STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425111	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morrell Nursing Center	900 North Marquis Hwy Hartsville, SC 29551

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** 25335 Based on observations, record reviews, and interviews the facility failed to ensure that Resident (R)66 was appropriately assessed and dosed for 1 of 5 residents reviewed for unnecessary medications. Findings included: The facility policy titled, Psychotropic Medication dated 1/18 stated: Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s). Review of the electronic medical record (EMR) revealed R66 was admitted to the facility on [DATE] with diagnoses including but not limited to major depressive disorder, persistent mood [affective] disorder and dementia with behavioral disturbance. On 12/04/24 at approximately 11:30 AM, a review of the EMR for R66 revealed that all doses had been administered according to the following physician orders: 1. quetiapine (Seroquel) fumarate Tab (tablet) 25 mg (milligram)-Give 1 tablet orally at bedtime related to Major depressive disorder with Start Date 07/01/2024 2000 (8:00 PM) and D/C (discontinued) Date 11/11/24 1232 (12:32 PM). 2. quetiapine fumarate Tab 25 mg (milligram)-Give 2 tablet by mouth at bedtime related to INSOMNIA with Start Date 11/11/2024 2000 and D/C Date 11/20/24 1025 (10:25 AM). 3. quetiapine fumarate Tab 50 mg (milligram)-Give 1 tablet by mouth at bedtime related to INSOMNIA with Start Date 11/20/2024 2000 (8:00 PM). (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	Further review of the EMR MAR (medication administration record) revealed the following physician order: Resident receives psychotropic medication. Monitor for the following behaviors: hitting, biting, yelling, kicking, resisting care, moaning, wringing hands, pacing, etc. every shift Document: 'Y' if monitored and none of the above observed. 'N' if monitored and any of the above was observed, select chart code 'Other/ See Nurses Notes' and progress note findings. Active O7/1/2024 0700 (7:00 AM) . On 12/04/24 at approximately 11:42 AM, review of the EMR MAR/TARs (medication administration record/treatment administration record) revealed: -7/2024 behaviors charted Yes on 16th, 26nd, 29th day shift and 9th, 24th, 29th evening shift with no description of the behaviors -8/2024 behaviors charted Yes on 10th, 12th day shift with no description of the behavior -9/2024 behaviors charted Yes on 10th day shift and 12th evening shift with no description of the behaviors -10/2024 behaviors charted Yes on 5th, 8th and and 2nd evening shift with no description of the behaviors -11/2024 no behaviors charted -12/2024 through 12/4/2024 no behaviors charted On 12/04/24 at approximately 11:55 AM, review of the EMR revealed AIMS (Abnormal Voluntary Movement) scores on 11/11/2024 and 9/3/2024 = 0.0 (0-29), which indicate no behaviors. On 12/04/24 at approximately 12:10 PM, review of R66's hard paper chart located at the nursing station revealed the following notes by NP (Nurse Practitioner)1: -11/6/2024 CHIEF COMPLAINT: Requested to review his medications per his daughter who is on HIPPA list to evaluate for what she thinks are some symptoms that are worsening with paranoia. HISTORY OF PRESENT ILLNESS: The patient does have dementia and does not have any significant behavioral disturbances here. He had obstructive sleep apnea and BIPAP has been added at bedtime within the last year. He does fairly well with that bust does not wear it the entire night. He also denies any significant issues. Appetite is good. He reports his breathing has been fine. He denies any shortness of breath. No significant activities are reported per nursing staff. MEDICATIONS: Reviewed on MAR. For depression and rest he is on Seroquel 25 mg at bedtime and also as an adjunct for pain he is on duloxetine 20 mg daily. He has Gabapentin t.i.d. (three times daily) for chronic pain and uses some hydrocodone. We have not seen any oversedation. No significant falls have been reported. ASSESSMENT/PLAN: 1. Dementia with some concerns for paranoia. 2. Hypothyroidism. 3. Chronic obstructive pulmonary disease with obstructive sleep apnea. 4. Gastroesophageal reflux disease. 5. Depression. 6. Dementia. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PLAN FOR THERAPY: We will request his recent labs to be reviewed. We will also try to discuss the concerns with his family members as well. Hate to adjust medications that would inhibit him more at night wearing his CPAP (continuous positive airway pressure). We will continue for chronic obstruction disease, his DuoNebs and budesonide b.i.d. (two times daily) Continue chronic pain medication. Certainly consider adjusting if paranoia is truly observed. We will also evaluate TSH (thyroid stimulating hormone). -11/11/2024 CHIEF COMPLAINT: Follow-up from last week's visit when I was requested to look at the medication list from the family. HISTORY OF PRESENT ILLNESS: The family called me back after a left a message on the 6th. They called me back today on the 11th to give me more clarity as to their concerns. The daughter reports that R66 heard his roommate talking loudly on the telephone to someone and it frightened him and made him feel that he was going hurt someone or hurt other ladies here although this is certainly what R66 is understanding. He does have difficulty hearing and is in room with a roommate and unsure if this certainly happened or not. The daughter is requesting that his medications be adjusted to see if he would be less worried and concerned about this. ASSESSMENT/PLAN: Dementia with some concerns for agitation. PLAN FOR THERAPY: We will increase his Seroquel to 50 mg at bedtime to try to improve the worries over the feeling that someone is going to hurt someone. We will follow up with this and continue to monitor very closely. Further review of the paper medical record revealed the following statement: 11/11/24; increase Serouquelto 50mgs po by (mouth) daily and HS (bedtime) signed by NP1. During an interview on 12/04/24 at 01:43 PM, NP1 stated that she had been working at this facility since 2023. When asked, she stated that she was unaware of the FDA Food and Drug Administration) and CMS (Centers for Medicare and Medicare Services) guidelines for prescribing Seroquel (quetiapine), but was aware of the black box warning. She stated that the daughter of R66 had expressed concern about R66 having been frightened by his roommate and had requested an increase in his Seroquel dose. NP1 stated that with some reluctance due to a recent room change and different roommate who talks loud, she had increased the dose from 25 mg to 50 mg. NP1 acknowledged that there had been no behaviors reported by staff or indication of behaviors on his AIMS assessments and proceeded to write an order decreasing the quetiapine dose for R66 back to 25 mg. During an interview on 12/04/24 at approximately 2:17 PM, Medical Director (MD)1 stated that he had been coming to this facility for quite a few years and also saw residents at another facility. When asked, he stated that in the case of R66 you have to look at his medical history and there may have been reason to increase the Seroquel dose, but he was unable to describe any specific behaviors beyond the one incident reported to the NP by the daughter, that could have warranted the Seroquel increase from 25 mg to 50 mg on 11/11/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/04/24 at approximately 3:42 PM, the Administrator and DON (Director of Nursing) stated that NP1 is employed by MD1, not the [NAME] Group, that issues related to psychotherapeutic medication are brought to QAPI (Quality Assurance and Performance Improvement) and when informed that no details related to the type of behavior could be found, stated that the American Health Tech (AHT, their previous EMR system) included those details. They were unsure if specifics related to observed behaviors was charted in Point Click Care which was implemented at the facility on 7/1/2024 and that they would further investigate and advise. During an interview on 12/05/24 at approximately 8:31 AM, the DON stated that behavior specifics were not presently included in PCC (Point Click Care) and that this issue was being worked on. The DON provided an attending MD note regarding R66 dated 11/15/24, stating it had been provided to her on the previous evening (12/4/24). The note stated: CHIEF COMPLAINT: Follow-up on chronic obstructive pulmonary disease and chronic pain. HISTORY OF PRESENT ILLNESS: Patient has had some worsening behavioral issues with worsening paranoia. Seroquel was increased. This seems to have improved. He is tolerating this without any other problems. Breathing seems to be stable. He starts with a CPAP at night but usually takes it off at some point. Chronic pain seems to be at baseline with what limited history we can get from him. ASSESSMENT/PLAN: 1. Severe obstructive sleep apnea. Continue BIPAP (bilevel positive airway pressure). 2. Chronic obstructive disease. Continue DuoNebs. 3. Chronic pain: Continue Lorcet 5/325 every 4 hours p.r.n. (as needed) as well as Gabapentin and duloxtine, 4. Dementia. Continue Aricept 10 mg daily. He does have some paranoia and psychosis involved. Increase Seroquel to 50 mg. 5. Depression. Again, continue Seroquel. On 12/05/24 at approximately 8:43 AM, review of November 2024 MAR paper copies provided by the DON revealed that Quetiapine 25 mg had been administered at bedtime from 7/1/24 through 11/10/14, was changed to 25 mg x 2 tablets (50 mg) at bedtime on 11/11/24, then changed to 50 mg (1 tablet) at bedtime on 11/20/24. On 12/05/24 09:04 AM during an interview, the Administrator and DON confirmed that the first Seroquel 50 mg bedtime dose was administered pursuant to physician orders on 11/11/24 and that the note from MD1 which had been received the previous evening (12/4/24) was dated 11/15/24.