

**Department of Inspections, Appeals, and Licensing
Health & Safety Division
Citation**

Citation Number #11198		Report Date July 29, 2026		
Facility Name Lutheran Living Senior Campus		Survey Dates July 15, 2026 to July 21, 2026		
Facility Address 2421 Lutheran Drive				
City Muscatine, IA 52761				
KG				
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date
50.7	481—50.7(10A,135C) Additional notification. A health care facility shall notify the department within 24 hours, or the next business day, by the most expeditious means available (I,II,III): 50.7(1) Of any accident-causing major injury. DESCRIPTION Based on clinical record review, staff interviews and facility policy review the facility failed to report an injury of unknown origin that resulted in serious bodily harm to the State Agency within the two-hour requirement for 1 of 1 resident (Resident #1) reviewed. The facility reported a census of 125 residents. Findings include: Review of the Facility Reported Incident submitted to the State Agency revealed: Date of Report: 6/29/26: Date of Event: May 7, 2026 Resident: [Name redacted, Resident #1] Nature of Report: Late self-report of an unwitnessed resident death with positional findings; reported upon supplemental QAPI (Quality Assurance and Performance Improvement) ... During an interview on 7/20/26 at 12:08 PM, Staff C, former Administrator stated the facility did complete a full investigation and timeline after the incident. He explained after reviewing with the facility physician,	Class II	\$500.00	Upon Receipt

If, within thirty (30) days of the receipt of the citation, you: (1) do not request a formal hearing or; (2) withdraw your request for formal hearing; and (3) pay the penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

Facility Administrator

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	the thought was Resident #1 passed away from natural causes and chose not to report the incident to the State Agency. Staff C stated in June the facility received a legal notice and the management company directed the incident be submitted as a self-report. He added the facility attorney advised a self-report also be submitted. During an interview on 7/20/26 at 12:12 PM, Staff B, former Director of Nursing (DON) stated she had discussed reporting the 5/7/26 incident to the State Agency, however Staff C, former Administrator stated he did not feel it was necessary. Staff B stated she deferred to Staff C as he did all of the reporting. Staff B added the facility assumed Resident #1 had a natural death and after they learned there was going to be an autopsy decided to wait until the results were available. During an interview on 7/21/26 at 12:30 PM, the Regional Director Quality and Clinical Services (RDQCS) stated she had a concern the May 7, 2026 incident of Resident #1's death had not been reported to the State Agency. Review of the facility policy titled Freedom from Abuse, Neglect, and Exploitation dated 11/2024 revealed, in part: It is the policy of this community to take immediate steps to prevent the occurrence of Abuse, Neglect and Misappropriation of resident property.			

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	It is also the policy of this community to take appropriate steps to ensure that all alleged violations of federal or state laws which involve mistreatment, neglect, abuse, injuries of unknown source, and misappropriation of resident property ("alleged violations") are reported immediately to the administrator of the community. If the events that caused the allegation involve abuse or serious bodily injury, it must be reported to the State agency immediately but no later than 2-hours after forming the suspicion per State and Federal regulation. Definitions: Injury of unknown source: Any injury should be classified as an "injury of unknown source" when both of the following conditions are met: a. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; b. The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. Reporting: a. Any employee who suspects an alleged violation immediately notifies the administrator. The administrator notifies the appropriate state agency immediately in accordance with state law. b. The results of all investigations are reported to the administrator and to the appropriate state agency, as			

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	required by state law and / or within five (5) working days of the alleged violation. c. The community reports to the State Nurse Aide Registry and licensure authorities any knowledge it has of any actions by a court of law which would indicate an employee does not or may not meet the requirements to work in a skilled nursing facility. d. The administrator, or his / her designee, notifies the resident's representative regarding the alleged violation and assessment findings and reassures the resident's representative that an investigation has been initiated and appropriate action will be taken. Note: "Immediately" means as soon as possible, but ought not exceed 24 hours after discovery of the incident, in the absence of a shorter state time frame requirement. FACILITY RESPONSE			

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