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

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 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 (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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(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	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 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 (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on facility record review, staff interview and facility policy review, the facility failed to staff a Registered Nurse (RN) for a minimum of eight consecutive hours per day for two of thirty (2 of 30) days reviewed. The facility reported a census of 40 residents. Findings include: Review of the nursing schedule for February of 2026, also including March 1-2 of of 2026, revealed no RN scheduled for the facility on the dates of February 14 and February 15. On 3/25/26 at 1:16 pm, via email, the Administrator stated there was no RN in the building on those days. The undated facility policy Nursing Services-Registered Nurse (RN) included the following documentation: Point 1: The facility will utilize the services of a Registered Nurse for at least 8 consecutive hours per day, 7 days per week. (The requirement for 8 consecutive hours of RN services can be met by any RN or multiples of RNs. The hours worked by the DON would be considered applicable towards the requirement.)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on the Centers for Medicare & Medicaid Services (CMS) Payroll Based Journal (PBJ) Staffing Data Report (October 1 - December 31, 2025) review, facility record review, staff interview and facility policy review, the facility failed to submit accurate staffing records to CMS. The facility reported a census of 40 residents. Findings include: The PBJ Staffing Report for Fiscal Year 2026, Quarter 1, reflected the facility failed to have licensed nursing coverage 24 hours a day on ten days of the quarter. Review of the staffing schedule for these days reflected nursing management had worked floor shifts for five of these ten days and staff nurses had worked the remaining five days. On 3/25/26 at 2:27 pm, via email, the Administrator stated the facility underwent a corporate management transition during this quarter. He noted this was his initial PBJ data entry and reported he lacked access to October payroll records as they were maintained by the prior corporation and did not show up in the payroll system.The facility policy Payroll Based Journal, implementation date 11/1/2025 included the following documentation: Policy Statement: It is the policy of this facility to electronically submit timely to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.Point 1: The facility will electronically submit timely to CMS complete and accurate direct care staffing information including the following:The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);Resident census data; andInformation on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).Point 7: Responsibilities for data submission:The Administrator, HR Director, and Director of Nursing are responsible for verifying accuracy of the staffing data that is submitted to CMS using various facility audit forms and/or payroll vendor reports.

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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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on clinical record review, staff interview and policy review the facility failed to inform the resident in advance of the risks and benefits of psychotropic medications (medications that affect a person's mental state), the treatment alternatives or other options and was able to choose the option preferred for 1 of 5 residents reviewed for psychotropic medications (Resident #16). The facility reported a census of 40 residents. Findings include: The Minimum Data Set (MDS) for Resident #16, dated 1/6/26, documented a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The resident had diagnoses to include stroke, anxiety disorder and depression. The MDS indicated the resident had taken antianxiety and antidepressant medication in the look back period. The Care Plan for Resident #16, with a revision date of 1/12/26, included a problem area the resident is at risk for adverse side effects due to use of antianxiety medication to aid with the treatment of the diagnosis of anxiety. The goal was for the resident to be free of adverse side effects from antianxiety medication use through the review date. Interventions included:a. Administer antianxiety medications as ordered by physician. Monitor for side effects and effectiveness every shift. b. Gradual dose reduction review completed by pharmacy/physician per facility protocol. c. Monitor/document/report as necessary to physician adverse reactions to antianxiety medications. Review of the Electronic Health Record (EHR) for Resident #16 revealed an order for Buspirone (antianxiety medication) HCl oral tablet 5 mg, give one tablet by mouth two times a day, with a start date of 11/4/24. Review of the EHR lacked documentation Resident #16 was informed in advance of the risks and benefits, the treatment alternatives or other options, and the resident was able to choose the option preferred with regard to the use of the psychotropic medication Buspirone HCl oral tablet. During an interview on 3/26/26 at 10:50 AM, the Director of Nursing (DON) acknowledged the EHR for Resident #16 lacked informed consent for the psychotropic medication Buspirone. The DON stated an expectation informed consent be signed for every psychotropic medication, or documentation be present in the EHR to show the resident was informed of the risk and benefits, the treatment alternatives or other options, and the resident was able to choose the option preferred. Review of the facility policy Use of Psychotropic Medication(s), revised 11/1/25, documented the resident's medical record shall include documentation of evaluation and the rationale for chosen treatment options. This includes any indicated documentation of rationale for prescribing multiple psychotropic medications or switching from one type of psychotropic medication, specifically an antipsychotic medication, to another category of psychotropic medication. Prior to initiating or increasing a psychotropic medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication, including any black box warnings for antipsychotic medications, in advance of such initiation or increase.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on clinical record review, staff interview and policy review, the facility failed to attempt a gradual dose reduction for a resident prescribed psychotropic medication (medication that affect a person's mental state) for 1 of 5 residents reviewed for 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 non-Alzheimer's dementia and depression. The MDS indicated the resident was taking an antidepressant 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 is at risk for adverse side effects due to use of antidepressant medication to aid with the treatment of the diagnosis of depression. The goad was for the resident to be free of adverse side effects from antidepressant medication use through the next review date. The interventions included: a. Administer antidepressant medications as ordered by physician. Monitor for side effects and effectiveness every shift. b. Gradual dose reduction (GDR) review completed by pharmacy/physician per facility protocol. c. Monitor/document/report as necessary to physician adverse reactions to antidepressant therapy. d. Obtain labs as ordered. Report any abnormal values to physician. Review of the Electronic Health Record (EHR) for Resident #10 revealed an order for Sertraline (antidepressant) HCl oral tablet 25 mg, give 12.5 tablet by mouth in the morning, with a start date of 6/19/25. Review of the EHR for Resident #10 lacked documentation to reflect an attempt at a Gradual Dose Reduction (GDR) or a rationale to indicate why a GDR should not be attempted. Review of the facility monthly Medication Regimen Review (MRR) from the facility contracted pharmacist revealed a MRR dated 12/18/25 for Resident #10 recommending a GDR for the antidepressant Sertraline. Review of the EHR for Resident #10 lacked documentation the Primary Care Physician (PCP) responded to the recommended GDR for Sertraline. During an interview on 3/26/26 at 2:48 PM, the Director of Nursing (DON) acknowledged the recommendation was made by the contracted pharmacist in December of 2025 for a GDR for Sertraline for Resident #10. The DON advised when the pharmacist makes a GDR recommendation, the DON is the staff responsible to follow up by sending the recommendation to the PCP and ensuring there is a timely response. During an interview on 3/26/26 at 4:30 PM, the DON advised an email was sent to the PCP for Resident #10 on two occasions in December with a request to review the recommended GDR for Sertraline with no response. The DON acknowledged she did not follow through after this time and acknowledged the GDR was not reviewed by the PCP. The DON stated an expectation the GDR is reviewed within a few days and stated she should have followed through with ensuring this was reviewed by the PCP with either an acceptance or declination with a rationale of the recommended GDR. Review of the facility policy Gradual Dose Reduction of Psychotropic Drugs, revised 11/1/25, documented residents who use psychotropic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to be managed at a lower dose or to discontinue these drugs. Within the first year in which a resident is admitted on a psychotropic medication or after the prescribing practitioner has initiated a psychotropic medication, the facility will attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated.

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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.

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	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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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, staff interview, and policy review the facility failed to provide appropriate incontinence care for one (Resident #7) of one resident reviewed. The facility reported a census of 40 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #7, dated 12/30/25, included diagnoses of stroke, hemiplegia (paralysis affecting one side of the body), and anxiety disorder. The MDS identified the resident was dependent on staff for toilet hygiene, was always incontinent of urine and bowel. The MDS indicated the resident had a Brief Interview for Mental Status score of 0, due to resident rarely/never understood. Observation on 3/23/26 at 11:13 AM, Staff A, Certified Nurse Aide (CNA) and Staff B, CNA washed hands and applied gloves and gowns. With Resident #7 lying in bed, Staff B cleansed the resident's front peri area. Staff A and Staff B turned the resident to her side, removed a visibly wet attends, and with a clean cloth wiped between the buttocks 3 times, folding the cloth each time, with smears of bowel movement with each wipe, failing to cleanse the buttocks and hips. Staff B applied barrier cream to the buttocks with the same gloves on, and then proceeded to remove gloves, applied new new gloves without completing hand hygiene, and then applied a new attends. Staff B removed her gown and gloves, took the trash bags out of the room, down the hallway, placed bags in a trash barrel, and then completed hand hygiene. The facility Perineal Care Policy revised 11/1/25, documented cleanse buttocks and anus front to back. Interview on 3/26/26 at 1:12 PM, the Director of Nursing stated expectation to cleanse buttocks and hips when completing incontinence care and to change gloves and complete hand hygiene when going from dirty to clean.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on clinical record review, staff interviews, and facility policy review, the facility failed to document a medical rationale for adding additional psychotropic medications and increasing the dosage of a current psychotropic medication for 1 of 5 (Res #8) residents reviewed for unnecessary medications. The facility reported a census of 40 residents. Findings include:The Minimum Data Set (MDS) Assessment of Resident #8 dated 9/9/25 identified a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS identified a PHQ-9 (Patient Health Questionnaire, a screening tool used to assess the frequency of depressed mood) score of 1, which indicated none to little depression. The MDS documented the resident displayed no behavioral symptoms, hallucinations or delusions during the look back period. The MDS documented diagnoses that included anxiety disorder, bipolar disorder and schizophrenia. The Comprehensive Care Plan identified a Focus Area of diagnosis of Bipolar, being at risk for mood swings, agitation, restlessness, poor concentration, increased energy, paranoia and rapid speech, dated 2/16/26. The Care Plan identified a focus of insomnia, dated 2/16/26, and a focus area of potential for negative behaviors, dated 12/22/25. The Medication Administration Record for November 2025, documented Resident #8 had the following psychotropic medications scheduled on 11/1/25:Fluphenazine (an antipsychotic), injection every 14 days.Fluphenazine oral tablet, 2.5 mg every bedtimeLorazepam (an anti anxiety), 0.75 mg every morningLorazepam 1 mg twice a dayMirtazapine (an antidepressant) 15 mg every bedtime. The Psychoactive Medication Consent documented Resident #8 signed it on 6/16/25. On 11/3/25, Staff C, Advanced Registered Nurse Practitioner (ARNP) prescribed an additional antipsychotic medication (Risperidone, 0.5 mg every morning). The Progress Note dated 11/3/25 at 8:39 pm documented a new order was received from Staff C, ARNP to initiate Risperidone as well as lab orders. On 3/26/26 at 2:00 pm, the Director of Nursing identified Staff C, ARNP as the facility's previous psychiatric provider. The DON noted that the risperidone order was written on Staff C's final day at the facility, just prior to a management transition when a new provider would be taking over psychiatric services. The DON confirmed she could not locate any progress notes or clinical documentation by Staff C justifying the new prescription. On 11/25/25, Staff D, Nurse Practitioner, increased Resident #8's Lorazepam order from the 1 mg twice a day and 0.75 mg once a day to 1 mg, four times a day. (from 2.75 mg to 4 mg). Additionally, she prescribed an additional antidepressant medication, Prozac 10 mg daily. Staff D's Progress Note dated 11/25/25 documented She (Resident #8) reports that her lorazepam is helpful. She does not wish to make any changes to her current treatment regimen at this time. Further into her note, Staff D documented Continue Risperidone, lorazepam and hydroxyzine as ordered.A handwritten order from Staff D for Resident #8 dated 11/25/25 directed the facility to begin prozac 10 mg daily for anxiety and to increase lorazepam to 1 mg every 6 hours while awake scheduled for anxiety. On 3/26/26 at 4:53 pm, Staff D, NP stated she did not specifically recall the visit on 11/25/25. She stated the current management corporation had just taken over management of the facility that month and all of the residents were new to her caseload at that time. During the interview, Staff D reviewed her progress note dated 11/25/25 and agreed the note stated she was not recommending any medication changes. She added she did not recall increasing the lorazepam or adding the prozac. She was unable to state a reason for these medication changes. She also clarified that her normal practice was to send prescription changes electronically and normally did not hand write orders and had no memory of writing the order. On 3/26/26 at 4:50 pm, via email, the DON stated she could only locate consents for Resident #8's original psychotropic medication regimen. No consents were located for the risperidone or the prozac. Additionally, the current psychiatric ARNP for the facility prescribed Busprione, 5 mg, an additional antianxiety medication on 3/19/26. A progress note with appropriate rationale for this medication was provided but no resident consent was found. The facility policy Use of Psychotropic Medication(s), dated 11/1/25 included the following documentation: Policy: It is the intent of this policy to ensure (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that residents only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated. Additionally, these medications should only be used to treat the resident's medical symptoms and not used for discipline or staff convenience, which would deem it a chemical restraint.Definitions: Adequate indications for use refers to the identified, documented clinical rationale for administering a medication that is based upon an assessment of the resident's condition and therapeutic goals and after any other treatments have been deemed clinically contraindicated. For psychotropic medications, without documentation in the record explaining that the practitioner has determined that other treatments have been deemed clinically contraindicated, the indication for use is inadequate. Also, adequate indication for use means that the medication administered is consistent with manufacturer's recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies or evidence-based review of articles that are published in medical and/or pharmacy journals.Point 2: Psychotropic medications are to be used only when a practitioner determines that the medication(s) is appropriate to treat a resident's specific, diagnosed, and documented condition and the medication(s) is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s).Point 5: The indications for initiating, maintaining, or discontinuing medications(s), as well as the use of non-pharmacological approaches, will be determined by evaluating the resident's physical, behavioral, mental, and psychosocial signs and symptoms in order to identify and rule out any underlying medical conditions, including the assessment of relative benefits and risks, and the preferences and goals for treatment.Point 7: The resident's medical record shall include documentation of this evaluation and the rationale for chosen treatment options. This includes any indicated documentation of rationale for prescribing multiple psychotropic medications or switching from one type of psychotropic medication, specifically an antipsychotic medication, to another category of psychotropic medication.Point 9: Prior to initiating or increasing a psychotropic medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication, including any black box warnings for antipsychotic medications, in advance of such initiation or increase.Point 10: The resident has the right to accept or decline the initiation or increase of a psychotropic medication.Point 11: The facility will document that the resident or resident representative was informed in advance of the risks and benefits of the proposed care, the treatment alternatives or other options and the preferred option to accept or decline in a format the facility deems to use (e.g., written consent form, narrative note, etc.).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, staff interviews and policy review, the facility failed to store drugs in a safe manner and in locked compartments. The facility reported a census of 41 residents. Findings include:During a continuous observation of medication administration on 5/27/26, beginning at 8:07 AM, Staff A, Licensed Practical Nurse (LPN), walked from the [NAME] hallway to the East hallway to obtain a narcotic from the main medication cart. Staff B, Certified Medication Aide (CMA), was the staff member responsible for the main medication cart located at this time in the East hallway. Upon arrival in the East hallway, observed the main medication cart to be unsupervised, with no staff member present. Several residents were observed in the hallway and near the hallway. Medications were observed located on top of the medication cart, to include a clear plastic medication container with several loose medications in the container, a medication card with two tablets remaining in the card (a medication of Spironolactone 100 mg), and a bottle of Sodium Bicarbonate 325 mg pills, approximately half full. The narcotic medication book was open with resident information identifiable, located on top of the medication cart. Staff A noticed these items and knocked on a resident's door and asked if Staff B was in the room, Staff B was not in the room. Staff A then walked to the end of the hallway to find another staff member to wait by the medication cart, this staff member, Staff C, CMA, walked to the medication cart and remained there while Staff A went to another location. At approximately 8:18 AM, Staff B, staff member responsible for the medication cart, came out of a resident's room in the East hallway and returned to the cart. Staff B had been in a resident's room with the door shut, Staff B was unable to observe the medication cart during the time she left the cart unsupervised with medications accessible on top of the cart. Staff B retrieved the loose medication in the plastic container and delivered it to a resident in the East hallway, Resident #3. During an interview 5/27/26 at 2:05 PM, Staff B, CMA, acknowledged she left medications for Resident #3, that she had popped out of the medication cards into a clear plastic container, unattended and unsupervised on the top of the medication cart on this date at approximately 8:00 AM. Staff B further acknowledged leaving a bottle of medication on the top of the cart and a medication card with two pills on top of the cart. Staff B stated she prepared the medications for Resident #3 and when she went into the resident's room to administer the medication, she did not see the resident. She placed the medication cup on top of the medication cart and went back into the resident's room and found the resident on the toilet, having had a bowel movement. Staff B obtained wash cloths from the hallway and went back into the resident's room to assist the resident in the bathroom, shutting the door to the resident's room and leaving medications unattended on the top of the medication cart. Staff B stated she should never leave medications unattended, they should always be securely locked. Staff B acknowledged leaving the medications unattended while assisting the resident in the bathroom for several minutes. Staff B advised after leaving the resident's medications in the plastic container on the medication cart unattended, she administered the medications to the resident. During an interview 5/27/26 at 2:15 PM, the Director of Nursing (DON) stated no medication, no matter the form it is in, should be left unsupervised on the medication cart. The DON stated an expectation that if a staff member with responsibility for the medication cart has to step away from the medication cart, the medications should be securely locked up in the medication cart and not accessible. The DON further stated that if a staff member cannot give medications right away that have already been removed from the medication card, she would want staff to dispose of the medication, especially if the medication had been left unattended. Review of the facility policy Medication Labeling and Storage, revised February 2023, documented the facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others.

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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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. Based on review of the facility's Quality Assurance Performance Improvement (QAPI) plan, the facilities past 5 surveys, and staff interview, the facility failed to correct their own deficiencies for 2 of 2 areas of concern. The facility reported a census of 41 residents. Findings include:The facility had the following concern identified at the current revisit survey that had been cited at the previous 4 recertification surveys: a.Infection Prevention and Control The facility had the following concern identified at the current revisit survey that had been cited at the previous recertification survey and the previous complaint survey:b.Services Provided Meet Professional StandardsThe undated facility Quality Assurance and Performance Improvement (QAPI) Plan documented the facility will develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility will develop and implement appropriate plans of action to correct identified quality deficiencies and act on available data to make improvements. This will include policies and procedures for feedback, data collection systems, and monitoring. Key components of this process include, but are not limited to, the following:Tracking and measuring performance.Establishing goals and thresholds for performance improvements.Identifying and prioritizing quality deficiencies.Systematically analyzing underlying causes of systemic quality deficiencies.Developing and implementing corrective action or performance improvement activities. Monitoring and evaluating the effectiveness of corrective action/performance improvement activities and revising as needed. During an interview 6/1/26 at 4:08 PM, the Director of Nursing (DON) acknowledged F880 was cited on the current survey and the previous 4 surveys, and further acknowledged the facility will be doing something different as the audits are not working given the new concerns during this survey for infection control and Enhanced Barrier Precautions. The DON acknowledged F658 was cited on the current survey and previously. The DON stated what the facility had in place was not fully working to address the repeated concerns.

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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. Based on observations, staff interviews, and policy review, the facility failed to follow Enhanced Barrier Protection (EBP) and appropriately discard soiled wound care dressings for 1 of 2 residents reviewed for wound care. 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 peripheral vascular disease (circulation disorder commonly in the legs and feet) . The MDS noted the presence of a surgical wound, requiring wound care, as well as a foot infection. The Care Plan, with a Target Date of 6/5/26, stated Resident #35 required EBP related to the presence of a right ankle wound. Interventions include using EBP during high contact activities. The Order Summary Report, obtained on 3/25/26, listed the use of EBP related to right ankle wound. The report also noted the following wound care order for an abscess to the right heel surgical wound: 1. Soak one gauze packing strip in betadine; 2. Loosely pack to inside of open incision wound on right medial heel; 3. Cut packing leaving a 1 inch tail externally; 4. Cover with ABD and secure with gauze and tape; 5. Appy ace wrap over; 6. Change daily and as needed if soiled or dislodged until healed. Both orders were initiated on 3/6/26.During an observation on 3/25/26 at 10:00 AM, Staff N, Registered Nurse, entered Resident 35's room for wound care. An EBP sign was noted outside the door. The sign directed staff to wear gown and gloves during high-contact care activities including wound care. After setting up supplies on the bedside table, Staff N completed hand hygiene, donned gloves, and initiated wound cares. While removing the old dressing, the soiled gauze and wound packing fell to the floor. Staff N completed wound cares as directed. Supplies and trash were gathered and disposed of, except for the soiled gauze and wound packing which remained on the floor. Staff N removed gloves and completed hand hygiene before leaving the room. Staff N did not wear a gown during wound cares. After cares were completed, Staff N acknowledged the need for EBP and lack of gown use. They were under the impression a gown was not indicated as there was not a splash risk. During a follow-up visit to the room on 3/25/26 at 11:15 AM, the solid gauze and wound packing were still on the floor. In an interview on 3/26/26 at 1:15 PM, the Director of Nursing (DON) stated gowns should be worn as part of EBP, regardless of the splash risk. The DON also stated all used wound supplies and soiled dressings should be picked up and discarded prior to leaving the room. The policy Enhanced Barrier Precautions, dated 3/25/24, outlined EBPs employ targeted gown and glove use during high-contact resident care activities, including wound care. Gloves and gowns are applied before performing high-contact resident care activities (as opposed to before entering the room). Face protection may be used if there is also a risk of splash or spray. Signs are posted indicating the resident requires EBP and personal protective equipment is available.