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	03/05/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review and staff interview, the facility failed to document non-pharmacological interventions prior to administering anti-anxiety medication for anxiety and/or restlessness for 1 of 1 resident sampled (Resident #39). The facility identified a census of 36. Findings include:Resident #39's Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 4, indicating a severe cognitive loss. The MDS listed diagnoses of non-Alzheimer's dementia, depression, and anxiety. Resident #39's Medication Administration Record (MAR) for February documented Haloperidol (an antipsychotic medication) 0.5 milligrams (mg). Administer every 8 hours as needed for agitation and irritability. Resident #39's MAR for February 2026 documentation reflected the nurse administered Haloperidol on the 15th, 18th, 20th, 22nd, 23rd, 24th, 25th, 26th, 27th and 28th. The supplemental documentation lacked documentation of nonpharmacological interventions tried prior to administering Haloperidol. Resident #39's March 2026 MAR documented Haloperidol 0.5 mg. Administer every 8 hours as needed for agitation and irritability. The documentation reflected the nurse administered Haloperidol on the 2nd and 3rd. The supplemental documentation lacked documentation of nonpharmacological interventions tried prior to administering the medication. The Care Plan undated indicated Resident #39 utilized psychotropic medications. The Targeted Goal of 3/15/26 aimed for Resident #39 to remain free of complications related to the use of psychotropic medication. The Care Plan Intervention directed staff to document the number of target behaviors, the behaviors observed, and interventions for Antipsychotic medication. Resident #39's Progress Notes lacked documentation of interventions prior to giving the as needed Haloperidol. On 3/4/26 at 9:48 AM Staff A, Registered Nurse (RN), reported the nurses should document the interventions tried in the progress notes prior to giving the psychotropic medication. On 3/4/26 at 9:50 AM Staff B, RN, said the nurses should document the interventions tried prior to giving a psychotropic medication in the progress notes. On 3/4/26 at 9:54 AM the MDS coordinator reported the staff should document the as needed psychotropic medications, the behaviors, and interventions tried prior to giving in the supplemental documents. She reported the staff did the supplemental documentation once each shift. She reported since it is done once a shift she could not say when the behaviors happened or what interventions the staff tried for each medication since it is done once a shift. On 3/4/26 at 10:32 AM the Director of Nursing (DON) reported the nurses should chart the behaviors and interventions done prior to giving as needed psychotropic medications in the chart. She acknowledged the resident's chart lacked documentation on several occasions. The facility policy titled Antipsychotic Medication Use revised December 2016 directed to not use antipsychotic medications unless behavioral symptoms are not sufficiently relieved by non-pharmacological interventions.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, and staff interviews the facility failed to report allegations of abuse to the Iowa Department of Inspections, Appeals, and Licensing (DIAL) for 2 of 3 residents reviewed (Resident #5, Resident #39, and Resident #20). The investigation determined the facility failed to report when Resident #39 pushed Resident #5 in one incident and grabbed her in another incident. in addition, the facility failed to report when Resident #39 poked Resident #20 in the head. The facility reported a census of 36 residents. Findings include:Resident #39's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview of Mental Status (BIMS) score of 4, indicating severe cognitive impairment. Resident #39 experienced verbal behavioral symptoms directed towards others for 1 to 3 days in the lookback period. The MDS listed Resident #39 as independent with walking 10 feet and 50 feet with two turns. She didn't use a wheelchair or a scooter. The MDS included diagnoses of non-Alzheimer's dementia, Alzheimer's disease, anxiety, and depression. Review of the facility report list to DIAL lacked documentation of reporting an allegation of resident-to-resident abuse involving Resident #39 on 1/31/26, 2/4/26, and 2/17/26. 1. The Behavior Note dated 1/31/26 at 4:17 PM indicated Resident #39 went into another resident's room (Resident #5). Resident #39 yelled at Resident #5, tried to get her out of her bed, and pushed her. In addition, Resident #39 got into a third resident's face and yelled at them to get out of her seat.2. The Behavior Note dated 2/4/25 at 9:37 PM reflected during supper Resident #39 got in another resident's space and slapping the air in front of her to get the resident's attention. Resident #39 took their supper and dumped it on another resident's plate. Resident #39 told them they to eat it after they already ate off of the plate. Resident #39 then started to lightly poke another resident in the head. The staff stepped in between to intervene. Resident #39 grabbed the staff's left wrist and thumb hard. Resident #39 bent the staff's thumb all the way back and knocked the staff member's radio out of their hand as they went to radio for help. Resident #39 called the staff member a b*tch and said they got them; no one was to help them. On 3/3/26 at 2:40 PM the Administrator reported the incident on 2/4/26 was not reported to DIAL when Resident #39 poked another resident in the head. On 3/4/26 at 7:45 AM the Director of Nursing (DON) reported the incident on 2/4/26 was not reported because they felt it could go either way because it was charted that she didn't poke her hard. She reported she was not sure who the resident was so will find out. On 3/4/26 at 8:06 AM the DON reported Resident #20 as the other resident in the incident on 2/4/26. 3. The SPN - Focused Evaluation Noted dated 2/17/26 at 1:50 PM indicated Resident #39 grabbed another resident's arm and held it until someone separated them. The note lacked documentation of the identity of the other resident. On 3/5/26 at 1:30 PM the DON reported Resident #5 as the resident grabbed by Resident #39 on 2/17/26. On 3/5/26 at 8:20 AM The DON and Administrator reported they reported the resident-to-resident incident on 1/31/26, but not the incident on 2/4/26. They reported after reviewing, they saw where they should have reported the incident. The facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevent Program revised April 2021 documented to report allegations within the required timeframe by federal requirements.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, and staff interviews the facility failed to investigate and review interventions to ensure interviews are adequate to prevent further abuse for a known resident with a history of aggression for resident-to-resident abuse for 2 of 3 resident reviewed. (Residents #5, #20, and #39). Resident #39 grabbed Resident #5 and poked Resident #20 in the head. The facility reported a census of 36 residents. Findings include:1. Resident #39's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview of Mental Status (BIMS) score of 4, indicating severe cognitive impairment. Resident #39 experienced verbal behavioral symptoms directed towards others for 1 to 3 days in the lookback period. The MDS listed Resident #39 as independent with walking 10 feet and 50 feet with two turns. She didn't use a wheelchair or a scooter. The MDS included diagnoses of non-Alzheimer's dementia, Alzheimer's disease, anxiety, and depression. The Care Plan Focus revised 2/13/26 indicated Resident #39 had a behavior problem and can become verbally aggressive towards staff and residents. The Care Plan documented the following interventions:a. 1/19/26: Resident #39 has a history of taking other residents' food, drinks, or personal belongings away from them stating they stole it from her. Please offer Resident #39 her own drink and food. The staff know of Resident #39's history and retrieve items at a later time. b. 2/2/26: Resident #39 gets upset with other residents and yells at them, or goes into their room and wake them up. Please intervene and redirect. c. 2/12/26: Resident #39 has placed her hands on another resident. Staff need to be aware and monitor their Interactions. d. 2/13/26: Intervene as necessary to protect the rights and safety of others. Approach and speak in a calm manner, divert attention as needed. Remove from the situation and take to an alternate location as needed.The Care Plan lacked interventions related to her aggression and what to do when she got aggressive to protect her and other residents. 1. The Behavior Note dated 1/31/26 at 4:17 PM indicated Resident #39 went into another resident's room (Resident #5). Resident #39 yelled at Resident #5, tried to get her out of her bed, and pushed her. In addition, Resident #39 got into a third resident's face and yelled at them to get out of her seat.The note lacked documentation of the identity of the third resident involved.2. The Behavior Note dated 2/4/25 at 9:37 PM reflected during supper Resident #39 got in another resident's space and slapping the air in front of her to get the resident's attention. Resident #39 took their supper and dumped it on another resident's plate. Resident #39 told them they to eat it after they already ate off of the plate. Resident #39 then started to lightly poke another resident in the head. The staff stepped in between to intervene. Resident #39 grabbed the staff's left wrist and thumb hard. Resident #39 bent the staff's thumb all the way back and knocked the staff member's radio out of their hand as they went to radio for help. Resident #39 called the staff member a b*tch and said they got them; no one was to help them. Further review lacked documentation of the residents involved in the incident during supper.On 3/4/26 at 7:45 AM the Director of Nursing (DON) reported the facility didn't report the incident on 2/4/26 because they felt it could go either way, as the documentation indicated she didn't poke her hard. She added she didn't know who the resident was, so she would find out. On 3/4/26 at 8:06 AM the DON reported Resident #20 as the other resident in the incident on 2/4/26. 3. The SPN - Focused Evaluation Noted dated 2/17/26 at 1:50 PM indicated Resident #39 grabbed another resident's arm and held it until someone separated them. The note lacked documentation of the identity of the other resident. The review of the list of incidents reported by the facility to DIAL lacked documentation of incidents of resident-to-resident abuse on 1/31/26, 2/4/26, and 2/17/26. On 3/5/26 at 8:20 AM The DON and Administrator reported they didn't do investigations for the incidents on 1/31/26 and 2/4/26, as they didn't have an incident report. They confirmed the staff didn't do an assessment after the incidents to make sure the other residents didn't have injuries, psychosocial harm, and they didn't initiate follow-ups after the incident. On 3/5/26 1:28 PM observed the DON coming out of a room behind the nurses' station with a statement about the 2/17/26 incident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/5/26 at 1:30 PM the DON reported Resident #5 as the resident grabbed by Resident #39 on 2/17/26. Review of the DON's investigation lacked documentation of identity of the other resident in the incident on 2/17/26. On 3/5/26 at 1:40 PM the DON reported she talked with Staff D, Registered Nurse (RN), on the 17th to clarify the incident of Resident #39 grabbing another resident's arm. She reported she was clarifying Staff D's statement she got from that day and had her sign it that day. She added that is why she walked out with the paper after seeing Staff D. She reported she wanted to make sure that is what she reported. The DON reported she did not do a follow up in the chart like she did with the other resident-to-resident incidents she clarified. She acknowledged the documentation didn't match the statement. She reported Staff D declared Resident #5 as the other resident. She acknowledged the facility didn't have a follow-up with Resident #5, documentation at the time, or an assessment of Resident #5. On 3/5/26 at 2:38 PM Staff D, described the incident on 2/17/26 as Resident #39 had her hand on her forearm, leaning towards the other resident's face, she told the other resident they wore her clothes. Staff D reported Resident #39 wasn't upset or agitated but Staff D told Resident #39 her name and asked her to remove her hand from the other resident's forearm. Resident #39 moved her hand as soon as Staff D said something to her. Staff D reported she didn't remember who the other resident was. When asked when they discussed the incident, Staff D wouldn't give a date but reported when asked by the DON to clarify. The facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevent Program revised April 2021 documented to report allegations within the required timeframe by federal requirements.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility policy review and staff interviews the facility failed to ensure staff protected and prevented resident-to-resident abuse for 1 of 3 reviewed (Resident #45). Resident #39 hit Resident #45 on the right upper arm. At the time of the incident Resident #45 sat with a staff member. The staff member failed to intervene until after Resident #39 hit Resident #45. Resident #39 had a known history of resident-to-resident altercations and the facility failed to evaluate the effectiveness of the interventions to prevent harm to other residents, see F609 and F610 for additional information regarding additional incidents. The facility reported a census of 36 residents. Findings include:Resident #39's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview of Mental Status (BIMS) score of 4, indicating severe cognitive impairment. Resident #39 experienced verbal behavioral symptoms directed towards others for 1 to 3 days in the lookback period. The MDS listed Resident #39 as independent with walking 10 feet and 50 feet with two turns. She didn't use a wheelchair or a scooter. The MDS included diagnoses of non-Alzheimer's dementia, Alzheimer's disease, anxiety, and depression. Resident #39's Care Plan with a Focus area revised on 2/13/26 I have a behavior problem and can become verbally aggressive towards staff and residents. The Care Plan Focus revised 2/13/26 indicated Resident #39 had a behavior problem and can become verbally aggressive towards staff and residents. The Care Plan documented the following interventions:a. 1/19/26: Resident #39 has a history of taking other residents' food, drinks, or personal belongings away from them stating they stole it from her. Please offer Resident #39 her own drink and food. The staff know of Resident #39's history and retrieve items at a later time. b. 2/2/26: Resident #39 gets upset with other residents and yells at them, or goes into their room and wake them up. Please intervene and redirect. c. 2/12/26: Resident #39 has placed her hands on another resident. Staff need to be aware and monitor their Interactions. d. 2/13/26: Intervene as necessary to protect the rights and safety of others. Approach and speak in a calm manner, divert attention as needed. Remove from the situation and take to an alternate location as needed.The Facility Incident Report documented on 3/3/26 indicated Resident #39 approached Staff C, Certified Nurse Aide (CNA), and tried to grab her belongings as she left work for the day. Staff C set them behind her. When Resident #39 attempted to strike Staff C, Staff C responded that was not nice. Afterwards, Resident #39 went to a dining room table where Resident #45 sat. As Resident #45 talked, Resident #39 told them to shut up and slapped Resident #45 on her right arm. Staff C sat between the residents to separate them. On 3/4/26 at 7:27 PM Staff C confirmed they worked at the time of the incident on 3/3/26. Staff C reported as they prepared to finish and leave their shift, she sat at the table with Resident #45 visiting when Resident #39 came and asked whose coat it was. Staff C reported it was hers and pushed it further under her feet at the table. Resident #39 yelled and swung at her but hit the air. Staff C said oh you must not be in a good mood. She continued to talk to Resident #45 at the table, when Resident #39 sat in a chair on the other side of Resident #45 away from Staff C. As Resident #45 talked to Staff C, Resident #39 proceeded to tell Resident #45 to shut up and then hit her on the shoulder. Staff C reported she got up right after the incident and got between the residents. Staff C reported she is well aware of Resident #39's behaviors and aggression but reported she is hard to redirect so it is best to just let her walk around and do her thing. She reported she knew about Resident #39 being aggressive toward staff and other residents. On 3/5/26 at 8:25 AM the Director of Nursing (DON) reported when a resident in the unit gets agitated or upset, the staff should redirect the resident away from other residents. They need to try to figure out why the resident is upset or agitated and separate them from other residents to protect the other residents. The facility policy titled Identifying Types of Abuse revised April 2021 defined physical abuse as not limited to hitting, slapping, biting, punching or kicking.The facility policy titled Abuse, Neglect, Exploitation and (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Misappropriation Prevent Program revised April 2021 instructed residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This included but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews and policy review the facility failed to maintain a sanitary kitchen; failed to serve and prepare food in accordance with professional standards for food safety to reduce the risk of cross contamination and food borne illness. The facility reported a census of 36 residents. Findings include:On 3/2/26 at 11:00 AM observed the ice machine covered in a mineral deposit build-up all over the sides of the machine. Inside the ice machine noted mineral deposit build-up streaks and small pin point black particles in the ice machine on the white plastic baffle (A shield that directs falling ice to the back of the bin, preventing it from jamming the door). On 3/3/26 at 3:54 PM observation of the Ice machine remained the same as the previous day. On 3/4/26 at 8:20 AM the Maintenance Supervisor reported he deep cleaned and descaled the ice machine every 6 months and the kitchen cleaned it weekly. He reported it has been an ongoing issue with the ice machine mineral deposit build-up. He reported nothing gets it fully cleaned. On 3/4/26 at 10:55 AM the Dietary Manager reported the ice machine is cleaned every other week. She reported she can't get the buildup off the machine and can't get the inside clean. She explained she tried several different products to get it cleaned but it just doesn't get cleaned. The facility policy title Ice Machine and Ice Storage Chests revised January 2012 documents the facility has established procedures for cleaning and disinfecting ice machines and ice storage chests which adhere to the manufacturer's instructions. Further review of the policy lacked direction if following the instructions the ice machine can't get cleaned properly what the facility should do.