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	08/15/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observations, resident interviews, staff interviews, facility investigation review, personnel file review and clinical record review the facility failed to ensure care was provided in a dignified manner for 3 of 14 residents (Resident #21, #11, and #6) reviewed for dignity. The facility also failed to ensure residents can exercise their rights by refusing cares for 1 of 3 residents (Resident #17) reviewed for resident rights. The facility reported a census of 32 residents. Findings include: 1. According to the Minimum Data Set (MDS) dated [DATE], Resident #21 had a Brief Interview for Mental Status (BIMS) score of 11 (moderate cognitive deficit). She required substantial assistance with dressing and was totally dependent with sit to stand transfers, chair to bed transfer and toilet transfers. Her diagnosis included cancer, anemia, heart failure and hemiplegia. The Care Plan, updated on 6/11/24, showed that Resident #21 required 2 staff assist with the sit to stand mechanical lift for transfers. She had self-care performance deficits related to weakness/impaired balance, hemiplegia affecting the right side and vertebra/back pain. She was unable to ambulate and required one assist to turn in bed. According to a facility incident investigation, on 8/1/24, a Family Member (FM) for Resident #21 called the facility and reported that Staff A, Certified Nurse Aide (CNA) had picked up Resident #21 and plopped her into her recliner on the previous evening shift. The FM indicated that she had previous concerns with Staff A manhandling the resident. Resident #21 was interviewed and stated that Staff A did not use a gait belt or a second person to assist with the transfer. When interviewed by the Administrator, Staff A reported that the resident was struggling to stand so he had her put her arms around his neck and used a gait belt to transfer. On 8/12/24 at 11:24 AM, Resident #21 said that Staff A was rough with her. She said that he picked her up by giving a bear hung up under her arms and it hurt her then he threw me down in the chair. She said that it hurt her back and typically, they would use two people and a gait belt to transfer her. She said that other residents had complained that he was rough also. (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/12/24 at 1:50 PM, the FM said she had witnessed Staff A transferring Resident #21 in a rough manner on more than one occasion. She said that Staff A would lift the resident, swing her around and just let her drop into the chair. She said that he did not have the temperament or the compassion to care for the elderly, and she had requested that he not provide cares to Resident #21. On 8/1/24 Resident #21 called the FM and said that Staff A had picked her up and let her fall into the chair, her back hurt, and she was crying. FM said that there were many times that Staff A would not use a gait belt, and he would just hold onto the resident on the back of the shirt. A review of the Personal Files revealed the following Supervisors/Managers Coaching Notes in the file for Staff A: -3/1/23 not consistently following team sheets when aiding or assisting with residents. He's been reminded multiple times that following the care plan is facility policy and the safest practice when caring for residents. - 7/7/23 Verbal Warning: it was reported that Staff A had been rushing through resident cares and not showing compassion to residents. While providing resident cares, Staff A had been rude, blunt, short tempered and did not show manners towards the residents. - 9/13/23 Written Warning: it was reported that on 9/2/23 and 9/13/23, Staff A did not follow the care plan or use appropriate equipment when transferring residents. - 9/20/23 Suspension: it was reported that on 9/18/23, Staff A rushed through resident care and did not show compassion to the residents. He was too rough and did not follow the team sheets. Numerous residents requested that he not work with them. The staff member was put on a 3-day suspension. Failure to meet expectations would result in termination. - 8/9/24 Notice of Termination: Reported that he transferred a resident correctly and rushed through cares. the team sheets stated that she should be transferred with one assist with one for safety when transferring. On 8/13/24 at 8:46 AM, Staff D, CNA said that Staff A would get a little rough, and in a hurry when transferring with the sit to stand. He said that he did tell one of the nurses one time about the concerns. On 8/13/24 at 8:56 AM Staff C, CNA said that a lot of the residents said they didn't want him to care for them, because he went too fast and he didn't listen to the residents to find out how they prefer to be transferred or when they ask him to slow down. On 8/13/24 at 9:50 AM, Staff B, Registered Nurse (RN) said she had some concerns with Staff A and how he transferred residents. She said he would get in a hurry and he wouldn't listen to the residents when they asked him to slow down and take it easy. On 8/14/24 on 6:27 AM Staff E, CNA said that several residents would ask Staff A to slow down when providing care. Many of resident didn't want him to provide care and they become more anxious if/when he was present. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/14/24 at 9:52 AM, the Care Coordinator acknowledged that Staff A had been disciplined previously for not following safe transfer techniques and rushing the residents. She said that Resident #21 was one assist with one stand by staff and Staff A was not following the care plan when he transferred her alone, without a gait belt, and by lifting her up under her arms. 2. According to the MDS dated [DATE], Resident #11 had a BIMS score of 13 (moderate cognitive deficit). She required partial assistance with dressing and footwear, and was totally dependent with sit to stand transfers with the mechanical lift. The Care Plan revised on 6/25/24, showed that Resident #11 had self-care performance deficits, impaired balance/gait of osteoporosis compression fracture. She had limited physical mobility was not able to ambulate. She had communication problems related to a hearing deficit and the potential for psychosocial well-being problems. Staff were directed to allow time to answer questions and verbalize her feelings, perceptions and fears. On 8/12/24 2:18 PM when asked about Staff A, Resident #11 said that he was very nervous, and always moving around and in a hurry. One night, the lights went out at the facility so she went to the room next door to check on her neighbor. Staff A saw her in the other resident's room, grabbed her by the shirt and yelled at her that she was not to be in another resident's room. He then pushed Resident #11 in her wheel chair back into her own room. She said that she did not like to see him coming into her room because I just don't know what he's going to do. 3. According to the MDS dated [DATE], Resident #6 had a BIMS score of 12 (moderate cognitive deficit). She was totally dependent on staff for toileting hygiene, dressing, sit to stand and transfers. The Care Plan last revised on 7/30/24, showed that Resident #6 had self-care performance deficits, weakness and impaired mobility. She was not able to ambulate, and required the help of 2 staff for transfers with the use of the sit to stand mechanical lift. She was at risk for pain related to muscle spasms, multiple sclerosis, tardive dyskinesia and seizures. On 8/12/24 at 10:55 AM Resident #6 said that she did not want Staff A to care for her because he got in a big hurry. She said that he would grab onto her to move her and she would always tell him to slow down. She said that one time, he got into a hurry when she was on the toilet and tried to transfer her and she fell . According to the Facility policy titled: Vulnerable Adult Abuse Prevention Plan modified January 2023 each resident had the right to be free from abuse including but not limited to verbal, sexual, physical and mental abuse, injuries of unknown origin, corporal punishment, misappropriation of property, mistreatment, neglect or involuntary seclusion. Any form of resident abuse would not be tolerated. The philosophy included service provided would be of the highest quality and designed to promote independence, dignity and holistic well-being. According to the facility policy titled: Gait Belts for Transfer and Ambulation dated December 2014, gait belts would be used for all transfers of weight bearing resident who require assistance with transfers and/or ambulation if indicated on the care plan. 47673 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. The MDS dated [DATE] for Resident #17 documented a BIMS of 12 indicating moderate cognitive impairment. Review of MDS also indicated Resident #17 required substantial / maximal assistance with showering and for self bathing. On 8/12/24 at 11:39 AM Resident #17 stated on the pm shift of 8/11/24 staff that told her that she had to shower. Resident #17 stated that she told the staff that she had showered the day before. Resident #17 stated the facility staff was talking down to her and not allowing her to say she did not want the shower. Resident #17 stated the facility staff told her that she had to shower. Resident #17 stated she once again told the facility staff that she showered the day before. Resident #17 stated the facility staff would not let her refuse. Resident #17 stated she did not know the facility staff's name. On 8/13/24 at 11:56 AM Resident #17 stated she did not feel like she was treated with dignity. Resident #17 stated she felt like she could not say no to the shower. Resident #17 stated she did not feel like the staff should be allowed on the facility grounds. Resident #17 stated she told her several times that she did not want to get into the shower but the staff was very forceful with her words. Resident #17 stated she did not feel was treated in a dignified manner because of the way she was spoken to by the facility staff. Resident #17 stated she just got into the shower because she felt like she did not have an option. Resident #17 stated she was not worried that she would be physically abused. Resident #17 stated the incident made her feel very upset and she felt like a child being told what to do. Review of document titled, 2024 Prairie Gate Shower Schedule: documented no signatures on Sunday 8/11/24 and signatures for Staff H and Staff J on 8/10/24. On 8/13/24 at 1:08 PM Staff J, Certified Nursing Assistant (CNA) stated she worked Saturday 8/11/24 on the am shift. Staff J stated she gave Resident #17 a shower on 8/11/24 during the day. Staff J stated Resident #17 told her she had a shower the night before. Staff J stated she spoke with Staff I the nurse working on 8/11/24. Staff J stated Staff I said the bath for Resident #17 was not documented. Staff J stated Staff I helped to transfer Resident #17 to the shower chair. Staff J stated she signed the shower sheet. Staff J stated she was not given a log in for the electronic health records (EHR). Staff J stated Staff I stated there were not enough people on the night shift prior. Staff J stated Resident #17 never said she did not want to take a shower. Staff J stated she signed the shower sheet and Staff H signed next to her when she came in on the pm shift that night. Staff J stated Staff H came in on 8/11/24 at 2pm and stated that she gave the shower the night prior. Staff J stated she was just in Resident 17 ' s room prior to lunch 8/13/24 and helped Resident #17 with applying hearing aids. Staff J stated Resident #17 did not seem mad or upset with her at that time. On 8/14/24 at 11:02 AM Staff I, Registered Nurse (RN) stated she worked 8/11/24 am shift. Staff I stated Staff J was the CNA that cared for Resident #17 and showered her that day. Staff I stated Staff J called her to Resident #17 room for transfer assistance. Staff I stated Resident #17 said she was showered the night prior. Staff I stated she entered Resident #17 room to ask if she would come down to breakfast and Resident #17 told her that she was not happy because of the shower situation. Staff I stated Resident #17 stated she wished the staff were all on the same page around there. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/14/24 at 11:53 AM Staff H stated she was familiar with Resident #17. Stated she worked 8/10/24 and 8/11/24 from 2:00 PM - 10:00 PM. Staff H stated she had given Resident #17 a bath on Saturday. Staff H stated she asked Resident #17 on 8/10/24 if she wanted to take a shower before dinner. Staff H stated Resident #17 stated she would be fine with taking one before dinner. Staff H stated she documented in the EHR that she did give the shower but forgot to mark it on the shower sheet. Staff H stated she ended up signing it the next evening when she had come back to work after Resident #17 had gotten another shower. Staff stated she found out that because Staff J told her that she completed the showers that were not given the night before. Staff H stated Resident #17 was very upset after taking both of the baths. Staff H stated Resident #17 told her Staff J was very mean when getting her into the shower when not listening to her and by telling her to just get into the shower. Staff H stated Resident #17 stated she did not feel abused. Staff H stated Resident #17 never said she was physically harmed by Staff J. Staff H stated Resident #17 talked about how upset she was about the way she had to take a second shower non-stop on 8/11/24 pm shift. On 8/14/24 at 1:16 PM the DON stated the staff were trained to re approach the resident if shower was refused. The DON stated the am nurse could have contacted the 2nd shift CNA to question about showers. The DON stated Staff I the nurse working am shift 8/11/24 was a brand new RN and did not look in the EHR. The DON stated if the resident refuses twice then staff are expected to notify the nurse and have the nurse attempt to approach the resident about bathing.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on observation, clinical record review, resident interview, and staff interview, the facility failed to maintain a safe, and comfortable environment by not changing the bed linen on 1 of 4 residents beds (Resident #9). The facility reported a census of 32 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #9 documented a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. On 8/12/24 at 3:36 PM Resident #9 stated she has not had her bedding changed in 2 weeks. Resident #9 stated the morning staff usually change the bedding. Review of the Medication Administration Record dated August 2024 revealed Resident #9 had a room number of 252. On 8/13/24 at 3:00 PM an observation revealed the same bedding on Resident #9's bed as on 8/12/24 observation. On 8/14/24 at 3:11 PM Staff G, Certified Nursing Assistant (CNA) stated she had worked at the facility since November of 2023. Staff G stated bed linen was changed per the schedule and rooms 250 through 252 are changed on Monday. Staff G stated she did not change bedding on Monday. Staff G stated usually the morning shift changes the linen and sometimes it was hard to get around to changing the linen. Staff G stated she cared for the residents in rooms 250 through 252. Staff G stated she told the next shift she had not changed the bed linen and asked the next shift to change the sheets if they had time. Staff G stated she spoke to Staff H, CNA about the need to change the bedding. On 8/14/24 at 3:56 PM the DON stated the CNA's are expected to strip the bed on the am shift. The DON stated the facility's expectation was that the bed linen for the residents were changed weekly. The DON stated there is a schedule for the bed linens to be changed on the wall in the nursing office. Review of documented titled, Bed Stripping Schedule found posted on the wall at the nurses station documented rooms [ROOM NUMBER] were to be completed on Mondays. On 8/14/24 at 4:19 PM Staff H CNA stated she did not change any bedding on 8/12/24 pm shift and am shift staff did not express to her that the bedding on any of the residents needed to be changed. Staff H stated she worked the hall with Resident #9 on 8/12/24 and cared for Resident #9 on 8/12/24.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 47673 Based on clinical record review, policy review, resident interview and staff interviews the facility failed to complete an accurate assessment that reflected the resident's status during the observation period of the MDS for 1 of 1 residents reviewed (Resident #1). The facility reported a census of 32 residents. Finding include: 1. The Minimum Data Set (MDS) assessment for Resident #1 dated 5/30/24 documented a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. On 8/12/24 at 2:36 PM Resident #1 stated she did not take insulin. Review of Resident #1's MDS revealed days of insulin injection as 1. Review of Resident #1's Medicaiton Administration Record (MAR) since admission for the months of May, June, July, and August 2024 revealed no physician orders for insulin. On 8/14/24 at 1:13 PM the DON stated the MDS should have been coded as an injection and not insulin. The DON stated the MDS was incorrectly coded. Review of the policy titled, Resident Assessment Instrument (RAI) Process, modified October 2022: MDS 3. 0, Care Area Assessments, Care Planning and Submission documented Minimum Data Set (MDS): is a core set of screening, clinical, and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare and/or Medicaid. An accurate assessment requires collecting data and information from multiple sources. These sources must include the resident and direct care staff on all shifts, and should also include the resident ' s clinical records, physician, and family, guardian or significant other as appropriate or acceptable. Documentation in the clinical record must support the items coded on the MDS.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on clinical record review, personnel file review, resident interview, staff interviews and policy review the facility failed to ensure that staff used safe transferring techniques for 1 of 3 residents reviewed. Resident #21 required the assistance of 2 with transfers and Staff A, Certified Nurse Aide (CNA), transferred her alone and without a gait belt. The facility reported a census of 32 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #21 had a Brief Interview for Mental Status (BIMS) score of 11 (moderate cognitive deficit). She required substantial assistance with dressing and was totally dependent with sit to stand transfers, chair to bed transfer and toilet transfers. Her diagnosis included cancer, anemia, heart failure and hemiplegia. The Care Plan, update on 6/11/24, showed that Resident #21 required 2 staff assist with the sit to stand mechanical lift for transfers. She had self-care performance deficits related to weakness/impaired balance, hemiplegia affecting the right side and vertebra/back pain. She was unable to ambulate and required one assist to turn in bed. According to a facility incident investigation, on 8/1/24, a Family Member (FM) for Resident #21 called the facility and reported that Staff A, Certified Nurse Aide (CNA) had picked up Resident #21 and plopped her into her recliner on the previous evening shift. The FM indicated that she had previous concerns with Staff A manhandling the resident. Resident #21 was interviewed and stated that Staff A did not use a gait belt or a second person to assist with the transfer. When interviewed by the Administrator, Staff A reported that the resident was struggling to stand so he had her put her arms around his neck and used a gait belt to transfer. On 8/12/24 at 11:24 AM, Resident #21 said that Staff A was rough with her. She said that he picked her up by giving a bear hung up under her arms and it hurt her then he threw me down in the chair. She said that it hurt her back and typically, they would use two people and a gait belt to transfer her. She said that other residents had complained that he was rough also. On 8/12/24 at 1:50 PM, the FM said she had witnessed Staff A transferring Resident #21 in a rough manner on more than one occasion. She said that Staff A would lift the resident, swing her around and just let her drop into the chair. She said that he did not have the temperament or the compassion to care for the elderly, and she had requested that he not provide cares to Resident #21. On 8/1/24 Resident #21 called the FM and said that Staff A had picked her up and let her fall into the chair, her back hurt, and she was crying. FM said that there were many times that Staff A would not use a gait belt, and he would just hold onto the resident on the back of the shirt. A review of the personal files revealed the following Supervisors/Managers Coaching Notes in the file for Staff A: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1) 3/1/23 not consistently following team sheets when aiding or assisting with of residents. He's been reminded multiple times that following the care plan is facility policy and the safest practice when caring for residents. 2) 7/7/23 Verbal Warning: it was reported that Staff A had been rushing through resident cares and not showing compassion to residents. While providing resident cares, Staff A had been rude, blunt, short tempered and did not show manners towards the residents. 3) 9/13/23 Written Warning: it was reported that on 9/2/23 and 9/13/23, Staff A did not follow the care plan or use appropriate equipment when transferring residents. 4) 9/20/23 Suspension: it was reported that on 9/18/23, Staff A rushed through resident care and did not show compassion to the residents. He was too rough and did not follow the team sheets. Numerous residents requested that he not work with them. The staff member was put on a 3-day suspension. Failure to meet expectations would result in termination. 5) 8/9/24 Notice of Termination: Reported that he transferred a resident correctly and rushed through cares. the team sheets stated that she should be transferred with one assist with one for safety when transferring. On 8/13/24 at 8:46 AM, Staff D, CNA said that Staff A would get a little rough, and in a hurry when transferring with the sit to stand. He said that he did tell one of the nurses one time about the concerns. On 8/13/24 at 8:56 AM Staff C, CNA said that a lot of the residents said they didn't want him to care for them, because he went too fast and he didn't listen to the residents to find out how they prefer to be transferred or when they ask him to slow down. On 8/13/24 at 9:50 AM, Staff B, Registered Nurse (RN) said she had some concerns with Staff A and how he transferred residents. She said he would get in a hurry and he wouldn't listen to the residents when they asked him to slow down and take it easy. On 8/14/24 on 6:27 AM Staff E, CNA said that several residents would ask Staff A to slow down when providing care. Many of resident didn't want him to provide care and they become more anxious if/when he was present. On 8/14/24 at 9:52 AM, the Care Coordinator acknowledged that Staff A had been disciplined previously for not following safe transfer techniques and rushing the residents. She said that Resident #21 was one assist with one stand by staff and Staff A was not following the care plan when he transferred her alone, without a gait belt, and by lifting her up under her arms. According to the facility policy titled: Gait Belts for Transfer and Ambulation dated December 2014, gait belts would be used for all transfers of weight bearing resident who require assistance with transfers and/or ambulation if indicated on the care plan.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on clinical record review, observations, resident interviews and staff interviews the facility failed to provide respiratory care and services in accordance with professional standards of practice for 1 of 2 residents reviewed (Resident #29) requiring the use of oxygen. The facility reported a census of 32 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #29 documented a Brief Interview for Mental Status (BIMS) of 11 indicating moderate cognitive impairment. Review of MDS also indicated Resident #29 required the use of oxygen. On 8/12/24 at 10:56 AM an observation of oxygen tubing without date. Observation of nebulizer mask on counter on paper towel also undated. On 8/12/24 at 10:56 AM Resident #29 stated she had not seen the tubing changed during her stay at the facility. On 8/13/24 at 2:58 PM Staff K, Registered Nurse (RN) stated oxygen supplies are usually changed out once a week on the night shift. Staff K stated she was not sure what day that respiratory supplies were changed out on during the week. On 8/13/24 at 3:00 PM Staff L, RN stated he did not know who or when the oxygen tubing and nebulizer equipment was changed out. Staff L stated he thought it was in the resident's care plan. Staff L stated he would talk to the DON and ask her. Staff L stated after talking to the DON there is a weekly duties sheet that has the pm shift changing oxygen supplies out every Saturday as well as a monthly check sheet that also makes sure tubing and respiratory supplies are changed out. On 8/13/24 at 3:25 PM Staff M stated nurses change the oxygen tubing. Staff M stated the tubing is changed on the am shift. Staff M stated also if tubing was soiled or broken. Staff M stated there is no scheduled time to change the oxygen tubing or nebulizer masks. Staff M stated he only changed the tubing if the tubing was soiled. Staff M stated he had not changed the tubing on Resident #29 since has worked at the facility. On 8/13/24 at 3:34 PM Staff N, RN stated he only works the PM / overnight shift. Staff N stated oxygen tubing is changed per the doctors orders. Staff N stated would also change oxygen tubing out when the tubing is soiled or broken. Staff N stated there was no routine or scheduled time to change the oxygen tubing. Staff N stated he did not change Resident #29's tubing on 8/10/24. Staff N stated he does not date the tubing when he does change the tubing. On 8/14/24 at 11:02 AM Staff I stated all oxygen tubing and resp equipment completed on overnight shift. Staff I stated oxygen tubing change was located in the TAR not on a specified date. Staff I stated the facility expected the oxygen tubing was dated with tape and the date would be applied to the tubing when changed. Staff I stated she did not know of any checklist that oxygen should be changed. (continued on next page)

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	165794	A. Building B. Wing	08/15/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/14/24 at 1:03 PM the DON stated the facility's expectation was the oxygen tubing would be changed weekly. The DON stated oxygen tubing change was on a nursing task calendar. The DON stated oxygen tubing should be dated. The DON stated going forward the task will be found on the treatment administration record.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on electronic health records (EHR), document review, resident interviews, and staff interviews the facility failed to provide nursing staff to assure residents safety by not responding to call lights in a timely manner for 4 of 4 residents reviewed (Resident #6, #8, #9, and #12). The facility reported a census of 32 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #9 documented a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. Review of EHR documented Resident #9 resided in room [ROOM NUMBER]. On 8/12/24 at 11:05 AM Resident #9 stated the facility was short of staff on the evening shift. Resident #9 stated sometimes there was only one person for the whole hall. Stated once in a while she had to wait longer than 15 minutes to have her call light answered. Review of document titled, Device Activity Report for room [ROOM NUMBER] documented on 8/14/24 call light was turned on at 8:56 AM and shut off at at 9:31 AM total of 34 minutes, 8/13/24 call light was turned on at 10:53 AM and shut off at 11:10 AM total of 17 minutes, 8/13/24 call light was turned on at 7:37 AM and shut off at 7:55 AM total of 17 minutes, and 8/8/24 call light was turned on at 7:54 AM and shut off at 8:13 AM total of 19 minutes. 2. The MDS dated [DATE] for Resident #12 documented a BIMS of 11 indicating moderate cognitive impairment. Review of EHR documented Resident #12 resided in room [ROOM NUMBER]. Review of document titled, Device Activity Report for room [ROOM NUMBER] documented on 8/11/24 call light was turned on at 7:20 AM and shut off at at 7:44 AM total of 24 minutes, 8/8/24 call light was turned on at 6:26 PM and shut off at 6:43 PM total of 17 minutes, and 8/8/24 call light was turned on at 6:46 AM and shut off at 7:08 AM total of 21 minutes. On 8/14/24 at 2:57 PM Resident #12 stated a couple days prior the call light was on and it rang and rang and rang so she took herself to the bathroom. Resident #12 stated she never had an accident related to call light length. Resident #12 stated she had to use the toilet a couple of times, had to wait longer than 15 minutes to prevent incontinence and took herself to the toilet. On 8/14/24 at 3:52 PM the DON stated the facility's expectation was less than 15 minutes and ideally less than 10 minutes for call light response. The DON acknowledged there were call lights that were longer than 15 minutes recently. The DON stated the staff have been educated to go by the nursing station to see which resident's room light has been on the longest and attend to that light first. 41785 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. According to the MDS dated [DATE], Resident #6 had a BIMS score of 12 (moderate cognitive deficit). She was totally dependent on staff for toileting hygiene, dressing, sit to stand and transfers. The Care Plan for Resident #6, last revised on 7/30/24, showed that she had self-care performance deficits, weakness and impaired mobility. She was not able to ambulate and required the help of 2 staff for transfers with the use of the sit to stand mechanical lift. She was at risk for pain related to muscle spasms, Multiple Sclerosis, Tardive Dyskinesia and seizures. On 8/14/24 3:21 PM a family member for Resident #6 said that she and other family members visited the facility on a regular basis, and they had noticed that the call light response took a long time. She said that there were several times that Resident #6 would call a family member from her cell phone and ask them to call the facility because her call light was not within reach and she couldn't find it. The resident had a small purse that she kept around her neck contained her cell phone. According to a 7-day, Device Activity Report, the call light responses included the following: On 8/14/24 at 9:15 AM response was 24 minutes On 8/12/24 at 8:58 AM response time was 26 minutes On 8/12/24 at 7:17 AM response time was 42 minutes On 8/11/24 at 8:25 AM response time was 47 minutes On 8/10/24 at 7:06 AM response time was 80 minutes On 8/8/24 at 9:39 AM response time was 60 minutes 4. According to the MDS dated [DATE], Resident #8 had a BIMS score of 15 (intact cognitive ability). She was totally dependent on staff for sit to stand, chair to bed transfer, toilet transfer. Her diagnosis included amyotrophic lateral sclerosis, muscle weakness, abnormalities of gait and mobility. The care plan revised on 6/28/24, showed that Resident #8 had self-care performance deficits, weakness, impaired range of motion to bilateral upper and lower extremities, impaired gait and balance. She required 2 staff assistance with the sit to stand on the mechanical lift. She was at risk for falls, and staff were to place the call light within reach and answer promptly. On 8/14/24 at 3:16 PM, Resident #8 said that it was not unusual for the call light response to take over an hour. She said that one night, it took 2 hours and 15 minutes for them to answer. The staff usually explained to her that they were busy answering other call lights. According to a 7-day, Device Activity Report, the call light responses included the following: On 8/13/24 at 9:43 PM response was 63 minutes On 8/12/24 at 7:24 AM response was 57 minutes (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/11/24 at 8:51 AM response was 36 minutes On 8/9/24 at 7:52 AM response was 25 minutes On 8/9/24 at 8:07 AM response was 40 minutes On 8/8/24 7:04 AM response was 58 minutes On 8/8/24 4:42 AM response was 57 minutes On 8/7/24 at 4:27 AM response was 33 minutes. A facility policy modified on November of 2022, and titled: Call Lights, indicated that the purpose of the policy was to respond promptly to residents call for assistance. Staff were directed to answer all call lights promptly whether or not they were assigned to the resident. Answer the call lights in a prompt, calm, courteous manner, turn off the call light as soon as possible.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 41785 Based on observation, staff interview and policy review the facility failed to post daily nursing census in a prominent area, accessible to visitors and residents. The facility reported a census of 32 residents. Findings include: In an observation on 8/13/24 at 2:46 PM it was discovered that the daily nursing census was posted in the nurse's station. There was no daily posting of the number of nursing and certified nurse aide hours. On 8/14/24 at 10:20 AM, Staff F Scheduling staff, said that she printed off the daily schedule with hours and posted it by the front door on the first floor. Given that the nursing home residents were all housed on the second floor, she said that she was not aware that it needed to be posted where the residents could see it. A facility policy modified on October 2022 titled, Nurse Hours Posting Policy, showed that nursing staff data would be posted in a designated public area by the staffing personnel. The data would be posted in a prominent place readily accessible to residents and visitors.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41785 Based on observation, interview and policy review the facility failed to ensure that food was stored according to safe practices. An initial tour of the kitchen revealed that there were many undated, open containers in the refrigerator and dry storage. The facility reported a census of 32 residents. Findings include: On 8/12/24 at 10:02 AM, the Dietary Manager (DM) provided an initial tour of the kitchen and the following items were found open and undated in the walk-in refrigerator: a. A tray of individual cups of fruit. b. A container of soup c. A bag of raw broccoli d. A bag of cilantro open. A container of raw chicken was sitting on the top shelf above other fresh foods. The dry storage area contained open and undated; 2 bags of potato chips, a bag of dehydrated cherries, and a container of cherries in the juice. The DM acknowledged that staff were expected to date packages so soon as they were opened. A facility policy titled; Safe Food Storage updated on 5/2019, stated that in order to ensure the safety for the food supply throughout, staff were to label, date and properly cover all food items upon opening of package. If food products were stored together in a refrigerator, they should be placed upon the shelf in the following order from top down: Prepared ready to eat Fish and Seafood items Whole cuts of raw beef Whole cuts of raw pork Ground or processed meats Raw poultry