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	02/27/2025

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

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48003 Based on record review, staff interviews, and Resident Assessment Instrument (RAI) Manual the facility failed to accurately code 2 of 12 residents' (Residents #1 and #33) Minimum Data Set (MDS) Assessment. The facility reported a census of 41 residents. Findings include: 1. Resident #1's Preadmission Screening and Resident Review (PASRR) assessment dated [DATE] listed her as a Level II PASRR due to a serious mental illness. Resident #1's annual MDS assessment dated [DATE] coded Resident #1 as a PASRR level I (a person without a serious mental illness). During an interview on 2/27/25 at 8:05 AM, the Social Services Coordinator reported Resident #1 had a level II PASRR approved with specialized services. During an interview on 2/27/25 at 8:35 AM the Assistant Director of Nursing (ADON) reported they had some confusion on Resident #1's PASRR, that is why the MDS didn't get coded as a level II. On 2/27/25 at 8:46 AM the Director of Nursing (DON) reported the facility didn't have a policy for MDS. She reported they follow the RAI Manual. The RAI Manual revised October 2024 directed to code yes for Level II PASRR, if PASRR Level II screening determined the resident had a serious mental illness. 46873 2. Resident #33's MDS assessment dated [DATE], identified a BIMS score of 11, indicating moderate cognitive impairment. The MDS included a diagnosis of non-Alzheimer's dementia. The MDS lacked documentation of Resident #33 exhibiting behaviors towards others in the 7-day lookback period. On 2/24/25 at 3:56 PM, Resident #7 reported Resident #33 is mean to her and makes her cry. She stated Resident #33 bullied her and she reported it to the Administrator. (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

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	02/27/2025

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

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/25/25 at 11:03 AM, the Administrator stated that Resident #33 gets very annoyed quickly with Resident #7. He stated both residents enjoyed spending a lot of the day in the dining area and Resident #7 tends to ask a lot of questions. He stated Resident #33 reached a point that she gets annoyed very quickly with Resident #7. He stated the staff discussed with Resident #33 regarding the way she speaks to Resident #7. He stated staff are always in the area and intervene before anything more happened. The staff are to spend time with Resident #7, if she is in a mood of asking a lot of questions, in an attempt to distract her from speaking to Resident #33. The Grievance/Concern Investigation form filed 2/6/25 documented Resident #7 filed a concern with the facility reporting that Resident #33 called her a derogatory name on 2/5/25. Resident #33's MDS assessment dated [DATE] documented she displayed no verbal behavioral symptoms directed towards others during the 7-day lookback period. The 2024 RAI Manual, under Steps for Assessment of question E0200 directed: 1. Review the medical record for the 7 day lookback period. 2. Interview staff, across all shifts and disciplines, as well as others who had close interactions with the resident during the 7 day lookback period, including family or friends who visit frequently or have frequent contact with the resident. 3. Observe the resident in a variety of situations during the 7 day lookback period. The 2024 RAI Manual listed additional Coding Instructions: Code 0, behavior not exhibited: if the behavioral symptoms were not present in the previous 7 days. Use this code if the resident never exhibited these symptoms or if they previously exhibited the behavior but hasn't in the previous 7 days. Code 1, behavior of this type occurred 1 3 days: if they exhibited the behavior for 1 3 days of the previous 7 days, regardless of the number or severity of episodes that occur on any one of those days. Code 2, behavior of this type occurred 4 6 days, but less than daily: if they exhibited the behavior for 4 6 of the previous 7 days, regardless of the number or severity of episodes that occur on any of those days. Code 3, behavior of this type occurred daily: if they exhibited the behavior daily, regardless of the number or severity of episodes that occurred on any of the days in the previous 7 days.

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	02/27/2025

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

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46873 Based on observations, clinical record review, and staff interview, the facility failed to follow the comprehensive Care Plan for 1 of 12 (Resident #24) reviewed for Care Plans. The facility reported a census of 41 residents. Findings include: Resident #24's Minimum Data Set (MDS) assessment dated [DATE] listed they required partial/moderate assistance for eating. The MDS included diagnoses of cerebral Infarction (stroke), multiple sclerosis, and dysphagia (difficulty swallowing). The Care Plan Focuses dated a. 5/16/23 indicated Resident #24 required assistance at meal time. The Interventions directed: i. She required one on one (1:1) with feeding. ii. Encourage her to take small bites and alternate bites with drinks, then tuck and swallow. b. 1/22/25 reflected Resident #24 had a nutritional risk related to stroke, Alzheimer's disease and multiple sclerosis. The Interventions directed i. She needed assistance with eating. ii. Recommend 1:1 supervision during eating to promote safety with use of swallow strategies, go slow, alternate liquids and solids, swallow twice to clear residue, and remain upright after meals for 30 minutes. A continuous observation on 2/26/25 starting at 7:56 AM, witnessed Resident #24, not yet served her meal, sitting at the dining room table. - At 8:02 AM, Resident #24 received her meal and she began drinking a glass of chocolate milk. A staff member sitting at the same table, didn't provide any observed direct assistance at first. When Resident #24 failed to feed herself, the staff member gave her a spoon, but she placed it back on the table. - At 8:05 AM, witnessed the staff member get up and leave the table. On 2/26/25 at 8:07 AM, watched Resident #24 begin to feed herself her bowl of pureed biscuits and gravy. Observed Staff B, Certified Nurse Aide (CNA), in the nearby area but they didn't provide any direct assistance to Resident #24. (continued on next page)

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	02/27/2025

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

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- At 8:08 AM, Staff C, CNA, asked Resident #24 if she could place her clothing protector on her, and assisted her with the protector. Staff C brought the bowl of biscuit and gravy closer to Resident #24. Watched Resident #24 continue to feed herself without staff assistance or cues provided. - At 8:13 AM, the Director of Nursing (DON) sat down at the table adjacent to Resident #24, overseeing the residents eating, monitoring for safety. - At 8:16 AM, observed another staff member enter the room. She took an empty chair from Resident #24's table, and placed it at the table where the DON sat and spoke with her. Neither staff member appeared to watch Resident #24. Staff C stood nearby in another area of the dining room. Resident #24 drank her full glass of chocolate milk prior to starting to eat the biscuits and gravy. While she ate, Resident #24 didn't drink anything since she began to eat. - At 8:16 AM, Staff D, Certified Medication Aide (CMA), brought a chair to the table and sat down. Witnessed Staff D and Staff C have a conversation as Resident #24 ate her breakfast. As Staff A, Cook, rounded, they noted Resident #24's drink glass empty and provided a second glass of chocolate milk. Resident #24 picked it up and took some drinks. - At 8:19 AM, Staff C left the area briefly, returned with a gait belt and spoke to another resident. Staff C remained in the area until 8:22. Resident #24 continued to eat her breakfast by herself throughout the observation. No observations of staff providing 1:1 assistance or reminding Resident #24 to alternate drinks and bites or to do chin tucking exercises. - At 8:24 AM, witnessed Resident #24 take 2 3 drinks of milk and returned to her biscuits and gravy. Staff D sat at the table speaking to another resident at the table, they offered no cues or assistance to Resident #24. A continuous observation on 2/27/25 starting at 8:14 AM revealed Resident #24 sat at the table with an empty glass of milk and she eating herself. No staff sat at the table with Resident #24. Staff E, CNA, sat at the next table. - At 8:16 AM, Staff B stopped and visited with Resident #24 briefly and then went on to other residents. - At 8:23 AM, Staff C arrived in the dining room, then Staff B left the area. Staff C sat down at a table to assist another resident as Resident #24 continued to eat by herself. On 2/27/25 at 8:25 AM, Staff E sat down at the table with a computer and her own food. She ate her own meal while she visited with another staff member. No observation of interaction from Staff E with Resident #24. Two minutes later, Staff E moved to the next table. On 2/27/25 at 8:29 AM, watched Resident #24 pickup and tip her nearly empty bowl. It appeared like she was looking to see if she had more food in the bowl. After receiving no assistance, Resident #24 put the bowl on the table and pushed herself away from the table. Staff E stood and assisted her to leave the dining room. (continued on next page)

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	02/27/2025

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

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/27/25 at 11:04 AM, Staff B stated Resident #24 required set up assistance generally for meals. She stated it depended on the day, as some days she needs help. She stated she believed Resident #24 had swallowing problems in the past but they got better since she started the pureed diet. On 2/27/25 at 11:15 AM, the DON stated she would verify if Resident #24 needed to still receive 1:1 assistance at meals. She stated she didn't feel that was accurate any longer but that the CNAs should follow the Care Plan.

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	02/27/2025

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

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46873 Based on clinical record review, facility policy review, resident and staff interview the facility failed to update resident Care Plans for 2 of 12 residents reviewed (Residents #7 and #33) for Care Planning. The facility reported a census of 41 residents. Findings include: 1. Resident #7's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 15, indicating cognition intact. The MDS included diagnoses of anxiety disorder, bipolar disorder and post-traumatic stress disorder. On 2/24/25 at 3:56 PM, Resident #7 reported Resident #33 is mean to her and makes her cry. She stated Resident #33 bullied her and she reported it to the Administrator. On 2/25/25 at 11:03 AM, the Administrator stated that Resident #33 gets very annoyed quickly with Resident #7. He stated both residents enjoy spending a lot of the day in the dining area and Resident #7 tends to ask a lot of questions. He stated Resident #33 has reached a point that she gets annoyed very quickly with Resident #7. He stated staff has had discussions with Resident #33 regarding the way she speaks to Resident #7. He stated staff is always in the area and are to intervene before anything more comes of it and to spend time with Resident #7 if she is in a mood of asking a lot of questions and to attempt to distract her from speaking with Resident #33. The Care Plan of Resident #7, review date 12/6/24, failed to address any conflict with other residents. 2. Resident #33's MDS assessment dated [DATE], identified a BIMS score of 11, indicating moderate cognitive impairment. The MDS included a diagnosis of non-Alzheimer's dementia. The MDS lacked documentation of Resident #33 exhibiting behaviors towards others in the 7-day lookback period. The Care Plan reviewed 2/19/25, lacked Resident #33 having any negative or aggressive behaviors directed towards others. The Appointment/Visit Note dated 9/24/24 at 11:18 AM reflected Resident #33 saw the mental health provider via telehealth. The provider ordered no changes and to revisit in 3 months. The Behavior Note dated 11/23/24 at 3:50 PM indicated as Resident #33 waited for coffee from the kitchen staff, another resident barged by her and started to talk to the kitchen staff. Resident #33 started yelling at the other resident. The other resident stated Resident #33 hit her and she started to cry. Resident #33 denied hitting her on purpose and accidentally bumped her with her arm. (continued on next page)

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	02/27/2025

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

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Appointment/Visit Note dated 12/10/24 at 11:51 AM indicated Resident #33 saw the mental health provider. The provider noted no concerns, listed Resident #33 as stable, may switch visits to as needed (PRN). The Behavior Note dated 2/26/25 at 6:17 PM reflected Resident #33 became agitated with another resident during lunch that day and spoke harshly to them. The Communication - with Resident dated 2/27/25 at 1:42 PM identified the DON and the Social Worker spoke with Resident #33 about the incident with the other resident who left the dining room in tears. Resident #33 said she would try to be more mindful before making remarks out loud. Resident #33 asked them to tap her on the shoulder and tell her when she is being rude. She asked they quietly whisper it to her, instead of yelling it across the dining room. The Social Worker would add the intervention to the Care Plan. On 2/27/25 at 8:01 AM, the MDS Coordinator stated she worked at the facility since December 2024. She explained she is new to the job and is working on updating the Care Plans. She stated the DON notified her when the Care Plan is missing something but otherwise she updates them as she completes the MDS assessments for each resident and as the residents have Care Conferences. On 2/27/25 at 11:04 AM, Staff B, Certified Nurse Aide (CNA), stated she knew of issues between Resident #7 and Resident #33. She explained they moved Resident #7 to a dining table further away from Resident #33. She stated on the prior day, Resident #7 had an altercation with another resident during lunch (Resident #45). She stated Resident #45 became upset when Resident #7 yelled at her and asked for assistance to go back to her room. Staff B stated she assisted Resident #45 to fill out a grievance form and turned into the DON. She denied knowing of staff receiving any education regarding interventions for Resident #7 when she is verbally aggressive. On 2/27/25 at 11:15 AM, the DON stated the Social Worker handled the new grievance form regarding Resident #33. She stated Resident #33 is on services with the psychiatrist who rounds in the facility and has received services for some time. She stated she has her next appointment in approximately 2 weeks. The Care Plan of Resident #33 failed to identify the resident receiving any psychiatric/mental health therapy. The Care Planning Interdisciplinary Team, policy revised September 2013 documented the facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive Care Plan for each resident.

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	02/27/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48003 Based on record review, policy review and staff interviews, the facility failed to ensure all residents received medication as ordered by a physician; and failed to prevent potentially serious medication errors when staff administered the wrong medications or dosage from 5/8/24 to 2/21/25 for 8 of 8 residents reviewed (Residents #6, #8, #35, 38, #44, #145, #146, #147, and #148). The facility reported a census of 41 residents. Findings include: During a confidential interview staff reported concerns with frequent medication errors and reported concerns that Staff G, Registered Nurse (RN), had several medication errors. The staff member reported they felt the facility didn't look into the medication errors to correct the issue. The facility provided the following Incident Reports related to medication errors: a. 5/8/24: Resident #148 received the wrong medications. Resident #148 received amiodarone (treat heart rhythm problems), colchicine (used to treat inflammation and pain), metoprolol (used to treat high blood pressure), potassium chloride and sertraline (antidepressant). b. 6/16/24: Resident #146 received half the dose of Lyrica (nerve pain medication) then she should have. c. 7/12/24: Resident #8 received the wrong dose of Clozapine (sedative medication used to help with panic attacks, anxiety, and seizures). She received double her ordered dosage. d. 7/17/24 7/19/24: Resident #35 received a double dose of Buspirone (treat anxiety) for 3 days in a row. e. 8/15/24 8/16/24: Resident #38 received hydrochlorothiazide (diuretic) that the provider discontinued for 2 days in a row. f. 9/25/24: Resident #145 received a double dose of Hiprex (antibiotic for urinary tract infections). g. 10/5/24: Resident #6 received both AM and MD doses of Gabapentin (nerve pain medication) at the same time. h. 12/29/24: Resident #44 received Famotidine instead of Lasix (diuretic) i. 1/15/25: Resident #38 received PRN (as needed) oxycodone (narcotic pain mediation) doses just an hour apart and is every 4 hours PRN and was given 3 hours sooner than should have received it. Oxycodone can cause respiratory distress and death when taken in high doses. j. 1/24/25: Resident #147 received lisinopril 20mg and Lisinopril HCTZ 20mg. Lisinopril was discontinued. Both are blood pressure medications. (continued on next page)

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	02/27/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	k. 1/28/25: Resident #147 received Glimepiride (diabetic medication) and lisinopril (blood pressure medication) and both medications were discontinued. l. 2/21/25: Resident #38 received Novolog (short acting insulin) 24 units instead of Glargine (long acting insulin) 24 units. 1. Resident #38's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score as a 14, indicating intact cognition. The MDS listed Resident #38 received insulin injections for 7 days in the lookback period. In addition, Resident #38 received a diuretic medication (used to flush the system of excess fluid) in the lookback period. Resident #38 received an opioid within the 7-day lookback period. Resident #38's August 2024 Medication Administration Record (MAR) included an order dated 7/25/24 and discontinued 8/14/24. 8/15/24 and 8/16/24 included x's indicating no active order as documentation. Staff G documented the morning and midmorning medications that day on the MAR. Resident #38's January 2025 MAR listed an order dated 3/4/24 for Oxycodone oral tablet 10 milligrams by mouth every 4 hours as needed for pain. Documentation reflected Staff H, RN, gave Resident #38 Oxycodone on 1/15/25 at 5:35 AM, then Staff G documented giving her Oxycodone on 1/15/25 at 6:52 AM. The Incident, Accident, Unusual Occurrence Note dated 1/17/25 at 9:21 PM identified Resident #38 notified the nurse and Certified Nurse Aide (CNA) that she received 2 doses of her Oxycodone the morning of her surgery (1/15/25). The nurse who worked that day gave a dose of Oxycodone approximately 1 hour after the first nurse gave the medication. Resident #38's Individual Narcotic Record dated 1/9/25 through 2/24/25 documented Staff G gave her 1 Oxycodone at 6:30 AM, after the previous nurse gave a dose at 5:35 AM. Resident #38's February 2025 MAR include an order for the following: a. Insulin glargine (long-acting insulin) solution 100 units/ml dated 1/16/25. Inject 24 units subcutaneously once a day for type 2 diabetes with hyperglycemia (high blood sugar). - Staff I, Licensed Practical Nurse (LPN), documented administering medication on 2/21/25. b. Novolog (rapid-acting insulin) solution dated 5/3/24. Inject 3 units subcutaneously 4 times a day for blood sugars above 150 due to type 2 diabetes with hyperglycemia. - Staff I documented 4, vitals outside of parameters for admission, for the morning, mid-morning, and evening doses. The Incident, Accident, Unusual Occurrence Note dated 2/21/25 at 12:32 PM reflected the nurse administered 24 units of Novolog insulin instead of the ordered 24 units of glargine. The provider ordered to check her blood sugars every 15 minutes for the next 2 hours. 2. Resident #147's January 2025 MAR included the following orders dated: (continued on next page)

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	02/27/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. 11/2/24, discontinued 1/27/25: Lisinopril-HCTZ (medication use to control blood pressure with a diuretic). b. 1/28/25, discontinued 2/5/25: Lisinopril oral tablet 20 mg. Give 1 tablet by mouth once a day for high blood pressure (hypertension). c. 1/23/25, discontinued 1/27/25: Glimepiride oral tablet 1 mg. Give 1 tablet by mouth once a day for diabetic. d. 12/19/24, discontinued 1/22/25: Glipizide oral tablet 5 mg. Give 0.5 (half) a tablet by mouth once a day for type 2 diabetes. The Incident, Accident, Unusual Occurrence Note dated 1/25/25 at 11:55 AM indicated on 1/24/25 Resident #147 received Lisinopril 20 mg (medication without diuretic to control blood pressure) and Lisinopril-HCTZ. Resident #147 only had an order for Lisinopril-HCTZ. The Nurses Note dated 1/27/25 at 1:57 PM indicated the diabetic center called to give an order to stop glimepiride and start metformin 500 mg. In addition, they ordered to stop the combination Lisinopril (Lisinopril-HCTZ) and start Lisinopril 20 mg once a day. The Incident, Accident, Unusual Occurrence Note dated 1/29/25 at 1:44 AM indicated on 1/28/25 Resident #147 received Glimepiride and Lisinopril. The provider discontinued the medication on 1/27/25. The Nurse removed the medication from the cart. 3. Resident #6's MDS assessment dated [DATE] identified a BIMS score of 12, indicating moderately impaired cognition. The MDS listed Resident #6 received an anticonvulsant (antiseizure) in the lookback period. Resident #6's October 2024 MAR listed an order for gabapentin (anticonvulsant) oral capsule 300 mg. Give 1 capsule by mouth 3 times a day related to polyneuropathy (pain caused by impaired nerves). - Documented as administered by Staff G on 10/5/25 for the morning and midmorning doses. The Incident, Accident, Unusual Occurrence Note dated 10/5/24 at 6:27 PM reflected Resident #6 reported she received 2 gabapentin 300 mg capsules at the same time for lunch when she usually only received one. During an interview 2/26/25 at 11:28 AM the Director of Nursing (DON) reported the facility did meetings to discuss medication errors. She reported she wrote Staff G up in August for the medication error. She didn't have further write ups since the first medication error Staff G did. She reported she didn't do any audits with medication administrations. They assigned all the nurses and medication aides an on line course to complete on common medication errors. On 2/26/25 at 12:18 PM the DON reported Staff G hadn't completed hers yet, but, noted it is due by the end of March 2025. (continued on next page)

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	02/27/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview 2/27/25 at 8:10 AM the DON reported she reported she discussed with Staff G on the phone on the frequent mediation error and Staff G reported it happened because staff interrupted her at the cart during her medication pass. Review of the facility policy titled Administering Medications revised April 2019 directed the staff to administer medications in accordance with the prescriber's orders, including any required time frame. In addition, the policy instructed the staff that the individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.

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	02/27/2025

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

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 46873 Based on facility records, review of the Facility Assessment, and staff interviews, the facility failed to have a clinically qualified nutrition professional who met the required qualifications of a Certified Dietary Manager or a full time Registered Dietician. The facility reported a census of 41 residents. Findings Include: On 2/24/25 at 10:20 AM, Staff A, [NAME] stated the facility didn't have a kitchen manager and haven't had one for approximately six months. She stated worked there for approximately three years. Staff A stated she assisted with some duties such as ordering supplies but she is not officially the kitchen manager. On 2/26/25 at 10:12 AM, the Administrator stated the prior Certified Dietary Manager, still worked at the facility but no longer in that position worked approximately 25 hours a week. He added she occasionally did pick up extra shifts. The Facility Assessment, dated 12/17/24 indicated the facility personnel should include a Registered Dietitian and Nutrition Services Staff. It further stated each department is led by a department manager. In addition, the Facility Assessment instructed the facility is to employ one full time Dietary Manager. On 2/26/25 at 4:16 PM, the Registered Dietitian stated she visited the facility approximately once a month. She stated the corporation has a traveling Certified Dietary Manager, who went to the facility several times to help out. On 2/27/25 at 9:34 AM, Staff F, Cook, stated she was the prior Dietary Manager for the building.

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	02/27/2025

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

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 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. 46873 Based on observation, facility documentation, staff, and resident interview, the facility failed to follow the posted menu and serve the appropriate portions for 3 of 3 residents who received pureed diets (Residents #13, #21, and #24). In addition, the facility failed to serve the ordered therapeutic menu for 5 of 5 residents with an order for low sodium diets. Additionally, 2 residents, (Residents #8 and #11) didn't get the substitution menu as they requested. 2 other residents (Residents #20 and #38) didn't receive their double proteins as directed on their menu cards. In addition, the facility had 19 residents with an order for the NIP (Nutritional Intervention Program), adding extra foods/calorie/nutrition to their meals. Of the 19 residents with the NIP on their menu cards, 9 of them didn't receive any extra food on their trays. The facility reported a census of 41 residents. Findings Include: Posted lunch menu for 2/26/25: Baked [NAME] Chicken, 4 ounces (oz) Poultry Gravy, 2 oz Garden [NAME] 1/2 cup or White [NAME] 1/2 (for residents on low sodium diet) Herbed [NAME] Beans 1/2 cup Wheat Roll Margarine Chilled Pears 1/2 cup During a continuous lunch observation on 2/26/25 starting at 11:05 AM, Staff A, Cook, reported she had 2 residents in the building on a puree diet but she always makes a little extra. Staff A performed hand hygiene, then took an unmeasured amount of baked rosemary chicken and placed it in the food processor using tongs. She added an unmeasured amount of broth. She described it as roughly three servings. After pureeing the food to the appropriate texture, she obtained 3 bowls and used a 4 oz, #8 scoop, and divided the puree into the 3 bowls. The food processor still had some chicken puree left in the bowl. Using a spatula, she took the leftover chicken and placed it in the fourth bowl. She placed lids on all of the bowls, and placed the 3 full bowls into the microwave, then she set the fourth bowl aside separately. No observation occurred of Staff A measuring the total volume of the puree prior to separating it into bowls. (continued on next page)

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	02/27/2025

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

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff A next used a 4 oz, #8 scoop and pureed 2 servings of green beans along with the juice to an appropriate texture. She divided the mixture into 2 bowls with no measurements. Staff A stated they pureed the fruit prior to the beginning of the observation. No observation occurred of Staff A pureeing any dinner rolls as directed on the menu. Staff A checked beginning food temperatures and gathered supplies. She performed hand hygiene and was ready to begin serving lunch at 11:30 AM. Staff A first prepared plates for the CCDI Unit (Chronic Confusion Dementing Illness, a locked unit for dementia residents). Resident #13, who resides on the CCDI, had a puree diet order. She received the pureed chicken with gravy, pureed green beans, and pureed fruit. Her meal didn't include a dinner roll. Service continued with multiple regular diet residents. Some residents requested substitute meals, some receiving deli sandwiches and some receiving grilled cheese in place of the main entree. Resident #21 received the next puree diet tray. This tray included pureed chicken with gravy, green beans, and pears, again they didn't receive a dinner roll. Resident #24 received the final puree diet tray. She received pureed chicken with gravy and pears, without a dinner roll. Per her menu card, she wished to have mashed potatoes rather than green beans. On 2/26/25 at 11:42 AM, Staff A took a bowl to the hot water dispenser and put an unmeasured amount of hot water in the bowl. She added an unmeasured amount of instant mashed potato flakes to the bowl, stirred it, and placed it on the tray for service with no measurement and/or temperature taken. Resident #37, low sodium diet ordered, received the next meal tray. He received garden rice rather than the white rice ordered for low sodium diet residents. Resident #40 received the next prepared plate. He received a wheat roll, making him the only resident of the entire building to receive a wheat roll as directed on the posted menu. When making his plate, Staff A obtained a single dinner roll from a zipped bag and provided it to him. No other dinner rolls were seen during the observation. In addition, noted Residents #5, #16, #23 & #30 all had orders for a low sodium diet. All of them also received garden rice rather than white rice. Resident #8 requested a grilled cheese sandwich per her menu card. Staff A stated she ran out of grilled cheese sandwiches, so she provided a ham salad sandwich as a substitute. Resident #20's menu card instructed to give double portions of protein. He had ordered a deli sandwich and he received the same deli sandwich as the other residents. No double proteins were observed. Resident #38 also had double proteins ordered on her menu card. She received green beans, pears and a single serving of cottage cheese. She did not receive any chicken or other protein. (Drinks were not observed). (continued on next page)

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	02/27/2025

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

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #11's menu card directed he requested a grilled cheese sandwich. Instead, he also received a ham salad sandwich. On 2/26/25 at 11:50 AM Staff A stated the facility ran out of ice cream, but they had a truck coming the following day. On 2/26/25 at 12:00 PM, Staff A said Staff C, Restorative Aide Certified Nurse Aide (RA, CNA), on the evening shift tallied all of the requests and didn't tally the grilled cheese sandwiches correctly so they didn't make enough. With 6 residents still remaining to get their meal, observed the steam table empty of the seasoned green beans. Staff A asked one of the dietary aides to open and warm up some wax beans to serve to the remaining residents. Service ended on 2/26/25 at 12:13 PM. On 2/26/25 at 12:16 PM, Staff A stated she knew the low sodium residents were supposed to receive white rice and she forgot to make it so she served the garden rice instead. She stated her normal process to puree is to puree the correct serving size and divide into bowls. An observation revealed a laminated document titled Puree Process hanging on the bulletin board near the steam table. It detailed step by step instructions of pureeing food. Step 4 read measure the total volume of the food after it is pureed. Step 5 directed to divide the total volume of the pureed food by the original number of portions, with instruction to see the Puree Scoop Chart for reference. When questioned about the puree instructions hanging on the bulletin board, Staff A replied she didn't know that adding broth, etc. would change the volume of the pureed food. Staff A stated she remembered they used to have a chart but she hadn't seen it in a long time. She stated she remembered a long time ago they had education on pureeing and using the chart but she forgot it as it happened so long ago. Staff A stated she had worked at the facility for three years. When asked how the residents choose their meals, and how that gets printed onto the menu cards, she responded the Restorative Aides take the meal orders. During the meal service observed several tray cards listed with the NIP alert on them (Nutritional Intervention Program). When questioned about what food to give to the NIP residents, Staff A replied the residents who received cottage cheese were the NIP residents. Upon a subsequent review of all menu cards, it revealed 19 residents had the NIP alert on their tray cards. The following 9 residents either had no additional foods ordered, or ordered but didn't receive due to food stock. a. Resident #6 no extra calories/food for the NIP alert on menu card or meal plate b. Resident #29 ordered ice cream on the menu card, but did not receive c. Resident #40 ordered ice cream on the menu card, but did not receive d. Resident #20 no extra calories/food for the NIP alert on menu card or meal plate (continued on next page)

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	02/27/2025

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

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. Resident #31 ordered ice cream on the menu card, but did not receive f. Resident #9 no extra calories/food for the NIP alert on menu card or meal plate g. Resident #25 no extra calories/food for the NIP alert on menu card or meal plate h. Resident #13, ordered ice cream on the menu card, but did not receive i. Resident #10 no extra calories/food for the NIP alert on menu card or meal plate On 2/26/25 at 1:19 PM, Staff B, Certified Nurse Aide/Restorative Aide (CNA, RA), explained whoever worked as the Restorative Aide on Mondays took the meal orders for all residents for Tuesday and Wednesday meals. On Wednesdays, they took the orders for Thursdays and Fridays, and on Fridays, they take the orders for Saturday, Sunday and Monday. She stated when she takes the orders, she goes to each resident who is cognitively aware and able to make choices. She reads them the menu, as well as the alternative menu and they choose what foods they want. She stated for the residents who are not cognitively aware and unable to make menu choices, she chose the foods she knew they enjoyed based on her knowing the residents well. She stated she worked at the facility for 5 years, so she generally knew the residents' likes and dislikes. She stated she then entered the orders into the computer and prints the meal tickets and gets them to the kitchen. On 2/26/25 at 1:24 PM, Staff C stated she takes orders from the residents as they come to the therapy room for Restorative exercise. She stated the residents who didn't come to Restorative, she went room to room or to the dining room to get everyone's orders. She stated the residents who can't make their own choices, she gives them what she knows they like. When asked about the residents on pureed diets, she stated she normally gave them the entree and a fruit. When asked why only one person in the entire facility received the dinner roll from the menu, she stated a lot of people just don't like bread and butter. When asked if they took the weight loss and the NIP program into account for the residents who can't make choices, and not being served the carbohydrates on the menu, she stated not really. On 2/26/25 at 4:16 PM, the Registered Dietitian (RD) stated if they didn't have enough grilled cheese sandwiches prepared, they should have stopped service and more made. She stated they are easy enough to make, and she expected them to provide those. In regards to only one resident receiving the dinner roll, she stated the cognitively aware residents can make their own choices. But residents who can't make choices should be provided the entire menu. The RD stated the NIP program is case by case. She stated everyone on NIP should receive some extra item, whether that is cottage cheese or yogurt or ice cream, etc. But should receive something on their trays. The RD said she expected the number of servings plus one additional to be completed in the puree process, then after pureeing, the staff need to use the volume method per the chart for the correct serving size. She received notification the kitchen didn't have an observed volume method chart. On 2/26/25 at 4:49 PM, Resident #8, who received a ham salad sandwich, instead of the grilled cheese she ordered, stated she remembered the ham sandwich and enjoyed it. She stated she thought she ordered something else but couldn't recall what. She stated she sometimes felt very rushed when they took the orders, and receives seconds to make a choice. She said overall the food could be better but it is okay. (continued on next page)

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	02/27/2025

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

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/27/25 at 11:15 AM, the Director of Nursing stated she thought the program for the menu cards indicated that if residents couldn't to select their menu, they should get the full meal, within their ordered diet. She stated she would verify the process.

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	02/27/2025

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

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 46873 Based on observation, staff interviews, guidance from the 2022 Food and Drug Administration (FDA) Food Code, and facility policy, the facility failed to serve food within the acceptable temperature range. The facility reported a census of 41 residents. Findings include: Continuous observation of lunch service stated on 2/26/25 at 11:05 AM. Observed Staff A, Cook, preparing the foods for the residents who required a pureed diet. After completing the task, she was ready to begin lunch service and proceeded to take the food temperatures of all foods prior to serving. All hot foods were found to be at an appropriate temperature. When she checked the cold foods, she documented the following at 11:23 AM: Chilled Pears 41.5 degree Fahrenheit (F) Chef salad 45 F Milk 38.9 F Cottage cheese 45 F Staff A left all items out at room temperature. Staff A gathered menu cards and other items needed for meal service, and service began at 11:30 AM. As Staff A prepared plates for each resident of the facility, noted several residents requested deli sandwiches in place of the scheduled entree. Witnessed a tray of deli sandwiches on a shelf above the steam table. No observed logged temperature of the lunch meat prior to serving. On 2/26/25 at 11:44 AM, Staff A placed the chef salad on the serving cart for Resident #34, 21 minutes after it had temped at 45 F at room temperature. Meal service was complete at 12:14 AM. The staff served all of the chef salads and cottage cheese. On 2/25/25 at 12:16 PM, when asked about the cold items being too warm when she took the food temperatures, Staff A replied they just came out of the refrigerator and she serves them, regardless of the temperature. On 2/26/25 at 4:15 PM, the Registered Dietitian stated she expected cold foods to be returned to the refrigerator and not served until they were at 41 F or colder. The facility policy Food Preparation and Service, revised April 2019 documented the following: (continued on next page)

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	02/27/2025

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

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. The danger zone for food temperatures is between 41 F and 135 F. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness. b. Potentially hazardous foods include meats, poultry, seafood, cut melon, eggs, milk, yogurt and cottage cheese. c. The longer foods remain in the danger zone, the greater the risk for growth of harmful pathogens. Therefore, PHF (potentially hazardous food) must be maintained below 41 F or above 135 F. The 2022 FDA Food Code directed Time/Temperature control for safety food shall be maintained: a. At 57 C (135 F) or above b. At 5 C (41 F) or less