STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165307	A. Building B. Wing	12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pillar of Cedar Valley	1410 West Dunkerton Road Waterloo, IA 50703

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to protect and prevent resident to resident abuse for 2 of 2 residents reviewed (Residents #1 and #5). The facility reported a census of 136 residents.Findings include:1. Resident #2's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 99, signifying the interview could not be completed. The MDS documented during the lookback period Resident #2 had physical behavior symptoms directed toward others that occurred daily. In addition, the MDS documented Resident #2 had verbal behavior symptoms directed toward others that occurred 4 to 6 days during the lookback period. Resident #2 had behaviors of rejection of care that occurred daily. The MDS included diagnoses of depression, anxiety, post-traumatic stress disorder (PTSD) and bipolar disorder (mental health condition causing extreme mood swings that include emotional highs, called mania, and lows, known as depression).The Care Plan Focus revised 11/5/25 identified Resident #2 frequently demonstrated physical and verbal aggressive behaviors toward staff or peers related to mental illness. The aggressive behaviors included yelling, screaming, name-calling, hitting, kicking, spitting, hair-pulling, throwing objects at others, and calling the police or sheriff to make false accusations or demands. The Interventions directed the staff to:Analyze behaviors for key times, places, circumstances, triggers, and what de-escalates behaviors. Document as needed.Document observed behavior and attempted interventions as needed.For details on managing Resident #2's behaviors, staff to refer to Temporary Crisis Plan located in a binder at the nurse's station on her unit.Give Resident #2 as many choices as possible about care and activitiesProvide physical and verbal cues as able to alleviate anxiety such as giving positive feedback, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated.When Resident #2 becomes agitated intervene before agitation escalates; guide away from source of distress; and attempt to engage calmly in conversation. Provide for the safety of others by removing them from the immediate area. If response is aggressive, staff to walk calmly away, and approach later.Intervene as necessary to protect the rights and safety of others. Approach and speak to her in a calm manner. Divert attention if able, remove from situation and take to alternate location as needed. Staff to provide cares in pairs.The Progress Notes dated 11/6/25 at 1:30 PM described Resident #2 as verbally aggressive with staff and towards other residents in the common area and when walking down the hallway. Resident #2 attempted to intimidate another resident (Resident #5) in the hallway due to her being in her way and not moving fast enough. As Resident #5 walked by Resident #2 in the dining room to get into the activity cabinet, Resident #2 became verbally aggressive towards Resident #5.The Progress Notes dated 11/13/25 at 10:22 AM indicated the staff observed Resident #2 being verbally aggressive toward a peer in the common area. She started yelling and using inappropriate language. The staff intervened by placing a petition between Resident #2 and her peer upon Resident #2's request. The staff reminded Resident #2 that if she has an issue, concern, and/or a compliant she should reach out to the staff for assistance.Review of Resident #2's Individual Program Plan dated 11/13/25 directed the staff the following:Immediately clear other residents out of the area for safetyStaff should be aware of their spatial positioning and stand at least an arm's length away from Resident #2 if possibleStaff may use the protective mats to deflect Resident #2's attempts at aggression towards staff and peers.Staff should assist Resident #2 in going to a calm, quiet space to de-escalate. Staff may approach Resident #2 to debrief when calm.Interdisciplinary team members or on-call designees will determine if increased supervision is necessary.The Individual Program Plan lacked updates following the resident-to-resident incidents.The Progress Notes dated 11/14/25 at 7:25 AM documented the staff heard Resident #2 yelling at someone. As the Certified Nursing Assistants (CNAs) started running toward the person and Resident #1, Resident #2 struck Resident #1 in the right ear. The Resident-to-Resident Incident Investigation Summary dated 11/14/25 reflected Resident #2 became physically aggressive toward Resident #1. After attempting to engage in aggression toward a staff member and missing, Resident #2 hit Resident #1 without intention. Resident #2 wore her noise canceling headphones at the time of the incident. The staff immediately separated the residents and initiated frequent checks with Resident #2. The Behavior Charting dated 11/15/25 at 8:58 AM identified as Resident #2 walked by a peer (Resident #1), who sat in his doorway/hallway visiting with the maintenance staff, she them in the ear with a closed fist. The staff escorted Resident #2 to her room and became combative/ verbally aggressive with staff during her care. Resident #2 stated Resident #1 called her a c*nt and made a hand

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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. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility records, policy review, resident and staff interviews, the facility failed to report alleged violations of physical abuse within the required time frame to the Iowa Department of Inspections, Appeals and Licensing (DIAL) for 3 of 4 incidents (11/14/25, 12/10/25 and 12/15/25) reviewed. The facility reported a census of 136.Findings include:Resident #2's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 99, signifying the interview could not be completed. The MDS documented during the lookback period Resident #2 had physical behavior symptoms directed toward others that occurred daily. In addition, the MDS documented Resident #2 had verbal behavior symptoms directed toward others that occurred 4 to 6 days during the lookback period. Resident #2 had behaviors of rejection of care that occurred daily. The MDS included diagnoses of depression, anxiety, post-traumatic stress disorder (PTSD) and bipolar disorder (mental health condition causing extreme mood swings that include emotional highs, called mania, and lows, known as depression).The Care Plan Focus revised 11/5/25 identified Resident #2 frequently demonstrated physical and verbal aggressive behaviors toward staff or peers related to mental illness. The aggressive behaviors included yelling, screaming, name-calling, hitting, kicking, spitting, hair-pulling, throwing objects at others, and calling the police or sheriff to make false accusations or demands. The Interventions directed the staff to:Analyze behaviors for key times, places, circumstances, triggers, and what de-escalates behaviors. Document as needed.Document observed behavior and attempted interventions as needed.For details on managing Resident #2's behaviors, staff to refer to Temporary Crisis Plan located in a binder at the nurse's station on her unit.Give Resident #2 as many choices as possible about care and activitiesProvide physical and verbal cues as able to alleviate anxiety such as giving positive feedback, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated.When Resident #2 becomes agitated intervene before agitation escalates; guide away from source of distress; and attempt to engage calmly in conversation. Provide for the safety of others by removing them from the immediate area. If response is aggressive, staff to walk calmly away, and approach later.The Care Plan Report lacked direction for staff to report resident-to-resident altercations and interventions to prevent further incidents following the incidents that occurred on 11/14/25, 12/9/25, 12/10/25 and 12/15/25.The Progress Notes dated 11/14/25 at 7:25 AM documented the staff heard Resident #2 yelling at someone. As the Certified Nursing Assistants (CNAs) started running toward the person and Resident #1, Resident #2 struck Resident #1 in the right ear. Resident #2 didn't give a reason for hitting Resident #1. The staff notified the Assistant Director of Nursing (ADON), physician, and husband.The Progress Notes dated 12/9/25 at 6:53 AM identified as Resident #2 talked very pleasant with the staff, she turned and saw Resident #1 walk over. Resident #2 called him a name and then hit him in the back of head. Resident #1 then struck Resident #2 in the right hip. The staff separated the residents at that time and escorted Resident #2 to her room and removed Resident #1 to his table. The assessment of each resident determined no injuries to either resident. The staff reported the incident to the Director of Nursing (DON), impact, and husband.The Behavior Charting dated 12/10/25 at 2:45 PM reflected Resident #2 refused to shower despite several verbal prompts and encouragement. Resident #2 refused to take her scheduled medication after multiple prompts. Resident #2 struck another resident (Resident #5) after the staff instructed her to not touch others. Resident #2 struck the writer in the back of the head while they assisted with providing her care. The staff redirected Resident #2, who completed her remaining cares independently. Resident #2 initially requested staff to assist them with tasks they could perform independently. The staff required the use of mats multiple times that day due to Resident #2's continued hitting behavior. Resident #2 continued to call the staff and other residents names. The staff attempted redirection and coping skills without success. Resident #2 came out name calling and started hitting staff members. The staff went to assist and redirected Resident #2 to her room. The staff directed Resident #2 to take a break in her room and when her behaviors got better to come and join the others. In addition, Resident #2 dug her nails into a staff member's arm.The Progress Notes dated 12/15/25 at 3:15 PM described Resident #2 as restless throughout the first shift. Resident #2 displayed aggressive behaviors including hitting, yelling, and calling staff names. While ambulating past peer Resident #5, Resident #2 stated, I'm going to take a big sh*t and drop it on you. After snack time, Resident #2 exited their room late and became upset about missing snack. As the staff redirected Resident #2 back to her room, she walked past Resident #5 and struck him on the

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, and staff interviews the facility failed to thoroughly investigate and put interventions in place following a resident-to-resident abuse for 1 of 3 residents reviewed (Resident #2). The investigation determined Resident #2 hit Resident #1 and Resident #5 on different occasions. The facility failed to conduct resident and staff interviews for the date of the incidents to determine the extent of the allegation or determine if other residents had been affected. The facility reported a census of 136 residents.Findings include:1. Resident #2's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 99, signifying the interview could not be completed. The MDS documented during the lookback period Resident #2 had physical behavior symptoms directed toward others that occurred daily. In addition, the MDS documented Resident #2 had verbal behavior symptoms directed toward others that occurred 4 to 6 days during the lookback period. Resident #2 had behaviors of rejection of care that occurred daily. The MDS included diagnoses of depression, anxiety, post-traumatic stress disorder (PTSD) and bipolar disorder (mental health condition causing extreme mood swings that include emotional highs, called mania, and lows, known as depression).The Care Plan Focus revised 11/5/25 identified Resident #2 frequently demonstrated physical and verbal aggressive behaviors toward staff or peers related to mental illness. The aggressive behaviors included yelling, screaming, name-calling, hitting, kicking, spitting, hair-pulling, throwing objects at others, and calling the police or sheriff to make false accusations or demands. The Interventions directed the staff to:Analyze behaviors for key times, places, circumstances, triggers, and what deescalates behaviors. Document as needed.Document observed behavior and attempted interventions as needed.Give Resident #2 as many choices as possible about care and activitiesProvide physical and verbal cues as able to alleviate anxiety such as giving positive feedback, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated. When Resident #2 becomes agitated intervene before agitation escalates; guide away from source of distress; and attempt to engage calmly in conversation. Provide for the safety of others by removing them from the immediate area. If response is aggressive, staff to walk calmly away, and approach later.The Care Plan Report lacked direction for staff to report resident-to-resident altercations and interventions to prevent further incidents following the incidents that occurred on 11/14/25, 12/9/25, 12/10/25 and 12/15/25.Resident #2's Progress Notes included documentation of resident-to-resident altercations on 11/14/25, 12/9/25, 12/10/25 and 12/15/25.The Resident-to-Resident Incident Investigation Summary dated 11/14/25 reflected Resident #2 became physically aggressive toward Resident #1. After attempting to engage in aggression toward a staff member and missing, Resident #2 hit Resident #1 without intention. Resident #2 wore her noise canceling headphones at the time of the incident. The staff immediately separated the residents and initiated frequent checks with Resident #2. The facility lacked a Resident-to-Resident Incident Investigation Summary for 12/10/25. The Resident-to-Resident Incident Investigation Summary dated 12/15/25 at 10:57 AM indicated the Inter-disciplinary team received notification of a physical altercation between Resident #2 and Resident #5. The staff immediately separated the residents and redirected Resident #2 to her room for a break while the staff monitored for safety and de-escalation. During that time, Resident #2 remained physically and verbally combative toward staff. During an interview on 12/23/25 at 11:40 AM with the Assistant Administrator and Administrator, the DON explained when resident-to-resident incidents residents are assessed. The Administrator stated they would investigate every incident with investigations to include staff interviews, chart reviews, review of cameras and follow up with interventions. The DON reported the facility didn't complete an investigation for the incident on 12/10/25 between Resident #1 and Resident # 5. Review of the facility policy titled Skilled and Senior Living Abuse, Neglect and Exploitation Policy and Procedure dated October 2022 directed any employee to take appropriate steps to ensure that all alleged violations of the federal and state laws which involve abuse are reported immediately to the administrator of the community. The community investigates each such alleged violation thoroughly and reports the results of all investigations to the administrator, as well as to the State agencies, as required by State and Federal law.