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	09/05/2024

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 48886 Based on clinical record review and staff interview, the facility failed to notify the Long-Term Care (LTC) Ombudsman for 1 of 1 resident who transferred to the hospital (Resident #65). The facility reported a census of 81 residents. Findings include: Resident #65's Clinical Census report reviewed 9/5/24 reflected the following: a. 7/29/23: discharged to the hospital; returned 7/31/23 b. 9/17/23: discharged to the hospital; returned 9/22/23 c. 10/6/24: discharged to the hospital; returned 10/10/23 d. 2/1/24: discharged to the hospital; returned 2/7/24 e. 3/21/24: discharged to the hospital; returned 3/24/24 The clinical record lacked documentation of notification to the LTC Ombudsman of Resident #65's discharges to the hospital as required by Federal regulation. During an interview on 9/5/24 at 11:36 AM, the facility Social Worker (SW) reported she is the person responsible for sending the notification to the Ombudsman for discharges. The SW acknowledged she didn't notify the Ombudsman Resident #65's discharges to the hospital. She explained she expected they get notified. During an interview on 9/5/24 at 1:17 PM, the Director of Nursing (DON) stated the facility didn't have a policy for notification to the Ombudsman, they follow regulations.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40907 Based on observations, interviews, and record review, the facility failed to bathe a resident on a frequent and consistent basis for 1 of 1 resident reviewed (Resident #140). Resident #140 only received 1 bed bath in the 2 weeks since her admission. The facility reported a census of 81 residents. Findings include: Resident #140's Minimum Data Set (MDS) assessment dated [DATE] listed their admitted as 8/21/24 from a short-term general hospital stay. The MDS identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #140 required partial/moderate assistance for showering/bathing. The MDS included diagnoses of a fracture (broken bone) and pain in left leg. The Care Plan Focus area related to activities of daily living (ADL's) dated 8/21/24 listed a Goal for Resident #140 to participate during her ADLS as her condition allowed. The Interventions reflected the following: a. An immobilizer on her left lower extremity, with no knee flexion (bending in) for 6 weeks. b. Resident #140 required assistance from 1 staff for bathing. An Appointment/Visit Note dated 9/4/24 at 12:02 PM, indicated the Ortho (orthopedics surgical procedures on your bones, joints, and surrounding tissues and structures) provider that day. The Ortho provider gave orders for TTWB (toe touch weight bearing) to her LLE (left lower extremity) and use an immobilizer (keep knee in straight) while up. The order instructed to keep the leg extended at all times and she may remove the brace to wash her leg, if her leg can stay extended. They gave her a cortisone (helps to reduce swelling medication) injection to her R (right) knee that day, no restrictions to RLE (right lower extremity). A Doctor's Order dated 9/4/24 at 2:00 PM, directed Resident #140 must have an immobilizer to her left lower extremity while up with her leg extended at all times. The order included staff could remove the brace to wash her leg, if she could keep her leg extended. On 9/3/24 at 2:05 PM, observed Resident #140 sitting in a recliner with a leg brace on her left leg. Resident #140 reported she had a concern. She explained a staff member tried to take off her brace to give her a shower. Resident #140 told the staff member she couldn't take her brace off. She stated the staff person then gave her a bed bath. Resident #140 reported it as the first bed bath she received in the 2 weeks she lived at the facility. The point of care (POC) response history lookback for the previous 30 days printed 9/4/24 related to ADL Self-Care - Shower/Bathe self on Mondays and Thursdays on the second shift reflected the staff provided total assistance for Resident #140's bath on 9/2/24. The remaining documentation reflected on 8/22/24, Resident #140 refused a bath, then on 8/29/24 and 9/4/24 indicated not applicable as the task not attempted. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/4/24 at 4:36 PM, Staff B, Certified Nurse Aide (CNA), stated he worked on 8/29/24 on the second shift. He explained he shouldn't have documented the bath as not applicable. He added if he did, it must be one of those zoned out mistakes on his end. Staff B didn't remember giving Resident #140 a shower that. Staff B didn't remember Resident #140 refusing a shower from him. Staff B stated he didn't offer Resident #140 a shower. He explained he showed up a few hours after the shift started and worked from 4:00 PM to 10:00 PM, as he had college classes until 3:15 PM. Staff B denied knowing Resident #140 needed a shower. On 9/5/24 at 10:14 AM, Staff C, CNA, reported she didn't remember documenting not applicable for Resident #140's shower. She said she must have hit the button on accident, as she never gave or offered Resident #140 a shower. On 9/5/24 at 8:45 AM, Resident #140 explained someone offered her a shower the day before. She stated they came in and said we are going to shower you now. She stated she wasn't ready for a shower. The staff told her she could have a shower because she could take off her brace from her leg now. Resident #140 reported she told the staff member she didn't feel comfortable yet to take a shower and requested to have a bed bath instead later that night after her company left. Resident #140 stated she had visitors in the room and wanted to visit more. She added no one had mentioned her taking a shower or bed bath that day to her, so she didn't know she should have one. Resident #140 explained a staff person came back into her room after this and had her sign a statement. Resident #140 stated she didn't know for sure what she signed but thought it might be something about refusing her shower. After her visitor left, she asked the CNAs if she could talk with the staff person who had her sign something. The CNAs left and when they returned to the room, they stated that the staff person's door was closed and they were gone for the day. On 9/5/24 at 9:00 AM, the Director of Nursing (DON) came in with the following 2 Internal Investigation Witness Statements. The DON stated that her ADON had the resident sign a witness statement regarding refusal of shower. The DON stated that she, the DON, then talked with the resident on this day and had her sign a Witness Statement as well. The DON was then asked if they would have documented bed baths in the tasks. She stated yes. a. An Internal Investigation Witness Statement dated 9/4/24 signed by Resident #140 reflected a statement that the girls always give her a bed bath every night. She didn't want to get a shower with her leg, so the girls give her one every night. b. An Internal Investigation Witness Statement dated 9/5/24, reflected the DON interviewed Resident #140 about a shower incident. The statement indicated Resident #140 got a bed bath the night before and they did a good job. The statement documented she still felt a little bit leery about taking a shower as they just took her stitches out. She added she didn't feel ready for a shower yet. The statement included Resident #140's signature. Following the conversation, the ADON came into the room and reported Resident #140 did say she had a bed bath every night. When told Resident #140's electronic health record didn't reflect that and she reported she received 2 bed baths since her admission which included the one from the night before, the ADON responded that wasn't what Resident #140 told her. When told Resident #140 didn't know for sure what she signed but thought it had to do with her refusing a shower the night before, the ADON repeated Resident #140 said she got a bed bath every night. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON returned shortly after the above conversations. She acknowledged the concern Resident #140 reported only having 2 bed baths and the documentation of not applicable regarding showers on 2 of the 4 entries reviewed. A Bath, Shower/Tub policy revised on February 2018, defined the purpose as to promote cleanliness, provide comfort to the resident, and to observe the condition of the resident's skin. The policy instructed to chart the date and time they performed the shower or tub bath. The name and title of the individual(s) who assisted the resident with the shower/tub bath. If the resident refused the shower/tub bath, the reason(s) why and the intervention taken. The signature and title of the person recording the data. The policy indicated to notify the supervisor if the resident refused the shower/tub bath and/or other information in accordance with facility policy and professional standards of practice.

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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** 40907 Based on interviews, observations, and record review, the facility failed to provide safety interventions for 1 of 4 residents reviewed (Resident #140). The facility was aware that Resident #140's wheelchair brakes didn't work. They continued to transfer her in and out of her wheelchair without repairing the wheelchair brakes or replacing the wheelchair with a different wheelchair which had working brakes. The facility reported a census of 81 residents. Findings include: Resident #140's Minimum Data Set (MDS) assessment dated [DATE] listed their admitted as 8/21/24 from a short-term general hospital stay. The MDS identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #140 required partial/moderate assistance for showering/bathing. The MDS included diagnoses of a fracture (broken bone) and pain in left leg. The Care Plan Focus area related to activities of daily living (ADL's) dated 8/21/24 listed a Goal for Resident #140 to participate during her ADLS as her condition allowed. The Interventions reflected the following: a. An immobilizer on her left lower extremity, with no knee flexion (bending in) for 6 weeks. b. Resident #140 required assistance from 1 staff for bathing. An Appointment/Visit Note dated 9/4/24 at 12:02 PM, indicated the Ortho (orthopedics surgical procedures on your bones, joints, and surrounding tissues and structures) provider that day. The Ortho provider gave orders for TTWB (toe touch weight bearing) to her LLE (left lower extremity) and use an immobilizer (keep knee in straight) while up. The order instructed to keep the leg extended at all times and she may remove the brace to wash her leg, if her leg can stay extended. They gave her a cortisone (helps to reduce swelling medication) injection to her R (right) knee that day, no restrictions to RLE (right lower extremity). A Doctor's Order dated 9/4/24 at 2:00 PM, directed Resident #140 must have an immobilizer to her left lower extremity while up with her leg extended at all times. The order included staff could remove the brace to wash her leg, if she could keep her leg extended. On 9/3/24 at 2:05 PM, observed Resident #140 sitting in a recliner with a leg brace on her left leg. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/4/24 at 1:56 PM, Resident #140 said her wheelchair (w/c) brakes didn't work. While at her ortho appointment, they told her to tell the facility her brakes didn't work. She reported she hadn't said anything about it but, the staff said something about it as they put their foot behind the wheel to stop the w/c from rolling back when they transferred her in and out. She declared she didn't want to fall again. That morning a gal from therapy transferred her and she did a wonderful job. She said the night before 2 gals came in who were difficult to understand, but they understood her because she told them to use the gait belt and they did. She said her ortho appointment went really well that day. Because she had a pain pill after she returned from her appointment that made her a little sleepy, so she hadn't relayed that she needed a different w/c to anyone yet. Resident #140 sat in her recliner with her legs elevated. On 9/4/24 at 3:23 PM, Staff E, Registered Nurse (RN), explained she gave direction to the 2 day shift Certified Nurse Aides (CNAs) to swap the w/c out for a different one. She confirmed she knew the w/c brakes didn't work and she told the CNAs to swap it out for one with working brakes. Staff E verified the w/c in the room was the one that needed to be swapped out for a new one. Staff E told Resident #140 that she would swap it out and took the w/c out of the room to change it. Staff E stated that she told the CNAs to change her w/c out that morning probably around 11:00 AM or 12:00 PM. On 9/5/24 at 8:45 AM, Resident #140 stated it was funny but after mentioning the wheelchair brakes to the surveyor, a half an hour later they came in and switched out her wheelchair. She stated they talked about how the wheelchair brakes didn't work and how she needed a different wheelchair since her admission. She stated the nurses, CNAs, the ortho clinic staff, and even the transport driver who took her to her ortho appointments talked about how she needed a different wheelchair with brakes that worked. On 9/5/24 at 11:01 AM, Resident #140 verbalized appreciation for the brakes being fixed on her wheelchair yesterday. She said that morning when the therapy staff took her to therapy, they said they fixed the wheelchair. On 9/5/24 at 11:02 AM, Staff F, Certified Occupational Assistant (COTA), stated she took her to therapy that morning. She reported being happy when she noticed they fixed the w/c brakes. Staff F explained they found Resident #140's wheelchair brakes not working sometime the previous week or the week before. She thought another therapy worker put in a work order for someone to fix them sometime last week. She declared it challenging to transfer Resident #140 in and out of the w/c with the brakes loose. Staff F said they had discussions about the wheelchair brakes needing fixed but they couldn't find any documentation of the conversations nor have documentation of a work order. On 9/5/24 at 11:30 AM, the Maintenance Supervisor stated he didn't receive a work order to fix Resident #140's wheelchair brakes. He stated he went through all of his work orders and couldn't find any for Resident #140. He added he didn't do anything with Resident #140's w/c. He reported if he received a work order to fix Resident #140's or any residents' wheelchair brakes he would have done them immediately. He stated that he wouldn't wait around to fix wheelchair brakes that didn't work because of the possibility that broken brakes could cause harm to a resident. On 9/5/24 at 1:18 PM, the Director of Nursing (DON), provided the Activities of Daily Living (ADLs), as the policy for the w/c brakes not functioning properly and pushing residents in w/c's with their feet on the floor. She reported it as the closest policy the facility had to cover the incident. This DON acknowledged the concern with the incidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Activities of Daily Living (ADLs), Supporting policy revised March 2018, directed staff to provide residents with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently, will receive the services necessary to maintain good nutrition, grooming, personal and oral hygiene. Policy Interpretation and Implementation a. Residents will be provided with care, treatment and services to ensure that their activities of daily living (ADLs) don't diminish unless the circumstances of their clinical condition(s) demonstrate that diminishing ADLs are unavoidable. The facility will provide the appropriate care and services for residents unable to carry out their ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with mobility (transfer and ambulation, including walking). b. Care and services to prevent and/or minimize functional decline will include appropriate pain management, as well as treatment for depression and symptoms of depression.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48886 Based on clinical record review, interview and policy review, the facility failed to serve the correct diet for 1 of 2 residents reviewed for nutrition (Resident #41). The facility reported a census of 81 residents. Findings include: Resident #41's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 5, indicating severe cognitive impairment. Resident #41 required set up help for eating. The MDS included diagnoses of cardiorespiratory (heart and lung) conditions, heart failure, renal insufficiency (impaired kidney function), arthritis, stroke, malnutrition (inadequate nutrition), non Alzheimer's dementia, and esophageal obstruction (blockage in the throat). The Care Plan Focus dated 10/19/23, reflected Resident #41 had a diet order for regular/no added salt (NAS), mechanical soft texture (a type of texture modified diet for people who have difficulty chewing and swallowing. Foods may be pureed, ground, finely chopped, or blended to make eating safer), and thin liquids. The Care Plan Interventions instructed the staff to provide her with meals that are within her diet. The Physician Order dated 10/19/23 listed a diet texture of mechanical soft. During an interview on 9/3/24 at 11:35 AM, Resident #41's family member stated Resident #41 has a mechanical soft diet. They explained the facility gave them meat not ground when the family member visited. One time they served Resident #41 a chicken leg, but Resident #41's family member sent it back. In the past July, the facility didn't grind the chicken leg and it had the bone intact. Resident #41 ate in her room. Also, in July the facility gave Resident #41 unground ham and fish. The family member reported she talked to the Administrator about this. During an interview on 9/4/24 at 11:30 AM, the Administrator denied any memory of the family member coming to him about how Resident #41 received their diet texture and added he didn't have knowledge of a grievance filed. The Administrator declared it a concern if a resident received food not according to their diet order. The Administrator expected the staff to follow diet orders. During an interview on 9/4/24 at 12:35 PM, Resident #41's family member reported she had pictures of the incorrect texture of food the facility served to Resident #41. Resident #41's family member stated she talked to the Administrator in July, after she took some pictures, she showed the Administrator the pictures of the unground meat. The Administrator told her that maybe they didn't grind up the fish because it is flaky. Resident #41's family member stated she stopped the Administrator in the hallway to talk to him, he stated he would look into it. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the photographs taken by Resident #41's family member revealed a plate containing two fillets of fish, a piece of bread with butter and rice. The picture didn't have a ticket next to it, they stated they took in July of that year. The second picture showed a plate with two pieces of dry bread with slices of ham in pieces and a whole piece of cheese. The picture included a ticket next to the plate with a date of 7/22/24, Resident #41's name at the top and food listed as 1 Milk chocolate (8 Fl oz), 1 Ham Sandwich Ground (4 oz), 1 Cream potato soup (6 oz), 1 Mashed Potatoes (1/2 Cup), 1 Crackers (2), 1 Pudding (1/2 cup), 1 Strawberry Shortcake (1 slice), 1 Iced tea (8 Fl oz). Under this is listed Diet: Mechanical Soft, *Regular/NAS Diet, Fluids Thin TN0. During an interview on 9/4/24 at 12:59 PM, the Dietary Manager (DM) advised knowledge of the residents' diets because the nurses brought the orders and it is printed on their meal ticket. Resident #41 is on a mechanical soft diet, she preferred soft foods as she has a harder time eating. The DM defined a mechanical soft diet as things easy to chew, are in small pieces, or ground up. The DM stated all of the meat served to Resident #41 should be ground up. The DM stated fish is not put in the grinder, however should be cut it up in small pieces. Chicken is ground up, it shouldn't be served on the bone. The DM advised it is possible the cook didn't follow the resident's diet order and served her incorrect food texture in July of that year. The DM stated they expected the resident's food meet the criteria for mechanical soft and advised chicken served on the bone, fish not cut up in small pieces up or ham not ground wouldn't fit the criteria for mechanical soft. The DM stated a concern for the resident choking. The DM stated she expected the facility to follow diet orders. During an interview on 9/5/24 at 1:03 PM, the DM advised the corporation sends out the spreadsheets for the diets, they follow the spreadsheet for the type of diet a resident received. The DM reviewed the spreadsheet for chicken on the bone for a mechanical soft diet, this documented for the chicken to be ground, off the bone. The DM stated a resident on a mechanical soft diet would receive chicken off the bone that they processed in the robot coupe (specialized blender) and ground, she usually used a chicken breast for this with no skin. The spreadsheet for a ham sandwich for a resident on a mechanical soft diet documented for the ham to be ground. The DM stated this would be done by placing the ham in the robot coupe to grind it and then placing the ground up ham on the bread. The spreadsheet for fish (tilapia fillet) for a mechanical soft diet documented for the fish to be ground. The DM stated fish didn't grind up well in the robot coupe, the fish should be broken apart into small pieces to be served to the resident on a mechanical soft diet. The Orders Designating Diet policy, revised September 2017, directed the physicians shall provide appropriate diet orders and the facility should provide the residents appropriate nutrition and hydration.