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	02/12/2026

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

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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, record review, staff interview and facility policy review the facility failed to follow fall interventions to prevent falls for 3 out of 4 residents reviewed with falls resulting in injuries. (Resident #11, #13 and #80). Staff failed to properly transfer Resident #11, resulting in a fractured ankle. The facility failed to follow fall interventions to prevent a fall for Resident #80, resulting in a hematoma and abrasion to forehead and a skin tear to left elbow. The facility failed to have interventions in place to prevent an abrasion to Resident #80's knee while in bed. The facility reported a census of 94 residents. Findings include. 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #80 revealed a diagnosis of coronary artery disease, hypertension, peripheral vascular disease, cerebrovascular accident and non Alzheimer's Dementia. The MDS revealed the resident had short and long term memory problem, with severely impaired decision making. The MDS indicated Resident #80 was dependent on staff for personal hygiene and dressing. Resident #80 needed substantial assist to roll left and right in bed, and had a history of falls. The Incident Report dated 2/1/26 at 5:30 PM revealed, Noted skin tear to left knee. Resident #80 was laying on his left side and Certified Nursing Assistant (CNA) states his knee where against the heater and the residents pants were pulled up to his knees. The Immediate Action Taken section of the Incident Report revealed, in part, Clean skin tear with soap and water and assist resident out of bed with 2x (two) person assist with hoyer lift (mechanical lift). No bleeding noted, skin bright red color and contact Administrator [Name Redacted] nurse on-call and notified new skin issue from the heater. Review of Resident #80's Nurses Note dated 2/1/26 at 6:27 PM revealed, in part, a certified nursing assistant notified the nurse at 5:30 PM about skin tear to left knee. Staff reported resident was laying on his left side and left knee and left was resting against the heater and resident pants pulled up to the left knee. Resident #80 turned on left side and noted skin tear to left knee. Skin tear measured 1 centimeter(cm) by 2 cm and 2 cm by 0.5 cm. Skin color pink, no bleeding noted and skin warm to touch .Contact [Name Redacted]-Administrator and notified the skin tear from heater and informed re-arrange the bed away from the heater. The Nurses Note dated 2/1/26 at 9:18 PM revealed the nurse reassessed area on left leg/knee and noted drainage on dressing and redness on leg. Total area of redness measured 13 cm x 5 cm with 2 abrasions measured 3 by 2 cm and and 3.5 cm by 1.5 cm with 0.1 cm depth. Staff noted resident facial grimacing and on call light frequently as needed pain medication given for comfort. Hospice notes from 2/3/26 revealed, left knee wounds appear to be popped blisters. Staff reports knees were resting on the radiator. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The nurse progress note dated 2/8/26 at 5:15 PM revealed, skin issue #1 front left knee issue type was a burn, described in note as superficial burn that was in-house acquired on 2/1/26. 3 cm depth with a 1 cm depth. Skin issue #2 front left knee superficial burn wound acquired in house on 2/1/26 with a 3 cm depth and 1.5 cm depth. On 2/04/26 at 4:41 PM, utilized a heat gun from maintenance and the register in Resident #80's room was 109.5 to 119 degree Fahrenheit within a 15 minute interval. On 2/05/26 at 7:55 AM, Resident #80 lying in bed which has been moved to along the wall and no longer next to heater. He was lying on his right side facing the wall, and the left knee was exposed and 3 open red areas exposed to air. No dressing on left knee. On 2/5/26 at 10:22 AM, Staff Y, Registered Nurse (RN) stated the CNA came and told [Staff Y] there was a skin tear on Resident #80 left knee and the bed was in the lower position, and he was laying on his side with his left knee touching the heater. [Staff Y] observed there was 2 skin tear on the left knee and it was red there was no blister when [Staff Y] saw it. There was no drainage to the wound. It was like 73 degrees in the room and the metal was warm. There was 2 areas on the left knee and it measured 1 cm x 2 cm and then 2 cm x 0.5 cm. Its because it was touching the heating vent that caused the skin tear. The skin tear would be defined as open and you could see the inner skin. [Staff Y] would not say it was a burn because there is blister a burn should have a blister first. The skin might be rubbing off when he was doing it. The register was hot. The skin was warm and not scalding hot. [Staff Y] notified Hospice and the daughter and informed the Administrator. [Staff Y] did tell her (Administrator) the knee was touching the heater and let her know we repositioned the bed away from the heater. [Staff Y] also let the daughter know we moved the bed away from the heater. All burns have blister and this is why I thought it was a skin tear. On 2/05/26 at 10:57 AM, observed 2 CNAs position Resident #80 in bed and body pillow placed on left side. The heating unit metal part registers 113.9 degree Fahrenheit on the side metal part and the top part registers 139.1 where vents are located and the heat blows out of it. On 2/05/26 at 11:02 AM, Staff E, Licensed Practical Nurse (LPN)LPN and Staff Staff W, LPN provided wound care to Resident #80. Staff W stated did skin assessments on area like this, and considered it an abrasion. Staff W explained they came to conclusion the skin was abrased from 2 areas unknown etiology. [Staff W] stated [Staff W] feel like it could be an abrasion or it could be a rug burn from friction or shear. [Staff W] did not feel like heat caused it because there was no blistering. [Staff W] did state burns do not always have blisters. [Staff W] did not think it was a burn because it was an abrasion and the pictures from Sunday to Monday show the redness around the wound is gone. [Staff W] did clarify she was unsure what caused skin to be rubbed off, the heat could be a factor . Staff W further explained it could be from anything that would cause the skin to come off and by Monday morning there was no redness, and the third area was a more like a bruised abrasion area and it was not open. Staff E obtained the following measurements for open areas on the left knee of Resident #80, top wound on left knee measures 2.9 (centimeter) cm x 1.1 cm, The middle wound was 2.8 cm x 0.7 cm and the bottom area on the wound was 1.7cm x 0.3 cm. Each area has full thickness of skin removed and wound base was yellow with the peri wound red. The wounds were all irregular shaped. Staff E confirmed no drainage on the dressing with little bit of blood when she removed the dressing. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 2/05/26 at 1:39 PM, Staff II, Hospice Registered Nurse (RN) stated regarding Resident #80 left knee there were 2 open areas on his left knee, the on call nurse got a call from the facility on 2/1/26 stated he had 2 skin tears on his left knee. Staff II, Hospice RN did come observe the wound and the nurse changed the dressing and [Hospice RN] saw it. [Staff II] observed it on 2/4/26 and it appeared to be popped blister areas. She was not able to say what caused the area but Hospice was notified the knee was on the vent of the heater. She revealed she does think the heat may have caused the knee blisters. She stated she had not seen Resident #80 knees on the register but he is able to pull his legs up and move them side to side. [Staff II, Hospice RN] informed/made the comment to the facility nurse as she changed the dressing on the left knee those are not skin tears. On 2/05/26 at 2:48 PM, Staff E, LPN confirmed she did the dressing change to Resident #80 left knee today and yesterday. It does not appear to have changed much since yesterday. [Staff E] did talk to Hospice about the area and told her we are calling it an abrasion. [Staff E] would suspect it might be a mild burn and he was supposed to have pillows on both sides [Staff E] suppose if the heater got hot enough it could be a burn. It could be an abrasion or a rug burn. On 2/05/26 at 3:02 PM, Staff Z, RN stated got in report Resident #80 had an incident and he was in bed and he was close to the wall heater and he got to little skin tears. When [Staff Z] checked it was bleeding through and it was a larger area and then he he had some other areas. It was a lot bigger that what the previous nurse documented . [Staff Z] did not think it was a skin tear, from [Staff Z's] experience it looked like a burn from the heater. A lot of the area was redness and he had two area that were more open they were full thickness skin gone and appeared to be like a second degree burn. His bed was moved away from the radiator. On 2/05/26 at 3:23 PM, Staff AA, CNA explained took care of Resident #80 on 2/1/26. [Staff AA] checked on him at 2:30 PM he was on his back and then the nurse told [Staff AA] he was awake and he needed to get up for supper. [Staff AA's] partner and [Staff AA] went in to get him up from bed and his pant leg went up exposed the sore. It looked like a burn and his leg was hot it felt warm to the touch. It felt warmer than it should have been. It couldn't have been on there very long [Staff AA] checked on him at 2:30 PM. [Staff AA] suspected a burn right away because he was laying near the heater, the way he was laying made me suspect it. The left knee was next to the metal, they don't get hot but they do get warm. [Staff AA] moved the room because [Staff AA] told them the bed should not be there you never stick a bed next to the heater. [Staff AA] think it was an accident he was on his back and flipped over. Observation on 2/09/26 at 1:15 PM with Maintenance Director in Resident #80 room revealed flat metal part of heater temperature on infrared heat gun read 107.3 - 116 degrees Fahrenheit on the heating unit. The top part of the heating unit measured 117.3 degree Fahrenheit. He stated they do not take temperature on them and have not had issues with them. This is the hottest [Maintenance Director] have ever seen them, and [Maintenance Director] did not know how hot they potentially could get. On 2/09/26 at 3:50 PM, the Director of Nursing (DON) stated she did see the left knee area on Resident #80 maybe a day or so after it occurred. It looked like a friction shearing from the mechanical lift. The DON explained the following about the situation: it was not only Resident #80 was leaned up towards the radiator and the pants were up to the knee and there was bedding present also. It was a known origin and I considered it was known friction and shearing. His knee must have rubbed up and down against the surface with material like a volley ball floor burn. That is why [DON] felt it was friction and shearing. The DON did not feel like the heat from the radiator contributed. [DON] (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	were previous to the current electronic health record. [Staff W] did not recall if the star was on his wheelchair that night. [Staff W] completed an assessment he had a hematoma and abrasion to his left upper forehead and skin tear to left elbow and left cheek was bruised. Staff W explained did not remember the root cause analysis for that fall, but I knew the intervention was a drop seat in his wheelchair. [Staff W] didn't know if education was provided but did talk to agency staff that night and let them know he was not supposed to be in his room up in his wheelchair by himself. On 2/12/26 at 12:24 PM the DON stated the wheelchair star program identifies the resident is not supposed to be left alone in room in wheelchair. There was a star on their wheelchair to identify they are at risk. Staff left Resident #80 alone to go get the equipment and he fell. The DON explained talked about falls in the morning meeting. [DON] did not check on his wheelchair but would expect for the star to be there. She revealed the staff did not follow the plan of care for Resident #80 and he fell. 3.The MDS dated [DATE] for Resident #11 revealed a diagnosis of hypertension (high blood pressure), diabetes, and depression. The Brief interview for mental status (BIMS) revealed a score of 7 out of 15 which indicated severe cognitive impairment. The MDS indicated the resident required maximal assistance from staff for transfers. The care plan intervention with a date initiated of 5/7/25 and a revision date of 8/27/25 revealed Resident #11 dependent on staff with assist of 2 with EZ stand (lift). An incident report dated 8/1/25 at 7:20 AM revealed CNA staff transferred Resident #11 by herself with the pull up bar, while resident is an assist of 2 with the EZ stand. Resident was eased to the floor by CNA staff because resident could not hold self up at the bar. No injuries from the fall. Facility provided education to staff on residents transfer status and if unsure to verify with nurse. An incident report dated 12/15/25 at 5:00 PM revealed Resident #11 told CNA she could walk and CNA pushed button on the recliner to raise it and when her partner saw this informed the CNA she was an EZ stand. Resident #11 started to slide and CNA could not hold the resident up and CNA assisted Resident #11 to the floor. Resident did not hit head. No visible injuries noted. Staff assisted resident #11 into the wheelchair per 3 assist and gait belt. The nurse progress note dated 12/16/25 at 7:13 AM revealed when Resident #11 woke for the day, staff noted her right ankle to be bruised, swollen and painful even to touch. She could not move her ankle at all. Condition report to nurse practitioner. Resident #11 sent to emergency room for evaluation and treatment. Review of the results of the x-ray of the right ankle revealed a mildly displaced obliquely oriented fracture of the lateral malleolus. The small bony knob on the outside of the ankle is broken at an angle, with pieces slightly shifted out of their normal position. On 2/04/26 at 2:20 PM, electric lift recliner chair in Resident #11 room. On 2/09/26 at 5:20 PM Staff BB, CNA stated on 12/15/25, was walking past Resident #11 room and observed another CNA getting ready to transfer the resident. She was in the recliner and and she was seated forward with her walker in front of her and had the lift chair in a raised position. [Staff BB] informed the CNA that is not how she transfers she needs the EZ stand, and [Staff BB] went to get the EZ stand and heard help help and by the time I got back to the room Resident #11 was on the floor. She revealed staff know how to transfer residents by they have little signs on the door. and (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	some paper they call it a wing sheet it has their transfer status on it. If EZ stand lift need to use 2 staff for transfer. [Staff BB] was upset because had just told her that is not how we transfer her and why would she not have put her back down. On 2/10/26 at 8:21 AM Resident #11 Lying in bed, head elevated and eyes closed. No signs and symptoms of discomfort. On 2/10/26 at 8:27 AM Resident #11 Staff B, CNA and Staff C, CNA provided transfer from bed to wheelchair with EZ lift (mechanical lift) with out problems. Resident had boot on right lower extremity. During the transfer Staff C stated could always ask the nurse what a resident needs for transfer assist and usually there was something on the door but it is not always updated and recently they have not been updating them. On 2/10/26 at 9:29 AM Staff CC, CNA stated would ask the other staff what the resident transfer status was and the residents had their own gait belts. [Staff CC] asked the staff on Sunday when [Staff CC] started and when hour of orientation on Sunday they did not go over how they transfer or communicate this to staff. [Staff CC] used [electronic health record system, (EHR)] a lot for another facility so had access to [EHR] and can look up in there. [Staff CC] am not aware of any way specific way they communicate transfer status of residents to agency staff. On 2/10/26 at 10:15 AM Staff T, CNA/CMA stated they don't always use the wing sheets anymore and she is not sure how updated they even are anymore. She went to the electronic health record to check the resident transfer status. We have communication board in the electronic health record that we all can read. The communication board gives us anything new and recent and supposed to look at it every shift. On 2/10/26 at 2:27 PM Staff DD, CNA stated the fall Resident #11 had was about 430 there was a gait belt in her room so it made [Staff DD] think she walked normally. They would have a plaque on the door that tells you her transfer status that might have been right around the time they were going to stop them. So [Staff DD] lifted her power chair up and had the gait belt up and [Staff DD] tried to stand her up. Another CNA agency said she was an EZ stand so while [Staff DD] was putting the chair back down and was looking for the remote on the ground, Resident #11 slid out of the power lift chair. Her walker was not in her room, she had just moved from Bluff View so [Staff DD] grabbed another residents walker and it was in front of her and was going to pivot her into her wheelchair. [Staff DD] did have the chair almost all the way up and was attempting to have her bear weight but she was not able to bear weight and then the other CNA said she was an EZ stand. No one told us how to look for the transfer status and there was no education. [Staff DD] explained talked to the activity staff and asked her how [Staff DD] was supposed to know how to transfer her and she told me about papers in a binder and those have the transfer status on them and other information on them about the resident. Staff DD explained used them now. At one of our most recent staff meeting Administrator did talk about them being in the binders. She did not say any where else to find there transfer status. On 2/10/26 at 4:11 PM Staff W, LPN, who documented resident's fall on 8/1/25, stated it was in the Bluff View shower room and was called into the tub room. Resident #11 had fallen the staff member had transferred her with the grab bar and she should have been an EZ stand. The CNA knows to use the Kardex in the electronic health record to know their transfer status and how the CNA should transfer. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 2/10/26 at 5:16 PM the Administrator states the wing sheets are still available but they are not always the most current so she encouraged the staff to use the kardesx because that is the most current. On 2/11/26 at 3:05 PM Staff GG, LPN stated was the nurse to document Resident #11 fall on 12/15/25. The CNA said she tried to transfer Resident #11 by herself. The resident told her she could do it by herself and she was in the recliner chair. The CNA raised the chair because it was an electric chair and the resident started to slide out of the chair. The staff could not stop her and she slid right out of the chair. On 2/12/26 at 12:15 PM the DON stated [DON] called staff to take the witness statement on Resident #11 fall and it was a facility staff. She was getting Resident #11 up for a transfer. Resident #11 has dementia and she told staff she could walk so the staff went to get her up from the power chair. An agency staff saw her getting her up from the chair and told her no she is a lift and the staff was in there in a lifted position and resident lost balance and was lowered to the ground. The DON explained there were several ways they could know how to transfer a resident and because we have a system that is able to update live time the care plan, kardex and communication board is the full up to date information. So [DON] would expect them to go to the care plan, kardex or communication board these are the current active up to date areas to get the information. The DON further explained was working to phase out the other programs in place. The education was completed in December to use the kardex not the magnets on the door frames and we tried to go around and remove them but staff continue to put them in place. Communication board is a way to know what was changed. The facility provided a policy titled Safe Lifting and Movement of Patients with a last revision date of July 2017 it directed the residents current transfer status is to be found by using the KARDEX/Care plan located in the electronic health record. 4. The MDS assessment dated [DATE] for Resident #13 informed a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. The MDS also revealed the resident had diagnoses of repeated falls, weakness, muscle weakness, difficulty in walking, unsteadiness on feet, and other abnormalities of gait and mobility. The MDS indicated Resident #13 had difficulty in walking and a need for assistance with personal care. The Care Plan instructed the Resident #13 needed assist of one for transfers and ambulation Ax1 with FWW in room and throughout the facility. The Care Plan also instructed to apply gripper socks (dated 3/21/25), auto-lock brakes to wheelchair (dated 9/10/25), and ensure wheelchair pedals are not attached, unless being propelled (dated 9/10/25). The Care Plan dated 1/22/26 instructed to remove white socks from room and only supply with gripper socks as the Resident removes shoes and gripper socks. The Fall Incident Report dated 2/10/26 at 9:00 AM Staff E, Licensed Practical Nurse (LPN) was called to resident room by Staff F, Certified Medication Aide (CMA). Staff F informed Resident #13 had been found on the floor kneeling on his knees, but upon entering the room resident got himself up and back in his wheelchair. Staff E, LPN started neuros and obtained vitals, resident was upset and yelled at Staff E, LPN. continued to state he did not fall, did not want to get vitals or assess him. The resident did not appear to have any red areas, bruising or open areas to his knees, and denied hitting his head and denied any pain or discomfort. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An observation on 2/4/26 at 12:01 PM Resident #13 sat on the edge of his bed with no shoes on. wearing white socks. Observed no shoes or gripper socks in the resident's room. The resident informed he did not know where his shoes were. Wheelchair pedals were on the wheel chair. An observation on 2/9/26 at 9:14 AM, Resident #13 wearing white socks, no shoes, and no gripper socks. The resident proceeded to stand up at the side of his bed, did not know where his shoes were. An observation on 2/10/26 at 8:10 AM the resident lying in bed, door open, right foot hanging off of foot of the bed, white socks on without shoes or gripper socks on. An observation on 2/10/26 at 8:47 AM Resident #13 lying in bed, wearing white socks, no gripper socks or shoes. Wheel chair pedals were on his wheel chair. Staff F, CMA knocked on the door, entered the resident's room, turned on light, and told the resident that it was time to get up for breakfast. Staff F, CMA asked Staff HH, CNA to help assist him and that he is willing to get up. An observation on 2/10/26 at 9:01 AM Staff HH, CNA assisted Resident #13, with the door open, observed the resident stand up, pivot turn, and sat down in his wheel chair without a gait belt on and no gripper socks or shoes. Resident was wearing his white socks, a t-shirt, and a brief. Socks on standing to turn around and sit in a wheel chair, t-shirt, brief. Staff E, LPN entered the residents room door shut Staff HH, CNA and Staff E, LPN left the room at 9:04 AM. An observation on 2/10/26 at 9:06 AM, Resident #13 self-transferred from his wheel chair into his bed. The resident still wearing only his white socks, t-shirt, and a brief. An observation on 2/10/26 at 9:08 AM Multiple staff walked past his room. Resident #13 still had white socks on without gripper socks. The resident was sitting in his wheel chair drinking a can of pop. An observation on 2/10/26 at 2:02 PM, Resident#13 stood up on his own, walker not in reach, wheel chair pedals were on wheelchair, wheelchair did not have the brakes locked, resident turned around and sat down in his wheel chair. The anti-lock brakes on the resident's wheel chair did not prevent the wheelchair from rolling backwards and his wheel chair bumped into his dresser. The resident stood up, picked up his walker, moved the walker, then sat down in another wheel chair that was near the center of his room. The resident proceeded to propel himself out of his room. The resident informed he was not sitting in his wheelchair. The Resident's wheel chair remained in his room. The anti-lock brakes were not tight, the right brake was on, and the left brake was off. An interview on 2/10/26 at 2:08 PM with Staff D, CNA informed she will put a work order to fix the antilock brakes. In an interview on 2/11/26 at 10:55 AM, the Maintenance Supervisor looked at the wheelchair and fixed the anti- lock brakes. He was informed by the CNA that she was unsure what needed to be fixed on the wheel chair and she had told him it was the front brakes that were not working. The maintenance man informed he was going to have therapy to check the wheel chair brakes. In an interview on 2/11/26 at 11:10 AM with Staff E, LPN was unsure why Resident #13's wheel chair was not in his room and indicated they did not have an alternate wheel chair that did not have the anti-lock brakes on it. Staff E reported she would go to the therapy room to check on his wheelchair. (continued on next page)

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	165513	A. Building B. Wing	02/12/2026

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview on 2/11/26 at 11:12 AM with Staff E, LPN indicated the anti-lock brakes were fixed and working appropriately. Staff E indicated she would assist him into his wheel chair. An interview with on 2/11/26 at 1:50 PM with Staff G, Scheduler/Certified Medication Aide (CMA) informed staff bring their concerns to me if there is not enough training or skills to provide for resident cares. If there are questions on how a resident transfers, the nursing staff can use the kardex, or the magnets, we are phasing out the magnets. An interview with on 2/11/26 at 1:50 PM at with Staff G, scheduler informed staff bring their concerns to her if there is not enough training or skills to provide for resident cares. If there are questions on how a resident transfers, the nursing staff can use the kardex, or the magnets, we are phasing out the magnets. An interview on 02/12/2026 at 12:25 PM the Director Of Nursing, (DON) indicated Resident #13 was not supposed to be wearing white socks and they were supposed to have removed them from his room for his personal safety.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, interviews, and policy review the facility failed to prevent physical contamination of food in the kitchen during 4 observations. Hair nets were improperly worn, the cleaning schedule was not followed, and staff did not adequately sweep and mop floors to remove dead cockroaches. The facility reported a census of 94 residents. Findings include:During a kitchen observation on 2/04/26 starting at 10:20 AM noted the following:Staff I, Dietary Director, wore a brown hairnet that left about 2 inches of hair exposed over each ear and about 3 inches exposed in the backStaff P, Dietary Aide (DA), wore a white hairnet with about 2-3 inches of hair exposed in the back.Staff N, DA, wore a hairnet with about 1-2 inches of hair exposed in the back and about an inch over each earStaff Q, Cook, wore a hairnet with hair exposed on the right side, about 1-2 inches out of hairnet over her earsStaff O, Cook, wore a hairnet with about 2 inches exposed in back and wisps out over both earsFreezer - Whipped cream sprayed on the right freezer wall. Staff I stated someone broke in before she started and sprayed it everywhere. She reported she started in September or October and just hadn't gotten around to it, but it was being cleaned on Saturday.Dry storage - Dry cereal under the can and cereal racks, additional pieces further out on the floor and partially crushed. Plate storage equipment next to the gelatin and pudding shelf had a white granular substance on it in addition to a clear sticky substance. There were 2 quarter size splotches of a yellowish orange substance under the pasta shelves and 3 smaller ones under the spices and baking products. Ice machine - A dry off-white film was found under the door, along with a sticky brown/orange substance on the inside rim.Floor - Observed dead roaches and debris under the pots/pans shelf, sanitizing sink, and dish machine.During a kitchen observation on 2/05/26 noted the following starting at 8:42 AM:Staff N, 3 inches of hair in back exposedStaff I, 2 inches of hair over both ears exposedStaff P, 2 inches of hair exposed on back left sideA blue paper was attached to a work surface in the kitchen with tape and plastic. The paper, plastic, and tape were pulled away from the surface leaving a sticky substance, the paper and plastic were jagged in appearance, and the tape had grey and brown substances stuck to it. The paper was discolored and showed dried moisture stains.Daily Cleaning Schedules dated 1/05/26 through 1/31/26 documented that out of 56 AM and 56 PM opportunities for the kitchen and dish room floors to be swept/washed, cleaning occurred 34 of 112 times. During the same time frame there were no cleaning entries for any task for 1/08/26 AM or PM, 1/09/26 PM, 1/10/26 AM or PM, 1/11/26 AM or PM, 1/12/26 AM or PM, 1/13/26 AM, 1/14/26 AM, 1/15/26 AM or PM, 1/16/26 AM or PM, 1/17/26 AM, 1/18/26 AM or PM, 1/19/26 AM or PM, 1/21/26 AM, 1/22/26 AM or PM, 1/23/26 PM, 1/24/26 AM or PM, 1/25/26 AM or PM, or 1/29/26 PM. The deep cleaning items listed on the bottom of schedules were cleaned 3 of 36 opportunities.During an interview on 02/05/2026 at 9:06 AM Staff I, Dietary Director did not confirm she had ever seen roaches in the kitchen. She stated pest control probably treated both the dry storage pantry and kitchen for roaches. On 2/05/26 at 9:18 AM confirmed that dead roaches remained in the kitchen under the sink, shelf, and dish machine.Upon follow up with Staff I on 2/05/26 at 9:22 AM, she stated she was not aware her hair was outside of her hair net and observed her attempt to tuck it in to a brown hair net. She stated she knew the brown hair nets slipped and she would have to make staff wear the bonnet style. She reported she would educate staff about the hair nets and ask them to change them if their hair was out. When asked about the dead roaches she stated she was not aware of them so could not say how long they had been there. She said staff should be sweeping and mopping according to the posted schedule. She thought staff probably didn't sweep far enough back to get them. Staff I then stated the facility had treated for roaches in the kitchen more than once and shrugged when asked why that was different than her answer before. She could not say if any other staff had seen the roaches.On 2/05/26 at 9:28 AM, the Administrator stated the roaches were sprayed and verified it was done by pest control on 1/20/26. She acknowledged that there had been multiple treatments and that if there (continued on next page)

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	165513	A. Building B. Wing	02/12/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	were still live roaches the treatment was not yet effective. During a follow up about the roach activity in the kitchen on 2/05/26 at 1:05 PM, the Administrator stated kitchen staff were responsible for cleaning under the shelves and all around the kitchen.On 2/10/26 at 9:21 AM, Staff Q stated there was a cleaning schedule, and staff in the dish area should clean the floors in that area. Cooks cleaned the floors in their area. She reported seeing a live roach recently, and dead roaches the day before. Staff Q stated cleaning them up should be part of sweeping and mopping floors, which should be done at the end of every meal as part of clean up. She reported hair net policy was to have them on the minute they entered the kitchen and all hairs need to be tucked in with the hair nets over ears to make sure hair was not sticking out. During an interview with the pest control company on 2/10/26 at 5:02 PM, they confirmed treatments since November and stated it was significantly better, but still an issue. Treatments included the kitchen, hallways, dry goods, dining room, and the memory care eating area. He confirmed finding dead and living roaches in the kitchen when he treated on 2/06/26 and stated the kitchen was the source of the infestation. On 2/11/26 at 11:22 AM, Staff S, Assistant Dietary Director reported staff were expected to follow the cleaning schedule with initials to show it was completed. Staff should have their cleaning done by the end of their shift. She thought everyone participated. She acknowledged there had been live roaches in the kitchen recently and reported it was much improved. She stated she noticed dead roaches under the dish machine rack. Staff S stated staff were supposed to wear hair nets immediately when they entered the kitchen and they should cover all of their hair. On 2/12/26 at 10:56 AM during a follow up with Staff I to get the February cleaning sheets she stated staff were not good about signing off on the cleaning sheets and that they would have to get better at that. She acknowledged the January and February sheets were not completed accurately and it appeared the kitchen wasn't being cleaned. A kitchen policy titled Sanitation revised November 2022 documented the food service area was maintained in a clean and sanitary manner. All kitchens were to be kept free of garbage and debris, and protected from rodents and insects. Utensils, counters, shelves, and equipment were kept clean and in good repair. Ice machines were drained, cleaned, and sanitized. A policy titled Food Preparation and Service dated 2001 with no revision dates documented food preparation staff should adhere to sanitary practices to prevent the spread of foodborne illnesses. Cross-contamination could occur when harmful substances such as chemicals or disease causing microorganisms were transferred to food by hands or food contact surfaces not adequately cleaned. Food and nutrition services staff wear hair restraints so hair does not contact food.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on the Centers for Medicare and Medicaid Services (CMS) Statement of Deficiencies forms, review of the facility Quality Assurance and Performance Improvement (QAPI) documentation, QAPI policy review, and staff interview the facility failed to carry out QAPI activities to obtain feedback, use data, and take action to conduct structured, systematic investigations and analysis of underlying causes or contributing factors of problems affecting the facility. The facility reported a census of 94 residents.Findings include:The CMS 2567 Statement of Deficiencies dated 10/17/24 included the following concern: F812 Food Procurement, Store/Prepare/Serve-Sanitary.The CMS 2567 Statement of Deficiencies dated 12/30/24 included the following concerns: F812 Food Procurement, Store/Prepare/Serve-Sanitary; F865 QAPI Program/Plan, Disclosure/Good Faith AttemptThe CMS 2567 Statement of Deficiencies dated 7/25/25 included the following concerns: F689 Free of Accident Hazards/Supervision/Devices; F880 Infection Prevention & ControlThe current survey, conducted 2/04/26 through 2/12/26 also identified the above concerns.Review of QAPI Sign-In Sheets documented the facility held QAPI meetings on the following dates: 11/05/24, 2/13/25, 5/13/25, 7/01/25, 9/25/25, 10/22/25, 11/19/25, 12/17/25, and 1/14/26.The facility was unable to locate documentation for performance improvement activities covering the CMS-2567 forms above.During an interview with the Administrator on 2/12/26 at 1:23 PM she stated all department heads were involved with QAPI meetings since she started in September 2025. She expected the committee to use grievance forms, survey results, nursing notes, clinical review meetings, resident concerns, walk around audits, and staff concerns to develop and prioritize performance improvement activities. If there was a long term concern, the committee should use a performance improvement plan (PIP). She thought they were improving QAPI and acknowledged they had a ways to go with 32 PIPs in place. The Administrator indicated fall monitoring was an active PIP and they used a lot of data from their risk management reporting. They had not been doing very well so they created a new witness statement they were hoping would help. She thought tracking and trending was important for monitoring performance improvement and stated they had to start over because nothing was left by the prior administration. The Administrator stated she had not wanted to make a lot of additional changes until after the survey to see what else needed to be addressed. She stated she was very aware F812 and F880 were ongoing issues.A document titled 2025 Quality Assurance & Performance Improvement plan for the facility indicated the purpose was to take a proactive approach to continually improve the way they cared for and engaged with residents, caregivers, and partners. QAPI was used to make decisions and guide day to day operations. The QAPI plan included 4 goals: stable workforce, fall with major injury reduction, turnover reduction, and antianxiety/hypnotic medication reduction. A policy titled QAPI Program - Feedback, Data, and Monitoring section 3a. indicated annual survey results were a system used to identify, collect, and evaluate data. Section 4 documented that data and information collected would be reviewed by the committee and prioritized according to risk, volume, and potential problems.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, invoices, resident and staff interviews, and policy review the facility failed to maintain a safe and sanitary environment for residents when the facility failed to keep vents between the kitchen and the dining room and in the dining room clean, failed to ensure facility windows, screens, and refrigerators were kept clean, and dead cockroaches from a prior treatment were found two days in a row in the family rooms in addition to sightings of live roaches. The facility reported a census of 94 residents. Findings include: 1. On 2/04/26 at 12:42 PM observed a live cockroach travel from the base of a cabinet under the sink in the family room to the inside of the cabinet. The cabinet contained a towel with brown and yellow stains on it that was stiff to the touch near the opening and damp towards the back. Where the water pipe entered the wall there was an approximately 1/4 inch gap between the wall and the sheetrock. On 2/04/26 at 5:16 PM the middle family room cabinets contained a live roach and 4 dead roaches surrounded by droppings. On 2/04/26 at 5:29 PM Resident #84 reported there had been mice and cockroaches in the building. On 2/05/26 at 8:13 AM observations included a live cockroach crawling on the cabinet under the sink in the family room. The dead cockroaches and droppings remained in the middle cabinet. On 2/05/26 at 10:11 AM, Resident #31 reported there was a black hard shell bug a couple of weeks prior on her curtain that dropped to the floor and crawled under her night stand. She has seen them in the dining room. On 2/05/26 at 1:07 PM, observed a dead roach in the refrigerator in the family room in the bottom shelf. The refrigerator contained a bottle of ketchup and two containers of yogurt. During a follow up about the roach activity in the family room on 2/05/26 at 1:05 PM, the Administrator stated housekeeping was responsible for cleaning the family room.Invoices dated 11/12/25, 12/09/25, and 1/20/26 revealed the pest control company treated for cockroaches in the kitchen, family room, and other living areas. A document provided with an additional invoice dated 2/06/26 (during the survey) titled What to Expect When Your Business has been Treated for Roaches indicated live roaches should be dead within 72 hours and to monitor for additional activity due to eggs in walls, cracks, and crevices hatching within the following 40 days. During an interview with the pest control company on 12/10/2026 at 5:02 PM they confirmed treatments since November and stated it was significantly better, but still an issue. Treatments included the kitchen, hallways, dry goods, staff break room, dining room, family room, memory care, and physical therapy. He confirmed finding dead and living roaches in both the kitchen and family room when he treated on 2/06/26 and stated the kitchen was the source of the infestation. 2. On 2/05/26 at 7:04 AM, entered the conference located next to the kitchen room after the light turned on walked over in front of the thermostat to check the temperature in the room. A cockroach fell and scurried across the top back of the blue chair and down the left side of the blue chair. On 2/10/26 at 9:15 AM, the 8 inch by 24 inch vent 100% covered in something black in the Dining room over the large white clock on the wall, between the main hall entrance and the door before kitchen serving door. The Maintenance man reported the vent looked black as a results of the paint. The other 3 vents in the dining room failed to look 100% black. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/10/26 at 9:15 AM, the ceiling vents located between the kitchen dirty door, the pop machine and the Dining room held 12 clumps of gray fuzz dangling from the vent grate 18 inches by 16 inches and 50% covered with gray fuzz on the 24 inches by 18 inches grate. On 2/10/26 at 11:02 AM the Maintenance man reported reported they clean the vents every 2 months. The vent looked clean. On 2/10/26 at 5:07 PM, the Administrator reported she knew of the dirty vents from the staff. On 2/11/26 at 11:20 AM, the Administrator reported the facility used a contract company for housekeeping services in the past and they are in the process of getting things in order. 3. On 2/12/26 at 9:25 AM, the refrigerator on Bluff View nurses station had large amount dried brown spills on bottom shelf and the bottom of the refrigerator. Observed a thick brown crusty substance on the grate on the front of the refrigerator. Spills on the door and expired items in the door included: -Thick & Easy apple juice dated 5/15 best if used by January 25, 2026 -Open container prune juice 11/25 dated -[NAME] jar with brown substance 1/3 full with no date -Applesauce on the shelf dated 1/30/26 -Paper plate with 3 slices of bread no date -Plastic container with meat no date on it The window screens at Bluff View nurses station had large amount of dirt and debris. The glass in the windows was covered in substance and appeared hazy. On 2/12/26 at 9:38 AM, Sunshine Valley nurses station refrigerator door shelves had large amount of dried brown substance on them. The shelves in the refrigerator had dried spills on them and container of cranberry juice dated 12/29/25 and open root beer dated 12/22. On 2/12/26 at 9:41 AM Staff X, Certified Medication Aide (CMA) stated had worked at facility for about 2 years and did not know who was responsible for the refrigerators at the nurses station. On 2/12/26 at 9:42 AM Staff V, Registered Nurse (RN) stated probable the night shift was responsible for the refrigerators at the nurses station. On 2/12/26 at 10:00 AM Staff W, Licensed Practical Nurse (LPN) stated the nurses were responsible for the refrigerators on the hallways, it was not assigned to a specific shift, and [Staff W] was not sure, would need to talk to maintenance, and was not sure who kept them clean or monitored expired outdated items. On 2/12/26 at 10:33 AM, the Maintenance Director stated the housekeepers would be responsible for the refrigerator. Per the Maintenance Director, had contracted service for environmental services and they were not taking care of it and then the nurses were responsible for it. Not sure who is (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	responsible for it currently. The Maintenance Director explained thought housekeeper should be but as of now there was no plan. The windows in those area tried to do twice a year, spray the screens off, and clean the windows. On 2/12/26 at 10:43 AM, the Director of Nursing, RN stated the staff was on duty and the nurses have been instructed to clean the refrigerators. Per the DON, was in transition from environmental services staff, nursing had been cleaning them, but [DON] didn't know if there was an actual schedule or if anyone was doing temperature logs. The DON explained would expect them to be clean, food should dated, labeled and removed after a period of time.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, policy review and staff interviews, the facility failed to notify the physician when bilateral lower extremity reduction kit wraps (velcro cloth wraps for legs to help reduce swelling) were not applied as ordered by the physician for 1 of 1 residents reviewed (Resident #89). The facility reported a census of 94 residents. Findings include: Review of Resident #89's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status exam (BIMS) score of 13 out of 15, which indicated intact cognition. The MDS included diagnoses of anemia (reduced quantity of red blood cells), high blood pressure (condition where the force of blood pushing against your artery walls is consistently too high) and lymphedema (swelling of arms or legs caused by build up of lymph fluid).Review of Resident #89's Treatment Administration Record (TAR) January 2026 revealed the resident to wear bilateral lower extremity reduction kit wraps (velcro cloth wraps for legs to help reduce swelling) to be put on at 8:00 AM and removed at 8:00 PM. Review of Resident's #89's Progress Notes showed 18 of 31 days in January 2026 when staff did not apply reduction kit wraps due to legs being too swollen. On 1/6/26 the Provider wrote an order that the resident needed compression wraps on everyday. Review of Resident #89's Progress Notes lacked Provider notification of not applying reduction kit wraps to bilateral lower legs due to swelling.On 2/4/26 at 2:00 PM and 2/5/26 at 11:15 AM, resident was not wearing reduction kit wraps.On 2/5/26 11:15 AM, Resident #89 verbalized she doesn't mind wearing them (reduction kit wraps) the staff just haven't put them on.On 2/10/26 12:48 PM Staff E, Licensed Practical Nurse (LPN), verbalized Resident #89 had weeping edema on bilateral lower legs and she was to wear special leg wraps to legs, but when they weep were able to leave off the wraps so they won't be soiled by the drainage. Per Staff E, the physician was aware.On 2/10/26 1:40 PM, the Director of Nursing (DON) reported her expectation was that staff follow the orders as prescribed by the physician, and if the treatment was held the staff, would notify the physician for further instruction.On 2/11/26 9:49 AM, the Administrator verbalized her expectations of the staff to follow the orders as ordered by the physician and to notify the physician if treatments were not being done.The facility policy titled Acute Condition Changes-Clinical Protocol revision date March 2018 revealed the following per the Monitoring and Follow-Up section: The staff will monitor and document the resident/patient's progress and responses to treatment, and the physician will adjust treatment accordingly. The physician will help the staff monitor a resident/patient with a recert acute change of condition until the problem or condition has resolved or stabilized.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, therapy documentation, resident interview, and staff interviews the facility failed to provide required Center for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice forms (CMS 10055 and CMS 10123) at the completion of skilled services for 1 of 3 residents reviewed (Resident #61). The facility reported a census of 94 residents.Findings include:Review of Resident #61's Minimum Data Set (MDS) dated [DATE] for the end of Part A stay documented the resident's Brief Interview for Mental Status (BIMS) score was 15/15, which indicated intact cognition. A therapy note dated 11/21/25 revealed Staff H, Occupational Therapy advised the social worker of therapy recommendations for 24 hour care at the end of skilled services. During an interview on 2/11/26 at 10:13 AM, Staff H stated the resident's therapy ended 11/24/25. She confirmed the discussion with the social worker documented in the therapy note, and reported the social worker should have then prepared CMS forms 10055 and 10123 documenting the end of services. Staff H stated the facility could not find the resident's CMS forms. A review of progress notes from 11/19/26 through 11/24/26 determined the facility social worker spoke to the resident and a family member about discharge planning but did not include documentation that the appropriate paperwork was discussed, signed, or provided to the resident or family member. During an interview with Resident #61 on 2/11/26 at 10:32 AM, when asked about the end of therapy and if she recalled talking to a social worker or other staff about the costs that could be associated with ending therapy, she said no. She did not recall receiving or signing any paperwork. On 2/11/26 at 10:42 AM the administrator reported the social worker responsible for ensuring the CMS forms were completed timely no longer worked at the facility. She stated she was the current social services resource, she had already reviewed the former social worker's emails and paperwork, and they were unable to find the resident's CMS forms.

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	02/12/2026

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, clinical record review and staff interview the facility failed to provide complete perineal care after incontinence for 2 out of 5 resident reviewed (Resident #11 and Resident #84). The facility reported a census of 94 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #11 dated 1/14/26 revealed the following diagnoses: Hypertension, Diabetes, Anxiety Disorder and Depression. The MDS revealed a Brief Interview for Mental Status score of 6 out of 15, which indicated severe cognitive impairment, and revealed the resident was dependent on staff for toileting hygiene and toilet transfers. The MDS reflected Resident #11 was always incontinent of bowel and bladder. The Care Plan intervention for Resident #11 dated 5/7/25 revealed the resident was frequently incontinent of bowel and bladder, utilize incontinent products for dignity. Provide incontinent cares as needed and utilize stock barrier ointment for skin protection from breakdown due to incontinence. On 2/10/26 at 8:27 AM, Staff B, Certified Nursing Assistant (CNA) and Staff C, CNA provided perineal cares to Resident #11. Staff B wet two washcloths and placed on towel on night stand next to bed. Resident #11 observed in bed lying on back. Staff B used the washcloth to wipe right side and left side of abdominal fold into the perineum. Staff B then used second washcloth to wipe the middle of the perineum and failed to separate the skin folds. Staff C assisted Resident #11 to roll on right side. Staff B then wiped the center of the buttocks with the third washcloth and swiped across the the left buttock with the same area of the washcloth. Staff B failed to change the surface of the cloth. They assisted Resident #11 onto her back and placed a clean brief on the resident. Staff failed to wash the hip areas on the left and right side and never washed the right buttock. On 2/12/26 at 10:07 AM, Staff W, Licensed Practical Nurse (LPN), Assistant Director of Nursing (ADON) stated staff should use soap and water in a basin when providing perineal cares. They should wipe both sides of the perineum and the middle. The abdominal folds should also be washed, rinsed and dried. She commented a clean surface should be used with each wipe of the washcloth. She would expect them to wash the buttocks and hips when staff provide perineal care. 2. The MDS for Resident #84 dated 12/3/25 listed diagnoses of the dementia and anxiety. The MDS reflected Resident #84 had short and long term memory problems, had severely impaired cognitive skills for daily decision making, was dependent on staff for toileting hygiene and toilet transfers, and was always incontinent of bowel and bladder. The Care Plan intervention for Resident #84 dated 2/22/25 directed a mandatory stand lift with assist of two staff for toilet transfers and assist of 1 staff with post-toileting hygiene tasks. The Care Plan intervention dated 2/22/25 identified Resident #84 was always incontinent of bowel and always incontinent of bladder. The Care Plan directed incontinent cares routinely and as needed. On 2/10/26 at 1:32 PM Staff C, CNA removed Resident #84's brief as it hung down appeared heavily soaked as she placed it into the trash can it plopped at the bottom of the trash can. On 2/10/26 at 1:39 PM Staff B, CNA stood Resident #84 up with the stand lift. Staff B used a wipe to swipe up her rectal area one time. Staff B failed to wash the front of Resident #84 and failed to wash her buttocks. (continued on next page)

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	165513	A. Building B. Wing	02/12/2026

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/10/26 at 1:43 PM Staff C reported they were to wash all the areas of the skin that got wet from incontinence. Staff C confirmed Staff B failed to wash Resident #84's front peri area. Staff C reported Resident #84 reported that she had a bath in the morning. On 2/11/26 at 1:20 PM, Staff T, Certified Medication Aide (CMA) reported if a resident was incontinent she cleaned them. Staff T explained a very wet brief that hit the trash can made a plop noise. Staff T said she uses soap and water to clean residents after incontinence provide care. On 2/11/2026 at 3:15 PM Staff M, Registered Nurse (RN) reported if she found a resident who is wet from urine the staff needed to clean them, clean all the area of the skin that was wet with urine. Staff needed to wash front to back change the cloth surface with each swipe, pat the skin dry. On 2/12/26 at 10:03 AM, the Administrator reported she expected the CNAs to provide incontinent care after each episode of bowel or bladder incontinence. She said the staff needed to wash all the areas that came in contact with the urine or bm (bowel movement). The Administrator stated she expected residents toileted every 2 hours or as they needed to go to the bathroom. The facility provided an undated Incontinent Care Checklist, undated, which directed to wash all soiled skin areas including hips. Ensure washing from front and back. Use clean area of the washcloth each stroke. Rinse and dry very well especially between skin folds.

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	165513	A. Building B. Wing	02/12/2026

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview the facility failed to provide adequate assessment and intervention after a fall for 1 of 3 residents reviewed with a fall (Resident #11). The facility reported a census of 94 residents. Findings include:The Minimum Data Set (MDS) assessment dated [DATE] for Resident #11 revealed a diagnosis of hypertension (high blood pressure), diabetes, and depression. The Brief interview for Mental Status (BIMS) revealed a score of 7 which indicated severe cognitive impairment. The MDS indicated the resident required maximal assistance from staff for transfers. An Incident Report dated 12/15/25 at 5:00 PM revealed Resident #11 told Certified Certified Nursing Assistant (CNA) she could walk and CNA pushed button on the recliner to raise it and when her partner saw this informed the CNA she was an EZ stand (mechanical lift). Resident #11 started to slide and CNA could not hold the resident up and CNA assisted Resident #11 to the floor. Resident did not hit head. No visible injuries noted. Staff assisted resident #11 into the wheelchair per 3 assist and gait belt. Review of the electronic health record failed to reveal any documentation of vital signs, skin or an assessment in the progress notes until 12/16/25 at 7:13 AM. The progress note revealed when waking up for the day Resident #11's right ankle bruised, swollen and painful to the touch. Resident #11 could not move her ankle. The resident's Provider was notified On 2/12/26 at 8:31 AM, Staff Z, Registered Nurse (RN) stated she did not recall Resident #11 having pain the night of her fall 12/15/25. Per Staff Z, would monitor for 72 hours after a fall and it is usually if they hit their head, and if unwitnessed fall would usually do neuros (neurological checks) every 15 minutes for the first hour, and follow up with skin check every 12 hours and vital signs every 8 hours. Staff Z explained they were told by the day shift nurse to do the 8 hours vital after fall first occurred and for 24 hours after the fall, and would be documented in the electronic health record if were completed. Staff Z did not recall a certified nursing assistant (CNA) told them Resident #11's ankle was swelling or bruised, and did not recall CNA telling [Staff Z] anything about pain. Per Staff Z, they (staff) were usually pretty good about telling [Staff Z] if there was pain. On 2/10/26 at 4:11 PM Staff W, Licensed Practical Nurse (LPN) stated after a fall, nurses document in the electronic health record. The vital signs should be documented in the vital section and a fall follow up in the nurse progress notes. The fall follow up protocol is for 72 hours there should be a neurological check, vital signs and body chart completed. Vital signs should be checked every 8 hours and skin needs to be documented on every 12 hours. On 2/11/26 at 3:05 PM, Staff GG, LPN stated remembered staff told [Staff GG] Resident #11 was on the floor so [Staff GG] went in her room. She (resident) did not complain of pain and [Staff GG] moved her arm and legs and she did not have any pain that night. No skin tears, no redness, no warmth or bruising. Staff GG explained worked the 6AM to 6PM that day, and another nurse came on after that. Per Staff GG, did pass it along to the other nurse, and could not remember who followed [Staff GG] that night. Staff GG further explained typically would document for assessment follow up, and it was different at this facility. Staff GG explained did the whole thing wrong because the next morning, they went into chart on it and [Staff GG's] assessment was wrong. The Administrator and Director of Nursing (DON) said they had to redo it because it was wrong, they had taken what [Staff GG] had written and put on the correct assessment. Per Staff GG, for follow up, nobody showed [Staff GG] how to do it correctly, and the next day [Staff GG] just went and did an nurses progress (continued on next page)

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	165513	A. Building B. Wing	02/12/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	note and that is when [Staff GG] found her ankle. Staff GG further explained every shift after the fall should have an assessment included head toe, pain, vital signs with it and should do range of motion if complaints of pain. Per Staff GG, the next morning [Staff GG] started their shift and after report the CNA came to [Staff GG] and said her ankle really hurts her, it was already terribly bruised, swollen and she could not move it, and Staff GG explained could tell by looking at it was probably broke. Staff GG explained didn't know if she (resident) didn't complain of any pain through out the night but it was the first thing told CNA in AM. Staff GG explained they were a nurse at their (current facility's) sister facility, did not have orientation or training about anything, was asked me to fill in, and was given an overview of what needed to be completed but nothing with paperwork. Staff GG explained they just figured it was the same as the other facility, they have the same electronic health record, and further explained it was completely different at this facility. On 2/12/26 at 12:03 PM, the DON stated at the time of the fall, the staff who found the resident assist them to stay in place, immediately assess before moving, and do vital signs and provide for safety. They initiate neurological checks on head strike or unwitnessed falls. The DON expected staff to assess for pain and reassess pain post fall, and would go back more frequently with any fall follow up in an hour to two hours at the most. The DON explained should document that in the electronic health record. Normal fall protocol is every 15 minutes x 1 hour and 30 minutes for the next couple hours. Per the DON, had to look at it to make sure what it was exactly, it was a blank excel template. Per the DON, would expect vitals to be documented, the DON knew falls have been a concern, and it was an area that [DON] had identified for a performance improvement project. Per the DON, did have a fall process. The DON explained wouldn't know the answer to how often an assessment should be completed after a fall, the computer triggered it, and [DON] could see if I had the paper. They should have documented before the next morning on Resident #11. The Facility Policy titled Falls - Clinical Protocol revised March 2018 directed the staff, with the physician's guidance, will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma have been ruled out or resolved. a. Delayed complications such as late fractures and major bruising may occur hours or days after a fall, while signs of subdural hematomas or other intracranial bleeding could occur up to several weeks after a fall.

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	165513	A. Building B. Wing	02/12/2026

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observation, clinical record review, facility documentation, resident interview and staff interview the facility failed to ensure 2 of 3 residents observed for room trays received their meals in a timely manner (Residents #31 and Resident #104). The facility reported a census of 94 residents. Findings include: 1.The Minimum Data Set (MDS) for Resident # 31 dated 11/19/25 documented a Brief Interview for Mental Status (BIMS) score of 15/15, indicating no cognitive impairment.During an observation on 2/5/26 beginning at 9:30 AM, Staff J, Restorative Aide, Staff K, Certified Nursing Assistant (CNA) and Staff L, CNA were heard at the nurses station on Bluff View discussing that Resident #31 just woke up and did not have a breakfast tray. During an interview on 2/5/26 at 10:30 AM, Resident #31 explained she did not get breakfast and no one woke her up for breakfast. She explained she does not get meals frequently and her son bought her a mini fridge for her room so she would always have food available. A mini fridge was observed between the bed and dresser. When asked if she wanted breakfast, she said since it was so close to lunch, she would have a doughnut for breakfast that her family provided. A gallon size zip lock bag was observed on her overbed table with 4 doughnuts with frosting and sprinkles. The facility document titled Documentation Survey Report v2 for February 2026 documented NA for breakfast on 2/5/26. Per the code at the bottom of the page on the report, NA meant not applicable. 2. The MDS for Resident #104 dated 2/2/26 revealed a BIMS score of 15/15, indicating no cognitive impairment. During an observation on 2/10/26, meal trays were delivered to Bluff View at 11:40 AM. At least 4 trays had orange sticky notes identifying the resident to get the tray, other trays had a meal ticket identifying the resident to receive the tray. The trays were distributed to residents. At 11:46 AM staff called dietary over the walkie talkie to report that Resident #104 did not have a tray on the cart. No response was received over the walkie talkie. At 12:11 PM, Staff R, CNA answered Resident #104's call light. The resident reported to Staff R that she had not had lunch yet. At 12:17 PM, Staff R delivered a room tray to Resident #104. Review of meal times document provided by the facility documents breakfast 7:15 AM to 9:00 AM and lunch 11:15 AM to 12:15 PM. During an interview on 2/10/26 at 12:18 PM, the Certified Dietary Manager (CDM) explained the dietary staff are notified a resident needs a meal tray by the meal ticket. If it is last minute, the CNAs call down on the walkies. She further explained meals are tracked by keeping the tickets and there has never been a problem with residents not getting served. On 2/11/26 at 2:51 PM, the Director of Nursing (DON) reported the CNAs were responsible for taking the trays to the rooms and documenting the intakes. She reported she expected residents to offered 3 meals a day.

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	165513	A. Building B. Wing	02/12/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review and staff interview the facility failed to provide appropriate practices to prevent the spread of infection during wound care for 1 of 2 residents observed for wound care (Resident #80). The facility identified a census of 94 residents. Findings include: Review of the Minimum Data Set (MDS) assessment for dated 1/14/26 revealed Resident #80 had severely impaired cognitive skills for daily decision making. Review of the Hospice order for wound care to Resident #80's left knee dated 2/4/26 revealed to cleanse left knee wounds with wound cleanser, apply triple antibiotic ointment, non adhesive dressing and wrap with cotton gauze twice a day and as needed. May discontinue when no longer draining and healed. On 2/05/26 at 11:02 AM, Staff E, Licensed Practical Nurse (LPN) provided wound care to abrasion on the left knee of Resident #80. Staff E removed the dressing from the left knee and cleansed the wounds. Staff E did not remove gloves or wash hands after she cleansed the wound Staff E used her index finger and applied triple antibiotic from the tube to each of the four areas on the left knee three of the areas were open skin. Staff E did not use a different finger or an applicator to put the ointment on the wound. On 2/12/26 at 8:54 AM, Staff U, Registered Nurse (RN) stated gloves should be changed after removal of soiled dressing for wound care and wash hands. He revealed he would use a sterile applicator for each area to put ointment on a wound. On 2/12/26 at 9:16 AM, Staff V, RN explained set up supplies, clean the wound, and take gloves off and wash hands. Per Staff V, they would put ointment with gloves on, and should change gloves with each area. If in same area could use the same gloves, take off gloves and wash hands, and apply clean dressing. On 2/12/26 at 10:03 AM, Staff W, LPN, facility wound nurse stated she noticed Staff E put the ointment for Resident #80's left knee wound on her gloved finger and she would have expected her to use an applicator. She also noted she should have cleaned her hands between cleansing the wound and applying the ointment. On 2/12/26 at 12:00 PM, the Director of Nursing stated staff should wash hands and change gloves between cleansing the wound and applying an ointment. Ointment should be applied with an applicator and each wound area should get a different applicator. The facility provided a policy titled Wound Care with a revision date of October 2010 which directed staff after removal of dressing to remove gloves, wash and dry hands thoroughly. The policy directed to use no-touch technique. Use sterile tongue blades and applicators to remove ointments and creams from their containers.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on record review, staff interview, and policy review the facility failed to offer and/or administer the influenza vaccine for 2 of 5 residents reviewed (Residents #19 and Resident #64). The facility reported a census of 94 residents. Findings include:1. The annual Minimum Data Set (MDS) for Resident #19 dated 9/03/25 included diagnoses of personal history of pulmonary embolism (when a blood clot gets stuck in an artery in the lung, blocking blood flow) and localized edema. The Brief Interview for Mental Status (BIMS) assessment was blank and the staff assessment indicated the resident's cognitive skills for daily decision making was moderately impaired. An immunization consent form dated 10/29/25 documented the Infection Preventionist/Assistant Director of Nursing (IP/ADON) spoke to the resident's Power of Attorney (POA) who gave verbal consent for the COVID vaccine, influenza vaccine, and Respiratory Syncytial Virus (RSV) vaccines. A document titled Iowa Immunization Registry Information System (IRIS) revealed Resident #19 received the influenza (flu) vaccine in 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, and January 2025. An email dated 2/10/26 at 1:22 PM from the IP/ADON indicated the facility had consent for the flu vaccine for fall of 2025 but Resident #19 and their spouse adamantly refused vaccination. The facility was unable to provide documentation that the resident or their spouse refused the vaccine after consenting. 2. The quarterly MDS for Resident #64 dated 12/10/25 revealed a Brief Interview for Mental Status (BIMS) assessment score of 11/15, which indicated moderately impaired cognition. The MDS revealed the resident did not receive the influenza vaccine in the facility for this year's influenza vaccination season, with none of the above as reason the influenza vaccine not received. The resident's IRIS revealed Resident #64 received the flu vaccine in 2017, 2018, 2019, 2021 (2020 variant), 2021, 2022, 2023, and 2024. An email dated 02/10/26 at 1:22 PM from the IP/ADON indicated the facility did not have consent for the vaccines on file, and the resident did not have a vaccine at the facility. Progress notes for resident #64 did not document why the resident was not offered or given the vaccine. An interview with the Director of Nursing (DON) and IP/ADON on 2/11/26 at 12:41 PM revealed resident vaccinations were completed in the fall. The facility used the IRIS documentation as part of the admission process for vaccination status and the facility would administer them in consultation with the physician. Verbal or written consent would be obtained prior to administration and documented. A policy titled Influenza Vaccine revised March 2022 documented all patients with no medical contraindications to the vaccine would be offered the influenza vaccine annually. The vaccine would be offered between October 1 and March 31 and/or within 30 days of the patient's admission to the facility. Refusal of the vaccine would be documented on the informed consent and placed in the medical record.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, record review, and interview the facility failed to ensure nursing department staffing information was posted with the required information on a daily basis for 3 of 6 days of the survey. The facility reported a census of 94 residents. Findings include:Observations of the staff posting by the nurses station included the following: On 2/04/26 at 12:09 PM the staff posting was dated 2/02/26.On 2/05/26 at 10:54 AM the staff posting was dated 2/04/26.On 2/10/26 at 12:08 PM the staff posting was dated 2/09/26. On 2/10/26 at 11:05 AM, the staff posting on the wall outside of the SS Unit (memory care) showed a date of 2/06/26. On 2/11/26 at 1:04 PM the Director of Nursing (DON) stated the only staff posting was by the nurses station. She said the scheduler was responsible for emailing it to the charge nurse, including the weekend schedule for posting. The DON stated third shift usually took care of it and would not forget because they didn't want the aides asking about it all day. She was not aware there were postings missing. Documents provided by the facility for 2/01/26 through 2/11/26 titled [Facility Name] Report of Nursing Staff did not include a staff schedule for 2/03/26. Documents provided by the facility for 2/01/26 through 2/11/26 titled [Facility Name] - SS Unit Report of Nursing Staff did not include staff schedules for 2/01/26, 2/03/26, or 2/04/26. They documented Certified Nurses Aides (CNAs) assigned to the area and did not include Registered Nurse (RN) or Licensed Practical Nurse (LPN) coverage for the area. On 2/12/26 at 1:23 PM, the Administrator acknowledged the gaps in staff posting and stated the DON was aware of it and would address it.