STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 16E728	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mercyone Centerville Medical Center	One St Joseph Drive Centerville,, IA 52544

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review and staff interviews, the facility failed to verify the dosage on a bottle of Morphine was correct when received from the pharmacy and failed to administer the correct dose of Morphine as ordered for one of four residents reviewed (Resident #1). The facility reported a census of 18 residents. Findings include:The Minimum Data Set (MDS) dated [DATE] identified Resident #1 as cognitively intact with a BIMS (Brief Interview for Mental Status) score of 12 and had the following diagnoses: Diabetes Mellitus, Anxiety Disorder and COPD (Chronic Obstructive Pulmonary Disease). The MDS also identified Resident #1 to be totally dependent on staff for assistance with showers/baths, lower body dressing, putting on and removing footwear and required substantial/maximal assist with toileting, upper body dressing and personal hygiene. On [DATE] the Care Plan identified Resident #1 with the problem of risk of discomfort related to end of life process and directed the staff to administer pain medications as ordered if non-medication interventions were ineffective. Evaluate effectiveness of pain relieving medications.A review of the Physician Orders revealed an order dated [DATE] for Morphine Sulfate Oral Solution 10 mg/5ml (milligrams per milliliter). Give 1 ml by mouth every 4 hours as needed for air hunger.A review of the copy of the label on the plastic bag which contained the bottle of Morphine dispensed [DATE] had documentation of the following instructions: 100 ml bottle of Morphine Sulfate give 1 ml (2mg) every 4 hours as needed for severe pain or air hunger. Maximum dose 12 mg per day.A review of the copy of the label on the box which contained the Morphine revealed it was dispensed [DATE] with directions: 30 ml Morphine Sulfate solution 100 mg per 5 ml (20 mg/ml). Take 1 ml (20 mg total) every 4 hours as needed for severe pain or air hunger.A review of the Controlled Medication Utilization Record revealed the following:Medication Label - Morphine 20 mg/ml. Take 1 ml (20 mg) q 4 hours prn severe pain or air hungerDate received [DATE]Quantity received: 30 mls.A review of the Progress Notes dated [DATE] at 12:24 PM documented the resident complaining of not being able to breathe. Head of bed elevated with oxygen in place at 2 liters per nasal cannula. Oxygen saturation level 94%. The [DATE] Medication Administration Records revealed an order for Morphine Sulfate 10 mg/5ml give 1 ml q 4 hours as needed for pain or air hunger. Doses signed out as given on [DATE] at 12:24 PM, and [DATE] at 00:50 AM and 4:50 AM.A review of the Progress Notes revealed the following:On [DATE] at 00:50 AM Resident having labored breathing respirations 40 per minute. MS (Morphine Sulfate) given to assist with breathing.On [DATE] at 4:50 AM Resident sitting up in recliner. CNA reported that resident was complaining of back pain when in bed and was transferred from bed to recliner with Hoyer. This nurse informed resident regarding medication to assist with her breathing per communication board. Resident took MS (Morphine Sulfate) orally and sips of water following. Note resident had audible crackles in upper airway, continues to have labored breathing, oxygen on at 2 liters per nasal cannula. Oxygen saturation was 92%On [DATE] at 12:50 PM Morphine discontinued awaiting new order and lasix discontinued due to resident not having any output in her catheter bag. Vital signs 97.5-96-24-100/42. She has been lethargic, not having any output and not able to take anything in except a sip of water with morning dose of lasix.On [DATE] at 1:51 PM New order received and noted from the ARNP for Morphine 10mg/5ml to give 1ml 2mg oral solution every 4 hours (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 - Minimal harm or potential for actual harm Residents Affected - Few	PRN.On [DATE] at 1:44 PM This order is outside of the recommended dose or frequency. Morphine Sulfate Oral Solution 10 Give 1 ml by mouth every 4 hours as needed for air hunger This dose fails a general dose range check based on drug inputs and/or the patient information provided. This drug's dose should be adjusted based on renal function. Manual screening is required.On [DATE] at 1:55 PM Family here with resident called LPN to room as resident was not breathing, no pulse no respirations at 1:50 PM.A review of the Facility Incident Report dated [DATE] had the following documentation:Two nurses asked this nurse to look at Morphine orders for Resident #1 and directions on the bottle.Morphine ordered was 10 mg/5 mls concentration with directions to give 1 ml(2mg) very 4 hours as needed for air hunger or pain.Bottle dispensed from pharmacy was 20 mg/ml with directions to give 1 ml Q 4 hours PRN.The nurses reported the resident received 3 doses of the 20 mg/ml.ARNP who wrote the original order and the primary care physician were notified.A review of the Facility Process Change Alert Form dated [DATE] documented a process change for Morphine administration due to a medication error. The process change documented when accepting Morphine from the pharmacy to check it against the order. Prior to dispensing medication/order and container, two nurses will ensure accuracy, two nurses will verify amount of morphine in syringe is correct prior to administration and documented.In an interview on [DATE] at 2:16 PM, Staff A, LPN reported when a nurse receives a narcotic from the pharmacy, the following process should be followed: a nurse will accept all medications from the pharmacy. The nurse should compare what was being sent and what was actually sent, look at the dosage and quantity, look at the paper sent with drugs and make sure they are the same. When administering a narcotic, the nurse should check the resident, look at the order, dosage, proper drug, sign it out on the narcotic sheet and on the EMAR. When she administered Resident #1's Morphine on [DATE] at 12:24 PM, she admitted she looked at the EMAR, did not look at the dosage on the EMAR, did not check the concentration. The EMAR said to give 1ml it did not say how many milligrams. Resident #1 had labored breathing and complained of back hurting. Staff A looked at the bottle, the directions on the bottle and the directions on the narc sheet. They were both the same. They both said to give 1 ml which was 20 mg (this was printed on the label on the bottle 20 mg per ml). She checked the printed discharge paperwork from acute care and found the order for Morphine. She could not remember the exact order, or if it said give 1 ml or not. According to what she was reading, she thought she had a med error. She assessed Resident #1 and her vital signs were normal, she was comfortable, easy to awaken. Her breathing wasn't as labored, she said she was comfortable. After that she talked to the nurses in the hospital to show them the bottle and the discharge paperwork, they had assured her that she had given the correct dose and it was not unusual to give that dosage and they give that dosage. The next day on [DATE], the nurses talked to ARNP and she told us that the nurses gave the incorrect doses. She had received the 20 mg for a total of 3 doses. The ARNP confirmed the order was supposed to be 2 mg per dose. On [DATE] at 1:50 PM she was laying in bed, no heart, no respirations. She was [AGE] years old and admitted to hospice for end stage COPD. When asked how the error could have been prevented, she reported the pharmacy sent the wrong concentration with the wrong directions. She admitted she should have double checked the dose. The EMAR only showed to give 1 ml, but did not designate what the concentration was. Changes to the process in accepting Morphine from the pharmacy included: when Morphine is received, the nurses compare what was received against the actual order in the EMAR against the bottle. There has to be 2 nurses to double check the dosage. The nurses are to make a progress note when this is completed until they are able to adjust this in the EMAR.In an interview on [DATE] at 6:18 AM, Staff B, RN reported the process when a nurse receives Morphine from the pharmacy is as follows: when the pharmacy delivers it, only a nurse can accept the Morphine. She would view to make it is for the right resident and make sure it's the right medication. She would check it in the computer to make sure it's the correct medication. If there is a discrepancy, she would send it back with that pharmacy person and get clarification. When asked what the process is when giving a narcotic she stated when administering Morphine, she should make sure she has the right resident, (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	right dosage, the correct time. With Morphine there have been different dosages, concentrations. She would check it against the order in the computer. When she administered the doses on [DATE] at 00:50 AM and 5:50 AM, she reported she went in and checked on her after rounds and her respirations were pretty rapid, O2 saturation (oxygen level) was 92% on 2 liters of O2. She was a little restless, her breathing was really labored at 40 per minute. She went to the med cart, pulled up the narcotic book and pulled up PCC. On the narcotic sheet, the dose was 20 mg/ml. She stated the house supervisor came over to assess her and determined that she could use the Morphine for the air hunger. Before she gave her the morphine at 00:50 AM and before the 2nd dose at 0450, she listened to her lungs and she was alert and talking. Her breathing was labored. Staff B stated she could not recall the actual the dose of Morphine that was ordered. The MAR had documentation to give Morphine 20 mg per ml and to give 1 ml every 4 hours as needed for air hunger and pain. She administered 20 mg. Staff B stated on [DATE], she was informed that Resident #1 expired early afternoon and that the wrong concentration of Morphine had been sent for her. The error could have been prevented by verification of the medication. She should have reviewed the actual documentation of the original order. She admitted she should have questioned if the 20 mg being a big dose for her. She was not sure what the normal dose would be for a hospice resident, would depend on history of taking narcotics in the past. She did work a lot with hospice residents. When asked if any changes made to the system for receiving Morphine from the pharmacy after this incident, she reported she had recommended to have someone else double check the order before giving the med and when receiving the Morphine from pharmacy. If there is any question, the nurse should call the physician to make sure she had the correct order and correct medication. The nurses are to make an entry on the nurse's note attached to the MAR to show the double check was completed.During an interview on [DATE] at 6:56 AM, when asked of Staff C, RN Night Shift Supervisor if he recalled checking on Resident #1 on the night of [DATE] , he reported she was asleep in bed, respirations were 40 per minute. He informed Staff B, RN about it and let her know her respirations were labored and if she had orders for Morphine to give it to her to help relax her breathing. He was not aware that Resident #1 received the wrong doses of Morphine that night. He was informed about it on [DATE] the next morning that pharmacy had dispensed the wrong concentration. When a nurse is preparing to give Morphine, the nurse should make sure it's the right patient, right dose, right medication, right time. The error could have been prevented if the nurse double checked the order, called the physician or hospice and questioned the 20 mg order.In an interview on [DATE] at 8:44 AM, Staff D, RN reported the process when receiving Morphine from the pharmacy is as follows: when pharmacy delivers, she would open the bag, remove the medication from the bag, it comes with a paper with what is sent, she would compare the bottle with what it says on the paper. Then she would take it to the nurse who has the cart and we would both look at it and make sure it's the right dose and put it in the narc box. She verified this was not the process when Resident #1's Morphine was delivered [DATE]. She verified that she was the one that signed the utilization record, however, did not think she was the one that accepted it from pharmacy. She could not recall what the dosage was on the bottle at that time. She was informed of the error on [DATE] when Staff A informed her that she made a medication error and gave Resident #1, 20 mg of Morphine. Staff D stated she should have received according to what the order read on the MAR Morphine 10 mg per 5 ml, give 1 ml which would been 2 mg. The box said 20 mg per 1 ml and give 1 ml. She gave 1 ml, but the dosage was wrong. She stated the Pharmacy made an error with the label and sending the wrong concentration. She recalled seeing the original orders. She thought the order was entered correctly into PCC in EMAR, but underneath it also said that what was sent by pharmacy that the dose. She stated to prevent a similar error, the nurse should double check the order with what was dispensed, make sure you have the right dose, make sure you have someone else double check it with you if you have doubts. She should've checked it with the house supervisor to double check it. Staff D stated the changes that were made after this incident were when the Morphine comes in, the nurse needs to double check with a second nurse, double check the actual (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bottle against the order and the utilization record and make sure everything is correct. After double checking, we document that in the progress note. The nurses need to double check with another nurse before administeringIn an interview on [DATE] at 12:30 PM, the DON reported when administering medications, she would expect the nurses to follow the 5 rights, verify the dosage was correct with another nurse for Morphine. When accepting Morphine from the pharmacy, she would expect the nurses to follow these steps: 2 nurses double check from the order in PCC (Electronic Health Record) against the drug. Any discrepancy, any question, the process needs to be stopped, contact the physician and the pharmacy. Two nurses need to verify the dosage against the MAR, just like they do for insulin. They would double sign in the narcotic book. She verified the original order for Resident #1 for the Morphine was 10mg per 5 mls and give 1 ml. When asked what could have prevented the error, she reported when Staff A, LPN accepted the medication from the pharmacy, she should have had another nurse double check and verify the dose of what was delivered against the PCC orders. Before it was given, it should have been double checked again before the nurse gave it. After Staff A, took the bottle itself and the order that came from the hospital transfer sheet to the nurse's station on Med/Surg where Resident #1 lived before coming to LTC. They verified that the 20 mg dose was correct as that what they gave. Staff A gave the 20 mg dose thinking she gave the correct dosage. The DON felt Staff A did not check it against the original order. Staff B, RN took what Staff A told her was correct and gave Resident #1 another 2 doses at almost 1:00 AM and 4:50 AM. She gave the 2nd dose because Resident #1 was still complaining of air hunger and pain. She added that it looks like the nurses failed to double check the dose against the order. It was correctly transcribed on the MAR. When Staff E, LPN came to work on [DATE], she pulled the Morphine out and verified it against the MAR and knew it wasn't right and that's when she called the physician and pharmacy to let them know of the error. She took medication out of service, wasted it and received new orders. She ended up expiring before she would get new orders.In an interview on [DATE] at 10:56 AM, the Pharmacist, reported when the pharmacy receives the order from the facility fax or electronic order the following process is followed: An order entry technician enters the order into our system. That order goes to a pharmacist that does an initial verification of the order, validating the order elements as well as doing a drug utilization review - allergies, reactions, those types of things. This then goes to the judication team, they would work the claim with insurance. At that point, the system will generate a label which the back end technician would then place label for that technician to fill the order by pulling the actual product from the shelf. Once the prescription has been filled and labeled, it will go to a pharmacist who will then verify the product against the label, to make sure what the label states against what has been filled. After that, it will go to the staging technician who scans it for delivery. Then the drug gets delivered to the facility by our delivery driver, obtains proof of delivery. The nurse who receives will sign for proof of delivery. This will then close the chain. When asked to explain the error for Resident #1's order for Morphine that was dispensed, she reported on [DATE], the order the pharmacy received was written for Morphine 10 mg per 5 ml and dispensed as 100 mg per 5 ml. Give 1 ml (20 mg) a 4 hours PRN severe pain. When asked what she felt could have caused the error she reported the error occurred at the initial data entry, the incorrect drug was selected. This is entered by the entry order technician. When asked if she felt this error could have been prevented, she reported she could not speculate that.In an interview on [DATE] at 11:51 AM, the ARNP (Advanced Registered Nurse Practitioner) reported the original order she wrote for Resident #1 on [DATE] when she was discharged from the hospital and admitted to LTC (Long Term Care) was for Morphine 10 mg per 5 ml and give 1 ml every 4 hours, PRN (as needed) for air hunger or pain. The maximum total dose for 24 hours was 12 mg. On [DATE], Staff E, LPN brought the box of Morphine and reported she did not think they received what she the ARNP ordered. The ARNP looked at the box and saw Morphine 20 mg per 1 ml. She verified that Staff E was correct, the ARNP did not order that dose. The ARNP called the pharmacist, she could not recall his name and asked her to read the order she sent and what did they dispense. The pharmacist reported they dispensed the wrong medication and were not aware of (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the error until the ARNP phoned them. The orders that she had sent to them was clear and showed that the order was for Morphine 10 mg per 5 ml and give 1 ml (2 mg) q 4 hours PRN. When asked what she felt Resident #1's cause of death was attributed to, she reported Resident #1 was declining and placed on hospice. She was pretty much not responding when she was admitted her to LTC. She was not conversing with the family, not eating, not drinking much. She was definitely declining. The ARNP called Staff E and instructed her to remove that Morphine from the area immediately.In an interview on [DATE] at 1:47 PM, Resident #1's Primary Care Physician reported she did not believe the cause of death for Resident #1 was due to the Morphine. The hospice nurse was the one that notified the physician. It was unfortunate that pharmacy sent the wrong dose. The dose should have been 2 mg instead of 20 mg. Resident #1's urine output was decreased starting the day before, her kidneys were starting to shut down. She was in the process of dying. A review of the Facility Policy titled: Drug Dispensing and Distribution dated as last revised [DATE] had documentation of the following:The pharmacist will verify the order in the hospital computer system, including review of the order.The technician will prepare any doses not available in the Automated Medicated Dispensing System as necessary. Prior to being sent to the nursing unit, all doses are checked by a pharmacist.Upon receipt of the medication, the nurse will compare the medication with the order on the MAR (Medication Administration Record) Discrepancies are clarified prior to administering the medication. The nurse will record doses given on the MAR.A review of the Facility Policy titled: Medications, dated as last revised [DATE] had documentation of the following:When the pharmacy is closed, the house supervisor or licensed designee will obtain the medications. An after-hours pharmacist is available to verify new medication orders via the electronic health record. The 5 patient rights are reviewed during medication administration. All medication are labeled by pharmacy personnel.