

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  10/16/2025
NAME OF PROVIDER OR SUPPLIER  Adel Acres		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0658  Level of Harm - Actual harm  Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality.  (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 0658  Level of Harm - Actual harm  Residents Affected - Few	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, staff interviews, and policy review the facility failed to follow the physician's order to complete blood sugar (BS) checks and administer intravenous (IV) antibiotics for a resident with diabetes and an infection and failed to notify the physician when an IV antibiotic was not available/or able to be administered for 1 (Resident #1) of 3 residents reviewed. The resident was re-hospitalized for sepsis and had high blood sugars. The facility reported a census of 42 residents. Findings include: The Minimum Data Set (MDS) for Resident #1, dated 9/9/25, included diagnoses of diabetes, septicemia (presence of bacteria in the blood stream), renal (kidney) failure, and aphasia (impairment in a person's ability to comprehend or formulate language). The MDS identified the resident was receiving insulin and hypoglycemic medication (medication for diabetes to lower the blood sugar levels). The MDS indicated the resident had a Brief Interview for Mental Status score of 6, indicating severe cognitive impairment for decision-making. Resident's Hospital Discharge Report dated 6/12/25 documented a diagnosis of diabetes with long-term current use of insulin, an order for metformin (oral diabetes medication) daily, and no insulin instructions available. Resident's Hospital Note Report, Provider Progress Notes dated 6/11/25 at 1:37 PM revealed continue sliding scale insulin 3 times daily after meals and nightly. Resident's Orders Management from provider dated 6/25/25, revealed admission orders for diabetic monitoring of BS checks AC (before each meal), HS (hour of sleep), PRN (as needed), and notify the provider if the BS is less than 60 or greater than 400. Resident's Nurses Note dated 6/12/25 at 2:36 PM documented resident arrived at facility via Emergency Management Services, resident is alert but only oriented to self, and is a diabetic that had AC and HS BS checks in the hospital but does not have an order for BS or insulin post hospitalization. Resident's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for 6/1-30/25 and 7/1-31/25 lacked documentation of any BS checks completed AC and HS as ordered. Resident's Nurses Notes dated 7/11/25 at 3:17 PM documented resident was not responding appropriately, clammy and pale with low grade temperate of 99. Provider advised to send to the hospital. Resident's hospital Discharge summary dated [DATE] revealed admitted from care facility for sepsis (can be a life-threatening complication of a bacterial infection in which the body responds improperly to an infection) from underlying urinary tract infection (UTI). A large abscess was found in the retroperitoneum (space located behind the lining of the abdominal cavity and contains kidneys, adrenal glands, and parts of pancreas, aorta, and rectum) and along the right kidney and a ureteral stent (tube inserted into the ureter to keep it open and allow urine to flow from the kidney to the bladder) exchange was completed. IV antibiotics for 2 weeks for infections recommended due to concern for myositis (a group of inflammatory muscle diseases that cause muscle weakness, pain, and other symptoms) and spinal involvement with the location of the cyst. Discharge medication order for IV antibiotic daily for 42 doses. Resident's Medication Administration Note dated 7/18/25 at 11:21PM revealed the IV antibiotic medication not administered due to none on hand. Resident's Nurses Notes revealed the following: 7/19/25 at 1:40 AM - PICC (peripherally inserted central catheter) (tube inserted into a vein in the arm and to a large vein near the heart, used for long term IV treatments) was no longer inserted. 7/19/25 at 6AM - late entry- per provider when ready to administer IV antibiotics to start a peripheral line (IV in arm/hand) and provider will try to have someone out on Monday (7/21) to replace the PICC line. 7/19/25 at 10 PM - IV placed in right wrist. 7/20/25 at 11:36 PM - waiting on call back from provider as resident removed IV again. 7/22/25 at 1:28 AM and 7/22/25 at 11:15 PM - IV antibiotic not administered due to no IV access, no documentation that provider was notified. 7/23/25 at 12:53 PM - notified provider to clarify orders for antibiotic due to resident pulling out PICC and IV line. Order to discontinue IV antibiotic and new order for oral antibiotic medication. 7/24/25 at 12:45 PM - Contacted provider due to drainage from insertion site of drain tube, pocket filled area above site, and resident in electrifying pain when palpating area. Sent to hospital. Resident's MAR for 7/1-7/31/25 revealed the IV antibiotic was administered 1 of the 5 days ordered, 7/19/25. Resident's hospital Discharge summary dated [DATE], revealed sepsis and worsening of retroperitoneal abscess. Resident's Lab Report dated 8/18/25 revealed a glucose level of 328 (high) with normal range 70-99. Resident's Lab Report dated 9/2/25 revealed a hemoglobin A1C (a type of protein in the blood that measures the average blood sugar (glucose) level over the past 2-3 months) of 9.8 (high) with the goal of therapy of less than 7.0 and action suggested at more than 8.0. Resident's Nurses Notes revealed the following: 9/7/25 at 3:48 PM - a new order for metformin 500 mg (milligrams) daily 9/15/25 at 7:50 PM - BS 554 (normal range</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on electronic health record review, document review, family and staff interviews, and policy review, the facility failed to promptly identify and intervene for a change in a resident's condition after falls for 2 of 3 residents reviewed for assessment and intervention (Residents #3 and #4). The facility reported a census of 42. Findings include: 1. The Minimum Data Set (MDS) assessment completed 5/19/25 revealed Resident #4 with a Brief Interview for Mental Status (BIMS) score of 7 indicating severe cognitive impairment. Diagnoses include anxiety disorder, frontal lobe and executive function deficit, hemiplegia (affecting right dominant side), schizophrenia, and stroke. The MDS noted Resident #4 with two or more falls with no injuries since facility admission on [DATE].</p> <p>The Care Plan, initiated on 5/16/25, identified Resident #4's impaired cognitive function and assessed at high risk for falls. Interventions included staff assist of 1 with walker and gait belt for transfers, asking yes/no questions to determine needs, cue/reorient/supervise as needed, present one thought/idea/command at a time, prompt staff response, and increased observation.</p> <p>The Incident Report #1920, dated 5/29/25 at 1:00 PM, reported Resident #4 was on the floor on her stomach. Vitals taken and no injuries observed with range of motion (ROM) noted to arms and legs. No pain reported. No further investigative reports or follow-up identified which described the incident in more detail.</p> <p>Fall Risk Evaluation completed 5/29/25 at 2:10 PM and documented at risk for falls.</p> <p>Neurological Evaluation facility form initiated on 5/29/25 at 1:00 PM and completed through 6/2/25.</p> <p>The Progress Note dated 5/29/25 at 4:31 PM documented an aide called the nurse to the dining area because resident was on the floor on her stomach. No documentation of provider notification on report.</p> <p>The Progress Note dated 5/30/25 at 4:51 PM documented Resident #4 on observation for recent fall. Denies pain or discomfort. Resident #4 had not slept for three days very well but slept during the shift. Frequent visual checks for safety completed as well as skin assessment.</p> <p>The Progress Note dated 6/1/25 at 9:51 PM documented no pain, discomfort, or adverse side effects at this time from the recent fall.</p> <p>The Progress Note dated 6/2/25 at 7:15 PM documented family taking Resident #4 to a local hospital as not acting right.</p> <p>The Progress Note dated 6/3/25 at 12:38 PM documented a facility nursing update from the hospital. Resident #4 admitted with a brain bleed. Hospital staff seeing a lot of confusion and delirium.</p> <p>Hospital records from 6/2/25 showed Resident #4 presented with confusion, agitation and bulging eyes. A computed tomography (CT) scan was completed. A chronic right subdural hematoma identified. Records indicated a normal CT reading from 5/9/25. Resident #4 was transferred to trauma center given the nature of the head injury.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The Death Certificate, filed on 6/20/25, noted Resident #4 passed away on 6/15/25 due to blunt force trauma to the head complicated by follicular lymphoma (form of blood cancer).</p> <p>During an interview on 10/8/25 at 1:05 PM, Staff A, Licensed Practical Nurse (LPN), described Resident #4 as impulsive and could not sit still. The resident would often try self-transfer on their own. Resident #4 would spend the majority of the time around the nurse's station so staff could monitor. The day after the incident on 5/29/25, Staff A was told Resident #4 was in the dining room, took a step, fell, and hit their head. Staff A did not believe Resident #4 was herself after this event. They felt the resident was not as impulsive and sleeping more. Staff A stated they had reported concerns to the Registered Nurses (RN) on duty. The RNs indicated Resident #4 was easily aroused, responded appropriately, and would go back to sleep. Vitals were acceptable. Since the RN assessed, Staff A did not notify the resident's Primary Care Provider (PCP) of these changes. Staff A reported the day before the resident was hospitalized, they had noticed Resident #4's eyes were bulged a little with no changes to neurological examination. This was not a significant change but enough to where Staff A noticed.</p> <p>During an interview on 10/8/25 at 1:30 PM, Staff B, Certified Nurses Assistant (CNA), described Resident #4 as anxious and on-the-go. The resident would take little cat naps during the day. After the incident on 5/29/25, Staff B reported the resident may have been sleepier and have more of a blank stare when trying to interact. Resident #4 would respond but Staff B felt the response was slower than usual.</p> <p>During an interview on 10/8/25 at 1:50 PM, Staff C, Certified Medication Aide (CMA), stated they were working during the incident on 5/29/25. Staff C reported hearing a commotion, possibly a wheelchair hitting a table, and saw Resident #4 on the floor with staff surrounding. The day family took Resident #4 to the hospital. Staff C felt the resident was more fidgety than usual. When family arrived to the facility on 6/2/25, they asked Staff C if Resident #4 had been acting this way during the day. Staff C stated family did not say why or how they felt the resident was acting different.</p> <p>During an interview on 10/9/25 at 11:00 AM, Staff D, CNA, explained Resident #4 as anxious and would self-propel themselves around the facility in a wheelchair. Staff D noted the resident couldn't hold a conversation but was able to alert staff if they needed anything (would wave arm around to get attention). Staff D was present during the incident on 5/29/25 and relayed the following:</p> <ol style="list-style-type: none"> <li>a. Staff D was assisting another resident to eat when heard a staff member shout out and point towards Resident #4</li> <li>b. Staff D saw Resident #4 stand up from the wheelchair trying to take step but feet were crossed</li> <li>c. Resident #4 then fell with the wheelchair flipped over on top. Staff D heard Resident #4's head hit the floor. Staff D could not recall which side of the head was struck but did motion to the right side of their head when describing how the resident fell</li> <li>d. Staff D ran over to the resident and alerted the nurse. Once the nurse completed their assessment, they two-manned the resident up to the wheelchair</li> <li>e. Staff D remembered Resident #4 being more tired than usual the rest of the day; Feels sleeping more often than usual but was easy to wake</li> </ol> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The day after this event, Staff D noted Resident #4 was more tired than usual. The resident's speech may have been a little more slurred than usual. Staff D remembered Resident #4 looking more clueless or looking through you with a blank stare. Staff D conferred with another CNA who confirmed Resident #4 was not acting like themselves. Staff D notified nursing staff (Staff A) but did not know what happened after this. The biggest change in Resident #4 after the incident that Staff D recalled was the amount of sleeping.</p> <p>During an interview on 10/9/25 at 2:10 PM, Staff E, CNA, recalled Resident #4 sleeping more after the incident on 5/29/25. This was not a drastic change. Staff E also noted Resident #4 not as energetic after the incident.</p> <p>During an interview on 10/9/25 at 2:25 PM, Staff F, CNA, noted Resident #4 was different after the incident on 5/29/25 but unable to elaborate further. Staff F recalled possible bruising to the top of the head/forehead area.</p> <p>During an interview on 10/9/25 at 3:35 PM, Staff G, CNA, noted Resident #4 was more fidgety after the incident on 5/29/25 and could not sit still. They were very restless and appeared uncomfortable.</p> <p>During an interview on 10/13/25 at 1:45 PM, Staff H, RN, described Resident #4 as a high fall risk who would try to self-transfer themselves. Staff H acknowledged being the nurse on duty at the time of the incident on 5/29/25. However, they could not recall any specifics of the event. Staff H could not recall how the resident was laying on the floor upon arrival nor if other staff members informed of Resident #4 hitting their head on the ground.</p> <p>During a follow-up interview on 10/13/25 at 2:10 PM, Staff D confirmed previous statement of hearing Resident #4 hitting their head on the ground. Staff D recalled telling Staff H of how Resident #4 fell and suspects they told the nurse of the head strike but unable to recall specifics of the conversation.</p> <p>During an interview on 10/13/25 at 2:25 PM, Staff I, CNA, explained they were in the dining room when Resident #4 fell. They were assisting another resident and noticed Resident #4 starting to stir a little bit. They looked back and saw Resident #4 go down. Staff I described the incident as rough. Staff I noted Resident #4 was off and felt the resident's eyes were bulgy.</p> <p>During an interview on 10/13/25 at 4:45 PM, Staff J, CNA, acknowledged working the day of the incident on 5/29/25. Staff J was at the nurse's station when they heard a loud noise. Staff J ran to the dining room and found Resident #4 on the floor, chest down on their stomach. It appeared Resident #4 fell face first with the wheelchair on top of the resident. Staff J noticed a red mark to the resident's right side of the forehead/cheek area and informed the RN.</p> <p>During an interview on 10/14/25 at 8:50 AM, resident's sister acknowledged going to the facility on 6/2/25. Upon arrival, they found Resident #4 sweaty and moving back/forth in the wheelchair. They felt the resident was more restless than usual and their eyes were bugged out. When asked, the nurse on duty stated the resident had been this way all day. The sister provided a shower to the resident. During this time, an unnamed staff member told them staff had been trying to tell the Director of Nursing (DON) that something was wrong with Resident #4, only to be told that the resident was fine. When family was taking the resident out to the car, another unnamed staff member told them that Resident #4 had been acting different since the incident on 5/29/25.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/14/25 at 2:30 PM, Staff K, CMA, stated she overheard the nurses giving report the morning of 5/30/25. Staff reported that Resident #4 had a fall, fell forward and hit their head.</p> <p>During an interview on 10/14/25 at 4:30 PM, Staff L, CNA, explained Resident #4's norm was to be up most of the night, did not sleep much. After the incident on 5/29/25, the resident was noted to be sleeping more. Staff L did not think the resident looked the same as their eyes were bulging. Staff L reported having informal conversations with the nursing staff about the changes but felt it was brushed off.</p> <p>During an interview on 10/15/25 at 9:45 AM, Staff M, PCP, acknowledged an initial office visit with Resident #4 and their family. At the time, Resident #4 appeared cooperative but confused with psychomotor agitation. Staff M noted a CT scan was completed on 5/9/25 with no acute intercranial process identified. Staff M confirmed the facility contacted their office to notify of an unwitnessed fall on 5/29/25 and reported no injury. There was no documentation of a possible head strike. Staff M would expect the facility to contact them with any changes to sleep patterns or activity, even when neurochecks are normal. Staff M would like to know what's going on especially when put in the context of a recent fall, a more heightened awareness of changes.</p> <p>The policy Notification of a Change in Condition, revised 2/6/25, outlined the attending physician/physician extender (nurse practitioner, physician assistant or clinical nurse specialist) will be notified of a change in resident condition. Guidelines for notification include a significant change in medial or cognitive baseline and accident/incident.</p> <p>The facility document Fall Management Program, dated 10/14/24, outlined if an injury is suspected, the provider is notified for further guidance.</p> <p>2. The MDS for Resident #3, dated 7/18/25, included diagnoses of left hip fracture, amputation of left midfoot, and Non-Alzheimer's Disease. The MDS identified the resident required substantial/maximal assistance of staff for transfers, toileting, and walking. The MDS indicated the resident had a BIMS score of 4, indicating severe cognitive impairment for decision-making.</p> <p>Resident #3's facility Fall Report dated 8/8/25 at 12:30 AM, revealed resident observed sitting on ground by his bed. Resident previously seen in recliner. Denies injury. Resident checked over head to toe, vitals taken, toileted, and placed in bed. No injuries observed post incident.</p> <p>Resident #3's facility Fall Report dated 8/9/25 at 9:00 PM, revealed resident observed on floor sitting next to the bed, back to bed. Head to toe, no injuries, vitals. No injuries observed post incident.</p> <p>Resident #3's hospital Summary of Care, with admission date of 8/11/25, revealed an x-ray report, dated 8/11/25, with a mildly displaced right intertrochanteric (hip) fracture in moderate varus (body part angles inward) malalignment and documented a right hip replacement surgery completed.</p> <p>Resident #3's Progress Notes revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>8/8/25 1:02 AM &amp;ndash; Nurses Note Late Entry- Resident observed on the floor, sitting with back to bed. Resident states I don't know when asked what has happened. Denies injury, head to toe reveals no injuries.</p> <p>8/8/25 5:06 PM &amp;ndash; Nurses Note- Resident continues on follow up (f/u) post fall in room. Neurological (neuros) checks (exam that evaluates the brain and nervous system functioning which is completed after falls with a possible head strike). Hand grips strong and equal. Denies headache, any pain, or discomfort with assessment.</p> <p>8/9/25 5:27 PM- Nurses Note- Resident continues on status/post (s/p) fall in room. Pupils equal, round, reactive, to light accommodation (PERRLA), range of motion (ROM) within baseline, denies pain with assessment.</p> <p>8/9/25 8:08 PM &amp;ndash; Medication Administration Note- Tylenol 500 milligrams (mg) given for pain.</p> <p>8/9/25 10:23 PM &amp;ndash; Medication Administration Note- Tylenol effective. Pain scale 1. (pain scale 1-10 with 1 the least pain and 10 the worst)</p> <p>8/10/25 5:06 AM &amp;ndash; Nurses Note- Resident observed on floor by bed, back to bed, unsure of what resident was doing at time. Denies injury and can't explain what happened. No injury found on head to toe. All parties notified.</p> <p>8/10/25 4:52 PM &amp;ndash; Nurses Note -Continues on observation for recent fall; no adverse reactions noted; continues on neuro checks; within normal limits (WNL).</p> <p>8/10/25 8:04 PM - Medication Administration Note- Tylenol 500 milligrams (mg) given for pain.</p> <p>8/10/25 11:58 PM - Medication Administration Note- Tylenol effective. Pain scale 1.</p> <p>8/11/25 3:22 AM &amp;ndash; Nurses Note - Resident complaining of more pain, skin observation reveals bruising on back, sacrum area and on side of right hip. Complains of pain in right leg hurting.</p> <p>8/11/25 4:20 AM- Medication Administration Note- Tylenol 500 milligrams (mg) given for pain.</p> <p>8/11/25 5:29 AM - Medication Administration Note- Tylenol effective. Pain scale 3.</p> <p>8/11/25 10:10 AM &amp;ndash; Nurses Note &amp;ndash; Staff and therapy reporting that resident is having increase in pain to left hip/leg, also staff noted bruise to right hip. Resident not tolerating stand, pivot transfer well and is not bearing weight. Call placed to Nurse Practitioner (NP) and received order for stat x-rays.</p> <p>8/11/25 12:23 PM &amp;ndash; Nurses Note &amp;ndash; Received final report on x-rays with acute fracture to right leg. NP in house and addressed. Send to emergency room (ER).</p> <p>Interview on 10/9/25 at 9:41 AM, Staff P, Certified Nurse Aide (CNA) stated Resident #3 was an assist of 1 staff with a gait belt for transfers, was doing well prior to the falls, and usually not try to get up on his own.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 10/9/25 at 10:25 AM, Staff B, CNA stated she was off when Resident #3 had the falls, but she worked the day he went out to the hospital. Staff B stated Staff D, CNA was working Resident #3's hall and asked for help getting the resident up as the resident wasn't doing as well as normal. Staff B stated she thought the resident was in a lot of pain as he was yelling OW when moving him, took 2 staff to get him up, not the usual. Staff B stated they got him up with a walker, gait belt and pivot transfer to the wheelchair (W/C). Staff B further stated the resident was saying OW while doing all this, did feel he was bearing most of his weight, took the resident to the dining room for breakfast in the W/C, and thinks she helped put him back to bed. Staff B stated Staff D talked to the nurse.</p> <p>Interview on 10/9/25 at 10:25 AM, Staff Q, CNA stated she worked the day Resident #3 got the x-ray, was helping Staff B get the resident up and the resident did scream out. Staff Q stated resident was some weight bearing with transfer, and when asked where he hurt pointed to his right hip. Staff Q stated the resident went to breakfast and back to his room, stated she notified the nurse and the nurse said x-ray was on their way.</p> <p>Interview on 10/9/25 at 11:15 AM, Staff D, CNA stated she was off the days Resident #3 fell. Stated resident normally will sit on the side of the bed, put the gait belt on and walk to the bathroom with assist of 1. Staff D stated on the day the fracture was found, she got him up, he was screaming, yelling that it hurt, swatting at her, and asked where he hurt and he wouldn't answer. Staff D stated Staff B helped get the resident up, he was not normal weight bearing, grabbing at his hip, not sure which one. Staff D stated they put the resident in his W/C, took him to the nurses station and told Staff H, Registered Nurse (RN) he was in a lot of pain and Staff H asked Staff K, Certified Medication Aide (CMA) if he had anything for pain and Staff K said the medication would have to be pulled. Staff D stated once the resident was in his W/C, he calmed down and ate breakfast and was taken back to his room. Staff D further stated she got Staff S, Occupational Therapy Assistant (OTA) as felt something was wrong, and [NAME] helped transfer resident and said he not right, when transferred from W/C to recliner, as was hollering out in pain. Staff D stated she was not aware the resident had a fall over the weekend, she notified the Director of Nursing (DON) to come look at him, and the DON told her the resident had a fall over the weekend when she spoke with her.</p> <p>Interview on 10/9/25 at 1:30 PM, Staff R, CNA stated she was not sure which night but she was in the breakroom and heard Resident #3 fall, sounded like a walker falling. Stated she went to the resident's room, screamed from his room for help and the resident was on his side or back, walker in front of him, close to the bed. Staff V, Registered Nurse (RN) assessed the resident and he was making noises like he was in pain. Staff V, Staff U, CNA, and herself moved the resident back to bed with a gait belt, and she didn't provide cares for the resident the rest of the night. Staff R further stated she was not aware of a 2nd fall with the resident but a couple days after the fall she turned him and he was screaming out but don't recall when.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Adel Acres		STREET ADDRESS, CITY, STATE, ZIP CODE  1919 Greene Street Adel, IA 50003	
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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 10/9/25 at 2:57 PM, Staff G, CNA stated she worked the 6 PM-6 AM shifts on 8/9 &amp; 8/10/25. Staff G stated she helped with the resident after the fall on 8/9 but on 8/10 Staff U, CNA said the resident was not rolling, so she helped assist with changing him, and when they went to turn him towards her, she was holding his right side and he yelled out pretty good, and that was on 12 midnight rounds. Staff G stated was reported to Staff V, it was the same each time they changed him at 2 AM and 4 AM, and he was pretty stiff but tried not to roll him on his right side. Staff G further stated that an Emergency Medical Services person taught her if when you rotate the hip like turning and the person yells out in pain, it is usually a fractured hip and did tell Staff V that. Stated Resident was sleeping before they did 4 AM rounds and he had a big bruise on his right buttock, lower back, and upper backside of leg.</p> <p>Interview on 10/13/25 at 12:23 PM, Staff S, stated she had been working with Resident #3 prior to his falls, he was doing ok, and was an assist of 1 staff. Staff S stated the day the resident had the x-ray, she went to get him from the dining room table for therapy and he said his back hurt and he didn't want to do therapy which wasn't the norm for him. Staff S stated she grabbed Staff D and transferred the resident with 2 maximum assist from his W/C to a recliner. Staff S stated she doesn't remember if the resident hollered out, but the transfer was not normal. Staff S stated she reported the resident's complaints of pain to the nurse, thinks it was the Director of Nursing (DON). [NAME] S further stated she was not aware of the resident's falls until after she reported the resident's pain to the nurse.</p> <p>Interview on 10/13/25 at 1:57 PM, Staff H stated she believes a CNA came and reported Resident #3 in pain on 8/11/25 AM shift, and she was doing something else. Staff H stated she doesn't recall assessing the resident, thinks Staff O, LPN may have assessed him. Staff H stated she doesn't recall doing anything with the resident that morning and she didn't call the physician.</p> <p>Interview on 10/13/25 at 2:42 PM, Staff I, CNA stated he worked evening on 8/10/25 and was told Resident #3 fell and a CNA (not sure who) reported something was wrong with the resident, he was having pain in the other side of his body, not the previous fractured hip. Staff I stated he did do cares on the resident that night while he was in bed, the resident was hollering out, he told the nurse the resident needed pain medication and he thinks nurse went and saw the resident but didn't know if the nurse gave him any pain medication. Staff I stated he got off at 10:00 PM and the next day he was told the resident was shipped out to the hospital.</p> <p>Interview on 10/3/25 at 4:47 PM, Staff T, CNA stated she worked on 8/10/25 the day after Resident #3's fall, was doing 2 staff with the resident after the fall as he was not standing well with 1staff, and the overnight CNA, Staff G stated the resident started complaining of hip pain and it was not his norm to complain as he didn't talk much. Staff T further stated that Staff G reported the resident couldn't sit on that right side and didn't want to bear weight on the right side. Staff T stated she does not recall if she cared for the resident that day and doesn't recall any conversations with the nurse about his pain.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 10/14/25 at 12PM, Staff U stated she was not present during Resident #3's falls, and until time of interview was not aware he fell more than once. Staff U stated the communication between shifts is not good, that the CNA gives report to the next CNA shift but usually just things like the last time the resident was changed and the nurses don't keep the CNAs updated with changes, falls, etc. Staff U stated she worked the night shift on 8/10/25, Resident #3 was in pain, she reported to the Staff V and Staff V came in and felt around the resident's area of the hip and said she didn't feel anything and you can't feel a fracture. Staff U stated she tried to have 2 staff assist with the resident's cares. Staff U further stated the resident usually would say no if asked if he was in pain, so you had to watch for facial grimacing and he was grimacing when moved to the one side of his R hip.</p> <p>Interview on 10/14/25 at 2:39 PM, Staff K stated she worked the day Resident #3 was sent out with the fracture. Staff K doesn't recall that she was told the resident was in pain and asked about if he had pain medication, but stated the nurse would have had to pull the medication from the ADU (automatic dispensing unit), as she is unable to get out a narcotic, and she would have given the medication if she was told to. Staff K did give the resident his AM meds, but doesn't remember if he was at the table or in bed.</p> <p>Interview on 10/14/25 at 11:00 AM, Staff A stated when a resident falls do an initial assessment which is a whole assessment, along with neuros, assess the whole body and document. She stated fall follow-up and assessments continued for 72 hours, also completing the neuros, asking and assessing for pain, and the range of motion. Staff O further stated if the resident assistance requirements increased and complaining of pain she would notify the physician and not move the resident around, with all assessments documented.</p> <p>Interview on 10/14/25 at 11:15 AM, Staff O stated she didn't recall any nurse asking her to assess Resident #3 on 8/11/25. Staff O stated she came to work about 7:00 AM and was talking with the DON regarding the resident's falls on the 24-hour report, and was trying to figure out if the resident had 1 or 2 falls. Staff O stated she assessed the resident with the DON later in the morning and noted a bruise to the resident's right hip. Staff O further stated when a resident falls do a full head to toe assessment, vital signs, check range of motion, look for rotation of legs, and document all. Staff O stated then need to observe everything on the resident, do neuro checks per policy, complete and document a fall follow-up every shift for 72 hours and if the staff are reporting the resident is having pain and requiring increased assistance would do a full assessment, notify the physician for possible x-rays, and provide pain medication if available.</p> <p>Interview on 10/14/25 at 3:45 PM, the DON stated she wasn't aware of Resident #3's falls and after she came in on 8/11/25 was the first she heard of the resident's pain and not bearing weight. The DON stated she thought it was at the 9:30 AM morning meeting that she was notified by therapy and a CNA, therapy told her the resident was complaining of pain and the left hip, staff told her was the resident's right hip and he was not bearing weight on his right leg. The DON stated noted a bruise on the resident's right hip and she called the physician who ordered an x-ray and the facility got the results of a hip fracture later that morning while the physician was in the building and the resident was then sent out via ambulance to the hospital.</p> <p>Resident #3's hospital Summary of Care dated with admission date of 8/11/25 revealed an x-ray report, dated 8/11/25, with a mildly displaced right intertrochanteric (hip) fracture in moderate varus (body part angles inward) malalignment and documented a right hip replacement surgery completed.</p> <p>(continued on next page)</p>		

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F 0684  Level of Harm - Actual harm  Residents Affected - Few	Facility's Healthcare Fall Management Program dated 10/14/24 revealed follow-up documentation should be completed every shift for at least 72 hours after the fall and should include: neuros (if applicable), vital signs, pain, and range of motion.		

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<p>F 0710</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care.</p> <p>(continued on next page)</p>

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<p>F 0710</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, staff interview, and policy review the facility failed to ensure the resident had a physician that would provide orders and respond promptly to notification of a resident's elevated blood sugars (BS), abnormal blood lab work, and intravenous (IV) medication for infection not able to be administered for 1 (Resident #1) of 3 residents reviewed. The facility reported a census of 42 residents. Findings include: The Minimum Data Set (MDS) for Resident #1, dated 9/9/25, included diagnoses of diabetes, septicemia (presence of bacteria in the blood stream), renal (kidney) failure, and aphasia (impairment in a person's ability to comprehend or formulate language). The MDS identified the resident was receiving insulin and hypoglycemic medication (medication for diabetes to lower the blood sugar levels). The MDS indicated the resident had a Brief Interview for Mental Status score of 6, indicating severe cognitive impairment for decision-making. Resident's hospital Discharge summary dated [DATE] revealed the resident admitted from a care facility for sepsis (can be a life-threatening complication of a bacterial infection in which the body responds improperly to an infection) from underlying urinary tract infection (UTI). A large abscess was found in the retroperitoneum (space located behind the lining of the abdominal cavity and contains kidneys, adrenal glands, and parts of pancreas, aorta, and rectum) and along the right kidney and a ureteral stent (tube inserted into the ureter to keep it open and allow urine to flow from the kidney to the bladder) exchange was completed. IV antibiotics for 2 weeks for infections recommended due to concern for myositis (a group of inflammatory muscle diseases that cause muscle weakness, pain, and other symptoms) and spinal involvement with the location of the cyst. Discharge medication order for IV antibiotic daily for 42 doses. Resident's Nurses Notes revealed the following: 7/19/25 at 1:40 AM - PICC (peripherally inserted central catheter) (tube inserted into a vein in the arm and to a large vein near the heart, used for long term IV treatments) was no longer inserted. 7/19/25 at 6:00 AM - late entry- per provider when ready to administer IV antibiotics to start a peripheral line (IV in arm/hand) and provider will try to have someone out on Monday (7/21) to replace the PICC line. 7/20/25 at 11:36 PM - waiting on call back from provider as resident removed IV again. 7/23/25 at 12:53 PM - notified provider to clarify orders for antibiotic due to resident pulling out PICC and IV line. Order to discontinue IV antibiotic and new order for oral antibiotic medication. 9/4/25 at 4:35 AM - Received lab results. Sent to provider to address. Awaiting response. 9/7/25 at 3:48 PM - Pharmacy faxed order for provider, ordered metformin (oral medication for diabetes to lower BS) daily. Resident's Lab Report dated 9/2/25 revealed a hemoglobin A1C (a type of protein in the blood that measures the average blood sugar (glucose) level over the past 2-3 months) of 9.8 (high) with the goal of therapy of less than 7.0 and action suggested at more than 8.0. Resident's Medication Administration Record (MAR) dated 9/1-9/30/25 revealed an order starting on 9/18/25 for sliding scale insulin per BS at AC, HS, and PRN and notify provider if BS 401 and above. Resident's Nurses Notes revealed the following: 9/18/25 7:03 PM - Resident with BS 413, left message for provider to call back with follow-up. (No documentation of return call from provider) 9/19/25 6:10 PM - Resident's BS at 5:30 PM was 548. Called provider. Received return call from provider but phone kept cutting out and could not hear for orders. No return call from provider. Rechecked BS at 6 PM and was 524. 9/20/25 3:19 AM - Resident's BS was 596 at 11:49 PM, called and left message with provider, no return call back from provider. 9/27/25 7:01 PM - Call to provider to inform BS 525 and insulin given. 9/28/25 2:29 AM - Provider returned call. 10/9/25 8:15 AM - Provider called as resident's BS 450, spoke with receptionist and he stated they are in a meeting, stated he will relay the message and return call. 10/9/25 2:08 PM - Provider recalled and sent to voicemail, left message. Provider's nurse in the facility, spoke with her, and she stated she will contact the doctor to return call. 10/9/25 2:13 PM - Resident's BS faxed to provider. 10/10/25 1:27 AM - Insulin dosage order changed for hour of sleep. Interview on 10/8/25 at 8:15 AM, Staff A, Licensed Practical Nurse (LPN) works full time and stated provider is very difficult. The provider does not return calls for 2-3 days. If it is something critical, she would notify the Medical Director. If she receives new labs with abnormal results, will call the provider, and if the provider does not call back by the end of her shift, she will call again. Staff A stated she does document in the resident's chart if the provider is notified and if new orders or no new orders from the lab results. Further stated the provider will call the pharmacy and order medications, medications are delivered, and unaware of the new medication order, so will have to call the provider and get the new order. Also, sometimes the provider will order x-rays, and get the x-ray report and the facility doesn't so the facility doesn't know the report is back and will have to</p>		