

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165314	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2025
NAME OF PROVIDER OR SUPPLIER Lamoni Specialty Care		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>46873</p> <p>Based on clinical record review, resident interview, staff interview and facility policy review, the facility failed to accurately transcribe a physician order, resulting in the order not being fully completed in a timely manner, for 1 of 1 residents (Res #14) reviewed. The facility reported a census of 35.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) of Resident #14, dated 1/30/25 identified a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderate cognitive impairment.</p> <p>On 2/10/25 at 11:30 am, Resident #14 stated she is hard of hearing and has had a lot of wax build up in her ears. She stated the Nurse Practitioner gave an order to the facility to have ear drops in her ears for five days, and then her ears were to be flushed. She stated she got the drops but nobody ever flushed her ears. She reported she had asked multiple staff members to flush her ears but nobody had completed it. She additionally reported she would like to make an audiology appointment to have her hearing aids adjusted but she cannot do this until her ears are clean of built up wax.</p> <p>The Medication Administration Report (MAR) for Resident #14 for February of 2025 reflected an order for Debrox Otic Solution (Earwax removal drops), instill five drops in each ear, one time a day for wax build up for six days. Flush on Day six. The MAR revealed documentation the order was written for the drops to be administered 2/1/25-2/6/25. There was no separate entry for the ears to be flushed. The MAR documented the drops were given for five days, 2/2/25 - 2/6/25. On the first day, 2/1/25 they were held with an indication to see progress notes. A review of progress notes from 2/1/25 documented the medication was not available.</p> <p>Review of the nursing schedule for 2/6/25 and 2/7/25 revealed Staff A, Licensed Practical Nurse (LPN) was the nurse on duty for day shift on both of those days</p> <p>(continued on next page)</p>

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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/11/25 at 1:59 pm, Staff A, LPN stated she was the nurse who placed the order into the Electronic Health Record (EHR) but she had not flushed Resident #14's ears. She stated the drops were started on day two of the order, once they arrived from the pharmacy. After reviewing the order, Staff A stated Resident #14's ears should have been flushed on 2/7/25. Staff A stated she was the nurse on duty on 2/7/25 but she had transcribed the order incorrectly so the need to flush the resident's ears did not come up as an order on 2/7/25. She stated she should have placed one order in the EHR for the drops and a separate order to flush the ears. Staff A also stated Resident #14 had not mentioned this to her until 2/10/25. She stated she had notified the Nurse Practitioner of this and the resident would be seen by the Practitioner later in the week when she was in the building.</p> <p>On 2/11/25 at 2:32 pm, Staff A, LPN stated she had now flushed the resident's ears and got discharge results from one of her ears only.</p> <p>On 2/11/25 at 2:50 pm, the Director of Nursing (DON) stated the facility had spoken to the Nurse Practitioner regarding the situation. She stated her expectation was for the order to have been placed as two separate orders to ensure the flush was completed.</p> <p>The Communication with Physician Note dated 2/11/25 at 2:56 pm documented Staff A had notified the Nurse Practitioner and received an order at that time to flush the resident's ears and this order was carried out.</p> <p>The facility policy titled Medication and Treatment Orders, Revision date July 2016 documented the following:</p> <p>Policy Statement: Orders for medications and treatments will be consistent with principles of safe and effective order writing.</p> <p>Point 9:</p> <p>Orders for medications must include:</p> <ol style="list-style-type: none"> a. Name and strength of the drug; b. Number of doses, start and stop date, and/or specific duration of therapy; c. Dosage and frequency of administration; d. Route of administration; e. Clinical condition or symptoms for which the medication is prescribed; and f. Any interim follow-up requirements (pending culture and sensitivity reports, repeat labs, therapeutic medication monitoring, etc.). 		