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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS Correction date: _____ The following deficiencies resulted from investigation of facility reported incident #2695755-I conducted December 22, 2025 - December 23, 2025. Facility reported incident #2695755-I resulted in deficiencies cited. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F0000		
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: 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:	F0600		

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 reverse for further 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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165307	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/23/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0600 SS = D	Continued from page 1 1. Resident #2's Minimum Data Set (MDS) assessment dated 11/19/25 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	F0600		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0600 SS = D	Continued from page 2 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 gesture suggesting f*llatio". The Progress Notes dated 11/16/25 at 2:45 PM listed	F0600		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0600 SS = D	Continued from page 3 personal time (no individual attention). At 6:00 AM, the staff observed Resident #2 in the dining area yelling at other clients using profanity. Resident #2 walked aggressively in hallway toward them in an attempt to intimidate the other residents. When the staff approached to offer assistance with cares, Resident #2 attempted to strike staff while continuing to yell. The staff made several de-escalation attempts but Resident #2 refused to follow directions. Resident #2 had disruptive behaviors of screaming, yelling, or hitting made throughout the day. The staff offered breaks to Resident #2, but her behavior continued. The staff gave Resident #2 3 opportunities to settle down and eventually the staff assisted her to her room a few times when she wouldn't de-escalate. Resident #2 laid calmly in a recliner for two hours without an incident. Staff attempted verbal redirection, assisted to a calm area, or back to her room, and used protective mats in a non-restrictive measure. At lunchtime, Resident #2's family arrived for a visit. The staff didn't observe escalation during Resident #2's time with their family until she sat at table for lunch. At that time, the staff effectively redirected Resident #2 to not to yell at the table. 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 facility lacked a Behavior Charting evaluation for the 12/9/25 incident of Resident #2 altercation with Resident #1. 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	F0600		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0600 SS = D	Continued from page 4 redirection and coping skills without success. Resident #2 came out name calling and starting 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 in to a staff member's arm. The Physician's Order Note dated 12/10/25 at 2:48 PM identified Resident #2 had 2 resident-to-resident altercations with Resident #1. The author requested to have the Advance Registered Nurse Practitioner (ARNP) see her and do a medication review. At 10:39 AM the Physician Office Registered Nurse (RN) questioned if the altercations occurred that day, as they already had Resident #2 on the schedule for that Monday. The Physician Office RN reported they would update the ARNP so she could review the medications and the EKG (external testing of the heart) if available by then. At 10:54 AM the Physician office RN indicated the ARNP directed to increase guanfacine (medication used to treat attention deficit hyperactivity disorder "ADHD") 1 milligram (mg) by mouth twice daily. The facility lacked a Resident-to-Resident Incident Investigation Summary for 12/10/25. The Progress Notes dated 12/13/25 at 10:21 AM documented at 8:40 AM, Resident #2 approached Resident #5. Resident #2 continued to engage Resident #5, despite Resident #5's request to be left alone. Resident #2 moved into Resident #5's personal space. Resident #5 lightly kicked Resident #2's walker, causing Resident #2 to lose her balance and fall to the floor. The staff immediately intervened and separated both residents. The staff implement an intervention to maintain separation and prevent further incidents. 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 head and back multiple times. The staff redirected Resident #2 back to her room, where she continued yelling and using profanity toward staff and struck the writer in the face. The staff used the mats to assist with de-escalation. Resident #2 remained in her room until the next snack time. Staff reported while Resident #2	F0600		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0600 SS = D	Continued from page 5 walked past Resident #5's room she yelled out "Resident #5 I'm looking for you," in a singing voice. In addition, Resident #2 came out calling Resident #1's names. 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. Review of the undated Temporary Crisis/Behavior Plan for Resident #2 directed the Management of verbal or physical aggression in common areas – If Resident #2 became verbally disruptive or physically aggressive toward staff or peers, staff may implement the following:Use protective mats in an open, upright position to decrease visual stimulation and/or create a safe space between Resident #2 and others.Redirect Resident #2 to a quieter environment, such as her room, when possible.Maintain safe staffing proximity and monitor for escalation.During an interview on 12/22/25 at 3:33 PM Resident #1 stated his name, date and where he resided. Resident # 1 verbalized Resident #2 has hit him on 3 separate occasions. Resident #1 reported he Resident #2 back. One of the times Resident #2 hit Resident #1, he reported his ear swelled up after being hit. Resident #1 denied being afraid of Resident #2. During an interview on 12/22/25 at 3:38 PM Staff C, CNA, reported she receiving training for dependent adult abuse (DAA). Staff C verbalized being familiar with Resident #2. Staff C reported Resident #2 has hit multiple residents and employees. Staff C stated Resident #1 tried to scare residents. Staff C couldn't recall dates or names of the residents Resident #2 hit. During an interview on 12/22/25 at 3:48 PM Staff A, CNA, stated she received training for DAA. Staff A verbalized she would report allegations of abuse to her supervisor, the nurse, or the ADON. Staff A reported being familiar with Resident #2. Staff A acknowledged Resident #2 has hit Resident #1 and #5. Staff A stated she witnessed Resident #2 hit Resident #1 during meal time. Staff A verbalized Resident #1 sat at the table when Resident #2 made a comment and used the back of her had to hit him on the shoulder. Staff A reported Resident #2 sought out Residents #1 and #5. During an interview on 12/23/25 at 9:28 AM, Resident #5	F0600		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0600 SS = D	Continued from page 6 verbalized her name, the date, and where she resided. Resident #5 stated a female resident had hit her in the shoulder and in the back of the head. Resident #5 denied being afraid of the female resident but more so afraid of what she will do. During an interview on 12/23/25 at 10:16 AM Staff B, Licensed Practical Nurse (LPN), acknowledged he received DAA training. Staff B reported allegations of abuse are reported to the ADON or the Director of Nursing (DON) as soon as possible. Staff B acknowledged being familiar with Resident #2. Staff B said Resident #2 had a couple incidents with hitting another resident. Staff B reported on 11/14/25 as he walked with Resident #1, Resident #2 came out of her room and hit Resident #1 in the ear. Staff B verbalized Resident #2 talked with him and witnessed her walk up to Resident #1, hitting him in the back of his head. Staff B stated Resident #1's ear turned red without injury. During an interview on 12/23/25 at 10:29 AM Staff D, ADON reported she received training on DAA. Staff D verbalized being familiar with Resident #2 and acknowledged she had behaviors. Staff D acknowledged Resident #2 hit Resident #1 on 11/14/25 and 12/9/25. Staff D explained Resident #1 didn't actually touch Resident #5 on 12/10/25. Staff D remembered talking with the DON about a third incident with Resident #1 where they needed to amend the reported summary to the Department of Inspections, Appeals, and Licensing (DIAL). Staff D verbalized Resident #2 hit staff daily with her aggression getting worse. Staff D reported they installed a door bell on Resident #2's door to alert staff when she exits her room. Staff D reported Resident #2 the staff provide one-to-one supervision when she exits her room. The Skilled and Senior Living Abuse, Neglect and Exploitation Policy and Procedure dated October 2022 defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Review of the facility policy titled Standards and Guidelines: PMI (Person with Mental Illness) Reporting Guidelines – Resident to Resident issued 8/15/22 directed the facility to ensure residents are free from abuse, neglect, and exploitation and are protected from	F0600		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0600 SS = D	Continued from page 7 harm by other residents. Resident-to-resident altercations will be assessed on an individual basis and reported when required by Iowa law, DIAL expectations, or federal regulations. Reporting determinations will consider injury, changes in supervision or level of care, and patterns of aggressive behavior indicating potential failure of current interventions or increased risk to resident safety. 2. Resident #1's MDS assessment dated 10/8/25 documented a BIMS score of 13, indicating intact cognition. The MDS documented Resident #1 had verbal behavior symptoms directed toward others that occurred daily during the lookback period. In addition, Resident #1 experienced behaviors of rejection of care for 1 to 3 days during the lookback period. The MDS included diagnoses of anxiety and schizophrenia (mental health condition that affects how people think, feel and behave). The Progress Notes dated 11/14/25 at 7:42 AM indicated the staff heard a resident yelling at someone. As the CNAs started running toward the person and Resident #1, the other resident struck Resident #1 in the right ear. The staff separated the residents and escorted the other resident (Resident #2) to her room. Resident #2 gave no reason for hitting Resident #1. The Progress Notes dated 12/9/25 at 7:14 AM Resident #1 sat at a table with another resident. Resident #2 saw Resident #1 and approached him, she called him a name and hit him on the back of the head. Resident #1 then hit Resident #2 in her right hip. The staff separated both residents. 3. Resident #5 MDS assessment dated 10/15/25 documented a BIMS score of 14, indicating intact cognition. The MDS documented the resident had verbal behavior symptoms directed toward others that occurred 1 to 3 days during the look back period. The MDS included diagnoses of anxiety and bipolar disorder. The Progress Notes dated 12/15/25 at 10:35 AM indicated Resident #5 and the Social Worker met following an altercation between Resident #5 and Resident #2 in the common area. The staff witnessed Resident #2 approach Resident #5 from behind and, without provocation, struck Resident #5 on the shoulder and back of the head. In addition, the staff reported Resident #2 stated, "I am going to take a big sh*t and put it on you." Staff immediately intervened, separated the residents, and redirected Resident #2 to her room to de-escalate. Resident #5 reported as she sat in the	F0600		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0600 SS = D	Continued from page 8 common area, Resident #2 struck her from behind three times. Resident #5 stated she felt “fine” physically but expressed emotional distress related to feeling Resident #2 didn’t like her. Resident #5 Progress Notes lacked documentation of the resident-to-resident altercation from 12/10/25.	F0600		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: 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:	F0609		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0609 SS = D	Continued from page 9 Resident #2's Minimum Data Set (MDS) assessment dated 11/19/25 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	F0609		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0609 SS = D	Continued from page 10 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 head and back multiple times. The staff redirected Resident #2 back to her room, where she continued yelling and using profanity toward staff and struck the writer in the face. The staff used the mats to assist with de-escalation. Resident #2 remained in her room until the next snack time. Staff reported while Resident #2	F0609		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0609 SS = D	Continued from page 11 walked past Resident #5's room she yelled out "Resident #5 I'm looking for you," in a singing voice. In addition, Resident #2 came out calling Resident #1's names. Review of the facility self-reported list of incidents reported to the Department of Inspections, Appeals, and Licensing (DIAL) revealed a report filed on 12/9/25 for an incident between Resident #2 and Resident #1. The list lacked reports for incidents that occurred on 11/14/25, 12/10/25 and 12/15/25. During an interview on 12/22/25 at 3:48 PM Staff A, CNA, stated she received training for Dependent Adult Abuse (DAA). Staff A verbalized she would report allegations of abuse to her supervisor, the nurse or the ADON. During an interview on 12/23/25 at 10:16 AM Staff B, Licensed Practical Nurse (LPN), acknowledged he received DAA training. Staff B reported allegations of abuse are reported to the ADON or the Director of Nursing (DON) as soon as possible. During an interview on 12/23/25 at 11:40 AM with the Assistant Administrator and Administrator present, the DON acknowledged the facility should have reported the incidents on 11/14/25, 12/10/25 and 12/15/25 to DIAL. Review of the facility policy titled Standards and Guidelines: PMI (Person with Mental Illness) Reporting Guidelines – Resident to Resident issued 8/15/22 directed the facility to ensure residents are free from abuse, neglect, and exploitation and are protected from harm by other residents. Resident-to-resident altercations will be assessed on an individual basis and reported when required by Iowa law, DIAL expectations, or federal regulations. Reporting determinations will consider injury, changes in supervision or level of care, and patterns of aggressive behavior indicating potential failure of current interventions or increased risk to resident safety. The policy listed the following Reporting Criteria for a resident-to-resident altercation when any of the following occur:InjuryAny altercation resulting in physical injury requiring assessment, treatment, or medical intervention.Injuries of unknown source reasonably suspected to have resulted from resident interaction.Change in Level of Care or SupervisionThe incident results in: o Increased supervision or staffing	F0609		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0609 SS = D	Continued from page 12 o Environmental modification o Initiation of 1:1 supervision o Transfer, emergency services involvement, or hospitalizationPattern of AggressionRepeated aggressive behaviors by the same resident that demonstrate: o Escalation in severity or frequency o Failure of existing program plan interventions o Increased risk to other residents or staffPatterns may indicate potential inadequate supervision and shall be reviewed for reportability. External ReportingIncidents meeting reporting thresholds shall be reported in accordance with: o Iowa Code Chapter 235B (Dependent Adult Abuse) when abuse, neglect, or exploitation is suspected o DIAL reporting expectations for incidents impacting resident safety o Federal CMS requirements related to abuse, neglect, or injuries of unknown sourceReporting determinations will be made promptly and in consultation with facility leadership as appropriate. Review of the facility policy titled Skilled and Senior Living Abuse, Neglect and Exploitation Policy and Procedure dated October 2022 directed any employee who suspects an alleged violation immediately notify the Administrator. The Administrator notifies the appropriate state agency of allegations of neglect, exploitation, misappropriation of resident property or mistreatment that do not result in serious bodily injury in no later than 24-hours. Allegations of abuse resulting in serious bodily injury must report immediately, but not later than 2 hours after the allegation is made. Initial reports must include sufficient information to describe the alleged violation with as much information as possible based on the knowledge at the time of the submission and indicate how resident(s) are being protected. The results of all investigations are reported to the Administrator and to the appropriate state agency as required by state law and/or within five (5) working days of the alleged violation.	F0609		
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation	F0610		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0610 SS = D	Continued from page 13 CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: 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 11/19/25 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	F0610		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0610 SS = D	Continued from page 14 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.	F0610		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0610 SS = D	Continued from page 15 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.	F0610		