STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165624	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brio of Johnston, LLC	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)
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. Based on observations and staff interview, the facility failed to provide services to protect residents from accident or hazards by transferring residents in a wheelchair without foot pedals for 3 out of 12 residents observed in wheelchairs (Residents #26, #31, and #29). The facility reported a census of 34.Findings include: 1. The Minimum Data Set (MDS) Assessment completed on 3/2/26 revealed Resident #29 had a Brief Interview for Mental Status score of 2, indicating severe cognitive impairment. The MDS reported Resident #29 utilized a wheelchair and required staff assistance to operate. During an observation on 4/6/26 at 12:55 PM, Staff D, Certified Nursing Assistant (CNA), pushed Resident #29 from the dining area to the common area without securing their feet on the attached foot pedals. Resident #29's feet dangled between the two pedals. 2. The MDS Assessment completed on 3/13/26 revealed Resident #26 had a BIMS score of 3, indicating severe cognitive impairment. The MDS indicated Resident #26 didn't use a wheelchair for ambulation but walked with staff supervision. The Care Plan, revised 4/1/26, noted Resident #26 ambulated with a walker with staff supervision. The Care Plan also noted Resident #26 recently began using a wheelchair for activities further away but used a walker for short distances. During an observation on 4/6/26 at 1:00 PM, Staff D pushed Resident #26 from the dining area to the TV area without securing their feet on the foot pedals. The wheelchair didn't have foot pedals attached. Resident #26's feet dangled during the transfer. 3. The MDS Assessment completed on 3/8/26 revealed Resident #31 had a BIMS score of 2, indicating severe cognitive impairment. The MDS reported Resident #31 utilized a wheelchair with staff assistance. The Care Plan, revised 9/18/25, noted Resident #31 required staff assistance with wheelchair mobility to and from their specific destination. The Care Plan also stated Resident #31 used the wheelchair independently at times. During an observation on 4/7/26 at 12:55 PM, Staff E, CNA, held Resident #31's hand and pulled the wheelchair along without securing their feet on the foot pedals. Resident #31 went to their room from another part of the unit. They didn't have foot pedals attached to their wheelchair. Resident #31's feet weren't in motion and dangled close to the floor during the transfer.In an interview on 4/7/26 at 4:00 PM, the Director of Nursing (DON) stated the staff should use foot pedals whenever transporting a resident in a wheelchair. In an email received on 4/8/26 at 2:00 PM, the Director of Social Services confirmed the facility didn't have a policy regarding transferring residents in wheelchairs.

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, manufacturer's recommendation and staff interview, the facility failed to administer insulin utilizing an insulin pen as recommended for 1 of 1 resident reviewed for insulin administration (Resident #4). The facility reported a census of 34 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 had a Brief Interview for Mental Status (BIMS) of 13, indicating intact cognition. The MDS included a diagnosis of Diabetes Mellitus (DM). Resident #4's Physician Orders included an order dated 1/27/26 to inject 20 units of Basaglar KwikPen insulin subcutaneously daily. On 4/8/26 at 9:15AM, observed Staff A, Licensed Practical Nurse (LPN), inject 20 units of insulin into Resident #4's abdomen utilizing the Basaglar KwikPen. After the injection, Staff A removed the insulin pen prior to waiting a minimum of 5 seconds. Following the removal of the insulin pen, when asked how long the pen is to remain in place following the injection, Staff A reported a few seconds and then stated 5-10 seconds. Review of the manufacturer's recommendation for the Basaglar KwikPen documented the following:a. Insert the needle into the skin.b. Push the dose knob all the way in.c. Continue to hold the dose knob in. d. Slowly count to 5 before removing the needle. Review of the facility policy titled, Insulin Pen Use, effective April 2025 instructed to insert pen at 90-degree angle; press the injection button all the way down and hold for 5-10 seconds. During an interview 4/8/26 at 10:45 AM the Assistant Director of Nursing (ADON) reported she expected an insulin pen to remain in place a minimum of 5 seconds following administration when using an insulin pen.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, staff interviews, and policy review, the facility failed to securely store resident medications for 2 of 6 residents reviewed for medication administration. The facility reported a census of 34. Findings include:1. Resident #29's Minimum Data Set (MDS) assessment identified a Brief Interview for Mental Status (BIMS) score of 2, indicating severely impaired cognition. On 4/6/26 at 12:45 PM, on the Chronic Confusion or Dementing Illness (CCDI) unit, observed Resident #29's medication drawer wasn't securely locked. The drawer opened easily and contained Resident #29's medication administration cards.2. On 4/6/26 at 2:45 PM, on the CCDI unit, observed Resident #19's medication drawer wasn't securely locked. The drawer opened easily and contained Resident #19's inhaler and nebulizer medications.During an interview on 4/6/26 at 3:30 PM, the Director of Nursing (DON) witnessed and acknowledged the unlocked drawers in Resident #19 and Resident #29's rooms. The DON explained medication drawers shouldn't stay unlocked. If a drawer lock broke, the staff should move medications to a different drawer with a working lock. They should also initiate a work order immediately or alert the Administrator to initiate one.The Medication Storage in Resident Apartment/Room policy revised August 2024 directed prescription and non-prescription medications must stay in a designated locked area within the resident's room. The policy instructed that only authorized persons should have access to the medication supply.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, policy review, and the 2022 Food Code United States (U.S.) Food & Drug Administration (FDA), the facility failed to protect food from contamination during preparation as evidenced by 3 observed instances of improper glove use and potential cross-contamination. The facility reported a census of 34 residents.Findings include: On 4/8/26 at 10:30 AM: observed Staff B, Cook, preparing the pureed meals for lunch. Staff B removed lasagna from the oven with gloved hands. Without performing changing their gloves or performing hand hygiene, Staff B completed the following:Placed three servings of lasagna in the blender and added a piece of garlic bread to the lasagna with their left gloved hand.Attempted to pureed the lasagna in the blender, which cracked. Staff B wiped the side of the blender off with their right gloved hand.Transferred the pureed lasagna to a second blender and added one piece of garlic bread with their left gloved hand.On 4/8/26 at 12:13 PM: observed Staff B during lunch service preparing meals.Staff B wore a glove on their right hand.Observed Staff B throwing a piece of trash in the garbage and touch the lid of the garbage can with their gloved right hand. Staff B failed to remove the glove or perform hand hygiene.Staff B then removed a hamburger from the warmer, removed the wrapping, picked up the hamburger with the same gloved right hand, cut the hamburger in half, placed it on a resident's plate, and added fries using the same gloved hand.Review of facility policy titled, Food Safety for [NAME] Life, effective August 2025 directed to be aware of food-borne organisms including poor personal hygiene; poor hand washing practices. Review of the 2022 Food Code U.S. FDA, if used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation.During an interview 4/9/26 at 9:05 AM, the Certified Dietary Manager (CDM) reported she expected the staff to not touch surfaces while wearing gloves and then touch ready-to-eat food with the same gloves.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, staff interview, and policy review, the facility failed to apply infection control practices during wound care for 1 of 1 residents reviewed for pressure injuries (Resident #29). The facility reported a census of 34. Findings include: The Minimum Data Set (MDS) Assessment completed on 3/2/26 revealed Resident #29 with a Brief Interview for Mental Status score of 2, indicating severe cognitive impairment. Diagnoses include non-Alzheimer's dementia and stroke. The Care Plan, last revised on 4/6/26, reported Resident #29 developed an unstageable pressure injury (a deep wound where the base is completely hidden by dead tissue) to the right heel. During an observation on 4/8/26 at 10:00 AM, Staff F, Licensed Practical Nurse, entered Resident #29's room to initiate wound cares and immediately put on a gown and gloves. Hand hygiene was not observed before putting on gloves. After the old, soiled dressing was removed, Staff F cleansed the right heel, as ordered, and began to apply the new dressing. Staff F realized the dressing was not dated and placed Resident #29's heel on their sock while labeling the dressing. Once labeled correctly, the heel was removed from the sock and the dressing applied. Hand hygiene nor glove change was observed before placing the new, clean dressing. In an interview on 4/8/26 at 10:30 AM, Staff F acknowledged the lack of hand hygiene and glove change during wound cares. Staff F explained the cleansed heel should have been placed on a barrier, such as a clean absorbent pad, and not the resident's sock when they were labeling the dressing. The undated Dressing Change Competency procedure outlined the following: 1. Perform hand hygiene and put on gloves prior to starting cares and opening supplies 2. Remove old dressing and discard in a garbage receptacle 3. Remove and discard gloves 4. Perform hand hygiene and put on gloves 5. Cleanse the wound and apply skin protected and/or prescribed medications if ordered 6. Discard used supplies 7. Remove and discard gloves 8. Perform hand hygiene