

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165432	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/21/2026
NAME OF PROVIDER OR SUPPLIER Lutheran Living Senior Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 2421 Lutheran Drive Muscatine, IA 52761	
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on clinical record review, staff interviews and facility policy review the facility failed to report an injury of unknown origin that resulted in serious bodily harm to the State Agency within the two-hour requirement for 1 of 1 resident (Resident #1) reviewed. The facility reported a census of 125 residents. Findings include: Review of the Facility Reported Incident submitted to the State Agency revealed: Date of Report: 6/29/26: Date of Event: May 7, 2026 Resident: [Name redacted, Resident #1] Nature of Report: Late self-report of an unwitnessed resident death with positional findings; reported upon supplemental QAPI (Quality Assurance and Performance Improvement) . During an interview on 7/20/26 at 12:08 PM, Staff C, former Administrator stated the facility did complete a full investigation and timeline after the incident. He explained after reviewing with the facility physician, the thought was Resident #1 passed away from natural causes and chose not to report the incident to the State Agency. Staff C stated in June the facility received a legal notice and the management company directed the incident be submitted as a self-report. He added the facility attorney advised a self-report also be submitted. During an interview on 7/20/26 at 12:12 PM, Staff B, former Director of Nursing (DON) stated she had discussed reporting the 5/7/26 incident to the State Agency, however Staff C, former Administrator stated he did not feel it was necessary. Staff B stated she deferred to Staff C as he did all of the reporting. Staff B added the facility assumed Resident #1 had a natural death and after they learned there was going to be an autopsy decided to wait until the results were available. During an interview on 7/21/26 at 12:30 PM, the Regional Director Quality and Clinical Services (RDQCS) stated she had a concern the May 7, 2026 incident of Resident #1's death had not been reported to the State Agency. Review of the facility policy titled Freedom from Abuse, Neglect, and Exploitation dated 11/2024 revealed, in part: It is the policy of this community to take immediate steps to prevent the occurrence of Abuse, Neglect and Misappropriation of resident property. It is also the policy of this community to take appropriate steps to ensure that all alleged violations of federal or state laws which involve mistreatment, neglect, abuse, injuries of unknown source, and misappropriation of resident property (alleged violations) are reported immediately to the administrator of the community. If the events that caused the allegation involve abuse or serious bodily injury, it must be reported to the State agency immediately but no later than 2-hours after forming the suspicion per State and Federal regulation. Definitions: Injury of unknown source: Any injury should be classified as an injury of unknown source when both of the following conditions are met: a. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; b. The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. Reporting: a. Any employee who suspects an alleged violation immediately notifies the (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on clinical record review, hospice contract review, and staff interview, the facility failed to ensure that a hospice service agreement was signed with 1 of 2 hospice providers currently serving 1 of 4 residents on hospice (Resident #1); and failed to ensure required language addressing immediate notification of hospice administration in the event of alleged abuse by hospice staff was included in 1 of 1 signed agreement for a provider currently serving 3 residents (Resident#2, #3 and #5). The facility reported a census of 125 residents. Findings include: 1. Review of the Care Plan for Resident #1, dated 1/6/2026, revealed the addition of hospice services starting on 12/26/25, with Hospice A identified as the provider. Heart failure listed as the admitting diagnosis. A review of the facility contract with Hospice A, dated 5/11/2023, revealed the agreement signed by a hospice representative but lacked a signature of a facility representative. During an interview on 7/16/2026 at 1:00 PM, the Administrator reported he could not find a copy of the contract with Hospice A and had to request a copy from the provider. The Administrator explained that while the hospice had signed the contract, the facility had not. The Administrator stated the facility will work with Hospice A to get an updated contract completed. 2. Review of the Care Plan for Resident #2, dated 6/7/2026, revealed that hospice services started with Hospice B on 5/18/2026. Combined systolic and diastolic heart failure listed as the admitting diagnosis.3. Review of the Care Plan for Resident #3, dated 5/6/2026, revealed that hospice services started with Hospice B on 5/7/2026. Brain mass listed as the admitting diagnosis. 4. Review of the Care Plan for Resident #5, dated 6/22/26, revealed that hospice services started with Hospice B on 6/15/2026. Congestive heart failure listed as the admitting diagnosis. Review of the facility contract with Hospice B, dated 12/16/2021, revealed, in part: .Incident reporting. Any of the following alleged incidents involving a Hospice Patient residing at a Facility: mistreatment or neglect; verbal, mental, sexual or physical abuse; injuries of an unknown source; or misappropriation of patient property. The contract language failed to specify facility staff must report alleged incidents of abuse, mistreatment, neglect or misappropriation of resident property by hospice staff to the hospice administrator immediately when the facility becomes aware. During an interview on 7/21/2026 at 3:44 PM, the Administrator reported that they did not have an updated contract with the Hospice B that included the required language that was missing from the 12/16/21 contract.		