STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165178	A. Building B. Wing	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Highlands	607 Highland Drive Decorah, IA 52101

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, clinical record review and staff interview, the facility failed to properly position resident clothing while positioned in bed for 5 of 5 residents reviewed (Resident #2, #3, #4, #5 and #6). The facility identified a census of 68 residents. Findings include: An observation 9/18/25 at 2:48 p.m. revealed Resident #2 positioned in bed with his sweatpants positioned around his ankles. Review of Resident #2's Medical Diagnoses included Alzheimer's Disease. During an interview 9/18/25 at 2:53 p.m. Staff A, Certified Nursing Assistant (CNA) confirmed the resident's sweatpants as positioned around his ankles and indicated staff should not have positioned the pants around the resident's ankles as she proceeded to remove them. During an interview 9/24/25 at 9:22 a.m. the resident's wife confirmed she observed the resident's pants positioned around his ankles at various time while in bed, she had not liked that at all, and directed the staff to have removed them. The resident's wife indicated the resident had not slept with his pants around his ankles while he resided at home. Random observations 9/18/25 at 2:54 p.m. with Staff A included the following: a. Resident #3 positioned in bed with a brief on and sweatpants positioned around his ankles, confirmed and removed by Staff A. b. Resident #4 positioned in bed with a brief on and sweatpants positioned around her ankles, confirmed and removed by Staff A. c. Resident #5 positioned in bed with a brief on and sweatpants positioned around his ankles, confirmed and removed by Staff A. d. Resident #6 positioned in bed with a brief on and jeans positioned around her knees.During an interview 9/18/25 at 3:00 p.m. Staff B, CNA confirmed staff positioned residents in bed with their pants around their ankles so they could have easily checked and changed them. During an interview 9/23/25 at 11:21 a.m. Staff E, CNA confirmed it had not been acceptable to have positioned residents in bed with their pants around their ankles and/or knees. The staff member indicated she observed pants around resident's ankles and/or knees at various times.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have enough outside ventilation via a window or mechanical ventilation, or both. Based on observation, clinical record review and staff interview the facility failed to properly monitor and intervene when an air conditioning unit became non-operational. The facility identified a census of 68 residents. Findings include: During an interview on 9/23/25 at 1:54 p.m. Staff C, Registered Nurse (RN) confirmed on 6/21/25 on the 10 p.m. - 6 a.m. shift the Chronic Confusion or Dementing Illness (CCDI) unit was warm, with a build up of quite a bit of humidity. Per Staff C, caused the floors to have been wet and slippery as the residents wandered throughout the unit. Staff C indicated Staff D, Certified Nursing Assistant (CNA) periodically dry mopped the floors as a means to have minimized the moisture build up. The staff member confirmed staff failed to notify members of management, to have included the maintenance department, related to the warm temperatures the evening and night of 6/21/25 into 6/22/25. During an interview 9/23/25 at 2:08 p.m. Staff H, Licensed Practical Nurse (LPN) confirmed she worked 6/21/25 from 6 p.m. - 10 p.m. or 6 p.m. - 6 a.m. in the CCDI unit. The staff member described the unit as a big unit which got to the point of condensation on floors in the hallways and dining room when the air went out, so she became worried residents would have fallen. The staff member described the unit at that time as hot, extremely hot, which had never been repaired while she worked. During an interview 9/23/25 at 11:08 a.m. Staff E, CNA confirmed she worked 6/21/25 on the 6 a.m. - 2p.m. shift in the CCDI unit and the T have been really warm and humid, without any air flow. The staff member confirmed she observed water on the floors in the resident rooms. The staff member also confirmed staff failed to have informed management of the high temperatures in the CCDI unit. During an interview 9/23/25 at 12:06 p.m. the Director of Human Resources (HR)/Interim Administrator (ADM) indicated she had been called on 6/21/25 by Staff F, Housekeeping who informed her it had been hot in the CCDI unit, the floors wet with humidity and staff had not been able to keep them dry so the Director of HR/Interim ADM called Staff G, Maintenance. During an interview 9/23/25 at 1:31 p.m. the Director of HR/Interim ADM indicated she thought the staff got ahold of her on 6/21/25, but the staff could have called her on 6/22/25. During an interview 9/23/25 12:34 p.m. Staff G confirmed he received a call from the facility staff on 6/22/25 at 6:30 a.m., and when he arrived at the facility he knew something had been wrong. Staff G explained he looked at the air unit, cleaned it, changed the filters, and went home. On 6/22/25 at 12:30 p.m. he received another call from Staff F who informed him the floors had been sweaty so he returned to facility and brought more fans and dehumidifiers. The staff member indicated the facility had fans and humidifiers in-house but on Monday, the next day, he purchased more dehumidifiers and portable air units for the CCDI unit and part of assisted living as they were the only units affected by the malfunction of the air unit/units. During an interview 9/23/25 at 1:43 p.m. the Director of Operations confirmed the Charge Nurses should have called and informed him of the situation and the direct care staff should have called if the nurses failed to follow through as expected. A Local Climatological Data v2 Daily Summary form dated June 2025 described the maximum temperature (T) on 6/21/25 as 91 degrees Fahrenheit (F), minimum T 77 degrees F, and the average T 84 degrees F.