STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165556	A. Building B. Wing	09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnycrest Manor	2375 Roosevelt Street 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, clinical record review, staff and resident interviews, and facility policy, the facility failed to ensure staff treated each resident with dignity and respect for one of four residents reviewed (Resident #1). The facility reported a census of 75 residents. Findings include:The MDS (Minimum Data Set) dated 7/30/2025 revealed Resident #1 had no cognitive impairment, required set up assistance with eating, required staff assistance to transfer from one surface to another, and used a wheel chair for mobility. The resident had diagnoses including legal blindness, hard of hearing, depressive disorder and anxiety.The resident's Care Plan revealed the resident had verbal aggression and outbursts related to mental illness initiated 9/11/2013. At times of increased agitation and difficulty with communication, it instructed staff to ensure the resident's cochlear processor (external component of cochlear implant) is placed with charged batteries. The resident, being blind and deaf required the cochlear implant in order to hear. The Care Plan directed staff to monitor the resident's eating and encourage him to eat slowly and alternate liquids and solids. The Facility Incident Investigation dated 8/1/2025 included: On 7/29/2025 the resident exhibited loud verbal outbursts and unsafe eating throughout the mealtime. Staff A, CNA (Certified Nursing Aide) told the resident he needed to leave the dining room. As Staff A transported the resident via his wheel chair towards the elevator, a witness observed Staff A remove the resident's processor (hearing device) from his head and place it in his pocket. Staff A placed the processor prior to arriving on the resident's third floor. Nurse managers were notified and separated the resident from Staff A. Staff A admitted to removing the processor and stated he thought it would help calm the resident down. Removing the processor left the resident without the ability to hear. On 9/2/2025 at 3:50 p.m., Staff B, Administrator reported she reviewed facility camera footage from the evening of July 29. She observed an incident with the resident's chicken, but he ate his food. The resident got upset but could eat his food after staff cut it up. She could not see Staff A remove the processor, but camera footage of inside the elevator allowed her to see him replace it. Staff A reported he thought it would calm the resident down. All staff were re-educated on the abuse policy after the incident occurred. On 9/2/2025 at 11:30 a.m., Staff C, CNA reported worked during the evening shift on July 29. In the dining room during dinner, she and Staff A were in the dining room assisting residents. They gave Resident #1 verbal cues and feared he would choke. Staff A took the resident's meat off the bone, and cut it up. The resident got upset and accused staff of stealing it. Staff A and Staff C assured the resident they only cut the meat up. Staff A appeared frustrated because the resident crammed food in his mouth and refused to listen. The resident did finish his food. Staff A removed him from the table, said I am just going to take him upstairs, he is done and is getting upset. Staff A took him towards the elevator, closest to the front door. Staff C continued to observe residents in the dining room and did not see Staff A remove the resident's processor. On 9/2/2025 at 2:36 p.m., Staff D, CNA reported worked on July 29. During the evening meal, Staff D assisted residents in the dining room. Resident #1 thought he had more chicken. Staff A informed him he had no more chicken, and that he ate it all. The resident insisted he had more. Staff A told the resident he was going to take him out of the dining room because of his disruptive behavior. The resident called Staff A names. Staff D observed Staff A remove the resident's processor and put it in his pocket. Staff D notified the nurse manager. During a phone interview on 9/2/2025 at 10:17 a.m., Staff A reported during the evening meal on July 29, the resident shoveled food into his mouth. Dietary took awhile getting the resident chicken his family had left for him the day before, and that upset the resident. Staff reminded him to slow down, but the resident refused to listen. When Staff A took the resident's chicken and cut it up into bite size pieces to prevent choking. That angered the resident. When the resident completed his meal, Staff A removed him from the table. The resident yelled at Staff A as he pushed his wheelchair towards the elevator. Staff A revealed the resident's behavior frustrated him and he removed the resident's processor. Staff A put the processor on once they were in the elevator. Staff A told the resident he needed to calm down, and had been eating too fast. Staff A thought removing the processor would calm the resident down. He replaced it after less than a minute. Staff A reported the facility terminated his employment due to his decision to remove the resident's processor. Observation during the noon meal on 9/2/2025 revealed staff sat with the resident and provided constant cues and reminders to eat slowly, eat one bite at a time and take a drink in between bites. The resident had episodes of coughing and staff asked him to take one bite at a time. On 9/2/2025 at 1:00 p. m., the resident sat in his room in a wheel chair. The resident said Staff A was pretty good, and some staff were fired because they did not perform as they should. When asked if Staff A ever removed his processor