STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165513	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Luther Manor at Hillcrest	3131 Hillcrest Road Dubuque, IA 52001

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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff and resident interview, along with policy and procedures, the facility failed to treat and manage pain, for 1 out of 3 resident reviewed (Resident #1) Resident #1 ran out of pain medication on 8/13/25-8/18/25, for which resulted in the resident being sent out to the local Emergency Department on 8/16/25 and 8/17/25 for pain medications. The facility reported a census of 99 residents. Findings include:The Minimum Data Set (MDS) assessment dated [DATE], documented Resident #1 with a Brief Interview For Mental Status (BIMS) score of 15 for which indicated no cognitive impairment. The MDS documented the resident with diagnosis for which included Peripheral Vascular Disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), Diabetes Mellitus (a condition in which the body has trouble controlling blood sugar and using it for energy), absence of left leg above the knee and back pain. The MDS documented a scheduled pain medication regimen with an opioid (a class of drugs that reduce moderate to severe pain by binding to receptors on nerve cells in the brain and body) given every day in the 7 day look back period. The MDS documented the resident required dependence with showering/bathing, personal/ toileting hygiene and dressing and a wheelchair used for mobility.The Plan of Care dated of 7/31/25, documented I am on pain medication therapy and Oxycodone (opioid pain medication used to treat moderate to moderately severe pain related to disease process. Interventions include, administer medications as ordered by physician. Monitor/document side effects and effectiveness every shift. Ask physician to review medication if side effects persist. Monitor/document/report adverse reactions to pain therapy: altered mental status, anxiety, constipation, depression, dizziness, lack of appetite, nausea, vomiting, pruritus (itching), respiratory distress/decreased respirations.The Discharge Summary Report dated 7/30/25 at 10:44 a.m., documented, patient discharge/transferred to a Skilled Nursing Facility. Diagnosis include; status post above knee amputation of left leg, peripheral vascular disease and generalized weakness. Medications include, Oxycontin 10 mg every 12 hours scheduled. The Internal Medicine Progress Notes dated 8/5/25, documented, Resident is seen today for a Skilled Care Admission. He reports pain 9/10 to left above-knee amputation site. Complex regional pain syndrome (chronic arm or leg pain developing after injury, surgery, stroke or heart attack, may involve abnormal inflammation or nerve dysfunction). Followed by pain clinic. No medication changes.The Internal Medicine Progress Notes dated 8/8/25, documented, His only complaint is of on-going pain. He notes pain in his left leg following the amputation. He also has pain in his right leg. He has a history of chronic pain. A review of systems is attempted with the patient. One point that the patient is most insistent on is one of chronic pain. He notes pain particularly from his left leg after the amputation, but also has pain in his right leg and other areas. He would like to have his pain medications given routinely at exactly 8 hour intervals. He believes with his anxiety, that antianxiety medications should be given with his pain medications to smooth things out'. No medication changes.The Internal Medicine Progress Notes dated 8/12/25, documented, Oxycontin 10 mg, one tablet every 12 hours for pain. Patient is rating pain 5/10 to left stump that is improved from last week, usually rating 9/10. Pain appears to managed. Continue with oxycontin 10 mg every 12 hours.The Medication Administration Note dated 8/13/25 at 9:26 a.m., reflected, oxycontin oral tablet, 10 mg every 12 hours, medication not available and waiting for script from the primary care provider.The Medication Administration Note dated 8/14/25 at 11:57 a.m., reflected, Oxycontin 10 mg oral tablet to be administered every 12 hours, medication not available. Awaiting script from Medical Doctor.The Social Services Note dated 8/14/25 at 3:23 p.m., documented, Resident reported that he was in pain and that he wanted his pain medications. Resident informed by nurse prior that he did not have any and that he needed to call the doctor to get more. The Internal Medicine Progress Notes with an encounter dated 8/14/25, documented, Patient is seen for follow-up from the nursing home. The patient primary complaint continues to be of pain. He notes in particular pain from his left leg after the above-knee amputation. He request stronger pain medications. He does note a history of anxiety. He notes that he is frequently using his call button at the nursing home because he is frequently lonely. He demonstrated mild confusion. He continues to have quite a bit of pain from the left leg as phantom pain. He insists on his need for stronger and more frequent pain medications. Will increase his antianxiety medications. Monitor things subsequently. They can call with problems.The Nurses Note dated 8/14/25 at 4:40 p.m., documented, Resident returned to the facility from Doctors appointment. No new orders for pain medication. A call made to orthopedic surgeon. Orthopedic surgeon

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, facility policy and procedure the facility failed to reconcile narcotic/controlled substance counts at the beginning and ending of every shift for one of three residents reviewed (Resident #2) for which resulted in a narcotic cassette missing. The facility census was 99 residents. Findings include:1. The Minimum Data Set (MDS) assessment dated [DATE], documented Resident #2 with a Brief Interview For Mental Status (BIMS) score of 15 for which indicated no cognitive impairment. The MDS documented the resident with diagnosis for which included heart failure, Peripheral Vascular Disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), Diabetes Mellitus (a condition in which the body has trouble controlling blood sugar and using it for energy), sepsis (a life-threatening complication of an infection) and chronic pain. The MDS documented a scheduled pain medication regimen with an opioid (a class of drugs that reduce moderate to severe pain by binding to receptors on nerve cells in the brain and body) given every day in the 7 day look back period. The MDS documented the resident required partial to moderate assistance with showering/bathing and dependent with toileting hygiene and dressing.The Plan of Care dated of 8/27/25, documented I am on pain medication therapy and received Tramadol (opioid pain medication used to treat moderate to moderately severe pain. Related to disease process of Osteomyelitis (inflammation of bone caused by infection, generally in the legs, arm, or spine) Interventions include:*Administer medications as ordered by physician. *Monitor/document side effects and effectiveness every shift.*Ask physician to review medication if side effects persist. *Monitor/document/report adverse reactions to pain therapy: altered mental status, anxiety, constipation, depression, dizziness, lack of appetite, nausea, vomiting, pruritus (itching), respiratory distress/decreased respirations.The Nurses Notes dated 8/29/25 at 9:23 a.m., late entry: Resident admitted around 11:55 a.m., on 8/26/25. Orders faxed to pharmacy. Resident complained level 4-8 pain to right heel and coccyx. Orders for oxycodone/Tylenol and Tramadol. At approximately 3:00-3:45 p.m., emergency medication removed for Emergency Box storage room and opened on counter at nurses' station. First large (tackle box) opened and medication was not in that box, box returned to medication room Second black box opened at nurses' station and oxycodone/Tylenol not in the inventory. Tramadol 50 milligram was in the box in a red cassette. One Tramadol removed and placed in a medicine cup. Red cassette returned to black box and black box put in medication room per facility guidelines. No extra lock tags where available in black box. RN (Registered Nurse) was sitting in front of this nurse when the above took place. Faxed a copy of the forms with the Tramadol that was removed and resident name and provider to pharmacy per facility guidelines. Interview on 9/16/25 at 1:30 p.m., Staff A, RN, confirmed and verified that a narcotic count was not completed prior to staff coming and going off of their shifts and that it is expected for staff to follow the facility policy and procedure for counting of narcotics.Interview on 9/16/25 at 3:30 p.m., Staff B, RN, confirmed and verified that a narcotic count was not completed prior to coming on and going off the shift with the resident narcotic count sheet, and it is the expectation of the nursing staff to count the narcotics per facility policy and procedure. Interview on 9/16/2 at 5:00 p.m., Staff C, LPN (Licensed Practical Nurse) confirmed and verified that no narcotic count was done prior to keys being exchanged between staff and that it is the expectation of the nurses to follow the facility policy and procedure for counting narcotics before coming on to your shift and prior to leaving your shift.Interview on 9/16/25 at 1:30 p.m., Staff D, RN confirmed and verified that the nurses are expected to count narcotics prior to coming and going off their shifts and it is the expectation of the nurses to follow the facility policy and procedures for counting narcotics.The Controlled Substances policy and procedure dated 4/2019, explained that the facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal and documentation of controlled substances.Policy Interpretation and Implementation: Controlled medications are counted at the end of each shift. The nurse coming on duty and the nurse going off duty determine the count together. Any discrepancies in the controlled substance count are documented and reported to the director of nursing services immediately.