

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 07/09/2025
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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on clinical record review, document review and staff interview the facility failed to protect residents from accidents and injuries for 1 of 3 residents (Resident #135) reviewed. The facility reported a census of 33 residents.</p> <p>Findings include:</p> <p>Review of the Minimum Data Set (MDS) for Resident #135 dated 6/10/25 documented an admission date of 3/27/25 and a Brief Interview for Mental Status (BIMS) score of 04 indicating severe cognitive impairment. The MDS documented diagnoses of vascular dementia, depression, rheumatoid arthritis, and cancer. The MDS revealed Resident #135 required partial/moderate assistance of a helper to complete transfers and used a wheelchair for mobility.</p> <p>A review of the facility self report documented on 6/25/25 at 1:50 pm Staff A, Certified Nursing Assistant (CNA) assisted Resident #135 after a meal with the wheelchair transfer. Resident #135 did not have her feet on the foot pedals and fell out of the wheelchair during the transfer, sustaining a contusion to the left forehead.</p> <p>A review of the electronic communication document titled Patient Fall between the facility and the Hospice Physician on 6/26/25 documented the following: a witnessed fall, facility aide was transporting patient from the dining room to her recliner in community room when she fell out and hit left eyebrow area and right arm on floor. 1.5 cm x 2.5 cm abrasion with blue bruising noted around abrasion. The physician confirmed an injury had occurred.</p> <p>A review of the document titled Resident Occurrence Report dated 6/26/25 revealed analysis and summary of causal factors as follows: Resident is declining, mental status declined that she suddenly/accidentally fell herself in the wheelchair with short-term intervention to place to bed for comfort measures and long-term intervention to tilt in space wheelchair for proper positioning.</p> <p>A review of the document titled Care Plan revealed Resident #135 had limited physical mobility related to weakness/impaired mobility/self-care abilities, and intervention in place to use a tilt in space wheelchair for mobility, date Initiated 02/14/2022.</p> <p>A review of the document titled Escorting Resident With Wheelchair dated June 25, 2025 documented all-staff training was provided following the incident with Resident #135.</p> <p>(continued on next page)</p>

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 07/08/25 at 9:15 am the Administrator stated the video camera footage showed Staff A, pulled Resident #135 wheelchair away from the dinner table and started pushing her forward while the resident's feet were under the foot pedals. The Administrator confirmed Staff A did not take time to place Resident #135 feet onto the foot pedals. As soon as they left the dining room and came around the corner, the resident fell out of the wheelchair.</p> <p>On 07/08/25 at 10:07 am in an interview with the Director of Nursing (DON), she confirmed Resident #135 did not have her feet on foot pedals during the transfer and her expectation was that the staff transfer residents who are in wheelchairs with feet placed on foot pedals.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review, and staff interview the facility failed to provide appropriate infection prevention practices when providing care to a resident with a catheter, that was on Enhanced Barrier Precautions (EBP) for 1 of 3 reviewed (Resident #24). The facility reported a census of 33 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) dated [DATE] for Resident #24 documented a Brief Interview for Mental Status (BIMS) score of 7 indicating severe cognitive impairment. The MDS also documented utilization of an indwelling catheter.</p> <p>An observation of catheter cares completed on Resident #24 on 7/8/25 at 9:48 AM by Staff B, Certified Nursing Assistant (CNA) revealed Staff B completed hand hygiene, applied gloves, applied gown, cleansed catheter tubing with alcohol swab about 4 - 6 inches down tubing, and removed gloves. She did not complete hand hygiene. She applied new gloves, placed barrier on the ground, obtained graduate, removed the tip of the catheter, emptied urine into the graduate (450 mL), cleansed the tip of the catheter with alcohol wipe, replaced the tip of the catheter, replaced the catheter bag in the privacy bag, removed gloves, and did not complete hand hygiene. She applied gloves, picked up the graduate, emptied the graduate into the toilet, turned on the faucet with gloves on in the bathroom to fill graduate with water, emptied the graduate into the toilet, removed gloves, removed gown, and completed hand hygiene.</p> <p>On 7/8/25 at 10:04 AM the DON stated she did not expect the catheter tip to be cleansed prior to emptying but after urine was emptied. The DON stated the facility's expectation was hand hygiene would be completed between glove changes and when moving from one contaminated area of the body to the catheter.</p> <p>Review of policy dated 2020 titled, Infection Control Standard Precautions documented it was the policy of the facility that hand hygiene procedures would be adhered to in order to prevent the transmission of pathogens. Hand hygiene should be performed before and after contact with the resident, after contact with visibly contaminated surfaces, before donning personal protective equipment (PPE), and after removing PPE.</p>		