STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165578	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Muscatine	3440 Mulberry Avenue Muscatine, IA 52761

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on clinical record review, facility policy review, and staff interviews, the facility failed to prevent both verbal and physical abuse of a dependent adult resident, for 1 of 4 residents reviewed (Resident #1), that resulted in the resident's physical injury. The facility reported a census of 62 residents.Findings include:A Facility Reported Incident, dated 8/7/25, documented Resident is impaired for cognition, and has a BIMS (Brief Interview for Mental Status) of 11 (moderate cognitive impairment per the assessment scale) a staff witness reports that alleged perp (perpetrator) was being verbally and physically abusive with the resident. The witness reports seeing the alleged perp call the resident names, threaten her and then pull on the residents arm. No new injuries to the resident per the facility as she has scratches to her arms which were noted prior to the incident. The alleged perp reports that the resident was having behaviors all night and then when they went to get back to her room to get her changed, the resident had her finger and she and to pry her finger from the residents fingers as it hurt. The alleged perp reports that she didn't mistreat the resident. Review of Resident #1's Minimum Data Set (MDS) assessment tool, dated 5/15/25, a list of diagnoses which included diabetes, paranoid schizophrenia, anxiety, and depression. The BIMS score of 11 out of 15 points indicated a moderately impaired cognition. The MDS revealed Resident #1 had no potential indicators of psychosis such as hallucinations or delusions; and no physical or verbal behavioral symptoms towards others in the 7 days that preceded the assessment. The MDS described the resident with bilateral lower and upper extremity impairments. The resident required substantial to maximal assistance to reposition in bed, transfer to and from bed or chair, dressing, bathing and personal hygiene, frequently incontinent of urine and always incontinent of bowel. Review of the Care Plan, revised 10/05/23, revealed a Focus area to address [Name redacted, Resident #1] has a behavior problem related to schizo-affective disorder, paranoid schizophrenia, PARANOID PERSONALITY DISORDER, delusional disorder and hallucinations. Interventions included, in part: a. Assist [name redacted] to develop more appropriate methods of coping and interacting. Encourage [name redacted] to express feelings appropriately, initiated 10/3/19.b. Caregivers to provide opportunity for positive interaction, attention. Stop and talk with [name redacted] as passing by, initiated 10/3/19.c. Explain all procedures to [name redacted] before starting and allow the resident several minutes to adjust to changes, initiated 10/3/19.d. If reasonable, discuss [name redacted] behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident, initiated 10/3/19.e. Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed, initiated 10/3/19f. [Name redacted] often times believes that staff members are trying to hurt her, she needs redirected when she is having these thoughts, initiated 10/3/19.g. Know that resident frequently lifts up shirt, attempts to pull pants down in common areas. Staff to monitor and assist with redirecting behaviors when noted. Staff to complete 1:1 and offer resident activities. Staff to assist resident to room, when needed or request for privacy, initiated 11/4/24.h. Minimize potential for [name redacted] disruptive behaviors by offering tasks which divert attention, initiated 10/3/19.i. Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes, initiated 10/3/19.j. Resident frequently refuses cares from staff, initiated 8/7/25.Review of a Behavior Note, transcribed by Staff A, Registered Nurse (RN) on 8/7/25 at 5:49 a.m., revealed Description of behavior: Resident has been up all-night exhibiting behaviors. Vocalizing loudly and being very disruptive to room-mate. Will not keep her clothes on while out in tv room. Non-pharmacological interventions used: Attempted to give food ad fluids. Assessment for Pain: No pain. What interventions was used and was it effective: Comfort interventions ineffective. Review of an Incident Note transcribed by Staff B, Licensed Practical Nurse (LPN) on 8/7/25 at 10:15 a.m. revealed On 8/7/25 at 7:47 a.m. ED (Executive Director) [name redacted, Administrator] was notified by staff at nursing home that a resident had allegedly been physically and verbally abused by third shift RN. Head to toe assessment completed by ADON (Assistant Director of Nursing) and documented. Resident continues to demonstrate self-inflicted scratches that have been noted in skin assessment. Resident was resisting cares and attempting to get out of bed during the HS (hour of sleep) hours. Resident was not easily redirected throughout the night and continued to have behaviors. CNA (Certified Nursing Assistant) at station 1 notified nurse of alleged abuse, statement collected and given to ED. Notified local Police Department, Officer (name redacted) arrived to facility to collect statements. Spoke to sister regarding investigation. Physician notified, will be in house today to see resident