

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165178	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER The Highlands		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, United States (US) Food and Drug Administration (FDA) Food Code, document review, and staff interview, the facility failed ensure staff washed hands prior to applying gloves and between glove changes. The facility also failed to prevent dirty gloves from coming into contact with food served to residents. The facility reported a census of 74 residents. Findings include: During an observation on 7/20/26 at 11:01 AM Staff B, Cook, reported she planned to prepare 16 servings of spinach, three moist and minced and thirteen puree. Staff B applied gloves without washing her hands, then opened the oven, removed a steam pan of spinach, touched a scoop, touched the blender, and continued to place sixteen, 4 ounce (oz) serving of spinach into the blender and blended. Staff B then removed three of the servings to a small steam pan for the moist and minced diets. Staff B then opened a bread bag and removed 5 slices of bread with her dirty gloves. Staff B and placed into the blender with hot water. Then, Staff B continued to prepare the spinach puree. Staff B then changed her gloves without washing her hands. The pureed spinach was served out during the lunch meal. Observation on 7/20/26 at 11:16 AM revealed Staff B verbalized she planned to prepare 16 servings of barbeque (BBQ) chicken, three servings of minced and moist and 13 servings of pureed chicken. Staff B applied gloves without washing her hands prior to food preparation. Staff B placed sixteen, 3 1/4 oz of BBQ chicken into the blender and blended. Staff B touched a scoop and removed three, 3 1/4 oz servings to a steam pan, then touched a measuring cup of chicken broth. Staff B added the chicken broth to the bottom of the steam pan. Staff B placed plastic wrap over the small steam pan of moist and minced chicken and placed the pan in the warmer. At 11:23 AM, Staff B returned to the preparation table and continued to wear gloves. Staff B obtained a bag of bread, removed the tie on the bread, opened the bread bag and pulled 13 slices of bread out of the bread bag with the dirty glove and placed it in the blender with the remaining chicken. Residents #1, #4, #10, #15, #18, #21, #28, #40, #54, #64, #69, #73, and #75 received the pureed BBQ chicken at the lunch meal. During the provision of the lunch service on 7/20/26 from 12:23 PM to 1:00 PM, Staff B changed her gloves without washing her hands, then proceeded to plate resident meals. Staff B plated four resident meals touching plates, scoops and steam pans with her gloves, then plated Resident #33 and #42's minced and moist BBQ chicken into divided plates, and tapped the top of the chicken down with her dirty right gloved hand. Staff B placed tater tots onto Resident #24's plate and proceeded to touch the top of the tater tots with her left dirty glove and handed the plate to the Nutritional Services Supervisor (NSS) to finish plating the vegetable, then was set up on the resident's lunch tray. On 7/20/26 at 1:00 PM, Staff B explained they had to use clean gloves or utensils to touch food. On 7/20/26 at 1:27 PM, Staff C, Dietary Aide reported if they had a solid food item, they could use gloves to handle the food. For other foods, they were to use a spatula or other serving utensil. On 7/21/26 at 9:20 AM, Staff D, Dietary Aide (DA) explained they were to wash their hands all the time. Staff D specified staff were to wash (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	their hands before they put gloves on, after they took gloves off, and any time they changed gloves. On 7/21/26 at 1:00 PM, the Food Service Supervisor reported the staff were expected to use gloves for handling food and change gloves with handwashing directly after touching the food item. The facility's Glove-ology Vendor Guidance and Glove Use Best Practices for Food Safety both mandate thorough handwashing before and after wearing or changing gloves and emphasize that a fresh set of gloves should be used when changing tasks. Furthermore, the FDA Food Code 2017 (Chapter 2-301.14 and 3-301.11) mandates handwashing before donning gloves to initiate food preparation tasks and prohibits contact with ready-to-eat foods with bare hands.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **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 ensure the Iowa Physician Orders for Scope of Treatment (IPOST) matched provider's orders on the electronic health record (EHR) for Do Not Resuscitate (DNR) for 1 of 2 residents sampled (Resident #6). The facility identified a census of 74 residents. Findings include: Resident #6's Electronic Healthcare Record (EHR) Census showed he was hospitalized [DATE] and returned to the facility on [DATE]. The After Visit Summary (hospital) dated [DATE] documented Resident #6 as a Do Not Resuscitate (DNR) status. A Clinic Note, Encounter date [DATE] documented after discussion with the Power of Attorney (POA), Resident #6 was changed to a DNR code status. A Nurses Note dated [DATE] at 4:40 PM written by the Director of Nursing (DON) documented the family had discussed due to the resident's continued decline, they would like to switch him to a DNR. The DON reached out to the Medical Director and received a verbal order for a DNR. The Physician Order dated [DATE] revealed, DNR. The Advanced Directives Care Plan included an updated intervention [DATE] for DNR status. During an interview on [DATE] at 8:27 AM Staff A, Registered Nurse (RN) reported they had an IPOST book they would refer to for a resident's code status. A review of the Hallway's IPOST Book revealed Resident #6's IPOST signed by the Healthcare POA on [DATE] stated if no pulse and not breathing cardiopulmonary resuscitation (CPR) to be provided. During an interview on [DATE] at 8:34 AM, Staff A verified the IPOST listed a full code status. Staff A checked Resident #6's EHR and verbalized Resident #6 was listed as a DNR. She stated in the situation, she didn't know what she would do. She would probably follow the IPOST as it was listed in the book to perform CPR. On [DATE] at 9:53 AM, the Administrator reported generally the IPOSTs were completed upon admission by the Social Worker (SW). If there were changes in the IPOST, those were usually completed as part of the care conferences and the DON would address those. During an interview on [DATE] at 11:43 AM, the DON explained the SW completed the IPOST with the family as part of the admission process. The SW and the MDS Coordinator also went over the IPOST as part of care conferences and updated the IPOST as needed. On [DATE] at 2:05 PM, the SW explained he completed the IPOST with the resident or the family at the hospital prior to admission to the facility or as part of the admission process. They reviewed the IPOST at each care conference and if there were changes requested, they would fill out a new IPOST and get a verbal order to change the code status. He further stated it would fall to him or the DON to ensure the correct IPOSTs (forms) were in the hallway books. The Advanced Directives Policy, revised 3/2026, directed upon return from a hospital or other facility, staff shall verify that any advance directives and IPOST forms on file are still current and that no revocations or amendments were made during the resident's absence. Updated documents shall be obtained and filed in the medical record. The Policy lacked direction on ensuring IPOSTs were updated in the hallway books.		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, Center for Medicare and Medicaid (CMS) Long-Term Care (LTC) Resident Assessment Instrument (RAI) Manual review, and staff interview the facility failed to complete a Minimum Data Set (MDS) Significant Change in Status Assessment (SCSA) within 14 days of hospice election for 1 of 2 residents receiving hospice services (Resident #30). The facility identified a census of 74 residents. Findings include: Resident #30's Hospice Certification and Plan of Care documented hospice care services started 12/31/25. Resident #30's SCSA MDS dated [DATE] documented he received hospice services. The MDS Summary Page documented the 1/6/26 SCSA MDS was completed on 1/15/26. During an interview on 7/21/2026 at 2:38 PM, the MDS Coordinator reported a SCSA has to be completed within 14 days of the admission to hospice including the day of admission to hospice. The MDS Coordinator verbalized she missed it and probably completed it late. She further reported she followed the RAI manual for completing the MDS. The CMS LTC RAI User Manual, Chapter 2, page 2-17 directed a SCSA MDS must be completed within 14 calendar days after the determination that a significant change in resident's status has occurred. Page 2-25 directed a SCSA was required to be performed when a terminally ill resident enrolls in a hospice program and remains a resident at the nursing home.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, document review, and staff interview, the facility failed to perform a new Preadmission Screening and Resident Review (PASRR, a federal mandate requiring all states to screen individuals before they are admitted to a Medicaid-certified nursing facility, ensuring they are placed in the most appropriate setting and receive necessary care) as required for 1 of 2 residents sampled (Resident #60). The facility reported a census of 74 residents. Findings include: An Electronic Health Record (EHR) Clinical Census showed Resident #60 admitted to the facility on [DATE]. The Hospital Discharge summary dated [DATE] documented a Secondary Diagnosis of intellectual disability (ID). The Baseline Care Plan dated 3/31/26 documented Resident #60 as cognitively impaired. A 3/25/26 Notice of Preadmission Screening and Resident Review (PASRR) Level I Screen Outcome documented no Level II was required due to no ID. The PASRR documented a reliable source, such as a family member, confirmed the presence of an ID prior to the age of 18 by answer the question, yes. The Clinical Reviewer Comments documented ID was not noted in the documentation (provided). Under Medical Conditions the documents available for review were the History and Physical Exam, Medication List and Medication Administration Records (MARs). The 3/25/26 PASRR Outcome Rationale documented a Level I screen indicated that a PASRR disability was not present because there was no evidence of a PASRR condition of an intellectual/developmental disability condition. If changes occurred or new information refuted the findings, a new screen must be submitted. The admission Minimum Data Set (MDS) assessment dated [DATE] showed Resident #60 was not currently considered a level II through the PASRR process and did not have a ID. The MDS documented a diagnosis of mild intellectual disabilities in the diagnosis section of the assessment. A Clinic Note, Encounter Date 5/14/26, documented the Patient Active Problem List included a diagnosis of mental retardation, dated 5/7/19. The Care Plan, revised 7/10/26, documented Resident #60 was independent in meeting his own emotional, intellectual, physical and social needs. During an interview on 7/21/26 at 2:04 PM the Social Worker (SW) reported he completed or reviewed the PASRRs as part of the admission process. He was still learning the PASRR process and had recently received more education regarding the PASRRs. He reviewed Resident #60's PASRR and reported the PASRR was not correct as Resident #60 did have an ID condition. He verbalized he had not read the PASRR thoroughly or correctly and the PASRR needed to be re-screened. The Preadmission Screening for Mental Illness/Mental Retardation Level II Policy, revised 3/2026, failed to address when a PASRR should be re-screened.		