STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165555	A. Building B. Wing	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adel Acres	1919 Greene Street Adel, IA 50003

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 49990 Based on direct observation, clinical record review, staff interview, and policy review, the facility failed to grant a resident the right to choose to wear personal clothing for 1 of 3 residents reviewed (Resident #5). The facility reported a census of 42. Findings include: The Annual Minimum data set (MDS) for Resident #5, dated 12/22/2023, included the following relevant diagnoses: diabetes mellitus (diabetes), cerebrovascular accident (stroke), above the knee amputation of the left leg. It documented the resident was dependent on staff for dressing his lower body and required moderate assistance to dress his upper body. It further documented the resident was dependent on staff for all transfers. The Quarterly MDS for Resident#5 documented that a 14 out 15 score for the Brief Interview for Mental Status, which indicated intact cognitive skills. The Care Plan for Resident #5, last revised on 11/14/2024, documented Resident #5 required staff assistance to dress. It also advised readers to document observed behaviors and all interventions attempted. In a document provided to surveyors by the facility titled Resident BIMS it documented the residents Brief Interview for Mental Status (BIMS) score as 14, indicating intact cognition. The Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated 12/01/2024 through 12/17/2024 did not document refusal to get dressed as one of the behaviors to monitor. It lacked any documentation from 12/01/2024 to 12/04/2024. It lacked documentation on 12/12/2024 during the 6 pm-6 am shift. It documented No indicating no behaviors occurred from 12/05/2024 to 12/16/2024. The Bedside Kardex Report, printed 12/17/2024 failed to document a resident preference for wearing a hospital gown or any specific behaviors to watch for. It did advise staff members to document observed behaviors and attempted interventions. The Care Plan history tab of the electronic health record (EHR), failed to document behaviors of any kind within the last six months. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165555	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/17/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Plan of Care Behavioral Tracking History did not contain documentation of any kind regarding Resident #5's behaviors within the 30 day lookback period. During an interview on 12/16/2024 at 2:03 PM with Resident #5 he stated he did not want to be in what he called a dress. He stated he wished to be wearing normal clothes. He was observed to be in a hospital style gown at this time. During an interview on 12/17/2024 at 9:49 AM with resident #5 he was observed to again be wearing a hospital style gown. When greeted, the resident noted he had been given a new dress, but stated he hoped he would be helped into normal clothes during the day. When asked if he had communicated his desire to wear traditional personal clothing to the facility, he stated he had tried in the past but had given up, as he had been in hospital style gowns for a while. In an interview on 12/17/2024 at 09:02 AM with Staff I, Certified Nursing Aide (CNA), she stated that Resident #5 often likes to wear no clothes at all. They use the hospital gown as a behavioral intervention to ensure he wears some clothes at all. She stated he often refused care, including getting dressed. She was unsure where Nursing staff document behaviors, but stated it was the CNA job to communicate behaviors observed to Nurses so they could document the behaviors. She stated she had never heard him voice a desire to wear personal clothes. In an interview on 12/17/2024 at 09:08 AM Staff C, CNA, reported she believed it was the personal preference of Resident #5 to wear hospital style gowns. She noted he had behavioral issues which prevented some care. When asked if she had witnessed behaviors, she stated she had seen him refuse bathing and nail trimming consistently. She had never seen him lash out or refuse to wear clothes for her. In an interview on 12/17/2024 at 08:28 AM with Staff B, Registered Nurse (RN), reported she believed the rationale for Resident #5 wearing hospital gowns was because of his personal preference. She stated she did know of an incident a while ago when Resident #5 had yelled at staff to help him into personal clothing, but stated she believed this was due to a doctor's appointment. She is unsure if staffed helped him into clothes on this occasion, as she got busy with other residents. When asked if Resident #5 had behaviors, she stated he can refuse care and he had a behavior tracking plan. She stated they document behaviors in the Treatment Administration Record (TAR) and in nursing progress notes. It is the nurses job to enter the nursing progress note and the CNAs job to inform nurses of behavioral issues. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/17/2024 at 09:14 AM with the Director of Nursing (DON), stated her expectation is that staff honor a residents' wishes regarding their choice of clothing. She noted if a resident refused to get dressed during the day she expected it would be tracked via a nursing progress note, and on the treatment administration record. She acknowledged the hospital style gown was an intervention if the resident refused to wear personal clothing that day. If documentation indicated there were no behaviors she would expect the resident to be dressed in personal clothing. She acknowledged four and a half days of documentation was missing from the December TAR, and all other documentation indicated the resident had not had any behaviors. Her expectation is for all documentation to be complete and accurate, and for charting to occur on every shift. She also expects documentation of all interventions attempted with the resident. During the interview she stated she believed there was a behavioral tracking book that might contain more information regarding Resident #5, and halted the interview at 09:22 AM to attempt to find the book. She returned at 09:30 AM and stated she believed the book was no longer available. The facility provided document titled Resident Right's Policy, issued on 02/01/2016, states under section K. all residents retain and use personal possessions to the maximum extent that space and safety permits. The facility provided document titled Comprehensive Person-Centered Care Plan, last revised on 10/23/2019, stated each resident will have a person centered plan of care to identify problems, needs, strengths, preferences, and goals that will identify how the interdisciplinary team will provide care.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47079 Based on clinical record review, staff interviews, and policy review, the facility failed to implement the resident's Care Plan for 1 of 3 residents who fell (#3). The facility reported a census of 42 residents. Findings include: The Annual Minimum Data Set (MDS) dated [DATE] indicated the resident had a Brief Interview for Mental Status (BIMS) of 02 out of 15 which indicated severely impaired cognition. It included diagnoses of Chronic Kidney Disease (CKD), Diabetes Mellitus (DM), cerebral infarction due to embolism of middle cerebral artery (stroke caused by a blood clot), intracerebral hemorrhage (stroke caused by brain bleed), hemiplegia (one-sided paralysis), aphasia (loss of ability to understand or express speech), and Chronic Obstructive Pulmonary Disease (COPD). It also revealed the resident was independent with oral hygiene, required setup assistance with personal hygiene, supervision with eating and toileting hygiene, moderate assistance with upper body dressing, maximum assistance with bathing and lower body dressing, and was dependent with putting on and removing footwear. A facility reported incident revealed Resident #3 fell on [DATE] at 2:12 AM. A Nurses Note dated 11/6/24 documented the following; Staff hearing resident yelling, entered resident room to find resident laying on back on floor in center of room. wheelchair tipped over lying next to resident. resident alert to staff, and VS taken with neuro's started. resident stated didn't know if he had hit head. complained of (c/o) right hip pain. resident able to move all extremities. No misalignment seen to right lower extremity. Resident assisted/ two assist/ gait belt into bed. Nurses Note dated 11/6/24 at 9:04 AM documented the following; Resident incontinent of BM this morning and screaming in his room. Screaming due to (d/t) back pain. Will address this pain with Advanced Nurse Practitioner (ARNP) today. Lab/Radiology Note dated 11/6/24 at 1:16 PM documented the following; Received x-ray results from Bio Tech. Called ARNP and read results. X-ray revealed acute or chronic subcapital femoral neck fracture (fx). ARNP suggested to call family and see if they would like him to be sent out or they can take resident to be seen by an orthopedic specialist. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Incident Note dated 11/6/24 at 3:29 PM documented the following; Text: Resident was out for lunch in a wheelchair for and brought himself back to his room. Approximately 15 minutes later, he was yelling in his bathroom and CNAs found resident on floor in his bathroom. Resident stated he did not hit his head but having pain in his right hip 10/10. Resident was incontinent. Assisted resident into w/c then to bed via gait belt and 2 assist. Cleaned resident, skin assessment performed. Notified ARNP and resident's son,. Talked with the resident's son and he decided it would be best to send resident to the hospital for further evaluation. Incident Note dated 11/6/24 at 3:45 PM documented as follows; Resident was unable to flex and extend right hip, unable to perform dorsiflexion. Resident guarding with movement. Stabilized hip with pillows while resident was supine and waited for EMS to arrive Nurses Note dated 11/12/24 at 10:25 Am documented as follows; Resident here for skilled nursing related to Open Reduction and Internal Fixation (ORIF, repair of broken bones with hardware, such as screw, plated, wires or rods). The Care Plan revised 11/14/24 revealed the resident had a history of falls and directed staff to leave the resident's bathroom light on at all times. Skilled Evaluation dated 11/14/24 at 10:54 AM documented the following; the resident complained of right hip pain, stiffness, and aching, and it was worse with movement. The resident had poor balance. At 12:58 AM, the resident was observed in bed with his bedroom and bathroom lights off. A sign on the resident's bathroom door indicated the resident's bathroom light was to be left on at all times. On 12/17/24 at 9:10 AM, the resident was observed in bed with his bedroom light off. The sign was still on the resident's bathroom door that directed staff to leave the bathroom light on at all times. Staff H, Certified Nurse Aide (CNA) opened the resident's bathroom door. The resident's bathroom light was observed off. Staff H left the light off and closed the bathroom door. On 12/17/24 at 9:33 AM, Staff I, CNA stated she did not know why the resident's bathroom light was off. She turned it on. A policy titled Comprehensive Person-Centered Care Plan reviewed 10/23/19 indicated assigned disciplines will be identified to carry out the interventions. On 12/17/24 at 9:53 AM, the Director of Nursing (DON) stated the staff should read and follow the Care Plan.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47079 Based on clinical record review, staff interviews, and policy review, the facility failed to provide assessment and interventions for 1 of 3 residents who fell (#3). The facility reported a census of 42 residents. Findings include: A Facility reported Incident revealed Resident #3 fell on [DATE] at 2:12 AM. The Annual Minimum Data Set (MDS) dated [DATE] indicated the resident had a Brief Interview for Mental Status (BIMS) of 02 out of 15 which indicated severely impaired cognition. It included diagnoses of Chronic Kidney Disease (CKD), Diabetes Mellitus (DM), cerebral infarction due to embolism of middle cerebral artery (stroke caused by a blood clot), intracerebral hemorrhage (stroke caused by brain bleed), hemiplegia (one-sided paralysis), aphasia (loss of ability to understand or express speech), and Chronic Obstructive Pulmonary Disease (COPD). It also revealed the resident was independent with oral hygiene, required setup assistance with personal hygiene, supervision with eating and toileting hygiene, moderate assistance with upper body dressing, maximum assistance with bathing and lower body dressing, and was dependent with putting on and removing footwear. The Electronic Health Record (EHR) progress notes dated 11/06/24 at 2:12 AM revealed the resident had an unwitnessed fall in his room. It also lacked documented follow-up neurological checks (neuro checks). The Client Uploaded Files section did not have a paper neuro check sheet uploaded. The electronic Neurological Check List forms stopped on 9/10/21. The Care Plan revealed the resident had a history of falls and an anti-rollback bar was added to his wheelchair. It did not direct staff to perform neuro checks after a fall. On 12/16/24 at 11:53 AM, Staff B, Registered Nurse (RN) stated staff must perform an initial resident assessment and complete the neuro sheets as indicated. At 11:57 AM, The Director of Nursing stated Staff G, Licensed Practical Nurse (LPN) was the one who scanned sheets into the EHR. At 11:58 AM, Staff G, LPN confirmed she was the one who scans documents into the EHR. She stated she was about a month past due but would go through them and try to locate the neuro sheets. At 12:55 pm, Staff G, LPN confirmed the resident's neuro sheets were not in the stack in her office. At 1:25 PM, Staff G, LPN confirmed the neuro checks for Resident #3's fall on 11/06/24 could not be located. At 4:05 PM, the Administrator stated he was informed the neuro check sheets were no longer available. Staff G, LPN confirmed the facility did not have neuro check sheets for Resident #3's fall on 11/06/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy titled Neurological Evaluation reviewed 3/28/23 indicated the Licensed Nurse shall perform a Neurological Evaluation as followed for a 72 Hour Timeframe, unless otherwise ordered by the Physician. The results will be recorded on the G.8(a) Neurological Evaluation Form. a) Every 15 Minutes X1 Hour b) Every 30 Minutes X1 Hour c) Every 1 Hour X2 Hours d) Every 2 Hours X8 Hours e) Every 4 Hours X12 Hours f) Every Shift X48 Hours On 12/17/24 at 10:00 AM, the Director of Nursing (DON) stated staff should document post fall neuro assessments and maintain paperwork.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47079 Based on observations, staff interviews and policy review, the facility failed to secure prescribed medications from the possibility of unauthorized access. The facility reported a census of 42 residents. Findings included: On 12/16/24 at 9:03 AM, two medication carts were observed in front of the nurses' station and facing the dining room Staff A, Certified Medication Aide (CMA) was observed preparing medications at one of the medication carts. She took medications into the dining room with her back positioned toward both medication carts. Both medication carts were observed unlocked with no other staff present. At 9:06 AM, Staff B, Registered Nurse (RN) walked up to the first laptop, put something in the medication cart, then locked it and walked away. At 12:40 PM, Staff B, RN, stated the medication carts should be locked when staff walks away from them. On 12/17/24 at 8:49 AM, Staff A, CMA stated the medication cart should be locked when staff walks away from it and it is never ok to leave it unlocked at that time. She stated she just forgot to lock it on 12/16/24. On 12/17/24 at 9:57 AM, the Administrator stated the medication carts should be locked at all times when staff are not present. A policy titled Storage of Medications revised 11/2018 indicated medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 47079 Based on observations, staff interviews, and policy review, the facility failed to properly protect resident information from unauthorized access. The facility reported a census of 42 residents. Findings include: On 12/16/24 at 9:03 AM, two (2) unlocked laptops were observed sitting on medication carts. Staff A, Certified Medication Aide (CMA) walked away from one of the laptops, turned her back to both, and gave medication to a resident. Both laptop screens faced an occupied dining room and had multiple residents' information visible. At 9:06 AM, Staff B, Registered Nurse (RN) walked up to the first laptop, put something in the medication cart, then locked the laptop screen. At 12:50 PM, Staff B, RN, stated when staff walks away from the medication cart, the laptop screen and cart should be locked. She also stated if staff's back is toward the laptop, the cart and laptop should be locked. On 12/17/24 at 8:49 AM, Staff A, CMA stated the medication cart should be locked when staff walks away from it and it is never ok to leave it unlocked at that time. She stated she just forgot to lock it on 12/16/24. On 12/17/24 at 9:59 AM, the Director of Nursing stated maintain HIPAA (resident privacy) and minimize and/or close the laptops when staff walks away from it. The facility did not have a policy regarding securing resident information.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47079 Based on observations, staff interview, and policy review the facility failed to implement the infection control policy as staff failed to perform hand hygiene during medication administration for one (1) resident (#4) and between feeding two (2) residents (#10, #11). The facility staff also failed to clean a mechanical lift between two residents' use (#6, #9). The facility reported a census of 42 residents. Findings include: 1) On 12/16/24 at 9:09 AM, Staff A, Certified Medication Aide (CMA) prepared Resident #4's medications at a medication cart. One (1) pill fell into the top drawer and Staff A grabbed it with her bare hand and placed it back into the resident's medication cup. She then took it to the resident. At 12:40 PM, Staff B, Registered Nurse (RN) stated if a medication fell and landed anywhere outside the resident's cup, it should be discarded and replaced. She said it was not ok to grab the pill and put it in the resident's cup and give it to them. At 12:45 PM, Staff A, CMA stated if a med fell anywhere other than the resident's medication cup, it should be discarded. She said it was not ok to pick it up and give it to the resident. She admitted the resident should not have received the medication she picked up with her hand. On 12/17/24 at 10:07 AM, the Director of Nursing (DON) stated staff should have disposed of the pill and performed hand hygiene. 2) On 12/16/24 at 1:02 PM, Staff C, Certified Nurse Aide (CNA) assisted Resident #10 with eating. She picked up Resident #10's fork and fed her. She turned to Resident #11, grabbed her fork and attempted to feed her. She put down the fork, picked up Resident #10's fork and fed her again. She removed a bib from another resident, put it on the table, then wheeled Resident #11 back to her room. Staff C did not perform hand hygiene between feeding each resident. At 1:03 pm, Resident #10 picked up her fork and fed herself. The CMA did not perform HH throughout the process. On 12/17/24 at 10:09 AM, the Director of Nursing (DON) stated staff should have performed hand hygiene between residents or secure the utensils to prevent the resident from grabbing the utensil. A policy titled Standard Precautions reviewed 10/25/22 directed staff to perform hand hygiene before/after direct contact with residents or when Hands are visibly soiled. 3) On 12/16/24 at 1:13 PM, a continuous observation revealed Staff D, Certified Nurse Aide (CNA) and Staff E, CNA transferred Resident #9 from a chair into her bed with a mechanical lift. At 1:17 PM, Staff D, CNA placed the mechanical lift in the hallway without cleaning it. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 2:00 PM, Staff D CNA took the mechanical lift into Resident #6's room and Staff F, Certified Occupational Therapy Assistant (COTA) transferred Resident #6 from his chair to his bed. The mechanical lift was not cleaned between Resident #9 and Resident #6's use. On 12/17/24 at 10:11 AM, the Director of Nursing (DON) stated staff should wipe the equipment down with disinfectant between resident use. A policy titled Standard Precautions reviewed 10/25/22 directed staff to follow procedures for routine care, cleaning and disinfection of environmental surfaces, especially frequently touched surfaces in patient care areas.