STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265868	A. Building B. Wing	02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Columbia Post Acute	3535 Berrywood Drive Columbia, MO 65201

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** Based on record review and interview, facility staff failed to ensure one resident (Resident #1) remained free of significant medication errors when facility staff administered an incorrect dosage of Morphine to the resident. The census was 67. 1. Review of the facility's Administering Medications policy, dated 04/2019, showed staff are directed as follows: -Medications are administered in accordance with prescribed orders; -Medication errors are documented, reported, and reviewed by the Quality Assurance and Performance Improvement (QAPI) committee to inform process changes and or the need for additional staff training; -The individual who administers the medication should check the label three times to verify the right resident, right medication, right dosage, right time, and right method of administration before medication is administered. 2. Review of Resident #1's Entry Minimum Data Set (MDS), a federally mandated assessment tool, dated [DATE], showed staff assessed the resident as: -Cognitively intact; -Received as needed pain medications; -Fracture of shaft of left fibula. Review of the resident's Physician Order Sheet (POS), dated [DATE], showed the physician orders directed staff as follows: -Morphine (opioid pain medication) Sulfate Oral tablet 15 milligrams (mg) every four hours as needed for pain; -Naloxone Hydrochloride (used to reverse opioid effect) Nasal Liquid 4 mg/0.1 milliliters (ml) as needed for opioid reversal; -Generic equivalent/liquid equivalent items may be used unless otherwise specified/indicated. (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's progress note, dated [DATE], showed Registered Nurse (RN) A documented resident requested morphine 15 mg Immediate Release (IRC) for intense pain. The only morphine in the Omnicell (automatic system for medication management) was morphine liquid 100 mg in 20 ml which equaled 20 mg per one milliliter. RN A documented he/she felt it was still immediate release and he/she could administer it as a liquid. He/She and Licensed Practical Nurse (LPN) D both read the bottle as 20 mg per five ml, and calculated to give 3.75 ml of the liquid morphine. RN A drew 3.7 ml of morphine up in a syringe and took to the resident and administered into his/her mouth. LPN D returned to inform RN A the correct dosage should have been 0.75 ml, so the resident received 75 mg of Morphine instead of the 15 mg as ordered. RN A called the Nurse Practitioner who ordered Narcan 4 mg/0.1 ml nasal spray to be given. Within three minutes the resident was yelling in much pain all over and having diarrhea and nausea. Oxygen down to 89% with respirations up to 24 breaths per minute with yelling. Nurse Practitioner communicated to send resident to emergency room for monitoring. Resident taken to emergency room. Review of the hospital emergency services note, dated [DATE], showed hospital staff documented resident presented to emergency department after he/she received morphine 75 mg instead of the prescribed 15 mg. Hospital staff documented the admission diagnosis as accidental morphine overdose. During an interview on [DATE] at 12:57 P.M., RN A said the resident had recently been admitted to the facility and he/she did not have resident's Morphine yet at the time resident was requesting Morphine for pain. RN A said he/she thought the liquid would be the same as the pill. RN A said he/she and LPN D both saw the concentrated part on the morphine vial as 20 mg/five ml instead of the one ml. He/She said directly after administering the medication into the resident's mouth, LPN D came and informed him/her about the incorrect dosage. RN A said he/she stayed with the resident to monitor and notified the Nurse Practitioner and received the order to administer Nasal Narcan. He/She said the resident had no side effects after the morphine or prior to receiving the Narcan dosage and then after the Narcan was administered the resident started having nausea and diarrhea. He/She said the Nurse Practitioner gave order to send resident to emergency room for monitoring. He/She said it was an honest mistake that shouldn't have happened. During an interview on [DATE] at 7:45 A.M., RN B said he/she was taking report from LPN D since he/she had just come on shift. He/She said RN A was in the background saying a newly admitted resident needed pain medication that they had not yet been received from the pharmacy. He/She said RN A obtained liquid morphine from the omnicell because that is all they had. LPN D said he/she was not sure if an order from the doctor was obtained, but thought it was since RN A had got the liquid morphine out of omnicell to administer. He/She said while still getting report they calculated the morphine dosage and RN A went down to give the morphine to the resident. LPN D said he/she then looked at the morphine vial and checked the residents order and realized the concentration was off for what was drawn up. He/She said he/she went down to the resident room and RN A had already administered the morphine. He/She said the Nurse Practitioner was contacted and received order to give Narcan which was obtained from the omnicell and given within five minutes. He/She said an order was obtained to send resident to the emergency room for monitoring. He/She knows the five rights of medication administration. He/She said, I was not paying as much attention as I should have when the morphine was being calculated because I was trying to receive report at the same time. During an interview on [DATE] at 2:20 P.M., the Nurse Practitioner said with the amount of morphine that was administered, the resident could have died because of suppressed respirations. He/She said that is the reason he/she prescribed the Narcan at that time. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 2:50 P.M., the Director of Nursing (DON) said there is a standing order in the chart the nurses can given the liquid equivalent of the prescribed medication. The DON said he/she felt the nurses took the correct steps once they realized it was the incorrect dosage and a medication error had occurred. The DON said he/she talked with the medical director afterwards and it was agreed the standing order was in the chart and it was a mistake on the dosage calculation by the nurse. The DON said he/she did an investigation after it occurred and has talked with RN A and counseled on medication errors. During an interview on [DATE] at 3:22 P.M., the administrator said he/she agrees what happened was a medication error because the wrong dosage was given. He/She said when a medication error occurs the staff should first ensure resident is safe, notify the physician, DON, administrator, and family. MO00249293