STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16E728	A. Building B. Wing	08/28/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on clinical record review, policy review, and staff interviews, the facility failed to ensure staff dressed a resident in a dignified manner and utilized incontinent products appropriately for 1 of 2 residents reviewed for dignity (Resident #4). The facility reported a census of 19 residents.Findings include:The Minimum Data Set (MDS) assessment tool, dated 7/11/25, listed diagnoses for Resident #4 which included non-Alzheimer's dementia, anxiety disorder, and diabetes. The MDS stated the resident was dependent on staff for lower body dressing and toileting hygiene and listed her Brief Interview for Mental Status (BIMS) score as 9 out of 15, indicating moderately impaired cognition. The facility policy Scope of Service-Long Term Care Department, revised 5/2019, stated the facility would maintain respect for residents. A Care Plan entry, revised 8/1/23, stated the resident required extensive assistance with all activities of daily living (ADLs). A Care Plan entry, revised 4/14/24, stated the resident required extensive assistance with dressing. On 8/27/25 at 12:52 p.m., Staff A Certified Nursing Assistant (CNA)/Activity Director stated she observed staff bring Resident #4 to the dining room after a shower in a nightgown with a lap blanket covering her legs. She stated she thought this was a dignity issue. On 8/27/25 at 1:09 p.m., Staff B Licensed Practical Nurse (LPN) stated she heard of a resident in the dining room with only a lap blanket covering the legs. She stated she educated the CNA regarding this. She stated she was aware that staff applied more than one incontinent product to Resident #4 such as a pull-up with a pad in it. Staff B stated she informed staff this was not appropriate and they did this because she soaked through. Staff B stated staff needed to change the resident more often (rather than placing double products on her). She stated she last saw this happen a couple of weeks ago. On 8/27/25 at 1:50 p.m., the MDS Coordinator stated she observed Resident #4 in the dining room with a shirt and a brief on and a blanket covering her. She stated she did not know why staff did this. She stated the resident threw the blanket off and she thought she should have pants on. She stated she also observed residents with double incontinent products on and stated she thought staff did this because they were heavy wetters. She stated she thought staff did this for convenience. On 8/28/25 at 10:54 a.m., the Director of Nursing (DON) stated staff should not bring residents to the dining room without pants and she was not aware that happened.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16E728	A. Building B. Wing	08/28/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. Based on clinical record review, policy review, and staff interviews, the facility failed to inform residents/resident representatives in advance of the risks and benefits of psychotropic medications for 5 of 5 residents reviewed for medications (Residents #3, #4, #10, #14, #18). The facility reported a census of 19 residents. Findings include: 1. The Minimum Data Set (MDS) assessment tool, dated 7/11/25, listed diagnoses for Resident #4 which included non-Alzheimer's dementia, anxiety disorder, and diabetes. The MDS stated the resident took antipsychotics and antidepressant medications and listed a Brief Interview for Mental Status (BIMS) score of 9 out of 15, indicating moderately impaired cognition. The facility policy Gradual Dose Reduction and Use of Antipsychotics/Psychoactive Drugs revised 4/2023, stated staff would notify the resident/responsible party of the initiation, increase, or decrease of any psychoactive medications. The Order Summary Report listed the following orders:a. 5/13/25 sertraline (an antidepressant) 100 milligrams(mg) 1 tablet by mouth one time a day for depressionb. 5/19/25 trazodone (an antidepressant) 50 mg 0.5 tablet by mouth one time a day for mood c. 8/12/25 olanzapine (an antipsychotic) 5 mg 1 tablet by mouth in the morning for episodic behaviorsd. 8/12/25 olanzapine 10 mg 1 tablet by mouth in the afternoon for episodic behaviors The facility lacked documentation they provided the resident/resident representative, in advance, information regarding the risks and benefits of the above psychotropic medications. 2. The MDS assessment tool dated 7/21/25, listed diagnoses for Resident #10 which included anxiety, osteoarthritis (inflammation of the bone and joints), asthma, chronic obstructive pulmonary disease, or chronic lung disease (diseases which can cause shortness of breath/difficulty breathing). The MDS stated the resident received anti-anxiety and antidepressant medications and listed her BIMS score as 14 out of 15, indicating intact cognition. The Order Summary Report listed the following orders: a. 1/18/24 alprazolam (an anti-anxiety medication) 0.5 mg by mouth two times a day for anxietyb. 9/24/24 duloxetine (an antidepressant) oral capsule delayed release sprinkle 20 mg by mouth one time a day for depression The facility lacked documentation they provided the resident/resident representative, in advance, information regarding the risks and benefits of the above psychotropic medications. 3. The MDS assessment tool, dated 6/16/25, listed diagnoses for Resident #14 which included anxiety, depression, and low back pain. The MDS stated the resident received an antidepressant medication and listed the resident's BIMS score as 14 out of 15, indicating intact cognition. The Order Summary Report listed the following orders: a. 2/28/25 duloxetine oral capsule delayed release sprinkle 60 mg capsule by mouth one time a day for depression (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16E728	A. Building B. Wing	08/28/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility lacked documentation they provided the resident/resident representative, in advance, information regarding the risks and benefits of the above psychotropic medications. On 8/27/25 at 3:22 p.m., the Director of Nursing (DON) stated she could not locate any consents for psychotropic medications. She stated she spoke with the pharmacist and they would assist her with completing them. 4. The MDS assessment for Resident #3, dated 6/23/25, identified the resident had diagnoses of chronic obstructive pulmonary disease, anxiety, and depression. The BIMS revealed a score of 15 out of 15 (indicative no cognitive impairment). The Clinical Physician Orders listed the following psychotropic medications (medications that affect mental processes and behaviors): a. Duloxetine delayed release sprinkle 60 mg capsule, give one capsule one time per day for depression, effective 4/10/25. b. Alprazolam 0.5 mg, give one tablet by mouth three times per day for anxiety, effective 3/27/25. The facility lacked documentation they provided the resident/resident representative, in advance, information regarding the risks and benefits of the above psychotropic medications. 5. The MDS assessment for Resident #18, dated 7/15/25, identified the resident had diagnoses of Hemiplegia (paralysis or weakness on one side) following cerebral infarct (stroke), insomnia, depression and anxiety. The Clinical Physician Orders listed the following psychotropic medications: a. Buspirone 5 mg tablet, give 5 mg by mouth three times per day for anxiety, effective 11/12/24. b. Sertraline 100 mg, give one tablet by mouth one time per day for depression, effective 10/1/24. c. Tylenol PM 500 mg-25 mg (Diphenhydramine) tablet, give one tablet by mouth, effective 4/15/24. The facility lacked documentation they provided the resident/resident representative, in advance, information regarding the risks and benefits of the above psychotropic medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16E728	A. Building B. Wing	08/28/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident interview, and staff interview, the facility failed to notify the State Long-Term Care Ombudsman of the hospitalization and discharge of residents for 2 of 2 residents sampled (Resident #3 and #23) with a hospitalization or discharge. The facility reported a census of 19 residents. Findings include:1.The Minimum Data Set (MDS) assessment for Resident #3, dated 6/23/25, identified the resident had diagnoses of chronic obstructive pulmonary disease and diabetes. The Brief Interview for Mental Status (BIMS) revealed a score of 15 out of 15 (indicative no cognitive impairment).On 8/25/25 at 1:19 PM, the resident reported a recent hospitalization in July 2025.Review of the clinical MDS list for Resident #3 revealed a lack of an MDS to indicate the resident discharged to the hospital with an anticipated return or reentry to the facility in the month of July 2025.On 8/28/25, review of Progress Notes for Resident #3 revealed the following:a. A progress note, titled Health Status Note, dated 7/15/25, included documentation the resident transferred to the hospital emergency room on 7/15/25. b. A progress note, titled Orders-Administration Note, dated 7/16/25, included documentation the resident was admitted to the hospital on [DATE].c. A progress note, titled Health Status Note, dated 7/21/25, included documentation the resident discharged from the hospital and returned to the nursing home on 7/21/25.The clinical record lacked documentation of notification of the State Long-Term Care Ombudsman.On 8/28/25 at 1:31 PM, the Administrator confirmed facility staff failed to notify the State Long-Term Care Ombudsman of Resident #3's hospitalization. The Administrator reported the facility did not have a policy to address notification of the State Long-Term Care Ombudsman.2. The MDS assessment for Resident #23, dated 7/27/25, indicated the resident was admitted to the facility on [DATE] and discharged on 6/27/25.A Progress Note, titled Health Status Note, dated 6/27/25, included documentation the resident discharged with hospice services to home with a plan to die at home. The clinical record lacked documentation of notification of the State Long-Term Care Ombudsman of the discharge for Resident #23.On 8/28/25 at 1:28 PM, the Administrator reported she and the Director of Nursing (DON) were unaware of the need to notify the State Long-Term Care Ombudsman of resident discharges and hospitalizations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16E728	A. Building B. Wing	08/28/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, and staff interview, the facility failed to complete required Minimum Data Set (MDS) assessments for 2 of 16 residents reviewed (Residents #3 and #7). The facility reported a census of 19 residents.Findings include:1. Resident #7's electronic health record (EHR) MDS list, reviewed on 8/28/25, documented her 7/24/25 quarterly MDS was in progress. The facility MDS Transmission Policy and Procedure, revised 3/2015, stated the facility would ensure accurate completion and submission of federally required assessments including quarterly, discharge, and reentry assessments. On 8/27/25 at 1:50 p.m., the MDS Coordinator stated she was aware she did not complete the MDS assessments very well lately and said she did not get enough time for this. She stated she found one that was due “last month” that was not completed. On 8/28/25 at 10:54 a.m., the Director of Nursing (DON) stated staff should complete MDS assessments in the appropriate time frames. 2.The MDS assessment for Resident #3, dated 6/23/25, identified the resident had diagnoses of chronic obstructive pulmonary disease and diabetes. The Brief Interview for Mental Status (BIMS) revealed a score of 15 out of 15 (indicative no cognitive impairment). On 8/25/25 at 1:19 PM, the resident reported a recent hospitalization in July 2025. Review of the clinical MDS list for Resident #3 revealed a lack of an MDS to indicate the resident discharged to the hospital with an anticipated return or reentry to the facility in the month of July 2025. On 8/28/25, review of Progress Notes for Resident #3 revealed the following: a. A progress note, titled Health Status Note, dated 7/15/25, included documentation the resident transferred to the hospital emergency room on 7/15/25. b. A progress note, titled Orders-Administration Note, dated 7/16/25, included documentation the resident was admitted to the hospital on [DATE]. c. A progress note, titled Health Status Note, dated 7/21/25, included documentation the resident discharged from the hospital and returned to the nursing home on 7/21/25. On 8/28/2025 at 12:07 PM, the DON confirmed staff should have completed MDS assessments related to Resident #3's hospitalization 7/15/25 to 7/21/25, including a MDS for discharge with anticipated return and a MDS re-entry to the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16E728	A. Building B. Wing	08/28/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on clinical record review, policy review, and staff interview, the facility failed to ensure the care plan identified diuretic (a medication which reduced fluid in the body) and antidepressant medications and failed to address the risk of skin impairment for a resident with a history of skin breakdown for 2 of 16 residents reviewed for care plans (Residents #10 and #17). The facility reported a census of 19 residents.Findings include:1. The Minimum Data Set (MDS) assessment tool dated 7/21/25, listed diagnoses for Resident #10 which included anxiety, osteoarthritis (inflammation of the bone and joints), asthma, chronic obstructive pulmonary disease, or chronic lung disease (diseases which can cause shortness of breath/difficulty breathing). The MDS stated the resident received diuretic and antidepressant medications and listed her BIMS(Brief Interview for Mental Status) score as 14 out of 15, indicating intact cognition. The facility policy Comprehensive Care Plans, effective 7/2025, stated Care Plans would include skin conditions and medications. The August 2025 Medication Administration Record (MAR) documented the resident received duloxetine (an antidepressant) and furosemide (a diuretic). Resident #10's Care Plan did not address the resident's diuretic or antidepressant medications or provide staff with information related to possible side effects to monitor. 2. The MDS assessment tool, dated 7/23/25, listed diagnoses for Resident #17 which included hemiplegia (paralysis on one side of the body), Parkinson's disease (a disease which caused tremors and lack of mobility), and muscle wasting. The MDS stated the resident was at risk for developing pressure ulcers and listed his BIMS score as 13 out of 15, indicating intact cognition. A Care Plan Focus area, revised 5/14/25, stated the resident was at risk for impaired skin integrity related to his suprapubic catheter (a catheter surgically inserted through the abdomen into the bladder to drain urine). The Care Plan did not address the resident's risk of skin breakdown on his coccyx (tailbone).An 8/13/25 Health Status Note stated the resident had an open area to the coccyx which measured 0.3 centimeters (cm) x 0.3 cm x 0.1 cm (length x width x depth). On 8/28/25 at 10:54 a.m., the Director of Nursing (DON) stated the care plan should address high risk medications and the risk for skin impairment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16E728	A. Building B. Wing	08/28/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16E728	A. Building B. Wing	08/28/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on clinical record review, resident and family interview, staff interview, hospice staff interview, and review of facility policy, the facility failed to ensure staff revised a resident's care plan to include hospice services within 7 days after the completion of a significant change in condition comprehensive assessment and failed to include hospice professional staff in the care planning process for 1 of 1 sampled residents reviewed for hospice services (Resident #2). The facility staff failed to include resident/family in the participation and development of their care plan for 1 of 1 residents reviewed for care planning participation (Resident #15). The facility reported a census of 19 residents. Findings include:1.The Minimum Data Set (MDS) significant change in condition assessment for Resident #2, dated 4/8/25, and the quarterly MDS assessment, dated 7/9/25, identified a facility admission date of 10/6/2014, indicating the resident received hospice services, and identified diagnoses of major depressive disorder, edema (fluid retention), unspecified joint pain, and hypertension (high blood pressure). The MDS assessment, dated 7/9/25, included documentation of an assessed Brief Interview for Mental Status (BIMS) score of 8 out of 15 (indicative of a moderate cognitive impairment).Review of the the current care plan for Resident #2 revealed a last goal update of 9/5/24, and anticipated target completion dates of all goals for 10/21/25. The care plan failed to identify the resident received hospice services or include any interventions in relation to hospice. Review of the clinical record for Resident #2 revealed a hospice document, titled Team Care Plan, dated 6/11/25, revealed a hospice admission date of 3/25/25, identified diagnoses of major depressive disorder, chronic obstructive pulmonary disease, pain in the thoracic spine, and heart failure. The hospice care plan included orders for hospice nursing, hospice aide, hospice social worker and spiritual counseling services.Review of the clinical record for Resident #2 revealed a lack of documentation to indicate whether or not facility staff had included hospice in care planning.On 8/27/25 at 1:44 PM, the MDS Coordinator reported being responsible for completing all of the MDS assessments and care plans on residents. The MDS Coordinator reported being the person responsible for inviting hospice staff to the care plan meetings and reported hospice should be included in the invite for resident care plan meetings. The MDS coordinator reported either she or the Director of Nursing (DON) maintained contact with hospice and documented all contact with hospice in the clinical record. The MDS Coordinator denied maintaining any type of documentation to show evidence that hospice had been invited to participate in the care planning meetings for Resident #2.On 8/27/25 at 2:47 PM, the Hospice Registered Nurse (RN) for Resident #2 reported she had not received an invite to the resident's care plan meeting. The Hospice RN reported hospice maintained documentation of all contact with the facility and had no documentation to support the facility had invited hospice staff to participate in care plan meetings.On 8/28/25 at 12:00 PM, the DON reported that hospice staff should be invited to the resident's care plan meetings. 2. The MDS assessments for Resident #15, dated 2/18/25, 5/19/25 and 8/16/25, identified diagnoses of hemiplegia (paralysis on one side of the body) following cerebral infarct (stroke), hypomagnesemia (low magnesium level) and obstructive sleep apnea (difficulty breathing or loss of breath when asleep). The MDS assessment, dated 8/16/25, included a BIMS score of 14 out of 15 (indicative of a mild cognitive impairment). On 8/25/25 at 1:48 PM, during an interview with Resident #15 and their family member, Resident #15 and the family member reported not being invited to care plan meetings and not participating in the care planning process. Review of the Care Plan for Resident #15 revealed facility staff last updated the Care Plan on 8/25/25.Review of the form, titled Plan of Care Meeting Attendance, for Resident #15 revealed documentation of care plan meetings, dated 11/19/24, 5/20/25, and 8/19/25. The meetings included documentation of staff signatures who were present for each of the meetings, but did not include the name/signature of the resident or the resident's family member. The Plan of Care Attendance form lacked documentation of a care plan meeting for the MDS assessment, dated 2/18/25.Review of the clinical record for Resident #15 revealed a lack of documentation of resident and/or family participation or refusal to participate in the care planning process and meetings. On 8/26/25 at 2:47 PM, the MDS Coordinator reported she invited residents to the care plan meetings. The MDS Coordinator explained that care plan meetings for residents were held in the DON's office, or if a larger location was needed, the meetings were held in the sunroom. The MDS Coordinator reported the DON sent the invite letter for care plan meetings to the family members. The MDS Coordinator reported only a handful of residents participated in the care plan meetings. On 8/26/25 at 2:50 PM, the DON reported sending out invitation letters to residents' family members for the care plan meetings, but did not have any documented evidence to show

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16E728	A. Building B. Wing	08/28/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16E728	A. Building B. Wing	08/28/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on clinical record review, resident interview, staff interview, and facility policy review, the facility failed to ensure nursing staff provided personal hygiene assistance to a dependent resident in a timely manner after an episode of bowel and urine incontinence for 1 of 1 resident's sampled (Resident #15) with a reported concern of delayed assistance in care. The facility reported a census of 19 residents. Findings include:The Minimum Data Set (MDS) assessment for Resident #15, dated 8/16/25, identified diagnoses of hemiplegia (paralysis on one side of the body) following cerebral infarct (stroke), hypomagnesemia (low magnesium level) and obstructive sleep apnea (difficulty breathing or loss of breath when asleep). The MDS assessment included a Brief Interview Mental Status (BIMS) score of 14 out of 15 (indicative of a mild cognitive impairment) and assessed the resident was dependent on staff for toileting hygiene, dressing and transfers, and required maximum assistance for personal hygiene. The Care Plan for Resident #15, last revised 8/25/25, revealed the resident had increased confusion at times and required extensive to total care with all activities of daily living related to dementia and impaired mobility. The Care Plan identified the resident had total bowel and bladder incontinence, was at risk for skin breakdown and required perineal care after each incontinence episode and should be toileted every shift.On 8/25/25 at 1:48 PM, during an interview with Resident #15 and their family member, Resident #15 reported he needed assistance from staff to move in bed and staff helped to reposition him every couple of hours. Resident #15 reported that he was a Hoyer lift (type of mechanical lift) for transfers and required an assist of two staff. Resident #15 reported being incontinent of bowel and bladder and identified that he used an incontinent brief. The resident reported one night, about one week ago, on either a Wednesday (8/20/25), or Thursday (8/21/25), staff did not come in and check on him during the night. Resident #15 reported that he had a large bowel movement (BM) and urinated a lot and laid in the BM and urine for 4 hours. Resident #15 reported Staff B, Licensed Practical Nurse (LPN), came in on the morning shift, found him soiled and cleaned him up. Resident #15 reported Staff B, LPN, was upset, told him that it was not acceptable to be left in BM and urine, and told him that she was going to talk with the staff responsible. Resident #15 reported being on fire from the urine and BM being on his skin and being mad that no one came in to check on him. Resident #15 was unclear on whether or not he used his call light. Resident #15's family member reported not being present, but confirmed the resident told the family member about the concern after it happened. On 8/26/25 at 2:25 PM, Staff B, LPN, reported she recalled the incident last week when she walked into Resident #15's room and found the resident incontinent of BM and urine. Staff B, LPN, was not sure which morning it happened, but reported she had worked on Wednesday (8/20/25), Thursday (8/21/25) and Friday (8/22/25) and started all three days at 6:00 AM. Staff B, LPN, reported she could smell the BM and urine when she walked into Resident #15's room. Staff B, LPN, reported the resident's call light was not on. Resident #15 told Staff B, LPN, that he had been incontinent of bowel and urine for 4 hours, no staff came to check on him, and he did not see his call light. Staff B, LPN, reported the call light was within reach of Resident #15, but slightly under the resident. Staff B, LPN, reported staff should have checked on Resident #15, and explained staff were supposed to do rounds on the residents between 3:00 AM and 4:00 AM. Staff B, LPN, reported the Director of Nursing (DON) had worked the floor starting at 2:00 AM on the morning it happened, but left prior to Staff B, LPN, getting to the facility at 5:45 AM. Staff B, LPN, reported that Staff E, LPN, worked nights, and was still present when Staff B started working on the floor at 6:00 AM. Staff B, LPN, reported she talked with Staff E, LPN, about the resident not getting checked and not getting incontinence cares. Staff B, LPN, reported that Staff E, LPN, told Staff B that Staff E thought the DON had checked on and took care of Resident #15. Staff B, LPN, reported Resident #15 could be an assist of one staff for personal/toileting hygiene. Review of the nursing schedule for August 2025 revealed the following: a. Staff B, LPN, worked Wednesday (8/20/25), Thursday (8/21/25) and Friday (8/22/25) starting at 6:00 AM.b. Staff E, LPN, worked Wednesday (8/20/25), Thursday (8/21/25) from 6:00 PM to 6:00 AM.c. The DON worked Thursday (8/21/25) from 2:00 AM to 6:00 AM. On 8/26/25 at 3:30 PM, the DON reported being unaware of a complaint voiced by Resident #15 of not getting his incontinence care done timely. The DON confirmed she had worked during the night one night last week. The DON reported Resident #15 was usually up off an on throughout the night, and the resident would use his call light. The DON explained the resident would take his continuous positive airway pressure (CPAP-breathing device used to help treat sleep apnea) machine off and put it back on, and the staff would try to bundle the CPAP application with the resident's incontinence cares. The DON reported the expectation that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16E728	A. Building B. Wing	08/28/2025

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, clinical record review, policy review, and resident and staff interviews, the facility failed to provide sufficient activities for 3 of 3 residents reviewed for activities (Residents #5, #6, and#18). The facility reported a census of 19 residents. Findings include: 1. The annual Minimum Data Set (MDS) assessment tool, dated 5/13/25, listed diagnoses for Resident #5 which included heart failure, anxiety, and depression. The MDS stated the following activities were very important to the resident: books, newspapers, being around animals, news, group activities, favorite activities, going outside for fresh air, and religious practices. The MDS listed the resident’s Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition. The facility policy Long Term Care (LTC) Resident Activities, effective 1/2025, stated the facility would provide an on-going person centered activity program. An 8/15/25 Care Plan entry stated the resident would continue to attend activities twice per day. On 8/25/25 at 11:40 a.m., Resident #5 stated the facility provided an activity calendar but 50-75% of the activities did not occur because staff had to work the floor. She also stated there were never activities on the weekends. The June 2025 Documentation Survey Report V2 report stated the resident participated in activities on 6/2/25, 6/3/25, 6/4/25, 6/9/25, 6/11/25, 6/13/25, 6/17/25, 6/18/25, 6/19/25, 6/23/25, and 6/26/25. The July 2025 Documentation Survey Report V2 stated the resident participated in activities on 7/1/25, 7/2/25, 7/16/25, 7/17/25, and 7/24/25. The August 2025 Documentation Survey Report V2 stated the resident participated in activities on 8/5/25, 8/6/25, 8/12/25 and 8/26/26. The facility lacked further documentation of activities offered during the period of 6/1/25 to 8/27/25. On 8/27/25 at 12:52 p.m., Staff A Certified Nursing Assistant (CNA)/Activity Director stated she was unable to complete activities at times due to working the floor (as a CNA). She estimated that she could not complete 40% of the activities due to this. She stated weekend staff were supposed to complete activities but she was told this was not done at times. On 8/28/25 at 10:54 a.m., the Director of Nursing (DON) stated she wanted to complete a couple activities per day but that had not happened because the AD worked as a CNA. She stated they worked on hiring. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16E728	A. Building B. Wing	08/28/2025

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The annual MDS assessment for Resident #6, dated 3/25/25, listed diagnoses of non-Hodgkin lymphoma, macular degeneration (degenerative eye disease) and edema (fluid retention). The MDS stated the following activities were very important to the resident: books, newspapers, magazines, news, going outside for fresh air, and religious practices, and it was somewhat important to the resident to do her favorite activities. The MDS listed the resident’s BIMS score as 15 out of 15, indicating intact cognition. The quarterly MDS assessment for Resident #6, dated 6/23/25, listed the resident's BIMS score as 15 out of 15. The electronic form, titled Activities Quarterly/Annual Participation Review, dated 6/26/25, documented Resident #6 attended most mid-morning activities and the resident's favorite activities included dice, exercise, church and going outside on good weather days. The resident visited with family most afternoons. On 8/25/25 at 12:24 PM, Resident #6 reported that she liked to participate in activities offered by facility staff. Resident #6 reported she participated every day unless the Activity Director got pulled to the floor to help with resident cares. On 8/25/25 at 3:05 PM, observation of the dining room/activity room revealed the room was empty of residents and staff. In an interview, at the same time of the observation, the MDS Coordinator confirmed a group activity had been scheduled at 3:00 PM and would have taken place in the dining room. The MDS Coordinator reported no activities had occurred today (8/25/25) due to the Activity Director, Staff A, CNA, being scheduled to provide resident cares for the day. The MDS Coordinator reported the Activity Director was pulled away from activities and scheduled to work the floor as a CNA and provide resident cares a couple times per week. On 8/28/25, review of document, titled Task, dated August 2025, revealed Resident #6 had participated in activities a total of 5 days in August (8/5, 8/6, 8/12, 8/26 and 8/27/25). 3. The quarterly MDS assessment for Resident #18, dated 7/15/25, identified the resident had diagnoses of Hemiplegia (paralysis or weakness on one side) following cerebral infarct (stroke), insomnia, depression and anxiety. The electronic form, titled Activities Quarterly/Annual Participation Review, dated 7/18/25, documented Resident #18 attended some activities and the resident's favorite activities included dice, bingo, church, parties, going outside and visiting with people. Staff described the resident as a social butterfly. On 8/25/25 at 12:05 PM, Resident #18 reported she participated in some of the activities offered at the facility. Resident #18 reported there were times the Activity Director cancelled scheduled activities due to having to work on the floor (provide resident cares). Resident #18 reported the Activity Director cancelled activities two times last week (the week of 8/18/25), and then cancelled activities today (8/25/25) due to having to work on the floor. On 8/28/25, review of document, titled Task, dated August 2025, revealed Resident #18 had participated in activities a total of 5 days in August (8/5, 8/6, 8/12, 8/26 and 8/27/25).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16E728	A. Building B. Wing	08/28/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on clinical record review, policy review, and staff interviews, the facility failed to adequately assess areas of skin impairment for 1 of 3 residents reviewed for skin concerns (Resident #4) and failed to document care planning and collaboration and communication with Hospice services for 1 of 1 residents reviewed receiving end-of-life care (Resident #2). The facility reported a census of 19 residents.Findings include: 1. The Minimum Data Set (MDS) assessment tool, dated 7/1125, listed diagnoses for Resident #4 which included non-Alzheimer's dementia, anxiety disorder, and diabetes. The MDS stated the resident was at risk for developing pressure ulcers and listed Brief Interview for Mental Status (BIMS) score 9 out of 15, indicating moderately impaired cognition. The untitled facility policy, dated 2025, stated residents were reassessed on a quarterly basis or sooner if their physical status changed. a. A 3/21/25 Health Status Note stated (staff) removed the resident’s sock and found a bandage over a 0.5 centimeter x 0.5 cm area with erythema(redness) which measured 10 cm x 9 cm. A 3/21/25 Non-Pressure Skin Condition Report stated the resident had an abrasion on her right third toe. The facility lacked documentation prior to 3/21/25 of an assessment of the skin area and the application of the bandages. b. A 6/23/25 Health Status Note stated the resident had a bandage on the right forearm on 6/22/25 and 6/23/25. The resident had a 0.5 cm skin tear to the area. The facility lacked documentation prior to 6/23/25 of an assessment of the skin area and the application of the bandage. On 8/27/25 at 12:52 p.m., Staff A Certified Nursing Assistant (CNA)/Activity Director stated she applied bandages before to Resident #4 but notified the nurse of this. On 8/27/25 at 1:22 p.m., Staff D Licensed Practical Nurse (LPN) stated Staff A applied bandages and the nurses then assessed the area. On 8/28/25 at 10:54 a.m., the Director of Nursing (DON) stated CNA's were not allowed to apply bandages. She stated she heard that Staff A applied one to Resident #4 and she asked her not to do that and notify the nurse. 2.The Minimum Data Set (MDS) significant change in condition assessment for Resident #2, dated 4/9/25, and the quarterly MDS assessment, dated 7/9/25, identified a facility admission date of 10/6/2014, indicated the resident received hospice services, and identified diagnoses of major depressive disorder, edema (fluid retention), unspecified joint pain, and hypertension (high blood pressure). The MDS assessment, dated 7/9/25, included documentation of an assessed Brief Interview for Mental Status (BIMS) score of 8 out of 15 (indicative of a moderate cognitive impairment). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16E728	A. Building B. Wing	08/28/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Review of the the current Care Plan for Resident #2 revealed a last goal update of 9/5/24, and anticipated target completion dates of all goals for 10/21/25. The Care Plan failed to identify the resident received hospice services or include any interventions in relation to hospice. Review of the clinical record for Resident #2 revealed a hospice document, titled Team Care Plan, dated 6/11/25, revealed a hospice admission date of 3/25/25, identified diagnoses of major depressive disorder, chronic obstructive pulmonary disease (COPD), pain in the thoracic spine, and heart failure. The hospice care plan included orders for hospice nursing, hospice aide, hospice social worker and spiritual counseling services. Review of the clinical record for Resident #2 revealed a lack of documentation to indicate whether or not facility staff had included hospice in care planning. On 8/27/25 at 1:44 PM, the MDS Coordinator reported being responsible for completing all of the MDS assessments and care plans on residents. The MDS Coordinator reported being the person responsible for inviting hospice staff to the care plan meetings and reported hospice should be included in the invite for resident care plan meetings. The MDS coordinator reported either she or the Director of Nursing (DON) maintained contact with hospice and documented all contact with hospice in the clinical record. The MDS Coordinator denied maintaining any type of documentation to show evidence that hospice had been invited to participate in the care planning meetings for Resident #2. On 8/27/25 at 2:47 PM, the Hospice Registered Nurse (RN) for Resident #2 reported she had not received an invite to the resident's care plan meeting. The Hospice RN reported that hospice maintained documentation of all contact with the facility and had no documentation to support the facility had invited hospice staff to participate in care plan meetings. b. Review of the clinical record for Resident #2 revealed the following discrepancy in oxygen orders: An electronic health record (EHR) physician order entry, dated 10/16/23, revealed an order for oxygen to keep stats (blood oxygen saturation level) above 90 percent. A hospice document located in the resident's hard chart, titled Team Care Plan, dated 6/11/25, revealed a physician order for oxygen 5 liters continuous per nasal cannula for COPD/dyspnea (difficulty breathing) and an effective start date of 3/25/25. A scanned hospice document, titled Recertification Statement for Second 90 Day Period, dated 6/23/25 to 9/20/25, revealed an ongoing order for oxygen 5 liters continuous per nasal cannula. The EHR lacked documentation of an updated oxygen order to reflect the order initiated by hospice on 3/25/25. c. Review of facility progress notes related to oxygen administration revealed the following: A note, titled Health Status, dated 3/28/25, included documentation of oxygen (O2) on per nasal cannula @ 2 liters, O2 sat (saturation) 95 percent. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16E728	A. Building B. Wing	08/28/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A note, titled Health Status, dated 4/1/25, included documentation of O2 sat of 97 percent on 2 liters per nasal cannula. A note, titled Orders-Administration Note, dated 4/6/25 included documentation that the resident had oxygen saturation level of 90 percent on room air (RA) when placed in bed for the night. Oxygen applied and saturation 98 percent on 2 liters per nasal cannula. A note, titled Orders-Administration Note, dated 4/10/25 included documentation that the resident had oxygen saturation level of 88 percent. Staff documented they applied oxygen at 2 liters per nasal cannula. O2 sat now 92 percent. A note, titled Health Status, dated 4/17/25, included documentation the resident oxygen saturation was 93 percent on room air. A note, titled Health Status, dated 4/18/25, included documentation the resident oxygen saturation was 92 percent on room air. A note, titled Health Status, dated 4/19/25, included documentation the resident oxygen saturation was 96 percent on 2 liters of oxygen. A note, titled Health Status, dated 4/21/25, included documentation the resident was on 2 liters of oxygen. A note, titled Orders-Administration Note, dated 5/30/25 included documentation that the staff placed oxygen on the resident at 2 liters. A note, titled Health Status, dated 6/2/25, included documentation the resident was on 2 liters of oxygen. A note, titled Orders-Administration Note, dated 6/20/25 included documentation that the staff placed oxygen on the resident at 2 liters. A note, titled Health Status, dated 6/24/25, included documentation the resident had taken her oxygen off when resting. Resident O2 sat was 82 percent on RA. Oxygen applied at 2 liters per nasal cannula. O2 SAT now at 98 percent with oxygen on. Encouraged resident to leave oxygen on while resting in bed. A note, titled Health Status, dated 7/7/25, included documentation the resident oxygen saturation was 93 percent on room air. A note, titled Orders-Administration Note, dated 7/22/25, included documentation the resident had removed the oxygen. Staff assessed the resident's oxygen saturation level was 75 percent on RA and came up to 91 percent on oxygen 2 liters. d. On 8/27/25 at 2:47 PM, the Hospice RN reported not being notified of the following changes in condition and medication changes: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16E728	A. Building B. Wing	08/28/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A note, titled Health Status, dated 5/13/25, included documentation the facility Advanced Registered Nurse Practitioner (ARNP) rounded today and gave orders for Prednisone 20 milligrams (mg) 1tablet by mouth daily for 5 days. The Hospice RN reported facility staff did not make her aware of this order change. The facility's clinical record for Resident #2 lacked documentation the facility notified hospice of the medication change. A note, titled Health Status, dated 7/7/25, included the following documentation: VS (vital signs)-98.1 (temperature), 67 (pulse), 18 (respirations), 132/66 (blood pressure), 93% (oxygen saturation level) RA (room air). Resident with c/o (complaint of) I feel sick, everywhere before supper meal this shift et. (and) refused to eat anything. Afebrile. PRN (as needed) Zofran given with effectiveness. Resident with c/o burning with urination as well. Fax sent to PCP (primary care physician) with update. Fluids encouraged et. taken poor. Urine with foul odor et. dark in color. Call light in reach. The facility's clinical record for Resident #2 lacked documentation the facility notified hospice of the resident's change in condition. A note, titled Health Status, dated 7/8/25, included documentation the facility ARNP was at the facility on rounds and received new orders to discontinue Colace (a medication used to treat constipation). The facility's clinical record for Resident #2 lacked documentation the facility notified hospice of the medication change. The Hospice RN reported the hospice continued to have a current order for the resident to receive Colace 100 mg, one capsule by mouth every day. A note, titled Orders-Administration Note, dated 8/12/25, included documentation the facility Medical Director rounded at the facility and ordered to hold Magnesium (400 mg by mouth every day) and monitor gastrointestinal habits. The facility's clinical record for Resident #2 lacked documentation the facility notified hospice of the medication change. The Hospice RN reported the facility staff did not notify her on the resident's Magnesium being held due to episodes of diarrhea until 8/25/25. On 8/28/25 at 12:00 PM, the DON reported she coordinated and communicated with hospice through emails and phone calls. The DON reported it was her responsibility to review hospice orders and care plans. The DON was unaware of the discrepancy between hospice and facility oxygen orders. Review of the contract, titled Hospice Service Contract, with Resident #2's hospice, dated 7/30/23, revealed the facility agreed to provide care and services per the Hospice Plan of Care. Services included medication administration. The facility agreed to contact the hospice immediately for any significant change in condition and any clinical complications that could result in alteration in the Hospice Plan of Care (medications, treatments, care or services). The hospice RN was responsible for overall coordination of the resident's care. The facility agreed to designate one person who was responsible for the implementation of the agreement.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16E728	A. Building B. Wing	08/28/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on initial kitchen tour observation, facility policy review and staff interview, the facility failed to ensure the removal of out dated nutritional supplement drinks from a dry good storage area in the kitchen in order to prevent the service and resident consumption of an unsafe, expired food product. The facility reported a census of 19 residents. Findings include: On 8/25/25 at 10:51 AM, during an initial tour of the kitchen, observation revealed a total of 13 Glucerna, a type of nutritional shake supplement, creamy strawberry flavor in 8 ounce individual serve cartons an expiration date of July 2025. The expired Glucerna drink was located on a dry storage shelf in kitchen with other supplement drinks, including other non-expired Glucerna flavors. The Dietary Manager confirmed the Glucerna in the creamy strawberry flavor had expired the end of July 2025. ON 8/26/2025 at 9:22 AM, the Dietary Manager reported dietary staff had removed the out dated Glucerna. The Dietary Manager explained Staff C, Dietary Aide, went through the supplements and looked for out dated product daily, but had over looked the creamy strawberry flavored Glucerna due to none of the residents being on that particular flavored supplement. Review of the facility policy, titled Food Safety, Temperature and Labeling, dated April 2026, revealed kitchen staff discarded any food item in storage after it's expiration date.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16E728	A. Building B. Wing	08/28/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, clinical record review, policy review, and staff interview, the facility failed to wear appropriate personal protective equipment (PPE) during personal cares for 2 of 2 residents (Residents #1 and#13) reviewed on Enhanced Barrier Precautions (EPB) and failed to clearly identify/carry out the correct level of infection control precautions for 1 of 1 residents reviewed for Transmission Based Precautions (Resident #3). The facility reported a census of 19 residents. Findings include:1. The Minimum Data Set (MDS) assessment tool, dated 7/15/25, listed diagnoses for Resident #13 which included arthritis, heart failure, and hypertension. The MDS stated the resident had 1 unstageable pressure ulcer and listed his Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition. The undated facility policy Enhanced Barrier Precautions, directed staff to carry out enhanced barrier precautions during high contact resident care activities such as wound care and catheter care. The policy directed staff to wear a gown and gloves. An 8/19/25 Health Status Note stated the resident had a raised area on his calf with a scant amount of bloody drainage. On 8/27/25 at 9:33 a.m., Staff D Licensed Practical Nurse (LPN) measured an area on the back of the resident’s left calf as 1.0 centimeters (cm) x 0.8 cm (length x width). The area had a scant amount of yellowish drainage. Staff A then measured an open area with a red wound bed in the resident’s intragluteal cleft as 0.1 cm x 0.4 cm x less than 0.1 cm depth. Staff D wore gloves but did not wear a gown during the measurements. On 8/27/25 at 1:09 p.m., Staff B LPN stated staff should follow enhanced barrier precautions (EBP) any time they completed catheter care or wound care. She stated with Resident #13, she would follow EBP guidelines including a gown and gloves. On 8/27/25 at 1:22 p.m., Staff D Licensed Practical Nurse (LPN) stated she did not wear a gown during Resident #13’s wound cares because she did not expect the wound to be draining. On 8/28/25 at 10:54 a.m., the Director of Nursing (DON) stated staff should wear a gown when completing catheter cares and wound cares. She stated if staff were in doubt, they should wear a gown. 2. The MDS assessment for Resident #1, dated 6/20/25, listed diagnoses of chronic obstructive pulmonary disease and fibromyalgia, required substantial or maximum assistance for personal hygiene and transfers, and was dependent on staff for toileting hygiene, bathing and dressing. The MDS identified the resident had an indwelling urinary catheter. The MDS listed a BIMS score of 7 out of 15, indicative of a moderate cognitive impairment. A physician order, dated 7/8/25, included an order for an 18 French Foley catheter with a 10 cubic centimeter (cc) (balloon device filled with a liquid to hold the catheter in place in the bladder). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16E728	A. Building B. Wing	08/28/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/26/2025 at 10:06 AM, Staff D, LPN, and Staff F, LPN, entered Resident #1's room. Staff F donned a gown and gloves. Staff D donned gloves, but not a gown. Resident #1 was laying in bed on her right side facing the window. Resident #1 was noted to have a catheter and wore an incontinent brief. Staff D positioned herself on the resident's right side and Staff F was on the resident's left side. Staff D assisted Staff F with repositioning the resident on her back and raised up the resident's shirt. Resident #1 had a visibly excoriated areas on her right and left lower abdominal area. Staff D identified the excoriated areas as a yeast infection. Staff D placed one hand on the resident's abdomen and the resident's hand with her other hand while Staff F applied Clotrimazole antifungal medicated cream to the excoriated areas. Staff D pulled the resident's incontinent brief down and pushed the top front of the brief through the resident's upper thighs. Staff D then held the resident's thighs open while Staff F cleansed the resident's perineal area with a wet disposable wipe. Staff D helped Staff F to roll the resident to her right side, and Staff D held the resident in place by putting one hand on the resident's upper hip and another on the resident's buttock area. Resident #1's leg was noted to be touching Staff D's scrubs while Staff F used wet wipes to clean the resident's buttock area. Staff F rolled the incontinent brief under the resident and started a new brief. Staff F assisted Staff D to roll the resident to her back and then to her left side while Staff D removed the old brief and positioned the new brief in place. Staff F and Staff D repositioned the resident on her back, and Staff D pulled the new brief up between the resident's legs. Staff D and Staff F started to apply the resident's pants over her feet and Staff F pulled the catheter bag through leg of pants. Both staff rolled the resident to the right and left to pull her pants up and place the Hoyer lift (type of mechanical lift) vest under resident. Both staff placed socks and shoes on the resident. Staff F positioned the lift by bed and Staff D connected the lift straps to machine. Staff F removed her gown and gloves, completed hand hygiene, left the room and returned with the resident's wheelchair. Staff F gloved and operated the lift to raise the resident from the bed while Staff D held the resident's catheter bag. Once the resident fully raised off the bed, Staff D took over running the lift. Staff D positioned the resident over the wheelchair and lowered her. Staff D then clipped the catheter bag to the wheelchair. On 8/27/25 at 1:25 PM, Staff D reported she did not wear a gown during the observation of Resident #1's personal cares and transfer because she was not doing catheter cares. 3. The MDS assessment for Resident #3, dated 6/23/25, identified the resident had diagnoses of chronic obstructive pulmonary disease and diabetes. The MDS identified the resident had an indwelling urinary catheter. On 8/25/2025 at 11:34 AM, during initial tour of the nursing home, observation of Resident #3's room door revealed an EBP sign and personal protective equipment (PPE) supplies hanging in a bag on the door. Observation of Resident #3 revealed the resident to have a urinary catheter. Review of the electronic Clinical Physician Orders revealed an order, dated 6/10/25, to change the Foley catheter using an 18 French every 2 weeks. Review of the form, titled Resident Matrix, dated 8/25/25, revealed no residents to be identified on transmission based precautions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16E728	A. Building B. Wing	08/28/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/28/25 at 8:54 AM, the Infection Preventionist (IP) reported Resident #3 was currently on transmission based precautions (TBP) for a Vancomycin Resistant Enterococci (VRE) infection of the urine. The IP reported Resident #3 had been on the TBP, specially contact precautions, since 8/12/25. The IP reported this meant staff needed to wear gown and gloves for any contact with the resident. The IP reported the resident and DON were aware. The IP explained staff implemented EBP for urinary catheters, tracheostomies, feeding tubes and open wounds or ulcers including diabetic foot wounds, venous stasis ulcers, any open wounds or pressure ulcers. The IP reported PPE, including gown and gloves, should be worn by staff for personal hands on care, wound care or touching the medical device system. On 8/28/2025 at 9:25 AM, the IP and surveyor observed the signage outside of Resident #3's room. The IP confirmed staff had placed the wrong sign outside of Resident #3's which only identified the resident was on EBP. The IP changed the sign to identify the resident was on contact precautions. On 8/28/2025 at 9:49 AM, Staff B, LPN, reported she did not know the difference between EBP and TBP. Staff B was not aware if any residents on contact precautions. On 8/28/2025 at 9:51 AM, the DON reported being aware Resident #3 was on contact precautions since 8/12/25. The DON reported she had a huddle with the nurses present on 8/12/25 and asked nursing staff to take the PPE and sign to place on the resident's door. The DON reported being unaware that Resident #3 was not identified on the matrix as being on TBP, and the DON had been unaware that Resident #3's room had not correctly identified the resident as being on contact precautions. On 8/28/25 at 9:55 AM, Staff D, LPN, reported that none of the residents were on TBP. Staff D, LPN, reported that Resident #3 was on EBP. Review of the facility policy, titled Infection Prevention and Healthcare Epidemiology Isolation Corporate Policy, dated 4/2025, revealed transmission based precautions included contact precautions. Staff used contact precautions for known or suspected infections with epidemiologically important microorganisms, including VRE, that could be transmitted by direct or indirect contact. Contact precautions included the use of gloves, gown, mask/eye protection/face shield if resident care activities were likely to generate contact with splashing, secretions, excretions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16E728	A. Building B. Wing	08/28/2025

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, Centers for Disease Control and Prevention (CDC) guidelines, and staff interview, the facility failed to offer the pneumococcal vaccine to 1 of 5 sampled residents reviewed for immunizations (Resident #2). The facility reported a census of 19 residents. Findings include:On 8/28/2025 at 8:52 AM, the Director of Nursing (DON) reported that it was the responsibility of the Infection Preventionist to ensure the residents got their immunizations.On 8/28/2025 at 8:54 AM, the Infection Preventionist (IP) reported she had worked in her role at the facility for 11 years. The IP reported the facility followed CDC guidelines when offering immunizations to residents. The IP reported the DON and nursing staff were responsible for ensuring residents were offered and received immunizations. Review of CDC guidelines, dated 10/2024, revealed the following recommendations:Administer Prevnar 20 (PVC20), Prevnar 21 (PVC21), or Vaxneuvance (PVC15) for all adults 50 years or older who have never received any pneumococcal conjugate vaccine, or whose previous vaccination history is unknown.If a person received just Prevnar (PVC13) at any age, administer PVC20 or PVC21 one year or greater after the administration of PVC13.If a person received PVC13 at any age and Pneumovax (PPSV23) vaccine at age [AGE] or older, administer PVC20 and PVC21 5 years or greater after the last dose of PPSV23. Review of the clinical record for Resident #2 revealed the following:a. The Minimum Data Set (MDS) assessment, dated 7/9/25, identified an admission date of 10/13/14, the resident was over age [AGE], and had diagnoses that included major depressive disorder and magnesium deficiency. The assessment identified a Brief Interview for Mental Status (BIMS) score of 8 out of 15 (indicated a moderate cognitive impairment).b. On 8/28/25, review of Resident #2's immunization status revealed the resident received a dose of Pneumovax (PPSV23), dated 9/14/2010. The resident was over age [AGE] at the time of the PPSV23 dose administration. The clinical record lacked documentation of whether facility staff offered or administered Resident #2 a pneumococcal conjugate vaccine, Prevnar 20 (PVC 20), Prevnar 21 (PVC21) or Vaxneuvance (PVC15), per CDC guidelines. On 08/28/2025 at 11:58 AM, the IP confirmed Resident #2 should have been offered a pneumococcal vaccine based on the resident's previous pneumovax immunization in September 2010. Review of the undated facility policy, titled Long Term Care Vaccination Program, revealed, in accordance with CDC guidelines for immunization, nursing staff were responsible for screening residents on admission for pneumonia vaccination status, providing education on the risks and benefits of receiving the pneumococcal vaccine, documenting education and obtaining a signed consent/declination form.