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	03/20/2024

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 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. 46873 Based on clinical record review, facility document review, hospital record review, staff, pharmacy and physician interviews, the facility failed to accurately transcribe and implement physicians orders for 1 of 1 residents reviewed (Resident #4). The facility reported a census of 29 residents. Findings include: The Minimum Data Set (MDS) of Resident #4 dated 2/15/24 identified a BIMS score of 14 which indicated cognition intact. The MDS documented diagnoses that included hyponatremia (low sodium), non Alzheimer's dementia, Parkinson's disease, schizophrenia, anxiety and depression. The undated facility document chronicled the following: On 12/15/23 the Director of Nursing (DON) notified by the Advanced Registered Nurse Practitioner (ARNP) that during a review of orders for Resident #4 she noticed an order she had submitted on 12/1/23 for Fluconazole (an antifungal medication) for 300 mg once per week for 4 weeks had incorrectly been transcribed. The facility wrote the order into the resident's Electronic Health Record (EHR) as 300 mg daily for 14 days. On Wednesday 12/13/23, Resident #4 sent via ambulance to the county hospital for shortness of breath, unsteady gait, and change in mental status. While at the county hospital, Resident #4 had a seizure and experienced cardiac arrest. The hospital life flighted him to a larger hospital in the closest metropolitan city. They determined the resident had a drop in sodium levels which caused the mental status change and lead to the seizure. The Physician Order form for Resident #4 dated 11/30/23 revealed a hand written order, authored by the ARNP to start Fluconazole, 300 mg, by mouth, once weekly for four weeks. Staff A, Licensed Practical Nurse (LPN) noted the order on 11/30/23. The orders section of the EHR documented Staff A entered the order as Fluconazole tablet, 150 mg, give 2 tablets one time a day for 14 days (300 mg total). The Medication Administration Record (MAR) of Resident #4 for December, 2023 revealed the resident received 300 mg of Fluconazole daily from 12/1/23 to 12/13/23. (continued on next page)

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The hospital records from a kidney specialist physician dated 12/18/23 documented the resident had been on a thiazide diuretic medication and this was the cause of the hyponatremia. On 3/19/24 at 8:29 am, the facility Pharmacist stated the dose of 300 mg a day is not out of normal dosing range for the medication. She stated the resident should not have had any adverse side effects due to the transcription error. She stated while the dose the facility prescribed is different than received, it is not an inappropriate dose per the drug manufacture's safe dosage recommendations. On 3/19/24 at 1:48 pm, Staff A, LPN stated she is not sure of why she transcribed the order incorrectly. She said she believed she just read the order wrong. She also said that once the error had been discovered, she replayed that day over and over in her head and stated she thinks about it daily and the error has traumatized her. She said that since the error, the facility put into place that each new order is double noted by two nurses and additionally when orders are written by the doctor, the nurse reads it verbally to the physician to verify it is correct. On 3/20/24 at 9:28 am, the ARNP stated the resident was not on the medication long enough for the error to be the cause of his hospitalization . She stated he had candida (a yeast/fungi infection) and ringworm on his chest and under his abdominal folds following a trip home with family and this was systemic and was the reason for the Fluconazole order. She stated she hand wrote the order and handed it directly to the nurse. On 3/20/24 at 2:30 pm, the DON stated her expectation is to have 2 nurses double note all orders for accuracy. She stated she also reviews all antibiotic or antifungal medication orders personally. The Medical Information for Fluconazole from the drug manufacturer documented a maximum daily dosage of the medication for adult patients to be 400 mg.