STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165579	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maquoketa Care Center	1202 German Street Maquoketa, IA 52060

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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, resident and staff interviews, and facility policy, the facility failed to provide a safe environment and protect one of seven residents reviewed from resident to resident abuse (Resident #2). On 4/19/26, Resident #1 stood over Resident #2 while Resident #2 was in a reclined wheelchair, and Resident #1 hit Resident #2 in the face with the handle of his cane 3 to 4 times. This deficient practice resulted in a slightly swollen eye for Resident #2 with bruising to the left cheek under Resident #2's eye. The facility reported a census of 37 residents.The facility corrected the deficient practice per past noncompliance through the following actions: -Medication Review for Resident #1 and Resident #2-Staff education on separation of residents-Physical Therapy (PT) evaluation for Resident #1-Psychiatric evaluation per Physician recommendationsFindings include:The MDS (Minimum Data Set) dated 4/1/2026 revealed Resident #1 had intact cognitive abilities for daily decision making, ambulated with a cane, and transferred from one surface to another without staff assistance. The resident had diagnoses including stroke, difficulty in walking and depression.Resident #1's Care Plan with a target date of 6/23/2026 included the resident had impaired cognitive function or impaired thought processes related to encephalopathy, history of TIA's (Transient Ischemic Attacks), and recent CVA (Cerebrovascular Accident), with the goal to be able to communicate basic needs on a daily basis. Initiated on 12/5/2025 the Care Plan directed staff to administer medication as ordered and monitor for side effects and effectiveness, use the resident's preferred name, identify yourself at each interaction, face the resident when speaking and make eye contact. Reduce any distractions and provide the resident with necessary cues - stop and return if agitated. On 4/20/2026, the Care Plan added: if staff notice that I am becoming agitated or having increased anxiety in common area, staff to assist me to quiet area and allow me time to de-escalate.An Incident Report dated 4/19/2026 at 7:45 a.m. revealed a resident to resident incident occurred in the dining room. A nurse heard commotion from the dining area while charting at the nurse's station. The nurse observed Resident #1 standing over Resident #2. Resident #2 sat against the east wall in a Broda (reclined wheel chair). Resident #1 hit Resident #2 in the face with the handle of the cane. Staff observed 3-4 hits before she could reach Resident #1 and obtain the cane. Resident #1 hit Resident #2 in the face with the handle of the cane. Resident #1 went back to the area where he normally eats breakfast. When asked why he got up and hit Resident #2, he replied because he ruins my life. Resident #1 then sat quietly at the table, and never asked for his cane back. Resident #2 had a slightly swollen eye, with slight discoloration. The resident (Resident #2) asked why Resident #1 did that to him. Staff immediately separated the residents, and initiated neurological checks on Resident #2. Staff notified the physician, administrator and on call nurse manager. Resident #2 injuries observed at the time of the incident: Bruise - face. Bruise started on the left cheek, under the eye, slightly swollen and measured 3 cm (centimeters) by 2.5 cm.Review of resident statements included as part of the facility's investigation revealed the following:a. Resident #1: On 4/19/2026, at approximately 0750 (7:50 AM), facility nurse asked [Resident #1] what happened, [Resident #1] stated, he [Resident #2] ruins my life and he called me a son of a b**ch. Facility ADON (Assistant (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165579	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maquoketa Care Center	1202 German Street Maquoketa, IA 52060

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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Director of Nursing) interviewed [Resident #1] again at approximately 0900am on 04/19/2026. Facility ADON noted that resident stated that [Resident #2] said to him you dirty rotten son of a b**ch. Facility Administrator interviewed [Resident #1] again on 04/20/2026 noting that [Resident #1] stated that they were conversing as normal when [Resident #2] changed conversation tone. Facility administrator educated resident on asking for help from facility staff. Facility administrator and facility ADON educated [Resident #1] on behavior toward other residents and not resulting to violence.b. Resident #2: On 4/19/2026 at approximately 0750 (7:50 a.m.), [Resident #2] stated to facility nurse why did he do that? Review of the Reasonable Explanation section of the Facility Investigation revealed, in part, It is reasonable to believe that [Resident #2] misheard what [Resident #1] had said that aggravated him. It is reasonable to believe that [Resident #1] misinterpreted what [Resident #2] had said causing [Resident #1] to become defensive and strike [Resident #2] with his cane. A progress note dated 4/19/2026 at 9:54 a.m. documented Resident #1 involved in incident this morning with another resident. Upon identification of incident, resident was immediately separated from the other resident. Administrator, physician and family notified. Resident continued to be separated from other resident and behaviors will be monitored. Statement obtained from resident.A progress note dated 4/19/2026 at 10:22 a.m. included the facility sent a fax to the physician to look through Resident #1's medications, with provider recommendation for no change at this time. Review of Condition Report/Communication Forms for Resident #1 revealed the facility requested an order from the physician for PT (Physical Therapy) to evaluate and treat. The physician ordered PT as well as a Psych evaluation on 4/23/2026. Observation on 5/12/2026 at 12:15 p.m. revealed Resident #1 seated at the dining room table near the nurse's station, the west end of the dining room, with his cane nearby. The resident ate his noon meal independently with his right hand and adaptive silverware. The resident appeared alert, engaged, and calm.Observation on 5/12/2026 at 1:50 p.m. revealed Resident #1 lying in bed on his right side facing the door, awake and alert. The resident reported no residents ever wandered into his room. He denied having friends at the facility. Observation on 5/13/2026 at 11:30 a.m. revealed the resident in bed, alert and verbal. When asked if he had an incident with Resident #2, he replied yes. When asked what happened, he replied he called me a worthless son of a b**ch, and that is why I hit him.2. Resident #2's MDS dated [DATE] revealed he had moderately impaired cognitive skills, dependent on staff for transfers using a mechanical lift, used a wheelchair for mobility, required supervision with eating, and had a diagnosis of dementia.Resident #2's Care Plan revealed he required assistance with ADL's (Activities of Daily Living). On 8/23/2021 the care plan added: per family, he may become short tempered. It directed staff to allow him to voice his frustrations, and he may ask staff to leave his room. On 4/1/2026, the Care Plan indicated comfort was to be the primary focus of care.The Care Plan addressed the resident's cognitive function/impaired thought processes related to dementia diagnosis that results in his frustration exhibited with verbal behaviors. It instructed staff to provide safety and allow him time to self-deescalate if he became agitated and/or showed signs of agitation by becoming verbally aggressive. Have a different staff reproach him at a later time when able. Initiated on 12/12/2023.Resident #2's progress notes 4/19/2026 at 10:11 a.m. included: Resident was involved in an incident at approximately 7:45 a.m. After completion of head to toe assessment, resident obtained a small bump/bruise measuring 3.0 by 2.5 cm. Administrator, physician notified and message left with family to call back.The progress note on 4/19/2026 at 10:41 a.m. revealed staff provided neurological and vitals assessments. The resident denied pain in the area and refused ice. Observation on 5/12/2026 at 12:20 p.m. revealed Resident #2 in a Broda chair with his noon meal on a tray table positioned in front of him. He wore sun glasses and a baseball cap. He ate independently with a spoon. His beverages were served in cups with straws. He sat at the east side of the dining room near the window with staff present.Observation on 5/13/2026 at 7:30 a.m. revealed Resident #2 in the Broda chair near the east side of the dining room eating breakfast with set up assistance of staff.On 5/13/2026 at 8:50 a.m. Resident #2 sat upright in bed after staff provided a shower. He wore a gown (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165579	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maquoketa Care Center	1202 German Street Maquoketa, IA 52060

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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	and a baseball cap. The resident had a light yellow bruise under his left eye. When asked what happened to cause the bruise, the resident answered I do not know. When asked if someone had hit him, he answered must have. When asked what could do to make life better for him while living at the facility, he answered I can't think of anything.On 5/13/2026 at 10:30 a.m., Staff A, Administrator reported Resident #1 and Resident #2 were prior roommates, however Resident #2 preferred to stay up late and have his television loud which affected Resident #1's sleep. Resident #1 moved to another room in the same hall. Resident #1 never showed aggressive behavior prior to this incident. Resident #2 states things but is easily redirected. Staff A felt Resident #1 got tired of Resident #2 saying things to others. Staff separated the two residents in the dining room, staff were educated to continue the separation and they have had no further incidents. Staff D, RN (Registered Nurse) worked at the time of the incident. Staff C, ADON (Assistant Director of Nursing) came to the facility in response to the incident. Staff A educated staff to maintain the separation during the investigation. The facility uses a group chat where all staff are notified at the same time. The incident occurred on a Sunday. On Monday, Staff A verbally spoke to staff, nursing and dietary about the separation. They found the separation successful and continued with it. Resident #2 had some incidents in the past which prompted medication changes and they have seen improvement. No other resident has ever struck Resident #2. The facility followed up appropriately, immediately separated the residents, initiated the investigation and notified state.On 5/13/2026 at 10:42 a.m., Staff C, ADON reported working at the facility for two years. She got a call from Staff D, RN stating Resident #1 hit Resident #2 in the face with his cane. Staff C reported to the facility and assessed Resident #2. He had a bruise under his left eye. Resident #1's current roommate said he felt safe. When she asked Resident #2 if he felt safe, he replied I was in a fight. Resident #1 is not an aggressive man, and there have been no further behaviors. Resident #1 said Resident #2 had been talking crap about some of the female residents and he could not take it any longer.On 5/14/2026 at 12:01 p.m. Staff D, RN via phone, reported working the day of the incident between Resident #1 and Resident #2. She had worked the night shift but was still at the facility. She had just completed doing a narcotic count in the medication room, walked out and planned to sit at the nurse's station to complete her charting. She heard a commotion, observed Resident #1 with his cane in the air, hitting Resident #2. Resident #2 normally did not sit near Resident #1's table. She saw the cane, ran over and grabbed it from Resident #1. Resident #2 wore a baseball cap which prevented the cane from directly hitting his face. She assessed the residents, assisted Resident #2 to his room and bed, and called the Administrator. Resident #1, normally a sweet man, never showed any aggressive behaviors prior or since. Resident #2 makes comments under his breath. Resident #1 said something about Resident #2 making his life miserable.On 5/13/2026 at 9:00 a.m., Staff B, DON (Director of Nursing) reported Resident #1 had a physician's referral for a psych evaluation at [Hospital Name Redacted]. They are waiting on insurance verification prior to setting up an appointment. Her understanding of the incident involving Resident #1 and Resident #2 is that Resident #2 threatened Resident #1, and he got up from the table, took his cane and hit him. They separated the residents, did urinalysis on both residents, and requested medication reviews with no changes made. Resident #1 had a physical therapy evaluation related to his ambulation. Therapy continues to work with him, is doing well, however the only option is to give him a walker instead of a cane at this time. He continues to use a cane. The facility Resident to Resident Incident Policy and Procedure, undated, included, It is the policy of this facility to ensure the safety, dignity, and well-being of all residents. Any resident-to-resident incident resulting in actual or potential physical, emotional, psychological, or sexual harm will be addressed immediately, thoroughly investigated, appropriately documented, and reported in accordance with applicable federal regulations .and facility abuse prevention policies.Resident-to-resident incidents may constitute abuse and will be evaluated under the facility Abuse Prevention, Identification, Investigation, and Reporting Policy.The policy defined as resident to resident incident was any interaction between residents that results in or has the potential to result in: Physical harm, pain, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165579	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maquoketa Care Center	1202 German Street Maquoketa, IA 52060

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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	mental anguish, emotional distress, intimidation, sexual coercion or inappropriate sexual contact, psychological harm, or threats or aggressive behaviors. Examples included, but were not limited to, hitting, slapping, pinching, kicking, biting, pushing, throwing objects, verbal threats or intimidation, sexual behaviors or unwanted sexual contact, and harassment or coercion. The policy noted, Resident-to-resident incidents may be considered abuse under federal and state regulations.