DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0432	A. BUILDING: _____ B. WING _____	C 06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE GATE MEMORY CARE	**16 VALLEY VIEW DRIVE CO BLUFFS, IA 51503**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 4 Number of tenants with cognitive impairment: 8 Total census: 12 No regulatory insufficiencies were cited during the investigation of Complaint #108363-C. The following regulatory insufficiency was cited during the recertification visit conducted to determine compliance with certification rules for an Assisted Living Program for People with Dementia.	A 000		
A 340	481-67.9(4)a Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: a. The program's newly hired registered nurse shall within 60 days of beginning employment as the program's registered nurse document a review to ensure that staff are sufficiently trained and competent in all tasks that are assigned or delegated. This REQUIREMENT is not met as evidenced by: Based on interview and record review the	A 340		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0432	A. BUILDING: _____ B. WING _____	C 06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE GATE MEMORY CARE	**16 VALLEY VIEW DRIVE CO BLUFFS, IA 51503**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 340	Continued From page 1 delegating nurse failed to ensure 2 of 2 staff reviewed were sufficiently trained within 60 days of her employment (Staff A, B). Finding follows: Record review on 6/13/23 reviewed the delegating nurse was hired on 12/28/2022. There was no evidence the nurse completed a review within 60 days to ensure Staff A (hired 9/18/20) and Staff B (hired 6/10/22) were sufficiently trained and competent in all tasks. Both staff had previously received training/delegations from a former nurse. When interviewed on 6/13/23 at 10:07 a.m. the delegating nurse confirmed she had not completed the required review to ensure staff were sufficiently trained and competent.	A 340		