STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165312	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fonda Specialty Care	607 Queen Street Fonda, IA 50540

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on record review, facility policy review, and staff interview, the facility failed to ensure residents received medications per the physicians orders for 1 of 3 residents (Resident #1). The facility reported a census of 42 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #1 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident had diagnoses including atrial fibrillation and heart failure. The resident received pain medication and had moderate pain. The Care Plan revised 7/1/23 identified the resident had altered respiratory status/difficulty breathing related to chronic reparatory failure with hypoxia. The interventions included oxygen (O2) via nasal prongs at 2 liters. The Progress Notes dated 12/27/23 at 1:08 p.m. documented an order received to obtain an influenza swab due to cough. The Progress Notes dated 12/27/23 at 3:58 p.m. documented the lab called with results. The resident tested positive for Influenza A. The Progress Notes dated 12/27/23 at 4:59 p.m. documented receipt of a new order received for Tamiflu 75 mg BID (2 times a day) for 5 days. The Progress Notes dated 12/29/23 at 11:42 a.m. documented receipt of an order to schedule albuterol nebulizer TID (3 times a day) for 5 days. The December 2023 Medication Administration Record (MAR) showed the order for Tamiflu Oral Capsule 75 mg two times a day for Influenza A for 5 Days with a start date of 12/27/23. The Tamiflu documented as given 12/27/23 at HS (hour of sleep/bedtime). The MAR showed the Tamiflu discontinued 12/28/23 and rewritten with a start date of 12/28/23. The resident received 1 dose on 12/28/23 at HS and 2 doses on the 29th, 30th, and 31st. (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 - Minimal harm or potential for actual harm Residents Affected - Few	The January 2024 MAR showed the order for Tamiflu Oral Capsule 75 mg two times a day for Influenza A for 5 days with a start date of 12/28/23. The MAR documented the resident received 1 dose of the Tamiflu 1/1/24. The Progress Notes dated 1/1/24 at 7:14 p.m. documented the resident's order for Tamiflu 75 mg 2 times a day for Influenza A for 5 days completed. According to the clinical record, the resident received 9 doses of the Tamiflu, and the order called for 10 doses. The Progress Notes dated 12/28/23 at 1:52 p.m. documented the resident was Influenza A positive. The resident stated she still did not feel well. The Progress Notes dated 12/29/23 at 12 a.m. documented an acute follow-up. The resident had Influenza A, having increased shortness of breath, and having to sleep with the head of the bed elevated. She had sinus congestion, and a cough with thick yellow mucus. She was very tired, wore out, and not sleeping well. She had been on Tamiflu since Wednesday, and on oxygen. Lungs were congested with rhonchi, moist cough, and breathing non labored. Encouraged the resident to force fluids and have good nutrition. The Progress Notes dated 12/29/23 at 11:19 a.m. documented the resident had notable congestion when conversing. The Nurse Practitioner saw the resident and added nebulizer treatments to help her cough up the secretions. The January 2024 MAR showed the order for Albuterol Sulfate Inhalation Nebulization Solution (2.5 mg/3 ml) 0.083% 1 inhalation, inhale orally via nebulizer three times a day for URI (upper respiratory infection) for 5 days, with a start date of 12/29/23. The Progress Notes dated 12/30/23 at 10:40 a.m. documented the resident had a moist cough and occasional headache. She had congestion you could hear in her voice. The Progress Notes dated 12/30/23 at 11:11 a.m. documented the resident's Albuterol Sulfate Inhalation Nebulization Solution on order. The Progress Notes dated 12/30/23 at 3:03 p.m. documented the the resident's Albuterol Sulfate Inhalation Nebulization Solution not available. The Progress Notes dated 12/31/23 at 3:01 p.m. documented the resident's Albuterol Sulfate Inhalation Nebulization Solution not available. The Progress Notes dated 1/1/24 at 6:41 a.m. documented the resident's Albuterol Sulfate Inhalation Nebulization Solution not available. The Progress Notes dated 1/1/24 at 3 p.m. documented the resident's Albuterol Sulfate Inhalation Nebulization Solution not available. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The December 2023 MAR documented the resident received the Albuterol nebulization 1 dose on 12/29/23 and 2 doses on 12/31/23. The January 2024 MAR documented the resident received the Albuterol nebulization 3 doses on 1/2/24 and 2 doses on 1/3/24. According to the December 2023 and January 2024 MAR's the resident only received 8 out of 15 doses ordered. The resident's orders included LiquaCel Oral Liquid (Amino Acids) Give 30 ml by mouth two times a day for the promotion of healing with a start date of 3/31/23. The January 2024 MAR showed the LiquaCel not given 1/23/24 through 1/30/24. The Progress Notes dated 1/27/24 at 4:18 p.m. documented a call placed to the on call Nurse Practitioner (NP). The resident was out of LiquiCel amino acids, they were on order. Requested order to substitute Arginaid until the Liquicel amino acids arrived. Order received from the NP. The January 2024 MAR showed the resident missed 8 doses of LiquiCel before the facility notified the provider, and a substitute ordered. The Progress Notes dated 3/23/24 at 6:33 a.m. documented LiquaCel Oral Liquid give 30 ml by mouth two times a day to promote healing, on order. The Progress Notes dated 3/27/24 at 3:07 p.m. documented regarding the LiquaCel order, the Registered Nurse requested Arginaid for medication on order. The Progress Notes dated 3/27/24 at 3:08 p.m. documented communication with the physician with notification LiquaCel was on back order and questioned if they could give the resident Arginaid until it arrived. The Progress Notes dated 3/28/24 at 9:06 a.m. documented the NP confirmed to give Arginaid a.m. and p.m. On 4/15/24 at 3:30 p.m. the resident stated she had not had medications available multiple times while a resident at the facility. She said she had Influenza A in January. The doctor ordered nebulizer treatments but she didn't get them for 5 days. They had run out of pain medication at times and she needed it to keep her pain under control. On 4/17/24 at 5:05 p.m. the Director of Nursing (DON) stated she would need to look into it more, but residents should receive the number of medications ordered. She said when they didn't get a medication they were supposed to call the provider and get a hold order until they received the medication. The facility policy, dated 2/2023, for Ordering and Receiving Medication included medications (prescription and non-prescription), related supplies, and equipment were to be routinely ordered and delivered in a timely manner. Anticipated 2 business days for delivery of reordered medication refills. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When there was a delay in the dispensing of medication such as unavailability prior to authorization, the Pharmacy would notify the nursing staff. Nursing staff would document reason for the delay and notify the Physician or prescriber. If there were further directions from the physician those directions would be communicated to the pharmacy.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on record review, staff and resident interview the facility failed to provide pharmaceutical services to meet the needs of 1 of 3 residents reviewed (Resident #1). The facility reported a census of 42 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #1 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident had diagnoses including atrial fibrillation and heart failure. The resident received pain medication and had moderate pain. The Care Plan revised 10/10/22 identified the resident had chronic pain related to cervical disc degeneration. The interventions included administering analgesic medications as ordered by my provider. Due to her diagnosis the resident had a low tolerance for pain, her acceptable level was 3. The resident had as needed (PRN) Tylenol available. She would continue to have a low pain tolerance and high pain rating. The Clinical Physician's Orders dated 4/18/24 documented the resident had the following orders: a. Percocet Oral Tablet 5-325 mg (milligrams) 1 tablet by mouth one time a day for pain active since 10/7/23. b. Percocet Oral Tablet 7.5-325 mg 1 tablet by mouth three times a day for pain active since 10/6/23. The Progress Notes dated 1/6/24 at 12:58 p.m. documented Percocet Oral Tablet 5-325 mg 1 tablet by mouth one time a day for pain not available from pharmacy. Staff called the pharmacy and left a message with no response. The Progress Notes dated 1/6/24 12:59 p.m. documented the resident received Acetaminophen Tablet 325 mg per request in replace of Oxycodone that was not available from pharmacy. At 2:56 p.m. the Acetaminophen ineffective with the follow-up pain scale a 4. The Progress Notes dated 1/7/24 at 11:01 a.m. documented the on call pharmacist gave the okay to remove one Percocet 5-325 mg from the Emergency (E)-kit for the resident's missing dose. The Progress Notes dated 3/4/24 at 8:20 p.m. documented the resident's Percocet 7.5-325 mg three times a day for pain was on order. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Notes dated 3/5/24 at 4:48 a.m. documented the resident was out of her Percocet. Staff called the pharmacy to see why they didn't send it. The pharmacy stated they sent it on February 29th but it was not on the delivery sheets. The pharmacist said he would look into it in morning due to it being after hours. The medication was not in the Emergency (E)-kit. Staff to get an order to put on hold until it became available. The nurse stated they needed to call the primary care provider (PCP) because he prescribed it. The PCP was out of the office due to after hours, so sent a fax. The Progress Notes dated 3/5/24 at 6:15 a.m. documented the resident's pain medication on order. On 4/15/24 at 3:30 p.m. the resident stated she had not had meds available multiple times while a resident at the facility. They had run out of pain medication at times and she needed it to keep her pain under control. On 4/17/24 at 5:05 p.m. the Director of Nursing (DON) stated she would need to look into it more, but residents should receive the number of medications ordered. She said when they didn't get a medication they were supposed to call the provider and get a hold order until they received the medication. The facility policy dated 2/2023 for Ordering and Receiving Medication included medications (prescription and non-prescription), related supplies, and equipment were to be routinely ordered and delivered in a timely manner. Anticipated 2 business days for delivery of reordered medication refills. When there was a delay in the dispensing of medication such as unavailability prior to authorization, the Pharmacy would notify the nursing staff. Nursing staff would document reason for the delay and notify the Physician or prescriber. If there were further directions from the physician those directions would be communicated to the pharmacy.