

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165325	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2026
NAME OF PROVIDER OR SUPPLIER Manor House Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1212 South Stuart Street Sigourney, IA 52591	
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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff interviews, and the facility policy, the facility failed to keep a urinary catheter bag off the floor for 1 of 2 residents reviewed for urinary catheters (Resident #42). The facility reported a census of 43 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #42 scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact. The MDS indicated resident dependent with toileting hygiene and used an indwelling catheter. The MDS revealed medical diagnoses for renal insufficiency and neurogenic bladder. The MDS indicated the resident took a diuretic. The Care Plan revealed a focus area dated 3/5/26 for use of an indwelling catheter related to comfort for end of life and fluid overload. The interventions dated 3/5/26 indicated to ensure dignity bag remained in place, monitor tubing for kinks and leaks, and ensure tubing remains off the floor. The Electronic Medical Record (EMR) revealed the following Physician Orders dated 3/5/26: 16 Fr (french) 5 cc (milliliters) Foley Catheter with Foley drainage bag due to hospice level of care and to promote skin integrity. Change foley catheter every 30 days. Change Foley drainage bag every 2 weeks. During an interview on 6/22/26 at 11:35 AM, Resident #42 stated she had a urinary catheter since being in hospice and retaining fluid. During an observation on 6/22/26 at 11:35 AM, Resident #42 catheter bag hung on the side of the trash can and touched the floor. The trash can had trash in it. During an observation on 6/23/26 at 1:44 PM, Resident #42 sat in her recliner and her catheter bag hung on the trash can and touched the floor. During an observation on 6/24/26 at 4:30 PM, Resident #42 sat in the recliner and her catheter bag hooked to the trash can and touched the floor. During an observation on 6/25/26 at 7:50 AM, Resident #42 sat in the recliner and the catheter bag hooked to the side of the trash can and touched the floor. During an observation on 6/25/26 at 9:14 AM, Resident #42 sat in her recliner and the catheter bag hooked on the recliner and touched the ground. During an interview on 6/25/26 at 9:36 AM, Staff A, Certified Nurse Aide (CNA) queried if the urinary catheter bag can touch the floor and Staff A confirmed the catheter bag cannot touch the floor. Staff A asked where she placed the catheter bag and Staff A stated they hooked it to the trash can so it hung higher. During an interview on 6/25/26 at 9:55 AM, Staff B, CNA asked if the urinary catheter bag can touch the floor and Staff B confirmed the catheter bag should be off the floor. Staff B asked if they ever seen Resident #42 catheter bag on the floor and Staff B stated they had. During an interview on 6/25/26 at 10:52 AM, the MDS Coordinator confirmed the catheter bag should not touch the ground and needed to be placed in a dignity bag because it was an infection control concern. During an interview on 6/25/26 at 12:23 PM, Staff C, Licensed Practical Nurse, LPN asked if a catheter bag can touch the floor and Staff C no, not unless the bag was placed in a dignity bag. Staff C asked if the catheter bag would touch the floor when hooked to the side of the trash can and Staff C confirmed it would and the reason it should (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 165325
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	touch the ground was to protect the valve on the catheter bag. During an interview on 6/25/26 at 12:31 PM, the Director of Nursing (DON) queried on a urinary catheter bag touching the ground and the DON stated that the catheter bag should not touch the ground for infection control. The DON queried if she noticed the catheter bag touching the ground today prior to observing catheter cares and the DON confirmed she saw the catheter bag touching the floor. The Facility Catheter Care: Indwelling Catheter Policy dated 12/2023 revealed Validate drainage bag is off the floor and in a dignity bag		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on clinical record review, policy review, and staff interview, the facility failed to ensure medical records were complete and accurate for 1 of 3 discharged residents reviewed(Resident #46). The facility reported a census of 43 residents.Findings included: The Minimum Data Set(MDS) assessment tool, dated 3/31/26, listed diagnoses for Resident #46 which included anxiety disorder, mild intellectual disabilities, and dysphagia(difficulty swallowing). The MDS listed her Brief interview for Mental Status(BIMS) score as 9 out of 15, indicating moderately impaired cognition. The MDS assessment tool, dated 4/20/26, documented death in facility. A 4/20/26 10:39 a.m. Orders-Administration Note stated the resident passed away.A 4/20/26 11:54 a.m. Incident Report stated the resident sat at the dining room table and ate bite sized pieces of pancakes. The resident reached for her chest and started gasping for air. Four nurses performed the Heimlich maneuver with no return(of food debris). Staff suctioned the resident and obtained a scant amount of residual. The ambulance arrived at this time. The resident's clinical record lacked further information regarding the resident's condition and if the resident left the building with the ambulance crew. The record lacked documentation regarding whether the resident passed away at the facility or at the hospital. The record did not contain any follow up information other than the above. The record lacked documentation as to a follow up call to the hospital regarding what occurred with the resident.On 6/25/26 at 9:35 a.m., the Administrator stated she had no additional documentation regarding the above incident. The undated, untitled facility policy related to medical records stated resident records would include treatments and services. On 6/25/26 at 12:22 p.m., the Director of Nurses(DON) stated documentation should reflect a clear picture of what occurred with a residnet. She stated there should be a paper trail for backup.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on clinical record review, policy review, and staff interviews, the facility failed to offer a Covid-19 booster to 1 of 5 residents reviewed for immunizations(Resident #9). The facility reported a census of 43 residents. Findings included: The Minimum Data Set(MDS) assessment tool, dated 6/16/26, listed diagnoses for Resident #9 which included Alzheimer's disease, non-Alzheimer's dementia, and a history of falling. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 2 out of 15, indicating severely impaired cognition. The resident's admission Record listed an admission date of 3/9/26. The resident's Immunization Details report documented the resident received a Moderna Bivalent booster(a booster immunization for Covid-19) on 1/5/23. The resident's clinical record lacked documentation of a more recent booster offered or a declination. The facility policy Infection Control Manual Vaccination and Screening, dated 10/25, stated the primary Covid-19 vaccine required a 2-step vaccine series. The policy stated the Centers for Disease Control and Prevention)CDC recommended a booster 6 months after the primary series and future vaccinations based on CDC recommendations. The CDC guidance Staying Up to Date with COVID-19 Vaccines retrieved from https://www.cdc.gov/covid/vaccines/stay-up-to-date.html on 6/24/26 at 11:28 a.m. stated the CDC recommended a 2025-2026 COVID-19 vaccine for people ages 6 months and older based on individual-based decision-making. The guidance stated protection from the Covid-19 vaccine decreased with time. On 6/24/26 at 2:32 p.m., the Infection Preventionist(IP) stated she was not aware residents should receive the booster until today. She stated moving forward, she would add this to the vaccine form.		

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F 0868 Level of Harm - Potential for minimal harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on Quality Assurance and Performance Improvement(QAPI) Committee Meeting Attendance Records, policy review, and staff interview, the facility failed to conduct meetings at least quarterly with the minimum required members. The facility reported a census of 43 residents. Findings included: Review of QAPI Committee Meeting Attendance Records revealed a 12/9/25 meeting held with the Director of Nursing(DON) present. Review of subsequent meeting attendance sheets for the period of 12/9/25 to 6/25/26 revealed the DON was not present for the following meetings: 1/20/26 2/17/26 3/31/26 4/20/26 5/26/26 The facility QAPI Policy, revised 10/2023, stated the QAPI team developed and implemented appropriate plans of action to correct identified quality of care, quality of life, or safety problems. The policy stated that QAPI members must meet at least quarterly. On 6/25/26 at 1:59 p.m., the Provisional Administrator stated she expected the DON or interim DON to attend QAPI meetings.		

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F 0847 Level of Harm - Potential for minimal harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. Based on record review, facility policy review and staff interview, the facility failed to ensure the signed binding arbitration agreements met requirements for 1 of 2 residents (Resident #42) sampled with an admission prior to 8/1/2024. The facility reported a census of 43 residents. Findings include: Review of the Minimum Data Set (MDS) Assessment for Resident #42, dated 4/28/26, revealed an admission date of 11/9/2022 and Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicative of an intact cognition. Review of the resident signed admission Agreement, dated 11/9/22, revealed a section of the agreement, titled Arbitration and Limitation of Liability, and revealed the following requirements were missing from the language of the binding arbitration agreement: 1.The document lacked an option for declination of the binding arbitration agreement as a condition of admission to, or as a requirement to continue to receive care at the facility. 2.The document failed to explicitly grant the resident or his/her representative the right to rescind the agreement within 30 calendar days of signing it. 3.The document failed to state that neither the resident or his/her representative was required to sign the binding arbitration agreement as a condition of admission to, or as a requirement to continue to, receive care at the facility. 4.The document failed to include language that allowed the resident or anyone else (e.g., resident's representative) to communicate with federal, state, or local officials such as federal and state surveyors, other federal or state health department employees and representative of the Office of the State Long Term Care Ombudsman. On 6/25/2026 at 10:11 AM, during an interview, the Adminstrator reported that Resident #42 signed the admission Agreement and Binding Arbitration prior to the current owner taking over the facility. She reported the current owner took over the facility 8/1/24 and changed the admission Agreement and Binding Arbitration Agreement to meet Federal regulatory standards. The Administrator reported they did not update the admission Agreement and Binding Arbitration agreement for Resident #42 when they updated the forms. Review of the facility policy, titled Voluntary Arbitration Agreement, revealed, in part, The Arbitration Agreement is voluntary and does not need to be signed in order for the Patient to be admitted to the Center or to continue to receive care at the Center .The Arbitration Agreement may be revoked in writing by certified mail at any time within sixty days after signing or within sixty days after your discharge from Center. Revocation will not affect the care the Patient receives . Nothing in this Agreement prohibits or discourages the Patient from communicating with any federal, state or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees and representatives of the long-term care ombudsman.		