STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165197	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Falls Health Care Center	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 0880 Level of Harm - Actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, Center for Disease Control and Prevention (CDC) Guidelines, Policy review and staff interviews, the facility failed to prevent the spread of infection for 2 of 2 residents who tested positive for influenza A (Residents #17 and #38). In addition, the facility failed to implement droplet precautions, sanitize the barrier used during a blood sugar check for 1 of 2 residents observed (Resident #23), and failed to adhere to infection control practices during medication administration when dirty gloves contacted oral medication for 3 of 7 resident observed (Residents #16, #19 and #34). On 1/2/26, the facility failed to follow infection control protocols after Resident #17 tested positive for influenza A. After Resident #17 tested positive for influenza A, the facility failed to initiate isolation or droplet precautions to prevent the spread of influenza A. On 1/6/26, Resident #38 (Resident #17's roommate) displayed signs and symptoms of an upper respiratory tract infection with wheezing (a whistling sound indicating difficulty of air moving through the lungs). Resident #38 required the use of prednisone (steroids used to reduce swelling), an antibiotic, and nebulizers to help them breathe. Resident #17's and #38's room didn't have a sign or supplies in or near their room to indicate influenza A present in the room. The facility failed to implement control measures to prevent the transmission of influenza A to other residents in the facility, causing Resident #38 physical harm. The facility identified a census of 43 residents. Findings include:1. Resident #17's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) Score of 6, indicating severe cognitive loss. The MDS listed diagnoses of altered mental state, acute respiratory (lung) failure, and adult failure to thrive. During entrance on 1/5/25 at approximately 9:30 AM the Administrator reported Resident #17 tested positive for influenza A. On 1/5/25 at 11:21 PM observed Resident #17 lying in bed on his right side, with his room door open. His room didn't have personal protective equipment (PPE) set up and/or no CDC sign regarding the use of isolation on their door. Resident #17's roommate sat in a recliner. They had the privacy curtain pulled approximately 3-4 feet out from the wall so each roommate could see each other. On 11/5/25 at approximately 11:30 PM watched Resident #17's roommate walk out of the room to the dining room without being offered a medical mask until approximately 70-75 feet to the dining room. He walked by 9 other resident room doors and by 3-4 tables of residents in the dining room. He sat at the back of the dining room with another male resident. Two nursing staff sat assisting other residents in the dining area. A certified medication aide (CMA) stood at the medication cart at the front of the dining room by the nurses' station and one dietary staff passed meal plates in the dining room. They had approximately 24 other residents in the dining room. The staff still didn't offer him a medical mask. On 1/6/26 at approximately 7:30 AM witnessed Resident #17 lying in bed with the room door open. The room didn't have an isolation sign noted and/or PPE available outside the room to go in and provide care to Resident #17. On 1/6/25 at 9:10 AM observed a plastic 3 drawer bin with gloves, gown, medical masks and face shields. Resident #17 door lacked and direction, documentation, and/or guidance regarding droplet precautions for Resident #17's room. During an interview on 1/6/26 at 9:12 AM Staff F, Certified Nursing Assistant (CNA), stated she had not worked since the previous Thursday and no one communicated Resident #17 had a respiratory illness. Staff F (continued on next page)

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 0880 Level of Harm - Actual harm Residents Affected - Few	added none of the staff knew the day before of him being ill. Staff F voiced Resident #17 should be on precautions. He still didn't have a sign for precautions on his door and he should so staff know what to do. He needed to wear a mask if he came out of the room. In addition, he had a roommate. Staff F pulled the curtain that morning as his roommate has been exposed and went out of the room the day before. Resident #17 laid in bed at the time in his room approximately four feet from the open room door. Interview completed on 1/6/26 at approximately 11:42 AM Staff F reported she just placed a PPE bin outside of Resident #17's room door. He tested positive for influenza. She didn't work the weekend and he should have been put on precautions when he returned positive with the flu. If she did work the weekend, she would have put an isolation bin outside his door. She stated she worn a mask and gloves in his room on 1/6/26 when she went in but they didn't place on precautions until just then. On 1/6/26 at 11:43 observed a CDC Droplet Precaution sign on Resident #17's room door. The CDC sign directed everyone must clean their hands, including before entering and when leaving the room. Make sure their eyes, nose and mouth are fully covered before room entry with illustrated pictures showing use of a medical mask and a face shield or medical mask and goggles. Remove face protection before room exit. On 1/6/26 at 11:44 AM watched Staff G, Dietary Aide (DA), roll a cart with lunch trays down the D hallway. Staff G wore a medical mask and delivered a room tray to Resident #3's room. Staff G came out of Resident #3's room and positioned the meal cart in front of Resident #17's room. She failed to remove her mask or perform hand hygiene prior to entering Resident #17's room. Staff G wore only a medical mask as she entered Resident #17 room and placed a plate of food on his bedside table within 6 feet of them. Without performing hand hygiene or changing their mask, Staff G delivered Resident #17's roommate's tray. At 11:48 AM Staff G came out of the room and without performing hand hygiene assisted a visitor to apply a medical mask. They didn't direct the visitor to perform hand hygiene prior to visiting Resident #17's roommate. Staff G failed to apply goggles or a face shield, remove her face mask before exiting the room and perform hand hygiene immediately upon exiting the room. Staff G placed her hands on the meal cart and moved it down the hallway a few feet, then asked Staff H, Certified Medication Aide (CMA), if she had some hand sanitizer. Staff G sanitized her hands and without sanitizing the meal cart, she touch it in the same place she just had her hands and continued to serve 4 more resident room trays. On 1/6/26 at 11:49 AM Staff H reported they are to wear a mask, gown, gloves, and make sure to wash their hands on way out of the room. She stated Resident #17 tested positive for influenza A. He went to the emergency department (ED) on Friday. She returned to work on Monday (1/5/26). He didn't have PPE outside the room, so she just wore a mask and gloves to go in his room on Monday. On 1/6/26 at 11:51 AM the Director of Nursing (DON) stated she would save everyone a lot of time and work. Resident #17 went Friday (1/2/26) to the ED and returned that same day positive for influenza A. The nurse didn't pass on the information through the report, so no one knew about it on the weekend. On Monday (1/5/26) she put signs on the front and back door of the facility regarding visitation. She just put the CDC Droplet Precaution Sign on Resident #17's room door and started to complete staff education regarding communication and isolation precautions. She printed off the policy for education and got a standing order for Tamiflu for the residents. She said the nurse should have notified the on-call nurse 1/2/26 which would have been her and then she would have alerted the Infection Preventionist. They would instruct to place Resident #17 on droplet precautions. The facility should have placed Resident #17 on precautions on 1/2/26 when he returned from the hospital, but it got missed. They just placed him on droplet precautions at that time. The General Progress Note dated 1/6/26 at 6:18 PM documented a Provider visit for Resident #38 (roommate of Resident #17) with a chief complaint of signs and symptoms of upper respiratory illness (URI) with chills and malaise (extreme tiredness) for 2 days. The Progress Note indicated the staff alerted the nurse that Resident #38 had signs and symptoms of a URI. The hospital diagnosed his roommate with influenza A on Friday (1/2/26). The Progress Note documented Resident #38 as alert and appeared sick with wheezing. The Provider ordered Resident #38 to start Z-pack antibiotics, a prednisone (steroid (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Few	therapy used to treat swelling) taper, and nebulizer (breathing) treatments as needed. On 1/7/26 at 8:11 AM Staff I, CNA, reported she worked 1/5/25 and they didn't have residents placed on isolation precautions. No one reported Resident #17 had influenza A. Interview completed on 1/7/26 8:16 AM Staff F reported she didn't work the weekend (1/2/26 - 1/3/26). If she would have worked the weekend, she would have put Resident #17 on precautions. Resident #17's roommate was out of the room and all over the facility all weekend and Monday (1/5/16). Resident #17's roommate had symptoms of the flu that morning and he is really sick. He even had a visitor yesterday and they tried to turn away the visitor, but they refused. The visitor at least wore a mask when she visited Resident #17's roommate. Resident #17 should have started precautions right away. During an interview on 1/7/26 at 10:11 AM Staff B, Registered Nurse (RN), reported he worked the weekend of 1/3/26 and 1/4/26. He didn?t put any residents on any type of isolation precautions. It was possible that staff could have gone in the room to provide care to Resident #17 without PPE, but he didn't go into Resident #17's room himself. Interviews completed on 1/7/26 at 10:25 AM Staff F and Staff H reported the instruction they received said they only had to wear masks and gloves to enter Resident #17's room. On 1/7/26 at 11:39 AM Staff E, Assistant Director of Nursing (ADON)/Infection Preventionist (IP), reported it happened late at night and it wasn't passed through report that Resident #17 tested positive for influenza A. The nurse should have notified the on-call nurse, passed it through report and placed the resident on isolation precautions. The resident should be kept in their room for 7 days or until no signs and symptoms. She reported being the on-call nurse on 1/2/26 and never received any calls regarding a resident with influenza. She worked on Saturday (1/3/26) and Sunday (1/4/26) night shift and still never received a report of a resident positive for influenza A. During an interview on 1/8/26 at 10:19 AM the DON explained she expected the nurses to place residents with influenza A on droplet precautions immediately. The nurses are to call the On Call nurse right away. The DON and ADON serve as the On-Call nurse contacts. They would instruct the nurses on what to do for precautions. Staff are to follow standard precautions, wear gloves, and masks to care for a resident with influenza A. When queried about the CDC Droplet Precaution sign on Resident #17's room door, the DON confirmed she placed the CDC sign on the door. She stated she didn't think their policy required the staff to use droplet precaution, specifically eye protection. The Influenza Exposure Control Policy dated 2025 directed procedures for prevention and controlling exposure to influenza. The Policy directed to implement droplet precautions for residents with suspected or confirmed influenza for seven days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer. Staff to follow the facility's transmission-based precaution procedures while the droplet precautions are in effect. The CDC Infection Prevention and Control Strategies for Seasonal Influenza in Healthcare Settings dated April 28, 2025 under Modes of Transmission documented the influenza viruses have been thought to spread from person to person primarily through large-particle respiratory droplets and small particles in the air (e.g. coughing/sneezing). Transmission via large-particle droplets occurs during close contact between source and recipient persons, because droplets generally travel only short distances (approximately 6 feet or less) through the air. All respiratory secretions and bodily fluids with influenza are considered to be potentially infectious. The CDC Guidance directs droplet precautions should be implemented for patients with suspected or confirmed influenza for 7 days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer. Healthcare Personnel should apply a facemask when entering the room of a patient with suspected or confirmed influenza and remove the facemask when leaving the room, dispose of the facemask in a waste container and perform hand hygiene. If a patient under droplet precautions requires movement outside of the room, have the patient wear a facemask and follow respiratory hygiene and cough etiquette and hand hygiene. 2. Resident #23 MDS dated [DATE] identified a BIMS Score of 6, indicating severe cognitive loss. The MDS included diagnosis of diabetes mellitus. The MDS indicated he received insulin injections 7 days a week. An Order Summary report signed by the provider on (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Few	11/17/25 listed an order to check blood sugars 4 times a day (AM, noon, evening and bedtime). During an observation on 1/5/26 at 4:02 PM Staff J, RN, unlocked the medication cart, removed a plastic container with Resident #23's blood sugar machine, and supplies. Staff J removed the lid of the plastic container and placed the lid with the inside portion of the lid facing down on top of the medication cart. Staff J placed the blood glucose meter with a strip, lancet, gauze, and alcohol prep pads on top of the lid and carried it into Resident #23's room placing the lid on the bedside table. Staff J informed Resident #23 she would check her blood sugar. Staff J picked up the plastic lid and placed it with the inside portion of the lid facing down on the resident's bed and proceeded to check her blood sugar. Once completed, Staff J brought the lid with the supplies out of the room and placed it on top of the medication cart. She disposed of the lancet in the sharp's container, cleaned the meter and placed inside the plastic container which also contained lancets, alcohol prep pads, bottle of testing strips and gauze. Staff J then placed the plastic lid back on the plastic container without sanitizing the lid and placed in the medication cart. On 1/8/26 at 8:15 AM Staff B reported they are to use a paper towel as a clean barrier if they have to set any supplies down in a resident's room. The resident bedside tables can be pretty dirty at times, so a paper towel barrier needed used. On 1/8/26 at 10:34 AM the Director of Nursing explained she expected the staff to place a paper towel barrier down prior sitting any blood glucose supplies down in a resident's room. The Obtaining a Fingerstick Glucose Level Policy revised October 2011 failed to address the use of a clean barrier when performing a blood glucose checks to prevent potential cross contamination. 3. On 1/6/26 at 7:39 AM observed Staff H do the Medication Task. Staff H prepared Resident #34's medications and reviewed the January 2026 Electronic Medication Administration Record (EMAR) which included the following medication orders:a. Aspirin Oral Tablet Chewable 81 Milligrams (MG), give 81 MG by mouth one time a day.b. Sertraline Hydrochloride (HCL) Oral Tablet 100 MG, give 1 tablet by mouth in the morning. c. Eliquis Oral Tablet 5 MG, give 5 MG by mouth two times a day. d. Metformin HCL Oral Tablet 500 MG, give 1 tablet by mouth two times a day. Staff H performed hand hygiene, placed gloves on both hands, opened the medication cart, and removed Resident #34's medication cards from the cart. Staff H punched the Sertraline out of the back of the medication card into her right gloved hand, then placed it in a medication cup. Staff H touched the (computer) tablet with her right gloved hand to move the EMAR screen to be able to see each medication order. The tablet had visible smudged fingerprints all over the front screen of the tablet. Staff H continued the technique of punching each oral medication out of the back of the card into her right gloved hand and touched the screen on the dirty tablet multiple times prior to administering the medication to Resident #34. 4. On 1/6/26 at 7:44 AM watched Staff H complete the Medication Task as they prepared Resident #19's medications. Staff H reviewed Resident #19's January 2026 EMAR which included the following medications:a. Amlodipine Besylate Oral Tablet 5 MG, give 5 MG by mouth in the morning.b. Aspirin Low Dose Tablet 81 MG, give 81 MG by mouth in the morning. c. Clopidogrel Bisulfate Oral Tablet 75 MG, give 75 MG by mouth one time day.d. Lasix Oral Tablet 20 MG, give 1 tablet by mouth in the morning. e. Losartan Potassium-Hydrochlorothiazide Oral Tablet 100-25 MG, give 1 tablet in the morning. f. Mirtazapine Oral Tablet 15 MG, give 15 MG one time a day.g. Carvedilol Oral Tablet 25 MG, give 1 tablet two times a day. h. Seroquel Oral Tablet 25 MG, give 25 MG two times a day. Staff H performed hand hygiene, removed Resident #19's medication cards from the medication cart, donned gloves and proceeded to punch each medication out of the back side of the card into the palm of her right gloved hand, then placed the pill into a medication cup. Staff H used the same right gloved hand to touch the dirty screen, covered with visible finger smudges on the front screen, of the computer tablet as she scrolled through Resident #19's physician orders. Staff H dropped the Carvedilol (blood pressure medication) pill onto the top of the medication cart and picked the pill up with her dirty right gloved hand and placed into the medication cup, the administered the medications to Resident #19. 5. On 1/6/26 at 7:51 AM observed Staff B do the Medication Task and prepare Resident #16's medications for administration. Staff B reviewed Resident #16's January 2026 EMAR which included the following (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Few	orders:a. Calcium Oral Tablet 500 MG, give 500 MG by mouth three times a day.b. Vitamin D 5000 Units, give two tablets by mouth in the morning. Staff B applied gloves, removed a total of nine medication cards from the medication cart for Resident #16, placing the cards on top of the medication cart. Staff B opened a drawer and removed a stock bottle calcium, opened, and shook a calcium tablet into the lid of the bottle, then transferred the pill into the medication cup. Staff B placed the calcium bottle back in the medication cart. Staff B took a stock bottle of vitamin D from the medication cart, opened the bottle, stuck his left gloved forefinger into the bottle of vitamin D to dig two vitamin D tablets from the bottle, then placed the tablets in the medication cup with his left gloved hand which had touched multiple other surfaces. Staff B administered the medication to Resident #16. During an interview on 1/7/26 at 2:50 PM Staff J, RN, explained they received instruction if they have to touch medications, then they need to wear gloves. If they punch a pill right out of the card into the cup, then they do not need to wear gloves. If they punch the pill into their hand and then put in the cup, they have to wear a glove. She stated that gloved hand should not touch any other surfaces or items between punching the pills out of the card of it the glove would have to be changed. On 1/8/26 at 10:03 AM Staff B reported they never received a guideline but he occasionally sanitized his computer with a germicidal wipe, but hasn't received guidance from the facility. On 1/8/26 at 10:05 AM the DON voiced the nurses shouldn't touch oral medications with dirty hands or gloves. She didn't where or why the nursing staff wore gloves during medication pass. On 1/8/26 at 10:10 AM the Administrator reported the facility didn't have a policy for sanitizing the laptops or tablet screens used for medication pass. Both the Administrator and DON agreed the laptops/tablets can be very dirty. The Administering Medications Policy revised December 2011 directed the staff to follow established facility infection control procedures (e.g. handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, resident, and staff interviews, the facility failed to have a restorative program available for all residents at the facility. The facility failed to implement a restorative plan for 2 of 2 residents that reported if they had an option to do therapy, they would (Residents #36 and #43). The facility reported a census of 43 residents. Findings include: 1. Resident #36's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) of 15, indicating no cognitive impairment. The MDS listed Resident #36 as dependent on staff (requires 2 staff to complete the task and the staff do all the work) for toileting, dressing, transfers and personal hygiene. The MDS included diagnoses of stroke, anxiety, depression, and hemiplegia (the loss of muscle function, causing an inability to move voluntarily to one entire side of the body, affecting the face, arm, and leg, caused by brain damage to the opposite side of the brain). Resident #36 Care Plan on 1/8/26 documented he is participating in the Restorative Nursing Program and needs strengthening and stretches to prevent contractures and to perform restorative exercises as order. The review of Resident #36's December 2025 Documentation Survey Report (a facility computer generated report from the resident medical record about the residents' activities of daily living, restorative, and activity attendance) on 1/8/26 lacked a restorative program. The review of Resident #36's January 2026 Documentation Survey Report on 1/8/26 lacked a restorative program. In an interview on 1/8/26 at 12:12 PM Resident #36 reported it was nice in the past to attend the restorative program. He added he thought might have participated twice in the past 5 years of living at the facility. He explained he would like to try a restorative program and if he liked it, he would possibly do it every day. 2. Resident #43's MDS assessment dated [DATE] identified a BIMS score of 6, indicating severe cognitive impairment. Resident #43 needed moderate assistance (required 1 staff to assist but do less than half the effort) for standing, transfers, and walking up to 50 feet. The MDS included diagnoses of depression, hypotension (low blood pressure), and hemiplegia (inability to move part of the body). The review of Resident #43's December 2025 Documentation Survey Report for December 2025 lacked a restorative program. On 1/8/26 Resident #43 Documentation Survey Report for January 2026 on 1/8/26 lacked a restorative program. In an interview on 1/8/26 at 12:17 PM Resident #43 reported he didn't have a restorative program he attended and probably wouldn't exercise every day, but would do it when he wanted to. In an interview on 1/8/26 at 11:24 AM the Administrator confirmed the facility didn't currently have a restorative program in place for residents in the facility but are working on implementing one. She described Resident #36 as non-compliant with cares and didn't know if he would complete a restorative program if it was implemented, but he would probably benefit from one. She added he used Part B therapy a few times in the past year. The Administrator described Resident #43 as new to the facility but would probably benefit from a restorative program. Review of the facility's Nursing Restorative Program manual dated May 2022 instructed on the implementation and maintenance of a restorative program in the facility.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, staff interviews, and policy review the facility failed to post daily nurse staffing on 3 of 4 days of the annual survey. The facility reported a census of 43 residents. Findings include: An observation on 1/5/26 at 10:17 AM revealed the facility had nurse staff posting for 1/3/26 posted. An observation on 1/6/26 at 1:41 PM revealed the facility had nurse staff posting for 1/5/25 posted.An observation on 1/7/26 at 3:47 PM revealed the facility had nurse staff posting for 1/5/25 posted.In an interview on 1/8/26 at 11:24 AM the Administrator reported she expected the night nurse to complete the nurse staff posting for the next day and post it on their shift, then have the staff update as changes occurred. She repotted it's never been identified as an issue that it has not been updated before, and unsure why it was not completed this week. Review of Nurse Staffing Posting Information policy revised in unknown month, 2025 informed it is the policy to make nurse staffing information readily available in a readable format to residents, staff, and visitors at any given time and the facility will post the nurse staffing at the beginning of each shift.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and policy review the facility failed to obtain informed consent prior to starting psychotropic medications that have black box warnings (the most serious safety warning the Food and Drug Administration (FDA) uses and requires the healthcare provider to have a comprehensive discussion with the resident about the risks, benefits, and alternatives for use) for 3 for 5 residents reviewed for psychotropic medications. (Resident #36, #40, and #8). The facility reported a census of 43 residents. Findings include: 1. Resident #36's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. It informed he received antipsychotic, antianxiety and antidepressant (3 types of psychotropic drug classes that are used to manage various mental health conditions by balancing chemical neurotransmitters in the brain, which are then released by nerve cells to transmit signals across tiny gaps to other neurons, muscles, or glands, allowing communication for all functions like thought, movement, mood, and sensation in the brain) medication in the past 7 days. The MDS also documented he has diagnoses of stroke, hemiplegia, anxiety, and depression. Resident #36's Order Summary Report signed on 11/17/25 included orders for antianxiety, antipsychotic, and antidepressant medications. Resident #36's December 2025 Medication Administration Record (MAR) documented he received antipsychotic and antidepressant medications daily Resident #36's MAR from 1/1/26 to 1/7/26 documented he received antipsychotic and antidepressant medications. Resident #36's Assessments in his medical record on 1/8/26 lacked the completion of an assessment regarding consent for antianxiety and antidepressant medications since admission to the facility. 2. Resident #40's Minimum Data Set (MDS) assessment dated [DATE] listed an admission date of 12/9/25. The MDS identified a BIMS score of 15, indicating no cognitive impairment. The MDS included diagnoses of anxiety, depression, and insomnia. The MDS indicated he received antipsychotic and antidepressant medications in the lookback period. Resident #40's After Visit Summary dated 12/9/25 included orders to take two (2) antidepressant medications daily. Resident #40's December 2025 MAR documented he received antianxiety and antidepressant medications while at the facility since his admission. Resident #40's Assessments in his medical record reviewed 1/7/26 lacked completion of an assessment regarding consent for antianxiety and antidepressant medications since his admission to the facility. In an interview on 1/7/26 at 4:14 PM the Director of Nursing (DON) reported they are working on getting informed consents for black box psychotropic medications for all residents at the behavior meetings they complete weekly. She added they should document the consents in the Assessments portion of the resident's medical record. (continued on next page)

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	165197	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Falls Health Care Center	1728 West Eighth Street Cedar Falls, IA 50613

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 1/8/26 at 11:24 AM the Administrator reported she didn't have documentation of informed consents for psychotropic drug use for Residents #36 and #40. She explained the facility started having weekly behavior meetings in December and that is something they are working on a plan to be in compliance within the next quarter. Review of the facility's Antipsychotic Medication Use policy revised December 2016, lacked instruction of when to communicate and obtain informed consent of medications with black box warnings to the resident or resident representative. 3. Resident #8's MDS dated [DATE] showed a BIMS score of 15/15, indicating intact cognition. The MDS documented a Patient Health Questionnaire-9 (screening tool for monitoring the severity of depression) score of 6/29, indicating mild depression. The resident exhibited verbal behaviors 4-6 days per week and rejection of care 1-3 days per week. The MDS included diagnoses of stroke, depression, schizophrenia. The MDS reflected Resident #8 used antipsychotic and antidepressant medications during the lookback period. The General Progress Note dated 12/9/25 at 10:09 AM documented a new physician order for olanzapine (antipsychotic medication). A New Pharmacy Electronic Order dated 12/9/25 listed an order for olanzapine 5 milligrams (MG). Take one tablet by mouth daily every morning and olanzapine 10 MG take one tablet at bedtime. Resident #8's December 2025 Electronic Medication Administration Record (EMAR) included the following orders: Start date 10/31/24: Olanzapine 20 MG, give 0.5 tablet by mouth two times a day related to schizophrenia and schizoaffective disorder, depressive type. Discontinued 12/9/25. Start Date 12/9/25: Olanzapine 10 MG, give 10 MG by mouth at bedtime relate to schizophrenia. Documented as given every day following the start date in December. Start Date 12/10/25: Olanzapine 5 MG, give 5 MG by mouth in the morning related to drug induced subacute dyskinesia. Documented as given every day following the start date in December. Start date 3/8/24: Sertraline 100 MG by mouth one time a day Documented as given every day in December. Start date 1/31/25: Trazodone 100 MG one time a day (both antidepressant medications). Documented as given every day in December. Resident #8's January 2026 EMAR listed the following medications administered daily through review date of 1/7/26: Start Date 12/9/25: Olanzapine 10 MG, give 10 MG by mouth at bedtime relate to schizophrenia. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Start Date 12/10/25: Olanzapine 5 MG, give 5 MG by mouth in the morning related to drug induced subacute dyskinesia. Start date 3/8/24: Sertraline 100 MG by mouth one time a day Start date 1/31/25: Trazodone 100 MG one time a day (both antidepressant medications). A 1/7/26 review of Resident #8's Electronic Health Record (EHR) Progress Notes, Assessments, and Miscellaneous documentation lacked documentation they facility informed them in advance of the risks and benefits of the medication, treatment alternative, or other options. During an interview on 1/7/26 at 12:33 PM the Administrator reported they didn't find any medication education or consent documentation for Resident #8 regarding his medications. They identified the issue of missing consent forms for psychotropic medications about a month ago and have tried to get any new medications orders addressed. On 1/8/26 at 10:20 AM the Administrator reported they identified the medication education consents as an issue. They worked on a quality assurance (QA) project and have added the consent education forms to the QA and will address it going forward.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review the facility failed to accurately code 1 of 2 residents with a Preadmission Screening and Resident Review (PASRR) (a federal assessment that is a requirement for Medicaid-certified nursing facilities to screen all applicants for serious mental illness, intellectual disabilities, or developmental disabilities to ensure they are placed in the most appropriate, least restrictive setting and receive needed services, preventing inappropriate institutionalization and promoting community-based care) (Resident #7) on the Minimum Data Set (MDS) assessment. The facility reported a census of 43 residents. Findings include: Resident #7 PASRR's dated 1/13/23 revealed she had a PASRR Level II outcome (a detailed evaluation confirmed an individual has a serious mental illness or intellectual disability related condition, that determined she needs specialized services, the result is not just a diagnosis but a decision about the necessary support, leading to recommendations for specialized care or community-based alternatives). Resident #7's MDS assessment dated [DATE] documented she didn't have a PASRR Level II outcome. In an interview on 1/8/26 at 10:17 AM the MDS Coordinator revealed she used a notebook to write down notes regarding the MDS's she completed. In the notebook she had Resident #7 as of 12/11/25 MDS, she had a PASRR Level I. She looked at Resident #7's PASRR dated 1/13/23 and confirmed she had a PASRR level II. The MDS Coordinator reported the MDS dated [DATE] was coded inaccurately. She explained her process normally worked but she must have looked at the PASRR too quickly. She reported she would modify the 12/11/25 MDS to fix the error. She added the facility didn't have a specific policy for completing MDS assessments and instead followed the Resident Assessment Instrument (RAI) manual (federal guidelines for completing the MDS in nursing facilities to assess long-term care residents) for instruction on how to complete the MDS.

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	165197	A. Building B. Wing	01/08/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, policy review and staff interview, the facility failed to assess 1 of 1 residents positive for influenza A (Resident #17). The facility identified a census of 43 residents.Findings include:Resident #17 Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) Score of 6, indicating severe cognitive loss. The MDS listed diagnoses of altered mental state, acute respiratory (lung) failure and adult failure to thrive. The Electronic Healthcare Record (EHR) Census documented Resident #17 resided in a room in the D hallway. A 1/2/26 Hospital After Visit Summary documented Resident #17 had a hospital emergency room (ER) visit for shortness of breath (SOB) with a diagnosis of influenza A and chronic obstructive pulmonary exacerbation (blockage in the lungs that makes it difficult to breathe). The After Visit Summary included to call the doctor or seek immediate medical care if they had any of the following:Trouble breathingFever with a stiff neck or severe headachePain or pressure in the chest or bellyFever or cough that returns after getting betterFeeling sleepy, dizzy, or confusedUnable to urinateExperience severe muscle pain, weakness or unsteadinessMedical condition worsensResident #17's Health Care Provider's Orders upon return from the hospital ER on [DATE] at 3:30 PM directed the following:Duo-nebulizer (breathing treatment) every 6 hours while awake for 7 days.Prednisone (steroid medication used to reduce swelling) 40 milligrams (MG) at 7 PM and then 1/3/26 every day for 4 additional days with their morning medications.Monitor pulse oximetry (blood oxygen level), if less than 90 percent (%) return to the emergency room. Start Tamiflu when arrives from pharmacy on 1/3/26. First dose given on 1/2/26 while at the ER. During entrance on 1/5/25 at approximately 9:30 AM the Administrator reported Resident #17 tested positive for influenza A. A 1/7/26 review of the Electronic Healthcare Record (E.H.R.) Assessments and Progress Notes lacked any physical assessment of Resident #17 since his return on 1/2/26 at 5:48 PM through 1/5/26. A 1/7/26 review of the EHR Vital Signs revealed the following:Temperature documented on 1/3/26 of 97.8 degrees Fahrenheit (F) at 12:15 PM onlyPulse documented 1/3/26 at 12:15 PM of 68 beats per minute (expected between 60-100).Respirations 1/2/26 at 8:15 PM and 1/3/26 at 12:15 PM of 16 breaths per minute (expected between 12-20).Blood pressure 1/3/26 at 12:15 PM of 116/69 (expected around 120/80). Oxygen oximetry1/3/26 at 2:22 AM of 91%1/3/26 at 8:34 AM 97%1/3/26 at 5:31 PM of 94%1/4/26 9:43 AM 94%1/5/26 7:36 AM 92%. The Daily Assignment Sheet for 1/3/26 and 1/4/26 documented the following staffing:6AM to 2 PM Staff B, Registered Nurse (RN), assigned to the A/B hallway and Staff C, Certified Medication Aide (CMA), assigned to the C/D hallway. 2 PM to 10 PM Staff D, Licensed Practical Nurse (LPN), assigned to the A/B hallway and Staff C assigned to the C/D hallway.10 PM to 6 AM Staff E, Assistant Director of Nursing (ADON) / Infection Preventionist, as the night nurse covering the facility. On 1/7/26 at approximately 11:00 AM, Staff B reported he worked the weekend of Saturday 1/3/26 and Sunday 1/4/26; but he didn't go into Resident #17 Room.On 1/7/26 at 11:39 AM Staff E reported everything with Resident #17 happened late at night and it didn't get passed through report that he tested positive for influenza A. She reported being the on-call nurse on 1/2/26 and never received any notification. She worked Saturday (1/3/26) and Sunday (1/4/26) on the overnight shifts and didn't know Resident #17 tested positive for influenza. During an interview on 1/7/26 at 1:17 PM the Director of Nursing (DON) reported she expected the nurse to assess a resident every shift when they have a change of condition. Specifically in regard to Resident #17 she expected the nurses to do a full set of vital signs, lung sounds, and a pulse oximetry every shift, then document it in the progress notes. The DON reviewed the January 2026 EMAR physician order for the pulse oximetry and reported she expected the nurses to actually document the oxygen level. She confirmed the facility's Infection Preventionist worked the night shift on 1/3/26 and 1/4/26, but said no one informed her a resident tested positive for influenza A. The Change in a Resident's Condition or Status Policy revised May 2017 under Policy Interpretation and (continued on next page)

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	165197	A. Building B. Wing	01/08/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implementation defined a Significant Change of condition as a major decline in the resident's status that wouldn't normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions. The Policy failed to address or direct when to complete a nursing assessment or what to include in the nursing assessment for a change of condition.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff, resident and Nurse Practitioner interviews, and policy review the facility failed to complete pre and post dialysis (an external method to remove the wastes and toxins from the body with poor functioning kidneys) assessments (assessments involving checking the residents blood pressure, temperature, pulse, and weight; and inspection of the dialysis access site on the body) for 1 of 1 residents that received dialysis (Resident #40). The facility reported a census of 43 residents. Findings include: Resident #40's Minimum Data Set (MDS) assessment dated [DATE] listed an admission date of 12/9/25. The MDS identified a BIMS score of 15, indicating no cognitive impairment. The MDS included diagnoses of anxiety, depression, and insomnia. The MDS documented he received dialysis treatment while at the facility. An interview on 1/7/26 at 9:40 AM the Social Worker at the local dialysis center reported Resident #40 received routine dialysis while living at the facility on 12/10/25, 12/12/25, 12/21/25, 12/23/25, 12/26/25, 12/29/25, 12/31/25, and 1/2/26. The Care Plan Problem revised 12/9/25 indicated Resident #40 required dialysis therapy. The Interventions directed to complete the dialysis flow sheet daily to observe shunt access site for complications and report abnormalities to the physician. Resident #40's December 2025 Medication Administration Record (MAR) lacked an a pre or post dialysis assessment directive except for 12/23/25, 12/29/25, and 12/31/25. The MAR didn't have anything to document an assessment for any other days in December 2025. On 1/8/26 review of Resident #40 MAR for January 2026 revealed he did not have a pre-dialysis assessment completed 1/2/26. In an interview on 1/7/26 at 2:42 PM the Director of Nursing (DON) reported the staff only document pre- and post-dialysis assessments on the MAR, and if they are not on there they didn't get done. In an interview on 1/8/26 at 10:14 AM Resident #40 said the staff at the facility did a good job monitoring him and denied issues related to dialysis. Review of the facilities Hemodialysis policy revised in 2025 instructed the facility to complete an assessment of the resident's condition and monitor for complications before and after dialysis treatments received at a certified dialysis facility. In addition, the policy directed the nurse to monitor and document the status of the resident's access site upon return from dialysis treatment to observe for bleeding or other complications.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, staff, resident, and Nurse Practitioner interview, the facility failed to have set blood sugar parameters (a numerical range the blood sugar should remain in) in place for 1 of 3 residents reviewed (Resident #40). In addition, the facility failed to notify a resident's doctor after the completion of elevated blood sugar assessments to ask if additional medication or treatment is needed for 1 of 3 residents reviewed for insulin medication usage (Resident #40). The facility reported a census of 43 residents.Findings include:Resident #40's Minimum Data Set (MDS) assessment dated [DATE] listed an admission date of 12/9/25. The MDS identified a BIMS score of 15, indicating no cognitive impairment. The MDS included diagnoses of anxiety, depression, and insomnia. The MDS documented he received dialysis treatment while at the facility. The MDS indicated Resident #40 received insulin medication during the lookback period.The Care Plan Problem revised 12/22/25 indicated Resident #40 had a diagnosis of diabetes mellitus and dependent on insulin.Resident #40's December 2025 and January 2026 Medication Administration Record (MAR) and Treatment Administration Record (TAR) lacked orders for blood sugar parameters. Review of Resident #40 Weights and Vitals Summary blood sugars from 12/9/25 to 1/7/26 documented the following blood sugars above 450 (milligrams per deciliter) mg/dL (typically expected between 70-150 mg/dL).a. 12/28/25 at 9:18 AM: 461 mg/dLb. 12/28/25 at 7:06 AM: 551 mg/dLc. 12/27/25 at 8:57 PM: 493 mg/dLd. 12/27/25 at 7:40 AM: 557 mg/dLReview of Resident #40 Progress Notes revealed the facility did not notify or call the Doctor for the following elevated blood sugars:a. 12/28/25 at 9:18 AM 461 mg/dLb. 12/28/25 at 7:06 AM 551 mg/dLc. 12/27/25 at 8:57 PM 493 mg/dLd. 12/27/25 at 7:40 AM 557 mg/dLReview of Resident #40 Progress Note dated 1/5/26 10:30 AM documented he vomited and refused to go to dialysis due to not feeling well. Instead he requested to go to the hospital.Resident #40 History and Physical from the local hospital dated 1/5/26 at 1:21 PM documented a blood sugar greater than 600 mg/dL. Documentation indicated he reported he feeling fairly well until the evening of 1/4/26 when his blood sugar started going up. At that time, he started experiencing abdominal discomfort with some nausea and vomiting. Review of Resident #40 Progress Note dated 1/5/26 at 5:31 PM documented the local hospital called to reported they admitted him for diabetic ketoacidosis (a life-threatening condition caused by a severe lack of insulin in the body, leading to high blood sugar, ketones, and blood acidity).In an interview on 1/7/26 at 4:14 PM the Director of Nursing (DON) explained she didn't know Resident #40's blood sugar parameters, but asked his doctor to get parameters orders in place for him. She explained she expected the nursing staff to call the Doctor if his blood sugar is below 70 or above 350 since they do not have sliding scale orders outside of that range (below 70 or above 350).In an interview on 1/8/26 at 10:14 AM Resident #40 reported the staff at the facility did a good job monitoring his blood sugars and said it always ran high, and the facility did nothing. He added that sometimes he refused medications or to go to the emergency room (ER) for evaluation and the facility did a good job monitoring him.In an interview on 1/8/26 at 11:24 AM the Administrator explained she expected staff to have parameters in place for Resident #40's blood sugars and to call his doctor outside of those parameters to seek guidance. In an interview on 1/8/26 at 11:44 AM Resident #40's Nurse Practitioner reported his blood sugars rapidly change, as he is very non-compliant with what he ate. She explained she expected the facility staff to notify her or his doctor of blood sugars below 40 mg/dL and above 450 mg/dL. She added she is at the facility on a rotating schedule, but usually came to the facility 3 times a week and the staff always let her know what his blood sugars are doing while she is onsite. She then informed his blood sugars can be at 350 mg/dL and then drop to 40 mg/dL in less than an hour and he can also go from 40 mg/dL to 350 mg/dL as well. Giving him extra insulin medication can be very hard to prescribe due to his diabetes being hard to manage.Review of the Hypoglycemia (elevated blood sugar) Management (continued on next page)

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	165197	A. Building B. Wing	01/08/2026

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	policy, copyright 2025 instructed residents with a diagnosis of diabetes or used medications that could lower the blood sugar should have orders for glucose monitoring and treatment for low blood sugars, unless otherwise ordered by their doctor.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, policy review, manufacturer's guide for use and staff interview, the facility failed to properly prime an insulin pen and prevent expired insulin from being administered for 1 of 1 residents observed (Resident #39). The facility identified a census of 43 residents.Findings include:During the Medication Task observation on [DATE] at 11:55 AM Staff B, Registered Nurse (RN) reviewed Resident #39's Electronic Medication Administration Record (EMAR). Resident #39's EMAR documented a physician order for Lantus Solostar Insulin Pen 100 Units/Milliliter (ML). Inject 10 units subcutaneously. Staff B, without placing a needle on the insulin pen, set the insulin pen, dated [DATE], to 2 units, hit the plunger and primed the pen with no insulin expressed from the pen. Staff B then set the insulin pen to ten units and placed the needle on the pen to give the insulin to Resident #39. Staff B failed to check the insulin pen expiration until after the Surveyor asked for the date. Staff B first stated it was okay, then responded no it wasn't okay to give the insulin. At 11:57 AM Staff B obtained a new insulin pen for Resident #39. Staff B set the dial on the pen to 2 units without placing a needle on the pen. He again hit the plunger to prime the pen without any insulin visibly expressed from the pen. Staff B failed to prime the insulin pen per the manufacturer's directions a second time. On [DATE] at 12:30 PM the Director of Nursing (DON) explained she dialed the insulin pen to two units and hit the plunger to prime the insulin pen. The DON stated if she was being honest, she didn't think she placed a needle on the insulin pen prior to priming the pen either. Their pharmacist provided them with the procedure, and it is hanging in the medication room. On [DATE] at 11:25 PM the DON explained they have a guide the nurses use that has the insulin expiration dates. The list are in the nurses' stations.Interview on [DATE] at 11:30 AM Staff B verified they had an expiration list for the insulins at the nurses' station at one time. He looked for the insulin list but could not locate it in the nurses' station. On [DATE] at 11:37 AM the DON reported she called the pharmacy to get new copies of the insulin expiration list for the nurses to have in the nurses' stations.The How to Use An Insulin Pen (guide from pharmacy) dated 2014 directed to peel back the cover on the needle, screw the needle onto the pen, remove the cap from the needle, turn the dial to 2 units, hold the pen so the needle is up in the air, push the end of the pen in to clear the air, watch the tip of the needle for a drop of insulin. It may need done more than once to see the insulin drop on the needle. The Insulin Administration Policy revised [DATE] lacked step by step direction or guidance on the priming of an insulin pen or administration of insulin via pen. The Manufacturer's Step by Step guide to using a Lantus Solo Star Pen dated 2022 directed after 28 days to throw the opened Lantus pen away even if it still had insulin in it. The Guide instructed under Step 2 and 3 the following procedure to prime the insulin pen:Wipe the pen tip (rubber seal) with an alcohol swab.Remove the protective seal from the new needle.Line the needle up straight with the pen and screw the needle on.Dial a test dose of 2 Units.Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose.Press the injection button all the way in and check to see that insulin comes out of the needle. The dial will automatically go back to zero after you perform the test.If no insulin comes out, repeat the test 2 more times. If there is still no insulin coming out, use a new needle and do the safety test again.An Appendix of Resources Medications with Special Expiration Date Requirements dated 2007 (document from the facility pharmacy) documented a Lantus pen, in use and not refrigerated remained good for 28 days.

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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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. Based on policy review, document review and staff interviews, the facility failed to ensure an effective Quality Assurance Performance Program (QAPI) to address previously identified quality deficiencies, resulting in repeated identified concerns during the current survey. The facility reported a census of 43 residents.Findings include:A review of the facility's 12/12/24 Statement of Deficiencies and Plan of Correction showed citations for F760 ensuring residents are free of significant medication errors. The facility's Plan of Correction identified the following: Immediate education on correction administration per the manufacturer's guidelines for the staff involved.The facility identified all other residents using insulin pens to ensure staff were following correct administration.Education was provided on 12/18/24.The Director of Nursing (DON)/Designee performed audits daily x 5, weekly x 4, monthly x 2 with the results being forwarded to the QAPI committee. The Statement of Deficiencies also showed a citation for F880 Infection Control regarding staff touching medications with their bare hands during medication administration. The Plan of Correction documented the following: Staff involved were educated on proper infection control procedures.Staff washed hands and sanitized the medication cart per the facility infection control policy.Education was provided to staff on 12/23/24.The DON or Designee performed audits daily x 5, weekly x 4, monthly x 2 with the results being forwarded to the QAPI committee.The facility documented compliance on 1/9/25. During the facility's annual recertification from 1/5/26 to 1/8/26 observations, clinical record review, document review and policy review revealed repeated concerns for F760 insulin pen priming and administration and F880 Infection Control with dirty gloves touching oral medication prior to administration as evidenced on the 2026 Statement of Deficiencies. Interview completed on 1/8/26 at 10:05 AM the Administrator and DON acknowledged the facility didn't correct the issues from the last survey. The DON stated she observed medication passes since 1/9/25 but she didn't document any of the audits. She didn't know why the nurses started using gloves, or how that came to be. The nurses should not handle oral medications with dirty gloves. They can't touch the meds after touching the tablet screen. The consulting pharmacist comes in and completed medication inspection every month. The DON reported they planned a nursing skills fair and then they didn't get it done prior to survey. The QAPI Quality Assessment Assurance (QAA) Plan updated 12/18/23 outlined the DON or Designee would be responsible for the development and ongoing monitoring of care giver proficiency. Ongoing proficiency shall be determined through the evaluation process and all other processes deemed necessary through the QAPI process. The Policy further outlined the QAPI Committee would review all Performance Improvement Plans and outcomes to assure efficacy and sustainability.