

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165794	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2025
NAME OF PROVIDER OR SUPPLIER Prairie Gate		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Electronic Health Record (EHR) review, policy review, family interview and staff interviews the facility failed to report an incident of possible physical abuse to the appropriate entity for 1 of 3 residents reviewed (Resident #1). The facility reported a census of 34 residents. Finding include: The Minimum Data Set (MDS) dated [DATE] documented Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. The MDS also documented a diagnosis of unspecified dementia without behavioral disturbances. Review of EHR dated 8/28/25 titled, Progress notes documented Resident #1 had a BIMS of 8 indicating moderate cognitive impairment at that time. Review of Resident #1's document titled, Clinical Summary dated 6/19/25 documented Resident #1 had a discharge diagnosis of right hip hematoma related to a ground level fall at home. Review of Resident #1's EHR titled, Progress notes revealed on 7/22/25 Resident #1 was sent to the Emergency Department (ED) via 911 ambulance and returned to the facility on 7/22/25 at 4:12 PM with a diagnosis of UTI. On 10/8/25 at 11:12 AM Staff C, RN Clinical Coordinator explained Resident #1 had passed away. Staff C stated she had no reports that staff were being rough with Resident #1. Staff C acknowledged it took longer to clean Resident #1 up at times because she had loose stools from C-diff. Staff C stated she had explained to Resident #1 that it took longer to clean her up and apply cream to the area because of this. Staff C stated if the resident reported staff being rough it would be reported as a grievance which then the Social Worker would have helped her with that. Staff C stated she had reported to the DON that Resident #1 had concerns when being cleaned up during the time she had a diagnosis of C-diff. Staff C stated she had spoke with Resident #1's daughter and a concern about staff being rough with the resident was never brought up. Staff C stated Staff D, the Previous DON left in July. On 10/8/25 at 11:28 AM Resident #1's daughter stated there was bruising noted on the legs related to a fall. Resident #1's daughter stated Resident #1 returned from the hospital and she spoke with Staff B, Licensed Practical Nurse (LPN) about the bruises that were on Resident #1's right hip. Resident #1's daughter stated Staff B said they were old bruises. Resident #1's daughter stated Resident #1 had complained about some female staff that would come in on overnight shifts and the female staff was pretty rough. Resident #1's daughter stated Resident #1 did not know who that staff was. Resident #1's daughter stated she and Resident #1 told the nurses about the incident. Resident #1's daughter stated she had spoken to Staff B about the bruising and how Resident #1 thought it was from the female staff turning her. Resident #1's daughter stated she had complained to her about it but did not believe that there was any mistreatment by staff at the facility when Resident #1 was at the facility after Staff B spoke to her. On 10/8/25 at 12:18 PM Staff A, Registered Nurse (RN) stated she had worked at the facility for 2 years and one month. Staff A acknowledged Resident #1 had several bruises on her body since admission. Staff A stated Resident #1 nor Resident #1's family never reported staff were rough with her during care. Staff A stated staff had never reported to her that any residents were treated rough including Resident #1. Staff A stated none of the nurses had ever reported to her as the charge nurse that a staff member was being rough with a resident. Staff A stated Staff B had never reported to her that staff on any shift were being rough with a resident including Resident #1. Staff A stated she would inform the Clinical Coordinator about any report of staff being rough with a resident because that would be considered abuse. Staff A stated if there was no Clinical Coordinator then she would report the incident to the Director of Nursing (DON) and if the DON was unavailable she would report it to the Administrator. On 10/8/25 at 1:36 PM Staff B, LPN stated she had worked at the facility for about 6 months. Staff B acknowledged she worked with Resident #1. Staff B stated she worked at the facility when Resident #1 first arrived at the facility. Staff B stated she was present on the first day of admission. Staff B stated Resident #1 had a lot of bruising on her legs from a fall at home. Staff B stated Resident #1 had really bad bruising on her thighs and hips the day she entered the facility. Staff B stated she spoke to Resident #1's family and to Resident #1 frequently. Staff B stated Resident #1 had bruising on her legs and it had not healed yet when she returned from the hospital visit. Staff B stated Resident #1's daughter acted like she did not know about the bruising. Staff B stated it was not from when Resident #1 was at the facility. Staff B stated body audits that were completed every week would reflect the bruising. Staff B stated the interaction with the daughter was passed on in report that day as well. Staff B stated there was a couple times Resident #1 had said one of the staff members was rough when turning her on overnight shift. Staff B stated Resident #1 stated she did not know the staff member's name but that she</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Electronic Health Record (EHR) review, policy review, family interview and staff interviews, the facility failed to investigate an allegation of abuse to the State Agency for 1 of 1 residents reviewed (Resident #1). The facility reported a census of 34 residents. Finding include: The Minimum Data Set (MDS) dated [DATE] documented Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. The MDS also documented a diagnosis of unspecified dementia without behavioral disturbances. Review of EHR dated 8/28/25 titled, Progress notes documented Resident #1 had a BIMS of 8 indicating moderate cognitive impairment at that time. Review of Resident #1's document titled, Clinical Summary dated 6/19/25 documented Resident #1 had a discharge diagnosis of right hip hematoma related to a ground level fall at home. Review of Resident #1's EHR titled, Progress notes revealed on 7/22/25 Resident #1 was sent to the ED via 911 ambulance and returned to the facility on 7/22/25 at 4:12 PM with a diagnosis of UTI. On 10/8/25 at 11:12 AM Staff C, RN Clinical Coordinator explained Resident #1 had passed away. Staff C stated she had no reports that staff were being rough with Resident #1. Staff C acknowledged it took longer to clean Resident #1 up at times because she had loose stools from C-diff. Staff C stated she had explained to Resident #1 that it took longer to clean her up and apply cream to the area because of this. Staff C stated if the resident reported staff being rough it would be reported as a grievance which then the Social Worker would have helped her with that. Staff C stated she had reported to the DON that Resident #1 had concerns when being cleaned up during the time she had a diagnosis of C-diff. Staff C stated she had spoke with Resident #1's daughter and a concern about staff being rough with the resident was never brought up. Staff C stated Staff D, the Previous DON left in July. On 10/8/25 at 11:28 AM Resident #1's daughter stated there was bruising noted on the legs related to a fall. Resident #1's daughter stated Resident #1 returned from the hospital and she spoke with Staff B, Licensed Practical Nurse (LPN) about the bruises that were on Resident #1's right hip. Resident #1's daughter stated Staff B said they were old bruises. Resident #1's daughter stated Resident #1 had complained about some female staff that would come in on overnight shifts and the female staff was pretty rough. Resident #1's daughter stated Resident #1 did not know who that staff was. Resident #1's daughter stated she and Resident #1 told the nurses about the incident. Resident #1's daughter stated she had spoken to Staff B about the bruising and how Resident #1 thought it was from the female staff turning her. Resident #1's daughter stated she had complained to her about it but did not believe that there was any mistreatment by staff at the facility when Resident #1 was at the facility after Staff B spoke to her. On 10/8/25 at 12:18 PM Staff A, Registered Nurse (RN) stated she had worked at the facility for 2 years and one month. Staff A acknowledged Resident #1 had several bruises on her body since admission. Staff A stated Resident #1 nor Resident #1's family never reported staff were rough with her during care. Staff A stated staff had never reported to her that any residents were treated rough including Resident #1. Staff A stated none of the nurses had ever reported to her as the charge nurse that a staff member was being rough with a resident. Staff A stated Staff B had never reported to her that staff on any shift were being rough with a resident including Resident #1. Staff A stated she would inform the Clinical Coordinator about any report of staff being rough with a resident because that would be considered abuse. Staff A stated if there was no Clinical Coordinator then she would report the incident to the Director of Nursing (DON) and if the DON was unavailable she would report it to the Administrator. On 10/8/25 at 1:36 PM Staff B, LPN stated she had worked at the facility for about 6 months. Staff B acknowledged she worked with Resident #1. Staff B stated she worked at the facility when Resident #1 first arrived at the facility. Staff B stated she was present on the first day of admission. Staff B stated Resident #1 had a lot of bruising on her legs from a fall at home. Staff B stated Resident #1 had really bad bruising on her thighs and hips the day she entered the facility. Staff B stated she spoke to Resident #1's family and to Resident #1 frequently. Staff B stated Resident #1 had bruising on her legs and it had not healed yet when she returned from the hospital visit. Staff B stated Resident #1's daughter acted like she did not know about the bruising. Staff B stated it was not from when Resident #1 was at the facility. Staff B stated body audits that were completed every week would reflect the bruising. Staff B stated the interaction with the daughter was passed on in report that day as well. Staff B stated there was a couple times Resident #1 had said one of the staff members was rough when turning her on overnight shift. Staff B stated Resident #1 stated she did not know the staff member's name but that she worked the overnight shift and was rough with her during care. Staff B</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Electronic Health Record (EHR) review, policy review, family interview and staff interviews the facility failed to complete an assessment when a resident reported bruising related to a staff being rough during care for 1 of 1 residents (Resident #1) reviewed. The facility reported a Census of 34 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] documented Resident #1 had a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. The MDS also documented a diagnosis of unspecified dementia without behavioral disturbances. Review of EHR dated 8/28/25 titled, Progress notes documented Resident #1 had a BIMS of 8 indicating moderate cognitive impairment at that time. Review of Resident #1's EHR titled, Progress Notes documented no assessment related to resident reports to Staff B, Licensed Practical Nurse (LPN) of Staff E Certified Nursing Assistant (CNA) being rough during care. Review of Resident #1's EHR titled, Assessments documented no assessment related to resident report to Staff B, LPN of Staff E being rough during care. Review of Resident #1's document titled, Clinical Summary dated 6/19/25 documented Resident #1 had a discharge diagnosis of right hip hematoma related to a ground level fall at home. Review of Resident #1's EHR titled, Progress notes revealed on 7/22/25 Resident #1 was sent to the ED via 911 ambulance and returned to the facility on 7/22/25 at 4:12 PM with a diagnosis of UTI. Review of Resident #1's EHR dated 6/19/25 titled, Body Audit completed by Staff F documented a large purplish bruise from fall at home on the left lateral outer thigh. Review of Resident #1's EHR's titled, Body Audit documented no sizes for any skin alterations for audits completed on 6/19, 6/24, 7/8, 7/17, 7/29, 8/5, 8/8, 8/15, 8/28, 9/22 and 9/23. On 10/9/25 at 8:06 AM Staff F, RN stated she worked at the facility for 2 years. Staff F stated Resident #1 had bruises all over her body during admission. Staff F acknowledged she was the nurse that completed the skin assessment upon Resident #1's admission. Staff F stated she could not remember which side of the body the hematoma was on Resident #1 during admission. Staff F acknowledged she had documented a large purplish bruise from fall at home on the left lateral outer thigh. Staff F acknowledged a hospital discharge document titled, Clinical Summary from admission to the facility described the large bruise on the right hip. Staff F stated she could not remember which hip may have gotten left and right confused during the assessment. On 10/8/25 at 11:28 AM Resident #1's daughter stated there was bruising noted on the legs related to a fall. Resident #1's daughter stated Resident #1 returned from the hospital and she spoke with Staff B, LPN about the bruises that were on Resident #1's right hip. Resident #1's daughter stated Staff B said they were old bruises. Resident #1's daughter stated Resident #1 had complained about some female staff that would come in on overnight shifts and the female staff was pretty rough. Resident #1's daughter stated Resident #1 did not know who that staff was. Resident #1's daughter stated she and Resident #1 told the nurses about the incident. Resident #1's daughter stated she had spoken to Staff B about the bruising and how Resident #1 thought it was from the female staff turning her. Resident #1's daughter stated she had complained to her about it but did not believe that there was any mistreatment by staff at the facility when Resident #1 was at the facility after Staff B spoke to her. On 10/8/25 at 1:36 PM Staff B, LPN stated she had worked at the facility for about 6 months. Staff B acknowledged she worked with Resident #1. Staff B stated she worked at the facility when Resident #1 first arrived at the facility. Staff B stated she was present on the first day of admission. Staff B stated Resident #1 had a lot of bruising on her legs from a fall at home. Staff B stated Resident #1 had really bad bruising on her thighs and hips the day she entered the facility. Staff B stated she spoke to Resident #1's family and to Resident #1 frequently. Staff B stated Resident #1 had bruising on her legs and it had not healed yet when she returned from the hospital visit. Staff B stated Resident #1's daughter acted like she did not know about the bruising. Staff B stated it was not from when Resident #1 was at the facility. Staff B stated body audits that were completed every week would reflect the bruising. Staff B stated the interaction with the daughter was passed on in report that day as well. Staff B stated there was a couple times Resident #1 had said one of the staff members was rough when turning her on overnight shift. Staff B stated Resident #1 stated she did not know the staff member's name but that she worked the overnight shift and was rough with her during care. Staff B explained she had determined the staff was Staff E. Staff B stated she completed an assessment on Resident #1 at the time and there were so many bruises on the legs. Staff B stated it was difficult to determine if anything Staff E had done caused any more bruising. Staff B stated she let the charge nurse know. Staff B stated the charge nurse would have been Staff A or Staff F Registered Nurse (RN) Staff R</p>		