PRINTED: 08/25/2021 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		165226	B. WING_			08/	19/2021
NAME OF P	ROVIDER OR SUPPLIER	less menseum en euro accommenseum en exemple and en		S	TREET ADDRESS, CITY, STATE, ZIP CODE	, 00/	1012021
MANIVSE	PECIALTY CARE		1	60	D1 E SOUTH STREET		
MANLI OF	LOIALTTOAKL			M	IANLY, IA 50456		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	۲	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	t.	FC	000	This Plan of Correction is prepare and submitted as required by law	. By	
	Correction date 9	1508 11			submitting this Plan of Correction Manly Specialty Care does not ac	lmit	
	annual health survey incidents #96888-I an	and the investigation of and the investigation of and #98233-I, and complaints 8-C completed August			that the deficiency listed on this f exist, nor does the facility admit to statements, findings, facts, or conclusions that form the basis for alleged deficiency. The facility reserves the right to challenge in	o any	
	Complaint #97466 wa	as not substantiated.			and/or regulatory or administrative proceedings the deficiency, statem facts, and conclusions that form the	re nents,	
	(See Code of Federal 483, Subpart B-C)	al Regulations (42CFR) Part			basis for the deficiency.	10	
F 658 SS=D	Services Provided Me	eet Professional Standards	Fe	558	F658		9/17/2021
	§483.21(b)(3) Compr The services provided as outlined by the comust- (i) Meet professional	ehensive Care Plans d or arranged by the facility, nprehensive care plan,			A correct order was received for Resident #15 on 8/18/2021. This reads staff is to administer oxyger 3L per nasal cannula PRN to keep saturations above 89%.	1-	
	by: Based on record revifacility failed to follow 16 residents reviewed physician's oxygen of directed staff to admit	iew and staff interview, the physician's orders for 1 of d, (Resident #15). The			A 100% audit will be performed be a literim Director of Nursing on all residents who use oxygen to ensu current order correctly fits residenceds.	l re the	
	when the facility adm rate (2.5 liters) and at facility reported a cen	the physician's oxygen order inistered oxygen at a higher a continuous flow. The usus of 37.			Education was provided to all numeritatif a resident needs an increas oxygen to notify the physician an obtain an order to do so.	e in	
	Findings include: A Minimum Data Set	(MDS) with an Assessment			During daily rounds current phys orders for oxygen will be monito		
LARGRATORY	DIRECTOR'S ARIPROVIDERA	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: SOIG11

Facility ID: IA0742

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		165226	B. WING_			08/	19/2021
	ROVIDER OR SUPPLIER PECIALTY CARE	·		601	EET ADDRESS, CITY, STATE, ZIP CODE E SOUTH STREET NLY, IA 50456		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	۲	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 658	Reference Date of 6/ #15"s diagnoses incluanxiety disorder, and Interview for Mental Socore of 9, indicating impairment. Resident assist of 1 staff for be personal hygiene. In an observation on through, it was noted running per nasal carasked to verify the nocoming from the oxyglow air loss mattress. On 8/17/21 at 2:31 P continued to run. The 2.5 liters and was de Resident #15 stated times. When asked istated "yes, every daher to breath. The orthis time and it read an as needed (PRN) liter(L) to keep an ox 89%. On 8/17/21 at 3:43 P (O2) remained on at On 8/18/21 at 8:46 A given Resident #15 at 2.5 L. When asked verified that it was orthe PRN order of 1L 1L, Staff A said she if	7/21, documented Resident uded Huntington's disease, abnormal posture. A Brief Status (BIMS) revealed a moderate cognitive that 15 required extensive ad mobility, toilet use, and 8/16/21 during initial walk Resident #15 had oxygen mula. When staff were olse they stated it was gen concentrator and not a	F	558			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		165226	B. WING	AUUAUU	08/19/2021	
	ROVIDER OR SUPPLIER PECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 601 E SOUTH STREET MANLY, IA 50456	\	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
F 761 SS=D	Nursing (DON), state for O2 to be titrated of today had turned the resident's POX was a earlier had said she if the oxygen order and was, the DON said so DON stated understate was not being followed on 8/18/21 at 4:22 Pethe facility corporation facility was not followed administering the oxygen order was to admander the order had a discontinual control of the facility's physical for the facility's physical for this order was to administered PRN. Administration Reconform the facility's physical for this order was to administer or PRN to keep saturate date for this order was Label/Store Drugs and CFR(s): 483.45(g)(h) §483.45(g) Labeling Drugs and biological labeled in accordance professional principle appropriate accessors.	d she just obtained an order -3L. She said the nurse oxygen up because this 39%. When told the RN had not had time to look at I did not know what the order he didn't realize that. The hading that a doctor's order ad. M, Staff C Senlor DON for h, stated understanding the hing doctor's orders when hing at 2.5L. Staff C verified hinister oxygen at 1L PRN for stration Record dated the staff to administer O2 at rations above 89%. The haded no documentation of hons or when it was The same Medication and revealed a clarification had solve 89%. The start has 8/18/21 at 9:15 AM. had Biologicals	F 65			

AND PLAN OF CORRECTION IDENTIF	DER/SUPPLIER/CUA ICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	165226	B. WING		And the second s	08/1	19/2021
NAME OF PROVIDER OR SUPPLIER MANLY SPECIALTY CARE			60	REET ADDRESS, CITY, STATE, ZIP CODE 11 E SOUTH STREET ANLY, IA 50456		
(X4) ID SUMMARY STATEMENT OF PREFIX (EACH DEFICIENCY MUST BE PI REGULATORY OR LSC IDENTIFY	RECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 761 Continued From page 3 applicable. §483.45(h) Storage of Drugs an §483.45(h)(1) In accordance with Federal laws, the facility must stoiologicals in locked compartment temperature controls, and permipersonnel to have access to the §483.45(h)(2) The facility must plocked, permanently affixed constorage of controlled drugs lister the Comprehensive Drug Abuse Control Act of 1976 and other diabuse, except when the facility package drug distribution system quantity stored is minimal and a be readily detected. This REQUIREMENT is not meable by: Based on observations, policy interviews, the facility failed to do medications for 1 of 2 medication medication storage room observed a census of 37. Findings include: Observation on 8/16/21 at 4:47 medication storage room contain medications stored and ready for all bottle of antacid relief with of 2/21 b. 2 bottles of antacid relief with date of 3/21 c. 1 bottle of mint antacid tablet expiration date of 6/21 d. 1 bottle of mixed fruit antacid	th State and tore all drugs and ents under proper it only authorized between the control of the provide separately apartments for din Schedule II of a Prevention and rugs subject to uses single unit are in which the amissing dose can between the control of the provide and staff liscard expired on carts and 1 of 1 oved. The facility	F	761	Education was provided to all nuto ensure they are checking for expiration dates and removing exmedications per nursing protocol. This will be monitored on an ong basis by the Nurse Management through audits.	oing	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION	COMPI	
		165226	B. WING			08/	19/2021
0.00	ROVIDER OR SUPPLIER PECIALTY CARE			60	TREET ADDRESS, CITY, STATE, ZIP CODE PIE SOUTH STREET ANLY, IA 50456		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 761	label on the back of the date. e. 1 bottle of mint flav an expiration date of f. 8 suppositories in the expiration date of 2/2 Observation on 8/16/medication cart contact ointment (used to hele an open date of 7/8/2 8/5/21. Review of the policy dated February 2020 outdated, deteriorate stored in a designate drugs. During interview on 8 Director of Nursing rehave all expired medical and supplementations.	he bottle and no expiration rored milk of magnesia with 1/21 he medication fridge with an 1. 21 at 4:53 p.m., revealed the ained Muro 128 5% eye by with corneal swelling) with 21 and discard date of	F .	761			

DEPART	MENT OF INSPECTIO	NS AND APPEALS				
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE S COMPLI	
*****************		IA0742	B. WING		08/1	9/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MANLY SI	PECIALTY CARE	601 E SOU MANLY, IA	TH STREET 50456			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
N 101 SS=D	481-50.7 (10A,135C) director or the director or the director notified within 24 hours, or the most expeditious med 50.7(1) Of any accide a. "Major injury " shawhich: (1) Results in death; (2) Requires admissisfor treatment, other the (3) Requires consultate physician, designed extender who determ designated by the de "major injury" based upon the accident, the previous resident, and the resident 's progn b. The following are reconsultated to the fall, even if the resided (2) Spontaneous fractions (3) Hairline fractures.	Additional notification. The r's designee shall be e next business day, by the ans available (I,II,III): ent causing major injury. all be defined as any injury or on to a higher level of care nan for observation; or ation with the attending of the physician, or physician ines, in writing on a form partment, that an injury is a the circumstances of the s functional ability of the osis. not reportable accidents: sident, as defined in rules -58.1(135C), and of alls when neither the ees have culpability related ent sustains a major injury; or stures; or	N 101	This Plan of Correction is prepared and submitted as required by law submitting this Plan of Correction. Manly Specialty Care does not at that the deficiency listed on this exist, nor does the facility admit statements, findings, facts, or conclusions that form the basis alleged deficiency. The facility reserves the right to challenge in and/or regulatory or administrate proceedings the deficiency, state facts, and conclusions that form basis for the deficiency. N101 Administrator and Director of Mat the time of incident #1 and #2 longer employed at Manly Spec Care. New Administration has educated of the regulation involutionally reporting. Staff will be reminded of this regulation through daily newsleand through all-staff education.	w. By on, admit form to any for the legal ive ements, the formal to any for the legal ive ements, the formal to a legal ive ements, the legal ive ements, the formal to a legal ive ements is a legal ive ements.	9/7/2021
	facility failed to repor Inspections and App	iew and staff interview the t to the Department of eals (DIA) a reportable				
DIVISION OF	HEALTH FACILITIES - STA DIRECTOR'S OR PROVIDER	TE OF IOWA SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	-1	(X6) DATE

Kadul Bowser

Administrator

9 3 2021

DEPARTMENT OF INSPECTIONS AND APPEALS (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: B. WING IA0742 08/19/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **601 E SOUTH STREET** MANLY SPECIALTY CARE **MANLY, IA 50456** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) N 101 N 101 Continued From page 1 incident involving a resident in a timely manner for 2 of 4 incidents/complaints reviewed, (Resident #28 and Resident #88). The facility census was 37 residents. Findings include: 1. Review of documentation for Resident #88 revealed an incident involving the resident occurred the evening of 3/26/21. The facility took appropriate steps to intervene and ensure the safety of the resident and informed the family and physician that same evening. Further review of documentation revealed the facility did not report this incident to DIA as required until 4/8/21, not within the 24 hours required by regulation. During an interview on 8/18/21 at 10:05 am the facility Nurse Consultant verified that administrative staff at the time of the incident involving Resident #88 did not report it to DIA within the time required. 2. The facility reported Resident #28 had a fall with major injury to DIA on 6/28/21. The fall occurred on 6/24/21. The facility did not report the fall within the 24 hours required by DIA. During interview on 8/18/21 at 1:35 PM, the Nurse Consultant, stated she was aware the incident was not reported to DIA within the regulated timeframe, (24 hours). She acknowledged the fall occurred on 6/24/21, the resident was hospitalized with serious injury on 6/25/21 and the facility reported the fall with injury on 6/28/21.

SOIG11

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		165226	B. WING	19.44 days state and a graph of the same and a second state and a second state and a second state and a second	08/	19/2021
	PROVIDER OR SUPPLIER SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 601 E SOUTH STREET MANLY, IA 50456		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	F 0	00		
	Correction date					
	annual health surve incidents #96888-I	encies relate to the facility's ey and the investigation of and #98233-I, and complaints 178-C completed August				
		was not substantiated. was not substantiated.				
F 658 SS=D	483, Subpart B-C) Services Provided	eral Regulations (42CFR) Part Meet Professional Standards 3)(i)	F 6	58		
	The services provided as outlined by the commustive (i) Meet professional This REQUIREMED by: Based on record refacility failed to follow the facility did not follow when the facility and facility reported a communication of the facility rep	prehensive Care Plans ded or arranged by the facility, comprehensive care plan, all standards of quality. NT is not met as evidenced eview and staff interview, the pw physician's orders for 1 of wed, (Resident #15). The order for Resident #15 minister oxygen at 1 liter per n as needed basis. The w the physician's oxygen order laministered oxygen at a higher at a continuous flow. The eensus of 37.				
	Findings include: A Minimum Data S	et (MDS) with an Assessment				
LABORATOR		DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

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.

Facility ID: IA0742

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	COMPLETED	
		165226	B. WING			08/1	19/2021
	PROVIDER OR SUPPLIER			6	STREET ADDRESS, CITY, STATE, ZIP CODE 601 E SOUTH STREET MANLY, IA 50456		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPROFICIENCY)) BE	(X5) COMPLETION DATE
F 658	Reference Date of #15"s diagnoses in anxiety disorder, an Interview for Menta score of 9, indicatir impairment. Reside assist of 1 staff for personal hygiene. In an observation of through, it was not running per nasal of asked to verify the coming from the oblow air loss mattres. On 8/17/21 at 2:31 continued to run. To 2.5 liters and was of Resident #15 stated imes. When asked stated "yes, every her to breath. The this time and it rea an as needed (PR liter(L) to keep an asymptotic state). On 8/17/21 at 3:43 (O2) remained on On 8/18/21 at 8:46 given Resident #15 at 2.5 L. When asymptotic was the PRN order of 1L, Staff A said should be some and said should be said to said should be said as a said should be said said said said said said said said	6/7/21, documented Resident cluded Huntington's disease, and abnormal posture. A Brief al Status (BIMS) revealed a ng moderate cognitive ent #15 required extensive bed mobility, toilet use, and on 8/16/21 during initial walk ed Resident #15 had oxygen cannula. When staff were noise they stated it was a xygen concentrator and not a		658			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		165226	B. WING			08/1	9/2021
	PROVIDER OR SUPPLIER			6	TREET ADDRESS, CITY, STATE, ZIP CODE 01 E SOUTH STREET IANLY, IA 50456		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 658	Nursing (DON), star for O2 to be titrated today had turned the resident's POX was earlier had said she the oxygen order a was, the DON said DON stated unders was not being follow. On 8/18/21 at 4:22 the facility corporate facility was not follow administering the order was to at a POX above 89%. A Medicaiton Admit 8/1/21-8/31/21, direction of the order was to at a POX above 89%.	atted she just obtained an order I 1-3L. She said the nurse is expected up because this is 89%. When told the RN is had not had time to look at and did not know what the order she didn't realize that. The standing that a doctor's order wed. PM, Staff C Senior DON for ion, stated understanding the owing doctor's orders when expect at 2.5L. Staff C verified liminister oxygen at 1L PRN for inistration Record dated exted staff to administer O2 at	F	658			
F 761 SS=D	order had a discon AM. This record reliter flow, O2 satural administered PRN. Administration Record from the facility's place of the staff to administer PRN to keep satural date for this order by Label/Store Drugs CFR(s): 483.45(g) Labelin Drugs and biological labeled in accordal professional principal propriate accessional staff.		F	761			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		165226	B. WING			08/	19/2021	
	PROVIDER OR SUPPLIER			601	REET ADDRESS, CITY, STATE, ZIP CODE E SOUTH STREET NLLY, IA 50456			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 761	applicable. §483.45(h) Storage §483.45(h)(1) In acceptance laws, the fabiologicals in locke temperature control personnel to have acceptance from the comprehensive control Act of 1976 abuse, except whe package drug district quantity stored is in the readily detected. This REQUIREME by: Based on observation for 1 comprehensive from the comprehensive from the readily detected. This REQUIREME by: Based on observation for 1 comprehensive from the facing from	cordance with State and acility must store all drugs and d compartments under proper les, and permit only authorized access to the keys. facility must provide separately ly affixed compartments for ed drugs listed in Schedule II of and other drugs subject to in the facility uses single unit libution systems in which the ininimal and a missing dose can l. NT is not met as evidenced liting, policy review and staff lity failed to discard expired of 2 medication carts and 1 of 1 aroom observed. The facility of 37. 16/21 at 4:47 p.m., revealed the eroom contained the following if and ready for use: id relief with an expiration date antacid tablets with an entacid tablets		761				

PRINTED: 08/25/2021 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED				
		165226	B. WING	i		08/1	9/2021
	PROVIDER OR SUPPLIER			6	STREET ADDRESS, CITY, STATE, ZIP CODE 601 E SOUTH STREET MANLY, IA 50456		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 761	label on the back of date. e. 1 bottle of mint flan expiration date of 8 suppositories in expiration date of 2 Observation on 8/1 medication cart corointment (used to han open date of 7/8 8/5/21. Review of the policidated February 20% outdated, deterioral stored in a designatings. During interview or Director of Nursing have all expired medicated.	f the bottle and no expiration lavored milk of magnesia with of 1/21 of the medication fridge with an		761			

Facility ID: IA0742

Event ID: SOIG11

(X3) DATE SURVEY

DEPARTMENT OF INSPECTIONS AND APPEALS

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	LETED
		IA0742	B. WING		08/1	9/2021
	PROVIDER OR SUPPLIER		JTH STREET	TATE, ZIP CODE -		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
N 101 SS=D	notification. 481-50.7 (10A,1350 director or the director or most expeditious most expedition mo	sion to a higher level of care than for observation; or lation with the attending of the physician, or physician mines, in writing on a form department, that an injury is a the circumstances of the bus functional ability of the gnosis. In the circumstances of the properties and the circumstances of the bus functional ability of the gnosis. In the circumstances of the properties accidents: resident, as defined in rules and falls when neither the properties have culpability related dent sustains a major injury; or actures; or	N 101			
	Based on record re facility failed to rep	eview and staff interview the cort to the Department of peals (DIA) a reportable				

(X2) MULTIPLE CONSTRUCTION

DIVISION OF HEALTH FACILITIES - STATE OF IOWA LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 08/25/2021 FORM APPROVED DEPARTMENT OF INSPECTIONS AND APPEALS STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING IA0742 08/19/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **601 E SOUTH STREET** MANLY SPECIALTY CARE **MANLY, IA 50456** (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) N 101 Continued From page 1 N 101 incident involving a resident in a timely manner for 2 of 4 incidents/complaints reviewed, (Resident #28 and Resident #88). The facility census was 37 residents. Findings include: 1. Review of documentation for Resident #88

1. Review of documentation for Resident #88 revealed an incident involving the resident occurred the evening of 3/26/21. The facility took appropriate steps to intervene and ensure the safety of the resident and informed the family and physician that same evening. Further review of documentation revealed the facility did not report this incident to DIA as required until 4/8/21, not within the 24 hours required by regulation.

During an interview on 8/18/21 at 10:05 am the facility Nurse Consultant verified that administrative staff at the time of the incident involving Resident #88 did not report it to DIA within the time required.

2. The facility reported Resident #28 had a fall with major injury to DIA on 6/28/21. The fall occurred on 6/24/21. The facility did not report the fall within the 24 hours required by DIA.

During interview on 8/18/21 at 1:35 PM, the Nurse Consultant, stated she was aware the incident was not reported to DIA within the regulated timeframe, (24 hours). She acknowledged the fall occurred on 6/24/21, the resident was hospitalized with serious injury on 6/25/21 and the facility reported the fall with injury on 6/28/21.

DIVISION OF HEALTH FACILITIES - STATE OF IOWA STATE FORM

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