

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

Printed: 10/09/2026
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 07/30/2026
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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on document review, time card review and staff interviews, the facility failed to ensure a Registered Nurse (RN) was in the facility for eight consecutive hours seven days a week. The facility reported a census of 49 residents. Findings include: A review of the May 2026 and July 2026 Nursing Schedules and Employee Time Detail Reports (Timecards) revealed the following: 5/24/26 Staff D, Licensed Practical Nurse (LPN), scheduled to work from 5:00 AM to 5:00 PM, clocked in at 4:57 AM and out at 5:31 PM per a Time Detail Report. Staff E, LPN, scheduled to work 5:00 PM to 5:00 AM, worked 4:55 PM to 5:26 AM on 5/25/26 per an invoice. The schedule lacked an RN 7/5/26 Staff D scheduled to work 5:00 AM to 5:00 PM, clocked in at 5:02 AM and out at 5:20 PM per the Time Detail Report. Staff F, LPN, clocked in at 5:00 PM and out at 5:19 AM on 7/6/26 per the Time Detail Report. The schedule lacked an RN On 7/27/26 at 11:30 AM the Director of Nursing (DON) reported an inability to hire nurses. On 7/29/26 at 10:32 AM the Administrator reported a staffing agency doesn't send notification when an RN calls off shift. The Administrator reported taking available nursing coverage at the last minute. The Administrator reported lacking proof from the staffing agency showing the RN called off shifts, but noted attempting to ensure 8 hours of RN coverage. The Administrator verified the facility lacked RN coverage on 5/24/26 and 7/5/26. On 7/29/26 a record review of the Daily Census Report dated 5/24/26 showed a census of 49 residents. A review of the Daily Census Report dated 7/5/26 showed a census of 50 residents, with 3 residents receiving Medicare Skilled services (short-term rehabilitative or skilled nursing care).		

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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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide timely toileting assistance and incontinence care to prevent Resident #6 from remaining in a wet brief and sitting on a urine-soaked wheelchair cushion for 1 of 1 resident (Resident #6) reviewed for incontinence care. The facility reported a census of 49. Findings include: Resident #6's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. Resident #6 required maximum assistance for toileting hygiene and toileting transfers. Resident #6 experienced occasional urinary incontinence (loss of bladder control) and frequent bowel incontinence (loss of bowel control). Diagnoses included fracture of left femur (broken thigh bone), chronic obstructive pulmonary disease (COPD) (long-term lung disease), bipolar disorder (mood disorder), anxiety (excessive worry), and dementia (memory loss). Resident #6's Care Plan initiated 6/26/26 and revised 7/1/26 identified a focus area for bladder incontinence, placing Resident #6 at risk for impaired skin, urinary tract infections (UTIs) (bladder infections), and peri-area (skin surrounding private areas) irritation. Resident #6's Care Plan initiated 6/26/26 identified a focus area for a self-care deficit requiring staff assistance with activities of daily living (ADLs), impaired balance during transitions requiring staff assistance or walking, and incontinence. Interventions directed two staff members for transfers. On 7/27/26 at 12:44 PM an observation revealed Resident #6 sitting on the edge of the bed while Resident #6 Representative stood at the foot of the bed and Staff A, Certified Nursing Assistant (CNA), remained in the room. Resident #6 Representative asked if the wheelchair cushion felt wet, stating Resident #6 couldn't sit on it. Resident #6 Representative removed the wheelchair cushion, displaying urine wetness soaked through to the bottom of the cushion. Resident #6 Representative asked if the fluid represented urine, and Staff A responded it could be. Resident #6 Representative stated the wheelchair felt wet too, asking staff to clean the wheelchair before placing Resident #6 into it. On 7/27/26 at 12:55 PM Resident #6 stated staff left them in a wet brief for 5 hours. On 7/28/26 at 1:00 PM Staff A stated changing residents every 2 to 3 hours. Staff A reported around lunchtime on 7/27/26 at 11:30 AM Resident #6 activated the call light requesting to use the bathroom. Staff A reported informing Resident #6 about lunchtime, stating plans to return after assisting in the dining room, and Resident #6 agreed. Staff A confirmed Resident #6's clothes and wheelchair cushion becoming wet with urine represented a normal occurrence. On 7/29/26 at 9:42 AM Staff C, CNA, stated if a resident requested bathroom assistance during lunch, staff provided help if sufficient staffing existed. Staff C reported dining room supervision required three staff members during lunch service. Staff C stated without enough staff, workers informed the resident assistance would occur after completing dining room duties. On 7/29/26 at 11:54 AM the Director of Nursing (DON) stated expectations for basic standards of care require changing residents every 2 hours upon rising, before and after meals, at bedtime, and as needed (PRN). The DON stated if a resident requests bathroom assistance during a meal, staff must assist the resident before going to the dining room. The Urinary Incontinence-Clinical Protocol policy revised April 2018 directed staff under treatment and management to provide scheduled toileting, prompted voiding, or other interventions to try to improve an individual's continence status.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and interview, the facility failed to ensure staff properly prepared and distributed medications for residents on leave from the facility when Staff G, Registered Nurse (RN), sent full medication cards belonging to another resident (Resident #16) home with Resident #1 during a leave of absence for 2 of 2 resident reviewed (Residents #1 and #16). The facility identified a census of 49 residents. Findings include: A Five-Minute Meeting Form dated 3/5/26 documented nurses could only send one dose or medication for leave of absence, or order bubble packs (blister cards containing individual doses) from the pharmacy, order medications for leave of absence, and mark on the medication card and narcotic (controlled substance) sheets. The Five-Minute Meeting Form showed Staff G signed in signature slot 9, verified by the Director of Nursing (DON), confirming attendance at the education. A Medication Error Report dated 3/19/26 at 8:30 PM documented the facility received a phone call from Resident #1's Family Member informing the staff the facility sent medications belonging to another resident (Resident #10) home with Resident #1, in addition to Resident #1's medications. A Corrective Action Form dated 3/23/26 documented Staff G received a written warning for sending another resident's medication packet out with a resident on leave from the facility with family. Staff G received education via text message on 3/20/26 regarding the six rights of medication administration. The Administrator spoke to Staff G immediately after the phone call from Resident #1 Family Member. The Corrective Action Form didn't contain documentation of education on setting up medications for leave of absence. On 7/28/26 at 9:50 AM Resident #1's Family Member stated they didn't let Resident #1 take the wrong medications on 3/19/26. Resident #1's Family Member reported another resident's medication cards accompanied Resident #1's medication cards, and the cards contained multiple medication doses. On 7/28/26 at 10:43 AM Staff G stated full responsibility for the incident, noting Staff G didn't triple check medication cards. Staff G reported another resident's medication cards sat in the wrong slot in the medication cart with Resident #1's medication cards, causing Staff G to pick up the wrong cards and send them with the family. On 7/29/26 at 8:35 AM Staff G stated the other affected resident was Resident #16. Staff G reported both residents maintained similar medications, requiring a better card review. Staff G reported Resident #16's cards sat in Resident #1's slot in the medication cart. Staff G reported the nurses send full resident medication cards out when residents leave the facility. Staff G reported Resident #1 left the facility on 3/19/26 between 3:00 PM and 5:00 PM, and Staff G sent their supper medication cards with the family. On 7/29/26 at 1:38 PM the Administrator stated staff send medication cards out when a resident leaves the facility. On 7/29/26 at 1:42 PM the DON stated corporate policy recently changed, requiring nurses to call the pharmacy to set up resident medications in a bubble pack for extended or overnight leaves. The DON reported the facility maintained a different policy when Resident #1 left the facility on 3/19/26. The DON reported providing education to nurses on 3/5/26 regarding medication dispensing for leaves of absence, noting Staff G received a written warning for sending full medication cards out with Resident #1. On 7/29/26 at 2:20 PM Staff G stated feeling upset about the incident, noting the facility changed procedures to prohibit dispensing full medication packs as previously practiced. On 7/29/26 at 2:55 PM the DON stated the pharmacy refilled resident medication cards as needed, resulting in varying numbers of medications in each card when sent out. On 7/29/26 at 3:05 PM the Administrator and the DON stated the Administrator expected nurses to place one medication in each envelope and label appropriately. The DON stated staff couldn't use envelopes any longer and expected nurses to set up (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	one medication per bottle with appropriate labeling, noting plans to order plastic medication bottles from the pharmacy. The Dispensing Medications to Resident's on Leave/Pass Policy dated April 2007 directed staff to provide scheduled and essential as-needed medications to residents away from the facility during medication passes, limited to the amount and doses needed for the anticipated absence. The policy directed the Charge Nurse to provide verbal and written directions to the resident or person signing out the resident, and directed staff to document absences on the Medication Administration Record (MAR) (medication tracking log). The policy directed the pharmacy to prepare and dispense medications for overnight or consecutive absences exceeding three days. The policy didn't reflect current regulatory requirements.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, record review, facility policy review, and interview, the facility failed to ensure staff administered medications safely as prescribed without crushing non-crushable medications for 1 of 5 residents (Resident #10) reviewed for medication administration. The facility identified a census of 49 residents. Findings include: Resident #10's Order Listing Report signed by the Provider on 6/30/26 listed the following orders: a. Medications may be crushed unless otherwise contraindicated. b. Potassium Chloride (mineral supplement) Extended Release (ER) 10 Milliequivalents (MEQ), give 10 MEQ by mouth in the morning. c. Aspirin (ASA) (clot prevention medication), give 81 Milligrams (MG) by mouth in the morning for clot prevention. On 7/29/26 at 7:41 AM Staff H, Certified Medication Aide (CMA), prepared medications for Resident #10. Staff H placed a 10 MEQ Potassium Chloride ER tablet from the medication cart into a medication cup. Staff H placed one stock ASA 81 MG enteric coated (special coating to prevent stomach breakdown) tablet into the medication cup. Staff H crushed Resident #10's medications, mixed them into applesauce, and administered them to Resident #10. On 7/28/26 at 2:07 PM the Pharmacy Vendor Licensed Pharmacist reported staff shouldn't crush and administer Potassium Chloride ER oral tablets in applesauce. The Pharmacy Vendor Licensed Pharmacist stated guiding documents direct staff to break extended-release tablets in half, dissolve them in 4 ounces (oz) of water for 2 minutes, and administer immediately. The Pharmacy Vendor Licensed Pharmacist reported lacking information indicating Resident #10 required crushed medication. On 7/28/26 the Pharmacy Vendor provided Potassium Chloride ER Highlights of Prescribing Information, directing under Dosage and Administration to swallow tablets whole without crushing, chewing, or sucking. In an email on 7/28/26 at 2:29 PM, the Pharmacy Vendor Licensed Pharmacist communicated staff could cut potassium in half or dissolve it in water, but couldn't crush it. On 7/29/26 at 7:25 AM Staff G, Registered Nurse (RN), reported staff shouldn't crush extended-release potassium and enteric-coated ASA medications. Staff G confirmed the yellow baby ASA represented stock enteric-coated aspirin and shouldn't be crushed. Staff G reported Resident #10 should've received chewable ASA, which staff can crush. On 7/29/26 at 7:30 AM Staff G reviewed Resident #10's Electronic Medication Administration Record (EMAR) and reported the EMAR didn't indicate Resident #10 received crushed medications. Staff G reported the EMAR didn't specify ER potassium shouldn't be crushed and noted the EMAR order for baby ASA didn't specify chewable form. On 7/29/26 at 7:33 AM the Director of Nursing (DON) questioned Staff G whether the EMAR listed crushed medications. The DON reported lacking knowledge whether the pharmacy received a list of residents requiring crushed medications. On 7/29/26 at 7:38 AM the DON reported the resident profile page lists crushed medications, but the information didn't flow to the medication administration record. The DON reported instructing Staff G to create a list of all residents requiring crushed medications to provide to the consulting pharmacist and supplying pharmacist. On 7/29/26 at 8:23 AM the DON reported completing Staff H's medication administration orientation and provided a copy of Staff H's Medication Administration Competency Checklist dated 4/23/26. The checklist documented Not Applicable/NA regarding medication crushing policies. The DON reported training Staff H on C/D Hallway, noting Resident #10 represented the only resident requiring crushed medications at time of training and resided on A/B Hallway, so training didn't cover medication crushing. The DON reported avoiding untrue statements, noting belief training didn't address crushing medications due to training location. On 7/30/26 at 10:45 PM the DON reported notifying the pharmacy of residents requiring crushed medications and placing medication reference sheets in nurse binders on each medication cart to prevent staff from crushing non-crushable medications. The Administering (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medications policy dated December 2012 directed staff to administer medications safely as prescribed. The policy instructed the DON to supervise and direct all nursing personnel administering medications or performing related functions. The policy lacked specific direction regarding crushed medication administration.		

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F 0774 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Help the resident with transportation to and from laboratory services outside of the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure staff scheduled and provided transportation for medical appointments for 1 of 3 resident (Resident #1) reviewed for medical services. This failure resulted in Resident #1 missing specialty medical appointments. The facility identified a census of 49 residents. Findings include: A Diabetes/Endocrinology Visit record dated 3/5/26 documented Resident #1's next appointment scheduled for 4/9/26 at 1:30 PM. Resident #1's April 2026 Progress Notes lacked documentation of a Diabetes/Endocrinology Visit on 4/9/26. A Diabetes/Endocrinology Visit Note dated 5/14/26 documented the next scheduled appointment set for 6/18/26 at 9:50 AM. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] documented severely impaired vision, seeing only light, colors, or shapes. Resident #1's MDS documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #1's MDS documented diagnoses including gastroesophageal reflux disease (acid reflux), end stage renal disease (kidney failure), and diabetes mellitus (high blood sugar). Resident #1's MDS documented Resident #1 received renal dialysis (blood filtering treatment). A Progress Note dated 6/18/26 at 10:44 AM written by Staff G, Registered Nurse (RN), documented an endocrinology clinic calling to report Resident #1 missed a scheduled appointment on 6/18/26, scheduling a virtual visit for 7/16/26 at 2:50 PM. On 7/28/26 at 9:50 AM Resident #1 Family Member stated Resident #1 missed several endocrinology appointments, adding Resident #1 maintains diagnoses of diabetes and legal blindness and cannot miss appointments. On 7/28/26 at 12:53 PM Resident #1 stated missing several endocrine and other medical appointments while residing at the facility. On 7/29/26 at 11:20 AM the Administrator provided a Ride Request Form documenting a scheduled bus ride for Resident #1 on 4/9/26 for an endocrinologist appointment at 1:30 PM with a return pickup time at 2:30 PM. The bottom of the form documented, We cannot do this ride today. The form contained a facsimile date of 4/8/26 at 8:51 PM. On 7/29/26 at 11:40 AM Dispatch at the Transportation Vendor stated vendor policy required transport notification by 4:00 PM the day prior to appointments or by 4:00 PM Friday for Monday appointments. On 7/30/26 at 8:01 AM Staff G reviewed the Progress Note dated 6/18/26 and reported lacking specific recollection regarding why Resident #1 missed the appointment. Staff G reported recalling the Director of Nursing (DON) mentioning clinic double-booking practices and noted staff typically document virtual appointments in progress notes. On 7/30/26 at 8:03 AM Lead Dispatch at the Transportation Vendor reported checking ride logs and finding no rides scheduled for the facility on 4/9/26, noting unscheduled transport occurs only when requests arrive after 4:00 PM the prior day. On 7/30/26 at 8:20 AM the Administrator reviewed the fax timestamp sent to the transportation service and stated the timestamps contained inaccuracies. The Administrator checked computer records for Resident #1's transportation scheduling on 4/9/26, which showed a fax sent to the transportation vendor on 4/8/26 at 8:55 PM. The Administrator reported the DON sent transportation request forms and noted receiving additional education on transport scheduling since taking over scheduling duties. On 7/30/26 at 8:40 AM the DON reported Resident #1 missed a gastroenterology (stomach and intestine specialist) appointment on 4/23/26 without record documentation explaining the absence, adding staff rescheduled the appointment for October 2026. The DON reported Resident #1 missed the 4/9/26 endocrinology appointment due to late transit setup and confirmed Resident #1 missed the 6/18/26 endocrinology appointment as well. The DON reported the corporation eliminated the facility scheduler position. The previous scheduler was upset her position had been eliminated. They found she had thrown resident appointment papers in the shredder. They retrieved as much (continued on next page)		

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F 0774 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident information as they could to reschedule appointments. Some appointments were missed because they had no idea the appointment had been scheduled. The previous scheduler did the scheduling on paper instead of in the computer, so when she left, they were left with nothing. They started from ground zero. The DON confirmed the missed appointments. She stated they did not have a policy on their scheduling process. The undated Facility admission Contract Resident Rights policy directed residents hold the right to receive information regarding total health status and medical conditions, participate in treatment planning, and see their physician.		