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 06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT CEDAR RAPIDS	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 impairment: 43 Number of tenants with cognitive impairment: 0 Total census: 43 The following regulatory insufficiencies were cited related to the investigation of Complaints #126260-C and #127806-C and the recertification visit conducted to determine compliance with certification an Assisted Living Program:	A 000	See attached POC 7/31/25	
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow established policies and procedures for 1 of 2 discharged tenants (Tenant C1) related to medication administration, 1 of 2 discharged tenants (Tenant C1) related to the completion of incident reports, 1 of 2 discharged tenants (Tenant C1) related to the abuse policy and 4 of 4 current tenants reviewed (Tenants #1, #2, #3 and #4) related to the documentation of tasks. Findings following: 1. When interviewed on 6/19/25 at 11:51 a.m. the Director of Health and Wellness (DHW) said she	A 150		

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was not sure of the timeframe but Tenant C1 said Staff B threw her into the wheelchair. The DHW asked Tenant C1 to describe what happened and Tenant C1 said the staff held on to her and guided her back into the chair and grabbed the back of her pants. The DHW said there was an older bruise located below the tenant's clavicle, that was faded yellow in color. She had no concerns related to the bruise. She said Tenant C1 did not like anyone helping her. Staff B said she guided her into the chair; otherwise she was going to end up on the arm rest of the wheelchair. She said after it was reported to her, Tenant C1 told the DHW she did not want Staff B in her apartment. She said she did not think anything was documented related to above allegation with Tenant C1 and Staff B.

When interviewed on 6/19/25 at 9:18 a.m. the Executive Director (ED) said Tenant C1 had thought Staff B had bruised her shoulder during a transfer. She said Tenant C1 said Staff B was loud and kept focusing on how loud she was. The ED did not see the bruise. She said Staff B said Tenant C1 was about to fall and went behind her to give her a boost back into her wheelchair. She said it occurred maybe a couple of months ago. She said Tenant C1 did not care for Staff B and did not want her in the apartment.

When interviewed on 6/19/25 at 10:32 a.m. Staff B said Tenant C1 did not like her and maybe it was because she thought she had a loud voice. At one time Tenant C1 said she was too rough with her. The transfer was from her bed to her wheelchair, and she guided the tenant's hips back into the chair. The way Tenant C1 moved into the wheelchair made her think she was going to fall. She said absolutely no force was used with the tenant.

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A 150	Continued From page 2 The Program reported there had been no internal investigations related to allegation of abuse for the past three months. Review Tenant C1's file on 6/17/25 and 6/18/25 revealed no documentation of the alleged incident, follow up assessment of Tenant C1's concerns or her preference not to have Staff B in her apartment. Tenant C1 was staged at a 1 on the Global Deterioration Scale, which indicated no cognitive decline. Her service plan indicated she used a manual wheelchair. She required staff to escort or push her in the wheelchair due to a physical limitation. Review of the Program's Abuse, Neglect, and Exploitation policy and procedure indicated any staff that had knowledge of, or was told by a tenant or staff of, an incident which appeared to be abuse, would be reported to the Director of Health and Wellness and Director and Executive Director. In all cases the Executive Director would be informed as soon as possible. Staff would take seriously any tenant comments about potential abuse or unusual signs that indicated abuse occurred. Immediate steps would be taken to ensure the tenant was protected from potential future abuse during the investigation. The alleged perpetrator would have no contact with tenants during the investigation. The tenant would be interviewed and responses would be documented. Witnesses or others people would be interviewed. The family and physician would be notified immediately. Tenant C1's initial report of the alleged concern, Tenant C1's interview, Staff B's interview and the assessment of the bruising reported by Tenant C1 were not documented. There was no	A 150		

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documentation provided of the family or physician notification.

When interviewed on 6/19/25 at 3:30 p.m. the ED and the DHW both confirmed there was no documentation of the investigation related to the allegation made by Tenant C1.

2. Review of Tenant C1's file revealed Progress Notes indicated the following:
- On 3/19/25 was seen by home health for a catheter change, skin breakdown to the right second toe, left inner thigh and right inner thigh. Triad cream was to be used.
- On 3/26/25 was seen by home health for a catheter check, physical assessment and wound check. It was noted she had wound on the right second toe, right buttock, right inner thigh and left posterior thigh. Orders were received to apply Triad cream twice daily and as needed to help heal wounds. Apply a Band-Aid to the right second toe daily.
- On 4/7/25 a fax was sent to the primary care provider (PCP) regarding an open sore to the right inner/upper thigh that was bleeding and painful. The left upper/inner thigh was raw, red and sore.
- On 4/18/25 was seen by home health for a catheter change, vitals, physical assessment and skin check. There were "pimples" noted to the groin and perineal area. There were wounds on the bilateral upper thigh and buttock. It was noted to provide offloading every one to two hours, good perineal care, to not wear Depends when possible and apply barrier cream as directed.
- On 4/23/25 was seen by home care on 4/22/25 and it was noted the wounds to the bilateral/posterior legs were improving. Mepilex was applied to right second toe. A new order was pending for tubi grips for the bilateral lower

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A 150	Continued From page 4	A 150		

extremities.
- On 4/24/25 an order was received for cephalexin 500 mg, four times daily for 7 days. It noted if her foot looked worse or if she developed red streaks or a fever to send her to the emergency department.
- On 4/28/25 was seen by home care. A new wound was noted to the left heel that measured 2 centimeters (cm) by 3 cm. The PCP was notified of the wound. Mepilex AG was ordered to the heel and she was to be assessed by podiatry on 4/29/25. Instructions were received to offload/float her heels, complete good hand hygiene and perineal care.
- On 4/30/25 was seen at the foot care clinic where it was noted she had a pressure ulcer to the back of the left heel. The toe ulcer and left heel were debrided. An appointment was set up at the wound clinic. It was ordered to continue with Mepilex AG to dressing for the right second toe and to keep pressure off of the toes and the back of the left heel. It was also noted to put a pillow under lower leg when sleeping.
- On 5/8/25 was seen at the healing center for the pressure injury of the left heel (not able to be staged), pressure injury of the right thigh (stage 3), pressure injury of toe of right foot (stage 3), skin ulcer to the second toe of right foot (fat layer exposed). A new order was received for doxycycline 100 mg capsules, take 1 capsule twice daily for 14 days.
- On 5/9/25 was seen by home care on 5/8/25 and would be discharged on Monday due to a higher level of care needed. She was not recertified by home care. The program would discuss private duty options for dressings.
- On 5/9/25 tenant had chronic wounds on the heel and mid foot. The heel was bleeding and prior fluid filled lesion on the top of her foot was not bruised and painful. The wound clinic provider

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recommended a higher level of care. Tenant C1 was educated on importance of proper wound care and need for a care center that would provide consistent dressing changes.
- On 5/15/25 Tenant C1 was instructed to follow up with the wound clinic to have someone come in for daily dressing changes. The Director of Health and Wellness (DHW) and the Executive Director (ED) were currently completing wound cares.
- On 5/23/25 it was noted nurse facility staff currently provided wound care daily.
- On 5/27/25 was seen at the wound clinic for a skin ulcer of the second right foot with a fat layer exposed, pressure injury of the right thigh (stage 3) and pressure injury of the left heel (not able to be staged). Current wound care orders were to be continued.
- On 6/3/25 Tenant C1 was discharged to a higher level of care.

Record review revealed Tenant C1's medication administration records (MARs) did not reflect the orders for daily wound care completed by the DHW and the ED.

The Program's Medication Management policy and procedure indicated staff would follow the six rights of medication administration. That included right documentation and to document with recording initials after it was completed.

When interviewed on 6/19/25 at 11:51 a.m. the DHW said Tenant C1's wound care was completed as ordered unless she had an appointment. The feet and heel wounds were completed by herself and the ED. Tenant C1 completed the right and left thigh wound care.

When interviewed on 6/18/25 at 10:40 a.m. an

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interview with ED and DHW was completed. Home health discharged Tenant C1 with one day notice. The home care nurse said Tenant C1's family was going to complete the wound care but the family was not aware of that. Tenant C1 was supposed to follow up with the wound clinic and get private duty but she did not do so. The ED and DHW completed her wound care until she was discharged from the Program to a higher level of care on 6/3/25. The completion of the wound care was not documented on a task log or MAR.

In summary, Tenant C1 had home care and had various wounds and treatments. She was discharged from home care on 5/9/25 and the Executive Director and Director of Health and Wellness completed her wound cares for the feet and heel until she was discharged from the Program to a higher level of care. The wound cares (provider ordered) were not documented as completed on the MAR per policy and procedure.

3. On 6/17/25 and 6/18/25 review of Tenant C1's file revealed a Progress Note dated 4/21/25 indicating it was reported Tenant C1 had bruising. There was bruising on her bilateral feet and toes (very swollen). Her right shoulder also had bruising that went down her arm.

Tenant C1's file lacked an incident report related to the bruising of unknown etiology.

When interviewed on 6/19/25 at 11:51 a.m. the DHW said she was not sure of the timeframe but Tenant C1 said Staff B threw her into the wheelchair. The DHW asked Tenant C1 to describe what happened and Tenant C1 said the staff held on to her and guided her back into the chair and grabbed the back of her pants. The

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A 150	Continued From page 7 DHW said there was an older bruise located below the tenant's clavicle, that was faded yellow in color. She had no concerns related to the bruise. Further review revealed Tenant C1's file lacked an incident report related to the bruising of unknown etiology. The Program's policy and procedure related to incident reports indicated an internal occurrence report would be completed by staff for all unusual occurrences, injuries, injuries of unknown origin and incidents. When interviewed on 6/19/25 at 11:51 a.m. the DHW confirmed all incident reports were provided for the tenants reviewed. 4. Review of tenant files on 6/17/25 and 6/18/25 revealed the following: - Tenant #1's task logs for April, May and June 2025 reflected tasks were not documented as completed including for bathing, dressing (socks) and laundry. - Tenant #2's task logs for April, May and June 2025 reflected tasks were not documented as complete including for garbage removal, laundry and visual checks. - Tenant #3's task logs for April, May and June 2025 reflected tasks were not documented as completed including for daily weights, denture care, laundry, garbage removal, bathing and toileting. - Tenant #4's task logs for April, May and June 2025 reflected tasks were not documented as completed including for activity reminders, meal reminders, garbage removal, visual checks and bathing.	A 150		

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A 150	Continued From page 8 Nurse Delegation (standard of practice) for Point of Care (tasks) indicated to ensure proper documentation had been completed on all tenants. When interviewed on 6/19/25 at 11:51 a.m. the DHW confirmed all task logs were provided for the tenants reviewed. When interviewed on 6/19/25 at 11:51 a.m. the Executive Director confirmed a task should be documented after the task was completed and by the end of the shift.	A 150		
A 361	481-67.9(4)f 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: f. Services shall be provided to tenants in accordance with the training provided. This STANDARD is not met as evidenced by: Based on interview and record review the Program failed to have staff provide services in accordance with the training provided. This pertained 1 of 1 staff observed on a medication pass (Staff A). Findings follow: 1. A medication pass was observed on 6/17/25 at 11:06 a.m. with Staff A. Staff D observed the medication pass for training purposes as a new hire. Staff A administered medications to three tenants (Tenants #5, #6 and #7). She signed off	A 361		

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A 361	Continued From page 9 the administration of medications to Tenant#5 and Tenant #7 prior to the administration of their medications. 2. Record review revealed Staff A had nurse delegations completed 8/15/23. The delegation for a Medication Management indicated staff would record their initials after administration of medications on the correct date on the medication administration record. 3. When interviewed on 6/19/25 at 11:51 a.m. the Director of Health and Wellness confirmed medications were supposed to be documented after they were administered to tenants.	A 361		
A 145	481-69.22(3) Evaluation of Tenant 69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review the	A 145		

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Program failed to complete evaluations as needed with significant change for 2 of 4 current tenants (Tenant #3 and Tenant #4) and 1 of 2 of discharged tenants reviewed (Tenant C1). Findings follow:

Record review on 6/17/25 and 6/18/25 revealed the following:

1. Tenant #3's file revealed change of condition evaluations were completed on 4/1/25, 4/10/25, and 6/17/25, post hospitalizations. The evaluations completed with significant change included a cognitive evaluation but did not include an evaluation of health or function.

2. Tenant #4's file revealed a change of condition evaluation was completed on 4/14/25. A cognitive evaluation was completed; however, an evaluation of health and function was not completed.

3. Tenant C1's file revealed Progress Notes indicating the following:
- On 3/19/25 was seen by home health for a catheter change, skin breakdown to the right second toe, left inner thigh and right inner thigh. Triad cream was to be used.
- On 3/26/25 was seen by home health for a catheter check, physical assessment and wound check. It was noted she had wound on the right second toe, right buttock, right inner thigh and left posterior thigh. Orders were received to apply Triad cream twice daily and as needed to help heal wounds. Apply a Band-Aid to the right second toe daily.
- On 4/7/25 a fax was sent to the primary care provider (PCP) regarding an open sore to the right inner/upper thigh that was bleeding and painful. The left upper/inner thigh was raw, red

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and sore.
- On 4/18/25 was seen by home health for a catheter change, vitals, physical assessment and skin check. There were "pimples" noted to the groin and perineal area. There were wounds on the bilateral upper thigh and buttock. It was noted to provide offloading every one to two hours, good perineal care, to not wear Depends when possible and apply barrier cream as directed.
- On 4/23/25 was seen by home care on 4/22/25 and it was noted the wounds to the bilateral/posterior legs were improving. Mepilex was applied to right second toe. A new order was pending for tubi grips for the bilateral lower extremities.
- On 4/24/25 an order was received for cephalexin 500 mg, four times daily for 7 days. It noted if her foot looked worse or if she developed red streaks or a fever to send her to the emergency department.
- On 4/28/25 was seen by home care. A new wound was noted to the left heel that measured 2 centimeters (cm) by 3 cm. The PCP was notified of the wound. Mepilex AG was ordered to the heel and she was to be assessed by podiatry on 4/29/25. Instructions were received to offload/float her heels, complete good hand hygiene and perineal care.
- On 4/30/25 was seen at the foot care clinic and it was noted she had a pressure ulcer to the back of the left heel. The toe ulcer and left heel were debrided. An appointment was set up at the wound clinic. It was ordered to continue with Mepilex AG to dressing for the right second toe and to keep pressure off of the toes and the back of the left heel. It was also noted to put a pillow under lower leg when sleeping.
- On 5/8/25 was seen at the healing center for the pressure injury of the left heel (not able to be staged), pressure injury of the right thigh (stage

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3), pressure injury of toe of right foot (stage 3), skin ulcer to the second toe of right foot (fat layer exposed). A new order was received for doxycycline 100 mg capsules, take 1 capsule twice daily for 14 days.
- On 5/9/25 was seen by home care on 5/8/25 and would be discharged on Monday due to a higher level of care needed. She was not recertified by home care. The program would discuss private duty options for dressings.
- On 5/9/25 tenant had chronic wounds on the heel and mid foot. The heel was bleeding and prior fluid filled lesion on the top of her foot was not bruised and painful. The wound clinic provider recommended a higher level of care. Tenant C1 was educated on importance of proper wound care and need for a care center that would provide consistent dressing changes.
- On 5/15/25 Tenant C1 was instructed to follow up with the wound clinic to have someone come in for daily dressing changes. The Director of Health and Wellness (DHW) and the Executive Director (ED) were currently completing wound cares.
- On 5/23/25 it was noted nurse facility staff currently provided wound care daily.
- On 5/27/25 was seen at the wound clinic for a skin ulcer of the second right foot with a fat layer exposed, pressure injury of the right thigh (stage 3) and pressure injury of the left heel (not able to be staged). Current wound care orders were to be continued.

Cognitive evaluations were completed on 2/24/25 and 5/27/25; however, health and functional evaluations were not completed at those intervals. Evaluations were not completed when wound clinic visits started, with the new wound on the heel, antibiotics related to the wounds, and when she was discharged from home care and

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PRAIRIE HILLS AT CEDAR RAPIDS	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 145	Continued From page 13 nursing staff completed the wound cares. 4. When interviewed on 6/19/25 at 11:51 a.m. the DHW confirmed all evaluations were provided for the tenants reviewed.	A 145		
A 290	481-69.25(1)i Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to document nurse's notes by exception. This pertained to 1 of 4 current tenants reviewed (Tenant #4) and 1 of 2 discharged tenants reviewed (Tenant C2). Findings follow: 1. Review of Tenant #4's file on 6/18/25 revealed Progress Notes indicating the following: - On 4/3/25 was seen by her medical provider. Tenant #4 had a wet cough, mostly after eating. - On 4/10/25 an order was received for albuterol inhalation solution 2.5 milligram (mg), 3 milliliters (ml), 1 vial via nebulizer, three times daily, for five days. It also indicated to administer 1 vial via nebulizer every six hours as needed for wheezing, congestion and/or shortness of breath. - On 4/15/25 an order was received for doxycycline 100 mg capsules, one capsule by	A 290		

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A 290	Continued From page 14	A 290		

mouth twice daily with food or 10 days. An order was also received for prednisone 20 mg tablet, 2 tablets by mouth for four days and then take one tablet by mouth for four days.

Continued review revealed nurse's notes were not completed by exception related to the completion of the prednisone, doxycycline and the scheduled albuterol breathing treatment or follow up on Tenant #4's cough.

2. On 6/17/25 and 6/18/25 review of Tenant C2's file revealed an After Visit Summary (AVS) dated 1/12/25 indicated Tenant C2 was seen in the emergency department (ED) on 1/12/25 and had diagnoses of pneumonitis and chest pain. A new medication was ordered (doxycycline). Tenant C2 administered his own medications.

An AVS dated 1/24/25 indicated Tenant C2 was seen at a cardiology clinic related to chest pain, dizziness and dyspnea on exertion. A new medication was ordered (nitroglycerin).

A History and Physical document dated 2/27/25 indicated over the past couple of weeks he had symptoms that included rhinitis, productive cough, fatigue and malaise. He had been to the ED recently and was diagnosed with pharyngitis and was discharged. He had been resting more during the day but his symptoms had not improved. He tested negative for COVID-19. The plan listed on the document indicated he had an upper respiratory infection (URI) for almost two weeks and it would be treated with an antibiotic (azithromycin). It was noted to consider a chest x-ray for new, worsening or persistent symptoms.

Further review revealed nurse's notes were not completed by exception including when Tenant

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A 290	Continued From page 15 C2 was seen in the ED on 1/12/25, with the cardiology visit on 1/24/25 and to follow up after the antibiotic was completed to ensure no further symptoms of a URI. 3. When interviewed on 6/19/25 at 11:51 a.m. the Director of Health and Wellness confirmed all nurse's notes were provided for the tenants reviewed.	A 290		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans as needed for 3 of 4 current tenants (Tenants #2, #3 and #4) and 2 of 2 former tenants reviewed (Tenant C1 and Tenant C2). Findings follow: Record review on 6/17/25 and 6/18/25 revealed the following: 1. Tenant #2's file revealed Progress Notes indicating the following: - On 5/22/25 a therapy note for 5/21/25	A 350		

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indicated physical therapy (PT) evaluated her on 5/19/25 for lower extremity strength, balance and gait, three times per week. Speech therapy (ST) was to evaluate on 5/22/25 related to cognition.
- On 5/28/25 orders were received to obtain weight three times per week and call with a weight gain of more than three pounds in one day or five pounds in one week.
- On 6/6/25 a new order was received to obtain daily weights and report a weight gain of three or more pounds in 24 hours or five pounds in a week.

Tenant #2's service plan dated 4/4/25 was not updated to reflect the outside therapy providers or the order for the three times per week weights and then daily weights.

2. Tenant #3's file revealed Progress Notes indicating the following:
- On 4/10/25 an order was received for PTand occupational therapy (OT) to evaluate and treat.
- On 4/15/25 it was noted on the After Visit Summary (AVS) dated 4/14/25 to weigh three times per week, call the provider if a gain of 3 pounds or have shortness of breath or any other symptoms. It also indicated to eat a heart healthy diet and limit fluids to less than 64 ounces daily.
- On 5/15/25 an order was received for a wheelchair.
- On 5/23/25 it was noted speech therapy (ST) had been working on functional cognitive skills. There was limited functional progress since she started services, and ST would discharge at the end of the week.
- On 5/27/25 tenant was discharged from ST on 5/27/25 due to maximum rehabilitation potential received.
- On 5/30/25 a note from 5/28/25 indicated Tenant #3 was advised to elevate legs when

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possible to reduce swelling. Compression hose were ordered to be worn daily and off at night.
- On 6/10/25 was taken to the emergency department (ED) and was admitted to the hospital.
- On 6/17/25 returned to the Program on oxygen. She would be admitted to hospice today.

Continued record review revealed service plans were dated 4/1/25, 4/10/25, 4/14/25, 6/17/25 and 6/18/25. The service plan reflected outside therapy; however, did not reflect when therapy services started and stopped and the types of therapies provided. It also did not reflect the when the order was received for the wheelchair, to elevate legs, and when the compression hose were ordered.

3. Tenant #4's file revealed Progress Notes indicating the following:
- On 3/24/25 the family was notified of a fall and increased confusion.
- On 3/25/25 was observed on the floor near her couch. Staff assisted her to transfer off the floor and back to bed.
- On 3/29/25 Tenant #4 "scooted herself out of bed due to restlessness." She had a small skin tear to the lower left extremity. She was assisted back to bed by staff.
- On 4/10/25 an order was received for albuterol sulfate solution 2.5 mg, 3 milliliters (ml), one vial via nebulizer three times daily, for five days and one vial via nebulizer every six hours as needed for wheezing, congestion, and/or shortness of breath.

The tenant's service plan, dated 4/14/25, reflected Tenant #4 had falls but did not provide any fall interventions. It did also not reflect the nebulizer treatments.

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A 350	Continued From page 18 4. Tenant C1's file revealed Progress Notes indicating the following: - On 3/19/25 was seen by home health for a catheter change, skin breakdown to the right second toe, left inner thigh and right inner thigh. Triad cream was to be used. - On 3/26/25 was seen by home health for a catheter check, physical assessment and wound check. It was noted she had wound on the right second toe, right buttock, right inner thigh and left posterior thigh. Orders were received to apply Triad cream twice daily and as needed to help heal wounds. Apply a Band-Aid to the right second toe daily. - On 4/7/25 a fax was sent to the primary care provider (PCP) regarding an open sore to the right inner/upper thigh that was bleeding and painful. The left upper/inner thigh was raw, red and sore. - On 4/18/25 was seen by home health for a catheter change, vitals, physical assessment and skin check. There were "pimples" noted to the groin and perineal area. There were wounds on the bilateral upper thigh and buttock. It was noted to provide offloading every one to two hours, good perineal care, to not wear Depends when possible and apply barrier cream as directed. - On 4/23/25 was seen by home care on 4/22/25 and it was noted the wounds to the bilateral/posterior legs were improving. Mepilex was applied to right second toe. A new order was pending for tubi grips for the bilateral lower extremities. - On 4/24/25 an order was received for cephalexin 500 mg, four times daily for 7 days. It noted if her foot looked worse or if she developed red streaks or a fever to send her to the emergency department. - On 4/28/25 was seen by home care. A new	A 350		

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wound was noted to the left heel that measured 2 centimeters (cm) by 3 cm. The PCP was notified of the wound. Mepilex AG was ordered to the heel and she was to be assessed by podiatry on 4/29/25. Instructions were received to offload/float her heels, complete good hand hygiene and perineal care.

- On 4/30/25 was seen at the foot care clinic where it was noted she had a pressure ulcer to the back of the left heel. The toe ulcer and left heel were debrided. An appointment was set up at the wound clinic. It was ordered to continue with Mepilex AG to dressing for the right second toe and to keep pressure off of the toes and the back of the left heel. It was also noted to put a pillow under lower leg when sleeping.
- On 5/8/25 was seen at the healing center for the pressure injury of the left heel (not able to be staged), pressure injury of the right thigh (stage 3), pressure injury of toe of right foot (stage 3), skin ulcer to the second toe of right foot (fat layer exposed). A new order was received for doxycycline 100 mg capsules, take 1 capsule twice daily for 14 days.
- On 5/9/25 was seen by home care on 5/8/25 and would be discharged on Monday due to a higher level of care needed. She was not recertified by home care. The program would discuss private duty options for dressings.
- On 5/9/25 tenant had chronic wounds on the heel and mid foot. The heel was bleeding and prior fluid filled lesion on the top of her foot was not bruised and painful. The wound clinic provider recommended a higher level of care. Tenant C1 was educated on importance of proper wound care and need for a care center that would provide consistent dressing changes.
- On 5/15/25 Tenant C1 was instructed to follow up with the wound clinic to have someone come in for daily dressing changes. The Director of

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Health and Wellness (DHW) and the Executive Director (ED) were currently completing wound cares.
- On 5/23/25 it was noted nurse facility staff currently provided wound care daily.
- On 5/27/25 was seen at the wound clinic for a skin ulcer of the second right foot with a fat layer exposed, pressure injury of the right thigh (stage 3) and pressure injury of the left heel (not able to be staged). Current wound care orders were to be continued.
- On 6/3/25 Tenant C1 was discharged to a higher level of care.

When interviewed on 6/19/25 at 11:51 a.m. the Director of Health and Wellness said Tenant C1's wound care was completed as ordered unless she had an appointment. The feet and heel wounds were completed by the Executive Director and Director of Health and Wellness (nurses). Tenant C1 completed the right and left thigh wound care.

Tenant C1's service plan was updated on 2/25/25 and 5/27/25. The service plan was not updated as needed to reflect when the wound clinic visits started, information related to the various wounds noted above, offloading and floating heels, the new wound on the heel, antibiotics related to the wounds, and when she was discharged from home care and nursing staff completed the wound cares. It also did not reflect Tenant C1 completed right and left thigh wound care.

5. Tenant C2's file revealed an AVS dated 1/24/25 indicating she was seen at a cardiology clinic related to chest pain, dizziness and dyspnea on exertion. A new medication was ordered (nitroglycerin). The service plan dated 9/21/24 reflected staff did not assist Tenant C2 with

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A 350	Continued From page 21 medications. The service plan was not updated after the nitroglycerin was ordered to reflect the new medication for chest pain, where it was stored and who administered. 6. When interviewed on 6/19/25 at 11:51 a.m. the Director of Health and Wellness confirmed all service plans were provided for the tenants reviewed.	A 350		
A 430	481-69.27(1)c Nurse Review 69.27(1) If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse: c. To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status; This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete nurse reviews every 90 days. This pertained to 4 of 4 current tenants reviewed (Tenants #1, #2, #3 and #4) and 2 of 2 former tenants reviewed (Tenant C1 and Tenant C2). Findings follow: Record review on 6/17/25 and 6/18/25 revealed the following: 1. Tenant #1 received assistance with personal	A 430		

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cares and was independent with medication administration. A Service Description-Full (service plan) was dated 11/6/24 and was provided related to a 90-day nurse review. A completed nurse review was not provided.

The following documents were provided when a 90 day nurse review was requested: a Global Deterioration Scale (GDS), Brief Interview for Mental Status (BIMS), a fall assessment, and an evacuation/safety assessment all dated 4/2/25. A Service Description-Full was also provided dated 4/3/25. A nurse review was not provided.

2. Tenant #2 received assistance with personal cares and medications. A Service Description-Full (service plan) dated 11/6/24 was provided related to a 90-day nurse review. A completed nurse review was not provided.

The following documents were provided when a 90 day nurse review was requested: GDS, BIMS, a fall assessment, an evacuation/safety assessment and elopement screening all dated 4/3/25. A Service Description-Full was also provided dated 4/4/25. A completed nurse review was not provided.

3. Tenant #3 received assistance with personal cares and medications. Evaluations were completed on 4/1/25, 4/10/25, 4/11/25 and 6/17/25; however, the evaluations provided lacked a nurse review. A completed nurse review was not provided with assessments provided.

4. Tenant #4 received assistance with personal cares and medications. A GDS, BIMS, fall assessment, elopement assessment and evacuation/safety assessment were completed dated 11/6/24; however, the evaluations provided

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A 430	Continued From page 23 lacked a nurse review. A Service-Description-Full (service plan) was also provided date 11/6/24. A completed nurse review was not provided. Continued record review revealed evaluations were dated 4/14/25 that indicated a fall assessment, evacuation/safety assessment, BIMS and GDS were completed; however, the evaluations provided lacked a nurse review. A Service-Description-Full (service plan) was also provided dated 4/14/25. A completed nurse review was not provided. 5. Tenant C1 received assistance with personal cares and medications. A GDS, BIMS, fall assessment, safety/evacuation assessment were dated 2/24/25 and again on 5/23/25; however, the evaluations provided lacked nurse reviews. Service-Description-Full (service plans) were also provided dated 2/26/25 and 5/27/25. Completed nurse reviews were not provided with the assessments. 6. Tenant C2 received assistance with personal cares and was independent with medications. Tenant C2 had a nurse review completed on 9/17/24 but did not have a 90-day nurse review completed before his death on 3/14/25. 7. When interviewed on 6/19/25 at 11:51 a.m. the Director of Health and Wellness confirmed all nurse reviews for the tenants reviewed were provided.	A 430		
A 510	481-69.28(8) Food Service 69.28(8) All perishable or potentially hazardous food shall be cooked to recommended temperatures and held at safe temperatures of	A 510		

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A 510	Continued From page 24 41°F (5°C) or below, or 135°F (57°C) or above. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to ensure food was served at required temperatures. This potentially affected all tenants (census of 43). Findings follow: 1. Observation on 6/18/25 at approximately 7:50 a.m. revealed there was individual containers of yogurt, individual cartons of milk, fruit, muffins and cereal sitting out on the sideboard/buffet in the dining room. The yogurt and milk were sitting in a dish with a another dish below it. Between the dishes there was cold water (melted ice); however, there was no other temperature control measures observed. These were continental breakfast items and tenants could also order a hot breakfast. Continued observation on 6/18/25 at approximately 8:45 a.m. revealed the yogurt and milk were still sitting out in the dishes. The outside of the milk and yogurt containers were not cold to the touch. At approximately 8:50 a.m. it was requested the temperature of the yogurt and milk be obtained. Staff C (dietary staff) obtained the temperature of the yogurt, which was 59 degrees and the milk was 48 degrees. The Executive Director was made aware of the temperatures to ensure the items were discarded due to the temperatures. 2. Record review of the food temperature logs for June did not indicate a temperature recording for the yogurt or milk observed as a part of the continental breakfast.	A 510		

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A 510	Continued From page 25 3. When interviewed on 6/19/25 at 11:06 a.m. the Executive Chef confirmed cold foods were to be maintained at 41 degrees or less.	A 510		

ok
7/29/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	PROVIDER/SUPPLIER/CLIA INDENTIFICATION NUMBER: S0277	DATE SURVEY COMPLETED: 6/19/2025
NAME OF PROVIDER OR SERVICER PRAIRIE HILLS AT CEDAR RAPIDS	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 F AVENUE N.W. CEDAR RAPIDS, IA. 52405	

Tag #	SUMMARY STATEMENT OF DEFICIENTCIES (EACH DEFICIENCY SHOULD BE PRECEDE BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY	Identify what changes to the provider's systems and practices were made to ensure compliance with the specific statute(s). Include information about how the provider will maintain compliance in the future.	COMPLETION DATE
Tag #1 **A 150**	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program.	**A 150**	**What initial correction was made?** DHW and ED conducted mandatory training on the Medication Management policy and procedure explicitly including the six rights of medication administration and documentation. This was initiated on 7/14/25 and will be completed by 7/31/25. DHW and ED conducted mandatory training for all staff on our incident reporting policy and the requirement to complete reports by the end of their shift. This was initiated on 7/14/25 and will be completed by 7/31/25. DHW and ED/or designee conducted mandatory training on the Abuse, Neglect, and Exploitation policy and procedure explicitly including when to report to the DHW and ED of potential abuse or unusual signs that abuse occurred. This was initiated on 7/14/25 and will be completed by all staff by 7/31/25.	**How will we ensure and maintain compliance going forward?** DHW to audit medication administration and documentation reports bi-weekly for 90 days and as needed thereafter. DHW and/or designee will audit incident reports bi-weekly for 90 days to ensure compliance with the reporting timeframe. DHW, ED, and/or designee will continue to provide ongoing training on the Abuse, Neglect, and Exploitation policy and procedure during all staff meetings for 90 days, with each new hire, and as needed thereafter.	Implementation Date: 7/14/25 Completion Date: 10/14/25 and ongoing Responsible Party: DHW and/or Designee

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Tag #2 **A 361**	**Regulation and Reg Number** 481-67.9(4)f 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: f. Services shall be provided for tenants in accordance with the training provided.	**Tag #** **A 361**	**What initial correction was made?** All staff were reeducated on staff delegation to ensure certified and non-certified staff are competent to meet the individual needs of tenants including that Services shall be provided for tenants in accordance with the training provided Education was provided in the week of 7/14/25 by the director of health and wellness.	**How will we ensure and maintain compliance going forward?** All new staff will be trained and delegated to ensure that all certified and non-certified staff are competent to meet the individual needs of tenants including that Services should be provided for tenants in accordance with the training provided by the director of health and wellness. This will be done upon hire. DHW and/or designee will audit every 30 days that this has been done for all staff.	**Implementation Date:** 7/14/25 **Completion Date:** 7/31/25 **Responsible Party:** DHW and/or Designee
Tag #3 **A 145**	481-69.22(3) Evaluation of Tenant 69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any	**A 145**	**What initial correction was made?** DHW educated on Policy AS01-Asessments on 7/22/25 by Regional Nurse. The resident assessments are completed/updated: a. Prior to move-in. b. 30 days after move-in. c. Every three (3) months (90 days). d. Annually and/or whenever there is a significant change in resident status.	**How will we ensure and maintain compliance going forward?** DHW and/or designee will audit four resident's charts once per week for twelve weeks for changes to ensure all residents residing in the community have functional, cognitive and health status evaluations and service plans documented accurately. Once the initial audit is completed, resident charts	Implementation Date: 7/22/25 Completion Date: Initial on 7/22/25. Completion date 10/22/25.

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	changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change.			will be audited on a quarterly basis. Results will be brought to ED to ensure compliance	Responsible Party: DHW, ED, and/or Designee
Tag #4 **A 290**	**Regulation and Reg Number** A 290 481-69.25(1)I Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: I: When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception.	**Tag #** **A 290**	**What initial correction was made?** DHW educated on 7/22/25 on documenting nurses' notes by exception by Regional Nurse.	**How will we ensure and maintain compliance going forward?** DHW and/or designee will audit four residents' charts once per week for twelve weeks to ensure all residents residing in the community have follow-up nurses' notes documented by exception and documented accurately. Once the initial audit is completed, resident charts will be audited on a quarterly basis. Results will be brought to ED to ensure compliance.	**Implementation Date:** 7/22/25 **Completion Date:** Initial on 7/22/25. Completion date 10/22/25.

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					Responsible Party: DHW, ED, and/or Designee
Tag #5 **A 350**	**Regulation and Reg Number** 481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed.	**Tag #** **A 350**	**What initial correction was made?** DHW educated on Policy AS05-Service Plans on 7/22/25 by Regional Nurse. Service Plans are created/updated: (1) a. Prior to move-in. b. 30 days after move-in. c. Every three (3) months (90 days). d. Annually and/or whenever there is a significant change in resident status. Tenant #2, 3, and 4 Service Plans will be updated by 7/31/25. Assessment system will be updated to trigger assessments and service plans prior to moving in, 30 days after moving in, and every 3 months (90) days.	**How will we ensure and maintain compliance going forward?** DHW or designee will audit four resident's charts once per week for eight weeks to ensure all residents residing in the community have functional, cognitive and health status evaluations and service plans documented accurately. Once the initial audit is completed, resident charts will be audited on an ongoing basis quarterly. Results will be brought to ED to ensure compliance	**Implementation Date:** 7/22/25 **Completion Date:** Initial on 7/22/25. Completion date 10/22/25. **Responsible Party:** DHW, ED, and/or Designee
Tag #6 **A 430**	**Regulation and Reg Number** 481-69.27(1)c Nurse Review 69.27(1) If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be	**Tag #** **A 430**	**What initial correction was made?** DHW educated on Policy AS05-Service Plans and Nurse Review on 7/22/25 by Regional Nurse Nurse Reviews: (3) a. Nurse reviews will be conducted by a licensed nurse.	**How will we ensure and maintain compliance going forward?** DHW and/or designee will audit four resident's charts once per week for twelve weeks to ensure all residents residing in the community have a nurse review every 90 days. Once the initial audit is completed, resident charts will be audited on a quarterly	**Implementation Date:** 7/22/25 **Completion Date:** Initial on 7/22/25. Completion date 10/22/25.

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	conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse: c. To assess and document the health status of A 370 A 430		b. Any resident experiencing a significant change in condition will have a nurse review. i. Residents who are observed having a significant change in condition will be assessed by a licensed nurse. ii. Residents receiving personal or health-related services will be: 1. Monitored quarterly or after the change in condition for any adverse reactions to medications and to make appropriate interventions. The assessment system was updated to trigger assessments and service plans prior to moving in, 30 days after moving in and every 3 months (90 days). 2. Assessed for their health status and have recommendations and referrals made as needed. a. Implemented recommendations and referrals will be monitored for at least ninety (90) days for progress related to previous changes in condition. Tenants #1, 2, 3, and 4 nurse review will be completed by 7/31/25.	basis. Results will be brought to ED to ensure compliance	**Responsible Party:** DHW, ED, and/or Designee
Tag #7 **A 510**	481-69.28(8) Food Service 69.28(8) All perishable or potentially hazardous food shall be cooked to recommended temperatures and held at safe temperatures of 41°F (5°C) or below, or 135°F (57°C) or above.	**Tag #** **A 510**	**What initial correction was made?** Milk and yogurt were discarded immediately once temperature obtained and found items to be out of required temperature range. Initiated temp log for continental breakfast items- milk, yogurt, and fruit.	**How will we ensure and maintain compliance going forward?** Executive Chef or designee will audit temp logs bi-weekly for 3 months then monthly on an ongoing basis. Results will be brought to ED to ensure compliance	**Implementation Date:** 6/18/25 **Completion Date:** Initial on 6/18/25 and ongoing.

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			Ordered small refrigerator to keep cold continental items in for self-serve. Initiated 7/23/25.		**Responsible Party:** Executive Chef, ED

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