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	04/02/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review, resident, staff, and Advanced Registered Nurse Practitioner (ARNP) interview, the facility failed to revise the Care Plan to include new interventions to address skin integrity and non-compliance with bed rest for one of 16 residents reviewed (Resident #2). The facility reported a census of 93 residents.Findings include: Resident #2's Minimum Data Set (MDS) Assessment, dated 2/10/26, documented a Brief Interview for Mental Status (BIMS) score of 10, indicating moderately impaired cognition. The MDS documented diagnoses of Parkinson's Disease, polyneuropathy (damage to multiple peripheral nerves throughout the body), and a left fibula (lower leg bone) fracture. The MDS identified Resident #2 as being at risk for pressure ulcers but indicated no unhealed pressure ulcers or injuries at that time.The Care Plan Focus revised 3/16/26 identified Resident #2 had a potential/actual skin integrity impairment. The Interventions dated 2/5/26 included the following:a. Avoid scratching. Keep hands and body parts from excessive moisture. Keep fingernails short.b. Cushion to wheelchairc. Provide education to prevent skin injuryd. Encourage good nutrition and hydration to promote healthier skine. Identify/document potential causes. Eliminate and resolve when possible.f. Follow facility protocols for treatment of injury.g. Pressure relieving/reducing mattressh. Treatments per providers orders.An Interdisciplinary Team (IDT) Note dated 2/20/26 at 2:15 PM documented a new pressure area on the buttocks. A Nurses Note dated 2/20/26 at 4:10 PM reflected the facility received a new order from the Advanced Registered Nurse Practitioner (ARNP) for zinc oxide (a thick, white cream that creates a waterproof barrier to protect skin from moisture and irritation) twice a day (BID) and as needed (PRN).An ARNP Progress Note dated 2/24/26 directed staff to treat the buttock wound with Calmoseptine (thick paste used to protect skin from moisture and promote healing), reposition Resident #2 frequently, and use a wheelchair cushion.A Nurses Note dated 3/3/26 at 8:53 PM documented a new order for a Wound Clinic referral.An After Visit Summary Note dated 3/6/26 at 11:00 AM from the Wound Clinic ordered Santyl (a debriding ointment) treatments and directed Resident #2 to be on bed rest, up for meals and physical therapy (PT) only.A Dietary Note dated 3/6/26 at 1:17 PM reflected the Dietitian (RD) recommended starting protein supplements and extra eggs due to the deterioration (worsening) of the wound.An After Visit Summary dated 3/19/26 the clinic reiterated Resident #2 should be up for meals only and then returned to bed immediately.An Orders Administration Note dated 3/21/26 at 3:18 AM indicated Resident #2 had an active order to be up for meals only and return to bed immediately every shift.A Nurses Note dated 3/23/26 at 1:59 PM reflected Resident #2 received new orders for doxycycline (an antibiotic) and vinegar soaks daily due to the infection. Staff continued the order of Dakin's (a type of diluted bleach used as a liquid medicine to clean wounds. It helps kill germs and prevents infections so the area can heal.) to pack the wound.During an interview on 3/30/26 at 2:58 PM, Resident #2 stated she believed she got sores from sitting in the wheelchair for too long and that the facility didn't track the skin on her buttocks when she first arrived. She reported a pain level of 7 on a 0-10 scale and stated she would stay up until 10:00 PM if allowed. She noted she should lie down but worried she might not get help to get back up if she did.During an interview on 3/31/26 at 10:57 AM, Staff B, Registered Nurse (RN), stated Resident #2 isn't good at staying on her side and staff (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have to remind her to change positions even though her bottom hurts.During an interview on 3/31/26 at 11:10 AM, Staff E, Certified Nurse Aide (CNA), stated Resident #2 had been in her wheelchair since breakfast and refused to get in bed, claiming she had things to do.During an interview on 3/31/26 at 11:27 AM, Staff D, CNA, stated Resident #2 directed her own care and sits in her wheelchair from breakfast to lunch.During an interview on 3/31/26 at 1:11 PM, the ARNP stated Resident #2 has cognitive impairment and did what she wants. During an interview on 3/31/26 at 2:48 PM, Staff C, RN, stated Resident #2 hardly ever allowed the staff to assist her to bed and refused daily, failing to adhere to the instruction to only be up for meals.During an interview on 4/1/26 at 2:05 PM, Resident #2 sat in a wheelchair in her room with a cushion in place. Resident #2 stated she told staff they can't force her into bed and acknowledged she should be lying down. She explained she's used 3 different wheelchairs since her admission. Resident #2 reported the facility attempted to find a wheelchair to help her pressure ulcers, but she instructed staff to stop because her current wheelchair's fine and shouldn't be changed. Resident #2 stated she received an air mattress after her pressure ulcer occurred. She reported the wound treatment doesn't really hurt and she won't take pain medication except for Tylenol (a medication used to treat pain and fever). Resident #2 explained she only complied with bed rest when her daughter visited and yelled at her to lie down because she wants to stay on her daughter's good side. Resident #2 noted she wouldn't get into bed even if a nurse told her.During an interview on 4/2/26 at 11:05 AM, Resident #2 returned from the wound clinic and remained in her wheelchair and refused to lie down. Resident #2 said she wouldn't lay down and has sat in her wheelchair since leaving that morning.The Care Plan reviewed on 3/31/26 lacked interventions after 2/5/26 attempted by the facility related to Resident #2's pressure ulcer. The Care Plan did not include 3 attempts to find alternate wheelchairs or the implementation of an air mattress. It also didn't address Resident #2's continued refusal to lie down in bed during the day, despite medical advice. Additionally, the Care Plan failed to include Resident #2's decisions to self-direct her care.During an interview on 4/2/26 at 11:21 AM, the Director of Nursing (DON) stated Resident #2 wasn't compliant (failing to follow medical advice or instructions) and self-transferred. The DON noted Resident #2 had a little confusion but was pretty with it. The DON added the facility should have updated her Care Plan to reflect her refusals. The facility expected the CNAs to round every 2 hours and offer assistance.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff and resident interviews, and policy review the facility failed to provide Peripherally Inserted Central Catheter (PICC) line dressing changes for 1 of 3 residents reviewed for intravenous lines (Resident #9). The facility reported a census of 93 residents.Findings include: Resident #9's Minimum Data Set (MDS), dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. Resident #9 had diagnoses including cellulitis of the buttock (skin infection), anemia (low iron), heart failure, renal insufficiency, diabetes mellitus, and hidradenitis suppurativa (painful skin lumps). The MDS documented Resident #9 had a PICC line in place.The Electronic Medication Administration Record (EMAR) lacked documentation of the transparent semi-permeable membrane (TSM) dressing change for the PICC site scheduled for 3/30/26.During an interview on 3/31/26 at 11:22 AM, Resident #9 reported staff flushed the PICC line but didn't change the dressing. An observation of the PICC site at that time revealed the dressing lacked a date or nurse initials.An observation on 4/1/26 at 10:00 AM showed the same dressing remained in place without a date or initials.During an interview on 4/2/26 at 10:30 AM, the Advanced Registered Nurse Practitioner (ARNP) stated the expectation is for the PICC line dressing to be changed weekly. The ARNP was unaware staff hadn't completed the change for the week.An observation on 4/2/26 at 10:37 AM showed the PICC dressing had a date of 4/1/26 and nurse initials. Resident #9 verbalized staff changed the dressing the previous day.During an interview on 4/2/26 at 11:20 AM, the Director of Nursing (DON) verbalized the PICC dressing should be changed weekly and as needed. The DON stated she wasn't aware the treatment wasn't done for 3/30/26 until 4/1/26.The facility policy titled Central Venous Catheter Dressing Changes revised April 2016 directed staff to change TSM dressings at least every 5 to 7 days and as needed if wet, soiled, or not intact.

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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 and resident interviews, and policy review, the facility failed to complete pre-dialysis assessments for 1 of 1 residents prior to their departure for dialysis services (Resident #5). The facility reported a census of 93 residents. Findings include:Resident #5's Minimum Data Set (MDS) dated [DATE] recorded a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS included diagnoses of type 2 diabetes mellitus (DM) with other diabetic kidney complications, (insufficient insulin production caused high blood sugar that damaged kidney vessels), anxiety, high blood pressure, depression, schizophrenia, seizures, and heart failure (the heart doesn't pump blood efficiently). The MDS reflected Resident #5 received dialysis (a treatment that filters waste, excess fluid, and salt from the blood when kidneys fail).Resident #5's Electronic Health Record (EHR) lacked documentation of a pre-evaluation for dialysis for the month of March 2026.On 3/31/26 at 12:58 PM, Resident #5 verbalized the staff didn't check her vitals before she left for dialysis.On 4/1/26 at 10:20 AM, Staff A, Registered Nurse (RN), commented Resident #5 left about 3:30 AM on dialysis days. Staff A didn't complete an assessment on Resident #5 before they left. Staff A reported she'd never received education on a dialysis assessment.On 4/1/26 at 10:42 AM, the Director of Nursing (DON) verbalized she expected a dialysis assessment to include obtaining the resident's weight and vital signs, observe the fistula site for signs and symptoms of complications, and document in the EHR the evaluation for the dialysis assessment.The End-Stage Renal Disease (ESRD), Care of a Resident policy dated October 2025 instructed staff regarding the general care of residents receiving dialysis treatment. A review of the policy lacked assessment direction of completing a pre- and post- dialysis treatment.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review, staff and physician interviews, and policy review the facility failed to ensure stock over-the-counter (OTC) medications were on hand for administration. This failure resulted in medications such as Miralax, Lidocaine patches, Sennaside, and Acetaminophen (APAP) being unavailable for multiple days.The facility reported a census of 93 residents.Findings include: 1. Resident #7's March 2026 Medication Administration Record (MAR) revealed he did not receive Poly-Iron 150 Oral Capsule (medicine used to treat an iron deficiency) 150 milligrams (mg) on 3/12, 3/14, 3/15, 3/16, 3/17, 3/21, 3/22, 3/23, 3/24, and 3/25.Staff documented a code of 9 for these dates, which directed the reader to the Progress Notes for further explanation. Resident #7 received all other medications as scheduled on these specific dates.Review of Resident #7's Progress Notes lacked clarification as to why the staff did not provide the supplement on the dates listed above.2. Resident #1's January 2026 MAR revealed an order dated 12/27/25 for Loratadine (used to treat allergies) Oral Tablet 10 mg. The instructions directed staff to give 0.5 tablet (5 mg) by mouth once daily for prophylaxis (action taken to prevent disease).Staff documented a code of 9 on 1/1, 1/3, 1/4, 1/5, 1/6, and 1/7, which directed the reader to the Progress Notes for further explanation. Resident #1 received all other medications as scheduled on these specific dates.Review of Resident #1's Progress Notes lacked clarification as to why the staff did not provide the medication on the dates listed above.During an interview on 3/31/26 at 10:30 AM, Staff B, Registered Nurse (RN), commented that marking a 9 on the Electronic Medication Administration Record (EMAR) meant they didn't give the medication. Staff B stated the facility previously directed staff to no longer chart drugs not available and instead must chart on order. She noted if the facility didn't have stock medications available, the office staff sometimes went out to a local store to purchase them.During an interview on 3/31/26 at 11:00 AM, Staff F, Certified Medication Aide (CMA), verbalized she marked a 9 on the EMAR for medications not given and adds a progress note. She stated the facility has been out of medications such as Miralax (a laxative), lidocaine patches (medicated patches for pain), sennoside (a medication used to treat constipation), and acetaminophen (APAP) (a medication used to treat pain and fever). Staff F confirmed she has been out of medication for multiple days at a time and didn't know if someone notified the physician when they didn't have the medications available.During an interview on 3/31/26 at 1:30 PM, the Advanced Registered Nurse Practitioner (ARNP) verbalized she didn't know of unavailable stock medications and no one notified her. She commented she would like to be aware if they didn't have the medication on hand. She added sometimes she ordered a wound treatment and the facility still didn't have the supply a week later.During an interview on 3/31/26 at 2:21 PM, Staff G, Licensed Practical Nurse (LPN), verbalized a 9 on the EMAR meant see progress note. She commented the facility didn't have stock medication available for multiple days. If they didn't have the medication available, she would notify the physician to see if they could replace it with something else on hand.During an interview on 3/31/26 at 2:48 PM, Staff C, RN, verbalized if medication is out of stock, she would write the needed item on a sheet in the medication room for a physician to address. She stated if a pain medication is not available, the Director of Nursing (DON) would sometimes send someone to a local store that sells over-the-counter (OTC) (medication that can be bought without a prescription) medications to get it.During an interview on 4/2/26 at 11:35 AM, the DON confirmed they try to stay on top of having medications available and that a 9 on the EMAR means they didn't give the drug. She stated the facility started a new process of checking and ordering medications on Tuesdays.The Ordering and Receiving Medication policy, dated May 2023, instructed the facility to transmit requests for non-prescription medications and supplies to the pharmacy provider as early as possible to assure that the necessary medications are on hand at all times. The policy recommended assigning a staff member one day a week to check for medications that need reordering before the weekend.