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	09/11/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, clinical record review, review of facility policy, personnel file review, resident and staff interview, the facility to ensure staff provided care with dignity and respect for 4 of 33 residents reviewed (Residents #1, #18, #31 and #49). The facility reported a census of 51 residents.Findings include: 1.The Minimum Data Set (MDS) assessment for Resident #1 dated 8/19/25 revealed the resident scored 9 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated moderately impaired cognition. The MDS revealed the resident had a diagnosis of Alzheimer's disease, used a wheelchair and was dependent on staff for toileting, transfers, and repositioning in bed. On 9/8/25 at 10:23 AM, interview conducted with the resident in Resident #1's room. The door to the room was shut to maintain the resident's privacy. At 10:29 AM during the interview Staff A, Certified Nurses Aide (CNA), opened the resident's room door and entered without knocking or announcing herself. Staff A dropped off the resident's breakfast, provided set up assistance, and left the room. When the resident queried if staff usually knocked before they entered the room, the resident stated, No, they (staff) just walk in. On 9/08/25 at 12:48 PM, observation revealed Staff A, CNA, entered Resident #1's room with her lunch without announcing herself or knocking.On 9/10/25 at 8:33 AM, Staff D, Registered Nurse (RN), entered Resident #1's room to perform wound care on the resident's sacral/coccyx wound. Staff E, Clinical Coordinator, entered the resident's room as well and reported being present to observe. The resident was lying in bed, and wound care supplies were observed in the over bed table. Staff D, raised the bed, removed the resident's call light, and pulled back the blanket covering the resident to the mid abdominal area. Staff E moved to the right side of the resident's bed (side nearest the outside wall) and faced the doorway. Staff E helped to position the resident on her right side with the blanket still covering the lower half of the resident. Staff D began opening wound care supplies including gauze pads, barrier film packages, and the package for the wound dressing. At 8:39 AM, Staff A, CNA, knocked as she was opening the door. Staff A immediately entered the room without announcing herself, or waiting for a reply to her knock. Staff A stood near the door for a few seconds, did not say anything, left the room, and shut the door behind herself. Still at 8:39 AM, Staff D gloved, and pulled the blanket down that was covering the resident's bare buttocks. Staff D began cleaning the coccyx wound area with gauze soaked in Normal Saline. At 8:41 AM, Staff A opened the resident's room door and entered without knocking or announcing herself. Staff A pushed a mechanical standing lift through the door, and exposed the resident's bare buttocks to the hallway while they pushed the lift into the room. Staff A then shut the room door. Staff E was facing the doorway when Staff A entered. Staff D and Staff E did not make any comment to Staff regarding entering the Resident's room. On 9/10/2025 at 11:53 AM, Staff C, Oral Medication Technician (OMT)/CNA reported staff received yearly education on respecting resident's rights. The education included instructions to knock before entering a room, announce who they were and tell the resident what they were going to do before starting whatever task they were doing. Staff C denied observing any staff not knocking before entering a residents' rooms. If staff were performing personal cares with a resident, and another staff knocked on the door to enter the resident's room, they would tell they staff they were giving cares. Staff were supposed to (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wait to enter until the resident was covered. On 9/10/2025 at 12:51 PM, Staff E reported that she observed Staff A enter Resident #1's room, knock, not announce herself, enter the room immediately after knocking, and not allow the staff in room time to respond. Staff E reported she then observed Staff A stand with the door open, then leave, come back to the resident's room and enter with the mechanical lift without knocking or announcing herself. Staff E reported she should have spoken up at that time, and did not know why she didn't. Staff E explained all staff received computer education in relation to resident dignity. Staff were taught to knock and announce who they were to the resident. If a door was shut and staff were doing cares, they were taught to yell out that they were doing cares if someone knocked on the door to enter. Staff E explained she reported Staff A to Staff A's supervisor. 2. The MDS assessment for Resident #49 dated 8/12/25 revealed the resident was severely cognitively impaired, and had diagnoses of dementia and anxiety disorder. The resident utilized a walker and wheelchair.On 9/08/25 at 12:12 PM, observation revealed Staff A provided hands on assistance while Resident #49 ambulated into the dining room with a walker and a gait belt around her waist. Staff A directed and assisted Resident #49 to sit in a straight-back chair located approximately 1.5 to 2 feet away from the dining room table. While standing behind the resident and without voicing her intent, Staff A lifted the left side of the chair the resident was sitting in off the dining room floor and pulled the chair forward, causing the resident's top half of her body tip in the chair to the right. The resident displayed a startled movement and grabbed for the chair and table to balance herself. Staff A then dropped the chair and repeated the movement on the right side of the chair.3. The MDS assessment for Resident #18 dated 8/26/25 revealed the resident scored13 out of 15 on BIMS exam, which indicated intact cognition. On 9/10/25 at 11:45 AM, observation revealed Staff B, CNA, knocked, announced herself, entered Resident #18's room with a mechanical lift and shut the door. At 11:46 AM, Staff C, CNA, opened the door and entered Resident #18's room without knocking or announcing herself, and then shut the room door.4. The MDS assessment for Resident #31 dated 7/8/25 revealed the resident had a BIMS score of 13 out of 15. On 9/10/25 at 11:51 AM, observation revealed Staff A walked into Resident #31's room without knocking, and walked up to the resident.On 9/10/2025 at 1:03 PM, the Administrator reported they had just provided education to Staff A, CNA, on Monday regarding concerns observed by staff on 9/8/25, and would provide education again if needed. On 9/10/2025 at 3:26 PM, review of the personnel file for Staff A revealed the following: Staff A had a hire date of 3/2/2018, and Staff A received education on 9/10/25 for the above mentioned dignity concerns. The Notice of Coaching/Education included the following: At this point in time further discussion may be warranted for corrective action regarding the following areas where improvements need to be observed: infection control, resident privacy, resident rights, & resident dignity. Review of the facility policy, titled Privacy and Dignity Policy dated April 2025 revealed staff would provide privacy and dignity while performing any personal care for residents and residents. Staff were to cover upper and lower body parts as needed to prevent unnecessary exposure of breasts and/or perineal areas. Staff would respect residents private space by knocking on doors and requesting permission before entering.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility discharge list, facility policy review, and staff interview, the facility failed to notify the Office of the State Long-Term Care Ombudsman of the discharge of residents for 3 of 3 residents sampled (Resident #56, #58 and #59) with a discharge to home. The facility reported a census of 51 residents. Findings include:Review of list of resident discharged from the facility, dated 6/1/25 to present (9/8/25), revealed a total of 3 residents discharged from the facility to home, Residents #56, #58 and #59.1.The Minimum Data Set (MDS) assessment for Resident #56 dated 7/10/25 indicated the resident was admitted to the facility on [DATE] and discharged on 7/10/25. A Discharge Summary/Recapitulation of Stay dated 7/7/25, included documentation the resident planned to discharge home with home health services including skilled nursing, occupational and physical therapy services. On 9/10/25, review of the clinical record revealed a lack of documentation regarding notification of the State Long-Term Care Ombudsman of the discharge for Resident #56.2. The MDS assessment for Resident #58 dated 6/28/25 indicated the resident was admitted to the facility on [DATE] and discharged on 6/28/25. The Progress Note dated 6/28/25 revealed the resident discharged to home. On 9/10/25, review of the clinical record revealed a lack of documentation regarding notification of the State Long-Term Care Ombudsman of the discharge for Resident #58.3. The MDS assessment for Resident #59 dated 7/14/25 indicated the resident was admitted to the facility on [DATE] and discharged on 7/14/25. A Progress Note titled Recapitulation of Stay and Discharge summary dated [DATE] revealed the resident discharged to home. On 9/10/25, review of the clinical record revealed a lack of documentation regarding notification of the State Long-Term Care (LTC) Ombudsman of the discharge for Resident #59.On 9/10/2025 at 1:18 PM, the Administrator reported she thought they were not notifying the LTC Ombudsman for discharges to home, only for hospital transfers. The Administrator reported she talked with Corporate staff, and they were not aware of need to contact LTC Ombudsman for residents that discharged to home. On 9/10/2025 at 1:31 PM Administrator confirmed facility staff had not notified the LTC Ombudsman regarding Resident #56's discharge from the facility to home. On 9/10/2025 at 1:45 PM, the Administrator confirmed facility staff had not notified the LTC Ombudsman regarding Resident #58's and Resident #59's discharge from the facility to home. Administrator reported a plan to start notifying the LTC Ombudsman of all discharges from the facility.Review of the facility's policy titled Discharge and Transfer Policy dated 3/2025 revealed, facility staff must send a copy of the resident's discharge notice to the Office of the State Long Term Care Ombudsman at the same time the facility issued the notice to the resident. The facility must issue the notice of discharge at 30 days in advance of the discharge unless the resident heath improves sufficiently to a more immediate discharge.

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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. Based on clinical record review, observation, facility policy review, resident and staff interview, nursing staff failed to perform assessment and intervention of a resident (Resident #28) after a meal observation revealed staff served the resident food the resident had documented as an allergy. The facility reported a census of 51 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #28 dated 8/17/25 revealed the resident scored 15 out of 15 on a Brief Interview for Mental Status exam, which indicated intact cognition. The Care Plan for Resident #28 included an intervention dated 9/22/24 to for staff to provide and serve the resident's diet as ordered. The main page of the electronic clinical record for Resident #28 identified the resident had a food allergy to shellfish (shrimp, crab, lobster, oysters, clams, mussels and scallops).A History and Physical report dated 8/8/25 scanned into the clinical record revealed Resident #28's had an allergic reaction of hives (small red bumps on the skin) to shellfish. On 9/8/25 at 12:16 PM, observation revealed Staff F, Server (dietary), set up the food to be served for Resident #28 on kitchen counter. Staff B, Certified Nurses Aide (CNA), took Resident #28's lunch to the table and set the food in front of the resident. The lunch included breaded coconut shrimp.On 9/8/25 at 12:18 PM, Resident #28 was observed to eat her lunch independently, including the breaded shrimp. On 9/8/25 at 12:24 PM, Staff A, CNA, stopped as she was walking by Resident #28 and looked at the resident's plate. Staff A told the resident she could not have shrimp because the resident was allergic to the shrimp, and removed the entire food plate from the resident. Staff A proceeded to alert Staff F of the allergy concern. Staff A brought the resident a replacement lunch.On 9/8/25, review of the food service ticket for Resident #28's lunch on 9/8/25 revealed a food order for coconut shrimp. The food service ticket included the following information printed in red: Allergens: Shell Fish.On 9/08/25 at 1:06 PM, Staff C, Oral Medication Technician (OMT), who was working in the same hall that Resident #28 resided, reported there was one nurse for the all of the resident halls in the building and identified the nurse for 9/8/25 was Staff H, Registered Nurse (RN). On 09/08/25 at 1:10 PM, Staff confirmed she was the nurse for all the residents. Staff H denied anyone had alerted her that Resident #28 had been served and ate shrimp at lunch. On 9/8/25 at 2:17 PM, during an interview with Resident #28 and a family member, Resident #28 reported when she had eaten shellfish in the past, she got itchy; she denied having any difficulty with her throat or swallowing issues after eating shellfish in the past. The Resident reported she only ate one to two of the shrimp before staff removed it from her at lunch. Resident #28 reported nursing staff had not checked on her since she ate the shrimp at lunch. The resident denied any allergic reaction symptoms at the time of the interview. On 9/08/2025 at 2:48 PM, Staff G, Clinical Coordinator, reported she was unaware that staff had served Resident #28 shellfish for lunch. Staff G reported the expectation that the CNA would have notified dietary staff and the charge nurse immediately in order to assess the resident for an allergic reaction. The charge nurse would then notify the resident's physician of the exposure to the allergen and of any symptoms. On 9/10/25, review of the clinical record for Resident #28 revealed the following:A progress note titled General Note dated 9/8/25 at 1:30 PM, documented as late entry, revealed CNA reported the resident ate one to two shrimp during lunch and the resident had an allergy history to shellfish. The note included documentation of a vital sign assessment of the resident including a blood pressure of 137/76, pulse 60, respirations 18, and temperature 97.1, blood oxygen saturation level of 94 percent and complaints of itchiness in the resident's hands. The resident refused as needed Benadryl (antihistamine) and denied any shortness of breath or dyspnea (difficulty breathing). The nurse documented she notified the resident's primary care physician via fax.Review of the facility policy, titled Food Allergy Policy, dated 9/2025, revealed staff were document food allergies upon admission and review during care planning development.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on clinical record review, meal service observation, review of facility policy, resident and staff interview, the facility failed to ensure they did not serve a resident food that was known to cause an allergic response during 1 of 2 resident meal service observations (Resident #28). The facility reported a census of 51 residents. Findings include:The Minimum Data Set (MDS) assessment for Resident #28 dated 8/17/25 revealed the resident scored 15 out of 15 on a Brief Interview for Mental Status exam, which indicated intact cognition. The Care Plan for Resident #28 included an intervention dated 9/22/24 to for staff to provide and serve the resident's diet as ordered. The main page of the electronic clinical record for Resident #28 identified the resident had a food allergy to shellfish (shrimp, crab, lobster, oysters, clams, mussels and scallops).A History and Physical report dated 8/8/25 scanned into the clinical record revealed Resident #28 had an allergic reaction of hives (small red bumps on the skin) to shellfish. On 9/8/25 at 12:16 PM, observation revealed Staff F, Server (dietary), set up the food to be served for Resident #28 on kitchen counter. Staff B, Certified Nurses Aide (CNA), took Resident #28's lunch to the table and set the food in front of the resident. The lunch included breaded coconut shrimp.On 9/8/25 at 12:18 PM, Resident #28 ate her lunch independently, including the breaded shrimp. On 9/8/25 at 12:24 PM, Staff A, CNA, stopped as she was walking by Resident #28 and looked at the resident's plate. Staff A told the resident she could not have shrimp because the resident was allergic to the shrimp, and removed the entire food plate from the resident. Staff A proceeded to alert Staff F of the allergy concern. Staff A brought the resident a replacement lunch.On 9/8/25, review of the food service ticket for Resident #28's lunch on 9/8/25 revealed a food order for coconut shrimp. The food service ticket included the following information printed in red: Allergens: Shell Fish.On 9/8/25 at 2:17 PM, during an interview with Resident #28 and a family member, Resident #28 reported when she had ate shellfish in the past, she got itchy; she denied having any difficulty with her throat or swallowing issues after eating shellfish. The Resident reported she only ate one to two of the shrimp before staff removed it from her. The resident denied any allergic reactions symptoms at the time of the interview. Review of the facility policy, titled Food Allergy Policy, dated 9/2025, revealed staff were document food allergies upon admission and review during care planning development. Allergy information must be visible to nutrition and culinary staff on food tickets. Food servers and cooks were trained to confirm allergy precautions prior to meal service.