

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/05/2025
NAME OF PROVIDER OR SUPPLIER Aspire of Muscatine		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 Cedar Street Muscatine, IA 52761	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, facility policy review, and resident and staff interviews the facility failed to protect a resident from physical abuse when Resident #1 struck Resident #2 in the face multiple times. While self-propelling his wheelchair through the dining room, Resident #1 unintentionally ran into Resident #2. This caused Resident #1 to become upset and in response he lashed out at Resident #1. The facility reported a census of 34 residents. Findings include: 1. Review of the Minimum Data Set (MDS) dated [DATE] for Resident #1 revealed a diagnoses list, which included cerebral vascular accident (stroke) without residual effects, violent behavior, dementia with behavioral disturbance, mood disorder due to known physiological condition with depressive features. The Brief Interview for Mental Status (BIMS) score of 8 out of 15 indicated a moderate cognitive impairment. The MDS identified the resident normally used a wheelchair, and independently wheeled self-50 feet with two turns, and 150 feet. The MDS indicated Resident #1 took antipsychotic and antidepressant medications. Review of the Care Plan for Resident #1 revealed Focus areas to address:a. Resident makes nonsensical verbal aggressive comments towards staff, will curse at staff members, resident has altered perception of reality and often forget what his is angry or paranoid about. Date Initiated: 8/25/25.b. The resident is/has potential to be verbally aggrieve r/t (related to) dementia. Date Initiated: 4/2/25.c. The resident is/has potential to be physical aggressive medical dx (diagnosis). 10/23/25 Physical aggression/Resident on Resident altercation. Date Initiated: 4/2/25. Revision on 10/23/25.Review of electronic health record (EHR) revealed a Behavior Note entered by Staff E, Licensed Practical Nurse (LPN) on 10/23/25 at 5:14 PM This resident [Resident #1] in dining room propelling self and ran into another resident [Resident #2]. The other resident, who is non-verbal, was attempting to move away from this resident and attempting to speak when this resident lashed out with right fist and struck other resident in the face 3 times. Incident witnessed by this nurse and [name redacted, Staff A, Registered Nurse (RN)]. This nurse intervened and separated residents and had a CNA (Certified Nursing Assistant) escort this resident [Resident #1] to his room. During the altercation this resident [Resident #1] received a 1x1 cm (centimeter) skin tear to his left arm as a result of also striking drink station table that was location of incident. Once in his room resident calmed down and is currently calm and resting. POA [name redacted] notified. DON (Director of Nursing) present at time of incident and notified Administrator. MPD (local police department) notified of incident. {Doctor name redacted} notified with no new orders. During an observation on 11/4/25 at 5:04 PM, Resident #1 sat in his wheelchair in dining room. Resident rocking himself, and quietly moving in a small circle area next to a table occupied by three men. Resident #2 sat directly across the table from Resident #1 who displayed no aggression. Staff I, LPN was sitting on other side of wall, at the nurses' desk approximately 20 feet from Resident #1.During an interview on 11/5/25 at 8:02 PM, Resident #1 made eye contact but did not respond to interviewer. During an observation on 11/5/25 at 9:35 AM, Resident #1 was in the dining room during an activity that involved a beachball. Resident #1 was outside of the circled residents, near his table, in a constant motion of rocking in his wheelchair. Resident #1 continued to rock in his wheelchair without engaging in the activity.2. Review of the MDS dated [DATE] for Resident #2 revealed a list of diagnoses which included diagnoses of diabetes mellitus, cerebral vascular accident (stroke), anxiety, and depression. The MDS indicated Resident #2 independent with transfers and ambulation. A BIMS score of 12 out of 15 indicated intact cognition.During an interview on 11/5/25 at 12:25 PM, Resident #2 stated he was hit in his face by Resident #1, pointed to a faint yellow bruising above his left eye down to his left temple. Resident #2 stated he was ok and He will do it again. When inquired Resident #2 if felt afraid of Resident #1, he shook his head no and swung his fist and arm in an upward motion with a serious look on his face and repeated, He will do it again. Resident #2 explained that Resident #1 would get angry often. Resident #2 opened a glasses box and stated he wanted his glasses fixed. Review of a document titled MedTelecare dated 9/17/25 revealed Patient [Resident #2] reports feeling very happy without concerns or complaints expressed. Patient had a history of insomnia that was controlled with melatonin and trazodone and diagnoses of depressive disorder stable, chronic illness in remission, and insomnia, stable, chronic illness.Review of the EHR revealed an Incident Noted entered by Staff E, LPN on 10/23/2025 at 5:35 PM revealed This resident [Resident #2] in dining room at kitchen door, to get coffee. Another resident [Resident #1] backed his wheelchair into resident and when this resident attempted to move and speak other resident lashed out and struck this resident on the left side of the face 3 times with closed fist resulting in bruising in</p>		

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents.</p> <p>Based on employee record review, and staff interviews the facility failed to ensure the staff were adequately trained in managing residents with dementia and difficulty managing their behavior. The facility reported a census of 34 residents. Findings include: During an interview on 11/5/25 at 1:05 pm, Staff E, Licensed Practical Nurse stated he had witnessed a resident-to-resident incident on 10/23/25. Staff E stated he had worked in this center for a month with a large population of Alzheimer's and dementia residents. Staff E stated he had not received training from the facility. During an interview on 11/5/25 at 1:38 pm, Staff I, LPN stated she had been employed at this facility for 4 years. She stated there had been a resident-to-resident altercation in 2024 and another last month. Staff I stated with there was not adequate training on how to manage people with dementia, or how to prevent aggressive behaviors. During an interview on 11/5/25 at 2:05 pm, Staff F, Certified Nursing Assistant (CNA) stated she had witnessed Resident #1 being aggressive with staff, expressed having fear of Resident #1 and would have to provide care for him with two staff as the behavior increased in the evening. Staff F stated the facility had not provided training for abuse in the last year and she could not recall having received training in behavioral management. During an interview on 11/5/25 at 12:00 pm, Staff J, CNA stated she had received dementia training from another facility and in the five months employed by this facility there had been a lack of training in this area. During an interview on 11/5/25 at 3:03 pm, Staff A, Registered Nurse (RN) stated she was fearful of Resident #1 and felt he was a loose cannon. Staff A felt the staff were not trained to handle this type of behaviors. During an interview on 11/5/25 at 2:46 pm, The Director of Nursing (DON) stated she had identified the lack of training for staff for behavioral health. The DON stated the facility planned to change mental health providers, to a group who will do in house visits and will provide future training for the staff. A review of five employees records revealed a lack of training for dementia management.</p>		