STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165794	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Gate	16 Valley View Drive Council Bluffs, IA 51503

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 37074 Based on clinical record review, staff interviews, medical clinic personnel interviews and facility policy review the facility failed to clarify a discrepancy in orders timely and failed to transcribe physician orders as directed for 1 of 3 residents (Resident #1) reviewed. The facility reported a census of 32 residents. Findings include: According to the quarterly Minimum Data Set (MDS) assessment tool with a reference date of 5/9/24, Resident #1 had a Brief Interview of Mental Status (BIMS) score of 15. A BIMS score of 15 suggested no cognitive impairment. The assessment tool documented she received a diuretic. The MDS listed the following diagnoses: acute and chronic respiratory failure with hypoxia and hypercapnia, heart failure, hypertension, respiratory failure, atrial fibrillation, hypertensive heart disease with heart failure, chronic systolic heart failure, obstructive sleep apnea, morbid obesity, adjustment disorder with mixed anxiety and depressed mood. The Care Plan focus area with an initiation date of 2/21/24 documented Resident #1 had potential fluid deficit due to diuretic use, medication side effects/chronic disease processes. The Care Plan directed staff to administer medications as ordered and observe for side effect and effectiveness, complete lab work per orders and monitor Resident #1's weight per facility policy. A document titled After Visit Summary dated 3/7/24 at 10:30 AM from the Health Clinic Heart Failure, documented the following changes to the resident's medication list as of 3/7/24 at 10:31 AM: a. Bumetanide (diuretic) 2 milligrams (mg), take 1 tablet (2 mg total) by mouth once daily. Take two times a day (BID) for the first three days, then go to once daily. This document lacked facility staff signatures as being noted. A document titled Physician's Visit Report dated 3/7/24 documented the following medication change: a. Bumetanide 2 mg BID for three days, then once daily. This document signed as noted by Staff B Registered Nurse (RN) and Staff C Clinical Coordinator. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Cardiology Note with an encounter date of 3/14/24 from a Health Clinic Heart Institute, documented a consult note made on 3/15/24 with the following order on page one: increase Bumetanide to 2 mg BID. On page two it documented approved medication requests as of 3/15/24 at 10:56 AM: change Bumetanide take one tablet (2 mg total) by mouth two times a day. Take two times a day for first three days, then go to once daily. This document signed as being noted by Staff B and Staff D RN. A Verbal Order with an order date of 3/27/24 at 11:31 AM documented the following order summary: Bumetanide 1 mg, give 1 tablet by mouth one time a day. The order confirmed by Staff A Licensed Practical Nurse (LPN). Review of March 2024 Medication Administrator Record (MAR) revealed the following orders: a. Bumetanide oral tablet 2 mg, give 1 tablet by mouth BID related to chronic systolic (congestive) heart failure for three days, with an order date of 3/7/24 and discontinued date of 3/10/24. b. Bumetanide tablet 2 mg give 1 tablet by mouth BID for fluid retention with a start date of 3/15/24 and discontinued date of 5/28/24. c. Bumetanide oral tablet 1 mg, give 1 tablet by mouth one time a day related to hypertensive heart disease with heart failure. Please give at noon, with a start date of 3/27/24 and discontinued date of 5/28/24. The facility failed to initiate the order for Bumetanide 2 mg once a day after the 2 mg BID order ended on 3/10/24. Resident #1 had no active Bumetanide order from 3/10/24 until 3/15/24. Resident #1 was ordered to receive 2 mg of Bumetanide daily from 3/11/24 through 3/26/24 but had received 4 mg daily. Resident #1 was ordered to receive 3 mg of Bumetanide daily starting 3/27/24 but had received 5 mg daily. Review of April 2024 MAR revealed the following orders: a. Bumetanide tablet 2 mg give 1 tablet by mouth BID for fluid retention with a start date of 3/15/24 and discontinued date of 5/28/24. b. Bumetanide oral tablet 1 mg, give 1 tablet by mouth one time a day related to hypertensive heart disease with heart failure. Please give at noon, with a start date of 3/27/24 and discontinued date of 5/28/24. Resident #1 continued to receive 5 mg daily when 3 mg daily was ordered. Review of May 2024 MAR revealed the following orders: a. Bumetanide tablet 2 mg give 1 tablet by mouth BID for fluid retention with a start date of 3/15/24 and discontinued date of 5/28/24. b. Bumetanide oral tablet 1 mg, give 1 tablet by mouth one time a day related to hypertensive heart disease with heart failure. Please give at noon, with a start date of 3/27/24 and discontinued date of 5/28/24. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 continued to receive 5 mg daily when 3 mg daily was ordered. On 5/30/24 at 1:03 PM Resident #1's Cardiologist's nurse verified her Bumetanide orders as the following: a. On 3/7/24 Bumetanide 2 mg BID x 3 days then 2 mg daily b. On 3/27/24 Bumetanide 2 mg in the morning and 1/2 tablet (1 mg) in the afternoon c. On 4/9/24 Resident #1 was seen in the clinic with no medication changes d. On 5/6/24 Resident #1 was seen in the clinic and to continue with 2 mg in the morning and 1/2 tablet (1 mg) in the afternoon. On 5/30/24 at 2:47 PM the Director of Nursing (DON) stated Resident #1's order for Bumetanide 2 mg BID x 3 days then once a day order was left that way and not entered correctly. They noted this order was written on 3/15/24 and it should have been clarified. They educated the nurses to look at all pages of documents when a resident returns from an appointment, not just the first page and to clarify the orders if needed. On 6/4/24 at 9:59 AM the Nurse Practitioner (NP) at Resident #1's Cardiologist office verified she was seen in their clinic in March and had orders for Bumetanide 2 mg BID x 3 days then once a day. After that Resident #1's Bumetanide order was 2 mg in the morning and 1 mg in the afternoon. She was unsure why they continued to give the resident 2 mg BID when it should have been daily along with the 1 mg in the afternoon. The NP indicated the facility should have called the clinic for clarification once they reviewed the orders that were sent back with the resident following her appointment. On 5/30/24 at 3:14 PM Staff C stated the doctor's orders were unclear on the first page and the medication list did not match what was written on the second page. When she discovered this on 5/23/24 she called the clinic to clarify the orders but the clinic nurse was unclear of what the physician had ordered. They completed education with their nurses to pay attention to all pages of documents returned with residents from appointments. If the orders do not match they need to reach out to get clarification. When asked what happened to the daily dose of 2 mg order she signed off as being noted on 3/7/24 she acknowledged she may have missed the second part of the order, not sure if she was pulled away and did not put in the second half of the order. On 6/5/24 at 9:11 AM Staff B stated two nurses sign the after-visit summaries and physician visit report sheets to ensure the orders are carried out. The day shift charge nurse usually carries out the new orders, the night charge nurse will counter sign that it was carried out. At night the charge nurse will make sure the order was put in the computer correctly. The clinical coordinator will also check the orders to make sure they are carried out correctly. When asked what happened when the Cardiologist ordered Bumetanide 2 mg BID x 3 days then once a day and the daily order was not implemented. Staff B stated it was checked by the day shift charge nurse, he presumed Staff C had confirmed with the physician what was ordered. There was an order on the first page of the visit sheet and the same order was on the second page, he thought it was a double entry order but he should have been clarified and he thought it was. It's the day shift charge nurse's duty to clarify orders since the night shift nurses don't have access to these physician's for clarification. The daily BID dose was put in and that's what he checked and signed off as being put in the computer. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/5/24 at 10:22 AM Staff D stated when a resident returns from an appointment with new orders the nurse is to look at the paperwork, see what orders have changed, update the orders in the computer. The night shift charge nurse will double check to make sure nothing was missed with the new orders and hopefully nothing is missed. When asked about the 3/15/24 order for Bumetanide 2 mg BID x 3 days then daily she stated one page said one thing and another page said something different. She should have seen this and clarified what the doctor wanted. A policy titled Order Processing Policy with a modified date of May 2024, documented the purpose of the policy is to obtain orders for care and treatment of the resident as necessary. The policy listed the following procedure for staff to follow: 1. Obtain an order from the prescriber. a. For orders written by a provider in the facility, telephone and verbal orders, the preferred document is Provider Order Form. b. Orders written during a consult or by a provider outside the facility will be processed on the original document. 6. Orders that include more than one dose or frequency will be transcribed in a manner that with each administration of the medication it can be documented the dose and/or the frequency the medication that was administered. 7. Each order should then be noted by the nurse to include the date and time the order was processed. A second review of all orders are required. One of the reviews may be completed by a trained Health Unit Coordinator. For sites with limited staffing on a specific shift, a process is to be implemented to ensure the orders received are second checked by a qualified staff within the next scheduled shift. A policy titled Medication Administration Policy with an approved date of January 2009, documented the purpose of this policy is to ensure safe, effective and timely drug therapy, to provide for an accurate and concise documentation system. A. Medication Administration 1. RN's, LPN's, CMA's will administer medications as ordered by the attending physician/nurse practitioner. B. Medication Administration Record 1. Accurate transcription of medication orders is the responsibility of licensed nursing staff. 2. Medications are transcribed from the physician order sheet to the MAR in the electronic medical record MAR (EMAR). 3. MAR will include the name of the medication, dosage, route, frequency, and any other information including specific monitoring required prior to administration of medication. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Discontinued dates are entered as indicated into the electronic medical record and will be reflected at the discharged time in EMAR.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37074 Based on clinical record review, Pharmacy Drug Book review, clinical staff interview, provider interview, staff interviews, and facility policy review the facility failed to follow physician's orders resulting in a significant medication error for 1 of 3 residents (Resident #1) reviewed. On 3/7/24 the Cardiologist ordered Bumetanide 2 mg BID x 3 days then 2 mg once a day. The facility failed to initiate the once a day order. The resident was without her Bumetanide from 3/10/24-3/15/24. On 3/15/24 at 8:00 PM through 5/23/24 the resident received Bumetanide 2 mg BID when it was ordered for her to receive 2 mg once a day. On 3/27/24 the facility initiated an order for Bumex 1 mg at noon, with the 2 mg order in place. The resident received 5 mg of Bumetanide a day for roughly 58 days when 3 mg was ordered. There was an immediate need for the facility to take steps to ensure residents were protected from significant medication errors. The facility reported a census of 32 residents. On 5/30/24 at 4:48 PM, the State Survey Agency informed the facility of the significant medication error creating an Immediate Jeopardy situation resulting in the resident being sent to the hospital with an admitting diagnosis of an acute kidney injury (AKI) on 5/23/24. The facility staff removed the immediacy on 5/31/24 at 10:12 AM when staff implemented the following Corrective Actions: a. the facility educated all nurses by 5/30/24 on processing, initiating, reconciling, and clarification of orders; b. starting 5/30/24 the clinical coordinator/designee will audit orders received to ensure staff initiate and clarify orders when new orders are received; and c. results of these audits will be reported to the QAPI committee for review and modifications as needed. The scope lowered from a J to a D at the time of the survey after ensuring the facility implemented educated of their policy and procedures. Findings include: According to the quarterly Minimum Data Set (MDS) assessment tool with a reference date of 5/9/24 Resident #1 had a Brief Interview of Mental Status (BIMS) score of 15. A BIMS score of 15 suggested no cognitive impairment. The assessment tool documented she received a diuretic. The MDS listed the following diagnoses: acute and chronic respiratory failure with hypoxia and hypercapnia, heart failure, hypertension, respiratory failure, atrial fibrillation, hypertensive heart disease with heart failure, chronic systolic heart failure, obstructive sleep apnea, morbid obesity, adjustment disorder with mixed anxiety and depressed mood. The Care Plan focus area with an initiation date of 2/21/2024 documented Resident #1 had potential fluid deficit due to diuretic use, medication side effects/chronic disease processes. The Care Plan directed staff to administer medications as ordered and observe for side effect and effectiveness, complete lab work per orders and monitor Resident #1's weight per facility policy. The following Progress Notes documented: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. On 3/7/24 at 4:25 PM Resident #1 and her sister went to her Cardiology appointment today. New orders to start Bumetanide 2 mg two times a day (BID) for 3 days, daily weights with instruction to call the physician with a 2-pound weight gain in 24 hours or 5-pound weight gain in one week, monitor blood pressure daily and send results in one week to cardiology. Note documented by Staff C Clinical Coordinator. b. On 3/15/24 at 12:57 PM new orders received per facsimile from resident's Cardiologist. New orders for Bumetanide 2 mg by mouth BID. Continue with daily weights and blood pressure checks, send at the end of the week. Note documented by Staff D Registered Nurse (RN). c. On 3/27/24 at 1:12 PM Cardiologist gave verbal order to start Bumetanide 1 mg at noon daily. Continue to monitor blood pressure and weight daily. d. On 5/22/24 at 3:25 PM residents blood pressure running low today, has voiced pain in stomach, heartburn and was nauseated this morning. She did not eat much lunch, isn't taking fluids in well, and stated overall does not feel well. She was given as needed (PRN) Tums and Zofran (anti-nausea) and it did help. She stayed in her room for lunch, did come out for breakfast. Staff encouraged to use manual blood pressure cuff on her and not automatic. Also noted a 15.4 weight loss in 11 days, has been a steady loss, reported these findings to RN, note was placed in (A Registered Nurse Practitioner (APRN) folder who will be coming tomorrow. Resident declined wanting to go to the hospital at this time when asked, encouraged to let staff know if any changes occur. e. On 5/23/24 at 12:47 PM Staff C received an order from resident's cardiologist to refer resident to hospital for further evaluation and management due to some deviated lab results. f. On 5/23/24 at 2:39 PM resident sent to the hospital at 1:20 PM. A document titled After Visit Summary dated 3/7/24 at 10:30 AM at a Health Clinic Heart Failure, documented the following changes to the resident's medication list as of 3/7/24 at 10:31 AM: a. Bumetanide (diuretic) 2 milligrams (mg), take 1 tablet (2 mg total) by mouth once daily. Take two times a day (BID) for the first three days, then go to once daily. This document lacked facility staff signature as being noted. A document titled Physician's Visit Report dated 3/7/24 documented the following medication change: a. Bumetanide 2 mg BID for three days, then once daily. This document signed as noted by Staff B Registered Nurse (RN) and Staff C. A Cardiology Note with an encounter date of 3/14/24 from a Health Clinic Heart Institute, documented a consult note was made on 3/15/24 with the following order on page one: increase Bumetanide to 2 mg BID. On page two it documented approved medication requests as of 3/15/24 at 10:56 AM: change Bumetanide take one tablet (2 mg total) by mouth two times a day. Take two times a day for first three days, then go to once daily. This document signed as being noted by Staff B and Staff D. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A verbal order with an order date of 3/27/24 at 11:31 AM documented the following order summary: Bumetanide 1 mg, give 1 tablet by mouth one time a day. The order confirmed by Staff A Licensed Practical Nurse (LPN). Review of March 2024 Medication Administrator Record (MAR) revealed the following orders: a. Bumetanide oral tablet 2 mg, give 1 tablet by mouth BID related to chronic systolic (congestive) heart failure for three days, with an order date of 3/7/24 and discontinued date of 3/10/24. b. Bumetanide tablet 2 mg give 1 tablet by mouth BID for fluid retention with a start date of 3/15/24 and discontinued date of 5/28/24. c. Bumetanide oral tablet 1 mg, give 1 tablet by mouth one time a day related to hypertensive heart disease with heart failure. Please give at noon, with a start date of 3/27/24 and discontinued date of 5/28/24. The facility failed to initiate the order for Bumetanide 2 mg once a day after the 2 mg BID order ended on 3/10/24. Resident #1 had no active Bumetanide order from 3/10/24 until 3/15/24. Resident #1 was ordered to receive 2 mg of Bumetanide daily from 3/11/24 through 3/26/24 but had received 4 mg daily. Resident #1 was ordered to receive 3 mg of Bumetanide daily starting 3/27/24 but had received 5 mg daily. Review of April 2024 MAR revealed the following orders: a. Bumetanide tablet 2 mg give 1 tablet by mouth BID for fluid retention with a start date of 3/15/24 and discontinued date of 5/28/24. b. Bumetanide oral tablet 1 mg, give 1 tablet by mouth one time a day related to hypertensive heart disease with heart failure. Please give at noon, with a start date of 3/27/24 and discontinued date of 5/28/24. Resident #1 continued to receive 5 mg daily when 3 mg daily was ordered. Review of May 2024 MAR revealed the following orders: a. Bumetanide tablet 2 mg give 1 tablet by mouth BID for fluid retention with a start date of 3/15/24 and discontinued date of 5/28/24. b. Bumetanide oral tablet 1 mg, give 1 tablet by mouth one time a day related to hypertensive heart disease with heart failure. Please give at noon, with a start date of 3/27/24 and discontinued date of 5/28/24. Resident #1 continued to receive 5 mg daily when 3 mg daily was ordered. On 5/30/24 at 1:03 PM Resident #1's Cardiologist's nurse verified her Bumetanide orders as the following: a. On 3/7/24 Bumetanide 2 mg BID x 3 days then 2 mg daily (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	b. On 3/27/24 Bumetanide 2 mg in the morning and 1/2 tablet (1 mg) in the afternoon c. On 4/9/24 Resident #1 was seen in the clinic with no medication changes d. On 5/6/24 Resident #1 was seen in the clinic and to continue with 2 mg in the morning and 1/2 tablet (1 mg) in the afternoon. Review of labs results for Resident #1 revealed the following: a. 2/5/24: potassium 4.3 (normal is 3.5-5.5), blood urea nitrogen (BUN)(measures the amount of urea nitrogen in your blood) 13 (normal is 6-22), creatinine (check function of kidneys) 0.31 (normal 0.50-1.20), glomerular filtration rate (GFR) (measures how well kidneys filter blood) 111 b. 3/4/24: potassium 4.3 BUN 14, creatinine 0.38, GFR 106 c. 3/15/24: potassium 5 BUN 15 creatinine 0.34, GFR 109 d. 4/5/24: potassium 3.4, BUN 19, creatinine 0.40, GFR 104 e. 5/13/24: potassium 5.2, BUN 22, creatinine 0.61, GFR 94 f. 5/22/24: potassium 6.5, BUN 67, creatinine 1.43, GFR 39 Review of the facility's 2024 [NAME] Pocket Drug Guide for Nurses with a copyright date of 2024 revealed on page 56 Bumetanide was a loop diuretic. Staff are to monitor electrolytes, hydration, hepatic function with long term treatment; water and electrolyte depletion is possible. Indication and dosage: treatment of edema associated with heart failure, kidney, hepatic diseases. Adult dosage is 0.5-2 mg every day by mouth. Dosage to be adjusted based on abnormal kidney function especially in older adults. Adverse effects listed as: anorexia, asterixis, drowsiness, headache, hypokalemia, nocturia, nausea, vomiting, diarrhea, orthostatic hypotension, and polyuria. A document titled Discharge Summary with an admitted [DATE] and discharge date of [DATE] listed a primary discharge diagnosis of acute kidney injury (AKI). Her past medical history for essential hypertension, hyperlipidemia, atrial fibrillation, chronic heart failure who presented to the emergency room (ER) secondary to abnormal labs. Resident stated that she had some nausea and heartburn the last couple of days. She indicated she was having mild diarrhea with 2-3 bowel movements a day for about a week and some of them were loose. Recent labs completed showed BUN of 67, creatinine of 1.4, and potassium of 6.5. Her supplement potassium was held and given kayexalate (treatment of high potassium levels). Repeat potassium level was drawn and was 5.6. Resident stated she has lost about 15 pounds in 11 days. She is on Bumetanide per cardiology. On 5/30/24 at 2:47 PM the Director of Nursing (DON) stated Resident #1's order for Bumetanide 2 mg BID x 3 days then once a day order was left that way and not entered correctly. They noted this order was written on 3/15/24 and it should have been clarified. They educated the nurses to look at all pages of documents when a resident returns from an appointment, not just the first page and to clarify the orders if needed. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/4/24 at 9:59 AM the Nurse Practitioner (NP) at Resident #1's Cardiologist office verified she was seen in their clinic in March and had orders for Bumetanide 2 mg BID x 3 days then once a day. After that Resident #1's Bumetanide order was 2 mg in the morning and 1 mg in the afternoon. She was unsure why they continued to give the resident 2 mg BID when it should have been daily along with the 1 mg in the afternoon. The NP indicated the facility should have called the clinic for clarification once they reviewed the orders that were sent back with the resident following her appointment. If Resident #1 was in fact receiving 5 mg instead of 3 mg of Bumetanide this could have cause her acute kidney injury. Bumetanide works with in the kidney because it is a loop diuretic and helps to excrete excess urine and fluid. Too much medication would force the kidney to cause excessive excretion which could have caused the kidney injury. She was unsure why the facility did not question the original order back in March. On 5/30/24 at 3:14 PM Staff C stated the doctor's orders were unclear on the first page and the medication list did not match what was written on the second page. When she discovered this on 5/23/24 she called the clinic to clarify the orders but the clinic nurse was unclear of what the physician had ordered. They completed education with their nurses to pay attention to all pages of documents returned with residents from appointments. If the orders do not match they need to reach out to get clarification. When asked what happened to the daily dose of 2 mg order she signed off as being noted on 3/7/24 she acknowledged she may have missed the second part of the order, not sure if she was pulled away and did not put in the second half of the order. On 6/5/24 at 9:11 AM Staff B stated two nurses sign the after-visit summaries and physician visit report sheets to ensure the orders are carried out. The day shift charge nurse usually carries out the new orders, the night charge nurse will counter sign that it was carried out. At night the charge nurse will make sure the order was put in the computer correctly. The clinical coordinator will also check the orders to make sure they are carried out correctly. When asked what happened when the Cardiologist ordered Bumetanide 2 mg BID x 3 days then once a day and the daily order was not implemented. Staff B stated it was checked by the day shift charge nurse, he presumed Staff C had confirmed with the physician what was ordered. There was an order on the first page of the visit sheet and the same order was on the second page, he thought it was a double entry order but he should have been clarified and he thought it was. It's the day shift charge nurse's duty to clarify orders since the night shift nurses don't have access to these physician's for clarification. The daily BID dose was put in and that's what he checked and signed off as being put in the computer. On 6/5/24 at 10:22 AM Staff D stated when a resident returns from an appointment with new orders the nurse is to look at the paperwork, see what orders have changed, and update the orders in the computer. The night shift charge nurse will double check to make sure nothing was missed with the new orders and hopefully nothing is missed. When asked about the 3/15/24 order for Bumetanide 2 mg BID x 3 days then daily she stated one page said one thing and another page said something different. She should have seen this and clarified what the doctor wanted. A policy titled Order Processing Policy with a modified date of May 2024, documented the purpose of the policy is to obtain orders for care and treatment of the resident as necessary. The policy listed the following procedure for staff to follow: 1. Obtain an order from the prescriber. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165794	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Gate	16 Valley View Drive Council Bluffs, IA 51503

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. For orders written by a provider in the facility, telephone and verbal orders, the preferred document is Provider Order Form. b. Orders written during a consult or by a provider outside the facility will be processed on the original document. 6. Orders that include more than one dose or frequency will be transcribed in a manner that with each administration of the medication it can be documented the dose and/or the frequency the medication that was administered. 7. Each order should then be noted by the nurse to include the date and time the order was processed. A second review of all orders are required. One of the reviews may be completed by a trained Health Unit Coordinator. For sites with limited staffing on a specific shift, a process is to be implemented to ensure the orders received are second checked by a qualified staff within the next scheduled shift. A policy titled Medication Administration Policy with an approved date of January 2009, documented the purpose of this policy is to ensure safe, effective and timely drug therapy, to provide for an accurate and concise documentation system. A. Medication Administration 1. RN's, LPN's, CMA's will administer medications as ordered by the attending physician/nurse practitioner. 2. The 8 rights of drug administration will be followed when administering all medication:\ a. Right resident b. Right drug c. Right dose d. Right dosage form (i.e. liquid, solid, crushed, etc.) e. Right route f. Right time g. Right reason h. Right documentation B. Medication Administration Record 1. Accurate transcription of medication orders is the responsibility of licensed nursing staff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165794	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Gate	16 Valley View Drive Council Bluffs, IA 51503

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Medications are transcribed from the physician order sheet to the MAR in the electronic medical record MAR (EMAR). 3. MAR will include the name of the medication, dosage, route, frequency, and any other information including specific monitoring required prior to administration of medication. 4. Discontinued dates are entered as indicated into the electronic medical record and will be reflected at the discharged time in EMAR.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165794	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Gate	16 Valley View Drive Council Bluffs, IA 51503

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ staff that are licensed, certified, or registered in accordance with state laws. 37074 Based on employee file review, staff interviews, position description and employee handbook review the facility failed to ensure 1 of 3 employed nurses had either a multistate license or a single state license for the State of Iowa. The facility reported a census of 32 residents. Findings include: Review of Staff A Licensed Practical Nurse (LPN) employee file revealed a hire date of 4/14/21 and termination date of 5/24/24. Staff A's employee file revealed two QuickConfirm License Verification Reports (provides online license verification to work in another state): a. A report dated 6/11/2021 documented Staff A had an unencumbered (full and unrestricted license to practice) multistate license, with an expiration date of 10/31/2021. Staff A was licensed to practice in Iowa. b. A report dated 6/4/2024 documented Staff A had an unencumbered single state license with an expiration date of 10/31/2025. Staff A was licensed to only practice in Nebraska. On 6/4/24 at 1:17 PM the Human Resources Manager II stated she took over the Human Resources Manager II position May 1, 2023. She acknowledged she is responsible for completing license verifications for new staff. When she was informed of Staff A's licensed verified as a single state license in Nebraska as of 6/2/24, she indicated she would need to follow up with their Regional Human Resource Director about that. She acknowledged she ran a report today because she noticed Staff A had not had a report ran since 2021. During a follow-up interview at 3:15 PM she indicated Staff A went from a multistate license to a single state license without notifying the facility. The Human Resources Manager II indicated she pulled all licensed staff member's reports for verification and they were all fine. On 6/5/24 at 11:05 AM the Administrator stated when Staff A renewed her licensed in 2023, they did not catch that it went from a multistate to single state license. He had the Human Resource Manager verify everyone with a license to ensure they are current and correct, they all were. The facility has a program that runs a report when triggered to check verification. When it triggered for Staff A, it must have been missed. The LPN Position Description and Performance Summary listed the following minimum qualifications: LPN with current licensure with the State Board of Nursing in state(s) in which he/she practices. The Employee Handbook with an effective date of 1/1/2024 indicated, as an employee staff are required to complete and update certain employment records and related forms. The following action may result in immediate termination: failure to maintain licensure as required for hired position.