STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165443	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Village of Ackley	**502 Butler Street , Ackley, Iowa, 50601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 ✓	INITIAL COMMENTS Correction date: 3/25/26 The following deficiencies resulted from the facility's annual recertification survey and investigation of complaints #2698510-C, conducted on March 9, 2026 - March 12, 2026. Complaint #2698510 -C resulted in no deficiencies cited. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F0000		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly-	F0641		

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F0641 SS = D	Continued from page 1 (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews the facility failed to accurately code 1 of 1 Minimum Data Set (MDS) assessments for residents with a Pre-Admission Screening and Resident Review (PASRR) Level II outcome (a formal determination that confirms if an individual with suspected serious mental illness or intellectual disability requires Medicaid-certified nursing facility care and defines their need for specialized services) (Resident #2). The facility reported a census of 27 residents. Findings Include: Resident #2's MDS assessment dated 12/11//25 identified she didn't have a state level II PASRR serious mental illness and/or intellectual disability or related condition. The MDS documented a Brief Interview for Mental Status (BIMS) of 15, indicating no cognitive impairment. The MDS included diagnoses of depression, schizophrenia and cognitive communication deficit. Resident #2's PASRR notice of nursing facility approval dated 6/16/25 reflected she experienced a significant change in status and met criteria for Level II with approved specialized services. In an interview on 2/19/26 at 1:52 PM the Administrator revealed when they completed the MDS back in March 2025 they had concerns with the MDS' accuracy by the MDS Coordinator at the time. The Administrator added she no longer worked at the facility, and they haven't had a problem since. On 3/11/26 at 12:00 PM, Staff A, Registered Nurse Assessment Coordinator, reported she is responsible for completing the MDS Assessment. Staff A reported she followed the Resident Assessment Instrument (RAI) manual when completing the MDS. Staff A verbalized the facility normally communicated with her if there is a	F0641		

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F0641 SS = D	Continued from page 2 change from a Level I PASRR to a Level II. Staff A acknowledged the MDS dated 12/11/25 lacked documentation of the Level II. Staff A confirmed Resident #2's Level II was approved on 6/16/25. Staff A acknowledged the MDS dated 12/11/25 wasn't accurately coded. On 3/11/26, the Director of Nursing (DON) verbalized Resident #2 met criteria for a Level II. The DON lacked evidence of communication to Staff A for the change in status. The DON expected the staff to code the MDS assessment accurately.	F0641		
F0812 SS = D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interviews, and policy review the facility failed to clean the kitchen convection oven, griddle on the stove, sink, cabinet under sink, and electric griddle. The facility reported a census of 27 residents. Findings include: During an initial kitchen walkthrough on 3/9/26 at	F0812		

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F0812 SS = D	Continued from page 3 11:44 AM observed the cabinet under the sink next to the ice machine, had a brown-like sticky discoloration alongside the surface of the cabinet doors, the height of the cabinet, and along the top of the cabinet doors. The sink next to the ice machine had mineral deposit build-up all over the faucet, handles, and down the back of the sink. The Bakerspride oven had a brown-like sticky discoloration on the doors. Also observed thick black discoloration on the Vulcan stove top, Vulcan stove top griddle, and Presto flat electrical pan. On 3/10/26 at 10:44 AM observations of the sink, cabinet, Vulcan stove, Vulcan stove top griddle, Bakerspride oven, and Presto electric griddle remained the same as the observation from the previous day. On 3/11/26 at 11:53 AM observations of the sink, cabinet, Vulcan stove, Vulcan stove top griddle, Bakerspride oven, and Presto electric griddle remained the same. On 3/11/26 at 11:53 AM observed a thick black discoloration on the griddle, stove top, and flat electrical pan. Staff B, Dietary Aide (DA), indicated they didn't use the griddle on the stove. They used the flat electric pan and try to clean it weekly, but it is getting bad. Staff B reported he cleaned the Presto electric flat griddle on Fridays. On 3/11/26 at 1:01 PM the Dietary and Housekeeping Manager reported she tried to get everything clean. They used scratch pads to clean the Vulcan stove on Sundays. She indicated the Presto, electric flat griddle was getting bad and didn't know how to scrub it. On 3/12/26 at 11:31 AM the Administrator informed he expected to have a clean kitchen with properly trained staff. He removed two griddles and had two new griddles ordered. Review of the facility's Performance Improvement Plan for Kitchen Cleanliness initiated 2/18/26 revealed a weekly check list that is to be checked daily to assure tasks are done with weekly audits for floors, walls, and equipment. Review of the Dietician Monthly Report dated 2/26/26 revealed they did a kitchen sanitation and meal service audit and reviewed the results with the Dietary Manager. Review of the Weekly Cleaning list for Week of 3/8/26-3/12/26 lacked documentation to indicate the	F0812		

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F0812 SS = D	Continued from page 4 stove top burners got cleaned. The cleaning list did not include the sink next to the ice machine, the cabinets, the oven, or the griddles. Review of the facility's Cleaning Duties Policy reviewed December 2023, instructed the following procedure: 1. The Director of Dining Services or lead hospitality coordinator in consultation with the Registered Dietitian Nutritionist /Licensed Dietitian will determine all cleaning and sanitation tasks needed. 2. Daily, weekly, and monthly cleaning check-off lists will be available and posted. 3. Employees will be trained on when and how each assignment is to be done. This will include cleaning compounds to be used 4. Cleaning duties will be assigned to specific positions. 5. A cleaning list/schedule will be posted for all cleaning duties and employees completing assigned tasks will date and initial duties completed. 6. Employees will be held accountable for cleaning assignments and may face disciplinary action if duties are not completed.	F0812		

The Village of Ackley

Plan of Correction

F0641

Resident #2's PASRR was submitted for updates on March 25th, 2026, and an MDS correction was completed on March 25th, 2026, to reflect the PASRR II. All residents with PASRRs were checked for possible needs for updates as well as inclusion on their MDS on March 16th,2026.

The facility will communicate with the MDS coordinator regarding changes of condition, PASRR changes and updates five times per week and more often as needed. This will be monitored by the director of nursing. The MDS coordinator has been re-educated regarding the importance of including PASRR II on the MDS as required. Audits will be conducted weekly for four weeks and then monthly thereafter. Reports will be made to the QAPI committee quarterly and more often as needed.

F0812

All residents of the facility have the potential to be affected. The facility has cleaned the kitchen and will maintain the cleanliness. Daily and weekly cleaning schedules are posted in the kitchen. Dining staff were educated regarding the cleaning schedules and the importance of completing the cleaning tasks on March 13th, 2026. The dietary manager or designee will monitor cleaning schedules three to five times per week. The administrator or designee will complete audits of the kitchen at least weekly and more frequently as needed for four weeks. Reports will be made to the QAPI committee quarterly and more often as needed.

Scott Kramer, LNHA

Scott Kramer