STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165362	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clarion Wellness and Rehabilitation Center	110 13th Avenue SW Clarion, IA 50525

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on clinical record review, staff interviews, and policy review, the facility failed to administer medications as ordered by the physician for 1 of 3 residents reviewed (Resident #1). The facility reported a census of 61 residents. Findings include:The Minimum Data Set (MDS) for Resident #1, dated 9/6/25, listed a diagnosis for hypertension (high blood pressure). The Physician's Order dated 10/22/25 directed to change Resident #1's order for amlodipine from 5 milligrams (mg) daily to 2.5 mg two times daily to start on 10/23/25. The Electronic Medication Administration Record (EMAR) indicated Resident #1 received 2.5 mg two times daily from 10/23/25 to 10/26/25 and on the morning of 10/27/25. In addition, the facility held evening dose for 10/27/25. The Electronic Health Record (EHR) indicated on 10/27/25 Staff A, Certified Medication Aide (CMA), informed Staff B, Licensed Practical Nurse (LPN), the medication cart had amlodipine 5 mg daily, when it should have a dose of 2.5 mg two times a day. Staff B contacted and received an order to hold the evening dose and resume 2.5 mg two times daily on 10/28/25. Resident #1 had a blood pressure of 157/96 (average 120/80) at that time. The facility notified Resident #1's sister and the DON of the medication error. In interview on 11/25/25 at 8:24 AM the Director of Nursing (DON) stated the order to change from amlodipine 5 mg daily to 2.5 mg two times daily on 10/23/25 did not get faxed to the pharmacy as their pharmacy is not integrated into their EHR. The nurse should have faxed the medication change to the pharmacy but forgot. They did not have the 2.5mg medication cards in the medication cart until 10/27/25 after catching the medication error. As corrective action, he spoke with all the nurses and CMAs about the 5 rights of medication administration and now prints off the order listing report daily and faxes it to the pharmacy as a double check. They also plan to change to a pharmacy that integrates with their EHR. The DON reported he didn't have documentation of the education as he did it verbally. When asked if the day shift gave the wrong dose of amlodipine 4 times and the evening shift charted, they gave a medication they did not have 4 times, he stated that they had. The Administration of Medications policy dated July 2017 directed all medication shall be administered as prescribed by the resident's physician, nurse practitioner, or physician's assistant. It also indicated that prior to administering the resident's medication, the nurse or medication technician should compare the drug and dosage schedule on the resident's MAR with the drug label. NOTE: If there is any reason to question the dosage or the schedule, the nurse or med tech should check the physician's orders.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE