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	07/02/2026

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	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, document review, policy review, resident and staff interviews, the facility failed to protect and provide a safe environment for 1 of 3 residents reviewed from resident-to-resident abuse (Resident #32). On 6/14/26 at 7:44 AM Resident #42 walked from his dining room chair over to Resident #32 who sat in a Broda wheelchair (specialty wheelchair) and struck Resident #32 on the left side of the head with his cane. This deficient practice resulted in a 5 Centimeter (CM) bump with a 1 CM lesion to Resident #32's head and facial bruising. The facility reported a census of 33 residents. The concern was identified and corrected June 16, 2026 with an all staff huddle to provide resident safety education, prior to surveyor entrance on June 29, 2026. The deficiency F600 is considered past non-compliance. Findings include:A Progress Note review of Resident #32 and Resident #42's charts revealed a prior resident-to-resident altercation in which Resident #42 struck Resident #32 in face with his cane several times which resulted in bruising to the eye and cheek on 4/19/26. 1. Resident #32's 6/3/26 Minimum Data Set (MDS) Assessment showed a Brief Interview for Mental Status (BIMS) score of 12 out of 15 indicating a moderate cognitive loss. Resident #32 was dependent upon staff for bed to chair transfers and did not walk. The MDS listed diagnoses of Non-Alzheimer's Dementia and depression. Resident #32's ADL Care Plan, target date 8/25/26, documented he was non-ambulatory, utilized a Broda chair for locomotion and was totally dependent upon staff to propel his wheelchair. The Care Plan Focus noted Resident #32 had potential verbally aggressive behaviors toward other residents related to dementia. The Care Plan specified to keep proper separation of the residents during an internal investigation of an incident from 4/19/26. If the resident had agitation and/or showed signs of agitation by becoming verbally aggressive, staff were to provide safety and allow time to de-escalate.An Incident Report dated 6/14/26 at 7:45 AM detailed Resident #32 was involved in a resident-to-resident altercation. Resident #32 was interviewed at 8:45 AM while sitting in his reclined Broda chair with ice on the left side of his head. Resident #32 had a 5 Centimeter (CM) by 2 CM bump with a 1 CM laceration in the center to his left forehead. Resident #32 stated he was sitting, minding his own business when Resident #42 walked by and struck him in the face. He didn't know what triggered (it) and felt unsafe around Resident #42. A 6/15/26 Provider signed Condition Report/Communication Form notified the Provider that Resident #32 was involved in a resident-to-resident altercation and new skin areas were noted. The Weekly Skin assessment dated [DATE] documented Resident #32 with bruising starting to the left hand, a skin tear bump inside above the left eye and a bump above the left eye.2.Resident #42's MDS assessment dated [DATE] documented a BIMS score of 13 out of 15 indicating intact memory. Resident #42 also had intact cognitive abilities for daily decision making, walked with a cane, and transferred from one surface to another surface without staff assistance. The MDS listed diagnoses of stroke and depression.Resident #42's 6/23/26 Care Plan Focus detailed he had the potential to be physically aggressive related to a history of resident-to-resident incident. The Care Plan directed the staff to note if becoming agitated or increased anxiety in the common area. Staff to assist to a quiet area and allow time to de-escalate; separate resident from another resident via room change while (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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F 0600 Level of Harm - Actual harm Residents Affected - Few	looking for placement at another facility; Resident #42 with a history of physical altercation with Resident #32. Staff to monitor and maintain separation between both residents. A 6/14/2026 8:45 AM Nurses Note written by the Director of Nursing (DON) documented she was contacted by the facility at 7:44 AM regarding a resident-to-resident altercation. She advised staff to assist Resident #42 to his room. She arrived at facility at 8:27 AM to interview residents and staff. Resident #42 was interviewed at 8:30 AM, while sitting in bed, in his room eating his cereal. Resident #42 was asked what happened. The resident stated, He got some more. The resident was asked, Why he hit the other resident with his cane? The resident stated, Because he deserved it. Inquired if the other resident had said or done anything to him that resulted in the incident. The resident stated, No, he was smiling about something. If he thinks he is going to get away with calling me a worthless son of a bitch, he has another thing coming. Asked again if the other resident said that to him this morning. The resident stated, No, from before. Then asked resident how many times he thought he hit the other resident. The resident stated, 4-5 times. Based on the conversation, it was determined the resident was still upset about the previous incident from April (4/19/26) and the incident (6/14/26) was unprovoked. The resident was asked if he were to see the other resident again, would he hit him for no reason? The resident stated, Yes. The staff reported the resident was sitting at his table (closest to wall of flowers, facing the wall with flowers) waiting for breakfast. The other resident was brought out and placed, in his Broda chair, next to the back medication cart approximately 15 feet from resident. The Resident had his back toward the other resident involved in the incident. There was one Registered Nurse (RN) and two Certified Medication Aides (CMAs) present in the main dining room when Resident #32 was brought out to the main dining room (MDR). The RN went to assist another resident in Hallway 2. One CMA went to assist a different resident in Hallway 2; two Certified Nursing Assistants (CNAs) were assisting a resident in Hallway 3, and one CNA was assisting a resident in Hallway 2. One CMA was standing at the front medication cart at the time of the incident. She stated she thought Resident (#42) was walking back to his room when he walked by her. The Resident (#42) is independent and comes and goes from the MDR at his leisure. The CMA glanced down at her computer screen when Resident #42 started striking Resident #32. Review of the Facility's Final Investigation revealed the following Direct Witness Statements:Staff H, CNA brought Resident #32 out to the dining room area and placed him next to the back medication cart. She thought placing him next to a staff member would be the safest in case anything happened while Resident #42 was eating breakfast in the dining room. She was in another resident's room when the incident occurred. She hadn't seen Resident #32 since she assisted him to the dining room and Resident #42 was at the dining room table waiting for breakfast. Staff F, CNA/CMA statement documented at approximately 7:44 AM, she was passing medications on the front medication cart when Resident #42 walked past her. She thought the resident was going back to his room. She glanced back down at the Medication Administration Record (MAR) on the computer and heard Resident #42 strike Resident #32. She looked up when Resident #42 struck Resident #32 with his cane. She immediately ran over and separated both residents and had Resident #42 go back and sit at his table. Staff I, Housekeeper statement documented she was behind the nurses' station cleaning the bathroom. She walked out of the bathroom to get rid of garbage when she saw Resident #42 get up from his table. She thought Resident #42 was going back to his room as he is independent. When she looked back up, she witnessed Resident #42 strike Resident #32 with his cane. She did not hear Resident #32 say anything to Resident #42 before the incident. Staff C, RN statement documented Resident #32 was sitting near the nurses' station on the [NAME] side close to the medication cart for Hallway 3/4. She informed the staff to keep an eye on Resident #42 and #32 before she left to go down hallway 2 to help another resident. Staff G, CNA/CMA statement documented at approximately 7:45 AM, she was at the back medication cart located on the [NAME] side of the nurses' station when Staff J, CNA called for help to walk a resident from their room to the main dining room. When she sat the resident down in dining room chair, she heard Staff F, say, No. No. No. When she turned around, she saw Staff F stopping Resident #42. She immediately paged Staff C (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	over the walkie talkie to come to the dining room. A review of the Facility Final Investigation included the following Resident Statements:Interview completed by the DON on 6/14/2026 at approximately 8:30 AM, Resident #32 was asked what happened this morning. Resident stated that he was sitting and minding his own business when Resident #42 walked by and struck him in the face. He didn't know what triggered that and felt unsafe around Resident #42. On 06/14/2026 at approximately 8:45 AM the DON conducted a resident interview with Resident #42. When asked why he hit the other resident, Resident #42 stated he believed Resident #32 deserved it. When asked if the other resident had said or done anything to him that resulted in the incident, Resident #42 stated there was nothing that triggered him in that moment. When asked again if the other resident said anything to him that morning, Resident #42 stated, No, from before. Based on conversation, it was determined Resident #42 was still upset about the previous incident and the incident (6/14/26) was unprovoked. The Administrator conducted another interview on 6/15/2026 with Resident #32. Resident #32 stated his head was sore but he didn't know what happened. When asked if Resident #32 felt safe in the building, Resident #32 stated he would if Resident #42 was not in the building. The Facility Final Investigation Root Cause Analysis determined the primary contributing factor was a failure to consistently maintain previously identified supervision and separation interventions between Resident #42 and Resident #32. Resident #42 remained fixated on the previous altercation and independently approached Resident #32, resulting in the resident-to-resident assault.A 6/29/26 review of Resident #32 and Resident #42's Electronic Healthcare Record Clinical Census revealed Resident #32 and #42 were roommates from 1/12/26 to 3/15/26. Further review revealed a Progress Note written by Staff J, RN which documented on 3/14/26 at 9:00 PM Resident #42 voiced he wished for a new room stating he was sick of his roommate's shit. He hadn't slept in three days and hadn't slept at all. His roommate would not be quiet or let him be. A 6/29/26 review of Resident #42's Clinical Record Progress Notes documented Resident #42 was discharged from the facility to another nursing facility on 6/15/25 at 1:15 PM. Observation on 6/29/26 at 12:40 PM Staff K, CNA assisted Resident #32 as he a sat in the Broda chair from the dining room to his room. Resident #32 did not show any fear of staff or other residents. In an interview completed on 6/29/2026 at 12:54 PM Staff K, CNA reported Resident #32 had been scared of Resident #42. Resident #42 hit him with his cane. There had been more than one episode of him hitting the resident with his cane. They kept Resident #32 in his room for meals and Resident #42 would eat out in the dining room to keep them separated. Staff K didn't feel Resident #32 was afraid of any residents now that Resident #42 was discharged from the facility.In an interview completed on 6/29/2026 at12:56 PM Resident #32 verbalized a while back another resident had hit him in the left side of the forehead with his cane. They had to move him once because of that. Then after he hit him again, they moved him out of the building. He felt safe now. Observation on 6/30/26 at 8:25 AM revealed Resident #32 sitting in a reclined Broda wheelchair in his room with a bedside table across his body. Resident #32 had his call light and his television was on. He showed no signs of distress. During interview on 6/30/2026 at 5:06 PM Staff F reported she was the only staff member in the (main) dining room at the time of the incident. She had positioned her medication cart facing toward the nurses' station so that her back was facing the residents in the dining room. Resident #42 got up from the dining room table, walked approximately 30 feet behind her heading down the 3 Hallway. Resident #32 was seated in the wheelchair across from the other side of the nurses' station (leading down to the 3 Hallway). She thought Resident #42 was going back to his room so she was looking back down at the Electronic Medication Administration Record (EMAR) and pulling medications out of the medication cart when she heard a hitting sound. She looked up and Resident #42 was hitting Resident #32 with his cane in the head. She told Resident #42 to lower his cane and had him go back to sit at the dining room table. Resident #32 had blood from a wound on his head and stated repeatedly, Ouch, ouch, ouch, why did he hit me? Resident #32 had not made any comments prior to the incident. She was shocked that it happened. Someone had told her to watch Resident #32 and #42 as they get into arguments. She thought that meant screaming/yelling. Staff F (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	voiced she didn't know Resident #42 was violent. They were instructed the Hallway 1-2 medication cart was to be positioned toward the residents in the dining room to provide supervision. Observation on 7/1/26 at 7:05 AM Staff F had the medication cart positioned in front of the nurses' station facing toward the residents to be able to provide supervision in the dining room. Observation on 7/1/26 at 7:06 AM Staff G had the 3 and 4 hallway medication cart positioned across from the nurses station on the [NAME] side facing the dining room to be able to supervise residents in the dining room. Interview on 7/1/26 at 8:35 AM Staff C voiced she had to remain in the dining room to provide supervision during the breakfast meal. In an interview completed on 7/1/26 at 9:31 AM Staff G recalled on that day (6/14/26), the CNA's assisted Resident #32 up and placed him by her hallway 3/4 medication cart which was by the activities board across from the nurses' station. There were only 3 CNA staff on duty that day. She got called away from the dining room to go walk a resident. She walked past Resident #42 who was sitting in his dining room chair by the entrance to Hallway 2. She walked another resident past where Resident #42 sat in the dining room and continued to walk the other resident to the back of the dining room by the assistive dining tables. Resident #42 must have gotten up the second she walked by. That was when Resident #42 started hitting Resident #32. She heard Resident #32 screaming. Staff F stopped Resident #42. Resident #32 was bleeding from the left side of his forehead. She and another aide assisted Resident #42 away from the situation. They were told to take him to the back dining room on Hallway 4. Staff G further reported Resident #32 kept repeatedly yelling, Ouch! Ouch! Ouch! Why did he hit me? She thought Resident #42 got in a few hits before Staff F was able to get them separated. After the incident, Resident #42 verbalized Resident #32 had more coming to him and he was a son of a bitch or something like that but definitely said he had more coming to him. She felt Resident #42 recognized Resident #32. Resident #32 did remember after the fact that he was hit by a man with a cane. Resident #32 had bruises to his chin and his hand the next day. Resident #42 did display aggressive behaviors hitting the dining room table when dietary staff did not bring his food out timely. She had reported that to the nurse. She would give Resident #42 a snack and he would be okay with that. She heard other staff state they had been roommates and she felt that was where the hate built up. She didn't recall either resident having any behaviors or interaction prior to the incident. Staff G voiced Staff F hadn't been fully informed of the full aspects of the situation between the two residents. She thought it was just verbal behavior, not physical altercations. When queried if Resident #42 hitting Resident #32 in the head with his cane was abuse, Staff G replied, Yes. The incident could have probably been prevented if Staff H would not have placed Resident #32 in Resident #42's walkway. It was preventable. During interview on 7/1/26 at 9:53 AM Staff C reported the incident occurred on 6/14/26 at 7:44 AM. Staff H assisted Resident #32 from his room out by the wall across from the nurses' station. Staff C said Resident #32's location was okay as long they could keep an eye on him. There were three staff in the dining room at that time. She left the dining room to go check on another resident, then she got a call that an incident happened. She assisted Resident #32 back to his room. She cleaned a small gash that was bleeding on his left forehead around his eye. It had started to bump and bruise. She stopped the bleeding with pressure, steri-stripped the wound, and placed ice on it. Resident #32 kept stating, Why would someone hit me? Resident #32 had been sitting there, not saying anything. Resident #42 walked from his dining room table approximately 10-20 feet to Resident #32. She had told Staff F to keep eyes on the two residents, but did not indicate specific behaviors. Resident #42 meant to hit Resident #32. When queried if Resident #42 hitting Resident #32 was abuse, Staff C stated, Yes. In hindsight, she should have had the staff leave Resident #32 in his room or in a different location in the dining room. Resident #32 emotional trauma was getting less and less. The day after he kept asking why anyone would want to hit him. Observation on 7/01/26 at 10:17 AM Resident #32 lay in bed with call light in rest with eyes closed resting. Interview on 7/1/26 at 10:21 AM Staff F thought Resident #42 got 2-3 more hits in before she was able to stop him. Resident #42 purposely hit Resident #32. Resident #42 said that mother F_cker deserved it or something like that. She felt that Resident #42 abused (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #32 because he hit him. Staff F voiced she felt the incident could have been avoided if Resident #32 was not been brought out to the dining room until after Resident #42 had eaten and gone back to his room. Resident #42 would get aggressive, worked up and start banging his fists on the table if he didn't get food right away. Staff F specifically voiced the incident could have been prevented, if they told new staff there are violent residents that would hit and not try to sugar coat it. During interview on 7/1/26 at 10:50 AM Resident #32's family member reported Resident #42 had hit Resident #32 in the head with a cane during two separate incidents. They were trying to keep the residents separated. The last time Resident #32 was just sitting next to the nurses' station when Resident #42 came along and decided to hit him with his cane. She had expressed to the nursing home staff that they should be very, very careful, as Resident #42 could hit anybody, even defenseless little ladies. The last thing they tried was to move Resident #42 to a different wing to keep a better eye on him. She wasn't sure that was enough. She was concerned for Resident #32 and all the residents. The first time Resident #32 forgot about the incident. The second time, Resident #32 said something about being concerned that the guy might come in and hit him again. Resident #32 had a bruise around his chin, side of his face, and to his hand. She thought for a while Resident #32 was scared to come out of his room and thought he would get hit again. During an interview on 7/1/26 at 11:38 AM the DON reported there was a prior incident in April 2026 where Resident #42 hit Resident #32 in the head with his cane. After that, they updated Resident #32 and #42's care plans to monitor for agitation and take to a quiet area. Resident#42 never really gave any precursor of being agitated. He has a switch and it just went off. The only person that had set that switch off is Resident #32. She was notified of the incident at 7:45 AM at home by Staff G. When she arrived Resident#32 was in his room with ice on his head. Resident #42 was in his room sitting, eating cereal. The DON reviewed the 6/14/26 Nurses Note that she had written and verbalized the note was what had happened. Based on the conversation she had with Resident #42 that day, Resident #42 intended to hit Resident #32. He knew exactly what he was doing. He recognized Resident #32. Staff F was the only CMA in the main dining room. In talking with Staff F, she didn't feel she was aware of the true prior incident. She expected Staff F to keep eyes on Resident #32 and #42 but with her not having the back ground knowledge and not knowing that Resident #42 had been physical with Resident #32, that may have affected things. The incident may have been prevented if staff had kept Resident #32 in his room until they were ready in the dining room. When queried if Resident #42 had abused Resident #32, the DON stated, Yes. Resident #32 had a bump on the left side of his head with a small laceration and some bruising on his jaw. Through the investigation, after the first encounter, they should have moved Resident #42 to a different room sooner where he wouldn't cross paths with Resident #32. During an interview on 7/1/26 at 12:14 PM the Administrator reported she was out of town on vacation when she got the call from Staff G. She got the details, resident locations, staff locations so that she could initiate a self-report to the State. She verified with Staff C that the residents were separated. She educated staff to keep the residents separated. The following Monday (6/15/26) she did an all-staff huddle running through the 4/19/26 situation and the interventions of medication reviews, identifying behaviors and continued separation since that time obviously didn't work and that was on them. The incident happened again and truly the incident was on them. She re-educated on continued separation. They had been looking at solutions on how to properly educate staff and make it effective. They potentially should have moved Resident #42 so that separation could have been maintained more effectively. The Administrator voiced per the SOM (States Operational Manual) Resident #42 hitting Resident #32 in the head with his cane was abuse. The Abuse Prevention, Identification, Investigation and Reporting Policy revised 4/5/17 included a Policy Statement all resident have the right to be free from abuse. Residents must not be subjected to abuse by anyone, including other residents. The Policy documented Resident Abuse under Federal Certification Guidelines (42 Code of Federal Regulations (CFR) 483.12 and 42 CFR 483.5 defined the following:Abuse means the willful infliction of injury resulting in physical harm, pain or mental anguish. Physical Abuse included hitting. Mental abuse included threats of punishment. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident-to-Resident physical contact that occurs, which includes where residents are hit and results in physical harm, pain and mental anguish is considered to be resident-to-resident abuse.