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	06/11/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, document review, policy review and staff interview, the facility failed to provide one to one supervision for resident safety for 1 of 10 residents sampled (Resident #4). The facility reported a census of 136 residents. Findings include:1. Resident #4's Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) Score of 3 out of 15 indicating a severe cognitive loss. Resident #4 exhibited physical behaviors (hitting, kicking, pushing, scratching, grabbing) 1-3 days and rejection of care 1-3 days of the lookback period. Resident #4 was independent with chair/bed to chair transfers and could walk distances of 10-150 feet independently. The MDS listed diagnoses of bipolar disorder, unspecified, Non-Alzheimer's Dementia, and anxiety disorder. Resident #4's Care Plan revised 4/17/26 specified the resident demonstrated physical aggressive behaviors toward staff and resident peers related to dementia and mental illness. Resident #4 would frequently yell, curse, scratch, pinch, hit, and bite staff when they attempt care. The Care Plan directed the staff in the following:a. Carry out frequent checks for resident' whereabouts and safety, 6/29/24.b. Motion sensor installed on room door to sound in the nurse's station to alert staff when resident leaves her room and may be in the presence of resident peers, 3/18/25.c. Resident #4 provided a private room for the safety of resident peers, 10/9/25. d. After episode of peer-to-peer aggression initiated by Resident #4 on 4/10/26, staff to provide 1 to 1 supervision during waking hours. A Behavior Progress Note dated 5/31/26 at 11:02 PM written by Staff A, Licensed Practical Nurse, (LPN) documented she was called to the hallway by Resident #12. Resident #12 stated Resident #5 was upset because Resident #4 had slapped her. A Certified Nursing Assistant (CNA) took Resident #4 back to her room. She was unable to tell what happened. 2. Resident #5's MDS dated [DATE] showed a BIMS score of 9 out of 15 indicating moderate cognitive loss. Resident #5 was dependent in chair/bed to chair transfers and able to propel a manual wheelchair up to 50 feet. The MDS listed diagnoses of schizoaffective disorder, bipolar type and anxiety. The Care Plan revised 9/5/25 documented Resident#5 had the potential to demonstrate verbal and physical aggressive behaviors related to multiple psychiatric diagnoses as evidenced by a history of actual aggression toward others. The Care Plan directed the staff to intervene before agitation escalates, guide away from source of distress; engage calmly in conversation, if response is aggressive, staff to walk away and approach later. The 5/31/26 Daily Schedule documented Staff B, CNA, scheduled to provide 1 to 1 supervision on the Oaks Unit from 2:00 PM to 8:00 PM. Staff B's 5/31/26 Time Card Report documented she clocked in at 2:00 PM and clocked out at 7:00 PM. A Facility Self-Reported Incident dated 5/31/26 at 8:52 PM on file with the Iowa Department of Inspection, Appeals and Licensing (DIAL) documented an Incident Summary at 5/31/26 at approximately 8:00 PM Resident #12 alleged to Staff A, Resident #4 made contact with Resident #5 in the Oaks common area. Resident #4 was unable to recall the incident. Resident #5 stated Resident #4 did make contact with her. Under Corrective Action Description both residents were separated, the incident was unwitnessed, and no injuries were found. A 5/31/26 Written Statement by Staff C, CNA, detailed she and another aide were helping other residents into bed that night. She nor the other CNA with her witnessed the (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident-to-resident contact. An Undated Witness Statement written by Staff D, CNA documented she and Staff E CNA were laying people down. Staff D last saw Resident #4 at 7:00 PM when Staff B went on break. A 5/31/26 Written Statement written by Staff E documented she was laying residents down with other aide on the Oaks (Unit). The last Staff E knew Staff B went to break and Resident #4 was still in her room. Staff E last saw Resident #4 in bed at 7:00 PM. A 5/31/26 Written Statement written by Staff F, Certified Medication Aide (CMA), documented she was in a resident room and was unaware they didn't have 1 to 1 (supervision) with Resident #4. A 5/31/26 Written Statement written by Staff G, LPN documented she was not on the floor at 7:30 PM and did not see Resident #4 after 7:00 PM. The Facility Investigation 5/31/26 Facility Camera Review documented the following:a. 7:00 PM Resident #5 sat in her wheelchair between the unit nurse's station and lounge, facing the nurses station.b. 7:10 PM Staff A observed on the opposite end of hallway at the medication cart from where Resident #4's room was located. c. 7:12 PM Resident #4 walked out of her room. Staff A remained at the same location. d. 7:13 PM Resident #4 pulls a dining chair out in the unit lounge and sits down. e. 7:14 PM Resident #4 stood up to sit in a recliner. Resident #5 propelled a foot or so closer to the nurse's station. The residents are approximately 10+ feet away with no interaction identified. f. 7:15 PM Staff F walked to the nurse's station to assist a resident. As she exited the area, Resident #4 sat in the recliner with her back facing Resident #5.g. 7:16 PM Staff C was across from the nurse's station, Resident #5 was in visual proximity. Staff C exited the area shortly after.h. 7:16:31 PM Resident #4 stood up, folded a blanket and walked to a recliner across the room to place a towel down. i. 7:16:39 PM Resident #4 walked from the dining and lounge area to Resident #5 near the nurse's station/Resident #5's room. It appears Resident #4 and #5 had a conversation. After this interactions Resident #4 walked behind Resident #5 and placed her hands on the handles of Resident #5's wheelchair. Resident #4 began to push Resident #5 in the wheelchair past the front of the nurse's station, past the large elevator, stopping at the window in the middle of the unit hallway right before the small elevator. No verbal interactions were noted. j. 7:20 PM Resident #4 stopped pushing Resident #5 in the wheelchair. Resident #4 walked in front of Resident #5 and appeared to be adjusting Resident #5's gown, trying to help her. k. 7:20:18 PM Resident #4 and Resident #5 are seen swatting hands toward each other. Resident #4 turned and walked toward the unit dining room. It appeared that Resident #5 did not want help from Resident #4. l. 7:22:26 PM Resident #5 walked back to the dining seat where she was at the beginning of the film footage. At this time Resident #12 propelled by Resident #5 and the two exchanged words. m. 7:22:45 PM Resident #12 propelled to a staff member to report Resident #4 punched Resident #5 in the face. A Typed Statement by Staff H, Assistant Director of Nursing (ADON) documented a follow up call placed 6/2/26 at 1:50 PM to Staff B. Staff B stated she was assigned 1 to 1 with Resident #4 on 5/31/26. When she left at approximately 7:00 PM, Resident #4 was in bed resting. Her demeanor at that time was calm and pleasant. She reported off to staff upon leaving Resident #4 was in bed. She had no concerns with Resident #4 when she left. Observation of the Camera Footage on 6/9/26 at 9:40 AM with Staff I, Maintenance Director, and Staff H showed Resident #4 on 5/31/26 from 7:12 PM to 7:22 PM without 1 to 1 supervision. The Camera footage showed there was no physical altercation and no hand contact between either resident. Resident #4 did not punch Resident #5 in the face. The Camera Footage showed Staff A remained on the hallway passing medications to resident rooms without eyes on Resident #4. Interview on 6/9/26 at 4:36 PM Staff B reported on 5/31/26 she left between 7:05 PM - 7:10 PM. She reported to Staff A she didn't take her break so she was leaving and Staff A said it was okay. When she left Resident #4 was laying on her right side facing the wall. The resident was calm. Two aides had assisted her to change the resident before bed and she was agitated, but calmed down once care was done. The Resident was laying down so she left. Resident #4 had been on 1 to 1 supervision since the last resident to resident incident. Observation on 6/10/26 at 8:13 AM Staff J, CAN, exited Resident #4's room. Resident #4 lay on her left side in bed, eyes open, fully dressed with her tennis shoes on. Staff J walked from Resident #4's room approximately 15 feet out the door to the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	utility room. Staff J entered the utility room out of the visual line of Resident #4 to get ice for another resident. At 8:15 AM Staff J came out of the utility room and handed the other resident a bag of ice, the went back into the utility room a second time out of visual line of Resident #4. Interview on 6/10/26 at 8:15 AM Staff J verbalized in her opinion, she felt Resident #4 maybe a risk to other residents without supervision. She is unpredictable and anything can trigger her. Resident #4 will say she loves you and appreciates you, and then turn on you. She thought Resident #4 was placed on 1 to 1 supervision after a resident-to-resident altercation. A 6/10/26 review of Resident #4's 5/31/26 Fifteen Minute Checks for Residents documentation showed Staff A signed off the 7:00 PM and 7:15 PM checks. During an interview on 6/10/26 at 9:40 AM Staff H, reviewed the 5/31/26 Fifteen Minute Check documentation for Resident #4. The Fifteen Minute Check Sheet, 5/31/26 showed Staff A signed off the 7:00 PM, 7:30 PM and 7:45 PM 15-minute checks. The Camera Footage viewed with Staff H on 6/9/26 revealed Staff A in the hallway passing medication. Resident #4 visualized on camera footage without 1 to 1 supervision while in the unit hallway, lounge, around the nurse's station and with Resident #5. Staff A not observed on camera checking on Resident #4's whereabouts. Staff H confirmed Resident #4 was to be under 1 to 1 supervision and to have 15-minute checks. Staff H confirmed the supervision was not provided at that time. During an interview on 6/10/26 at 3:53 PM Staff A reported she was passing medications down the hallway that evening on 5/31/26. Staff B came down the hallway. She asked Staff B if Resident #4 was asleep. Staff B replied no but she was calm and laying down. Staff B reported she had already talked with the aides. Staff A thought Staff B was leaving to go on break. Staff B did have her purse with her but she didn't know she was leaving for the night. Staff A voiced as far as she knew, staff were not to leave early if Resident #4 was down in bed. Staff B should have been there the time she was scheduled. Resident #4 had hurt another resident so they put her on 1 to 1 supervision. Staff A reported there is a little box in the nurse's station that alarms when Resident #4 leaves her room. Staff G had been at the desk, but got called away so she wasn't there to hear the alarm when Resident #4 got up. The aides were all busy putting residents to bed when Staff B left. None of the staff knew that Resident #4 was left unsupervised. She thought the resident was being taken care of and someone was with her. Most of the time Resident #4 is sweet and then she can be unpredictable and will hit someone. They can only hear the room alarm, if they are up by the nurse's station. She cannot hear Resident #4's door alarm ding if she is at the end of the hallway passing medications. Resident #4 was to have 1 to 1 supervision when she was up. In an interview completed on 6/11/26 at 8:48 PM the Administrator verbalized that if a resident requires frequent checks, she expects the staff to lay eyes on the resident every 15 minutes or sooner. If a resident is on 1 to 1 supervision, she expects the employee to be there and have eyes on the resident the whole time. If the employee needs to take a break, a team member needs to fill in that spot. The Standard Supervision and Monitoring Policy dated 11/25/19 directed the guideline emphasized a proactive intervention promoting enhanced physical and psychosocial well-being. The facility recognizes supervision and guidance to the resident is an essential part of nursing care in which standard approaches are successful in meeting the resident's physical and psychosocial needs. The Procedure specified when a resident cannot be guided, supervised or redirected during regular intervals of rounds, the resident may require 30-minute, 15 minute or 1 to 1 supervision.