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	05/23/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 37074 Based on record review, staff, resident and family interviews, and facility policy review the facility failed to treat the resident with respect and dignity for 1 of 3 residents (Resident #4) with dignity and respect during personal cares. The facility reported a census of 35 residents. Findings include: According to Resident #4's Admission Minimum Data Set (MDS) assessment tool with a reference date of 3/27/2025, she had a Brief Interview of Mental Status (BIMS) score of 15. A BIMS score of 15 suggested no cognitive impairment. The MDS documented she had no impairments to her upper and lower extremities, and she utilized a walker and wheelchair for mobility. The MDS indicated she required supervision or touching assistance to go from a sitting to lying position, lying to sitting position, from a chair/bed to chair, and toileting transfer. The MDS listed the following diagnoses for Resident #4: polyosteoarthritis and thyroid disease. The Care Plan Focus Area with an initiation date of 3/21/2025 documented she had an Activities of Daily Living (ADLs) self-care deficit due to advanced age, weakness, impaired mobility, self-care abilities, osteoarthritis and physical debility. The Care Plan documented she required the assistance of one staff with a gait belt, and walker for ambulation and transfers. Staff are to assist as needed (PRN)/requested for bed mobility. The following Progress Note was documented for Resident #4: on 5/15/2025 at 2:22 PM her physician was notified of right shoulder pain. Resident had an appointment at the clinic earlier and was aware of the right shoulder pain. The physician requested staff to continue to monitor her pain. Record review revealed Staff C Registered Nurse (RN) completed a body audit for Resident #4 on 5/15/2025. Staff C documented the following in the additional comments on skin integrity section: skin is clean, dry and intact. Claimed pain on right upper arm on hyperextension movement; rated a 2-3 on the pain scale. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/22/2025 at 1:10 PM Resident #4's daughter and emergency contact #1 stated her mom said one of the people on staff at night came in to her room a couple times during the night to see if she wanted to go to the bathroom. That night the staff member woke her up, told her to roll over. Her mom said she couldn't unless she has something to grab on to. She was flat on her back, in bed. The staff kept saying roll over, you're wet as Resident #4 said I can't. The staff member jerked her arm to roll her over. She indicated her mom had fallen a week or so before and her arm was just starting to feel better. After that staff helped her, that arm hurt. Her mom stated the staff member had a gruff attitude and she did not show compassion for those that couldn't help themselves. Her mom wondered about others that couldn't speak up and how could they report these things. That one particular night she was pretty upset about it. Her mom could not recall her name but described her as a tall slender black girl that wore a turbine. Resident #4 reported no further concerns since that day, that gal has not been back in. On 5/22/2025 at 2:12 PM observed Resident #4 sitting in the recliner in her room, reading a book. When asked if anyone was ever rough when they were assisting her with care, she stated about 2-3 weeks ago some tall, black lady on the overnight shift was. She could not think of her name. She came in three times that night. At about 2:30 AM the staff member came in her room after she had her call light on, pulled her covers off and asked what she wanted. The resident stated she needed to go to the bathroom. Resident #4 pointed to two signs in her room that read call don't fall. She knew the staff member could read and see them, that's why she asked for help. The staff member said she was wet then positioned her bed flat, crossed her own arms and said turn on your side. The resident told her she is lying flat and couldn't turn on her side, especially when she does not have something to grab on to. The staff member said, I said turn over. The resident motioned her arms in the air in a patting manner then pulled her arms toward her. When asked what that meant, she stated she pulled on her right arm and pulled her over on her side. The staff member then told her to stay on her side because she needed to be changed. The resident stated the staff member gave her a sitz bath front and back. After she was done, she threw her covers on her and left. After this her right shoulder/arm started to hurt. She had grabbed that arm to turn her. She reported this because it bothered her and she worried about the residents that don't know what's going on or what is wrong or right. She told the facility she did not want that girl in her room any more. She couldn't stand to think about what happened because it really bothered her. She was told the facility took care of it and she denied further issues. On 5/22/2025 at 12:39 PM Staff A Clinical Coordinator stated Resident #4's daughter reported to her that her mother had said the Certified Nursing Assistant (CNA) that worked overnight was rough with her. Staff came in checking to see if she was wet. The staff member said she was wet and needed to be changed. The staff member told the staff to roll over and the resident said she couldn't, so the staff member helped her to roll over. The resident said the staff member was rough and pulled on her arm. When asked what arm she pulled on, Staff A said she could not remember but remembered it was an arm she had previously injured during a fall a couple of weeks ago. When asked what staff member the resident spoke of, Staff A stated all she knew was it was one of the black ladies. When they did their investigation, they narrowed it down to two CNAs: one being Staff B. Once the Director of Nursing (DON) and Social Worker interviewed residents they were able to narrow it down to Staff B based on the responses from the residents. When Staff A spoke with the resident she stated she was done with the staff member. She was rough with her and pulled on her arm. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/22/2025 at 1:01 PM Resident Services Director stated when she spoke to Resident #4 she sated her shoulder was sore when she was trying to move it around; her right shoulder. She was kind of napping so she left her rest. On 5/22/2025 at 1:15 PM Staff C Registered Nurse (RN) stated she went in and completed an assessment on Resident #4 after the alleged incident was reported. She checked her mobility and when she checked her right arm and shoulder, she complained of pain. She only complained when her arm was hyperextended. She believed the resident rated it a 3 out of 10. The physician was notified and wanted them to continue to monitor. She did not need an as needed (PRN) for pain management. When she assessed her later that day her pain had subsided. On 5/22/2025 at 1:48 PM the Administrator stated Staff B Agency CNA could have been nicer when assisting Resident #4. Since the staff member was an Agency CNA they notified her agency and asked that she not return. He suggested the agency do more training with Staff B with ADL assistance. On 5/22/2025 at 3:29 PM Staff B stated she went in to Resident #4's room, changed her diaper, turned her and that was it. The resident resisted and pulled back on her. When turning someone you can see and feel when they are resisting and she did that as she tried to pull her dress up and her diaper down. Staff B stated the resident was fighting her and did not want to turn. Nothing can be done because it's her word against the resident's. People like that have a plan and do things on purpose. It's a catch 22, anyone can do that and now she's stuck. She denied pulling on her arm or shoulder. She acknowledged the bed was flat and she had no side rails to hold on to when rolling. She kept saying, I don't know if this was planned or what but it's her job to clean their butts. Anyone can get you in trouble. On 5/22/2025 at 3:48 PM Staff D CNA stated she was working on the other side of the floor but was assisting with call lights. She came out of a different room, and heard a call light going off, so she decided to see what was going on. She had no idea where Staff B was, she was working that night as well. When she walked in to Resident #4's, first thing the resident did was give out a huge sigh of relief that she was in here. Resident #4 then stated finally someone that knows what she is doing, she was in tears. Resident #4 told her she was flat on her back all night, couldn't find her remote or call light, her back hurt, and her bed was wet. Staff D assisted Resident #4 to the bathroom then to her in her chair while she changed her bedding. Resident then stated she did not want to be caught in bed. Resident #4 stated Staff B got rough with her she positioned her, was not listening to bring head and legs up in bed, roughing her shoulders around and tossing her around in bed. Staff D felt bad, but made sure she was comfortable and left. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/23/2025 at 8:34 AM Staff E CNA, that took care of Resident #4 the morning after alleged incident, went in to the resident's room and the resident was pretty upset. When she asked the resident what was wrong, the resident asked Staff E to sit her up, because she had been laying down. She stated she felt trapped, could not get up or move. The resident's bed was flat, she had to help set her up. Resident #4 stated I don't know if you know who that overnight aide was but she was too rough. When she came in, she rolled her over way too rough, did not give her time to turn, and handled her with too much force. She was not happy, said she was sore not sure from laying down or being turned too hard. Resident #4 stated that staff member was not very friendly, just turned her over. Staff E still turned it in because no one should be treated like that. Resident #4 described the staff as a tall black lady, the facility has not scheduled her lately. Staff E added Resident #4 is not a complainer, never heard her complain about staff or treatment before. Goes with the flow kind of person. She did not want to get anyone in trouble but the resident used the words rough and in pain, so she had to report it. The facility provided a document titled Resident Rights Policy with a modified date of November 2022. The purpose of the policy is to make residents aware of Resident Rights, to ensure the correlation between person-centered care and resident rights, and to be in full compliance with all rules, regulations, and standards regarding Resident's Rights.

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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. 37074 Based on observation, record review, staff interview and facility policy review the facility failed to properly check an alarmed door after a resident (Resident #1) exited the care center. The facility reported a census of 35 residents. Findings include: According to Resident #1's annual Minimum Data Set (MDS) assessment tool with a reference date of 10/2/2024 documented he had a Brief Interview of Mental Status (BIMS) score of 5. A BIMS score of 5 indicated severe cognitive impairment. Resident #1 did not exhibit wandering behavior during the review period, he utilized a walker and wheelchair for mobility. The MDS indicated he required partial/moderate assistance for chair/bed to chair transfer and toilet transfers. The Care Plan Focus Area with an initiated date of 8/31/2024 documented he was at risk for elopement. Staff were directed with the following: -Assist Resident #1 to his destination of choice when seen wheeling in the hallway (not to dining room). Resident does enjoy wheeling himself to the dining room. -Distract/redirect resident from wandering by offering diversional and/or structured activities, food, conversation, television, book. Prefers to socialize or observe activities in the day room. -Resident requires a door security system on unit and double doors closed on unit at all times when wandering. -Observe for verbalizations of wanting to leave the building. -Provide resident with activities of interest. -Updated on 12/17/24: every 15 minute checks. Record review revealed the following Progress Note on 12/17/2024 at 8:00 PM: At 7:31 PM Resident #1 eloped off the unit through the double doors to the Independent Living apartments trying to find a screw for his room. Resident #1 was assisted to his room, assessed with no injuries found. He was assisted to bed and 15-minute checks were implemented. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility Report #136837 revealed the facility investigation was initiated on 12/17/24. The report documented on 12/17/24 at 7:31 PM Resident #1 noted outside care center double doors leading into the independent bistro dining room. Resident stated he was looking for his room to find a screw. Resident returned to his room with no injuries noted by Staff C. Family notified and resident assisted to bed per his request and 15 minute safety checks initiated and care plan updated. The investigation found Staff F turned off the door alarm between 7:15 and 7:30 PM when he heard it sounding . He looked down the hall and saw a male resident in the hall heading toward the Bistro. Staff F mistakenly thought it was another resident that will get signed out by independent living. The investigation revealed steps taken including: -The resident transferred on 12/18/24 to the secure memory unit with family and physician approval. -New elopement assessment completed on all residents. -Door code changed. -Twice daily door checks implemented on the door alarm. -Staff education implemented. On 5/23/2025 at 12:59 PM it was observed to be roughly 62 feet from the double doors off of the dining room to the bistro. On 5/22/2025 at 1:55 PM the Administrator stated Staff F Cook/Chef should not have assumed that he thought it was a resident that was in Independent Living. He should have verified who it was. On 5/23/2025 at 10:33 AM Staff F stated since Resident #1 went out the double doors, he has been educated on letting nursing staff know the alarm sounded and if possible assist the person back to the care center side. That day he heard the alarm sounding, saw someone on the other side of the door but did not think too much of it. He only saw the back of the resident's head but was not 100% on who it was. Staff F should have checked on the resident and been more proactive. On 5/23/2025 at 12:49 PM in an email correspondence, the Administrator stated the protocol for staff to follow in the event a door alarm is activated is to notify the charge nurse if they are unable to state what set off the alarm. The facility provided a policy titled Wandering and Elopement Policy with a modified dated of December 2022. This facility promotes the least restrictive environment for all residents while recognizing the potential of residents wandering from the facility. The facility may utilize monitoring and alarm systems; sign in and out logs on all units/ households and maintain pictures of all residents. The facility will maintain a response plan for implementation in the event of a missing resident.