STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165443	A. Building B. Wing	11/20/2025

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

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 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 electronic health record (EHR) review, facility records, policy review, resident and staff interviews the facility failed to ensure residents are free from neglect following a fall for 1 of 3 residents (Resident #2) reviewed. The facility reported a census of 32.Findings Include:Resident #2's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 6, indicating severe cognitive impairment. The MDS documented Resident #2 required substantial/maximal assistance (Helper does more than half the effort. Helper lifts, holds, and supports trunk or limbs, but provides the efforts) from sit to stand (The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed). The MDS documented Resident #2 had been dependent (Helper does all of the effort. Resident does none of the effort to complete the activity, or the assistance of 2 or more helpers is required for the resident to complete the activity) for chair/bed-to-chair transfer (The ability to transfer to and from a bed to a chair or wheelchair). The MDS documented diagnoses of Parkinson's disease, anxiety disorder and depression. The Care Plan Report initiated on 6/18/25 identified Resident #2 had been at risk for falls. The Care Plan Report directed staff to:Ensure appropriate footwear is worn of non-skid socks or shoes when ambulation or mobilizing in wheelchair.Wheelchair loweredNon-skid strips on floor in front of chair and bedBe sure call light/pendent is within reach and encourage use for assistance as needed.The personnel file documented Staff D had a Single Contact License & Background cleared on 7/3/25 with no record of Dependent Adult Abuse. The personnel file documented a hire date of 7/14/25.The Certified Nursing Assistant (CNA) Orientation included the following training:Fall prevention and protocols. Review falls policy and procedures including who should be contacted and review all interventions used to prevent falls.Elder abuse. Trainee able to identify all types of elder abuse and knows reporting protocols including timeframes and who to notify. Includes identification of suspected or actual resident to resident abuse and/or employee abuse.Staff D signed the CNA Orientation on 8/5/25, indicated all checkpoints had been completed. Review of the facility payroll punches revealed Staff D had a start time of 5:59 AM and end time of 3:20 PM on 8/16/25. A Progress Note dated 8/16/25 at 3:20 PM documented the following:the nurse called to resident's room by another resident who reports hearing yelling coming from phoenix hallway. the nurse enters residents' room and observes resident lying prone on floor between bathroom and recliner. Resident noted to have neck turned to left, right side of face lying flat on floor. Resident noted to be attempting to prop self-up on left arm. Left hand palm down on floor, right arm bent at elbow and underneath resident. Both lower extremities (BLE) laid straight out towards bed. Resident's walker within easy reach. Appropriate footwear to bilateral (both) feet. Room free of clutter. Call light is within easy reach, not activated at time of fall. Recliner noted to be in upright and lifted position, foot of chair down. Resident yelling out for help continuously when the nurse enters room, telling nurse, I'm scared, I'm scared. Reassurance is provided while help arrives to room. Resident reports pain to bilat knees and right arm, yells get me up, this floor is hard!. No internal/external rotation noted to BLE. No shortening noted to BLE. No open areas noted to area of head/face nurse is able to assess. Left arm is positioned at resident's left side, resident is (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assisted to roll to back with assistance from 3 staff. Bilateral Upper Extremities (BUE) with range of motion (ROM) per normal ability. Resident denies pain to RUE once she is no longer lying on it, continues to report pain to bilateral knees. Hip pain is denied. Assistance from 3 staff, a gait belt and front wheeled walker (FWW) utilized to assist resident from floor to wheelchair. Resident able to bear weight per normal ability. Gait is not assessed. Small, superficial abrasions noted to bilateral elbows, bilateral knees. Neuros initiated. Resident accompanies the nurse to nurse's station. Family, primary care provider (PCP) and the Director of Nursing (DON) to be notified.In an interview on 10/15/25 at 9:54 AM, former Staff D, Certified Nurse Aide (CNA), reported she assisted Resident #2 to transfer from the bed to a lift recliner using a gait belt and walker on 8/16/25. Staff D verbalized she removed the gait belt from Resident #2 and turned to remove the personal protective gown she had on when she heard a noise. Staff D turned towards Resident #2 and viewed her laying on the floor on her right side. Staff D verbalized the walker was laying on the floor beside Resident #2. Staff D reported Resident #2 had been conscious. Staff D verbalized she panicked, exited the resident room and left the facility without assisting Resident #2 or reporting the fall to the nurse. Staff D acknowledged she had received training on reporting incidents and what she did by not reporting the fall was wrong. Staff D reported she left the facility around 3:30 PM on 8/16/25.In an interview on 10/20/25 at 10:32 AM Resident #2 recalled she fell recently. Resident #2 stated she didn't lay on the floor very long and that she had been yelling for help. Resident #2 verbalized she was scared and the floor was cold. Resident #2 had been unable to recall if a staff member had been in the room at the time of her fall.In an interview on 10/20/25 at 1:10 PM, Staff B, Registered Nurse (RN) Nurse Mentor, reported Resident #4 alerted her Resident #2 needed help on 8/16/25 around 3:30 PM. Staff B assessed Resident #2 and called for other staff to assist Resident #2 up of the floor. Staff B verbalized she notified the DON of Resident #2's fall around 4:00 PM.In an interview on 10/20/25 at 1:52 PM, the DON reported she received a call from Staff B on 8/16/25 around 4:00 PM. The DON verbalized she had been informed of Resident #2's fall and that Staff D had left prior to the end of her shift. The DON verbalized she had called Staff D on 8/16/25 around 4:25 PM. The DON verbalized Staff D reported she had transferred Resident #2 to her lift recliner, removed the gait belt and turned to remove the gown when she heard Resident #2 fall. The DON reported Staff D stated she panicked and freaked out, exited Resident #2's room and left the facility. The DON verbalized it hadn't been until later that evening she had been informed Staff D had not reported Resident #2's fall prior to leaving the facility. The DON reported she notified the Administrator and [NAME] Director of Quality Care and Clinical Services on 8/16/25 at approximately 8:15 PM.The Incident/Accident Prevention facility policy effective April 2024 documented residents are to receive adequate supervision and assistance devices to prevent accidents. The Incident/Accident Prevention facility policy directed staff to do the following:Upon admission, nurse completes a fall risk assessment and will be updated quarterly with MDS/CP review thereafter. Interventions should be considered upon admission.Fall incidents will be reviewed 3-5 x's/week with DON and Administrator. Interventions will be evaluated for appropriateness. Residents to be visually monitored per Care Plan. When restless, assess need for repositioning, assist to bathroom, assisted ambulation, diversionary activity, 1:1 attention, snacks, drinks, or any verbal expressed needs from resident.Fall interventions will be included on the care plan and available to caregivers.Fall interventions will be reviewed and modified after each fall.The policy lacked direction for staff in reporting falls.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 electronic health record (EHR) review, facility records, policy review, resident and staff interviews the facility failed to report an allegation of abuse within the required time frame to the Iowa Department of Inspection, Appeals, and Licensing (DIAL) for 1 of 1 resident (Resident #2) reviewed. The facility reported a census of 32.Findings Include:Resident #2 Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 6, indicating severe cognitive impairment. The MDS documented Resident #2 required substantial/maximal assistance (Helper does more than half the effort. Helper lifts, holds, and supports trunk or limbs, but provides the efforts) from sit to stand (The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.) The MDS documented Resident #2 had been dependent (Helper does all of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity) for chair/bed-to-chair transfer (The ability to transfer to and from a bed to a chair or wheelchair). The MDS documented diagnoses of Parkinson's disease, anxiety disorder and depression. The Care Plan Report initiated on 6/18/25 identified Resident #2 had been at risk for falls. The Care Plan Report directed staff to:Ensure appropriate footwear is worn of non-skid socks or shoes when ambulation or mobilizing in wheelchair.Wheelchair loweredNon-skid strips on floor in front of chair and bedBe sure call light/pendent is within reach and encourage use for assistance as needed.A review of the facility reported Incidents to DIAL lacked reports of Resident #2 allegation of neglect after knowledge of Staff D, Certified Nursing Assistant had been in Resident #2's room when she fell on 8/16/25 and did not assist or notify the nurse of the fall prior to Staff D leaving the facility.In an interview on 10/15/25 at 9:54 AM, former Staff D, Certified Nursing Assistant (CNA) reported she assisted Resident #2 transfer from the bed to a lift recliner using a gait belt and walker on 8/16/25. Staff D verbalized she removed the gait belt from Resident #2 and turned to remove the personal protective gown she had on when she heard a noise. Staff D turned towards Resident #2 and viewed the resident laying on the floor on her right side. Staff D verbalized the walker was laying on the floor beside Resident #2. Staff D reported Resident #2 had been conscious. Staff D verbalized she panicked, exited the resident room and left the facility without assisting Resident #2 or reporting the fall to the nurse. Staff D acknowledged she had received training on reporting incidents and what she did by not reporting the fall was wrong. Staff D reported she left the facility around 3:30 PM on 8/16/25.In an interview on 10/16/25, the Administrator acknowledged he hadn't reported the incident of Staff D neglecting care for Resident #2 to DIAL due to: Resident #2 had no lapse in careStaff responded to Resident #2's call for help within a minute per video footage.Staff D had been terminated.In an interview on 10/20/25 at 10:32 AM Resident #2 recalled she fell recently. Resident #2 stated she didn't lay on the floor very long and that she had been yelling for help. Resident #2 verbalized she was scared, and the floor was cold. Resident #2 had been unable to recall if a staff member had been in the room at the time of her fall. In an interview on 10/20/25 at 1:10 PM, Staff B, Registered Nurse (RN) Nurse Mentor, reported Resident #4 alerted her Resident #2 needed help on 8/16/25 around 3:30 PM. Staff B assessed Resident #2 and called for other staff to assist Resident #2 up of the floor. Staff B verbalized she notified the DON of Resident #2's fall around 4:00 PM.In an interview on 10/20/25 at 1:52 PM, Director of Nursing (DON) reported she had received a call from Staff B on 8/16/25 around 4:00 PM. The DON verbalized she had been informed of Resident #2's fall and that Staff D had left prior to the end of her shift. The DON verbalized she had called Staff D on 8/16/25 around 4:25 PM. The DON verbalized Staff D reported she had transferred Resident #2 to her lift recliner, removed the gait belt and turned to remove the gown when she heard Resident #2 fall. The DON reported Staff D stated she panicked and freaked out, exited Resident #2's room and left the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility. The DON verbalized it hadn't been until later that evening she had been informed Staff D had not reported Resident #2's fall prior to leaving the facility. The DON reported she notified the Administrator and [NAME] Director of Quality Care and Clinical Services on 8/16/25 at approximately 8:15 PM.In an interview on 10/21/25 at 11:53 AM, the DON verbalized Staff D's lack of assisting and reporting met the facility policy definition for neglect. The DON acknowledged it should have been reported to DIAL.A review of the Abuse Prevention, Identification, Investigation and Reporting Policy revised March 2025 defined Dependent adult abuse under Iowa law, pursuant to Iowa Code Ch. 235E as any of the following as a result of the willful misconduct or gross negligence or reckless acts or omissions of a caretaker, taking into account the totality of the circumstances:A physical injury to, or injury which is at a variance with the history given of the injury, or unreasonable confinement, unreasonable punishment, or assault of a dependent adult which involves a breach of skill, care, and learning ordinarily exercised by a caretaker in similar circumstances. Assault of a dependent adult means the commission of any act which is generally intended to cause pain or injury to a dependent adult, or which is generally intended to result in physical contact which would be considered by a reasonable person to be insulting or offensive or any act which is intended to place another in fear of immediate physical contact which will be painful, injurious, insulting, or offensive, coupled with the apparent ability to execute the act.The commission of a sexual offense under Iowa Code chapter 709 or Iowa Code section 726.2 with or against a dependent adult.Exploitation of a dependent adult. Exploitation means a caretaker knowingly obtains, uses, endeavors to obtain to use or who misappropriates a dependent adult's funds, assets, medications, or property with the intent to temporarily or permanently deprive a dependent adult of the use, benefit, or possession of the funds, assets, medication or property for the benefit of someone other than the dependent adultNeglect of a dependent adult. Neglect of a dependent adult means deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care, or other care necessary to maintain a dependent adult's life or physical or mental health.