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	11/19/2025

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review and staff interviews, the facility failed to appropriately provided assessment and interventions for the necessary care and services, to maintain the residents' highest practical physical well-being for 2 of 3 residents reviewed (Resident #1 & #2). R#1 returned from a hospital stay, at which time staff failed to notice the resident had duplicate laxatives order for five days, and during that time the resident fell. R#2 complained of pain after a fall the facility staff failed to perform a thorough assessment, and call the physician provide intervention. The facility reported a census of 50 residents. 1.The Quarterly Minimum Data Set (MDS) dated [DATE] for Resident #1 revealed the diagnoses of diabetes mellitus, kidney disease, dementia, anxiety, depression and required maximal assistance for toileting, shower or bathing and personal hygiene. The MDS documentation revealed Resident #1 was incontinent of bowels and bladder. The brief interview for mental status (BIMS) score of 3 suggested severe cognitive impairment. The Care Plan with initiated date of 4/2/25 for Resident #1 identified a self-care performance deficit and directed the staff to bath, dress, groom, provide hygiene with the assistance of one staff member. The Progress Notes for Resident #1 revealed: 1. (General Note) On 10/24/25 Resident #1 completed taking full course of antibiotic for urinary tract infection on 10/23/25. 2. (Physician's Order Note) 10/25/25 On-call provider updated related to transcription error and multiple watery loose stools, ordered Miralax, Senna-s and Lactulose on hold until tomorrow morning. Discontinue extra dose of Miralax.3. On 10/29/25 at 2:26 pm, Resident #1 was observed laying on her back, on the shower floor, and a CNA was with her. The CNA reported she showered Resident #1 to cleanse her due to having loose stools all over her and she became combative, grabbed the grab bar in the shower room and slid on the wet floor. MAR October 2025 for Resident #1 revealed:1. On 9/11/25 order for MiraLAX Powder 17 grams (gm) gm per scoop, give 1 time a day for constipation, administered in the morning. Held on October 3rd, 4th, 25, & 26th. (MiraLAX also known as Polyethylene Glycol 3350 powder)2. On 10/17/25 order for Polyethylene Glycol 3350 powder give 1 scoop by mouth one time a day for constipation. Administered on 10/17/25 am then order changed the time to be administered in the evening. Administered on 10/18 through 10/24/25. On 10/25/25 held then discontinued. 3. On 10/18/25 order for Lactulose 10 gm per 15 milliliters (ml). Give 15 ml by mouth for constipation. Administered in the am and pm on 10/21/25 through 10/25/25 am. Held the pm dose on 10/25/25 and am dose 10/26/25. Resumed and administered on 10/26/25 pm and discontinued after the 10/29/25 am dose was given. 4. Senna S oral tablet 8.6-50 mg give 1 tablet two times a day for constipation. Administered in am and pm. Held pm dose on 10/25/25 and discontinued on 10/29/25 after am dose. 5. On 8/8/25 order for Bisacodyl Rectal Suppository 10mg insert 1 suppository rectally every 24 hours as needed for constipation. Administered on 10/16/25 at 1:48 pm. 6. On 4/2/25 order for Loperamide HCL 2 mg give 2 tablets by mouth as needed for loose stools. Give 2 tablets after the first loose stool & 1 tablet after each additional loose stool as needed with a maximum dose of 4 a day. This was not administered in October 2025 and was discontinued on 10/18/25. 7. On 10/17/25 order for Milk of Magnesia 400 mg/5 ml. give 30 ml by mouth every 24 hours as needed for constipation. This was not administered in October 2025. 8. Order on 4/2/25 for Polyethylene Glycol 3350 powder give 1 scoop by mouth every (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 0684 Level of Harm - Actual harm Residents Affected - Few	24 hours as needed for constipation if no bowel movement for 3 days. Administered on 10/8/25 at 1:36 pm and 10/15/25 at 1:43 pm. Point Of Care document for Resident #1 bowel movements (BM) descriptions and shower revealed:1. On 10/21/25 1 medium putty like BM and 2 large BM loose diarrhea, received a dependent (helper does all of the effort or 2 or more helpers to complete the activity) shower 2. On 10/22/25 2 large BM loose diarrhea, received a dependent shower.3. On 10/23/25 1 large BM loose diarrhea.4. On 10/24/25 1 medium BM and 1 large BM both loose diarrheas, received a maximal assist shower. 5. On 10/25/25 2 medium BM both loose diarrheas. 6. On 10/26/25 No BM documented.7. On 10/27/25 1 large BM loose diarrhea, received a dependent shower. 8. On 10/28/25 1 large BM loose diarrhea, received a maximal assist shower9. On 10/29/25 1 large BM loose diarrhea. The shower was not documented that occurred during fall. Point of Care document for Resident #1 aggressive during care behavior, intervention, & effectiveness revealed:1. On 10/21/25 Aggressive during care day shift, redirect, intervention not effective.2. On 10/24/25 Aggressive during care evening shift, redirect, intervention not effective.3. On 10/25/25 Aggressive during care evening shift, conversation, intervention not effective. 4. On 10/26/25 Aggressive during care day shift, reassure, intervention not effective.5. On 10/28/25 Aggressive during care evening shift, reassure, intervention not effective.6. On 10/29/25 Aggressive during care overnight and evening shift, reassure, interventions not effective. Falls Follow up Form dated 10/29/25 at 2:46 pm for Resident #1 identified a change in elimination: Alteration from baseline bowel pattern. Staff completing the document: Staff I, Registered Nurse (RN) on 10/29/25 at 2:26 pm.admission Hospital record dated 10/29/25 for Resident #1 revealed the daughter at bedside reported mother fell in shower, used shower chair after being incontinent of stool (BM). Resident #1 slipped on the stool present on the shower floor. Resident #1 had diarrhea since 10/17/25 due to multiple laxatives.During an interview on 11/12/25 at 2:09 pm with Resident #1's daughter who was the POA, stated she had taken mother to hospital on [DATE] for back aches, slouching and she was treated for a urinary tract infection (UTI) with antibiotics. Daughter stated Resident #1 did not have a bowel movement for multiple days and the physician ordered Lactulose and MiraLAX, which she was already taking daily and Senna two times a day. Daughter stated she did not want her mother treated with Lactulose and was unaware the staff were giving the MiraLAX two times a day. The daughter stated her mother had diarrhea for a week and the facility staff stated she would cover herself in the bowel movement (BM) so she was showered daily. The daughter stated her mom did not like showers and on 10/29/25 the facility called her to report that she had slipped on the BM in the shower and fell.During an interview on 11/13/25 at 10:33 am, Staff E, Certified Nursing Assistant (CNA) stated she had notified nursing on multiple occasions that Resident #1 did not like showers and would require two CNA's to provide her showers due to aggressive behavior toward staff and attempts to get off the shower chair. Staff E stated Resident #1 was incontinent of bowels and would be found to have the BM on her hands and body multiple times that required a shower to remove it. During an interview on 11/13/25 at 9:22 pm, Staff K, CNA stated she had worked in the facility for a year. Staff K stated she worked the 6am to 2pm shift on 10/29/25. Staff K stated Resident #1 was not eating well and had requested to eat in her room. Staff K stated for the past 3-4 weeks Resident #1 began to deteriorate, slouched in her recliner and was more combative. Staff K stated she reported to the nurses for 2 weeks that something was wrong. Staff K stated she was aware that Resident #1 had a UTI but that day she was lethargic (weakness), slouching back in the recliner and patted abdomen saying ouch.During an interview on 11/12/25 at 3:28 pm, Staff A, CNA stated Resident #1 required two staff for 2 weeks almost daily for showers due to the diarrhea and having BM all over herself. During an interview on 11/13/25 at 11:36 am, Staff H, Life Enrichment (Activity) Assistant stated she was aware that Resident #1 would swing, kick, and bite staff. Staff H stated Resident #1 was strong and did not like showers but was covered with BM multiple of times.During an interview on 11/17/25 at 12:18 pm, Staff P, CNA stated Resident #1 was often confused and had declined, not willing to move, more combative, and incontinent of bowels. Staff P stated it took two CNA's to shower Resident #1, to clean her from the (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	BM, and she would immediately get out of the shower chair as she hated showers. Staff P stated she reported to the nurses that it took 2 staff to provide care for Resident #1. During an interview on 11/19/25 at 1:01 pm The DON stated the clinical coordinator reviewed resident records. That information was then brought into the interdisciplinary team (IDT) meetings that occur daily in the mornings. The DON was unable to recall if Resident #1's bowel regimen, bought of diarrhea, or behaviors with ineffective interventions were brought to the attention of the IDT. Grievance form dated 10/28/25 received an e-mail on 10/28/25 at 7:09 am from Resident #1's daughter who was not satisfied with Resident #1's bowel regimen and meals for diabetics. Staff follow up: dietitian recommended daughter to utilize e-menu access. Followed up with a new bowel regimen. Dietitian offered a meeting, no response. Information relayed to the clinical and dietary staff & nutritionist. Dated 10/28/25 Staff S, Social Worker, Resident Services Director.2. The Quarterly MDS dated [DATE] for Resident #2 revealed the diagnoses of type 2 diabetes mellitus, Alzheimer's disease, bone density disorder, macular degeneration, and had a history of falls. Resident #2 required the use of walker, one staff to assist and a wheelchair and able to self-propel. Resident #2 required maximum assistance with toileting, dressing upper body and showers, and was dependent on staff for dressing her lower body. Resident #2 was independent with moving in a bed and was continent of bladder but had frequent incontinent bowel movements. During the assessment, Resident #2 had no complaints of pain, experienced two falls without injury and one fall with a minor injury, no major injuries noted. The Care Plan revised on 10/12/25 for Resident #2 directed staff to provide the assistance of one for transfers and ambulate with gait belt and wheelchair pulled behind her as she weakens and may need to sit quickly. The Care Plan directed staff to place her call light within reach, answer promptly and assist to bed when eye glasses and hearing aid was removed. Observe for agitation, restlessness, confusion and falls. The Progress notes for Resident #2 revealed on 10/26/25 at 8:56 pm, Staff O, Licensed Practical Nurse (LPN) documented at 7:15 pm, she was called by staff to respond as Resident #2 was laying on the floor on the right side next to her wheelchair and her head was resting on the wheel. Resident #2 was alert, smiling and talkative, stated she was standing next to the bed and went down to the floor. Resident #2 was able to move upper extremities and lower left extremity without pain. Resident #2 complained of right hip pain and initially was unable to move her right lower extremity due to the pain, cried out with attempted movement. Resident then spontaneously bent her right knee and lifted her foot into the air, held unsupported without discomfort. When attempted to roll Resident #2 to the left side, she cried out, grabbed her right hip and said oh it hurts. Staff assisted Resident #2 into a sitting position, resident stated she hurt just this one and grabbed her left hip. Assisted with two staff with the mechanical lift and stated it was fun but she did not recommend falling down to get one. Vital signs were BP 140/65, P 65, T 99.3, Oxygen Saturation 96% on room air. Resident #2 was able to move all extremities after she was in bed with no complaints of pain and reported to daughter who stated she did not want her sent for an evaluation, rather to wait a few hours and see how she does. The on-call manager Staff R, RN was notified and placed in the Medical Director's folder for notification. Falls Follow Up Form dated 10/26/25 at 7:15 pm for Resident #2 revealed:1. Vital Signs: T 99.3, P 65, BP 140/65, R 19, Oxygen Saturation 96% on room air.2. No change of condition identified for intrinsic risk factor.3. No change in elimination.4. No change in sensory impairments.5. No change in gait or balance.6. No pain7. Resident #2 did not remember she could not walk and got out of wheelchair to go to bed. 8. Short Term intervention: Don't leave Resident #2 in a wheelchair unattended. 9. Signed by Staff O, LPN on 10/26/25 at 10 pm.During an interview on 11/18/25 at 8:39 am, Resident #2's daughter Power of Attorney (POA) stated the facility nurse called her at 7:45 pm to report her mother fell to the floor, had some pain but after they got her into the bed, she was fine now with no complaints of pain. The daughter stated she told the nurse if she was not having pain, then they could wait and monitor her. The daughter stated she received a call at 1:44 am from the nurse who stated when they turned her mother, she had some pain that they treated with Tylenol and then she was just laying there without pain. The daughter stated they could call for a (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	portable x-ray in the morning and she agreed. The daughter stated they had returned from a vacation and she had not slept yet. The daughter stated she slept in but had not received a call so she called at 12:07 pm and was informed they had not called the physician for the x-ray yet and the staff had her mother up in a wheelchair. The daughter requested to have her mother put in bed and call for an x-ray. The daughter stated she arrived to the center at 4:45 pm and the X-ray mobile unit had just left, and the nurse reported she was up for both meals, but was hooting and hollering all day and pushing on her hip and had trouble getting the x-rays done due to pain. The daughter stated she was a nurse and assessed her mother's hip and she moaned when touched and when the bed was elevated her mother grimaced. The daughter stated at 6:28 pm she went to the nurse station, was told the x-ray was not back yet, but the night nurse found the fax on the machine that read suspected fracture. The daughter stated she told the nurse to transfer her mother to the Orthopedic Hospital. The daughter stated the hospital nurse reported she was in so much pain that they administered Morphine. The daughter stated she could not send her mother back to the facility after surgery because of the poor assessment skills of the nurses. During an interview on 11/18/25 at 10:18 am Staff N, CNA stated she worked on 10/26/25 and provided care for Resident #2 who had a steady gait with the walker, then transferred to the wheelchair for supper. Staff N stated she found Resident #2 on the floor at the foot of her bed with her head against her wheelchair. Staff N radio called for Staff O, LPN, who responded immediately. Staff N stated Resident #2's right leg hurt her, she was screaming and clearly was in pain but she was able to pick it off the floor. Staff N stated she waited with Resident #2 on the floor while Staff O called the daughter. Staff N stated Staff O returned with the mechanical lift and Resident #2 screamed in pain when they got her off the floor and during care, changed the brief. Staff N stated she gave report to Staff J, CNA reported that Resident #2 fell and had increased pain when she provided care.During an interview on 11/18/25 at 11:28 am, Staff O, LPN stated three residents fell on [DATE] and Resident #2 was one of them. Staff O stated the staff called her to the room and Resident #2 was on the floor, unable to move her right leg and said it hurt but lifted it off the floor before she left the room to call her daughter so she felt it was fine. Staff O notified the daughter that her mother could move her leg and had intermittently had pain so she felt that it was not broken. Staff O stated she did not call and report to a physician but placed a report on the physician clip board. During an interview on 11/17/25 at 10:49 am, The Medical Director stated he was on vacation when Resident #2 fell, normally the facility will call the office or the emergency department team. The Medical Director stated if there was a significate change in a resident's condition, increased pain, no movement of an extremity or the family disagreed with the nurse recommendation, then the nurse could call the Emergency Room. The Medical Director stated he reviewed Resident #2's situation with the fall, and initially the family declined to send her, but if there was a change or the nurse suspected a fracture and it was overnight, then they are to call the Emergency Room. There is staff on call 24/7 there for anything serious. The Medical Director stated the facility could send a fax for the non-urgent situations. The Policy titled Fall Prevention and Management Program Policy dated 2021 revealed the nurse will immediately evaluate the resident for any injury, change in status or pain and will proceed with emergency procedures and interventions as indicated.

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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 0689 Level of Harm - 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 observation, clinical record review, family and staff interviews, the facility failed to provide appropriate and sufficient supervision to ensure each resident's individual safety and to prevent an avoidable accident for 2 of 3 residents reviewed for falls (Resident #1 & #2). The facility reported a census of 50 residents. 1. The Minimum Data Set (MDS) dated [DATE] for Resident #1 revealed the diagnoses of Diabetes Mellitus, kidney disease, dementia, anxiety, depression, visual hallucinations, osteoarthritis and required maximal assistance for toileting, shower or bathing and personal hygiene with moderate assistance for dressing. Resident #1 required moderate assistance to transfer into and out of the shower and was independent with sit to stand, chair to bed transfers, and toilet transfers. Resident #1 was independent with ambulation up to 10 feet (ft) and required moderate assistance for ambulation 50 ft to 100 ft, utilizing a walker. The MDS documentation revealed Resident was unable to answer the pain assessment interview and the staff assessment for pain revealed Resident #1 had indicators of pain in non-verbal sounds, vocal complaints of pain, facial expressions and protective body movements or postures observed for 1 to 2 days in the 5-day assessment. The MDS identified 1 fall without injury. Resident #1 rejected care for 3 days and had physical behavior symptoms directed toward others. Resident #1 was incontinent of bowels and bladder. The brief interview for mental status (BIMS) score of 3 suggested severe cognitive impairment. The Care Plan for Resident #1 revealed the risk for falls due to cognitive impairment, confusion, history of falls, incontinence and directed staff to alert the resident to changes to the environment. The care plan identified a self-care performance deficit and directed the staff to bath, dress, groom, provide hygiene with the assistance of one staff. The care plan identified an alteration in mood or behavioral expression, behaviors were physical or disruptive and directed staff to approach or speak in a calm manner, divert her attention and remove her from the situation. The Care Plan Conference on 10/11/25 for Resident #1 revealed:1. Required assistance of one with dressing, toileting and personal hygiene. 2. Her weights have been stable with August at 166.8, September at 166.8 and October at 168.8. 3. She had a fall in the last quarter where she was lowered to the floor.4. She spent most of her day in her room relaxing and watching television, coloring, or listening to music, enjoyed participating in exercise and afternoon socials.5. There were no concerns at the Care Plan Conference and the Power of Attorney (POA) daughter was not present.Point of Care document for Resident #1 was aggressive during care behavior, intervention, & effectiveness of the intervention revealed:1. On 10/21/25 Aggressive during care on the day shift, redirected and the intervention was not effective.2. On 10/24/25 Aggressive during shower & care on the evening shift, redirected and the intervention was not effective.3. On 10/25/25 Aggressive during care on the evening shift, conversation provided and the intervention was not effective. 4. On 10/26/25 Aggressive during care on the day shift, reassured and the intervention was not effective.5. On 10/28/25 Aggressive during shower & cares on the evening shift, reassured and the intervention was not effective.6. On 10/29/25 Aggressive during care overnight and the shower during the evening shift, reassured and both of the interventions were not effective. The Progress Notes for Resident #1 revealed:1. Resident was having high blood sugars (400) after readmission to the dementia unit on 10/18/25 and was treated for a urinary tract infection (UTI) with an antibiotic.2. On 10/25/25 Resident #1 completed the antibiotic and began having watery loose stools. 3. On 10/27/25 at 3:15 pm, Resident #1 was found on the floor in her room in front of her recliner, without injuries and the root cause analysis determined the silk pajamas was the reason she slipped out of the recliner.4. On 10/29/25 at 2:26 pm, Resident #1 was observed laying on her back, on the shower floor, and a CNA was with her. The CNA reported she showered Resident #1 to cleanse her due to having loose stools all over her and she became combative, grabbed the grab bar in the shower room and slid on the wet floor. Resident #1 said, Oh it hurts and screamed when nurse (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	touched her left leg that was internally rotated. The daughter arrived to the facility around 3 pm and the ambulance arrived around 3:25 pm. Resident #1 was transferred to the tertiary hospital at 3:50 pm. The intervention was that Resident #1 needed assistance of 2 staff when completing care and showers. 5. On 10/31/2025 at 10:08, the Interdisciplinary Team (IDT) Root Cause Analysis: Regarding fall on 10/29/2025 at 2:26, Resident #1 was incontinent of bowel and staff attempted to give her a shower, she was combative and aggressive towards staff, grabbed the bar in the shower, stood up and slipped on the wet floor. The intervention based on root cause analysis: Staff education to step away and change staff members when resident was agitated and combative.Falls Follow up Form dated 10/29/25 at 2:46 pm for Resident #1 revealed:1. Vital Signs: Unable to take her blood pressure (BP), Temperature 98.0, Pulse (P) 99, Respirations 18, Oxygen Saturation 91%. 2. Change in condition: Range of motion.3. Sensory impairments: None.4. Change in elimination: Alteration from baseline bowel pattern.5. Gait/balance impairments: Change in Range of Motion (ROM).6. Pain: Competitiveness with staff7. Change in activity patterns: None 8. Extrinsic risk factors: Wet flooring.9. Summary: Resident #1 was combative with staff who attempted shower her. Resident #1 suddenly grabbed the bar in the shower area and pulled herself out of the shower chair and slid on the wet floor.10. Short term intervention: Needed an assist of 2 staff during cares and showers.11. Staff completing the document: Staff I, Registered Nurse (RN) on 10/29/25 at 2:26 pm.admission Hospital record dated 10/29/25 for Resident #1 revealed:1. Ground level fall in the shower at her dementia unit.2. Daughter at bedside reported mother fell in shower, used shower chair after being incontinent of stool (BM). Resident #1 slipped on the stool present on the shower floor. Resident #1 had diarrhea since 10/17/25 due to multiple laxatives, diagnosed with UTI on 10/17/25 treated with antibiotic and denied pain on urination. The daughter confirmed Do Not Resuscitate (DNR) status.3. On arrival, the vital signs were BP 147/104, P 96. Lab results revealed an elevated blood glucose level of 316, elevated white blood count (WBC) of 13.1, abnormal sodium 134, and calcium 8.3 levels.4. Imaging revealed a severe femoral fracture of the left knee with significant impaction and medial displacement as well as significant osteopenia. 5. Pain was managed with oral acetaminophen and oxycodone. 6. Consulted the Orthopedics, admitted for closed left distal (farthest away from the center of the body) periprosthetic (around a prosthetic) knee fracture.7. The daughter was the designated POA. 8. Assessment & Plan: Left distal femur fracture, Leukocytosis (abnormal elevated WBC), Asymptomatic (without symptoms) Bacteriuria (bacteria in the urine), Vascular Dementia, severe, with psychotic disturbance and Type 2 Diabetic Mellitus.9. Consult Notes Orthopedics: Past history for a left total knee replacement in 2005. Resident #1 ambulated with a walker and had not complained of left knee pain prior to the fall. The patient's daughter (POA) was consented for her to undergo a left femur operative fixation.10. Care Coordination Progress Note dated 11/3/25 with expected discharge date of 11/6/25. The Social Worker met with Resident #1's daughter, POA, at the resident's bedside to discuss the discharge plan and the need for physical and occupational therapy at a Skilled nursing facility. The patient came from a skilled nursing facility but the daughter refused for her to return there. During an interview on 11/12/25 at 2:09 pm with Resident #1's daughter who was the POA, stated she had taken her mother to hospital on [DATE] for back aches, slouching and she was treated for a urinary tract infection (UTI) with antibiotics. Daughter stated Resident #1 did not have a bowel movement for multiple days and the physician ordered Lactulose and MiraLAX, which she was already taking daily and Senna two times a day. Daughter stated she did not want her mother treated with Lactulose and was unaware the staff were giving the MiraLAX two times a day. The daughter stated her mother had diarrhea for a week and the facility staff stated she would cover herself in the bowel movement (BM) so she was showered daily. The daughter stated her mom did not like showers and on 10/29/25 the facility called her to report that she had slipped on the BM in the shower and fell. The daughter requested an ambulance and she was on her way there. The daughter stated on arrival, her mother was on the bathroom floor surrounded by BM, her left leg bowed out and her mother was screaming in pain. The daughter stated the ambulance took 20 minutes to arrive and their staff placed (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	an Intravenous (IV) and gave her mother pain medication in the IV. The daughter stated her mother was on the shower floor for over an hour in pain. During an interview on 11/13/25 at 10:33 am, Staff E, Certified Nursing Assistant (CNA) stated she had notified nursing on multiple occasions that Resident #1 did not like showers and would require two CNA's to provide her showers due to aggressive behavior toward staff and attempts to get off the shower chair. Staff E stated Resident #1 was incontinent of bowels and would be found to have the BM on her hands and body multiple times that required a shower to remove it. During an interview on 11/13/25 at 9:22 pm, Staff K, CNA stated she had worked in the facility for a year. Staff K stated she worked the 6am to 2pm shift on 10/29/25. Staff K stated Resident #1 was not eating well and had requested to eat in her room. Staff K stated for the past 3-4 weeks Resident #1 began to deteriorate, slouched in her recliner and was more combative. Staff K stated she reported to the nurses for 2 weeks that something was wrong. Staff K stated she was aware that Resident #1 had a UTI but that day she was lethargic (weakness), slouching back in the recliner and patted abdomen saying ouch. Staff K stated at 2pm, she reported to Staff A, CNA that Resident #1 did not have a BM today. Staff K stated the brand-new CNA's only received 5-7 days of training and do not know the residents. Staff K stated she did not understand why they were not with a seasoned nurse and there were times when she had worked in the dementia unit by herself until someone came and she had left. Staff K stated Staff C, CNA had not worked in the dementia unit and Staff C, had assisted on 10/29/25 but did not toilet Resident #1. During an interview on 11/12/25 at 3:28 pm, Staff A, CNA stated she obtained the CNA certification in September 2025 and this was her first employment as a CNA. Staff A stated she was trained by another new CNA that had been employed by the facility for a month and felt the training was lacking skills to equip her to manage the residents with aggressive dementia behaviors. Staff A stated she worked the unit multiple times by herself during a shift or with a staff member who was not certified to assist her with providing care to the residents who needed two staff for assistance. Staff A stated on 10/29/25 at 2 pm, Resident #1 had BM all over her and the second CNA called in to say she would be late. Staff A stated she had requested assistance and a CNA had come in to the room to provide gowns and to transfer Resident #1 to the shower chair but she was left to complete the shower alone. Staff A stated she called on the radio for staff assistance again as Resident #1 became aggressive but there was no response and during the shower, Resident #1 fell. Staff A stated Resident #1 required two staff for 2 weeks almost daily for showers due to the diarrhea and having BM all over herself. Staff A stated on 11/11/25, the CNA was pulled from the dementia unit to assist in the main facility and was left to provide care alone for two hours then again for an hour at the end of shift. Staff A stated an activity person would be there until 5 pm but she cannot assist her with the residents except to monitor them. During an interview on 11/13/25 at 10:54 am, Staff C, CNA stated she had only worked in the dementia unit a few times, for four hours at most, to provide assistance. Staff C stated she had worked in the dementia unit on 10/29/25 but was pulled to assist the other 3 halls as a float CNA. Staff C stated she was aware someone had called in to report they would be late and she had answered a radio call to assist transfer Resident #1 to the shower chair. Staff C stated she then left the unit and went to the bathroom. Staff C stated she had never assisted Resident #1 with a shower and was unaware Staff A, CNA was alone on the dementia unit. Staff C stated she was aware there should be two staff in the dementia unit and an activity staff worked on the unit until 5 pm but was not certified to assist with resident care. During an interview on 11/13/25 at 11:36 am, Staff H, Life Enrichment (Activity) Assistant stated on 10/29/25, the day shift staff had left, Staff A, CNA was by herself and was unsure other staff was aware she was alone, Staff H stated she had not informed Staff L, CNA Scheduler that Staff A was by herself. Staff H stated there were usually two staff and could not count herself as the 2nd as she was not certified. Staff H stated she turned her radio down to low as it would aggravate the residents in the living area, failed to hear Staff A's calls for assistance, but was aware that Resident #1 would swing, kick, and bite staff. Staff H stated Resident #1 was strong and did not like showers but was covered with BM multiple of times. Staff H (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	stated that Staff K, CNA was still in the unit when Staff A, CNA came out of Resident #1 room, stated she was covered in BM and asked for gowns. Staff H stated she called on radio for gowns and Staff K stated she wished she could help then left the unit. Staff H stated she did not report to Staff L, CNA Scheduler that Staff A needed assistance. Staff H stated she did not see Staff C, CNA come into the unit as the residents in the living area thought people were in the TV and she attempted to calm them down with exercise and a snack. Staff H stated she had become aware something was wrong when the nurse arrived, then the daughter arrived and the ambulance came after 3:30 pm. Staff H stated Staff B, CNA had arrived to work and both Staff A and Staff B began to prepare for supper. Staff H stated when she would leave at 5 pm, the residents start to sundown (late afternoon and evening, patients experience increased confusion, agitation, anxiety and irritability) and she felt sorry for the new girls as it was so hard. During an interview on 11/13/25 at 12:22 pm, Staff L CNA Scheduler stated in the dementia unit, she scheduled two CNA's on the day and evening shifts and the activity staff from 9am to 5 pm. Staff L stated if staff were late then the charge nurse would take care of it in the evenings. Staff L stated she was not aware that Staff B, CNA was late on 10/29/25 and was unaware that Resident #1 had fallen. During an interview on 11/13/25 at 1:12 pm, Staff I, Registered Nurse stated she was the charge nurse on 10/29/25 and was unaware staff had called in late for their shift in the dementia unit or that Staff A, CNA was working by herself. Staff I stated she was unaware that Resident #1 was combative during showers. Staff I stated she was aware that when Resident #1 was resistive, it would take two staff to shower her, but she was not always resistive. Staff I stated she was unaware Staff A was working without a 2nd CNA when she had radio called for assistance. During an interview on 11/17/25 at 8:45 am, Staff F, RN stated she had worked on 10/29/25, assigned to pass medications in two halls. Staff F stated she had heard a call on the radio that room [ROOM NUMBER] (Resident #1) had a large loose BM and they needed gowns. Staff F stated she answered the call to inform them that the gowns were located in the basement storage area. The CNA then called out for assistance. Staff F stated she was unaware that Staff B, CNA was to arrive late and Staff A, CNA was by herself in the dementia unit. During an interview on 11/17/25 at 12:18 pm, Staff P, CNA stated Resident #1 was often confused and had declined, not willing to move, more combative, and incontinent of bowels. Staff P stated it took two CNA's to shower Resident #1, to clean her from the BM, and she would immediately get out of the shower chair as she hated showers. Staff P stated she reported to the nurses that it took 2 staff to provide care for Resident #1. Staff P stated the management provided a float CNA after 5pm in the dementia unit but that changed after the census dropped. Staff P stated the census was low in the main facility, not the dementia unit where the rooms were full. During an interview on 11/17/25 at 9:52 am, Staff Q, RN stated she had spoken with the Administrator about her concerns with guidance and training as the entire 2nd shift was new and they had an increase in falls. Staff Q stated the census was down in the main area but the census was not down on the dementia unit. Interview on 11/13/25 at 12:49 pm The Administrator stated there must always be two certified staff on the dementia unit during the day and evening shifts. The Administrator was unaware that Staff A, CNA was alone in the unit on 10/29/25 at the beginning of the shift and at times during shifts on breaks.2. The MDS dated [DATE] for Resident #2 revealed the diagnoses of type 2 diabetes mellitus, Alzheimer's disease, bone density disorder, macular degeneration, and had a history of falls. Resident #2 required the use of walker, one staff to assist and a wheelchair and able to self-propel. Resident #2 required maximum assistance with toileting, dressing upper body and showers, and was dependent on staff for dressing her lower body. Resident #2 was independent with moving in a bed and was continent of bladder but had frequent incontinent bowel movements. During the assessment, Resident #2 had no complaints of pain, experienced two falls without injury and one fall with a minor injury, no major injuries noted. The Care Plan revised on 10/12/25 for Resident #2 directed staff to provide the assistance of one for transfers and ambulate with gait belt and wheelchair pulled behind her as she weakens and may need to sit quickly. The Care Plan directed staff to place her call light within reach, answer promptly and assist to bed when eye (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	glasses and hearing aid was removed. Observe for agitation, restlessness, confusion and falls. The Progress notes for Resident #2 revealed on 10/26/25 at 8:56 pm, Staff O, Licensed Practical Nurse (LPN) documented at 7:15 pm, she was called by staff to respond as Resident #2 was laying on the floor on the right side next to her wheelchair and her head was resting on the wheel. Resident #2 was alert, smiling and talkative, stated she was standing next to the bed and went down to the floor. Resident #2 was able to move upper extremities and lower left extremity without pain. Resident #2 complained of right hip pain and initially was unable to move her right lower extremity due to the pain, cried out with attempted movement. Resident then spontaneously bent her right knee and lifted her foot into the air, held unsupported without discomfort. When attempted to roll Resident #2 to the left side, she cried out, grabbed her right hip and said oh it hurts. Staff assisted Resident #2 into a sitting position, stated she hurt just this one and grabbed her left hip. Assisted with two staff with the mechanical lift and stated it was fun but she did not recommend falling down to get one. Vital signs were BP 140/65, P 65, T 99.3, Oxygen Saturation 96% on room air. Resident #2 was able to move all extremities after she was in bed with no complaints of pain and reported to daughter who stated she did not want her sent for an evaluation, rather to wait a few hours and see how she does. The on-call manager Staff R, RN was notified and placed in the Medical Director's folder for notification. Falls Follow Up Form dated 10/26/25 at 7:15 pm for Resident #2 revealed:1. Vital Signs: T 99.3, P 65, BP 140/65, R 19, Oxygen Saturation 96% on room air.2. No change of condition identified for intrinsic risk factor.3. No change in elimination.4. No change in sensory impairments.5. No change in gait or balance.6. No pain7. Resident #2 did not remember she could not walk and got out of wheelchair to go to bed. 8. Short Term intervention: Don't leave Resident #2 in a wheelchair unattended. 9. Signed by Staff O, LPN on 10/26/25 at 10 pm.During an interview on 11/18/25 at 8:39 am, Resident #2's daughter Power of Attorney (POA) stated she was visiting her mother on 10/26/25 and left about 6 pm after taking her mother in the wheelchair to her room. The daughter stated she gave the call light to her mother and had the TV on to occupy her as there were no staff around. The daughter stated the facility nurse called her at 7:45 pm to report her mother fell to the floor, had some pain but after they got her into the bed, she was fine now with no complaints of pain. The daughter stated she told the nurse if she was not having pain, then they could wait and monitor her. The daughter stated she received a call at 1:44 am from the nurse who stated when they turned her mother, she had some pain that they treated with Tylenol and then she was just laying there without pain. The daughter stated they could call for a portable x-ray in the morning and she agreed. The daughter stated they had returned from a vacation and she had not slept yet. The daughter stated she slept in but had not received a call so she called at 12:07 pm and was informed they had not called the physician for the x-ray yet and the staff had her mother up in a wheelchair. The daughter requested to have her mother put in bed and call for an x-ray but was told it was they were waiting to allow the mobile unit to have their lunch time. The daughter stated she told the nurse to call them and when she called back, her mother was next in line. The daughter stated she called her sisters and based on what the staff informed her, she was having no pain and up to the wheelchair, then she must be ok. The daughter stated she arrived to the center at 4:45 pm and the X-ray mobile unit had just left, and the nurse reported she was up for both meals, but was hooting and hollering all day and pushing on her hip and had trouble getting the x-rays done due to pain. The daughter stated she was a nurse and assessed her mother's hip and she moaned when touched and when the bed was elevated her mother grimaced. The daughter stated at 6:28 pm she went to the nurse station, was told the x-ray was not back yet, but the night nurse found the fax on the machine that read suspected fracture. The daughter stated she told the nurse to transfer her mother to the Orthopedic Hospital. The daughter stated the hospital nurse reported she was in so much pain that they administered Morphine. The daughter stated she could not send her mother back to the facility after surgery because of the poor assessment skills of the nurses. During an interview on 11/18/25 at 10:18 am Staff N, CNA stated she worked on 10/26/25 and provided care for Resident #2 who had a steady gait with the walker, then transferred to the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	wheelchair for supper. Staff N stated her daughter and husband just returned from vacation and visited with Resident #2 in the dining room. Staff N stated she had a busy evening and the last time she visualized them, they were together in Resident #2's room. Staff N stated she need assistance transferring a different resident and Staff M, CNA assisted then she asked Staff M to check on Resident #2. Staff N stated when she completed with those cares, she found Resident #2 on the floor at the foot of her bed with her head against her wheelchair. Staff N radio called for Staff O, LPN, who responded immediately. Staff N stated Resident #2's right leg hurt her, she was screaming and clearly was in pain but she was able to pick it off the floor. Staff N stated she waited with Resident #2 on the floor while Staff O called the daughter. Staff N stated Staff O returned with the mechanical lift and Resident #2 screamed in pain when they got her off the floor and during care, changed the brief. Staff N stated she gave report to Staff J, CNA reported that Resident #2 fell and had increased pain when she provided care. During an interview on 11/18/25 at 11:28 am, Staff O, LPN stated three residents fell on [DATE] and Resident #2 was one of them. Staff O stated the staff called her to the room and Resident #2 was on the floor, unable to move her right leg and said it hurt but lifted it off the floor before she left the room to call her daughter so she felt it was fine. Staff O notified the daughter that her mother could move her leg and had intermittently had pain so she felt that it was not broken. Staff O stated she returned to Resident #2's room, assisted with the mechanical lift and not complaining of pain. Staff O stated Staff N, CAN provided care to Resident #2 and did not report further complaints of pain. Staff O stated she did not offer Tylenol as Resident #2 was sleeping when she had assessed her again and was not alarmed. Staff O stated she reported to the night nurse that she had three falls to complete assessments checks. Staff O stated Resident #2 had dementia and the daughter took her to her room. Staff O stated the staff do not leave Resident #2 in the wheelchair in her room due to she had fallen before and she will follow family direction, and the daughter told her to monitor her. Staff O stated she did not call and report to a physician but placed a report on the physician clip board. During an interview on 11/18/25 at 3:09 pm, Staff M, CNA stated on 10/26/25 she worked the 2p-6pm shift. Staff M stated after the evening meal time, she assisted Staff N, CNA with a transfer of a resident and was asked to check on Resident #2 in her room. Staff M stated Staff D, Certified Medication Assistant, reported Resident #2 was in her room and she was not to be in her room by herself in the wheelchair because she would get up and fall. Staff M stated Resident #2 was in her wheelchair in her room and stated she assumed that Staff N or Staff D would take care of her and returned to her assigned unit. Staff M stated she heard on the radio that Resident #2 was on the floor shortly after and returned to find Resident #2 on the floor with Staff M and the nurse. Staff M stated she did not remember Resident #2 moving her legs but she yelled out in pain when she was turned on her side for the mechanical lift sling to be placed under her. During an interview on 11/19/25 at 2:46 pm, Staff D, CMA stated he was passing medication on 10/26/25 and was aware Resident #2's daughter pushed her into her room, left her in the wheelchair at 6:45pm with the TV was on, she was fine. Staff D stated he left the room to pass medication when Staff N, CNA called on the radio for assistance and when he responded, Resident #2 was on the floor. Staff D stated Staff N and the nurse were present and stated they did not need his assistance and no one requested for him to give prn pain medication to Resident #2.During an interview on 11/17/25 at 10:49 am, The Medical Director stated he was on vacation when Resident #2 fell, normally the facility will call the office or the emergency department team. The Medical Director stated if there was a significate change in a resident's condition, increased pain, no movement of an extremity or the family disagreed with the nurse recommendation, then the nurse could call the Emergency Room. The Medical Director stated he reviewed Resident #2's situation with the fall, and initially the family declined to send her, but if there was a change or the nurse suspected a fracture and it was overnight, then they are to call the Emergency Room. There is staff on call 24/7 there for anything serious. The Medical Director stated the facility could send a fax for the non-urgent situations. The IDT (Interdisciplinary Team) meeting was held on 10/28/2025 to review the event on 10/26/25. Root cause analysis determined that the resident had (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	self-transferred from her wheelchair to bed and lost balance. The intervention established was to avoid leaving the resident in her wheelchair unattended in her room. The effectiveness of this intervention was to be monitored, and the care plan would be updated accordingly. Resident #2 was transferred to hospital for further evaluation and the investigation is ongoing. The Facility Assessment stated staffing levels were assessed to determine if capable of admitting additional patients, and may hold admissions based on staff levels or if staff are not trained in the areas of care that a new admission may require. Acuity management was based on the census report, related to activities of daily living needs and historical trends. The number of staff will be prioritized based on the residents with higher needs. Staff was instructed not to perform a task that they do not feel competent to perform. The assessment was reviewed with the Quality Assurance and Performance Improvements and Quality Assurance Committee on 4/16/25.The Policy titled Fall Prevention and Management Program Policy dated 2021 revealed the Clinical Coordinator was responsible for the supervision of the personnel in delivering safe and personalized care, to evaluate the effectiveness of interventions and to collaborate with the interdisciplinary team in the prevention of falls. The prevention interventions/strategies included the care plans will indicate the resident specific interventions to prevent falls. The nurse will notify 911, the primary physician and the nurse practitioner based on the initial evaluation.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, family and staff interviews, and policy review, the facility failed to provide appropriate pain management for 1 out of 3 residents reviewed (Resident #2). The MDS dated [DATE] for Resident #2 revealed the diagnoses of type 2 diabetes mellitus, Alzheimer's disease, bone density disorder, macular degeneration, and had a history of falls. Resident #2 required the use of walker, one staff to assist and a wheelchair and able to self-propel. Resident #2 required maximum assistance with toileting, dressing upper body and showers, and was dependent on staff for dressing her lower body. Resident #2 was independent with moving in a bed and was continent of bladder but had frequent incontinent bowel movements. During the assessment, Resident #2 had no complaints of pain, experienced two falls without injury and one fall with a minor injury, no major injuries noted. The MDS documented that the resident scored a 3 out 15 for the Brief Interview for Mental Status (BIMS), which indicated severely impaired cognitive status.The Care Plan revised on 10/12/25 for Resident #2 directed staff to provide the assistance of one for transfers and ambulate with gait belt and wheelchair pulled behind her as she weakens and may need to sit quickly. The Care Plan directed staff to place her call light within reach, answer promptly and assist to bed when eye glasses and hearing aid was removed. Observe for agitation, restlessness, confusion and falls. The Progress notes for Resident #2 revealed on 10/26/25 at 8:56 pm, Staff O, Licensed Practical Nurse (LPN) documented at 7:15 pm, she was called by staff to respond as Resident #2 was laying on the floor on the right side next to her wheelchair and her head was resting on the wheel. Resident #2 was alert, smiling and talkative, stated she was standing next to the bed and went down to the floor. Resident #2 was able to move upper extremities and lower left extremity without pain. Resident #2 complained of right hip pain and initially was unable to move her right lower extremity due to the pain, cried out with attempted movement. Resident then spontaneously bent her right knee and lifted her foot into the air, held unsupported without discomfort. When attempted to roll Resident #2 to the left side, she cried out, grabbed her right hip and said oh it hurts. Staff assisted Resident #2 into a sitting position, stated she hurt just this one and grabbed her left hip. Assisted with two staff with the mechanical lift and stated it was fun but she did not recommend falling down to get one. Vital signs were BP 140/65, P 65, T 99.3, Oxygen Saturation 96% on room air. Resident #2 was able to move all extremities after she was in bed with no complaints of pain and reported to daughter who stated she did not want her sent for an evaluation, rather to wait a few hours and see how she does. The on-call manager Staff R, RN was notified and placed in the Medical Director's folder for notification.MAR October 2025 for Resident #2 revealed Acetaminophen (Tylenol) 325 milligrams (mg), administer 2 tablets every 4 hours as needed for pain (not to exceed 3000mg/24hrs). Administered on 10/27/25 at 1:03 am for pain described as 4/10 and at 1:08 PM for pain described as 5/10. During an interview on 11/18/25 at 8:39 am, Resident #2's daughter Power of Attorney (POA) stated she was visiting her mother on 10/26/25 and left about 6 pm after taking her mother in the wheelchair to her room. The daughter stated she gave the call light to her mother and had the TV on to occupy her as there were no staff around. The daughter stated the facility nurse called her at 7:45 pm to report her mother fell to the floor, had some pain but after they got her into the bed, she was fine now with no complaints of pain. The daughter stated she told the nurse if she was not having pain, then they could wait and monitor her. The daughter stated she received a call at 1:44 am from the nurse who stated when they turned her mother, she had some pain that they treated with Tylenol and then she was just laying there without pain. The daughter stated she arrived to the center at 4:45 pm and the X-ray mobile unit had just left, and the nurse reported she was up for both meals, but was hooting and hollering all day and pushing on her hip and had trouble getting the x-rays done due to pain. The daughter stated she was a nurse and assessed her mother's hip and she moaned when touched and when the bed was elevated her mother grimaced. The daughter stated at 6:28 pm she went to the nurse station, was told the x-ray (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was not back yet, but the night nurse found the fax on the machine that read suspected fracture. The daughter stated the hospital nurse reported she was in so much pain that they administered Morphine. The daughter stated she could not send her mother back to the facility after surgery because of the poor assessment skills of the nurses.During an interview on 11/18/25 at 10:18 am Staff N, CNA stated she worked on 10/26/25 and provided care for Resident #2 who had a steady gait with the walker, then transferred to the wheelchair for supper. Staff N stated she found Resident #2 on the floor at the foot of her bed with her head against her wheelchair. Staff N radio called for Staff O, LPN, who responded immediately. Staff N stated Resident #2's right leg hurt her, she was screaming and clearly was in pain but she was able to pick it off the floor. 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Staff O stated Staff N, CAN provided care to Resident #2 and did not report further complaints of pain. Staff O stated she did not offer Tylenol as Resident #2 was sleeping when she had assessed her again and was not alarmed.During an interview on 10/26/25 at 3:09 pm, Staff M, CNA stated on 10/26/25 she worked the 2p-6pm shift. Staff M stated she heard on the radio that Resident #2 was on the floor shortly after and returned to find Resident #2 on the floor with Staff M and the nurse. Staff M stated she did not remember Resident #2 moving her legs but she yelled out in pain when she was turned on her side for the mechanical lift sling to be placed under her. Staff D stated Staff N and the nurse were present and stated they did not need his assistance and no one requested for him to give prn pain medication to Resident #2.During an interview on 11/13/25 at 1:12 pm, Staff I, Registered Nurse stated she was the charge nurse on 10/26/25 at 10pm and during report, Staff O, LPN informed her that Resident #2 had fallen, complained of pain but was able to move. Staff I stated she was told to monitor for pain. Staff I stated the CNA tried to change Resident #2 during the night as she was wet with urine, and had to stop the care due to complaint of pain. Staff I stated she assessed Resident #2 who said she could not move, hurt too much and Tylenol was administered. Staff I stated 30 minutes passed and Resident #2 continued to complain of pain with care. Staff I attempted to raise Resident #2's leg and she said enough of that it hurts. Staff I stated she called the daughter immediately as she was concerned about a fracture but the daughter did not want to send her mother to the hospital, just continue to monitor because the other nurse said she could move her legs. Staff I stated she told the oncoming nurse Staff G, LPN to call the doctor to obtain an order for a portable x-ray. Staff I stated it only hurt Resident #2 when she was moved.The Progress Note on 10/27/25 at 1:39 am, Staff O, RN documented she assisted the staff to change Resident #2's brief and attempted to roll her on her side, she yelled out of pain and reports pain on her right hip down to right knee without shortening or external rotation of limbs noted. Resident #2 was able to move her left leg without issues. Resident #2 was able to move her right lower leg a bit to the right but was not able to bend or raise it because of pain. Resident #2 was able to slightly bend her right leg with support. Called the POA to update resident's condition and requested to continue to monitor her mom, give pain pills as needed and do a portable Xray in the morning. On 10/27/25 at 3:44 am the Tylenol was effective. During an interview on 11/17/25 at 2:36 pm, Staff G, LPN stated Resident #2 was usually up for meals and ambulated, but in report on 10/27/25 at 6 am, she was informed of her fall and pain with range of motion focused on her right leg to hip. Staff G stated she peeked in to Resident #2's room at 7 am to find her asleep. Staff G stated the assessment at 9:45 am revealed pain in (continued on next page)

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	165566	A. Building B. Wing	11/19/2025

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

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2's right hip, grabbed her upper thigh, but was unable to describe the pain. Staff G stated the CNA's then transferred Resident #2 to a wheelchair, who said ouch a couple of times when stood and reported the pain location in the right hip. Staff G stated she did not treat the pain at that time as it was brief. Staff G stated she spoke with the daughter around lunch time, reported her mom had pain and the daughter was concerned with the time it was going to take for the x-ray, so she was making arrangements to come to see her mother. Staff G stated when the portable x-ray staff attempted to roll Resident #2, she verbalized pain, Oh my god that hurts and grabbed at her right hip. Staff G stated the daughter arrived when the x-ray staff left at 4 pm. Staff G stated at 6pm, she gave report to the oncoming nurse when the daughter approached the desk requesting the x-ray results. Staff G stated the result revealed a possible fracture and she had a concern with pain management during care. Staff G stated she did not remember administering pain medication as Resident #2 only complained of pain during care and she was not crying. The Progress Note on 10/27/25 at 7:30 am, Staff G, LPN documented she assisted staff with cares of Resident #2 who stated the right hip hurts pretty bad but not too bad at the moment. When attempted to turn Resident #2 in bed, she cried out to stop, it's really hurting. Resident #2 then stated that she wanted to get up for breakfast, two staff stood and pivoted to her to a wheelchair. Resident #2 considered the pain of the transfer a 6/10, once she sat in the wheelchair, no further complaint of pain. At 1:08 pm Tylenol was administered for pain and was effective. At 6:35 pm the x-ray results were reviewed with the POA at bedside. At 8:10 pm the ambulance arrived with departure to the hospital at 8:20 pm. During an interview on 11/17/25 at 10:49 am, The Medical Director stated he was on vacation when Resident #2 fell, normally the facility will call the office or the emergency department team. The Medical Director stated if there was a significate change in a resident's condition, increased pain, no movement of an extremity or the family disagreed with the nurse recommendation, then the nurse could call the Emergency Room. The Medical Director stated he reviewed Resident #2's situation with the fall, and initially the family declined to send her, but if there was a change or the nurse suspected a fracture and it was overnight, then they are to call the Emergency Room. There is staff on call 24/7 there for anything serious. The Medical Director stated the facility could send a fax for the non-urgent situations. Pain Assessment and Management Policy dated 2025 revealed the purpose was to properly identify, treat and manage pain and discomfort by the observations and statements of staff and resident feedback. The procedure included the evaluation of resident reports or signs of increased pain and factors such as activities or care that exacerbate pain.

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews and facility assessment review, the facility failed to ensure there was a sufficient number of direct care staff to provide care for residents with dementia, mental and psychosocial disorder. The facility also failed to provide supervision and skills training for staff in how to approach a resident who may be agitated, combative, verbally or physically aggressive, or anxious, and how and when to obtain assistance in managing a resident with behavior symptoms. The facility reported a census of 50 residents. The findings include:The Minimum Data Set (MDS) dated [DATE] for Resident #1 revealed the diagnoses of dementia, anxiety, depression, visual hallucinations and required maximal assistance for toileting, shower or bathing and personal hygiene with moderate assistance for dressing. Resident #1 rejected care for 3 of the 5 days reviewed and had physical behavior symptoms directed toward others. Resident #1 was incontinent of bowels and bladder. The brief interview for mental status (BIMS) score of 3 suggested severe cognitive impairment. Point of Care document for Resident #1 was aggressive during care behavior, intervention, & effectiveness of the intervention revealed:1. On 10/21/25 Aggressive during care on the day shift, redirected and the intervention was not effective.2. On 10/24/25 Aggressive during care on the evening shift, redirected and the intervention was not effective.3. On 10/25/25 Aggressive during care on the evening shift, conversation provided and the intervention was not effective. 4. On 10/26/25 Aggressive during care on the day shift, reassured and the intervention was not effective.5. On 10/28/25 Aggressive during care on the evening shift, reassured and the intervention was not effective.6. On 10/29/25 Aggressive during care overnight and evening shift, reassured and both of the interventions were not effective. During an interview on 11/13/25 at 10:33 am, Staff E, Certified Nursing Assistant (CNA) stated she had notified nursing on multiple occasions that Resident #1 did not like showers and would require two CNA's to provide her showers due to aggressive behavior toward staff and attempts to get off the shower chair. Staff E stated Resident #1 was incontinent of bowels and would be found to have the bowel movement (BM) on her hands and body multiple times that required a shower to remove it. During an interview on 11/12/25 at 3:28 pm, Staff A, CNA stated she obtained the CNA certification in September 2025 and this was her first employment as a CNA. Staff A stated she was trained by another new CNA that had been employed by the facility for a month and felt the training was lacking skills to equip her to manage the residents with aggressive dementia behaviors. Staff A stated she worked the unit multiple times by herself during a shift or with a staff member who was not certified to assist her with providing care to the residents who needed two staff for assistance. Staff A stated on 10/29/25 at 2 pm, Resident #1 had BM all over her and the second CNA called in to say she would be late. Staff A stated she had requested assistance and a CNA had come in to the room to provide gowns and to transfer Resident #1 to the shower chair but she was left to complete the shower alone. Staff A stated she called on the radio for staff assistance again as Resident #1 became aggressive but there was no response and during the shower, Resident #1 fell. Staff A stated Resident #1 required two staff for 2 weeks almost daily for showers due to the diarrhea and having BM all over herself. Staff A stated on 11/11/25, the CNA was pulled from the dementia unit to assist in the main facility and was left to provide care alone for two hours then again for an hour at the end of shift. Staff A stated an activity person would be there until 5 pm but she cannot assist her with the residents except to monitor them. During an interview on 11/12/25 at 4:02 pm, Staff B, CNA stated she had obtained the certification in August of 2025 and was trained to work in the main facility by Staff C, CNA. Staff B stated the typical people that received showers in the dementia unit required two CNA's to assist due to their dementia and behaviors. Staff B stated she had called the facility on 10/29/25 to notify them she would be late to work on 2nd shift and when she had arrived, Resident #1 was on the floor in the shower, assisted by Staff A, CNA and Staff I, (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse. During an interview on 11/13/25 at 10:54 am, Staff C, CNA stated she had only worked in the dementia unit a few times for four hours or to provide assistance. Staff C stated she had worked in the dementia unit on 10/29/25 but was pulled to assist the other 3 halls as a float CNA. Staff C stated she was aware someone had called in to report they would be late and answered a radio call to assist to transfer Resident #1 to the shower chair. Staff C stated she had never assisted Resident #1 with a shower and was unaware Staff A, CNA was alone on the dementia unit. Staff C stated she was aware there should be two staff in the dementia unit and an activity staff worked on the unit until 5 pm but was not certified to assist with resident care. During an interview on 11/13/25 at 11:36 am, Staff H, Life Enrichment (Activity) Assistant stated she had participated in a D.O.V.E. (Development through Observation, Validation and Enrichment) program that the facility used to provide in the past and it taught how to communicate and manage behaviors for people with dementia. Staff H stated now the new CNA's must complete a training online before they can work the behavior unit. Staff H stated the younger staff have not had experience with dementia residents and do not know how to communicate with them. Staff H stated the dementia unit is full and have a lot of behaviors and described working on the unit as hard right now. Staff H stated on 10/29/25, the day shift staff had left, Staff A, CNA was by herself and was unsure other staff was aware she was alone, Staff H stated she had not informed Staff L, CNA Scheduler that Staff A was by herself. Staff H stated there were usually two staff and could not count herself as the 2nd as she was not certified. Staff H stated she provided activities throughout the day in the living area, exercise at 3pm then a social with hydration and a snack before she left at 5 pm. Staff H stated she turns her radio down to low as it would aggravate the residents in the living area, failed to hear Staff A's calls for assistance, but was aware that Resident #1 would swing, kick, and bite staff. Staff H stated Resident #1 was strong and did not like showers but was covered with BM multiple of times. Staff H stated the afternoons was when the residents were always mean. During an interview on 11/13/25 at 12:22 pm, Staff L CNA Scheduler stated in the dementia unit, she scheduled two CNA's on the day and evening shifts and the activity staff from 9am to 5 pm. Staff L stated if were late then the charge nurse would take care of it in the evenings. Staff L stated she would rotate the staff out of the dementia unit to prevent burn-out. Staff L stated she was not aware that Staff B, CNA was late on 10/29/25 and was unaware that Resident #1 had fallen. Staff L stated the new staff would be onboarded with policies then trained but the trainer had been on maternity leave and the entire 2nd shift was hired at the same time so she was unsure of who had trained Staff A, CNA. During an interview on 11/13/25 at 1:12 pm, Staff I, Registered Nurse stated she was the charge nurse on 10/29/25 and was unaware staff had called in late for their shift in the dementia unit or that Staff A, CNA was working by herself. Staff I stated she was unaware that Resident #1 was combative during showers. Staff I stated she was aware that when Resident #1 was resistive, it would take two staff to shower her, but she was not always resistive. Staff I stated that staff would receive a two-week orientation and felt that Staff B, CNA was off orientation and appropriate to be the senior trainer for Staff A, CNA. Staff I stated she was unaware Staff A was working without a 2nd CNA when she had radio called for assistance. Staff I stated the staff are to call to inform the nurse if they need to leave early so she can send staff to assist the dementia unit. During an interview on 11/13/25 at 8:45 pm, Staff F, RN stated she noticed the facility had several new CNA's and they were trained in the main facility on hire then management assigned them to work on halls by themselves and that was concerning. Staff F stated she thought they should put more experienced staff on those halls. Staff F stated she was aware that Staff B, CNA was only hired for a month, a new CNA with no experience, who trained Staff A, CNA in the dementia unit, who was also a new CNA without experience. During an interview on 11/17/25 at 9:52 an, Staff Q, RN stated she had spoken with the Administrator about her concerns with guidance and training as the entire 2nd shift was new and they had an increase in falls. Staff Q stated the census was down in the main area but the census was not down on the dementia unit. Staff Q stated the charge nurse was required to sign off on the training the staff receive, provide care for 50 residents (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and may not get it everything but there was no time for follow-up. A review of staff training documents revealed Staff A, CNA was 80% completed with the resident rights and 80 to 90% completed with multiple dementia trainings. Staff B, CNA was 80% completed with multiple dementia trainings. Interview on 11/13/25 at 12:49 pm, The Administrator stated there must always be 2 certified staff in the dementia unit during the day and evening shifts and 1 CNA on the night shift. The Administrator stated she was unaware that Staff A, CNA was the only CNA in the dementia unit on 10/29/25 at the time of Resident #1's fall, at the beginning of the shifts when staff came in late and at the time staff would take a break on multiple occasions. The Administrator stated dementia training for staff was to be completed before the staff could work in the dementia unit. The Administrator stated the Clinical Coordinator's review resident documentation to monitor if interventions were effective and she was unaware that Resident #1's behavior interventions were not effective during care. The Facility Assessment stated staffing levels were assessed to determine if capable of admitting additional patients, and may hold admissions based on staff levels or if staff are not trained in the areas of care that a new admission may require. Acuity management was based on the census report, related to activities of daily living needs and historical trends. The number of staff will be prioritized based on the residents with higher needs. Staff was instructed not to perform a task that they do not feel competent to perform. The assessment was reviewed with the Quality Assurance and Performance Improvements and Quality Assurance Committee on 4/16/25.In an email on 11/17/25 at 7:45 am, The Administrator stated, While we do not have a standalone written staffing policy specifically for this unit, our approach is guided by resident-centered care principles and regulatory requirements. To ensure appropriate coverage and quality of care, we continuously evaluate staffing levels and make adjustments as needed. We are committed to meeting or exceeding all state and federal staffing requirements.