

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165513	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/23/2025
NAME OF PROVIDER OR SUPPLIER Luther Manor at Hillcrest		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165513	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/23/2025
NAME OF PROVIDER OR SUPPLIER Luther Manor at Hillcrest		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and facility policy review the facility failed to remove a transdermal patch prior to administering a new patch on 1 of 1 resident (Resident #2) which caused increased confusion and required an admission to the hospital for treatment of acute encephalopathy. The facility reported a census of 90 residents. Findings include: Review of the Minimum Data Set (MDS) assessment for Resident #2, dated 8/8/25, revealed a list of diagnoses which included coronary artery disease, hypertension, Parkinson's disease, and bipolar disease. The MDS indicated the resident experienced short term memory problems and difficulty with decision making. The MDS assessed the resident required extensive assist with toileting, bathing and dressing. Review of Resident #2 September 2025 Medication Administration Record (MAR) revealed an order for Rivastigmine Transdermal Patch (a medication in the neurotransmitter class that helps with memory and cognition that is delivered through a patch placed on the skin) 24 hour 13.3 MG (milligram). Apply 1 patch transdermally at bedtime for Parkinson's/Dementia. Take off old patch before applying a new one and remove per schedule. Start Date 12/2/24. Review of the electronic health record (EHR) revealed a Medication Administration note entered on 9/23/25 at 8:00 PM Rivastigmine Transdermal Patch 24 Hour 13.3 MG/24HR Apply 1 patch transdermally at bedtime for Parkinson's/Dementia, take off old patch before applying a new one and remove per schedule old patch was not there. Review of the document titled Medication Error, Date: 9/29/25 at 20:00 [8:00 PM] revealed: Resident [name redacted, Resident #2] . Incident Description: Nursing Description - Resident was standing naked in room holding on to closet door. Resident was breathing heavily. Resident was assisted to sitting position on his walker. When Med aide went behind resident, she noted he had two Rivastigmine patches on., They were immediately removed and vitals were taken. Immediate Action Taken: Resident was immediately assessed and vitals were taken. Resident was given HS (bedtime) with his Alprazolam. Resident was then assisted to the bathroom and washed up and dressed for bed. Resident was then assisted to bed. Resident has been assessed again at 2200 [10:00 PM]. Frequent checks have been performed on resident. Resident is resting in bed and is stable. Review of a document titled Psych Med Check Progress Note, dated 9/30/25 at 1:25 PM revealed, in part: History of Present Illness: he got an overdose of the rivastigmine patches, they did not take the old patch off and put the new one on, he was confused and agitated, last night, he has trouble in the right hand and his mouth felt worse, more confusion, hypertension, and hyper ventilating; they thought he had a UTI (urinary tract infection) few days ago, he did not have one, he seemed confused more than usual. Review of a Medication Administration note entered on 9/30/25 at 7:40 PM revealed in part. Take off old patch before applying new one and remove per schedule hold per DR (doctor) until side effects are gone. Review of a document titled Physician Visit Form (out of office) signed by [provider name redacted] on 9/30/25 revealed, in part: Reason for Visit: Routine Visit? had adverse reaction from Rivastigmine patches had 2 patches on 3 days in row. B/P: 155/90, 105, O2 (oxygen) 99% - hyperventilating - increased confusion -gave Xanax (anti-anxiety medication) then 1.5 hours later 93/62 - 83-O2 99%. Progress Note: Worse after OD (overdose) of Rivastigmine. Review of a hospital Discharge Summary revealed, in part: Date of Service: 10/3/25 at 12:46 PM [physician name redacted] admit date : [DATE]. discharge date : [DATE]. Summary of Hospitalization: Reason for Hospitalization: Patient is [AGE] year-old who was brought to the ER after developing confusion and having falls. He had been noted by family to have more falls and to have change in his overall mental status in the past 2 weeks. He had occasional hallucinations. No fevers, chills, dyspnea (shortness of breath). He has found at his nursing home to have 3 Exelon (brand name for rivastigmine transdermal patch). He was seen by his psychiatrist who felt that his symptoms could be from this, but he was brought to the ER for further evaluation. Diagnoses: Principal Problem: Acute encephalopathy (rapid onset of altered brain function). Hospital Course: Patient was admitted to the medical service. His Exelon was discontinued. He had gradual improvement in his mental status and appeared to be back to his baseline by discharge. Repeat head CT showed no evolving changes to suggest stroke. EEG (an electroencephalogram - a test to record electrical activity in the brain to diagnose and monitor neurological conditions) showed no seizure activity. On 10/22/25 at 11:30 AM, the consultant pharmacist stated the facility had reached out to her and informed her of the medication error for Resident #2. She stated she did not feel the medication error contributed to his recent falls but it could have caused the acute encephalopathy. She stated she could see why the hospital physician is attributing to it because the hallucinations and confusion did clear after the</p>		