STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265634	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2025
NAME OF PROVIDER OR SUPPLIER: Lacoba Homes Inc		STREET ADDRESS, CITY, STATE, ZIP CODE: 850 Highway 60 Monett, MO 65708	

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 - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31464 Based on record review and interviews, the facility failed to ensure all residents were free from significant medication errors when staff failed to clarify orders for an antibiotic the resident was listed as allergic to prior to administration for one resident (Resident #1) resulting in a negative reaction to the medication administered. A sample of nine residents was reviewed in a facility with a census of 45. Review of the facility's policy entitled Infection Prevention and Control Policies: Antibiotic Stewardship, not dated, showed the following: -The antibiotic stewardship program is a set of commitments and actions intended to optimize the treatment of infections while reducing adverse events associated with antibiotic use. -Nursing plays a key role in improving the appropriate use of antibiotics by assessing and monitoring residents and communicating with providers, residents, and families; -Residents suspected of having an infection are thoroughly assessed and referred to the provider with the following information: current situation including resident complaints, vital signs, recent laboratory results, relevant diagnosis; and relevant background information including disease state, renal function, drug allergies, recent antibiotic therapy, and use of potentially interacting medications; -Drug Interaction screens are run at the time of order entry. Severe interactions, those warranting the need for therapeutic monitoring or an adjustment in therapy, are conveyed to the prescriber; -All antibiotic-associated adverse drug events, including allergic reactions and adverse reactions and adverse antibiotic-drug interactions are reported to the prescriber. Antibiotic-associated adverse drug events which require a significant alteration in treatment, for example treatment to be stopped or changed, or a new form of treatment be commenced to address a clinical complication, will be reported to the Infection Prevention and Control committee for evaluation; -Pharmacy partnership ensures access to Clinical Pharmacists with advanced training in infectious disease and antibiotic stewardship. The Consultant Pharmacist is responsible for providing advice, education, and feedback on antibiotic prescribing. 1. Review of Resident #1's face sheet (shows basic profile information) showed the following: (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 0760 Level of Harm - Actual harm Residents Affected - Few	During an interview on 02/14/25, at 11:25 A.M., Registered Nurse (RN) A said the Director of Nursing (DON) had called him/her at the facility and told him/her the physician had just called to give him/her a new order for an antibiotic for the resident and since the DON was out of the facility at the time asked RN A to enter the order. RN A said he/she entered the order for the Bactrim, but did not check the resident's allergy list. The electronic system does give pop-up warnings about allergies and any possible interactions with other medications, but he/she did not read any available warnings when he/she entered the order and probably flew through them. He/she should have checked the resident's allergies, but probably didn't think it was necessary since the DON had called him/her with the physician's order. RN A was aware that the resident did experience an adverse drug reaction, a rash breakout. During an interview on 02/14/25, at 11:45 A.M., Pharmacist B said Pharmacist C had called the facility to ask about the resident's sulfa drug allergy prior to dispensing Bactrim. Pharmacist C was told by RN D that the physician had given the order, so it was okay to give it. During an interview on 02/14/25, at 11:52 A.M., RN D said he/she took a call from the pharmacy regarding the resident's order for Bactrim. The resident showed an allergy to sulfa drugs. RN D said he/she looked at the order and told the pharmacy that the physician had given the order, so it was okay to give the drug. He/she did not ask the resident about his/her sulfa drug allergy. When staff enters medication orders the electronic system gives multiple pop-up warnings regarding allergies and any potential interaction with another medication, but the warnings don't pop up during medication administration. RN D said when staff asks the physician for an order, they should give the scenario including signs and symptoms, and review the allergy list with the physician. During an interview on 02/13/25, at 12:27 P.M., the Medical Director said the electronic medical system would flag a resident's allergy upon entering a new order, and the pharmacy would notify the facility staff if they noted an allergy or medication interaction. The physician said the pharmacy wouldn't send the ordered medication unless the resident verified a previous drug reaction wasn't an allergy, but something like an upset stomach. During an interview on 02/14/25, at 12:06 P.M., the DON said when staff should call the physician with lab results when requesting medication orders they should review possible drug allergies with the physician. When entering a new order, the electronic system will give pop up warnings regarding any listed allergy or medication interaction. The staff should notify the physician of warnings and clarify orders if necessary. The pharmacy would also call prior to dispensing a medication if there was a concern regarding a listed allergy or a notable interaction with another medication. Staff should notify the physician of any pharmacy alerts or concerns. While he/she was out of the facility and was driving, he/she received a call from the physician, who had reviewed lab results while in the facility. The physician gave an order for Bactrim for the resident. The DON called back to the facility and asked the charge nurse, RN A, to enter the order. During an interview on 02/14/25, at 3:35 P.M., the Administrator said when receiving and/or entering a new medication order, staff should notify the physician if there is a drug allergy listed for a resident. Staff should also clarify orders if the pharmacy has concerns regarding allergies or possible medication interactions. MO00249283