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	03/26/2026

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

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on clinical record review, staff interview and policy review, the facility failed to follow physician orders for 1 of 5 residents reviewed for unnecessary medications (Resident #10). The facility reported a census of 40 residents. Findings include:The Minimum Data Set (MDS) for Resident #10, dated 3/3/26, documented a Brief Interview for Mental Status (BIMS) score of 8, indicating moderate cognitive impairment. The resident had diagnoses to include renal insufficiency, hypertension, diabetes mellitus, hyperlipidemia and stroke. The MDS indicated the resident was taking a diuretic, a high risk medication, in the look back period. The Care Plan for Resident #10, with a revision date of 3/3/26, included a problem area the resident has edema/fluid volume overload and is at risk for selling/cracking/weeping of affected areas, shortness of breath, stiffness, ability to ambulate and infection. The goal indicated the resident will demonstrate stable fluid volume as evidenced through the next review date. The interventions included:a. Inform physician of any increase in edema.b. Labs as ordered.c. Medications as ordered. Monitor for side effects and effectiveness. d. Notify physician promptly of: altered mental status change, tachycardia, hypertension, unrelieved symptoms, worsening symptoms, breathing difficulties, chest pain, significant weight gain, signs/symptoms of dehydration, poor skin, dry mucous membranes, concentrated urine. Review of the Electronic Health Record (EHR) for Resident #10 revealed a physician order dated 12/8/25 to weigh resident daily, notify physician of changes in weight (3 pounds in 1 day or 5 pounds in 7 days), obtain prior to eating and drinking and send to clinic for review. Review of the March 2026 Medication Administration Record (MAR) for Resident #10 revealed the following weight changes:a. On March 18th, weight of 172.3 pounds.b. On March 19th, weight of 165.7 pounds, a change of 6.6 pounds in one day. c. On March 20th, weight of 170.7 pounds, a change of 5 pounds in one day. d. On March 23rd, weight of 169.6 pounds.e. On March 24th, weight of 173.9 pounds, a change of 4.3 pounds in one day.Review of the EHR for Resident #10 revealed a lack of documentation to reflect the physician was notified of the weight changes as indicated in the parameters of the order dated 12/8/25. During an interview on 3/26/26 at 4:29 PM, the Director of Nursing (DON) stated the facility did not notify the physician regarding the weight changes for Resident #10 in March as required under the order by the physician for weight changes. The DON acknowledged the facility should have notified the physician of the weight changes according to the physician order and acknowledged they did not follow the physician orders. The DON stated an expectation that physician orders are followed. Review of the facility policy Provision of Physician Ordered Services, undated, documented the purpose of this policy is to provide a reliable process for the proper and consistent provision of physician ordered services according to professional standards of quality.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on clinical record review, facility document review, staff interviews, and policy review, the facility failed to ensure a significant medication error did not occur for 1 of 5 residents reviewed for medication administration. Resident #35 received one dose of 25 milligram (mg) Oxycodone HCl (an opioid narcotic used for pain management) and two doses of 45mg Oxycodone HCl when Physician Orders stated to administer 15mg. The facility reported a census of 40.Findings include:The Minimum Data Set (MDS) Assessment completed on 3/10/26 revealed Resident #35 with a Brief Interview for Mental Status score of 8, indicating a moderate cognitive impairment. Diagnoses include anxiety, chronic obstructive pulmonary disease, depression, heart failure, and respiratory failure. The MDS noted the use of opioids for pain management. The Care Plan, with a target date of 6/5/26, identified Resident #35 with chronic pain related to history of back surgery, history of hip fracture, and neuropathy (nerve damage). Interventions included to monitor for side effects of opiate pain medication, such as blurred vision, confusion, dizziness, fatigue, low blood pressure, and low heart rate. The Order Summary Report, obtained on 3/25/26, showed the order of Oxycodone HCl 15mg to be administered every six hours initiated on 3/6/26.The Controlled Drug Record for Resident #35 indicated the pharmacy dispensed 5mg tablets of Oxycodone HCl. This report correlates with the medication administration card which facility staff retrieves medication from. Instructions direct staff to administer three tablets every six hours. The facility acknowledged receiving this on 3/7/26 with a Registered Nurse (RN) signing. A total of three medication administration cards were received at this time On 3/24/26, a new Controlled Drug Record and medication administration card was received and signed by Staff E, Licensed Practical Nurse. This new supply of Oxycodone HCl for Resident #35 was dispensed as 15mg tablets instead of the previous 5mg tablets. Instructions on the new record direct staff to administer 1 tablet every six hours.On 3/24/26 at 4:35 PM, Staff F, Certified Medication Aide (CMA), signed the Controlled Drug Record and documented using two 5mg Oxycodone HCl tablets. This completed the medication administration card but did not provide the Physician ordered dose of Oxycodone HCl. Staff F then documented the use of one Oxycodone HCl tablet from the new medication administration card which had the new 15mg tablets. A total of 25mg Oxycodone HCl was provided to the resident. The March 2026 Medication Administration Record (MAR) showed Staff F signed off on the 3/24/26 6:00 PM Oxycodone HCl dose as complete for Resident #35.On 3/25/26 at 5:18 AM, Staff E signed the Controlled Drug Record and noted using three 15mg Oxycodone HCl tablets. A total of 45mg Oxycodone HCl was provided to the resident. The March 2026 MAR showed Staff E signed off on the 3/25/26 6:00 AM Oxycodone HCl dose as complete for Resident #35.On 3/25/26 at 11:57 AM, Staff F signed the Controlled Drug Record and noted using three 15mg Oxycodone HCl tablets. A total of 45mg Oxycodone HCL was provided to the resident. The March 2026 MAR showed Staff F signed off on the 3/25/26 12:00 PM Oxycodone HCl dose as complete for Resident #35.The Progress Note dated 3/25/26 at 1:20 PM documented Resident #35 appeared pale with garbled speech and not making sense. The resident was alert and oriented to person only and able to follow basic commands. Pupils pinpoint.The Progress Note dated 3/25/26 at 4:54 PM documented Resident #35 reaching out to grab air. When asked what they were grabbing the resident laughed and said Well that is silly, huh. Pupils were 1 millimeter (normal size 2-4 millimeters in bright light and 4-8 millimeters in the dark). Resident noted to doze off to sleep occasionally during exam but easily arousable to verbal stimuli.The Progress Note dated 3/25/26 at 6:04 PM documented new orders to hold Oxycodone HCl until further notice.The facility Incident Report #89 Medication Error, dated 3/26/26 at 7:20 AM, outlined Resident #35 was administered Oxycodone HCl at 45mg instead of 15mg (three tablets instead of one) by both the overnight nurse and the CMA on 3/25/26.During an interview on 3/26/36 at 10:45 AM, Staff G, CMA, explained they worked earlier in the week (3/23/26 and 3/24/26) and recalled the medication administration card had 5mg Oxycodone HCl tablets. When returning to work on 3/26/26, they noticed the medication administration card had 15mg Oxycodone (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	HCl tablets and notified the Director of Nursing (DON). Staff G stated it is typically the nurses who will place new resident medication cards in the correct medication carts. If a medication card does not have the correct dose, as a CMA, they would need to notify a nurse of the discrepancy.During an interview on 3/26/26 at 11:00 AM, Staff F reported they provided Resident #35 with three 15mg Oxycodone HCl tablets the day before. Since the resident's admission earlier in the month, they have always given three tablets. Staff F acknowledged did not triple check during the medication administration. When left work on 3/24/26, Staff F reported 5mg tablets were left. When came to work on 3/25/26, both Staff E and Staff F completed the narcotic medication count at the end of Staff E's shift. Staff E verified they had provided Resident #35 with three Oxycodone HCl tablets earlier in their shift. Staff F was not aware of the new medication administration card with the 15mg tablets of Oxycodone HCl. They continued to provide the resident with three tablets as had done previously. During an interview on 3/26/26 at 11:55 AM, Staff E reported they provided Resident #35 with three 15mg Oxycodone HCl tablets the morning of 3/25/26. Staff E acknowledged they did not look at the medication administration card or the dose of the tablets. Staff E explained the shift before they provided 3 tablets to the resident. Staff E stated there is no formal process in place to track or check the specific dose of pills with new medication administration cards compared to previous cards.During an interview on 3/26/26 at 1:00 PM, Staff H, RN for Resident #35's Primary Care Provider (PCP), reported they were at the facility the afternoon of 3/25/26, approximately 4:00 PM. At this time, Resident #35 was responding to verbal stimuli but was drowsy. The resident's right arm was contracted at the elbow and was holding it up. Their left hand was shaky. Pupils were assessed as pinpoint. Vitals obtained and were stable. Staff H reported Resident #35 was not right and the PCP was contacted via Telehealth visit. The PCP initially believed symptoms were possibly related to one of the following: 1. Overdose with the need for Narcan use (would need to send out to the hospital if used); 2. Not tolerating current use of opioids; or 3. Transient ischemic attack/mini stroke (would need to send out to the hospital). Resident #35's son was present throughout. After further discussion, the decision was made to keep the resident at the facility to observe. Approximately 45 minutes later, Resident #35 was more alert, not shaky. Orientation was at the resident's baseline. They were up in a wheelchair and ready for the evening meal. When Staff H left the building for the evening, they were under the impression Resident #35 had received the prescribed Oxycodone HCl dose of 15mg for the morning and noon administrations on 3/25/26.On 3/26/26 at 7:20 AM, Staff H stated the facility had contacted them to inform of the medication error the day before. Staff H contacted the PCP with new orders to hold any further oxycodone administrations. The PCP completed a Major Injury Determination Form and determined the event to be a major injury. The PCP noted Resident #35's prognosis as guarded due to their underlying medical conditions of severe dementia with behavioral disturbance, congestive heart failure, chronic kidney disease and oxygen dependent. The resident noted with opioid dependence.During an interview on 3/26/26 at 1:15 PM, the DON explained staff should and would expect them to compare medication administration cards to the MAR to ensure the correct medications were provided.During in interview on 3/26/26 at 2:00 PM, Staff I, RN, explained during medication administrations, the six rights should be followed to ensure accuracy. Staff I noted there is no formal process in place to notify staff when there is a dose change with new, incoming medication administration cards. Staff I stated when they are aware of such a situation, they would try to alert oncoming staff of the change. The policy Administering Medications, version 2.0 (H5MAPL0028), outlined the following:1. Individuals administering medications must check the label three times to verify the right resident, right medication, right dosage, right time, and right route before giving.2. As required or indicated for a medication, the individual will record in the resident's medical record the date/time of the administration, the dosage, route, any complaints/symptoms, any results, and the name/title of the individual administering.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, staff interviews, and policy review, the facility failed to ensure appropriate puree portion sizes for two residents who received a puree diet. The facility reported a census of 40.Findings include:During on observation on 3/25/26 at 11:00 AM, Staff I, Dietary Aide, prepared the lunch meal for two residents on a puree diet. Upon entering the kitchen, Staff I had already pureed the Salisbury Steak to the correct texture. The puree meat was then immediately transferred to a serving dish on the steam table and covered. Staff I did not measure out the puree meat. Staff I explained they had placed two pieces of the Salisbury Steak in the food processor.After equipment had been washed and sanitized, Staff I spooned out two servings of cauliflower, placed in the food processor, and pureed until the correct texture achieved. Staff I transferred the puree cauliflower into a measure cup, obtained the measurement, and referred to the Pureed Diet Portion Sizes/Scoops for the scoop size to use for lunch service. The cauliflower was transferred to a serving dish on the steam table and covered. Staff I reported a #6 scoop size was indicted for the cauliflower. A blue scooper was obtained and placed with the vegetable. Staff I then obtained another blue scooper and placed it with the puree meat. When asked, Staff I explained the puree Salisbury Steak was the same as the puree cauliflower and used the same scoop size.After lunch service concluded, Staff I confirmed there was approximately half a serving puree cauliflower left over and approximately one full serving of puree Salisbury Steak left over. Both residents on a puree diet received their lunch plates with the steak, cauliflower, and mashed potatoes. Staff I explained they typically will have extra puree food left over after service.The Pureed Diet Portion Sizes/Scoop chart listed the smallest number of puree servings needed as three and does have a line for only two servings. Staff I reported needing a #6 scoop, which is a white handle and measures out to 5.3 ounces. The blue scoop Staff I used during lunch was a #16 and measures out to 2.66 ounces. During an interview on 3/25/26 at 2:35 PM, the Registered Dietitian (RD) explained staff should be following the volume method to determine the correct scoop size and serving sizes. The RD acknowledged and confirmed Staff I did not measure out the puree meat to establish what scoop size to use. The RD noted there should not have been a serving size of the puree meat after lunch service if the correct scoop utilized.The policy Pureed Diet Policy & Procedure, revised January 2024, outlined the following: 1. Add the correct number of servings of food to the food processor 2. Puree until the proper final consistency is reached 3. Pour the food into a clear volume measure cup and determine the final volume 4. Use chart to determine serving size 5. If chart not available or the final volume is too small, convert the volume to ounces and divided by the number of servings started to determine serving size 6. Cover, label with serving size, and place in appropriate hot or cold area

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews, and policy review the facility failed to ensure appropriate kitchen sanitation practices were followed. The facility reported a census of 40. Findings include: Monthly Cleaning Checklists, obtained on 3/23/26, observed posted on the reach-in cooler door. Lists were divided up by position (AM Aide, AM Cook, PM Aide, PM Cook). All four sheets were dated for the month of March and listed out different cleaning assignments for each day of the week. Each sheet reflected the vast majority of daily cleaning assignments had only been addressed once during the month. There were several assignments that had no initials and indicated it had not been addressed. During the initial kitchen tour on 3/23/26 at 10:15 AM, the following noted: Drink pitchers without a label (product name or date) on 4 out of 8 pitchersBottom of reach-in cooler floor with dried liquid/food debrisMetal pan with 3 larger tubes of ground hamburger stored on shelf above ready-to-eat cold cuts (ham, turkey, hot dogs) with various incomplete labels (no open date)Plastic storage bag of what appears to be hard-boiled eggs (no label or date) Covered green resident bowl with no identifying information/no labelSmall plastic storage container with no identifying information/no labelStorage container labeled cream of chicken soup with date of 3/12/26 Storage container of what appears to be pickles (no label or date)Multiple storage containers of cereal with no identifying information/no labelUnlabeled storage container of cereal covered with plastic wrap with a hole in the plastic wrapKitchen floor with dried liquid/food debris throughout which was not related to current day's menu.Debris noted under dish machine/dish machine table, coffee/drink prep table (next to the reach-in cooler), under the ice machine, and around legs of steam tables. Debris included dried food/liquid splatter, plastic lids, condiment packets, used rag, wrappers, and dust Dried food splatter on Kitchen Aid stand mixer and Robot CoupeBuild-up of food crumbs and dried food splatter on outlet box and utility pole between the prep table and steam tableDuring a continuous observation on 3/23/26 at 12:35 PM, two separate carts with resident room trays left the kitchen with uncovered dessert plates. One cart was delivered to residents on the [NAME] hallway. The other cart was delivered to residents on the East hallway. During a continuous lunch service observation on 3/25/26 at 12:00 PM the following noted:Random white rags under the ice machine, hand washing sink, reach-in cooler, and back side of overStaff I, Dietary Aide, placed on gloves at the start of service. Proceeded to touch service cart handles, wiped gloves off on their shirt and pants, pushed eye glasses up and then portioned out brownies from the baking pan to plate with same gloved handsStaff I removed gloves, wiped their nose, took a sip from personal mug, placed gloves on, and resumed lunch service; No hand hygiene observedStaff J placed dirty dishes in dishmachine, rinsed hands under water at hand washing sink, and resumed passing resident trays; No proper hand hygiene observedIn an interview on 3/25/26 at 2:35 PM the Dietary Director and the Registered Dietitian both acknowledged the state of the kitchen and poor cleanliness. The Dietary Director feels the kitchen is adequately staffed and has the time to sweep/mop and wipe the kitchen down after meal service. A cleaning check list is utilized for staff to refer and check off. The Dietary Director and the Registered Dietitian both acknowledged the improper gloves use and inadequate hand hygiene noted during lunch service. The undated policy Food Safety Requirements outlined the following: Food safety practices shall be followed throughout the facility's entire food handling process. Elements of this process include a. Storage of food in a manner that helps prevent deterioration or contamination of the food, including growth of microorganisms b. Distribution and service of food to the resident including transportation c. employee hygienic practicesSeparating raw foods (e.g. beef, fish, lamb, pork, and poultry) from each other and storing raw meats on shelves below fruits, vegetables, or other ready-to-eat foods so that meat juices do not drip on to these foodsCovering all food when traveling a distance (i.e. down a hallway or to a different unit or floorWashing hands properly before distributing traysWashing hands between contact with residents and after collecting soiled plates and food (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wasteStaff shall follow facility procedures for cleaning fixed cooking equipmentStaff shall not touch food with bare hands, exhibiting appropriate use of gloves, tongs, deli paper, and spatulas