STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165566	A. Building B. Wing	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Ridge Care Center, LLC	102 Highland Circle Williamsburg, IA 52361

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 48452 Based on observation, clinical record review, and staff interviews the facility failed to investigate an injury of unknown origin for 1 of 6 residents (Resident #3) reviewed. The facility reported a census of 55 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #3, dated 2/14/24, revealed diagnoses of Alzheimer's disease, dementia with behavioral disturbance, and anxiety. The resident was unable to complete the Brief Interview for Mental Status (BIMS) due to short- and long-term memory problems. The MDS indicated a need for partial to moderate assistance with toileting and bathing, and supervision or touch assistance with personal hygiene. The Care Plan, dated 2/8/24, included focus areas for impaired skin integrity, and for risks of falls. The focus area for skin integrity included an intervention to assess/evaluate my risk status per policy, upon admission, quarterly and as needed. indicated the resident was at risk for impaired skin integrity. Another area indicated a psychosocial well-being problem related to anxiety, dementia with behavioral disturbance, and impaired cognition/communication. Neither addressed picking or scratching as symptoms or behaviors to monitor. A Progress Note dated 4/26/24 at 3:10 AM indicated the resident was scratching the back of his head and picking at scabs, small amounts of dried blood noted. A Progress Note dated 4/26/24 at 10:55 AM documented the resident had dried blood on his head due to picking at scabs and scratching his head. The Progress Notes lacked assessment information, including origin, size and notification of the provider. A document titled Body Audit - V4 on 4/28/24 at 5:48 PM documented a skin alteration on top of the scalp as scratches healing with no signs of infection. The clinical record lacked information, including origin, size and notification of the provider. A document titled Task: Skin Observation documented the resident had a skin alteration on 4/26/24 at 3:40 AM, and on 4/27/24 at 10:15 AM. The skin alteration on 4/26/24 at 3:40 AM assessed as an open area. The 4/27/24 at 10:15 AM assessed the area as not open. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165566	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/21/2024
NAME OF PROVIDER OR SUPPLIER: Highland Ridge Care Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 102 Highland Circle Williamsburg, IA 52361	

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/15/24 at 1:32 PM observed the resident resting on a sofa in his room. The area in question on his head appeared healed. The resident moved independently on the sofa and his walker was nearby. The resident's legs were tangled in his blanket as he rolled into a seated position. He fell back asleep, still sitting up. Resident remained in that position at 1:54 PM. During an interview on 5/14/24 at 9:21 AM Staff C, Registered Nurse (RN) stated she was told the resident was confused and knelt down on the floor to pick something up and did not have a fall. She stated there was a dressing on his head and she was not sure what it was from. On 5/14/24 at 10:08 AM Staff A, Certified Nursing Assistant (CNA), stated Resident #3 had fallen a couple of times. She thought he had scratched his head this time, but later noted the area started to bruise and thought it might be from a fall. She reported this to a nurse and to the DON. A clinical record review revealed a lack of documentation regarding a resident fall. During an interview 5/14/24 at 1:41 PM, Staff B, CNA, stated on that she did not see the incident but worked with the resident. She stated he was acting out of the ordinary. She stated she saw a spot of blood on the floor and talked to the nurse. The CNA noted that the resident would not remember if he was on the floor and no one actually saw him fall or on the floor. During an interview with the Director of Nursing (DON) on 5/14/24 at 4:42 PM, she stated the nurse was called in because the resident's head was bleeding. She cleaned and dressed it. The nurse thought it was scratching and picking. The DON said he did this behaviorally and it could cause bruising. During an interview on 5/16/24 at 8:49 AM, the DON stated if there is an concern with a resident and it is unknown what occurred the facility would try to figure out what happened. This involves talking to the resident, look at staffing patterns, resident behavior, time of day, if anything different about the day, resident behaviors related to possible urinary tract infection or respiratory concern. When asked how the process for different accounts of a concern is handled, the DON stated determine if resident can answer questions, look at information have, look at injury, what is the injury consistent with, try to assess is there is anything can figure out. It is detective work, and need to err on the side of caution.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 48452 Based on clinical record review, interviews, and policy review the facility failed to complete neurological assessments after unwitnessed falls for 1 of 6 residents (Residents #2)reviewed. The facility reported a census of 55 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #2, dated 3/5/24, included diagnoses of vascular dementia with psychotic disturbance, anxiety disorder, and insomnia. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 5 out of 15, which indicated severely impaired cognition. Progress notes dated 2/2024 x 2, 2/29/24, 3/11/24, 3/13/24 x 2, 3/15/24, 3/17/24, 3/19/24, 3/23/24, 3/24/24, 3/30/24, 4/18/24 x 2, 4/22/24, and 4/25/24 documented Resident #2 ' s unwitnessed falls. Facility documentation titled Neuro-Check Flow Sheet documented neurological assessments were completed for the fall that occurred on 3/23/24. The facility lacked neurological assessments for the other 15 unwitnessed falls. During an interview with Staff C, Registered Nurse (RN), on 5/14/24 at 9:21 AM she indicated that staff should start neurological assessments with unwitnessed falls, as well as if the resident 's health declined or if they aren't sure if the resident hit their head. Staff E, RN stated on 5/14/24 at 3:48 PM the policy for falls was to start neurological assessments to determine resident status. With a lower BIMS it could be difficult to tell if the resident was a good witness and necessary to start the checks. She stated it is better to be safe than sorry. Staff E stated she recently laminated and posted the policy at the main nursing station in case staff had questions. An interview with the Director of Nursing (DON) on 5/14/24 at 4:42 PM revealed the interdisciplinary team (IDT) completed fall follow up. She stated the policy for starting neurological assessments with residents with cognitive impairment was not different and they just took what they said at face value. A policy titled Fall Prevention and Management Program Policy, modified April 2021, stated members of the interdisciplinary team were responsible for assessing, treating, and implementing strategies for the prevention of resident falls. For unwitnessed falls where the resident is not able to state if they hit their head, staff should perform neuro checks for 3 days according to a documented protocol. The policy lacked clarification regarding residents with impaired cognition.