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	03/05/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, Center for Medicare and Medicaid (CMS) Long-Term Care (LTC) Facility Resident Assessment Instrument (RAI) 3.0 User Manual, and staff interview the facility failed to accurately code a diagnosis for 1 of 1 resident reviewed for hospitalization (Resident #7). The facility identified a census of 72 residents.Findings include:Resident #7's Electronic Medicare Record (EMR) Census showed the resident transferred to the hospital on 1/3/26.Resident #7's 1/3/26 chest x-ray under Impression documented findings suggesting congestive heart failure exacerbation with pulmonary edema (a progressive condition where the heart muscle cannot pump blood efficiently enough to meet the body's needs, causing blood to back up and fluid to build up (congestion) in the lungs, legs, and other tissues).A 1/7/26 Hospital Medicine Discharge Summary documented Resident #7 had a diagnosis of acute heart failure with preserved ejection fraction (HFpEF, congestion of the heart caused by increased stiffening and high filling pressure in the heart which causes severe shortness of breath and fatigue) exacerbation (flare up).Resident #7's MDS dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 15/15 indicating intact cognition. The MDS diagnoses list lacked documentation of heart failure (from the most recent hospitalization).The MDS dated [DATE] also lacked a documentation of a diagnosis of heart failure.A 3/3/26 review of Resident #7's Care Plan lacked direction to the staff on how to monitor for congestive heart failure. A review of the January 2026 Electronic Medication Administration Record (EMAR) showed an active order for a daily diuretic medication for a diagnosis of congestive heart failure and daily monitoring of the resident weights for fluid retention. During an interview on 3/4/26 at 10:00 AM the MDS Coordinator reviewed Resident #7's EMR Medical Diagnoses List, then reviewed Resident #7's 1/7/26 Hospital Discharge Summary. She reported at the time she completed Resident #7's 1/13/26 MDS the facility had not received the hospital records. She confirmed the Hospital Medicine Discharge Summary had a diagnosis of heart failure that should have been coded on the 1/13/26 MDS. She reported they use the RAI manual for coding the MDS. The CMS LTC RAI User's Manual, October 2025, Version 1.20.1, Page 1-4 documented the RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require the assessment accurately reflects the resident's status. The RAI User's Manual directed to identify current/active diagnoses. The disease conditions require a physician-documented diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 60 days. Medical record sources for physician diagnoses include progress notes, the most recent history and physical, transfer documents, discharge summaries, diagnosis/problem list, and other resources as available. If a diagnosis/problem list is used, only diagnoses confirmed by the physician should be entered. Code active diagnoses that have a direct relationship to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.

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

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

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F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review the facility failed to provide 1 of 1 resident unable to carry out activities of daily living (ADLs) with the services necessary to maintain good personal hygiene (Resident #69). The resident had a brown substance under his nails for 3 days during the survey. The facility reported a census of 72 residents.Findings include:Resident #69's Minimum Data Set (MDS) dated [DATE] identified they had okay short-term memory with moderately impaired decision-making skills for daily decisions. The MDS included diagnoses of mild intellectual disability, legal blindness, and altered mental status. Resident #69 required partial/moderate assistance with personal hygiene. A Care Plan (CP) intervention revised 12/16/25 listed certified nurses' aides (CNAs) and nurses as responsible for checking Resident #69's nail length. The Intervention directed them to trim and clean nails on bath day and as necessary. Resident #69's March 2026 Documentation Survey Report indicated they had a shower on 3/2/26. On 3/2/26 at 2:21 PM Resident #69 held out his hands and stated his fingernails and toenails needed to be trimmed. Observed the nails less than 1/4 inch longer than the top of his fingers with a brown substance noted under 2 nails on his left hand and one nail on his right hand. On 3/4/26 at 9:36 AM a second observation revealed Resident #69's nails remained the same length. Observed a brown substance under 4 nails on the right hand and 3 nails on the left hand with a jagged pinky nail on his left hand. Resident #69 reported his nails still needed trimmed and cleaned. He didn't think someone checked them since Monday. On 3/4/26 at 9:38 AM Staff A, Registered Nurse (RN), stated CNAs monitored skin and nails on at least the bath day. If they were long the nurses clipped them. She stated they worked together to get it done if needed.On 3/5/26 at 8:13 AM Staff B, Clinic Unit Nurse Supervisor, stated if a resident was diabetic the nurses cut their nails and if not, a CNA could clip them. She expected the staff to check and clean nails on bath days, as part of the skin assessment, and as needed. On 3/5/26 at 10:39 AM the Administrator described the care for Resident #69's nails as unacceptable and asked Staff B to address it.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, document review, policy review and staff interview the facility failed to provide an updated pneumococcal vaccination per the Center for Disease Control and Prevention (CDC) Immunization schedule for 1 of 5 residents sampled (Resident #7). The facility identified a census of 72 residents.Findings include:An Electronic Healthcare Record (EHR) Census documented Resident #7 admitted to the facility on [DATE]. The Census Record listed Resident #7 as [AGE] years old. The Immunization Care Plan initiated 9/15/25 contained a Goal Resident would accept screening process for immunizations and directed to administer the vaccines. A review of the Pneumococcal Immunization Consent Form showed Resident #7 signed a consent to receive an updated pneumococcal vaccination on 10/3/25.The EHR Census Record documented Resident #7 discharged to the hospital on 1/3/26.A 1/3/26 Hospital Transfer Summary documented a history of pneumonia from 10/8/25. A 1/7/26 Hospital Medicine Discharge Summary documented Resident #7 hospitalized with a diagnosis of acute hypoxic respiratory failure.A review of the Progress Notes from 1/7/26 - 1/19/26 documented Resident #7 received post hospitalization skilled services due to a diagnosis of pneumonia. Resident #7 Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating intact cognition. The MDS listed a diagnosis of pneumonia. The MDS Assessment listed Resident #7's pneumococcal vaccination status as up to date. A 3/2/26 review of Resident #7's EHR Immunization Record documented they had a pneumococcal vaccination pending with a confirmation date of 10/3/25. The Immunization Record documented Resident #7 received a pneumococcal dose 1 on 8/19/16 and dose 2 on 10/18/18.A 3/2/26 facsimile to the Provider documented Resident #7 received a Pneumococcal Conjugate Vaccine (PCV) 13 on 8/19/16 and a Pneumococcal Polysaccharide Vaccine (PPSV) 23 on 8/9/16 (dates did not match the EHR Immunization Record) and inquired if wanted Resident #7 to have a PCV 20 vaccination. A 3/3/26 review of Resident #7's Progress Notes from 1/7/26 to 3/3/26 and review of the January, February and March 2026 Electronic Medication Administration Records (EMARs) lacked documentation Resident #7 had contraindications to receive the vaccination, received an updated pneumococcal vaccination or rationale why the vaccination was not administered.A review of the Physician Orders from 1/7/26 to 3/4/26 lacked documentation of order to hold the pneumococcal vaccination. A 3/3/26 at 6:08 PM Health Status Progress Note documented the facility prepared a facsimile for the provider regarding the pneumococcal vaccination and requested orders. On 3/4/26 at 11:46 AM the Infection Preventionist (IP) explained the resident is still on the problem list regarding her pneumococcal vaccination. Resident #7 had several hospitalizations and they wanted her to be well enough to take the pneumococcal vaccination. The immunization screening should be done upon admission. It is newly on the Problem list this week (3/3/26). She didn't think their current policy addressed the Problem List. She stated all the nurses needed to assist with getting the vaccinations completed in a timely manner. A 3/4/26 review of the Problem Lists from 1/7/26 to 3/2/26 provided by the facility lacked documentation the facility had addressed an updated pneumococcal vaccination with the provider.During an interview on 3/4/26 at 3:16 PM the IP reported they need to do comprehensive education to the nursing staff on the importance of vaccinations. The education and consent were addressed, but then there was no follow through to get the vaccination completed. She is working on the follow through with the nurses. A 3/4/26 at 5:26 PM Health Status Note documented the facility received an order to give an updated pneumococcal vaccination.The Resident Immunization Guidelines reviewed February 2026 documented a Purpose to offer immunizations to residents in an effort to prevent or minimize communicable diseases including respiratory infections that are known to adversely affect the quality of life in the elderly, debilitated and immunocompromised. The Policy directed the following:a. the facility would follow the recommendations of the CDC for the prevention of pneumococcal infections, including immunization (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	offerings;b. a physician order would be obtained for the vaccination;c. a registered nurse (RN) or licensed practical nurse (LPN) would administer the vaccination according to the manufacturer and pharmacy recommendations.The Policy under Pneumococcal Vaccine directed if it had been five years since the last pneumococcal vaccination see the CDC guidelines. The CDC Adult Immunization 2025 Schedule directed for routine pneumococcal vaccination for adults over [AGE] years of age who previously received both the PCV13 and PPSV23, and the PPSV23 was received at age [AGE] years or older based on shared clinical decision-making, provide 1 dose of PCV20 or 1 dose of PCV21 at least 5 years after the last pneumococcal vaccine dose.