

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165579	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER Maquoketa Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 (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	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 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 (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	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 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 (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	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. 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.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, policy review and staff interviews, the facility failed to maintain a safe, sanitary, and infection-controlled environment to prevent the potential development and transmission of disease and pathogenic organisms. Specifically, the facility failed to ensure proper hand hygiene protocols were executed during wound care dressing changes for 2 of 2 residents observed (#6 and #24); failed to utilize a gown as part of Enhanced Barrier Precautions (EBP) for 1 of 2 residents observed with indwelling medical devices (Resident #5); and failed to ensure medications were administered free from significant contamination and errors for 2 of 7 residents observed during oral medication administration passes (Resident #18 and Resident #43). Staff dropped oral medications onto the top of a medication cart, retrieved the pills with bare hands, and administered them to the residents. These deficient practices placed the residents at risk for cross-contamination, and created a potential for the introduction of infectious pathogens. Findings include: 1.A Brief Interview for Mental Status, BIMS, evaluation conducted on 6/30/2026 for Resident #5 revealed a score of 15 out of 15 which indicated cognition intact. The Care Plan initiated on 4/13/26 identified a focus area for Enhanced Barrier Precautions related to the resident's feeding tube per Centers for Disease Control and Prevention (CDC) guidelines. The Care Plan established a goal for the resident to remain free from signs and symptoms of infection related to the feeding tube throughout the review period. The Care Plan directed staff to implement the following interventions: a.Ensure a storage bin containing PPE per CDC guidelines is maintained in the resident's room. b. Ensure an EBP alert sign is posted on the resident's door. c. Follow CDC guidelines for Enhanced Barrier Precautions during care. Observation on 6/30/26 at 10:18 AM revealed Staff B, Registered Nurse (RN), entered Resident #5's room to perform a feeding tube site treatment and gauze dressing change. Staff B performed hand hygiene and applied clean gloves, but failed to don a protective gown. A review of the resident's room entry revealed an Enhanced Barrier Precautions (EBP) sign posted on the door, signaling the requirement for full Personal Protective Equipment (PPE) during high-contact cares. In an interview on 6/30/26 at 10:25 AM, Staff B, RN, acknowledged she failed to follow EBP protocols during the feeding tube care. Staff B stated she should have donned a gown for the treatment and confirmed she performed the procedure incorrectly. 2. The MDS dated [DATE] for Resident # 24 identified a BIMS score of 13 out of 15 which indicated cognition intact. The Care Plan initiated on 5/31/26 identified a focus area for multiple venous stasis ulcers of the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bilateral lower extremities related to congestive heart failure (CHF) and peripheral vascular disease (PVD). The Care Plan established a goal for the resident to remain free from signs and symptoms of infection. A secondary focus area initiated on 5/31/26 identified the requirement for Enhanced Barrier Precautions (EBP) related to the bilateral lower extremity venous stasis ulcers per Centers for Disease Control and Prevention (CDC) guidelines. The Care Plan established an ongoing goal for the resident to exhibit no signs or symptoms of infection. The Care Plan directed nursing staff to implement the following interventions: a.Ensure a storage bin containing personal protective equipment (PPE) is maintained in the resident's room per CDC guidelines. b. Ensure an EBP alert sign is posted on the resident's door. c. Follow CDC guidelines for Enhanced Barrier Precautions during care Observation on 7/1/26 at 7:19 AM revealed Staff C, Registered Nurse (RN), entered Resident #24's room to perform a left leg dressing change. Staff C performed hand hygiene, donned a protective gown and clean gloves, and gathered treatment supplies. Staff C removed the soiled dressing, cleaned the wound bed, and removed her contaminated gloves. Staff C failed to perform hand hygiene prior to donning a new pair of clean gloves, applying medication to the wound, and covering the site with gauze. Staff C realized she lacked an abdominal (ABD) pad to complete the dressing. Staff C removed her personal protective equipment (PPE), performed hand hygiene, and exited the room to retrieve the supply. Upon returning to the room, Staff C donned a new protective gown and clean gloves, but failed to perform hand hygiene prior to contact. Staff C placed the ABD pad over the wound bed and removed her gloves, failing to perform hand hygiene. Staff C then wrapped the resident's leg with gauze and secured it with tape. Staff C removed the disposable gown and applied compression stockings to the resident. Staff C exited the room to locate clean socks. Upon her return to the room, Staff C performed hand hygiene. In an interview on 7/1/26 at 3:00 PM, The Director of Nursing (DON), stated the facility expected employees to perform hand hygiene prior to entering a resident's room, before and after touching a resident, upon leaving a room, after using the bathroom, after eating, and between glove uses and glove changes. When asked regarding expectations for Enhanced Barrier Precautions, The DON stated staff must implement EBP and wear proper personal protective equipment during any care involving a resident's feeding tube, including dressing changes, application of split gauze, or cleaning the site. She further stated EBP applied to wound care, catheter care, or any direct contact with a resident on contact isolation. When asked to clarify the facility's policy regarding glove changes during a single dressing change and whether hand hygiene is required between removing contaminated gloves and applying clean gloves to administer medication, The DON stated employees must utilize hand hygiene anytime they change their gloves. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #6's MDS assessment dated [DATE] showed a BIMS score of 15 out of 15 indicating intact cognition. Resident #6 had diagnoses of coronary artery disease (CAD), high blood pressure, peripheral vascular disease (PDV), diabetes mellitus, and stroke. The MDS documented Resident #6 with an unhealed stage 3 pressure injury, not present upon admission and a diabetic foot ulcer. The Resident received pressure injury care, application of nonsurgical dressings, and application of dressing to the feet. Resident #6's July 2026 Electronic Treatment Administration Record (ETAR) listed the following Physician Orders:a.Left Heel: Cleanse with Vashe (skin cleanser used to clean/irrigate chronic wounds). Apply collagen (advanced wound dressing used to treat complex or stalled wounds) to any areas of undermining, cover with Poly Mem AG (scored) (an advanced wound care dressing infused with silver to fight germs and infections), then cover with ABD pad and secure in place with roll gauze and tape, one time a day every Wednesday and Saturday for wound treatment. Start date 6/27/2026.b.Right Lateral Foot: Cleanse with Vashe. Apply collagen to any areas of undermining, cover with Poly Mem AG (scored), then cover with ABD pad and secure in place with roll gauze and tape. Change one time a day on Wednesday and Saturdays for wound treatment. Start date 6/27/2026. Observation on 7/01/26 at 1:42 PM Staff C, donned a mask, isolation gown, washed her hands and donned gloves. Staff C set up two clean barriers on the floor with the dressing supplies sitting on a clean barrier to Staff C's left side. Resident #6 sat in his wheelchair. Staff C sat directly on the floor. During the provision of the treatment, Staff C measured the left heel pressure wound, then laid the measuring tape and her pen directly on the floor to her right side. Staff C placed the collagen, PolyMem Ag dressing, ABD pad and Kling gauze. Staff C picked the dirty pen from the floor with her right gloved hand, dated a piece of tape with the pen then used her gloved hands to secure the tape over the left foot pressure injury wound dressing. Staff C changed her gloves without performing hand hygiene, removed Resident #6's padded boot and gripper sock from his right foot. Staff C changed her gloves and performed hand hygiene, applied new gloves and proceeded to cleanse Resident #6's diabetic wound as ordered. Staff C measure the diabetic wound to the right outer foot. Picked up the dirty pen from the floor, wrote down the measurements, then laid the measuring tape and pen back down directly on the floor. Staff C picked up the scissors cut the collagen dressing and AG dressing to fit the wound. Staff C placed the collagen dressing on the wound, tapping her contaminated glove on top of the collagen dressing on the wound. Staff C proceeded to open a package of rolled gauze on the clean barrier. She placed the black AG dressing, ABD pad and covered the wound dressing with the Kling gauze. Staff C measured a 0.6 Centimeters (CM) by 0.6 CM area to the top of the right foot. Staff C then applied betadine to the area. Staff C removed her gloves, performed hand hygiene, gloved and finished applying the Kling wrap to the right foot. Staff C then picked up the dirty pen from the floor, wrote the date on a piece of tape and secured the Kling gauze with the piece of tape. Staff C used the same dirty gloves to apply Lamictal lotion to the left and right lower legs and toes. Staff C then picked up the measuring tape from the floor and placed along the left toes to measure what she called scabby areas then placed the measuring tape back directly onto the floor. Observation on 7/1/26 at 2:59 PM of the July 2026 Electronic Treatment Administration Record (ETAR) revealed Staff C signed off the physician ordered treatments as completed. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/1/26 at 3:13 PM the DON explained it should be second nature as Staff C had done Resident #6's treatments before. She would expect all supplies, anything the nurse needed to touch to be on a clean barrier. A plastic bag or dirty barrier should have been set up to contain any dirty items. After she handled the dirty pen from the floor, she should have removed her gloves, performed hand hygiene and put on clean gloves. Ideally, she would have the nurse set a pen on a barrier and remove her gloves before using the pen to write down measurements. The Clean Dressing Change Policy revised 1/2026 documented it was the policy of the facility to provide wound care in a manner to decrease potential for infection and/or cross-contamination. The Policy directed to set up a clean field on the overbed table with needed supplies for wound cleansing and dressing application. Place a disposable cloth or linen saver on the overbed table. Place only the supplies to be used per wound on the clean field at one time (wound cleanser, gauze for cleansing, disposable measuring guide and pen/pencil, skin protectant products as indicated, dressings and tape. Establish area for soiled products to be placed (chux or plastic bag). 4. Observation of the afternoon medication administration on 6/29/26 at 4:17 PM revealed Staff D, Certified Medication Aide, (CMA) performed hand hygiene. She then opened the medication administration drawer with her right hand, pulled out the medication bin, and placed it on top of the medication cart with her right hand. Staff D pulled the tab from a single unit dose of Metformin 50 Milligrams (MG) and placed the medication into a dispensing cup. Staff D pulled the tab from a single dose unit of Tramadol 50 MG (one tablet). The pill missed the dispensing cup and landed directly on the top of the surface of the medication cart. Staff D picked up the fallen Tramadol tablet directly from the cart surface using her bare right hand. Staff D placed the contaminated Tramadol pill back into the medication dispensing cup and proceeded to administer the medications to Resident #43. Review of Resident #43's June 2026 Electronic Medication Administration Record (EMAR) showed Staff D signed that Resident #43's medications (including Metformin and Tramadol) were administered during the afternoon medication pass on 6/29/26. 5. Observation of the morning medication administration on 6/30/26 at 6:59 AM revealed Staff E, RN began setting up morning medications to administer to Resident #18. During the medication set up, Staff E opened and closed the medication cart drawers four times. Staff E touched the Tylenol bottle, multiple vitamin bottle, Zyrtec bottle, Ferrocite medication pack, and the medication bin containing single-dose medication cassettes. Staff E also touched the physical tabs on each medication cassette. Staff E knocked over the medication cup during the setup process. Two pills fell out of the dispensing cup and onto the top surface of the medication cart. Staff E picked up the two fallen pills directly from the cart surface using her bare right hand. Staff E placed the contaminated pills back into the resident's medication cup and proceeded to administer the pills to Resident #18. The June 2026 Electronic Medication Administration Record (EMAR) showed Staff E signed the EMAR documenting Resident #18 received the medications. During interview completed on 6/30/26 at 2:01 PM Staff E reported when a medication falls out of the medication cup, staff should discard the medication or pick up the pill using a glove or a spoon. Staff E further explained she realized she should not have picked up Resident #18's pill when it fell out of (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the cup earlier during the medication pass. In an interview conducted on 7/1/26 at 7:08 AM Staff F, CMA explained if a pill falls out of the dispensing cup onto the top of the medication cart, she destroys the medication due to possible contamination and administers a new pill to the resident. During an interview on 7/1/26 at 9:29 AM the Director of Nursing (DON) explained if a pill falls out of the medication cup onto the medication cart, she would expect the nursing staff to utilize a glove or a spoon to pick up the medication. If the medication fell on the floor, the nurses should destroy the medication and administer a new pill. Interview on 7/1/26 at 9:40 AM Staff G, CMA reported if she drops a pill, she will destroy the medication and take the extra pill that is in the single dose cassette to administer to the resident. The Administering Medications Policy, revised December 2012 directed the DON would supervise and direct all nursing personnel who administer medications and/or related functions. Staff should follow established facility infection control procedures (e.g. handwashing, antiseptic technique, gloves, precautions) for the administration of medications, as applicable.		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident interview, staff interviews, and policy review the facility failed to respect a resident's right to choose when to go to bed in the evening (Resident #28). The facility reported a census of 33 residents. Findings include: The Minimum Data Set (MDS) for Resident #28 dated 06/03/2026 documented diagnoses of limitation of activities due to disability, anxiety and depression, and acute pain due to trauma. The Brief Interview for Mental Status (BIMS) score of 15/15 indicated intact cognition. Section F of the Annual MDS dated [DATE] indicated it was very important to the resident to choose her own bedtime. The resident's Care Plan with an admission date of 05/03/2024 indicated the resident required assistance with ADLs (activities of daily living) related to weakness and balance deficits which placed her at risk for falls, injury, and skin breakdown. She needed the assistance of 1 staff for evening cares, toilet transfers, and getting in and out of bed. The resident's Care Plan and Kardex (point of care tracking) did not include the resident's bedtime preference. On 06/29/2026 at 11:23 AM Resident # 28 stated she was not able to choose when to go to bed at night. When asked why, she reported sometimes her medications were late which delayed her bedtime or she was waiting for staff. Resident #28 revealed she had been to bed as late as 12:30 AM because she had to go around their schedule. She stated some residents required a lot of staff time so others had to wait. On 07/01/2026 at 2:06 PM the Director of Nursing (DON) confirmed the resident verbalized to the nurse and to the DON that she had received her medications later than she would like. The DON stated she educated staff that 11:30 PM or 12:00 AM was too late. She expected staff to manage time better and pass medications on time. On 07/01/2026 at 2:30 PM Staff L, Registered Nurse (RN) acknowledged she had a window of time to administer medications, and stated Resident #28 needed to have her medications early to get to bed on time. She reported staff tried to help each other with resident care, and she assisted with transfers which usually meant she got behind. Staff L confirmed she knew Resident #28 had been given medications and assisted to bed later than she wanted. A Resident's Rights Policy dated 01/2026 documented that all residents have the right to a dignified existence and self-determination.		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual the facility failed to submit a quarterly assessment within the required time frame for 1 of 2 residents reviewed (Residents #38). The facility reported a census of 33 residents. Findings include: During the annual recertification survey a review of the clinical records for Resident #38 revealed the Minimum Data Set (MDS) quarterly assessment dated [DATE] was completed on 05/22/2026. It was not marked as submitted. The MDS summary screen revealed the assessment had been marked as not required. On 07/01/2026 the Director of Nursing (DON) stated she would have to ask the MDS Coordinator, Staff M, about the submission timelines for quarterly assessment. Staff M responded by text that the timeline would depend on the type of assessment and indicated their system reported when it had to be submitted. On 07/02/2026 at 9:36 AM the Administrator stated she would prefer the MDS Coordinator address the timeline for submission and contacted her at another facility during the interview. Staff M returned the call and stated this was the same thing that happened with another resident. She reported she caught the first one but must have missed this one. Staff M stated this one was 40 days overdue and she would need to correct it. Page 2-18 of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated October 2025 indicated the quarterly assessment should be submitted 14 days after the MDS completion date.		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, resident interview, staff interview, facility policy, and facility record review, the facility failed to ensure sufficient nursing staff were available to answer call lights in a timely manner to meet the needs of residents. This affected 3 of 3 residents reviewed for sufficient staffing (Residents #5, #24, and #28). The facility reported a census of 33 residents. Findings include: 1.A Brief Interview for Mental Status, BIMS, evaluation conducted on 06/30/2026 for Resident #5 revealed a score of 15 out of 15 which indicated cognition intact. On 6/29/26 at 2:28 PM, Resident #5 stated he experienced prolonged call light response times throughout his residency. He stated staff often took 45 minutes to one hour to answer his call light. He noted the response times worsened in the morning before breakfast when multiple residents required concurrent assistance to get out of bed. He stated the facility required additional staff to cover that period. In an interview on 6/30/26 at 10:10 AM, Resident #5 stated his call light remained active and unanswered from 7:00 AM to 7:30 AM that morning. While in the resident's room on 6/30/26 at 10:13 AM, Staff A, CNA, entered the room and confirmed the resident's call light remained unanswered for an extended duration that morning. Staff A acknowledged she failed to answer the call light sooner due to completing cares for other residents with higher acuity needs. 2. The MDS for Resident #24 dated 5/24/2026 identified a BIMS score of 13 out of 15 which indicated cognition intact. In an interview on 6/29/26 at 11:55 AM, Resident #24 stated he waited 30 minutes for staff to answer his call light that morning. He stated call light response times varied by shift, and noted the third shift experienced increased delays before the morning shift arrived. He stated staff left him on the commode and promised to return, but failed to do so. He stated he reactivated his call light and waited an additional 30 minutes for staff to return. He further noted staff frequently deactivated his call light without completing cares and forgot to return. He stated he routinely reactivated his call light to ensure staff returned. An observation on 7/1/26 at 6:23 AM revealed Resident #24's call light was active. In an interview on 7/1/26 at 6:36 AM, Resident #24 stated no staff members entered his room since he activated the call light. Observation on 7/1/26 at 6:39 AM revealed facility staff entered the room and answered the call light, resulting in a 16-minute response time. (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/1/26 at 3:00 PM, The Director of Nursing (DON), stated the facility expected call lights to be answered within 15 minutes of activation. The DON stated if a delay occurs, staff must speak with the resident to inform them that assistance is coming. DON acknowledged that leadership educated staff to not deactivate a call light prematurely because they may forget to return to the resident, noting this is an ongoing issue within the facility. When asked how the facility ensures resident safety during 30-minute response gaps when staff claim they are too busy with other residents, DON stated administration attempted to reinforce that all facility employees, including dietary staff, are authorized to answer call lights. She stated if an employee cannot directly assist with a resident's physical needs, they must page for assistance on the radio and leave the call light illuminated until the resident's need is fully met. When asked how daily sufficient staffing is determined and whether adjustments are made for resident acuity, DON stated the facility census was currently on the lower side. She stated the facility attempts to staff with four to five Certified Nurse Aides (CNAs) daily. The DON acknowledged that some resident care areas are more time-consuming than others, and stated she reaches out to alternative personnel if staff members call in absent. The DON explicitly acknowledged she was aware of an ongoing facility issue regarding long call light wait times. She stated she wanted staff nurses and medication aides to assist with call lights rather than staying confined strictly to their primary job duties, and noted leadership is trying to teach those staff to answer call lights. 3. The Minimum Data Set (MDS) for Resident #28 dated 06/03/2026 documented diagnoses of limitation of activities due to disability, acute pain due to trauma, and generalized muscle weakness. The Brief Interview for Mental Status (BIMS) score of 15/15 indicated intact cognition. The resident's Care Plan indicated the resident required assistance with ADLs (activities of daily living) related to weakness and balance deficits which placed her at risk for falls, injury, and skin breakdown. During an interview on 06/29/2026 at 11:23 AM Resident #28 stated she had been to bed as late as 12:30 AM partially because of waiting for staff. She reported that on Saturday (06/27/2026) or Sunday (06/28/2026) her light was on in her bathroom for 45 minutes while she waited for help. She stated she knew it was 45 minutes because she took her phone into the bathroom with her, and had to call the front desk for help when no one came. A document titled Resident Council Meeting dated 06/03/2026, start time 10:29 AM, indicated residents reported call lights took a while to get answered, at times 20 minutes or more. A document titled Resident Council Follow-Up Meeting Department Concerns and Corrections, dated 06/24/2026 at 10:35 AM documented the Administrator told the residents she would have an education meeting for nursing staff about answering call lights. At 11:14 AM on 07/02/2026 the Administrator reported she had a copy of the phone calls made to the facility on [DATE] and 06/28/2026. The report documented Resident #28 placed calls to the facility from her cell phone both days. A policy titled Call Lights: Accessibility and Timely Response reviewed/revised 01/2026 documented (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	all staff members who saw or heard an activated call light were responsible for responding. Guideline 11.a. documented the first step in responding to call lights was to turn off the signal light in the resident's room. The policy did not include the length of time in which staff should respond.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, clinical record review, interviews, and policy review the facility failed to ensure timely medication administration was conducted in accordance with manufacturer instructions and professional standards to prevent a significant medication error for 1 of 1 residents observed during medication administration (Resident #33). Specifically, a Registered Nurse (RN) prepared to inject 5 units of Novolog insulin instead of the prescribed 3 units by combining the safety prime and the therapeutic dose into a single mechanical step. The facility further failed to administer medications at the scheduled time for 1 of 1 residents reviewed (Resident #28). The facility reported a census of 33 residents. Findings include: 1. The Minimum Data Set (MDS) for Resident #28 dated 06/03/2026 documented diagnoses of restless leg syndrome, anxiety disorder, and acute pain due to trauma. The Brief Interview for Mental Status (BIMS) score of 15/15 indicated intact cognition. The resident's Care Plan indicated the resident used buspirone and lorazepam for anxiety disorder. The associated task directed nurses to administer the medications as ordered by the physician. A document titled Resident Council Follow-Up meeting dated 05/27/2026 documented a resident was concerned they did not receive their medication until 10:00 PM on 05/05/2026. An investigation confirmed the incident and noted the Director of Nursing (DON) would continue to monitor. On 06/29/2026 at 11:23 AM Resident #28 stated she often didn't get to bed on time because of late medications in the evening. She reported being up as late as 12:30 AM by the time all of her medications were given and cares were done. A document titled Medication Administration Audit Report downloaded from the resident's Electronic Health Record on 07/01/2026 at 9:15 AM documented the following medications scheduled for 19:00 (7:00 PM): a. Tylenol PM extra strength oral tablet 500-25 MG (diphenhydramine-acetaminophen) Give 1 tablet by mouth one time a day for sleep aid related to acute pain due to trauma. b. lorazepam oral tablet 1 MG Give 1 tablet by mouth 3 times a day related to anxiety disorder. c. primidone oral tablet 50 MG Give 2 tablets by mouth two times a day for restless leg syndrome. These medications were administered to the resident on 06/22/2026 at 8:23 PM, 06/23/2026 at 9:20 PM, 06/24/2026 at 9:29 PM, 06/25/2026 at 9:24 PM, 06/26/2026 at 9:39 PM, 06/29/2026 at 9:05 PM, and 06/30/2026 at 9:33 PM. On 07/01/2026 at 2:06 PM the Director of Nursing (DON) confirmed the resident verbalized to both the nurse and the DON that she had often received her medications later than she would like. The DON stated she educated in house and agency staff that 11:30 PM or 12:00 AM (which included medications and treatments) was too late. She expected staff to manage time better and pass medications on time. The DON stated it was on her to do list to have another conversation with a staff member who was often late with this resident's medication. She stated when she was informed about (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	late medications, which are technically a medication error, she communicated with the doctor pretty regularly. She stated the medication error process was to talk with the nursing staff, send the information to the pharmacy, speak with the medical director and/or the primary care provider, and to discuss it at Quality Assurance Process Improvement (QAPI). She did not think all of these steps were done for all of the dates listed here. During an interview with Staff L, Registered Nurse (RN) on 07/01/2026 at 2:30 PM she stated the nurses usually had a window of an hour to administer medication. The Staff L reported that if she didn't give Resident #28 her medication first, then it was usually late because she helped with transfers. Staff L acknowledged she was late with Resident #28's medication a lot, and stated she never reported late medication to the doctors because she knew 2 of them would say it wouldn't make a difference, but she guessed that if the medication could have an immediate impact she would probably call. 2. Review of Resident #33's Minimum Data Set (MDS) Assessment, dated 5/13/26, revealed a Brief Interview for Mental Status (BIMS) score of 5 out of 10, indicating severe cognitive loss. The MDS documented active diagnoses of diabetes mellitus and Non-Alzheimer's Dementia. The assessment further verified the resident received insulin injections on all 7 days of the assessment look-back period. Review of Resident 33's June 2026 Electronic Medication Administration Record (EMAR) revealed a current physician's order to administer Novolog (insulin) injection, 3 units under the skin (subcutaneously) with meals. On 6/30/26 at 12:47 PM, during the Medication Administration Task observation, Staff B, Registered Nurse, (RN) reviewed Resident #33's June 2026 EMAR. Staff B obtained Resident #33's Novolog insulin pen and set the dosage dial to 5 units. Staff B verbalized 2 units were for the air shot to prime the pen, and 3 units were for the ordered dose. Staff B began to approach Resident #33 to administer the injection. Staff B was stopped from administering the 5 units of Novolog to Resident #33. Immediately following the intervention on 6/30/26 at 12:48 PM Staff B stated a pharmacist had previously taught them to administer insulin pens in that manner. Staff B further verbalized she would administer the insulin the old-fashion way. She dialed the insulin pen to 2 units and compressed the injection button into the air. No insulin was observed coming from the tip of the needle. Staff B then set the dial on the pen to 3 units and administered the insulin to Resident #33. Staff B failed to perform the air shot to prime the needle according to the manufacturer's instructions for insulin administration. During an interview on 6/30/26 at 1:02 PM the Pharmacist explained she provided a power point education on adherence to insulin administration to maintain blood sugars within the acceptable ranges. She did not discuss insulin administration or anything about an air shot at that time. She further explained the nurses should set the insulin pen to 2 units to ensure the needle is patent, then set the pen to the ordered amount of insulin for administration. Nurses should follow the manufacturer's directions for insulin administration. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165579	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER Maquoketa Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 6/30/26 review of the 1/30/26 Insulin Power Point Education provided by the Pharmacist confirmed the education did not cover insulin administration. During an interview on 6/30/26 at 3:05 PM, the Director of Nursing (DON) explained she expected the nurses to: 1. Set the insulin pen dial to 2 units.2. Depress the injection button and ensure insulin cleared the needle.3. Set the pen to the prescribed insulin dosage to be administered. The DON verified she expected the nursing staff to perform two separate steps, priming the pen, then administering the insulin and follow the manufacturer instructions for administration. The Insulin Pen Policy revised 5/2026 directed insulin pens would be primed prior to each use to avoid collection of air in the insulin reservoir. The Policy Procedure further directed to prime the pen, dial 2 units by turning the dose selector clockwise. With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears. Turn the dose selector to the ordered dose. A click will be heard for each unit dialed. Check the dose a second time and administer the insulin. The Novolog Instructions for Use directed the following:a. Turn the dose selector to 2 units.b. Hold the insulin pen with the needle pointing up. Tap the cartridge gently with a finger a few times to make any air bubbles collect at the top of the cartridge.c. Keep the needle pointing upward, press the push-button all the way in until the dose selector returns to zero. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than six times.d. Check and ensure the dose selector is set at zero. e. Turn the dose selector to the number of units needed for injection.		