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	02/19/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on review of facility policy, observation and interview, the facility failed to ensure Resident (R)66 was free from a significant medication error. Specifically, R66 was administered insulin via an insulin pen by Registered Nurse (RN)1 who failed to correctly prime the pen before administering the needed 12 units of insulin, for 1 of 1 residents observed receiving insulin during med pass. Findings include: Review of the facility policy titled Insulin Pens states as the policy, It is the policy of this facility to use insulin pens in order to improve the accuracy of insulin dosing and provide increased resident comfort. The Policy Explanation and Compliance Guidelines states under #6, Insulin pens will be primed prior to each use to avoid a collection of air in the insulin reservoir. Number 11, Prime the insulin pen: i. Dial 2 units by turning the dose selector clockwise. ii. With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears. Review of R66's Face Sheet revealed the facility admitted R66 with diagnosis including but not limited to Diabetes Mellitus Type 2. During an observation on 02/18/2026 at 9:47 AM, during med pass, revealed RN1 preparing a Novolog Insulin pen to administer 12 units of insulin to R66. RN1 wiped the hub with an alcohol prep and then placed the needle. She then removed the needle cover, dialed the 2 units in order to prime the pen, held the insulin pen downward to expel the 2 units to ensure air was removed and to ensure the correct dosage, and then dialed up the ordered dosage of 12 units. RN1 then proceeded to administer the 12 units of Novolog Insulin to R66. During an interview on 02/18/2026 at 9:50 AM, RN1 confirmed that she had primed the pen holding it downward. After administering the insulin, RN1 could not ensure that R66 had received the full 12 units due to the incorrect priming.

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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on review of facility policy, observation and interviews, the facility failed to ensure expired medications were removed, and not stored with medications in date and in use for residents, from Medication Cart #1 on Rehab Hall 400, for 1 of 4 medication carts reviewed.Findings include: Review of the facility policy titled Storage Of Drugs states as the policy, All drugs shall be stored appropriately . Under Procedure, . 4. Drugs shall not be kept on hand after the expiration date on the label. 5. Discontinued drugs shall be returned to the provider pharmacy for destruction. During an observation on 02/18/2026 at 8:35 AM, of the Medication Cart #1 located on Rehab Hall 400, with Licensed Practical Nurse (LPN)1 revealed, 3 boxes of Systane Lubricant Eye Drops with Lot #23463A, 30 vials with each vial containing 0.7 milliliters, was expired on 10/2025 and were stored in the medication cart with meds in use for residents. Further observation of Medication Cart #1 revealed, Refresh Classic Eye Drops, 7 vials with Lot #483633 were expired in 10/2025. During an interview on 02/18/2026 at 8:35 AM LPN1 confirmed the expired medications and removed them from the medication cart.