STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165594	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brooklyn Community Estates	406 North Street Brooklyn, IA 52211

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, staff interview, clinical record review, and facility policy review, the facility failed to obtain informed consent prior to the installation of bed rails for 2 of 2 residents (Resident #4 and Resident #25) and failed to attempt bed rail alternatives prior to installation for 1 of 2 residents (Resident #25) reviewed for bed rails. The facility reported a census of 42. Findings include:1. Review of the Minimum Data Set (MDS) assessment, dated 5/13/26, revealed a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated severe cognitive impairment. The list of diagnoses included non-Alzhemier's dementia, stroke with hemiplegia (impaired mobility) affecting right dominant side, malnutrition, and anxiety disorder. Resident #4 required substantial to maximal amount of staff assistance with bed mobility and dependent on staff assistance to transfer. The MDS revealed that a bed rail was used daily as a physical restraint. Review of the Care Plan, initiated 3/27/24, revealed the Focus area: Resident #4 uses full bed side rail for safety and to promote independence with bed mobility and assist with personal cares; Per staff assessment, considered restraints. The Care Plan identified a goal that Resident #4 would remain free from injury related to bed rail use. Interventions instructed the following, in part: Discuss and record with the resident/family/caregivers, the risks and benefits of the restraint, when the restraints should be used/applied, routines while restrained, and any concerns or issues regarding restraint use. Date initiated: 3/27/24. Ensure provider order is received for use of bed rails when assessed as a restraint. Date initiated: 3/27/24. Evaluate Resident #4's bed rails/restraint use at least quarterly: Evaluate/record continuing risk/benefits of restraint, alternatives to restraint, need for ongoing use, reason for restraint use. Date initiated: 3/27/24.Monitor/document/report as needed, any changes regarding effectiveness of restraint, less restrictive device, if appropriate, any negative or adverse effects noted. Date initiated: 3/27/24. Staff will provide frequent monitoring of Resident #4 when bed rails are used to ensure Resident #4 remains free of injury related to use. Date initiated: 3/27/24. Review of the Order Summary, dated 5/28/26, listed an order for restraints type 2 for full rail on one side of bed and 2 half rails on the right side of bed for safety and fall prevention, boundary. Review of the Restraint/Device/Enabler Assessment, dated 4/01/26, identified the use of one full side rail and one half side rail on Resident #4's bed that prevented independent exit/entry from the bed when in use. The assessment revealed that no other alternative measures were attempted or also used, besides the full bed rail and half bed rail, with an entry explaining: One day Resident #4 is lethargic, the next day up and talking, can not trust her. The Assessment identified risk of the device included loss of dignity, and listed benefits of the device included: Increases sense of safety/security per resident request.Mitigates risk of resident rolling out of bed.Mitigates the resident from self injury. The Assessment indicated with a checkmark that the following had been completed for restraint use: Consent obtained from the resident/family. Provider order obtained. Care Planned.Reassess monthly and with significant changes until discontinued. During an observation on 5/26/26 at 10:31 AM, Resident #4 laid in bed, a half bed rail at the top right of bed was in an upright position and the entire right side of the bed was placed alongside the wall. The left side of the bed had a full bed rail in an (continued on next page)

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
	165594	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brooklyn Community Estates	406 North Street Brooklyn, IA 52211

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	upright position with padding fixed along the inside of the full bed rail. During an interview on 5/28/26 at 11:24 AM, the Director of Nursing (DON) reported that Resident #4 had utilized a low bed and a fall mat prior to implementation of the full bed rail. The DON was unable to provide documentation of informed consent for use of bed rails prior to installation. 2. Review of the MDS Assessment, dated 3/18/26, revealed Resident #25 had a BIMS score of 8 out of 15, which indicated moderate cognitive impairment. The list of diagnoses included non-Alzheimer's dementia, heart failure, respiratory failure, and adjustment disorder with mixed anxiety and depressed mood. Resident #25 was dependent upon staff assistance for bed mobility and transfers. The MDS indicated that Resident #25 had not used restraints or alarms.Review of the Care Plan revealed an intervention, initiated on 3/17/25, for bed side rails as follows: Top half rails and lower half rails used to move self in bed, considered an enabling device per staff assessment, as it helps with functionality to promote independence, provides boundary and does not meet restraint criteria. Position assessment for use and safety completed by staff at least quarterly or with change in condition. Review of the Care Plan, initiated 9/18/24, revealed a Focus area for Resident #25 moderate risk for falls related to history of falls prior to admission, gait/balance problems, incontinence, side effects of antidepressants, and hearing problems. Interventions included the following, in part: Rail attempted with pool noodle to block the arm going down between the bed mattress and rail, which extreme force was not effective, so tried a padded overlay. Grab bar would be less boundary and she might roll out quicker but low bed for now. Grab bars are not considered safe or effective as assistive devices like the half rail. Date initiated: 4/23/26. Low bed. Date initiated 4/21/26. Housekeeping and maintenance look at spacing with mattress and rail. Date initiated: 4/21/26. Review of the Restraint/Device/Enabler Assessment, dated 3/12/26, identified the use of four half bed side rails on Resident #25's bed that did not restrict or prevent normal/independent movement due to physical limitations as resident cannot voluntarily exit the bed. The Section #5: Device/Enabler Assessment with Subcategory: Safety Assessment, revealed the following, in part: #2e: Has the risk of injury when enabler or device(s) are in use been addressed? Assessment response left blank. #2f: Select additional safety measures used. Assessment response left blank. During an observation, on 5/27/26 at 9:45 AM, Resident #25 laid in bed with four half bed rails in upright position. A half bed side rail on both top left and top right of the bed were in the upright position. A half bed side rail on both bottom left and bottom right of the bed were also in the upright position. During an interview on 5/28/26 ay 10:05 AM, the DON stated that an informed consent had not been obtained on Resident #25's four half side rails prior to implementation and explained this was because the side rails were not used as a restraint. The DON was unable to provide documentation of alternative interventions attempted prior to installation of the four half side rails on Resident #25's bed. Review of the facility policy titled, Side Rails Use Policy, not dated, revealed the purpose of policy was to prevent injury to a resident and allow for independent bed mobility. The Section titled Procedure, instructed the following, in part: Explain the purpose of side rails to the resident.Elevate side rails on those residents determined in need by the Care Plan process.Check the resident frequently for safety and security of side rails.