STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165226	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manly Specialty Care	601 E South Street Manly, IA 50456

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 48003 Based on clinical record review and staff interview the facility failed to send notice to State Long Term Care Ombudsman of transfer for 2 of 3 residents reviewed (Residents #13 and #26). The facility reported a census of 37 residents. Findings include: 1. The Progress Note written on 11/20/23 at 6:43 PM for Resident #13 documented the resident was on therapeutic leave with family. The Progress Note written on 1/1/24 at 6:08 PM for Resident #13 listed they admitted to the hospital. The Readmission Assessment completed on 1/3/24 at 3:28 PM. The Progress Note written on 2/8/24 at 12:22 PM for Resident #13 documented the resident went to the emergency room (ER). The Progress Note written on 2/8/24 at 4:31 PM reflected the hospital admitted them. The Progress Note written on 3/13/24 at 7:46 AM for Resident #13 documented the resident went to the ER. Readmission Assessment completed on 3/20/24 at 3:08 PM. Review of the Ombudsman reports for January 2024, February 2024 and March 2024 lacked documentation of resident transferring to the hospital. The November 2023 Ombudsman report lacked documentation of therapeutic leave. During an interview on 4/23/24 at 2:51 PM the Administrator verbalized the facility runs a report on the Electronic Health Record (EHR) program for the report the facility fills out for ombudsman reports. He didn't know why they missed those residents in those months. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/23/24 at 3:37 PM the Administrator reports the facility does not have a policy for ombudsman reporting. He reported the facility followed the regulations for reporting. 2. The Progress Note written on 9/29/23 at 11:38 PM for Resident #26 documented the resident went to the ER. The Progress Note written on 9/30/23 at 2:20 AM documented the resident returned to the facility from ER. The Progress Note written on 11/26/23 at 11:00 PM for Resident #26 documented the resident went to the ER. The Progress Note written on 11/27/23 at 1:25 AM indicated the hospital admitted them. The Progress Note written on 3/3/24 at 11:05 PM for Resident #26 documented the resident went to the ER. The Progress Note written on 3/4/24 at 12:14 AM documented the resident would return to the facility. Review of the Ombudsman reports for September 2023, November 2023, and March 2024 lacked documentation of resident transferring to the hospital.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48003 Based on clinical record review and staff interview, the facility failed to complete a new Preadmission and Resident Review (PASRR) evaluation as required for 1 of 1 reviewed (Resident # 36). The facility reported a census of 37 residents. Findings include: Resident #36's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 11 indicating moderately cognitive impaired. The MDS include diagnoses of depression, Bipolar disorder, and dementia. Resident #36's Notice PASRR Level II Outcome dated 10/16/23 listed the date the short term approval ends as 4/13/24. During an interview on 4/24/24 at 4:20 PM, the MDS Coordinator reported they submitted a new PASRR on 4/13/24 for review and the it was determined on 4/18/24. The MDS Coordinator reported she didn't know she needed to have a new PASRR completed and determined prior to the expiration of the approved short term ending. During an interview on 4/24/24 at 4:50 PM, the Administrator reported the facility didn't have a policy for PASRR. He reported the facility followed the regulations.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40907 Based on observations, interviews, and record review, the facility failed to properly care for and accurately document pressure ulcers for 1 of 3 residents reviewed (Resident #23). During a pressure ulcer dressing change, observed the staff failed to use a cleanser to clean Resident #23's sacral/coccyx (tailbone area) pressure ulcer. During record review of this resident's pressure ulcers, determined the facility didn't update the stages of the pressure ulcers with worsening changes. The facility reported a census of 37 residents. Findings include: The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers: NOTE: Regardless of the staging system or wound definitions used by the facility, the facility is responsible for completing the MDS utilizing the staging guidelines found in the RAI (Resident Assessment Instrument) Manual. Stage 1 Pressure Injury (PI): Non blanchable erythema of intact skin Intact skin with a localized area of non blanchable erythema (redness). In darker skin tones, the PI may appear with persistent red, blue, or purple hues. The presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes of intact skin may also indicate a deep tissue PI (see below). Stage 2 Pressure Ulcer (PU): Partial thickness skin loss with exposed dermis Partial thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar is not present. This stage should not be used to describe moisture associated skin damage including incontinence associated dermatitis, intertriginous dermatitis (inflammation of skin folds), medical adhesive related skin injury, or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Ulcer: Full thickness skin loss Full thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the wound bed, it is an Unstageable PU/PI. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Stage 4 Pressure Ulcer: Full thickness skin and tissue loss Full thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible on some parts of the wound bed. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the wound bed, it is an unstageable PU/PI. Unstageable Pressure Ulcer: Obscured full thickness skin and tissue loss Full thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) should only be removed after careful clinical consideration and consultation with the resident's physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws. If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. If the anatomical depth of the tissue damage involved can be determined, then the reclassified stage should be assigned. The pressure ulcer does not have to be completely debrided or free of all slough or eschar for reclassification of stage to occur. Other staging considerations include: o Deep Tissue Pressure Injury (DTPI): Persistent non blanchable deep red, maroon or purple discoloration Intact skin with localized area of persistent non blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure ulcer. Once a deep tissue injury opens to an ulcer, reclassify the ulcer into the appropriate stage. Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions. A Minimum Data Set (MDS) assessment dated [DATE], documented that Resident #23 had 2 Stage 1 pressure ulcers and 1 Stage 3 pressure ulcer. It documented that Resident #23 had no Stage 2, Stage 4, unstageable pressure ulcers or deep tissue injuries. A Doctor's order dated 4/13/24 and discontinued on 4/23/24, directed staff to cleanse sacral wound with cleanser and pat dry. Apply calcium alginate cover (highly absorbent biodegradable dressing) with large Mepilex (highly absorbent foam dressing) daily and PRN (as needed). On 4/23/24 at 10:48 AM., the Director of Nursing (DON) and Staff E, Licensed Practical Nurse (LPN) washed hands and applied gloves and gowns. Staff E removed the larger dressing from resident's sacral area. Staff E then used a damp towel and patted at site and then used the dry part of the towel to pat it dry. Staff E then removed smaller dressing from coccyx. Noted a yellow slough was covering the wound. Staff E then placed a small dressing of calcium alginate cut into a circle to fit the wound over the wound. She then placed a large Mepilex dressing over the smaller wound dressing. Staff E said Resident #23 had a dressing change daily. Staff E stated the Mepilex didn't have a date upon removal. When asked about cleaning the wound, Staff E stated she didn't know if she was to use wound cleanser to the wound, she would have to look. Staff E stated she just dampened part of the towel. The DON stated she would have to look at the doctor's orders as orders can differ from resident to resident. The DON did not know if he had an order to use wound cleanser. The DON acknowledged concern the nurse used a dampened towel but didn't clean the wound between removing the old dressing and applying the new one. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/24 at 12:39 PM, Staff F, Advanced Registered Nurse Practitioner (ARNP) stated she would redo the wound order, to have the wound cleaned more effectively and make sure it doesn't get infected. She acknowledged the concern of not cleaning the wound effectively. She stated she took Resident #23 on her caseload approximately a month ago. She stated Staff G, ARNP, had Resident #23 on her caseload before Staff F took over. On 4/23/24 at 1:06 PM, when told about the sacral/coccyx dressing change observation, Staff G stated that the cleaning was not sufficient. She stated she knew they used the wound cleanser on his legs. Staff G stated it definitely was not appropriate to clean the wound with a towel dampened with water to clean his coccyx wound. Staff G stated she would say soap and water with sterile dressing and/or a wound cleanser would be appropriate. Staff G stated that the pressure ulcers on this resident heals were unstageable the last time she saw them. A Doctor's order dated 4/24/24, directed staff to cleanse sacral wound with wound cleanser and pat dry. Apply calcium alginate with large Mepilex daily and PRN. A Skin and Wound Evaluation dated 4/22/24, documented a Stage 3 coccyx pressure ulcer with slough covering 80 percent of the wound. A Skin and Wound Evaluation dated 4/6/24, documented a Stage 1 pressure ulcer on Resident #23's right heel. The picture showed open areas on his heel. A Care Plan revised on 4/22/24, documented that this resident had a Stage 1 pressure ulcer to right heel and a stage 3 pressure ulcer to his left heel. It documented that Resident #23 had a Stage 3 pressure area to coccyx. It documented that Resident #23 needed wound care as ordered by his physician. On 4/23/24 at 1:00 PM, the Assistant Director of Nursing (ADON) stated the stage of the coccyx pressure ulcer should be unstageable due the slough covering it. She stated that the Stage 1 pressure ulcer on the right heel they should code it as Stage 2 after verifying there is depth to the wound on 4/6/24. On 4/23/24 at 1:30 PM, the Director of Nursing (DON) acknowledged the concerns with not staging the pressure ulcers properly. A Wound Care policy revised October 2016, directed to verify the physician's order for this procedure. Assemble the equipment and supplies as needed. Prepare antiseptic (as ordered). Wash tissue around the wound where the dressing covers the wound, tape or gauze with antiseptic or soap and water. Apply treatments as indicated.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 40907 Based on interviews and record review, the facility failed to forward a pharmacy recommendation for the physician to re evaluate the renewal of a 14-day PRN (as needed) Haloperidol (Haldol)(antipsychotic) for 1 of 5 residents reviewed for medication regimen review (Resident #33). The facility reported a census of 37 residents. Findings include: A Condensed Summary of All Recommendation written by the pharmacist on 1/3/24, directed that the Haloperidol (Haldol)(anti-psychotic medication) 2 mg (milligrams) every 4 hours PRN (as needed) for anxiety delusions ordered for Resident #33 on 12/22/23, documented that the order needed to have the mandatory 14-day end date (1/5/24) per CMS Regulations due to the use of PRN antipsychotics for acute situations. It documented that at the end of the 14 days, the Physician can re evaluate the resident in person to determine if they need another 14-day PRN order. A January 2024 Medication Administration Record (MAR), documented haloperidol 1 mg give 2 tablets by mouth as needed for anxiety and or delusions. It documented the start date was 12/22/23 and the discontinue date was 1/23/24 The MAR included 28 times Resident #33 received the medication from 1/6/24 through 1/23/24 On 4/24/24 at 3:30 PM, the Assistant Director of Nursing (ADON), stated she didn't know what happened. She couldn't provide the rationale to continue the PRN Haldol, nor could she provide information the provider reviewed and set a stop date for the PRN Haldol. She stated they should have definitely forwarded the information to the physician. The ADON acknowledged they didn't discontinue Resident #33's PRN Haldol order after 14 days. A PRN Medication Policy dated December 2016, directed to not renew PRN orders for antipsychotic medications beyond 14 days unless the healthcare practitioner has the resident for the appropriateness of that medications.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40907 Based on observations, interviews and record review, the facility failed to provide the Dietitian approved menu for 4 of 4 residents who were on a pureed diet (Residents #12, #22, #37 and #38). During the lunch observation on 4/24/24, observed four residents did not receive pureed bread per therapeutic menu. The facility reported a census of 37 residents. Findings include: 1. A doctor's order dated 1/26/24, directed that Resident #12 receive a pureed texture diet. A Minimum Data Set (MDS) assessment dated [DATE], documented that Resident #12 was not able to complete the Brief Interview for Mental Status (BIMS). Resident #12 required substantial/maximal assistance for eating. The helper did and provided more than half the effort. The assessment indicated Resident #12 ate a mechanically altered diet, for example pureed food. 2. A doctor's order dated 11/20/23, directed that Resident #22 receive a pureed texture diet. A Minimum Data Set (MDS) assessment dated [DATE], documented that Resident #22 was not able to complete a Brief Interview for [NAME] Status (BIMS). It documented that Resident #22 required partial to moderate assistance for eating. The helper does less than half of the effort. It documented mechanically altered diet for example pureed food. 3. A doctor's order dated 11/20/23, directed that Resident #37 receive a pureed texture diet. An MDS assessment dated [DATE], documented that Resident #37 scored a 3 out of 15 on the BIMS. This indicated that this resident had severely impaired cognition. It documented that Resident #37 required supervision or touching assistance. The helper provided verbal cues and /or touching /steadying and /or contact guard assistance as resident completes the activity. The MDS indicated Resident #37 received some assistance throughout the activity or intermittently. It documented mechanically altered diet for example pureed food. 4. A doctor's order dated 11/20/23, directed that Resident #38 receive a pureed texture diet. An MDS assessment dated [DATE], documented that Resident #38 scored 0 out of 15 on the BIMS. This indicated that this resident had severely impaired cognition. It documented that Resident #38 was dependent for eating. The helper does all the effort and the resident does none of the effort to complete the activity. It documented mechanically altered diet for example pureed food. On therapeutic Spread Report Spring/Summer Menu '24, it directed that residents on a puree diet were to receive puree bread for lunch. On 4/24/24 at 11:00 AM., Staff B, Cook pureed meat (beef roast) and potato/carrot vegetable side. She stated those were the only things she was pureeing as they were serving pudding for dessert. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/24/24 at 12:15 PM, when asked about there not being pureed bread for the residents who received a pureed diet, Staff B answered that she has never served pureed bread. She stated she wouldn't even know how to puree it. The Certified Dietary Manager (CDM) stated she has not served pureed bread before. The CDM acknowledged the menu listed the bread for lunch that day. Both the CDM and the cook stated they did not and have not served pureed bread. On 4/24/24 at 3:45 PM, the Administrator acknowledged the concern regarding not pureeing bread as part of the lunch today. He stated their Dietitian is working on this. He acknowledged that both the CDM and Staff B both stated they have never pureed the bread. He acknowledged that this was a concern related to the Dietitian approving the diets as meeting the nutritional needs for each diet. The Director of Nursing (DON) and the Assistant Director of Nursing (ADON), acknowledged the same concerns earlier on this day. On 4/24/24 at 4:01 PM, Staff C, Registered Dietitian stated that she had been in the facility before, on 2/20/24, and asked to see the pureed process. Bread was not on the menu the day she had asked. Staff C stated she remembered they had talked about pureeing the bread when it was on the menu. She stated it was the cook that said it, but doesn't remember her name. Staff C stated they had a new therapeutic diet menu that came out for spring and summer. Staff C stated that Staff D, Dietitian was the new Dietitian. Staff C stated they should be pureeing bread when it is on the menu. On 4/24/24 at 4:09 PM, Staff D stated she did not have any knowledge of the kitchen not pureeing bread. Staff D stated that when she signed therapeutic Spread Report Spring/Summer '24 menus she was signing that the daily diets were nutritionally adequate. She stated that the residents certainly can vary from the diets. Staff D stated they should have pureed the bread for the menu. She stated she would definitely be talking to the kitchen staff about following the menus and pureeing the bread. Staff D stated she had not been at this facility for very long. She stated she hadn't seen anyone puree bread there nor had she heard anyone talk about not being able to puree bread. She stated she had only watched a few meal services since she started there. On 4/25/24 at 8:20 AM., Staff D stated that the tickets (used for plating at meal times) for the ladies who received a puree diet, did not have bread listed on them. When asked who filled out the tickets, she stated sometimes it's the CDM and other times it's the CNA's. This Dietitian stated that some of the residents cannot say and acknowledged they should offer bread if listed on the menu for pureed diets. On 4/25/24 at 10:45 AM., the CDM stated she is the one who took the bread off for yesterday's lunch meal. She stated she had tried pureed bread with the 4 ladies once before and they did not like it so she stopped serving it when it's just plain bread and butter or toast on the menu. She acknowledged that this changed the number of calories, carbohydrates, and nutrients offered for the day and that it veered off the planned menu approved by a Dietitian. The CDM stated she had not let the Dietitian know about the removal of bread. This CDM stated that when there is a ham sandwich they puree the bread right in with the ham or if it's a cheeseburger they puree the bun right in with the burger. She stated that she could puree the toast right in with the eggs for breakfast instead of omitting the toast and that they could have pureed the bread right in with the roast beef yesterday as well. She said they would start including the breads with the main meals. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Menus policy revised on October 2017, directed to develop and prepare menus to meet resident choices including religious, cultural and ethnic needs while following established national guidelines for nutritional adequacy. It directed that deviations from posted menus are recorded (including the reason for the substitution and/or deviation) and archived.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 48003 Based on facility record review, staff interview, and policy review, the facility failed to have the minimum required members at the Quality Assessment and Assurance (QAA) meetings to identify issues with respect to which quality assessment and assurance activities are necessary. The facility reported a census of 37 residents. Findings include: Review of the facility QAA sign in sheets revealed the Administrator, Medical Director, Director of Nursing (DON), Infection Preventionist and one other staff member were present at the meetings for the first 4 of 6 quarters reviewed. During an interview of 4/25/24 at 10:15 AM, the Director of Nursing (DON) reported she thought the regulation only required a total of five members needed to be present not the six the regulation required. Review of the facility's Quality Assurance and Performance Improvement (QAPI) Program undated revealed the QAA Committee was to meet at least quarterly and would include the Administrator, DON, Medical Director, Infection Preventionist, and Representatives from six other departments, as requested by the Administrator.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48003 Based on observation, record review, staff interview and policy review the facility failed perform proper hand hygiene and proper personal protective equipment guidelines to prevent the spread of potential infection and germs during peri cares for 1 of 1 resident reviewed (Resident # 13). The facility reported a census of 37 residents. Findings include: The Minimum Data Set (MDS) assessment completed for Resident #13 on 4/12/24 documented the diagnoses of septicemia, recurrent enterocolitis (inflammation in your intestines) due to clostridium difficile (a contagious infection that causes diarrhea), and hypertension (high blood pressure). During an observation on 4/23/24 at 11:30 AM, Staff A, Certified Nursing Assistant (CNA), assisting Resident #13 off of the bedpan. Staff A did hand hygiene, then applied a gown and gloves. Staff A did Resident #13's peri-care. After completing the peri-care, she used the same dirty gloves to grab a clean brief and place it under the resident. Without hand hygiene or removing their gloves, Staff A pulled Resident #13's gown down and grabbed the full-body mechanical lift sling and placed it under the resident, then removed her gloves. During an interview on 4/23/24 at 11:50 AM, the Assistant Director of Nursing (ADON) reported she expected staff to change gloves after doing peri care prior to touch a clean brief During an interview on 4/24/24 at 2:55 PM, the Director of Nursing (DON) reported she expected the staff to changes gloves from dirty to clean. Review of the facility policy titled Perineal Care revised February 2018 lacked direction for removing gloves after completing peri-care prior to touching any clean surface.