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
	S0277	A. BUILDING: _____ B. WING _____	C 07/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS SENIOR LIVING	2903 F AVENUE NW CEDAR RAPIDS, IA 52405

(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 are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive disorder: 43 Number of tenants with cognitive disorder: 0 Total census of Assisted Living Program: 43 The following regulatory insufficiency was cited during the investigation of Incident # 98189-I.	A 000	8/19/21	
A 225	481-67.4(5) Program Notification to Department 481-67.4(231B,231C,231D) Program notification to the department. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: 67.4(5) When a tenant attempts suicide, regardless of injury. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to notify the Department within 24 hours or the next business day of an attempted suicide (Tenant #1) Findings include: Review of an incident report dated 6/17/21, Tenant #1 pushed his pendent button on 6/17/21 at 5:30 AM. Staff A and Staff D responded to the pendent push at 5:35 AM. Prior to entering Tenant #1's room at 5:35 AM, Staff A had last seen him during a safety head check in bed at 4:30 AM. Upon entering Tenant #1's room at 5:30 AM, Staff A observed Tenant #1 laying on his bed	A 225	Plan of Correction is attached D	

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
	S0277	A. BUILDING: _____ B. WING _____	C 07/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS SENIOR LIVING	2903 F AVENUE NW CEDAR RAPIDS, IA 52405

(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 225	Continued From page 1 angrily yelling at staff. Staff noticed two pill bottles on his table with pills spilled on the table and floor. The bottles were empty. Staff A asked Tenant #1 if he took some of the pills and he stated he had approximately 30 minutes prior. Staff also noted Tenant #1's locked medication drawer had been forced open and broken. Tenant #1 continued to be threatening toward the staff members. Staff members left the apartment and called 911 and waited outside of the apartment until emergency personnel arrived. Tenant #1 was admitted to the hospital for monitoring and psychiatric evaluation. At approximately 7:30 AM after reviewing the pills spilled in the room and the medication administration records (MARS), the Health Care Director determined Tenant #1 took approximately 37 tablets of Seroquel 25 mg and 60 tablets of Seroquel 50 mg. On 6/30/21, a review of the Department intake revealed the Program self-reported the incident on 6/24/21. On 7/6/21 at 3:54 PM, the Health Care Director confirmed they were initially instructed by a corporate staff member the incident was not required to be reported. A second corporate staff member reviewed the incident on 6/24/21 and informed the Program administration that the incident was to be reported to the Department. On 6/24/21, the Program reported the suicide attempt by Tenant #1 on 6/17/21.	A 225		

2903 F AVE NW
CEDAR RAPIDS, IA 52405

PRAIRIE HILLS
CEDAR RAPIDS
ASSISTED LIVING COMMUNITY

PHONE: 319-390-7700
PRAIRIEHILLSCR.COM

Incident #: 98189-I.

Plan of Correction (POC) Submitted For:

- Investigation Date: 6/30/21 through 7/6/2021.

8/19/21

A. 481-67.4(5) Program Notification to Department

481-67.4(231B,231C,231D) Program notification to the department. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available:
67.4(5) When a tenant attempts suicide, regardless of injury.

Program POC:

1. Elements detailing how insufficiency was corrected for residents:

a. Program reported incident to Department.

2. Actions program taking to protect tenants in similar situations:

a. The Program Director has reviewed current regulations and requirements of Program Notification to Department with attempted suicide, regardless of injury.

3. Measures taken to ensure problem does not recur:

a. The Program Director and or Community Representative will report incidents within 24 hours, or the next business day, by the most expeditious means available.

The Program will be in substantial compliance by August 4, 2021.

Disclaimer for POC

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the program of the truth of the facts alleged or conclusions set forth in the statement of regulatory insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state law.

8/13/21