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	06/18/2026

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 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, facility document review, and staff interview, the facility failed to provide adequate supervision for residents with wandering behaviors for 2 of 3 residents reviewed for supervision (Residents #1 and #2). The facility failed to ensure staff from the area of the facility where the Resident #1 resided responded to a door alarm, resulting in Resident #1 eloping from the facility on 3/7/26 via the front door of the facility. A staff member from assisted living responded and assisted Resident #1. The facility failed to prevent Resident #2, who had a history of entering other resident's rooms, from entering Resident #3's room without staff knowledge, resulting in a physical altercation between Resident #2 and Resident #3. The facility reported a census of 71 residents.Findings include: 1. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 scored 5 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. Resident #1's Face Sheet recorded an admission date of 3/2/26.The Wandering Risk Scale dated 3/2/26 identified the resident as a high risk for wandering.The Progress Note written on 3/2/26 at 6:00 PM documented the resident was anxious and agitated with placement, wanting to leave, saying he would walk if he had to.Review of the Care Plan focus area dated 3/3/26, revised on 3/7/26, revealed the resident was an elopement risk/wander resident has eloped from building r/t (related to) Dementia. The Intervention dated 3/3/26 revealed, Has a [wander alert device] watch that will lock doors/sound when close to or attempting to leave the health center. The Progress Note dated 3/3/26 at 1:23 AM documented the resident was talking about going home. The Progress Note dated 3/3/26 at 9:44 PM documented the resident was a wanderer and had been redirected from the front door x6 (times six). The Progress Note written on 3/4/26 at 4:32 PM documented the resident became argumentative with staff, looked for his car, and requested to go home. The Progress Note written on 3/5/26 at 9:02 PM documented the resident was anxious, confused, and constantly wanted to leave the facility.The Progress Note written on 3/7/26 at 1:17 PM documented the resident was found in the assisted living parking lot by a staff member from the facility's assisted living. He was assisted back into the facility. The resident explained he was trying to go home.The facility provided [wander alert device] log recorded the resident left the faciity on 3/7/26 at 12:26 PM, and reentered the facility at 12:29 PM.The State Climatologist reported the temperature in [City Name Redacted] around the time the resident left the facility was 39 degrees Fahrenheit (F) and the wind chill at that time was 31 degrees F.During an interview on 6/16/26 at 3:19 PM, Staff A, assisted living universal worker, explained she was returning dishes to the kitchen from the assisted living. She heard the door alarm for exit A sounding. She quickly walked to the door and went outside. She observed Resident #1 walking toward the Assisted Living (AL). The resident was fully dressed but did not have a coat on. No staff from the care center responded to the alarm. Staff A explained she called a Certified Nursing Assistant (CNA) from the care center to come get the resident.During an interview on 6/11/26 at 12:05 PM, Staff B, CNA explained she worked the resident's unit on 3/7/26. She explained she left her co-worker on the unit and went to another unit to assist with the noon meal. She reported she received a text message from the AL worker that the (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident had been outside and she needed to come get him. She reported her cell phone did not alert her to the door alarm going off.Review of Staff B's Staff Investigation Questionnaire for the resident's incident on 3/7/26 revealed Staff B believed the alarms didn't go off. During an interview on 6/11/26 at 12:11 PM, Staff C, CNA explained she worked on the resident's unit on 3/7/26. She explained she was assisting another resident in their room and when she was done with that, she observed the nurse assessing the resident. She explained she did not see the resident go out or come back in. She reported she did not recall the cellphone alerting her the door alarm had gone off, was beeping the call lights. Review of Staff C's Staff Investigation Questionnaire for the resident's incident on 3/7/26 revealed Staff C didn't hear any alarm from their call light phone around the time that the incident occurred. During an interview on 6/16/26 at 4:21 PM, the Administrator and the Director of Nursing (DON) explained the [wander alert device] alarms go to the cellphones the CNAs carry with them. The [wander alert device] alarm sounds different than the call lights that go to the cellphones as well. They reported the exit A door alarm has gone off before, being set off by someone not entering the code, and staff from the care center have responded to the alarm. They were unable to explain why staff from the care center did not respond this time.The facility policy titled Elopements and Wandering Residents last revised 12/2025 explained the facility was equipped with door locks/alarms to help avoid elopements. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. The policy also explained adequate supervision would be provided to help prevent accidents or elopements.2. Resident #2's Face Sheet recorded an admission date of 2/5/26.The MDS assessment dated [DATE] revealed Resident #2 had severely impaired cognition, and identified a short term and long term memory problem. Per this assessment, the resident wandered 1 to 3 days of the review period. The resident used a walker and wheelchair, and was independent to wheel 150 feet in her wheelchair. Resident #2's Care Plan focus area dated 3/19/26 revealed the resident was an elopement risk/wander r/t (related to) Dementia. The interventions included distract from wandering by offering pleasant diversions (initiated 3/19/26) and [wander alert device] placement on 3/19/26.The Progress Note for Resident #2 written on 5/19/26 at 7:30 PM documented the resident was wandering into other resident's rooms, bathrooms and closets.The Progress Note for Resident #2 written on 5/20/26 at 4:03 PM documented the resident enjoyed wheeling around the facility to see what everyone is up to.The Incident Report dated 5/22/26 at 3:45 PM documented an occurrence of Resident #2 and Resident #3 having a loud verbal interaction in the dining area. Once the residents were separated, Resident #3 reported Resident #2 had been in the doorway of his room, in his things. He explained he asked her to leave the room and she said something smart like him going to h*ll. He reported grabbing her wrist, told her it was his room and get out. They then had the loud verbal interaction in the dining area. Resident #2 reported that Resident #3 had grabbed her wrist. Per the Incident Report, three CNAs and a Nurse were in rooms providing cares at the time, and there were no witnesses to the altercation in Resident #3's room. The Progress Notes for both residents lacked an entry related to the occurrence.During an interview on 6/11/26 at 1:42 PM, Staff D, Activity Aide, explained on 5/22/26 she heard a woman's voice yelling something, help maybe. She then heard a man with a raised voice. She entered the dining room and observed Resident #3 standing with his walker and Resident #2 in her wheelchair. She separated the residents, encouraging Resident #3 to sit down and guiding Resident #2 to her room.3. Resident #3's Face Sheet recorded an admission date of 12/22/25.The MDS dated [DATE] revealed Resident #3 scored 13 out of 15 on a BIMS exam, which indicated intact cognition. The facility policy titled Elopements and Wandering Residents last revised 12/2025 explained adequate supervision will be provided to help prevent accidents or elopements, and interventions to increase staff awareness of the resident's risk, modify behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated with appropriate staff.