

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>165521</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>07/07/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>NELSON MANOR</b>		STREET ADDRESS, CITY, STATE, ZIP <b>1500 FIRST AVENUE EAST NEWTON, IA 50208</b>	
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 0837  <b>Level of harm</b> - Potential for minimal harm  <b>Residents Affected</b> - Many	<b>Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility.</b> <b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of staff licensure and staff interviews the facility failed to ensure staff renewed professional licensure for 1 of 3 staff reviewed. The facility reported a census of 20 residents. During an interview with the Administrator on [DATE] at 11:37 a.m., the administrator was unable to locate her Administrator's license. She reported she will print it off. During an interview with the Administrator on [DATE] at 2:08 p.m., the administrator revealed that her license is not active and she will need to reactivate it. She reported her Continuing Education Units (CEU's) have been completed, but she does not know why she did not submit them. She revealed she has 41.75 credits completed and needs 40 for her license. Review of the online public license search by the, Bureau of Professional Licensure for Iowa, the Administrators license has been expired since [DATE]. The status noted as inactive. The facility failed to ensure all professional licenses are active.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER  
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.