

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165197	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/01/2025
NAME OF PROVIDER OR SUPPLIER Cedar Falls Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1728 West Eighth Street Cedar Falls, IA 50613	
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)		
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy, and staff interviews, the facility failed to notify the physician when the facility failed to administer medications as prescribed for 1 of 3 residents reviewed (Resident #1). The facility reported a census of 43. Findings include:Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score as 15, indicating intact cognition. The MDS included diagnoses of anxiety, depression, other psychoactive (mind altering) substance use, unspecified with mood disorder, and psychophysiologic insomnia (loss of sleep linked to the excessive worry about sleep).Resident #1's Medication Administration Record (MAR) for September 2025 and October 2025 documented Gabapentin (pain medication also used as an antianxiety medication) ordered for three times a day omitted (not documented) from 9/18/25 through 10/7/25.Resident #1's Progress Notes lacked documentation of the physician being notified of the omission of Gabapentin.On 10/22/25 at 3:25 PM The DON stated the CMA should have contacted the nurse when noted the medication was not available, then the nurse should have contacted the physician.On 10/22/25 at 3:30 PM The Administrator stated the nurse should have been notified by the CMA of medication not available and then the nurse should have notified the physician. The facility policy titled Acute Change in Condition Policy lacked direction for staff if medication was not available.		

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy, and staff interviews, the facility failed to administer medication as prescribed by the physician for 1 of 3 residents reviewed (Resident #1). The facility reported a census of 43. Findings include:Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score as 15, indicating intact cognition. The MDS included diagnoses of anxiety, depression, other psychoactive substance use, unspecified with mood disorder, and psychophysiologic insomnia.Resident #1's Medication Administration Record (MAR) for September 2025 and October 2025 documented Gabapentin (pain medication also used as an antianxiety medication) ordered for three times a day omitted from evening dose 9/18/25 thru 10/7/25. On 10/21/25 at 12:35 PM the Director of Nursing (DON) provided the pharmacy delivery records for Gabapentin since admission On 8/1/25. She reported she would look further into the discrepancy with the medication.Resident #1's pharmacy delivery records noted they delivered 42 tablets on 8/1/25, 90 tablets on 8/14/25 and 90 tablets on late evening of 10/6/25. When compared to the MARs for August, September, and October of 2025 noted Resident #1 received their last dose of Gabapentin on 9/18/25 at noon, and they didn't receive any of the medication for the 3-times-a-day order after that. On 10/21/25 at 1:11 PM the DON reported she reviewed the number of Gabapentin available from the pharmacy to the MARs. Resident #1 last received their dose on 9/18/25 at noon. The facility didn't receive the new medication until 10/6/25.On 10/22/25 at 9:15 AM the DON reported they started having trouble with the Certified Medication Aides (CMA) not reporting to the nurses when medications are unavailable. On 10/22/25 at 1:30 PM the DON reported no staff reported concerns with pharmacy. They didn't know for sure what the staff did with faxes back from the pharmacy. On 10/22/25 at 3:25 PM the DON reported the CMAs should contact the nurse when they found the medication unavailable. then the nurse should have contacted the physician, pharmacy and the responsible party. She verbalized if the pharmacy didn't deliver the medication the next day, the nurse should have followed up with the pharmacy until they resolve the issue.On 10/22/25 at 3:30 PM the Administrator reported the staff should have notified the nurse of the unavailable medication, then the nurse should notify the physician and pharmacy as soon as possible. If the facility didn't receive the medication on the next delivery, the nurse should call the pharmacy again to resolve the situation.The facility policy titled Acute Change in Condition Policy lacked direction for staff if medication was not available.		