purple sling, the resident was non-ambulatory, and wheelchair mobility required assistance of one.4. Resident #1 was at risk for falls.5. Resident #1 desired to discharge home.6. Resident #1 had a deep vein thrombosis (DVT - a blood clot forms in deep veins) (initiated on [DATE]).The Medication Administration Record (MAR) recorded Resident #1 received the following: Aspirin 81 mg (milligram) delayed release (antiplatelet medication) one time per day, administered on [DATE]. The resident's anticoagulant medication, Warfarin, was on hold from [DATE] to [DATE].The facility CPR (cardiopulmonary resuscitation) Policy indicated Resident #1 requested do not resuscitate (DNR), which indicated she didn't want to be given cardiopulmonary resuscitation. Resident #1 signed the document on [DATE]. The physician signed on [DATE].A Nursing Advanced Skilled Evaluation note dated [DATE] at 8:21 AM documented Resident #1's vitals: temperature 97.7 degrees, blood pressure 101/64, pulse 61, respirations 18, O2 (oxygen saturation) 94% by continuous positive airway pressure (CPAP) and weight 294.4 pounds. Alert and orientated times 3 (indicating a patient is aware of three key areas: person (name), place (location), and time (date/time)). Resident #1 communicated verbally, speech was clear, able to understand and be understood when speaking. Resident was able to move all extremities with weakness noted to right and left leg, and to her feet.An Incident Note dated [DATE] at 5:00 PM documented the facility was notified regarding a motor vehicle incident between the medical appointment and transportation to return to the facility. [Redacted] Police Department informed [facility] of Resident #1's passing in route. Family and physician notified. Review of the Facility Summary of Alleged Incident Report for Resident #1's incident on [DATE] completed by the Administrator on [DATE] revealed, On [DATE] at approximately 1400 hours (2:00 pm), a resident [Resident #1] of [Facility Name Redacted] was involved in a motor vehicle-related incident while being transported from a cardiology appointment to the facility in a company-operated vehicle driven by a facility staff member [Staff A, Driver]. Per driver statement, the resident was secured in her wheelchair and the vehicle ramp was properly secured prior to departure. While traveling approximately 25 miles per hour in a 30 mile-per-hour zone near the intersection of [Street Redacted] and [Street Redacted] in [City Redacted], Iowa, another vehicle initiated a turn into the path of the transport van, creating an imminent risk of collision. The driver reported taking evasive action, including braking and swerving, to avoid a direct impact. Emergency Medical Services were immediately contacted. First responders, including [Police Department] and [Fire Department], arrived on scene. The resident was removed from the vehicle and emergency interventions were initiated. The resident was subsequently pronounced deceased at the scene.At this time. [Facility] cannot confirm that all required securement procedures were fully implemented at the time of transport, and the resident's cause of death remained under investigation.The Root Cause Analysis section of the Facility Summary of Alleged Incident Report revealed, in part, At this time, we are unable to confirm if an over-the -lap or cross-body seat belt was applied in addition to securing the wheelchair in the van. This may have contributed to the resident moving forward in the van compartment during the braking of the vehicle.A Calls for Service Report for the police department (PD) listed a received date of [DATE] at 2:10 PM. The report listed the nature of the incident as hemorrhage/lacerations. The report listed an officer was dispatched at 2:11 PM to [Street Redacted] and [Redacted Street, [City Redacted], Iowa. The report listed the officer arrived on scene at 2:11 PM.A Fire Department incident report listed the incident date of [DATE] at 2:08:50 with the primary reason listed as unconscious victim. The dispatch code listed hemorrhage/laceration. The Fire Department Patient Care Record dated [DATE] revealed at 2:14:00 the report documented Resident #1's mental status as unresponsive and skin as cold, cyanotic, lividity (discoloration due to settling/pooling of blood), mottled, and pale. The report revealed the patient had been wedged between the front driver seat and the middle row seats. Upon removal of the patient, it was noted she had a DNR bracelet. Ambulance services called to affirm the DNR and (continued on next page)

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On [DATE] at 9:59 AM through email correspondence, Staff E explained the driver didn't receive a citation as he didn't have to stop or yield. The other driver would have been likely deemed at fault as they would have had a stop sign and would have needed to yield to the van.On [DATE] at 11:09 AM, Staff A, Driver stated that he had driven the bus and 2 vans for the facility. Staff A verbalized when he was trained, he was told to strap down the wheelchairs and use seat belts when residents were seated in the seats. Staff A verbalized he was trained in [second facility van, not used during time of Resident #1's incident, referred to as Van B] to use lap and shoulder restraints for residents in wheelchairs. Staff A reported his training was hands on and didn't involve any literature or videos for the restraints for the wheelchair or the lap/shoulder restraint seatbelts. Staff A verbalized he was not taught how to secure a resident in a wheelchair with lap and shoulder residents with the van involved in the incident. Staff A reported there was a lap/waist restraint and Staff A thought it was red. Staff A verbalized no one used it. Staff A reported he was only taught how to secure the wheelchair in the van involved in the incident. Staff A reported the wheelchair was locked firmly in place. Staff A reiterated he never used the lap/shoulder restraint when transporting residents in this particular van. Staff A verbalized he transported Resident #1 on 2 occasions. The first time he used [Van B] and the second time on [DATE] he used [Van A]. Staff A revealed he didn't secure a lap/shoulder restraint across the resident when he picked her up from her medical appointment. Staff A verbalized when he used [Van B], he used the lap/shoulder restraint belt for wheelchairs.Staff A reported he turned onto [Street Redacted] and when he was near [Street Redacted] a car came across and then another car pulled out and turned to the right. Staff A reported he swerved and put on the brakes and Resident #1 came out of the wheelchair. Staff A reported Resident #1 never asked about the lap/shoulder restraint. Staff A reported Resident #1 had been alert and orientated. Staff A believed he was going 25 mph (miles per hour) in the posted 30 mph zone when he swerved to avoid being hit by a car that turned on to [Street Redacted]. Staff A parked the van near the curb.Staff A exited the vehicle and opened the sliding passenger door for the second-row seating on the driver's side. Staff A verbalized he called 911. Staff A thought she (resident) was conscious at first. Staff A did not notice the resident had any injuries until the first Police Officer arrived, and then noticed blood coming out of her nose. Staff A verbalized Resident #1 did not say anything, and Staff A did not notice any other injuries. Staff A verbalized Resident #1 did not eat or drink anything while being transported. Staff A reported he did carry a cell phone and had not been on the phone prior to the incident.Staff A reported he returned to the facility at approximately 2:40 PM on [DATE]. Staff A explained he had reported to the Administrator's office when he returned. Present in the office were the Administrator, the Health Administrator, and the Executive Director. Staff A reported what occurred at the incident. Staff A revealed the Executive Director asked him about the lap/shoulder restraint the next morning when he came in to sign his statement.Staff A revealed he asked Staff B, Driver the week prior if he used the lap/shoulder restraint belts in [Van A] and was told no. On [DATE] at 2:13 PM, the EVS Director demonstrated how to secure a wheelchair in [Van A] with lap/shoulder restraint seatbelts. The van was parked and the rear door opened. He extended the folding ramp and pushed a wheelchair up the platform and locked the brakes. He attached the floor restraints to the rear of the wheelchair and then went to the driver's side passenger door. The second-row seat was folded down. He reached over the seat to attach the floor restraints to the front (continued on next page)

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