STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366076	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ohio Eastern Star Hlth Care Ctr The	1451 Gambier Road Mount Vernon, OH 43050

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569 Based on closed medical record review, review of medication prescribing information, facility policy and procedure review and interview, the facility failed to prevent a significant medication error from occurring involving Resident #75 related to the administration of prescribed narcotic pain medication. Actual Harm occurred on 01/13/25 at 12:25 A.M. when Registered Nurse (RN) #201 administered Morphine Concentrate Solution, with a concentration strength of 100 milligrams (mg) per five milliliters (ml) (100 mg/5 ml), five milliliters (100 mg) to Resident #75, who had an order to receive 15 mg every eight hours. Following the identification of the significant medication error, the on-call physician was notified and Narcan (reversal agent) nasal spray was administered. As a result of the medication overdose, Resident #75 experienced tingling to the right side of the body with random spastic movements, chills (complaints of being cold) with clammy skin and diarrhea and required increased monitoring. This affected one resident (#75) of three residents reviewed for Morphine administration. The facility census was 73. Findings Include: Review of Resident #75's closed medical record revealed an admitted [DATE] with diagnoses including displaced fracture of the right femur, chronic obstructive pulmonary disease (COPD), and high blood pressure. The resident was discharged home on 01/30/25. Review of Resident #75's signed physician orders revealed an order dated 01/11/25 for Morphine Immediate release tablet 15 mg give one tablet every eight hours for pain. However, due to the medication being unavailable on 01/12/25 an order was obtained for Morphine (liquid) solution 10mg/5ml give 0.75 ml to equal 15 mg every eight hours. Review of the pharmacy's Authorization for Accessing Controlled Substances from Medication Starter Kit form dated 01/12/25 at 7:46 A.M. revealed Licensed Practical Nurse (LPN) #203 requested authorization to remove Morphine Sulfate solution 20mg/ml from the starter kit for Resident #75. Authorization was received from pharmacy at 8:56 A.M. and LPN #203 removed the Morphine Sulfate 20mg/ml bottle (a 15 ml bottle) for Resident #75 and implemented a narcotic count sheet for the Morphine Sulfate solution. The narcotic sheet did not include the Morphine order. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #75's Morphine Sulfate narcotic count sheet dated 01/12/25 revealed the sheet reflected the Morphine Sulfate (20 mg/ml) with 15 ml as the beginning amount of Morphine in the bottle. The following entries were documented: a. On 01/12/25 at 9:24 A.M. RN #333 administered 0.75 ml of Morphine Sulfate to Resident #75 leaving 14. 25 ml of Morphine in the bottle. b. On 01/12/25 at 4:06 P.M. RN #333 administered 0.75 ml of Morphine Sulfate to Resident #75, leaving 13. 50 ml in the bottle. c. On 01/13/25 at 12:25 A.M. RN #210 administered five (5) ml of Morphine Sulfate. Review of Resident #75's progress note dated 01/13/25 at 2:45 A.M. and authored by RN #201 revealed RN #201 had administered an incorrect dose of Morphine Sulfate at 12:25 A.M. The resident's current order indicated Morphine 10mg/5ml with a dosage of 0.75 ml to be administered. However, RN #201 had given Resident #75 five (5) mls of Morphine Sulfate which equaled 100 mg of Morphine Sulfate from the bottle it was obtained from. RN #201 noted the available bottle of Morphine was 20 mg/ml which did not match the current order of Morphine 10 mg/5 ml with the administration of 0.75 mls. However, the order (10mg/5 ml give 0.75 ml to equal 15 mg) was not accurate as the administration of 0.75 ml would result in the resident receiving 1.5 mg of Morphine Sulfate and not 15 mg. The progress note included the on-call physician was notified (of the medication error/overdose). At 12:55 A. M. Resident #75 received Naloxone (Narcan) four mg intranasally. RN #201 continued to monitor Resident #75 and obtained vital signs throughout the shift. At 1:05 A.M. Resident #75 reported tingling to the right side and at 1:15 A.M. Resident #75 experienced random spastic movements. The on-call physician was notified of the observations with no new orders implemented. At 1:45 A.M. Resident #75 had a large bowel movement with clammy skin noted. Resident #75 requested more blankets due to feeling cold. Resident #75's vital signs at 4:00 A.M. included: temperature 98.2, blood pressure 154/64, pulse 93, respirations 16 and blood oxygen (SP02) level 98% at room air. Review of Resident #75's January Medication Administration Record (MAR) revealed on 01/13/25 at 1:05 A. M. LPN #232 administered one spray of Naloxone (Narcan) four mg nasally to Resident #75 with results being effective with no respiratory distress observed. Further review of the medical record revealed the Morphine Solution order was clarified on 01/13/25 to administer Morphine Solution 20mg/ml, administer 0.75 ml (15 mg) every eight hours. Review of the January 2025 MAR revealed the Morphine was administered every eight hours until 01/14/25 at 8:00 A.M. when the pharmacy delivered Morphine 15 mg Immediate Release tablets and the Morphine concentrate was discontinued. The facility did not have an investigation regarding the significant medication error involving Resident#75 and the administration of 100 mg of Morphine. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #75 had intact cognition with a Brief Interview of Mental Status (BIMS) score of 15 out of 15. The assessment revealed Resident #75 required assistance from staff to complete activities of daily living (ADL) tasks including transfers, dressing, and medication administration. Further review revealed Resident #75 had pain requiring daily administration of pain medication. Interview on 02/25/25 at 10:30 A.M. with RN #333 revealed on 01/12/25 Resident #75 had been administered the Morphine Sulfate concentrate 0.75 ml which equaled 15 mg of Morphine at 9:24 A.M. and at 4:06 P.M. (The Morphine bottle the medication was obtained from contained 20 mg per every one ml). Interview on 02/24/25 at 4:25 P.M. with RN #201 confirmed she administered Resident #75 100 mg of Morphine Sulfate on 01/13/25 at 12:25 A.M. RN #201 stated the only part of the order that was read was the five ml. RN #201 stated she did not check the order against the bottle of Morphine prior to administration and only questioned the order when RN #201 was signing the narcotic count sheet and realized the two prior doses had only been recorded as 0.75 ml of Morphine administered. RN #201 stated she administered the Morphine in a cup (Morphine concentrate is to be dosed with an included syringe, measured in 0.1 ml increments from 0.1 ml to1.0 ml) Once RN #201 realized the mistake she notified LPN #232 and compared the bottle of Morphine against the current order. The on-call physician was notified and LPN #232 administered Naloxone (Narcan) four mg to Resident #75. RN #201 stated she was responsible to provide one on one care with Resident #75 throughout the shift to monitor the resident's vital signs and observe for any negative outcome. During the onsite investigation, attempts to reach LPN #203 were unsuccessful and no return calls were provided. Interview on 02/24/25 at 2:06 P.M. with Pharmacist #118 revealed the facility had requested an authorization to remove Morphine from the emergency medication dispenser at 7:47 A.M. on 01/12/25. At 8:41 A.M. the pharmacy received the physician script for Morphine Concentrate Solution 100mg/ml (20mg/ml) administer 0. 75 ml to equal 15 mg every eight hours for pain and granted authorization to the facility to remove the Morphine. The order for the Morphine Solution was temporary until the Morphine 15 mg (oral) tablets were delivered to the facility. Pharmacist #118 stated the administration of 5 ml of Morphine was a significant medication error resulting in Resident #75 receiving 100 mg of Morphine instead of the prescribed 15 mg. Interview on 02/24/25 at 3:15 P.M. with the Chief Executive Officer (CEO) confirmed the facility did not complete an in-depth investigation at the time the medication error occurred but were currently completing one. The CEO stated the Director of Nursing had provided education to RN #201 and LPN #203 for the importance of accuracy when implementing new orders, not practicing the 6 Rights of medication administration and to question an order if the order didn't seem correct. However, the facility was unable to provide written evidence of this education. The CEO revealed DON #500 was no longer employed by the facility and had since resigned. Review of RN #201's personnel file revealed a hire date 10/29/24 with an Employee Coaching form dated 01/13/25 issued by the previous Director of Nursing (DON #500), addressing the medication error which occurred on 01/13/25. The coachable form was issued regarding resident safety where an incorrect dose of pain medication was administered to Resident #75. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of the facility undated policy titled, Medication Administration revealed Safely and accurately administer physician-ordered medication to each resident. Remember the six Rights of correct medication administration - Right Resident, Right Drug, Right Dose, Right Dosage Form, Right Time, and Right Route. Review of the Federal Drug Administration Highlights for Prescribing Information- Morphine Sulfate Solution revealed a warning for risk of medication errors as Morphine Sulfate Solution was available in 10 mg per five ml, 20 mg per five ml and 100 mg per five ml (20 mg/ml) concentrations. The 100 mg per five ml (20 mg per ml) concentration was indicated for use in opioid tolerant patients only. Take care to avoid dosing errors due to confusion between different concentrations and between milligrams and milliliters, which could result in accidental overdose and death. Further review under warnings and precautions revealed to use caution when prescribing, dispensing, and administering Morphine Oral Solution to avoid dosing errors due to confusion between different concentrations and between mg and mL, which could result in accidental overdose and death. Use caution to ensure the dose is communicated clearly and dispensed accurately. Always use the enclosed calibrated oral syringe when administering Morphine Oral Solution 100 mg per 5 ml (20mg/ml) to ensure the dose is measured and administered accurately. Serious adverse reactions include respiratory depression, respiratory arrest, shock and cardiac arrest. Other adverse reactions may include sweating, tremors, agitation, low blood pressure. Review of the information located on the website narcan.com revealed naloxone, the acting ingredient in Narcan nasal spray competes with opioids to bind with the same receptors in the brain, reversing the effects of an opioid overdose in two to three minutes. This deficiency represents non-compliance investigated under Complaint Number OH00162170.