STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165314	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lamoni Specialty Care	215 South Oak Street Lamoni, IA 50140

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22506 Based on clinical record review, Individual Narcotic Records, Controlled Drugs-Count Records and staff interviews, the facility failed to report 4 milliliters of morphine missing from a resident's supply. (Resident #5) The facility reported census was 31. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #5 had a Brief Interview for Mental Status (BIMS) score of 15, indicating an intact cognitive status. Resident #5 was Independent with transfers, mobility, dressing, toilet use and personal hygiene needs, occasionally incontinent of bladder and always incontinent of bowel. Resident #5's diagnosis included atrial fibrillation, coronary artery disease, diabetes mellitus, emphysema. According to the Individual Narcotic Record (INR), Resident #5 received a 30 milliliter bottle of Morphine Sulfate 20 milligrams per milliliter on 12/24/24. The initial dose of 0.5 milliliters every two hours as needed for pain was administered that same day. Doses were administered as ordered with no math errors noted through 1/9/25 at which time 4 milliliters should have been remaining. A photo provided of 30 ml bottle of liquid has clear markings visible at 3 milliliter increments. In an interview on 4/24/25 at 3:00 p.m. Staff D, Registered Nurse, stated she recalled the evening (1/9/25) in which Staff I was unable to get the entire dose (0.5 ml) of Morphine Sulfate from Resident #5's bottle. Staff D stated the usage record indicated there was 4.25 milliliters remaining, but there were only 0.25 milliliters that could be drawn from the bottle. Staff D stated she assumed the missing morphine was the result of spillage over time. Staff D stated she signed off on the Individual Narcotic Record (INR) with Staff I indicating the count was corrected and she then discarded the bottle. Staff D stated she was unaware that missing narcotics should be reported immediately to the DON. Staff D stated she was working a 2:00 p.m. to 10:00 p. m. shift on 1/9/25 and completed a narcotic count at the 2:00 p.m. shift change and signed indicating all narcotics were accounted for. Staff D stated she did not complete a shift change narcotic count with Staff I at 4:00 p.m. before handing over the medication cart keys to her. (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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Lamoni Specialty Care	215 South Oak Street Lamoni, IA 50140

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/24/25 at 10:39 a.m. Staff I, Licensed Practical Nurse, stated she was working a 4:00 p. m. to 8:00 p.m. shift (1/9/25), noting it was very hectic. Staff I admitted she had not completed a narcotic count with Staff D at 4:00 p.m. before receiving the medication cart keys. That evening, while preparing to give a dose (0.5 ml) of morphine to Resident #5 (7:52 p.m.) she discovered the bottle of liquid morphine only had about 0.25 milliliters in it, while the Individual Narcotic Record (INR) indicated 4.25 milliliters should have been available. Staff I consulted with Staff D and initialed the INR as corrected despite 4 milliliters that were unaccounted for. In an interview on 4/24/25 at 1:58 p.m. Staff H, Registered Nurse, stated on 1/10/25, Staff C and another aide had brought to her attention an Individual Narcotic Record for Resident #5's liquid morphine which should have had 4.0 milliliters remaining was documented as completed. Staff H stated she reviewed the page for errors and after finding none, contacted the DON. In interviews on 4/24/25 and 4/28/25 the Director of Nursing (DON) stated on 1/10/25 at 4:48 p.m. she was informed by Staff H that there were 4 milliliters of liquid morphine missing from Resident #5's supply (bottle). The DON stated when investigating, she discovered Staff D had used the last of the bottle and discarded it, not aware of what would warrant concern and a need to immediately report the discrepancy. The DON stated she questioned most of her staff (Staff K, Staff B, Staff D, Staff H) and all reported no issues with spillage and did not notice the count to be off. Staff M stated she did not notice the count to be off on 1/8/25. Staff reported the clear liquid was difficult to read. On 1/10/25 at 9:12 p.m. Staff I contacted her and reported two incidents in which she had spilled morphine. Once on 12/25/24 and again on 1/1/25. The DON stated the manufacturer's instructions stated a 30 milliliter bottle may have as much as 2.5 milliliters missing from the start. (Manufacturer's instructions estimated volume variance for a 30 milliliter bottle may have a plus or minus 2.5 milliliter variance). The DON stated based on the manufacturer's instructions the original bottle may have been 2.5 milliliters short, that left only 1.5 milliliters unaccounted for. When Staff I called and stated she spilled the morphine twice, it appeared a reasonable explanation for the discrepancy. The DON stated since there was an explanation for the discrepancy, she did not think there was any drug diversion and did not report it to the State Agency.

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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** 22506 Based on clinical record review, Individual Narcotic Records, Controlled Drugs-Count Records and staff interviews, the facility failed to ensure an accurate reconciliation of all controlled medications. (Resident #5) The facility reported census was 31. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #5 had a Brief Interview for Mental Status (BIMS) score of 15, indicating an intact cognitive status. Resident #5 was Independent with transfers, mobility, dressing, toilet use and personal hygiene needs, occasionally incontinent of bladder and always incontinent of bowel. Resident #5's diagnosis included Atrial fibrillation, coronary artery disease, diabetes mellitus, emphysema. According to the Individual Narcotic Record (INR), Resident #5 received a 30 milliliter bottle of Morphine Sulfate 20 milligrams per milliliter on 12/24/24. The initial dose of 0.5 milliliters every two hours as needed for pain was administered that same day. Doses were administered as ordered with no math errors noted through 1/9/25 at which time 4 milliliters should have been remaining. A photo provided of 30 ml bottle of liquid has clear markings visible at 3 milliliter increments. In an interview on 4/24/25 at 3:00 p.m. Staff D, Registered Nurse, stated she recalled the evening (1/9/25) in which Staff I was unable to get the entire dose (0.5 ml) of Morphine Sulfate from Resident #5's bottle. Staff D stated the usage record indicated there was 4.25 milliliters remaining, but there were only 0.25 milliliters that could be drawn from the bottle. Staff D stated she assumed the missing morphine was the result of spillage over time. Staff D stated she signed off on the Individual Narcotic Record (INR) with Staff I indicating the count was corrected and she then discarded the bottle. Staff D stated she was unaware that missing narcotics should be reported immediately to the DON. Staff D stated she was working a 2:00 p.m. to 10:00 p.m. on 1/9/25 and completed a narcotic count at the 2:00 p.m. shift change and signed indicating all narcotics were accounted for. Staff D stated she did not complete a shift change narcotic count with Staff I at 4:00 p.m. before handing over the medication cart keys to her. (continued on next page)

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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	In an interview on 4/24/25 at 10:39 a.m. Staff I, Licensed Practical Nurse, stated she was working a 4:00 p. m. to 8:00 p.m. shift (1/9/25), noting it was very hectic. Staff I admitted she had not completed a narcotic count with Staff D at 4:00 p.m. before receiving the medication cart keys. That evening, while preparing to give a dose (0.5 ml) of morphine to Resident #5 (7:52 p.m.) she discovered the bottle of liquid morphine only had about 0.25 milliliters in it, while the Individual Narcotic Record (INR) indicated 4.25 milliliters should have been available. Staff I consulted with Staff D and initialed the INR as corrected despite 4 milliliters that were unaccounted for. Staff I stated the next evening (1/10/25), she was directed to call the DON. Staff I recalled being on the phone with the DON that evening trying to explain the discrepancy. Staff I stated during their conversation, she remembered a time or two in which there may have been some morphine spilt, but not nearly to the amount that was missing. Nevertheless the DON persisted at pressuring her to admit she spilled the morphine, stating if she did not, the police might need to get involved. Staff I stated she was a new nurse and feared for her license so agreed to indicate she had spilled the morphine. In an interview on 4/23/25 at 12:29 p.m. Staff M, Registered Nurse, stated on 1/10/25 it was discovered Resident #5 was missing 4 ml of morphine. Staff M stated Staff I called her upset, following her conversation with the DON. Staff I stated she was the last person to administer the morphine (1/9/25 at 7:52 p.m.) and she had also failed to complete a narcotic count with Staff D at shift change. Staff I told Staff M that she felt coerced by the DON into falsely claiming she had spilled the morphine in order to account for the discrepancy. Staff I stated she denied spilling the morphine, but was told by the DON if she did not claim she had, they would have to get the police involved. In an interview on 4/24/25 at 1:58 p.m. Staff H, Registered Nurse, stated on 1/10/25, Staff C and another aide had brought to her attention an Individual Narcotic Record for Resident #5's liquid morphine which should have had 4.0 milliliters remaining was documented as completed. Staff H stated she reviewed the page for errors and after finding none, contacted the DON. In an interview on 4/24/25 at 1:30 p.m. the Director of Nursing (DON) stated on 1/10/25 at 4:48 p.m. she was informed by Staff H that there were 4 milliliters of liquid morphine missing from Resident #5's supply (bottle). The DON stated when investigating, she discovered Staff D had used the last of the bottle and discarded it, not aware of what would warrant concern. The DON stated she questioned most of her staff (Staff K, Staff B, Staff D, Staff H) and all reported no issues with spillage and did not notice the count to be off. Staff M stated she did not notice the count to be off on 1/8/25. Staff reported the clear liquid was difficult to read. On 1/10/25 at 9:12 p.m. Staff I contacted her and reported two incidents in which she had spilled morphine. Staff I was educated on the importance of having a witness during these instances and documenting on the Individual Narcotic Record. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a follow up interview on 4/28/25 at 4:05 p.m. the DON stated upon hearing of the discrepancy she contacted her Regional Manager and initiated an investigation which included reviewing Resident #5's morphine use records. The DON stated she found no error in doses or documentation errors. The DON stated she sent out a group text asking if anyone was aware or could explain why there were 4 milliliters missing. The DON stated that was when Staff I called her and stated she may have spilled some twice. Once on 12/25/24 and again on 1/1/25. The DON stated the manufacturer's instructions stated a 30 milliliter bottle may have as much as 2.5 milliliters missing from the start. (Manufacturer's instructions estimated volume variance for a 30 milliliter bottle may have a plus or minus 2.5 milliliter variance). The DON stated based on the manufacturer's instructions the original bottle may have been 2.5 milliliters short, that left only 1.5 milliliters unaccounted for. When Staff I called and stated she spilled the morphine twice, it appeared a reasonable explanation for the discrepancy. The DON stated since there was an explanation for the discrepancy, she did not think there was any drug diversion and did not report it to the State Agency. The DON was asked if her assertions were true and the spillage and variance accounted for 4 milliliters of missing morphine as of 1/1/25, why was the missing morphine not discovered during 45 shift change narcotic counts prior to the bottle being empty on 1/9/25. The DON shrugged her shoulders and indicated she did not know.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 22506 Based on clinical record review, Individual Narcotic Records, Controlled Drugs-Count Records and staff interviews, the facility failed to ensure medical records were accurately documented. The facility reported census was 31. Findings include: In an interview on 4/24/25 at 3:00 p.m. Staff D stated she was working a 2:00 p.m. to 10:00 p.m. on 1/9/25 and completed a narcotic count at the 2:00 p.m. shift change and signed the Controlled Drugs-Count Records indicating all narcotics were accounted for. Staff D stated she did not complete a shift change narcotic count with Staff I at 4:00 p.m. before handing over the medication cart keys to her. In an interview on 4/24/25 at 10:39 a.m. Staff I, Licensed Practical Nurse, stated she was working a 4:00 p. m. to 8:00 p.m. shift (1/9/25), noting it was very hectic. Staff I admitted she had not completed a narcotic count with Staff D at 4:00 p.m. before receiving the medication cart keys. According to the Controlled Drugs-Count Records (shift change narcotic count record), Staff D and Staff I both signed the record dated 1/9/25 at 4:00 p.m. despite both acknowledging the count was not completed.