STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165298	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinnacle Specialty Care	1223 Prairieview Road 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, staff, and resident interviews, the facility failed to ensure 1 of 3 residents received adequate nursing supervision and follow up assessment after a staff member transferred a resident using less than the required staff needed to transfer him as directed in the Care Plan and resulted in him being lowered to the floor (Resident #4). The facility reported a census of 93 residents. Findings include:The Minimum Data Set (MDS) dated [DATE] for Resident #4 documented a Brief Interview for Mental Status of 9, suggesting moderate cognitive impairment. The MDS documented he is dependent on staff (staff does all the effort) for transferring from chair or bed to chair transfers. The MDS revealed he had diagnoses of cancer, malnutrition, and septicemia (a life-threatening condition where an infection spreads throughout the bloodstream).Review of Witnessed Fall report for Resident #4 dated 8/4/25 at 10:00 AM informed Resident #4 wife called and reported a CNA lowered Resident #4 to the floor on 8/1/25. The facility implemented an intervention to educate staff on how he is transferred. Record review of the Corrective Action Form dated 8/4/25 for Staff D documented the following verbal warning: Staff D transferred the resident with one assist, despite the resident's mention that they would require a second person for the transfer. As a result, the CNA dropped the resident to the floor without reporting the incident to any nursing staff. During an interview on 10/13/25 at 12:15 PM Resident #4 informed he had a fall at the facility in August 2025 after returning from the hospital. He revealed he told Staff D, Certified Nurse Aide (CNA), she could not do it herself and needed someone else to help her, but Staff D did not listen. He explained Staff D had to lower him to the floor. During an interview on 10/14/25 at 1:18 PM with the Administrator informed Staff D did not notify a nurse when she lowered Resident #4 to the floor on 8/1/25 and he was not assessed by a nurse at the time of the fall. She then informed on 8/4/25 Resident #4 wife informed the facility of the incident on 8/1/25 and the Director of Nursing (DON) provided education for Staff D, and a fall report was completed. During an interview on 10/14/25 at 1:24 PM with the Director of Nursing (DON) informed she provided education on 8/4/25 to Staff D regarding Resident #4 fall on 8/1/25 and no injuries resulted from being lowered to the floor. She informed Staff D informed her she thought he only needed one (1) staff to assist him. She informed staff D was educated all falls even if lowered to the floor need to have assessments completed by a nurse. Review of Resident #4 current Care Plan on 10/14/25 instructed staff starting on 4/30/25 he needs assistance of two (2) staff for transfers. The Care Plan also documented a fall intervention implemented on 8/1/25 informing fall education was provided to staff.Review of the facility policy, Falls - Clinical Protocol, Assessment and Recognition, revised March 2018 instructed the following: Staff will evaluate and document falls that occur while the individual is in the facility; for example, when and where they happen, any observations of the events, etc.

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, electronic health record (EHR), facility policy review, resident and staff interviews, the facility failed to consistently respond to activated call lights within a reasonable amount of time. Residents reported having to wait 1.5 to 2 hours for the call light to be answered. Observations revealed response time had been greater than 15 minutes for 1 of 4 residents observed (Resident #7). The facility reported a census of 93.Findings include:An evaluation for Nursing Section GG completed on 10/3/25 at 10:43 PM documented Resident #7 required partial/moderate assistance (Helper does LESS THAN HALF the effort. Helper lifts,holds, or supports trunk or limbs, but provides less than half the effort.) for toileting hygiene and toilet transfers. A Brief Interview for Mental Status (BIMS) evaluation completed on 10/10/25 for Resident #7 documented a BIMS score of 15, indicating intact cognition. The Care Plan Report Focus initiated 10/11/23 for activities of daily living (ADL's) indicated Resident #7 has glasses and at times she refused to wear her ankle-foot orthoses (AF0s - lower lime orthoses). The Interventions included: a. Ambulation - walk with an assist of 1 with walker, wheelchair (w/c) for mobility, she could self-propelb.Toileting - Resident #7 required 1 assist. c. Transfer - Resident #7 required 1 assist with walkerDuring an observation on 10/13/25 at 6:45 PM, the lighted hall display on the 300-hall indicated Bath 308 ecall (call light) had been activated. In an interview on 10/13/25 at 6:53 PM, Resident #7 reported staff are not very prompt at responding to call lights. Resident #7 reported she has waited 1 1/2 and up to 2 hours for staff to respond to her needs. Resident #7 reported she transferred herself to the toilet and set a timer to monitor staff response. Resident #7 held her left arm up revealing a device that appeared to be a smart watch. Resident # 7 stated it had been about 10 minutes since she activated her call light. Resident #7 reported when her timer reaches 15 minutes, she pulls the string to reactivate the system. Resident #7 voiced staff care more about charting than caring for residents. During an observation on 10/13/25 at 7:03 PM, the Champion ecall monitor at the nurses' station revealed the following:Bath Ecallroom [ROOM NUMBER]Age: 00:18:02Third resoundDuring an observation on 10/13/25 at 7:05 PM, Staff A, Certified Nursing Assistant (CNA), exited a resident room and pushed a mechanical lift down the hall leaving it outside of room [ROOM NUMBER]. Staff A proceeded to walk by room [ROOM NUMBER] without responding to the activated ecall light. During an observation on 10/13/25 at 7:07 PM, Staff B, Certified Medication Aide (CMA)/CNA, passed by room [ROOM NUMBER] without entering.During an observation on 10/13/25 at 7:08 PM, Staff B and Staff C, Licensed Practical Nurse (LPN) passed by room [ROOM NUMBER] without entering. During an observation on 10/13/2025 at 7:14 PM, Staff A entered room [ROOM NUMBER] to assist Resident #7. In an interview on 10/13/25 at 7:31 PM, Staff B verbalized activated call light response should be within 5 minutes.In an interview on 10/13/25 at 7:36 PM, Staff C verbalized activated call light response is within 5-12 minutes and she assists CNA staff if a second person is needed. In an interview on 10/14/25 at 11:03 AM, the Administrator reported she used call light audit forms to audit call lights that have been identified. The Administrator verbalized the expectation of activated call light response is within 15 minutes or less. The Administrator reported staff are trained on the call light system upon hire. Review of the employee file for Staff B documented a hire date of 12/21/23.The Job Description with a position title of Certified Nursing Assistant directed to assure residents have call lights at hand and answer call lights promptly. The Job Description lacked a definition for promptly. Staff B signed the Job Description on 12/21/23. The Job Description lacked the supervisor signature. The Orientation Checklist: Nursing Assistant for Staff B included the call light system was reviewed on1/4/24. Staff B signed the Orientation Checklist: Nursing Assistant on 1/4/24 verifying all had been reviewed. Review of the employee file for Staff C documented a hire date of 4/10/25. The Job Description with a position title of Charge Nurse - LPN directed to supervise response to resident's call for (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assistance.The Job Description lacked defining response to resident's call for assistance. Staff C signed the Job Description on 4/10/25. The Orientation Checklist: Licensed Nurses included the call light system. Staff C signed the Orientation Checklist: Licensed Nurses verifying all had been reviewed. The document lacked a date of completion. Review of Call Light Audit Reports revealed 33 rooms with activated call lights had been audited. Audits dated back to 9/9/25 and revealed the facility identified 2 call lights exceeded 15 minutes. The Call Light Audit Report lacked the identified room of 308.Review of the Answering Call Light facility policy reviewed March 2021, indicated the purpose of the procedure is to ensure timely response to the resident's request and needs. The policy directs staff:1. Identify yourself and politely respond to the resident by his/her name (e.g., this is Mrs. [NAME], Mr. [NAME], how may I help you?)a. If the resident needs assistance, indicate the approximate time it will take for you to respond.b. If the resident's request requires another staff member, notify the individual.c. If you are uncertain as to whether or not a request can be fulfilled or if you cannot fulfill the resident's request, ask the nurse supervisor for assistance. 2. If assistance is needed when you enter the room, summon help by using the call signal. The policy lacked defining timely response to the resident's needs.