DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0456	A. BUILDING: _____ B. WING _____	C 08/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRKWOOD VILLAGE OF TAMA-TOLEDO	308 SECOND AVENUE TOLEDO, IA 52342

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A 000	Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Tenants without cognitive impairment: 24 Tenants with cognitive impairment: 5 Total census: 29 The following regulatory insufficiencies were cited related to the investigation of Complaint #131611-C:	A 000		
A 116	481-67.2(2) Program Policies and Procedures 67.2(2) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow its policy and procedure related to incident reports. This pertained to 1 of 2 current tenants reviewed (Tenant #2). Findings follow: Record review on 8/5/26 and 8/12/26 of Tenant #2's file revealed an incident report indicated on 7/21/26 at 4:00 a.m. Tenant #2 reported two falls on cement and she got back into a wheelchair. She fell asleep with the cigarette burning and fell to the ground. She received skin tears and bruises. It indicated the skin tears were cleansed and triple antibiotic ointment was applied and it was covered. The Director of Nursing (DON) was the person who completed the incident report form. The DON's signature at the bottom of the form had a date of 8/10/26 with a line through the date and then a date recorded of 7/21/26. The	A 116		

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A 116	Continued From page 1 incident report also had a signature of the Executive Director and a date of 7/21/26. Continued record review revealed the incident report noted Tenant #2 reported she had two falls; however, the incident report did not indicate who the falls were reported to or when the falls had occurred. Additionally, the incident report form indicated she had skin tears and bruises. The incident report form did not provide information related to injuries including location and size of the skin tears or location, size and description of the bruises. Further record review on 8/5/26 of the Program's policy and procedure related to accident, incident and medication error reporting indicate an incident report form would be used to document any accidents, incidents or medication errors. The incidents would be documented in detail on the incident report form, the staff in charge at the time would complete the forms, if there were any witnesses to the incident the incident report form would also include a witness statement and all incident or accidents that occurred in the building or on the premises would be reported as incidents. When interviewed on 8/12/26 at 11:30 a.m. and approximatley 1:20 p.m. the DON said Tenant #2 fell outside when smoking and no one saw her fall. She said staff found her outside and it was reported to the DON.	A 116		
A 201	481-67.9(4)g Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(4)?Nurse delegation procedures. The	A 201		

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A 201	Continued From page 2	A 201		

program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall include the following:

g. The program will have in place a system by which direct care staff communicate in writing occurrences that differ from the tenant's normal health and functional and cognitive status. The program's nurse or designee will train staff on reporting to the program's nurse(s) or designee(s) and documenting occurrences that differ from the tenant's normal health and functional and cognitive status. The written communication required by this paragraph will be retained by the program for a period of not less than three years and be accessible to the department upon request.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review the Program failed to document in writing occurrences that differed from a tenant's normal health, functional and cognitive status. This pertained to 1 of 2 discharged tenants reviewed (Tenant C2). Findings follow:

1. Record review on 8/5/26 to 8/12/26 of Tenant C2's file revealed Progress Notes indicated the following:

-On 2/18/26 it was noted Tenant C2 came down the hallway without pants and needed help. She did not know how to push the pendant. Tenant C2 had loose stools with dark blood to her buttock and down the legs. She was assisted to her apartment and assisted to shower. The bathroom and apartment were cleaned as she was incontinent "all over." Her stool was dark,

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A 201	Continued From page 3	A 201		

loose and had dark red blood. There was no active bleeding and no trauma, injury or external hemorrhoid. Family was notified and discussed the incident. A decision was made that if it occurred again she would go to the emergency department (ED). Family planned to make an appointment in the morning to follow up with the primary care provider (PCP) for labs and an exam. Tenant C2 reported she did not feel ill.

-On 2/19/26 it was noted Tenant C2 ate supper last evening and breakfast that morning. No further bleeding or stool incontinence noted. Family had an appointment scheduled for the afternoon on 2/19/26. An update and medication list were sent to the PCP for the office visit.

-On 2/19/26 it was noted a change of condition assessment was completed related to a move to memory care. Safety checks were scheduled. She recently had an episode of stool incontinence with blood and she did not know how to push the pendant or how to get help. The nurse strongly encouraged a move to memory care and family agreed.

2. When interviewed on 8/12/26 at 11:50 a.m. Staff A said Tenant C2 was walking down the hallway with no pants on and there was blood everywhere. It was down her legs, up her back and a trail in the hallway to her room. When inside her apartment there was a trail of blood to her bathroom and by her bed. Staff A said it looked like blood she was not sure if it was stool and blood. Before Tenant C2 was taken back to her apartment, Staff A got the Former Director of Nursing (DON). They went back to her apartment, the Former DON showered Tenant C2 and Staff A cleaned up the apartment. Staff B brought down the carpet shampooer. Staff A said

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A 201	Continued From page 4 Tenant C2 had stool and blood in her brief two to three more times on her shift. She called the Former DON and reported it. She asked about sending her out to the ED and the Former DON said there would not be anything else they could do at that point. Staff A asked if an incident report needed to be completed and was told she did not need to because the Former DON was there. When interviewed on 8/11/26 at 10:04 a.m. the Former DON said she was at the front desk and heard what sounded like a kitten whimper sound. One of the staff was coming up the hallway with Tenant C2 and Tenant C2 did not have any pants on. She had stool all over her and it was loose stool. The apartment needed to be cleaned up and the Former DON got Tenant C2 in the shower. In the shower there was no active bleeding noted. She said the staff cleaned up the apartment, it was all over and she described it as stool smear and it was not major blood loss. Vital signs were taken and were normal and the family was called. The family member was not able to go to the ED with Tenant C2. The Former DON said that someone would need to be with Tenant C2 and to bring her back. It was decided to keep an eye on her and Tenant C2 would need to go to her PCP. They would watch her brief. She was already getting hourly checks due to her cognition. Regarding any further communication of loose stool (blood tinged) she thought a couple (times) and said it would be charted if it was reported. The next day or day after the Former DON made multiple calls to family regarding needing a higher level of care. She was examined by the PCP and had lab work (a couple of times) and her hemoglobin was dropping rapidly. When interviewed on 8/11/26 at 11:30 a.m. Staff	A 201		

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A 201	Continued From page 5	A 201		

B said she was coming up the hallway and heard a meowing sound. As she got closer Staff B thought it sounded like Tenant C2's voice. Tenant C2 was nude from the waist down and was holding her private area. Staff B alerted Staff A. When Tenant C2 started walking towards her apartment Staff B noticed blood dripping down her legs onto her ankles. Tenant C2 did not communicate well, had a soft voice and looked scared. Staff A called the Former DON and Staff B was not involved much after that. Staff B said she peaked in the apartment but did not see any blood. Tenant C2 did not have any other incidents that Staff B was aware of. Staff B said did not fill out an incident report or staff statement.

3. Continued record review revealed Tenant C2 was staged at a five on the Global Deterioration Scale, which indicated moderately severe cognitive decline. She moved to the memory care unit on 2/20/26. Review of her prior service plan dated 1/26/26 reflected Tenant C2 was continent of bowel. The evaluation dated 2/19/26 indicated she had a recent episode of stool incontinence with bleeding. There were no staff to nurse communication sheets completed related to the initial episode of stool incontinence with blood or the subsequent episodes that occurred (staff noted it in her brief).

Further record review of Tenant C2's file revealed two staff to nurse sheets were provided dated 1/6/26 and 1/26/26; however, none were provided related to the occurrences above that differed from Tenant C2 normal status.

4. When interviewed on 8/12/26 at 2:33 p.m. the Executive Director said the staff to nurse sheets were completed if the nurse was not there or not

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A 201	Continued From page 6 available. When interviewed on 8/12/26 at 3:19 p.m. the DON confirmed no additional staff to nurse sheets completed for Tenant C2.	A 201		
A 285	481-69.26(4)a Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and indicate: a. The tenant's identified needs and preferences for assistance; This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to develop a service plan to reflect the identified needs of the tenant. This pertained to 1 of 2 discharged tenants reviewed (Tenant C2). Findings follow: 1. Record review on 8/5/26 to 8/12/26 of Tenant C2's file revealed Progress Notes indicated the following: -On 2/18/26 Tenant C2 came down the hallway without pants and needed help. She did not know how to push the pendant. Tenant C2 had loose stools with dark blood to her buttock and down the legs. She was assisted to her apartment and assisted to shower. The bathroom and apartment were cleaned as she was incontinent "all over." Her stool was dark, loose and had dark red blood. There was no active bleeding and no trauma, injury or external hemorrhoid. Family was notified and discussed the incident. A	A 285		

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A 285	Continued From page 7	A 285		

decision was made that if it occurred again Tenant C2 would go to the emergency department (ED). Family planned to make an appointment in the morning to follow up with the primary care provider (PCP) for labs and an exam. Tenant C2 reported she did not feel ill.

-On 2/19/26 Tenant C2 ate supper last evening and breakfast that morning. No further bleeding or stool incontinence noted. Family had an appointment scheduled for the afternoon on 2/19/26. An update and medication list were sent to the PCP for the office visit.

-On 2/19/26 a change of condition assessment was completed related to a move to memory care. Safety checks were scheduled. She recently had an episode of stool incontinence with blood and she did not know how to push the pendant or how to get help. The nurse strongly encouraged a move to memory care and family agreed.

Continued record reviewed Tenant C2's service plan was updated on 2/19/26; however, the service plan did not reflect the episode of stool incontinence with blood and interventions or monitoring related to it.

2. When interviewed on 8/12/26 at approximately 1:20 p.m. the Director of Nursing confirmed the service plan reflected the safety checks but did not reflect the above (related to the stool incontinence and blood).