STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165595	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Akron Care Center, INC	**991 Highway 3 , Akron, Iowa, 51001**

(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 x DC	INITIAL COMMENTS Correction date: 7/2/26 The following deficiencies resulted from the facility's annual recertification survey conducted June 15, 2026 to June 18, 2026. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F0000		07-01-2026
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observations, staff interviews and Electronic Health Record (EHR) review the facility failed to provide reasonable accommodations of needs and preferences by not placing a resident's call light to be within reach for 1 of 6 residents reviewed (Resident #1). The facility reported a census of 41 residents. Findings include: Review of the Minimum Data Set (MDS) dated 4/2/26 documented Resident #1 had a Brief Interview for Mental Status (BIMS) of 3 that indicated severe cognitive impairment. The MDS further documented Resident #1's functional abilities as dependent with all care areas. Review of Resident #1's Electronic Health Record (EHR) titled, Medical Diagnosis documented Resident #1's diagnosis of dementia and alcohol use accompanied by an alcohol-induced psychotic disorder featuring delusions. Review of Resident #1's Electronic Health Record (EHR) titled, Care Plan documented no focus, goal,	F0558	F558 In respect to resident #1 and similarly situated residents. The Facility will ensure that all residents' call lights are in proper placement and that care plans will reflect when a resident with special needs has additional interventions for placement of call lights. The care plan for resident #1 was updated with interventions for placement of call light on 6-22-2026. Director of Nursing or Designee will audit call light placement as follows: 3x weekly x 1 month 2x weekly x 2 month; 1x weekly for 1 month and then randomly. Audits will be reviewed in QA for further recommendations.	

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 reverse for further 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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F0558 SS = D	Continued from page 1 or intervention for placement of call light related to behaviors. On 6/15/26 at 2:55 PM an observation revealed Resident #1 lying in bed with a fall mat present and a circular, soft-touch call light lying on the floor, out of the resident's reach. On 6/16/26 at 9:18 AM an observation revealed Resident #1 lying in bed with a fall mat present and a circular, soft-touch call light lying on the floor, out of the resident's reach. On 6/17/26 at 9:58 AM an observation revealed Resident #1 lying in bed with a circular, soft-touch call light tied around the bedrail with Resident #1 unable to reach the call light. Call light was was tied around the upper part of the bedrail hanging on the outside of the bed out of reach of Resident #1. On 6/18/26 at 11:00 AM Staff A, Certified Nurse Assistant (CNA) stated that her process for positioning a call light depends on the resident's cognitive status. Staff A explained that she either hands the device directly to the resident or uses a clip to attach it to their clothing, blanket, or chair. Staff A further noted that staff secures the call light to the resident or nearby items if the resident does not understand its function, based on the resident's cognitive abilities. On 6/18/26 at 11:06 AM Staff B, Licensed Practical Nurse (LPN) stated based on Resident #1's cognition was how she decided if she hands the resident the call light or if she will clip it to their clothing or chair. On 6/18/26 at 11:42 AM the Director of Nursing (DON) stated she would expect call lights to be in reach of the resident. DON further stated she would expect specific behaviors to be charted in the care plan for staff awareness on what kind of call light the resident needed and interventions for if a resident is having difficulty properly using a call light. The DON stated the facility did not have a policy for call lights.	F0558		
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 -	F0812		

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F0812 SS = D	Continued from page 2 §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 and staff interview the facility failed to prepare food in accordance with professional standards by not completing appropriate hand hygiene during meal service to prevent cross contamination. The facility reported a census of 41 residents. Findings include: On 6/17/26 at 11:30 AM an observation of Staff D, AM Cook revealed Staff D prepare a grilled cheese sandwich. Staff D applied gloves, picked up bread bag with both hands, removed bread from sack with both hands, picked up butter container with both hands, picked up knife with right hand, placed bread on the counter top, applied butter to both slices of bread, removed gloves, applied gloves, no hand hygiene completed, left hand opened plastic bag, removed cheese with right hand, 1 slice of bread, 1 slice of bread and 2 slices of cheese placed in left hand, both hands utilized to stack into a sandwich in skillet, picked up the knife with right hand, knife in right hand and left gloved hand utilized to flip sandwich, gloves removed, no hand hygiene completed, obtained foil, placed foil on the table, gloves applied, placed sandwich in foil, removed gloves, completed hand hygiene. On 6/17/26 at 2:58 PM Staff C, Certified Dietary Manager (CDM) stated gloved hands should touch only the food. Staff C explained if the gloved hand touches anything else then the glove is contaminated. Staff C said hand hygiene should be	F0812	F0812 In respect to hand hygiene while preparing resident meals the facility will ensure that all dietary staff are educated on facility procedure for glove use and hand hygiene. Dietary Manager or designee will audit glove use and hand hygiene as follows: 3x weekly x 1 month; 2x weekly for 1 month; 1x weekly for 1 month and then randomly. Audits will be reviewed in QA for further recommendations.	07/02/2023

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F0812 SS = D	Continued from page 3 completed before meal preparation before, after glove changes or when hands are contaminated. On 6/18/26 at 12:00 PM the survey team requested a policy or procedure for the puree process, serving sizes, or following the menu from facility management. Policy nor procedure was ever sent by facility management.	F0812		