DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0356	A. BUILDING: _____ B. WING _____	C 09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANNING SENIOR LIVING	**203 11TH STREET MANNING, IA 51455**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 19 Number of tenants with cognitive impairment: 6 Total census: 25 No regulatory insufficiencies were cited during the investigation of Incident #129130-I, Complaint #130311-C or Complaint #130353-C. The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification rules for an Assisted Living Program for People with Dementia.	A 000	See attached POC 9/30/25	
A 145	481-69.22(3) Evaluation of Tenant 69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change.	A 145		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 145	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to complete evaluations as a result of significant change in tenant condition for 1 of 6 tenants reviewed (Tenant #6). Findings follow: Record review on 9/29/25 indicated Tenant #6 was admitted to the program on 1/6/22. An entrance form provided by the program identified Tenant #6 received hospice services. Review of an unsigned evaluation dated 8/12/25 failed to reflect Tenant #6 received hospice services. When questioned on 9/30/25, the LPN (Licensed Practical Nurse) Health Care Coordinator confirmed Tenant #6 received hospice services. The LPN Health Care Coordinator provided a copy at 2:09pm of the physician orders signed and dated 9/16/25 by Hospice Services to evaluate and admit Tenant 6 to hospice services. The LPN Health Care Coordinator provided a copy of the most recent evaluation on file, dated 8/13/25. No evaluation based on the significant change 9/16/25 could be located which reflected Tenant #6 began hospice services, listed a hospice provider, or what service assistance hospice personnel provided to Tenant #6. On 9/30/25 at 3:05pm the Community Director, LPN Healthcare Coordinator, (and Regional Director of Operations and Regional Nurse Specialist by phone) confirmed the above findings.	A 145		
A 350	481-69.26(1) Service Plans	A 350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0356	A. BUILDING: _____ B. WING _____	C 09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANNING SENIOR LIVING	203 11TH STREET MANNING, IA 51455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 350	Continued From page 2 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to update the service plan following a significant change for 1 of 6 tenants reviewed (Tenant #6). Findings follow: Record review on 9/29/25 indicated Tenant #6 was admitted to the program on 1/6/22. An entrance form provided by the program identified Tenant #6 received hospice services. Review of an undated/unsigned service plan failed to reflect Tenant 6 received hospice services. When questioned on 9/30/25, the LPN (Licensed Practical Nurse) Health Care Coordinator confirmed Tenant #6 received hospice services. The LPN Health Care Coordinator provided a copy at 2:09pm of the physician orders signed and dated 9/16/25 by Hospice to evaluate and admit Tenant #6 to hospice services. The LPN Health Care Coordinator provided a copy of the most recent service plan on file, signed and dated 8/13/25. No service plan based on the significant change 9/16/25 could be located which reflected Tenant #6 began hospice	A 350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 350	Continued From page 3 services, listed a hospice provider, or what service assistance hospice personnel provided to Tenant #6. On 9/30/25 at 3:05pm the Community Director, LPN Healthcare Coordinator, (and Regional Director of Operations and Regional Nurse Specialist by phone) confirmed the above findings.	A 350		
A 395	481-69.26(4)a Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to ensure service plans were individualized and identified tenants' needs for 1 of 6 tenants reviewed (Tenant #1). Findings follow: 1) During Medication Administration Observation on 9/29/25 at 11:55am, Staff A dispensed Tenant #1's medications into a medication cup and left the medications with Tenant #1. Staff A stated Tenant #1 was allowed to self-administer her medications and was service planned to do so. Record review 9/29/25 revealed Tenant #1 admitted to the program on 8/25/24. A service plan dated 6/9/25 noted Tenant #1 was independent with medication administration and the medications were stored per resident	A 395		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0356	A. BUILDING: _____ B. WING _____	C 09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 395	Continued From page 4 convenience, but failed to reflect program staff were responsible for dispensing the medications and failed to reflect medications could be left with Tenant #1. When questioned during an interview on 9/30/25 at 12:30pm with the Community Director and LPN (Licensed Practical Nurse) Healthcare Coordinator, the LPN Healthcare Coordinator stated Tenant 1 won't take her medications while staff is in the room so Tenant #1's physician had given permission for Tenant 1 to self-administer and had written an order for Tenant 1's pills to be left bedside/chairside. The program provided a physician's order dated 10/1/25 following the exit on 9/30/25 which noted Tenant #1's medications could be left bedside with the tenant. The LPN Healthcare Coordinator confirmed neither the program nor the physician's office could locate a previously dated order. 2) The service plan dated 6/9/25 identified Tenant #1 received mental health services but failed to identify who Tenant #1 utilized as a provider for mental health services, a contact person, contact information, and a description of services provided, despite the service plan prompting for this information. When questioned during an interview on 9/30/25 at 12:30pm with the Community Director and LPN Healthcare Coordinator, the LPN Healthcare Coordinator acknowledged the service plan failed to include this information. 3) The service plan dated 6/9/25 under the category "Additional Nursing Services" identified Tenant #1 utilized a Home Health Aide but failed to detail what services the home health aide provided to Tenant #1. When questioned during an interview on 9/30/25 at 12:30pm with the Community Director and LPN Healthcare	A 395		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0356	A. BUILDING: _____ B. WING _____	C 09/30/2025

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A 395	Continued From page 5 Coordinator, the LPN Healthcare Coordinator stated Tenant #1 no longer utilized a Home Health Aide but acknowledged the service plan had not been updated at the time of discontinuation of services. On 9/30/25 at 3:05pm the Community Director, LPN Healthcare Coordinator, (and Regional Director of Operations and Regional Nurse Specialist by phone) confirmed the above findings.	A 395		

Ok
11/7/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	PROVIDER/SUPPLIER/CLIA INDENTIFICATION NUMBER:	DATE SURVEY COMPLETED:

Tag #	SUMMARY STATEMENT OF DEFICIENTCIES (EACH DEFICIENCY SHOULD BE PRECEDE BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY	Identify what changes to the provider's systems and practices were made to ensure compliance with the specific statute(s). Include information about how the provider will maintain compliance in the future.	COMPLETION DATE
Tag #1	**481-69.22(3) Evaluation of Tenant 69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and**	**Tag # A 145**	**What initial correction was made?** **COC was completed on 9/30/2025.**	**How will we ensure and maintain compliance going forward?** Discuss at stand-up meetings about residents' needing COCs done.	**Implementation Date:** **9/30/2025.** **Completion Date:** 9/30/2025. **Responsible Party:** **Director/HCC and or designee.**

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of regulatory insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state law.

	record review, the program failed to complete evaluations as a result of significant change in tenant condition for1 of 6 tenants reviewed (Tenant #6). Findings follow: Record review on 9/29/25 indicated Tenant #6 was admitted to the program on 1/6/22. An entrance form provided by the program identified Tenant #6 received hospice services. Review of an unsigned evaluation dated 8/12/25 failed to reflect Tenant #6 received hospice services. When questioned on 9/30/25, the LPN (Licensed Practical Nurse) Health Care Coordinator confirmed Tenant #6 received hospice services. The LPN Health Care Coordinator provided a copy at 2:09pm of the physician orders signed and dated 9/16/25 by Hospice Services to evaluate and admit Tenant 6 to hospice services. The LPN Health Care Coordinator provided a copy of the most recent evaluation on file, dated 8/13/25. No evaluation based on the significant change 9/16/25 could be located which reflected Tenant #6 began hospice services,				

	listed a hospice provider, or what service assistance hospice personnel provided to Tenant #6. On 9/30/25 at 3:05pm the Community Director, LPN Healthcare Coordinator, (and Regional Director of Operations and Regional Nurse Specialist by phone) confirmed the above findings.				
Tag #2	**481-69.26(1) Service Plans** **69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to update the service plan following a significant change for 1 of 6 tenants reviewed (Tenant #6). Findings follow: Record review on 9/29/25 indicated Tenant #6 was admitted to the program on 1/6/22. An entrance form provided by the program identified Tenant #6 received hospice services. Review of**	**Tag # A 350**	**What initial correction was made?** **COC/Care plan updated on 9/30/2025.**	**How will we ensure and maintain compliance going forward?** Discuss/Review COC/care plans at stand-up meetings.	**Implementation Date:** **9/30/2025.** **Completion Date:** 9/30/2025. **Responsible Party: Director/HCC**

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	an undated/unsigned service plan failed to reflect Tenant 6 received hospice services. When questioned on 9/30/25, the LPN (Licensed Practical Nurse) Health Care Coordinator confirmed Tenant #6 received hospice services. **The LPN Health Care Coordinator provided a copy at 2:09pm of the physician orders signed and dated 9/16/25 by Hospice to evaluate and admit Tenant #6 to hospice services. The LPN Health Care Coordinator provided a copy of the most recent service plan on file, signed and dated 8/13/25. No service plan based on the significant change 9/16/25 could be located which reflected Tenant #6 began hospice services, listed a hospice provider, or what service assistance hospice personnel provided to Tenant #6. On 9/30/25 at 3:05pm the Community Director, LPN Healthcare Coordinator, (and Regional Director of Operations and Regional Nurse Specialist by phone) confirmed the above findings.**				

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Tag #3	**481-69.26(4)a Service Plans** **69.26(4) The service plan shall be individualized and shall indicate, at a minimum:** **a. The tenant's identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: A 395 Based on interview and record review the program failed to ensure service plans were individualized and identified tenants' needs for 1 of 6 tenants reviewed (Tenant #1). Findings follow:** **1) During Medication Administration Observation on 9/29/25 at 11:55am, Staff A dispensed Tenant #1's medications into a medication cup and left the medications with Tenant #1. Staff A stated Tenant #1 was allowed to self-administer her medications and was service planned to do so. Record review 9/29/25 revealed Tenant #1 admitted to the program on 8/25/24. A service plan dated 6/9/25 noted Tenant #1 was independent with medication administration, and the medications were stored per resident convenience, but failed to reflect program staff were responsible for dispensing the medications**	**Tag # A 395**	**What initial correction was made?** **Care plan updated on 10/17/2025.**	**How will we ensure and maintain compliance going forward?** **Education provided to nurse on ISP expectations on 10/24/2025.** **Nurse will review all residents' service plans for personalization items.**	**Implementation Date:** **10/17/2025.** **Completion Date:** 10/24/2025. **Responsible Party:** **Director/HCC.**

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	and failed to reflect medications could be left with Tenant #1. When questioned during an interview on 9/30/25 at 12:30pm with the Community Director and LPN (Licensed Practical Nurse) Healthcare Coordinator, the LPN Healthcare Coordinator stated Tenant 1 won't take her medications while staff is in the room so Tenant#1's physician had given permission for Tenant 1 to self-administer and had written an order for Tenant 1's pills to be left bedside/chairside. The program provided a physician's order dated 10/1/25 following the exit on 9/30/25 which noted Tenant #1's medications could be left bedside with the tenant. The LPN Healthcare Coordinator confirmed neither the program nor the physician's office could locate a previously dated order. 2) The service plan dated 6/9/25 identified Tenant #1 received mental health services but failed to identify who Tenant #1 utilized as a provider for mental health services, a contact person, contact information, and a description of services provided, despite the service plan				

	prompting for this information. When questioned during an interview on 9/30/25 at 12:30pm with the Community Director and LPN Healthcare Coordinator, the LPN Healthcare Coordinator acknowledged the service plan failed to include this information. **3) The service plan dated 6/9/25 under the category "Additional Nursing Services" identified Tenant #1 utilized a Home Health Aide but failed to detail what services the home health aide provided to Tenant #1. When questioned during an interview on 9/30/25 at 12:30pm with the Community Director and LPN Healthcare Coordinator, the LPN Healthcare Coordinator stated Tenant #1 no longer utilized a Home Health Aide but acknowledged the service plan had not been updated at the time of discontinuation of services. On 9/30/25 at 3:05pm the Community Director,** **LPN Healthcare Coordinator, (and Regional Director of Operations and Regional Nurse Specialist by phone) confirmed the above findings.**				

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Compliance Date: 11/6/2025

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Must Haves on ISP's (Individualized Service Plans)

All high risk diagnoses that could lead to an exacerbation or hospitalization should be identified on the residents' service plan (dx such as CHF, COPD, Diabetes etc.) w/ s/s of what staff need to monitor for and report to the nurse.

All high risk medications should be identified on the residents service plan with instruction for the staff on when and how to administer the medication, where the medication is stored and any adverse effects to monitor for. (Meds such as Warfarin, Xarelto, Eliquis, Nitroglycerin etc.).

ISP Sections

Medications:

- Who is responsible for administering medications (staff or Independent)
- How medications are stored (if community administers medications must be locked up)
- Who is responsible for ordering medications (staff or independent). If family reorders medications for the resident please identify this.
- If medications are being crushed for administration this needs identified in this section. An informational order also needs put into the orders tab as well.
- If a resident is med managed by the community and has medications that they prefer to self-administer, we need a physician order to "keep at bedside and resident to self-administer". All medications that a resident chooses to self-administer should be identified in this section on the service plan. EX: Diclofenac 1% Gel, may keep at bedside and resident to self-administer.
- Hx of refusals with interventions for the staff to follow when the resident refuses.
- Medication planners – if a resident has a medication planner staff can only administer these medications if a nurse or the pharmacy is the person who is setting up the planner, staff cannot administer from a planner that has been set up by family. Planners should only be used for VA residents or to exhaust current supply of medications upon move in with plans to switch to the preferred pharmacy.
- Any injections administered by the nurse should also be specifically identified in this section, ensure the order for these medications are assigned to the Nurse to administer so staff do not accidentally sign this medication out as given.

Skin Integrity/Wound Care:

- All skin integrity issues should be identified in this section. This can be rashes, wounds, eczema, psoriasis etc. The current treatment w/ frequency should also be identified in this section along with who is responsible for completing (RA, Nurse, Outside Provider).
- If an outside provider such as Home Health or Hospice is performing the wound care, the skin issue, treatment and who is responsible for completing it should be

identified in this section. If resident is going to the wound clinic routinely this also needs identified in this section.

- Hx. of cellulitis and other skin infections/acute illnesses should also be identified in this section with signs/symptoms that staff should monitor for. EX: Resident has a hx of cellulitis to BLE's, staff to monitor for redness, warmth, swelling, pain to BLE's and report concerns to the nurse.

Psychosocial:

- If a resident has a dx of anxiety or depression (or any other mental health issues) this should be identified in this section along with what s/s staff should monitor for and how staff need to intervene when these issues are noted.
- Wandering/Exit seeking behaviors: this should be identified in this section along with interventions for the staff specific to that resident to be able to successfully re-direct that resident.
- Physical and verbal aggression behaviors: this should be identified in this section along with interventions specific to that resident for staff to be able to de-escalate the resident when these behaviors occur.

Pain/Discomfort:

- If a resident has a pain related diagnosis such as Sciatica, Chronic low back pain etc. this should be identified in this section along with interventions for staff to utilize if pain is noted.
- If a resident is taking scheduled pain medications or has PRN pain relief medications such as Oxycodone, Diclofenac Gel, Biofreeze then the resident should have a pain/discomfort NGA on the service plan with these specific medications identified in this section.

Falls:

- If a resident is taking Warfarin, Xarelto, Eliquis or Plavix (any anti-coagulant other than ASA) then a specific fall intervention related to high risk of bleeding will need added to this section along with what staff need to monitor for. EX: Resident currently takes warfarin which is a medication that thins the blood. Staff to monitor for bleeding or abnormal bruising with falls. Abnormal bleeding would be blood in urine or stool, blood in eyes, nasal bleeding or coughing up blood. Abnormal bruising would be bruising in areas not easily explained, large bruises or bruising that appears rapidly. Report concerns to the nurse.

Dressing:

- If a resident has ted hose, braces, splints, slings or AFO's these items should be identified in this section along if resident needs assist with these devices. An informational order for the ted hose should be in the orders tab of the chart as well.

Meal Consumption:

- If the resident has an altered diet ordered such a mechanical soft with nectar liquids, this needs identified in this section along with what staff should be monitoring for to report to the nurse. An informational order should also be put into the order tab of the chart.
- Weight loss, poor appetite, stealing others foods from their plate, finger foods, adaptive equipment such as weighted silverware should also be identified in this section. Weight loss, poor appetite, stealing others foods from their plates should all have resident specific interventions to provide guidance to staff when these issues occur.
- If the resident needs prompting, cueing or hand over hand assistance at meals this should be identified in this section.
- Any nutritional supplement use such as Ensure or Boost should be identified in this section as well along with the frequency of use.
- Severe food allergies should be identified in this section with interventions for staff to utilize in the event an allergic reaction is noted.

Toileting:

- UTI's, diarrhea, constipation, hemorrhoids, prolapsed bladder/uterus, etc. should be identified in this section with s/s for staff to monitor for and interventions available for staff to utilize for these concerns.
- Catheters: indwelling, suprapubic and straight caths should be identified in this section along with who is responsible and frequency for emptying, changing and maintaining devices. Specific s/s of what staff should monitor for should also be identified in this section.
- Ostomy's should be identified in this section along with who is responsible and frequency for emptying, changing and maintaining devices. Specific s/s of what staff should monitor for should also be identified in this section.

Additional Nursing Services:

- PT/OT/ST should be identified with who is providing the services and what they are working on.
- Home Health should be identified with who is providing, what services are being provided along with the HH agency's contact number.
- Hospice should be identified with admit date, dx, name & # of the agency, disciplines being provided with frequency and weight loss and falls statement.

Cardiac:

- Should identify any cardiac dx along with s/s to monitor for and report to the nurse.
- Nitroglycerin PRN use should be identified here with specific instructions on when and how to use this medication, where the medication is stored and who is responsible for administering the medication.
- Any routine vitals associated with the dx should also be included in this section (daily weights, daily blood pressures etc.)

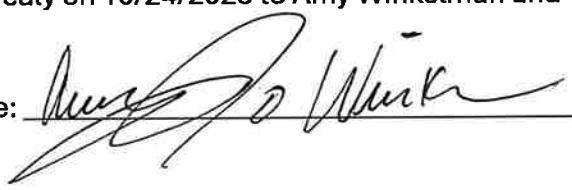
Respiratory:

- Should identify any respiratory dx along with s/s to monitor for and report to the nurse. PRN medications and interventions related to the dx. should be identified in this section as well.

Endocrine:

- Should identify any endocrine dx along with s/s to monitor for and report to the nurse.
- Diabetes – if on insulin or checking blood glucose levels need to have frequency of checks with MD call parameters. Need to identify what s/s of hypo/hyperglycemia that staff should monitor for along with interventions to utilize when occurs.
    - If resident is utilizing a Dexcom or Libre system, this should specifically be identified here along with frequency of changing of the sensor and who is responsible. Need to also identify that finger sticks to obtain blood glucose level can be done PRN if Dexcom or Libre is not functioning. Need an order for both in the orders tab of the chart as well.

Training provided by Tasha Kanealy on 10/24/2025 to Amy Winkelman and Tonya Zimmerman.

Date: 10/24/2025 Signature: 

Date: 10/24/25 Signature: Tonya Zimmerman

Date: 10/24/2025 Signature: Tasha Kanealy, RN