STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345306	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Iredell Memorial Hospital Inc	557 Brookdale Drive Statesville, NC 28677

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38515 Based on record review, and staff, Nurse Practitioner, and Pharmacy Clinical Director interviews, the facility failed to have a documented diagnosis for the use of an antipsychotic medication (Seroquel/quetiapine) for 1 of 5 residents reviewed for unnecessary medications (Resident #54). The findings included: Resident #54 was admitted to the facility on [DATE] with diagnoses that included anxiety and hypertension. Review of Resident #54's care plan initiated on 12/02/24 revealed she had a care plan for the use of psychotropic medications. A physician order dated 12/02/24 read; quetiapine (an antipsychotic medication) 25mg - give 1 tablet at bedtime. The order was discontinued on 12/08/24. A physician progress note dated 12/08/24 written by Nurse Practitioner #1 read in part; Patient is requesting scheduled extra strength [acetaminophen] for chronic back pain. She is also requesting something more for insomnia. Seroquel (quetiapine) increased . A physician order dated 12/08/24 read; quetiapine 50mg - give 1 tablet at bedtime. The order was discontinued on 12/16/24. Review of Resident #54's admission Minimum Data Set assessment dated [DATE] revealed Resident #54 was cognitively intact with no delusions, behaviors, rejection of care, or instances of wandering. Resident #54 was coded as taking antipsychotic medication on a routine basis, a gradual dose reduction had not been attempted and was not clinically contraindicated. A physician progress note dated 12/16/24 written by Nurse Practitioner #2 read in part: Patient reports she is feeling great today. She denies any increase dyspnea or cough. She reports difficulty with sleep since previous admission. Seroquel increased. A physician order dated 12/16/24 read; quetiapine 100mg - give 1 tablet at bedtime. (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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Nurse #1 on 01/09/25 at 8:55 AM revealed she was familiar with Resident #54 and reported she was aware that she was receiving scheduled quetiapine and stated she was being monitored for potential side effects of the medication. Nurse #1 indicated that she did not see a psychological condition listed in Resident #54's diagnoses that would indicate a reason for her to take quetiapine but reported she was aware that some of the physicians in the hospital used it as a sleep aide. Nurse #1 indicated it appeared as though Resident #54 was being prescribed quetiapine as a sleep aide. An interview with Nurse Practitioner #1 on 01/09/24 at 09:06 AM revealed she was familiar with Resident #54 and stated she was also aware Resident #54 was prescribed a scheduled dose of quetiapine. Nurse Practitioner #1 revealed she believed that Resident #54 had been taking the quetiapine at home prior to her admission to the hospital as a sleep aide. Nurse Practitioner #1 stated she would not typically use quetiapine as a sleep aide but since Resident #54 had admitted to the facility already taking it for help with sleep, she just continued it. She continued, stating that typically, when a resident transitioned from the acute care side of the hospital to the long-term care side, the pharmacy staff reviewed the resident's medications and would flag any medications that did not have supporting diagnoses for so they can be discontinued, or the resident could be reevaluated for a supporting diagnosis. She stated based on the records she could see in her charting system; it did not appear as though the pharmacy had sent that initial medication review to her with the quetiapine flagged for not having a supporting diagnosis. Nurse Practitioner #1 indicated there did not appear to be an appropriate supporting diagnosis for the continued use of Resident #54's quetiapine. An interview with Pharmacy Clinical Director on 01/09/24 at 11:02 AM revealed that when a resident transitions from acute care to long-term care, they reviewed their medications and flagged any medications that did not have supporting diagnoses so the clinicians could adjust, discontinue, or reevaluate the residents. She stated according to her records, a review was completed on 12/03/24 and they flagged Resident #54's quetiapine for not having a supporting diagnosis. She reported her records indicated the alert was emailed to Nurse Practitioner #1. She stated once they flag the medication, they have no follow-up procedures to ensure the recommendation was addressed and stated if it was not addressed, they would not know until the following monthly medication review was completed. An interview with the Director of Nursing on 01/09/24 at 12:52 PM revealed she was aware of federal regulation that required appropriate diagnoses for the use of antipsychotic medications and the hospital would occasionally prescribe quetiapine as a sleep aide. She also reported most of the time, the residents admitted to her unit were only there for a very short period and so they continue the medications they were admitted with. She stated the pharmacy usually notified them, along with the physicians, when there was a lack of a supporting diagnosis for the use of antipsychotics. She stated if the facility would be notified that there was a lack of a supporting diagnosis for the use of antipsychotics, it would be solely up to the attending physicians to address the discrepancy. The Director of Nursing indicated she was unsure whether the initial medication review occurred and reported the lack of a supporting diagnosis should have been caught by pharmacy and or the physician and addressed.