

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165624	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/19/2024
NAME OF PROVIDER OR SUPPLIER Brio of Johnston, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6901 Peckham Street Johnston, IA 50131	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42134</p> <p>Based on observation, clinical record review, policy review and staff interview the facility failed to ensure the garden gate closed securely allowing 2 residents to leave the garden unnoticed. (Resident#1 and #2) The facility reported a census of 35 residents.</p> <p>Findings Include:</p> <p>1. The Admission Minimum Data Set (MDS) dated [DATE] for Resident #1 documented a Brief Interview for Mental Status (BIMS) of 6 which indicated severe cognitive impairment. The MDS documented diagnosis including non-traumatic brain dysfunction, Alzheimer's disease and hypertension (high blood pressure). The MDS documented that the resident was independent with walking.</p> <p>The Care Plan for Resident #1 included a focus area of elopement risk/wanderer related to history of attempts to leave the facility and impaired safety awareness dated 5/2/24. The Care Plan interventions included use of wander guard, provide structured activities, redirect/distract when wandering and provide an assortment of nuts/bolts/washers for resident to sort.</p> <p>The Progress Note written on 6/2/24 at 2:59 PM documented Resident #1 was found outside the designated patio and was returned inside the facility within 5 minutes.</p> <p>2. The Quarterly MDS for Resident #3 dated 4/3/24 documented a BIMS of 2 which indicated severe cognitive impairment. The MDS documented diagnosis including non-traumatic brain dysfunction, Alzheimer's disease and anxiety disorder.</p> <p>The Care Plan for Resident #3 included a focus area of elopement risk related to wandering and Alzheimer's disease dated 10/12/22. The Care Plan interventions included distract from wandering by providing diversional activity and identify purpose of wandering (looking for the bathroom). The Care Plan documented that the resident walked independently.</p> <p>The Progress Note written on 6/2/24 at 3:22 PM documented Resident #3 escaped through a locked gate on the patio and was found walking along the side of the building on the sidewalk.</p> <p>(continued on next page)</p>

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165624	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/19/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/17/24 at 2:20 PM, Staff A, activities and Lifestyles Coordinator, explained she had worked the morning of 6/2/24. After she got off work, she went home and returned a short time later about 1:00 PM and had been fishing on campus. She had caught a good-sized fish. She took a picture and released the fish. There were residents sitting in the gated garden area. She entered the garden area using the key pad release from the outside. She showed a few residents the picture. There was a family member sitting outside with the residents but no staff present. Staff A continued, explaining when she left the garden gate, she heard it hit to latch but did not turn around to visualize the gate had properly latched.</p> <p>During an interview on 6/17/24 at 2:41 PM the Director of Plant Operations explained he conducted an inspection of the latch on the morning of 6/3/24. There was no explanation why the gate did not latch, there was nothing structurally or mechanically wrong with the latch.</p> <p>During an interview on 6/17/24 at 4:27 PM the Executive Director stated they take resident safety very seriously; the residents are safe.</p> <p>Review of the security camera footage at 4:38 on 6/17/24. The footage for 6/2/24 showed Resident #1 entering view in front of garage at 1:41:44 PM. Resident #3 entered into the view in front of garage at 1:42:25 PM and stood next to Resident #1. Both residents turn and walk up the sidewalk along the building. Both residents walk out of camera view at 1:45:45 PM. Team member comes quickly out of garage side door towards residents at 1:46:02.</p> <p>Facility document titled Elopement Precautions Policy last revised 4/22 directs that the electronic door alarms must remain active at all times.</p> <p>During an interview on 6/19/24 at 1:53 PM the Executive Director explained she would expect facility staff to follow facility policies.</p>		