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	06/09/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on electronic health record (EHR), facility records, facility policies and staff interviews the facility failed to timely report an allegation of abuse for 1 of 2 residents (Resident #33) reviewed. The facility reported a census of 92 residents. Findings include:Resident #33's Minimum Data Set (MDS) assessment dated [DATE] included a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS documented Resident #33 had no hallucinations (seeing things not there) or delusions (false beliefs). The MDS identified Resident #33 as occasionally incontinent of urine. The MDS documented Resident #33 had a recent surgery and required surgical wound care. The MDS included diagnoses of heart failure (weak heart), diabetes mellitus (high blood sugar), and hip fracture (broken hip). The Care Plan Report initiated on 4/15/26 identified Resident #33 had skin impairment to a surgical hip and a blister to the top of the left foot. The Care Plan included the following Interventions:4/15/26: Staff to educate Resident #33, family, and caregivers of causative factors and measures to prevent skin injury.4/16/26: Staff to monitor for and document the location, size, and treatment of skin injury.4/30/26: Staff to apply Tubi grips (elastic bandages) from knees to toes in the morning and off in the afternoon. A Grievance/Concern Investigation form dated 4/29/26 signed by a Resident #33's Representative alleged negligent care. The section labeled Action and Follow-up indicated the Administrator discussed Resident #33's care with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) - all care was performed appropriately and per the doctor's orders. The Administrator signed 4/29/26. A Grievance/Concern Investigation form dated 4/30/26 alleged the facility didn't follow the wound orders and Resident #33 had wraps left on all night that were to be taken off. The wraps were too tight and cut off blood circulation which left bruises and blisters. The Traveling Director of Nursing Services (DON) documented the provider saw Resident #33 on 4/28/26 and gave new orders. The provider saw Resident #33 on 4/30/26 and explained to Resident #33's daughter, her feet appeared better than prior. A Social Service Note on 4/30/26 at 11:14 AM documented Resident #33's daughter came in today to talk with the Social Worker about issues with her mom's foot. The daughter felt very concerned with Resident #33's feet and felt scared to take her home. An Order Administration Note on 4/30/26 at 6:02 PM documented Resident #33 discharged at 3:40 PM. Review of the Self Reports provided by the facility documented an incident dated 4/15/26 filed 5/28/26 with the incident type listed as other. On 5/28/26 at 3:20 PM, the Area Administrator verbalized when they reviewed the Grievance/Concern Investigation Form, she realized they should have submitted a facility self-report. The Area Administrator acknowledged they submitted the facility self-report on 5/28/25 for an allegation of abuse that occurred in April 2026. The Area Administrator acknowledged the facility didn't submit the self-report timely. The Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigation policy revised April 2021 directed the following:Reporting Allegations to the Administrator and AuthoritiesIf resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law.The administrator or the individual making the allegation immediately reports his or her (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	suspicion to the following persons or agencies:i. The state licensing/certification agency responsible for surveying/licensing the facility;ii. The local/state ombudsman;iii. The resident's representative;iv. Adult protective services (where state law provides jurisdiction in long-term care);v. Law enforcement officials;vi. The resident's attending physician; andvii. The facility medical director. Reporting Results of InvestigationsThe administrator, or his/her designee, provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident.The resident and/or representative are notified of the outcome immediately upon conclusion of the investigation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on electronic health record (EHR), facility records, personnel file and staff interview the facility failed to develop and implement a comprehensive Care Plan for 1 of 3 residents (Resident #22) reviewed. The facility reported a census of 92 residents. Findings include:Resident #22's Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of anxiety disorder (excessive worry), type II diabetes mellitus (high blood sugar), and osteoarthritis (chronic joint pain). Resident #22 received scheduled pain medications and occasionally experienced pain in the five-day look-back period. The Care Plan Report initiated on 7/25/24 identified a focus area for activities of daily living (everyday tasks) that directed staff to follow these interventions:Two-assist with bed mobility.Toileting: Two-assist with a mechanical lift when toileting.Provide care in pairs initiated 5/14/26. The Documentation Survey Report V2 for April 2026 revealed Staff B, Certified Nursing Assistant (CNA), provided bowel and bladder elimination for incontinence (loss of bladder or bowel control) care on 4/26/26 at 12:49 AM and also on 4/27/26 at 2:42 AM on the overnight shifts. On 5/27/26 at 3:55 PM, Resident #22 verbalized a CNA changed her brief and verbalized she felt a knuckle in her back and reported it to Staff A, the Interim Administrator. Resident #22 couldn't recall the date, but verbalized it occurred on the overnight shift. Resident #22 reported she's very sensitive to touch. On 5/8/26 at 9:32 AM, Staff B reported she's familiar with Resident #22. Staff B reported Resident #22 required the assistance of 2 staff members. Staff B recalled providing care for Resident #22 on an overnight shift from 10:00 PM to 6:00 AM on Sunday night, 4/26/26. Staff B verbalized for bed mobility; Resident #22 only required the assistance of one staff member. Staff B revealed she's the only CNA scheduled on the unit. Staff B admitted they had no other staff members in the room when she changed Resident #22's incontinent brief. Staff B reported she entered the room and asked Resident #22 if she needed changed. Staff B verbalized Resident #22's a heavier lady and placed an open hand on Resident #22's shoulder and an open hand on Resident #22's waist/back to assist Resident #22 to roll to one side to be changed. Staff B reported at no time would her knuckles touch a resident's back since staff use open hands with fingers extended and the palm side of the hand touching the resident. On 6/2/26 at 1:15 PM, Staff C, Licensed Practical Nurse (LPN), verbalized she's familiar with Resident #22. Staff C reported that for a check and change of an incontinent brief for Resident #22, 2 staff members must assist with care in pairs. On 6/3/26 at 12:20 PM, the Traveling Director of Nursing (DON) acknowledged Resident #22 required the assistance of 2 staff members for bed mobility. The Traveling DON expected care provided per the plan of care for each resident. The Job Description for the position of Certified Nursing Assistant dated April 2021 within Staff B's Personnel File documented a hire date of 4/23/21. Staff B electronically signed the Job Description on 4/2/21 at 4:29 PM. The form instructed the employee to fulfill the following essential functions:Review care plans and perform nursing care as outlined.Assist residents with activities of daily living as documented in the resident's care plan. Staff B's Orientation Checklist: Nursing Assistant dated February 2023 signed by Staff B 2/11/23 verifying all of the above had been reviewed. The form documented Staff B received training on Care Plans and Care Guides.

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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 up to 2 hours for a call light to be answered. Observations revealed a response time greater than 15 minutes for 2 of 2 residents observed (Residents #12 and #35). The facility reported a census of 92.Findings Include:1. Resident #35's Minimum Data Set (MDS) assessment dated [DATE] included a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. The MDS listed Resident #35 as dependent (helper does all effort) for toileting hygiene. Resident #35 required partial/moderate assistance (helper does less than half effort) for toilet transfers. The MDS included diagnoses of diabetes mellitus (high blood sugar), Alzheimer's disease (progressive memory loss), and post-traumatic stress disorder (PTSD) (trauma-induced anxiety). The Care Plan Focus initiated 1/13/26 related to Resident #35's activities of daily living (ADLs) (everyday tasks). The Interventions directed staff that ambulation (walking) required an assist of 1, toileting required an assist of 1, and transfers required an assist of 1. The Care Plan Focus initiated 4/18/26 indicated Resident #35 had a risk for falls. An intervention initiated on 4/18/26 directed staff to encourage Resident #35 to use the call light for assistance. On 6/1/26 at 2:24 PM, Staff D, Certified Nursing Assistant (CNA), stated staff are alerted to activated call lights through the monitor at the nurse's station. Staff D reported they should respond to a call light right away. Staff D revealed Resident #35 voiced concerns about the length of time it took staff to respond to call lights. On 6/1/26 at 2:33 PM, observed Resident #35 sitting in his wheelchair outside his room. Resident #35 stated he waited for someone to take him to the bathroom. He stated he had to go now. On 6/1/26 at 2:44 PM, the Call Light monitor at the nurse's station revealed a bed E-call (electronic call light) for room [ROOM NUMBER] Bed 2 with an age of 44 minutes and 16 seconds at the eighth resound. 2. Resident #12's MDS dated [DATE] included a BIMS score of 15, indicating intact cognition. Resident #12 required partial/moderate assistance for toileting hygiene and toilet transfers. The Care Plan Focus revised 9/25/24 indicated Resident #12 had a risk for falls related to weakness, seizures, and a fall on 6/29/23 that resulted in a left hip fracture. The Intervention revised 9/25/24 directed staff to educate Resident #12 to use her call light for assistance. On 5/28/26 at 1:10 PM, the Call Light monitor at the nurse's station revealed a bath E-call for room [ROOM NUMBER] with an age of 15 minutes and 58 seconds at the third resound. On 5/27/26 at 2:58 PM, Resident #12 reported sometimes it took a long time for staff to respond to her call light. Resident #12 explained about 2 to 3 weeks ago she went to the bathroom and it took 2 hours for staff to respond. Resident #12 reported the bathroom door stayed open and she could see the clock on the wall from her bathroom. Resident #12 stated she had episodes of incontinence (loss of bladder control) since she cannot hold her urine like she did when she lived as a younger woman. On 6/2/26 at 1:15 PM, Staff F, Licensed Practical Nurse (LPN), stated an appropriate response time to an activated call light equaled 15 minutes. On 6/3/26 at 12:20 PM, the Traveling Director of Nursing (DON) stated the facility policy didn't state a targeted time for answering a call light. She acknowledged regulations state 15 minutes as an appropriate response time. On 6/4/26 at 11:29 AM, Staff E, Maintenance, reported if a call light does not operate properly, staff report the issue to him and enter a maintenance ticket in the work order system. Staff E acknowledged he didn't have any recent work orders for the call lights in rooms 302 or 516. The facility's Call Light policy guidelines revealed the age of the alarm displays in hours, minutes, and seconds on the display unit. Once an alarm hits a 5-minute interval, it turns yellow and re-alarms. Alarms resound every 5 minutes for an hour. The Answering the Call Light Policy reviewed March 2021 instructed the purpose of the procedure is to ensure timely response to the residents' requests and needs. The policy directed staff to identify themselves and politely respond to the (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident by name. If the resident needs assistance, staff must indicate the approximate time it will take to respond. If the resident's request required another staff member, staff must notify that individual. If staff feel uncertain whether a request can be fulfilled, or if they cannot fulfill the request, they must ask the nurse supervisor for assistance. If assistance is needed when entering the room, staff must summon help by using the call signal. The policy lacked a definition for what constitutes a timely response to a resident's needs.

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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, electronic health record (EHR), Medication Administration Record (MAR), facility records, facility policy review, resident and staff interviews, the facility failed ensure medication administration was performed in accordance with physician orders and failed to maintain accurate medical record documentation for 2 of 8 residents (Resident #16 and #19) reviewed. The facility reported a census of 92 residents. Findings Include:1. Resident #19's Minimum Data Set (MDS) assessment dated [DATE] included a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented Resident #19 had no hallucinations (seeing things that aren't there) or delusions (false beliefs). The MDS documented Resident #19 was dependent on a helper for all effort to roll left and right and for chair/bed-to-chair transfers. The MDS documented Resident #19 received scheduled and as-needed pain medications. The MDS identified Resident #19 experienced pain almost constantly. The MDS included diagnoses of multiple sclerosis (MS - a chronic autoimmune disease that affects the central nervous system), quadriplegia (paralysis of all four limbs), and anxiety disorder. The Care Plan Focus revised 2/5/26 indicated Resident #19 used opioid medications as needed (PRN). The Intervention dated 3/9/21 directed to administer opioid medication as physician ordered and monitor for side effects. A Physician Order dated 4/29/26 at 12:53 PM directed staff to give Resident #19 morphine sulfate extended release (ER) 30 milligrams (mg) by mouth every 8 hours for pain. The order noted that morphine sulfate is an opioid analgesic (pain reliever) and a controlled drug. A Physician Order dated 5/13/26 at 2:12 PM directed staff to give Resident #19 hydrocodone-acetaminophen 5-325 mg by mouth every 12 hours as needed for pain, not to exceed 3,000 mg daily. The order noted that hydrocodone-acetaminophen is an opioid analgesic and a controlled drug. Resident #19's Individual Narcotic Record for morphine ER 30 mg for May 2026 revealed Staff H administered 1 tablet on 5/19/26 at 4:20 PM and another tablet on 5/19/26 at 8:00 PM. Resident #19's May 2026 Medication Administration Record (MAR) identified Staff H, Licensed Practical Nurse (LPN), morphine sulfate ER 30 mg at 4:00 PM with a reported pain level of 10 (indicating severe pain). Staff H marked completed that the advanced registered nurse practitioner (ARNP) on call should receive notification of any change in condition. The MAR lacked documentation of Resident #19 receiving a dose of morphine sulfate ER 30 mg at 8:00 PM on 5/19/26. The Weights and Vitals report printed 5/28/26 related to pulses on 5/19/26 listed the following:4:32 PM: 94 (a typical persons is expected between 80-100) with an unable to determine pulse type (a typical persons is expected as a regular rhythm and rate).11:32 PM: 66 with an unable to determine pulse type. The Weights and Vitals Report printed 5/28/26 related to blood pressures on 5/19/26, listed the following:4:32 PM - 126/78 (a typical person's is expect around 120/80).11:32 PM - 90/60 The Weights and Vital Report printed 5/28/26 related to oxygen levels on 5/19/26, listed the following:4:32 PM - 97% on room air (expected greater than 90% on room air).11:32 PM - 95% on 6 Liters (L) of oxygen A Physician Order documented in a Nurses Note on 5/19/26 at 10:12 PM directed staff the following:Discontinue Wegovy (diabetic medication also used to treat excessive weight)Start senna+ (medication used to treat/prevent constipation)1 tablet dailyGive hydrocodone with bathing and changing. The Nurses Note dated 5/20/26 at 12:08 AM identified Resident #19 received morphine 30 mg ER at 4:20 PM and 8:00 PM. Staff I, LPN, discovered the extra dose during the narcotic count on 5/19/26 at 10:40 PM. Vital signs taken at the time showed a BP of 90/50, a pulse of 66, a T of 97, and O2 sats of 85 percent on 4 liters of oxygen. The note described Resident #19 as alert and oriented times four. Staff contacted the ARNP, who gave and order to send Resident #19 to the emergency room to monitor the effects of the morphine. The Encounter note dated 5/21/26 documented a post-emergency room encounter for Resident #19. The note stated they saw Resident #19 in her room lying in bed, which represented her baseline and preferred position. She reported ongoing chronic pain, and staff discussed they placed a referral to the pain clinic and was currently being arranged. The (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	note recorded on 5/20/26, Resident #19 received morphine ER 30 mg at 4:20 PM and again at 8:00 PM, and the medication variance was discovered during the narcotic count at 10:40 PM. Vital signs obtained were unremarkable except for an O2 saturation at 85 percent on 4 liters of oxygen. The note described Resident #19 as alert and oriented times four at that time. The facility transferred Resident #19 to the emergency room (ER) for evaluation. While at the ER, they monitored Resident #19 and gave her 1 L of normal saline, then returned her to the facility with no new orders. The clinical record progress notes lacked documentation of an attempt of non-pharmacological interventions for pain on 5/19/26. In addition, the progress notes lacked an Orders-Administration Note for the morphine 30 mg provided on 5/19/26 at 8:00 PM and lacked monitoring for side effects after the 8:00 PM administration. On 5/28/26 at 10:46 AM, Resident #19 stated that a new nurse accidentally gave her an overdose of medication. Resident #19 reported she takes morphine 3 times per day at 8:00 AM, 4:00 PM, and midnight. Resident #19 stated she received the 4:00 PM pill, and then the nurse gave her another morphine at 8:00 PM. On 6/2/26 at 1:34 PM, Staff I stated on 5/19/26, he identified a narcotic count discrepancy involving morphine 30 mg ER during the end-of-shift count with Staff H. An investigation confirmed Resident #19 received a cumulative dose of 60 mg of morphine within a four-hour window due to doses administered at 4:20 PM and 8:00 PM. Following the error, Resident #19's oxygen saturation levels dropped into the 70s. Staff implemented immediate emergency procedures, including vital sign monitoring, provider notification, and transferring Resident #19 to the emergency department. Staff I stayed with Resident #19 and monitored her until the ambulance arrived. Staff H came to take vitals, and Staff J came and informed them they had to send Resident #19 to the emergency room. Staff I documented the discrepancy in the narcotic count book and his personal notes, but he did not chart the incident in the MAR. He stated Staff J was responsible for completing the official incident report, notifying the provider, and communicating with management. On 6/3/26 at 2:15 PM, Staff H confirmed she administered morphine sulfate ER 30 mg to Resident #19 at 4:20 PM and again at 8:00 PM. Staff H acknowledged the 8:00 PM administration reflected a medication error because Resident #19 had a physician order for as-needed hydrocodone-acetaminophen, not morphine sulfate. The error was not recorded in Resident #19's MAR, and Staff H failed to chart the incorrect medication administration or the omission of the ordered as-needed medication. Staff H stated she documented the error on personal report notes and submitted them to Staff A, the Interim Administrator, instead of using the facility's electronic health record (HER) as policy required. Staff H reported feeling distracted and overwhelmed during her shift and stated she lacked the necessary orientation and support to safely manage high-acuity residents like Resident #19 independently. She noted the error was discovered during the end-of-shift narcotic count, and Resident #19 was subsequently transferred to the emergency department. On 6/3/26 at 11:59 AM, Staff J stated she acted as the training nurse for the 2:00 PM to 10:00 PM shift and confirmed a narcotic count discrepancy for morphine 30 mg ER regarding Resident #19 on 5/19/26. Staff J confirmed her trainee, Staff H, incorrectly administered morphine 30 mg ER instead of the ordered as-needed hydrocodone. Staff J noted the trainee failed to record the medication administration on Resident #19's MAR and used personal notes instead. Upon discovering the discrepancy, Staff J initiated emergency procedures, including notifying the physician and family, and the oncoming nurse monitored vitals. Staff J stated she didn't observe Resident #19 between the 8:00 PM administration and the later discovery of the medication error. The Hospital Emergency Department record showed Resident #19 arrived via ambulance on 5/20/26 at 12:21 AM for an emergency admission under emergency medicine services. The admit time was 12:22 AM, and the discharge time was 3:36 AM. The final diagnoses listed accidental poisoning by other opioids, multiple sclerosis, and a personal history of nicotine dependence. The reason for the visit recorded a drug overdose after accidentally receiving an extra dose of morphine at the facility. The record noted Resident #19 takes morphine 30 mg by mouth every 8 hours and received doses at 4:00 PM and 8:00 PM, but she had no symptoms upon arrival. The visit diagnoses included initial encounter for (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	accidental overdose, initial encounter for accidental codeine poisoning, brain stem multiple sclerosis, and a history of tobacco use. The Emergency department staff administered a 1 L bolus of 0.9 percent sodium chloride intravenously starting at 12:57 AM, which finished infusing at 2:15 AM. The physician's differential diagnosis and rationale listed an accidental overdose, noting the patient didn't appear toxic, dehydrated, or septic, was hemodynamically stable, had unremarkable lab and vital signs, and stayed under observation for over 8 hours without issue. The physician counseled Resident #19 on the plan, and she expressed clear understanding. The discharge plan noted the hospital staff contacted poison control, who recommended monitoring for central nervous system and respiratory depression, noting no specific observation window was needed because the dose was within a safe range for her weight. Poison control directed that if respiratory depression occurred, staff should give Narcan and observe for 4 to 6 hours afterward. The facility provider received notification. Staff H's LPN Charge Nurse Job Description revised April 2018 signed 5/12/26 by Staff H. Staff H's Personnel File documented a hire date of 3/3/26. Essential functions required the employee to follow established standards of nursing practices, implement facility policies and procedures, and assume responsibility for unit compliance with rules, regulations, and standards of practice. Staff had to ensure residents received needed nursing care and services according to the plan of care and physician instructions, document care and resident responses, and provide a detailed shift report to oncoming nurses. Staff had to conduct daily resident rounds, report problems, and initiate corrective action. Functions required staff to administer and document medications and treatments per physician orders, accurately record all care, and administer or approve as-needed medications. Staff had to promptly report changes in condition to the physician, DON, and responsible party, monitor medication administration according to regulations, and notify the physician of medication errors or changes in condition. The Personnel File lacked documentation that Staff H received orientation for her specific position. A Suspension Pending Investigation Form dated 5/21/26 for Staff H documented the facility suspended Staff H for a medication administration error while an investigation was pending. The outcome of the suspension noted the ADON educated Staff H on medication administration and completed a return demonstration check. Staff H signed the form on 5/21/26. A Disciplinary Action Form dated 5/20/26 for Staff H recorded no prior coaching or disciplines and listed the infraction type as performance/conduct, resulting in a final warning. The description of the infraction noted that the LPN administered a pain narcotic that was not scheduled to be provided. The nurse received training on the rights of medication but didn't follow those guidelines because she didn't read the MAR. The resident received a second dose approximately four hours before the ordered time, staff completed an assessment and vital signs, and the provider and family received notification. Resident #19 was sent to the emergency room for observation, no injuries or harm occurred, and she returned to the facility approximately four hours later. Staff H acknowledged the form via a phone call on 5/27/26 at 10:30 AM. 2. Resident #16's MDS assessment dated [DATE] included a BIMS score of 15, indicating intact cognition. The MDS listed diagnoses of cerebral palsy (a neurological disorder affecting movement), seizure disorder, and memory/recall ability problems. The MDS documented Resident #16 received antipsychotic, antidepressant, and hypoglycemic (blood sugar lowering) medications. A Grievance/Concern Investigation Form dated 5/11/26 showed Resident #16 reported on 5/8/26, staff didn't give her midday or 4:00 PM medications. The form documented the medications were popped out of the packaging, but the MAR was marked off as given. Management sent an email to the staffing agency requesting a statement from the nurse, Staff G, who worked and documented the medications as given. The Traveling DON signed the form on 5/11/26. The form recorded the facility received an email response from Staff G on 5/13/26 at 1:40 PM. The email stated on Friday, 5/8/26, she popped the midday medications but Resident #16 wasn't in her room or the dining room. Staff G asked a CNA about Resident #16's location, and the CNA stated Resident #16 was out of the facility with family. Staff G disposed of the medications when Resident #16 didn't return, and on 5/14/26, Staff G came to the facility and fixed the documentation. Resident (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#16's May 2026 MAR showed on 5/8/26, Staff G documented for the midday and PM administration, they administered the lurasidone HCL 40 mg and artificial tears ophthalmic solution, and marked gabapentin 600 mg with a code 9 directing staff to see progress notes. The clinical record progress notes lacked documentation regarding medication errors occurring on 5/8/26 or notification to the physician for the missed medications. A Release of Responsibility for Leave of Absence record for Resident #16 revealed Resident #16 hadn't signed out of the facility on 5/8/26. On 6/1/26 at 10:15 AM, Resident #16 stated there was one day she didn't receive her medications as ordered. Resident #16 reported she didn't remember the exact date but didn't receive her midday and afternoon medications. Resident #16 confirmed she didn't leave the facility that day. On 6/3/26 at 8:04 AM, Staff G stated she worked the first shift from 6:00 AM to 2:00 PM on 5/8/26. Staff G confirmed she had medications for Resident #16 ready, but they weren't in their room and she couldn't find them. Staff G stated a CNA told her Resident #16 had left the building. She confirmed she returned to the facility later to correct her documentation for 5/8/26. On 6/3/26 at 12:20 PM, the Traveling DON stated the expectation is that medications get administered as ordered. She revealed she didn't know about Resident #16's error until a few days after it occurred, but staff notified the physician once the facility became aware. She confirmed Resident #16 didn't sign out to leave the facility on 5/8/26, and stated the nurse should've notified the physician and documented that the resident was unavailable. She acknowledged Resident #16's MAR didn't accurately reflect midday and afternoon medication administration for the medications the resident didn't receive on 5/8/26. The Traveling DON also confirmed a discrepancy occurred with medication administration for Resident #19 on 5/19/26, noting Resident #19 received an additional 30 mg dose of morphine sulfate extended release instead of an ordered as-needed dose of hydrocodone. On 6/4/26 at 10:15 AM, the Traveling DON revealed they hadn't located an orientation checklist for Staff H, but she provided a list of Staff H's training dates. Training on the 200 and 300 halls occurred from 2:00 PM to 10:00 PM on 3/22/26, 3/28/26, 3/29/26, 4/4/26, 4/11/26, 4/12/26, 4/18/26, 4/25/26, 4/26/26, and 5/3/26. Training on the 400 hall from 2:00 PM to 10:00 PM occurred on 5/10/26, 5/12/26, and 5/19/26. Staff H's Personnel File lacked documentation of what she had been trained to do. The Administering Medications policy revised April 2019 instructed that medications are administered in a safe and timely manner, and as prescribed. The policy directed that medications are administered in accordance with prescriber orders, including required timeframes, and that administration times are determined by resident need and benefit, not staff convenience. The policy directed that medication errors are documented, reported, and reviewed by the Quality Assurance and Performance Improvement (QAPI) committee to inform process changes or additional training needs. Medications must be administered within one hour of their prescribed time unless otherwise specified. If a dosage is believed to be inappropriate or excessive, or if a medication is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, attending physician, or medical director. The individual administering medications must verify the resident's identity before giving medications by checking the identification band, checking the photograph attached to the medical record, or verifying identity with other personnel. The individual must check the label 3 times to verify the right resident, right medication, right dosage, right time, and right method of administration. Allergies and vital signs must be verified prior to administration if necessary. If a drug is withheld, refused, or given at an alternate time, the individual must initial and circle the MAR space. The individual initials the MAR after giving each medication and before administering the next ones, and records the date, time, dosage, route, injection site, complaints or symptoms, results achieved, and their signature and title. The Adverse Consequences and Medication Errors policy revised April 2014 instructed the interdisciplinary team evaluates medication usage to prevent and detect adverse consequences and medication-related problems, and reports adverse consequences to the attending physician, pharmacist, and federal agencies as appropriate. The policy directed residents receiving any medication with a potential for an adverse consequence are monitored. An adverse consequence was (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	defined as an unpleasant symptom or event due to a medication, such as an impairment or decline in a mental or physical condition, including adverse reactions, side effects, or interactions. An adverse drug reaction was defined as a secondary, usually undesirable effect of a drug that is noxious and unintended. Staff must minimize consequences by following clinical guidelines and manufacturer specifications. A medication error was defined as preparation or administration not in accordance with physician orders, manufacturer specifications, or accepted standards, and included omissions, unauthorized drugs, wrong doses, wrong routes, wrong forms, wrong drugs, and wrong times. In the event of a significant error-defined as requiring discontinuation or dose modification, requiring or extending hospitalization, resulting in disability, requiring prescription treatment, resulting in cognitive deterioration, or being life-threatening or fatal-immediate action is taken to protect resident safety, and the attending physician is notified promptly and the resident is monitored for 24 to 72 hours.

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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 document review, staff interviews, and facility policy review the facility failed to demonstrate good faith attempts to correct quality deficiencies based on issues identified with repeat deficiencies during the current survey process in 1 area and corrections that remained incomplete in a reasonable time frame. The facility reported a census of 92 residents.Findings include:Review of the Federal Centers for Medicare and Medicaid Services (CMS) form 2567 for the survey results with correction dates of 11/29/25 indicated the facility had received deficiency F725 related to insufficient nursing staff. On 6/9/26 at 11:47 AM, the Assistant Director of Nursing (ADON) reported the facility is continuing to monitor call lights with audits. The ADON further revealed the facility provided education to staff on the spot when they observed staff sitting at the nurse's station with active call lights present. The Quality Assurance and Performance Improvement (QAPI) Program - Governance and Leadership policy revised March 2020 directed: The responsibilities of the QAPI Committee are to:Collect and analyze performance indicator data and other information;Identify, evaluate, monitor and improve facility systems and processes that support the delivery of care and services;Identify and help to resolve negative outcomes and/or care quality problems identified during the QAPI process;Utilize root cause analysis to help identify where identified problems point to underlying systematic problems;Help departments, consultants and ancillary services implement systems to correct potential and actual issues in quality of care;