

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425411	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2024
NAME OF PROVIDER OR SUPPLIER Bishop Gadsden Episcopal Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Bishop Gadsden Way Charleston, SC 29412	

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)
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25335</p> <p>Based on observations, record reviews and interviews the facility failed to assure a medication error rate of less than 5% (percent) based on medication pass observations for 1 of 3 residents. There were two medication administration errors resulting in an error rate of 7.67%.</p> <p>related to medication administration to Resident (R)224 who was admitted to the facility on [DATE] with diagnoses including, but not limited to acute respiratory failure with hypoxia.</p> <p>Findings include:</p> <p>During observation of Medication Administration on 03/18/24 at approximately 4:00 PM, Registered Nurse (RN)1 stated she was going to give Azelastine Nasal Spray to R224 and took a pharmacy labeled dispensing vial for R224 from the medication cart which had been labeled by pharmacy as Azelastine Nasal Spray for R224. RN1 then removed a container of Fluticasone Nasal Spray from the pharmacy labeled Azelastine vial. After punching other medications for R224 from medicine cards, she started toward the resident's room when the Surveyor stopped her asking that she review the name of the container of nasal spray in her hand as being the intended medication. After looking at the dispensing vial and bottle of nasal spray RN1 stated I have the wrong medicine, she is supposed to get Azelastine, not Fluticasone and someone put the wrong medicine in the pharmacy labeled Azelastine vial. At approximately 4:06 PM, RN1 proceeded to the resident's room and administered all oral medications, then at approximately 4:11 PM, RN1 administered 2 sprays of the Azelastine Nasal Spray into each of R224's nostrils.</p> <p>On 03/18/24 at approximately 4:19 PM during medication reconciliation, a review of the March 2024 physicians orders revealed an order for Azelastine 137 mcg (microgram) (0.1%) nasal spray aerosol 1 spray in NASAL twice a Day for ALLERGIC RHINITIS, UNSPECIFIED and an order for Fluticasone Allergy Relief 50 mcg/actuation nasal spray, suspension [Fluticasone propionate] Nasal 2 sprays into each NASAL Every Day for Allergic RHINITIS, UNSPECIFIED.</p> <p>During an interview on 03/18/24 at approximately 4:27 PM, RN1, after reviewing the medication administration record and medications for R224, stated she had given too many sprays of Azelastine to R224.</p>

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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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28154</p> <p>Based on observation, interview, and policy review, the facility failed to ensure the kitchens were maintained and operated in a safe manner to minimize the chances for potential spread of foodborne illness to all 21 residents in the facility. Failures included not storing food properly, handling ready to eat foods with gloves that had been in contact with potentially contaminated surfaces, failure to air dry pans and food containers before storage, and failure to ensure employee hair restraint while in the kitchens.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Storing Staples, revised September 2016, revealed: .2. Procedure.2.1 All dry staples food items are stored in the dry storage area. Certain food items are stored off the floor on clean racks for ventilation and cleaning purposes. 2.2 Other staple items are stored in containers to be protected from splashes and other contamination. 2.3 Food items are rotated frequently. New stock is stored behind older stock to prevent deterioration and spoilage .</p> <p>Review of the facility's policy titled Storing Perishable Food Items, revised November 2016, showed: 1. Policy. All perishable food items are stored in either refrigerator or freezer equipment. Perishable food items are stored above the floor on clean shelves for cleaning purposes and to prevent contamination (6 inches above the floor). Leftover food items are stored in covered containers. Each container is labeled as to the contents and dated.</p> <p>Review of the facility's policy titled Sanitary Conditions, effective April 2016, showed: A. Policy. It is the policy of [NAME] to prevent the spread of foodborne illness and abstain from those practices that result in food contamination and compromised food safety. Sanitary conditions are defined as proper storage, preparation, distribution and serving food in order to prevent food borne illness.B. Procedure Dishwashing.Manual: Compartment sink (wash, rinse, and sanitize): Sanitizing solution used according to manufacturer's instructions. -Scrape, remove all food -Wash and thoroughly rinse surfaces -Immerse in sanitizer solution 150-400 ppm (machine automatically dispenses proper amount. ----All surfaces should be exposed to sanitizer solution for no less than one minute. -Allow to dry before storage .</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the facility's policy titled Labeling, effective February 2008, showed: Purpose: The purpose of this policy is to ensure the safety and quality of food served in our skilled nursing facility by implementing guidelines for labeling and dating all food items stored in the kitchen. Scope: This policy applies to all staff members responsible for handling, storing, and preparing food within the kitchen premises of the skilled nursing facility. Responsibility: It is the responsibility of the kitchen staff to adhere to this policy and ensure proper labeling and dating of all food items in accordance with CMS [Centers for Medicare and Medicaid] regulations. Labeling Guidelines: a. All food items, including raw ingredients, prepared meals, leftovers, and perishable items, must be labeled with the following information: -Name or description of the food item; -Date of preparation or opening; -Use-by or expiration date, if applicable. b. Labels should be clear, legible, and affixed to the container or packaging of the food item using a permanent marker or adhesive label. c. Dating Procedure: -Food items should be dated at the time of opening or preparation. -Use the following format for dating: Month/Day/Year -If a food item has been opened, transferred to another container, or repackaged, it should be dated with the current date.</p> <p>Review of the facility's policy titled Hair Restraints, effective June 2002, showed: Policy: 1. Food employees shall wear hair restraints such as hats, hair covering and nets, beard restraints, and clothing that covers body hair that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils, linens, and unwrapped single-service or single-use articles.</p> <p>Review of the facility's policy titled Food Preparation & Handling, effective July 2016, showed: .D. Food employees should wash their hands immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: a. After touching bare human body parts other than clean hands and clean, exposed portions of arms; b. After using the toilet room; c. After caring for or handling animals; d. After coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating, or drinking; e. After handling soiled equipment or utensils; f. When switching between working with raw food and working with ready-to-eat food; g. Before donning gloves to initiate a task that involves working with food; h. After engaging [NAME] [sic] other activities that contaminate the hands.</p> <p>During the initial tour of the first-floor kitchen on 03/18/24 at 10:50 AM, the Executive Chef (EC) introduced himself and was noted to not have his hair restrained. During the tour, five blue tied plastic bags were observed on the top shelf of the walk-in cooler with no identification as to contents or date of storage. The EC confirmed at 11:05 AM the bags contained flatbread and were not labeled. The EC stated the flatbreads had been removed from the original box that morning. Continued observation revealed a commercial size [NAME] mixer was noted to have the bowl stored uncovered and in the lowered position with the paddle blade attached. When asked the last time the mixer was used, the EC stated that was unknown and confirmed debris and organic matter could settle in the bowl. At 11:15 AM observation of racks of clean pans and acrylic food storage containers revealed a stack of nine full shallow steam table pans stacked with moisture in between the pans and a stack of five acrylic containers with moisture in between. The EC confirmed the moisture and removed the two stacks to be rewashed. At 11:20 AM, the Robo Coupe (food processor) was noted assembled with the blade inside with moisture in the interior. The EC confirmed the presence of moisture and took the bowl/blade to the dishwasher room.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 03/18/24 at 11:24 AM, the EC was questioned as to whether he was required to restrain his hair while he was in the kitchen and responded (as he fished a hairnet out of his pocket), When I heard you were here I just left the office and forgot to put it on.</p> <p>During an observation on 03/19/24 at 11:53 AM, of the second-floor kitchen revealed a staff member in a gray jacket walking through the kitchen without a hair restraint on. At 11:65 AM, the Certified Dietary Manager (CDM) joined the observation tour. A bin labeled Flour Sugar Powder Leavener was noted to have an expiration date of 02/11/24. At 12:02 PM the CDM stated It's full so it tells me he didn't change the sticker. At 12:03 PM another bin labeled chocolate candies and flavored chips was noted to have an expiration date of 02/11/24, when pointed out to the CDM, she picked up the bin and passed it through the window to the dishwasher. At 12:08 PM the staff member in the gray jacket walked out of the dishwash room and through the kitchen again. The CDM identified him as a title of Utility Healthcare (UHC)3 and instructed him to go to the office and get a hair restraint. At 12:10 PM when asked about the evening service time for the Rehab unit, the CDM stated that evening trays could be served from downstairs [first floor kitchen] occasionally. When asked how often per week that occurred, the CDM responded, Right now, every evening as we are short line cooks. The surveyor entered the dishwasher room by the three-compartment sink to observe UHC1 towel drying a sheet pan at 12:12 PM. When asked if he was trained to towel dry pans, UHC1 stated no. The CDM walked up as UHC1 was answering and stated, Not supposed to dry with a towel, air dry. UHC4 confirmed the sheet pan being towel dried had been washed in the three-compartment sink.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an observation 03/20/24 at 11:29 AM, of the Rehab mid-day meal service, Cook 1 was observed wearing gloves and slicing scallions. At 11:38 AM, meal service started and Cook 1 was observed to remove two portions of chicken with tongs from the steam table pan; held the chicken with gloved hands and sliced them on the cutting board, picked each portion up with gloved hands and placed them onto a plate. After serving the other food items, used the same gloved hands to place scallions and an orange slice on the plates as garnish. Cook 1 then went over by the cooler table and opened a bread wrapper, removed 4 slices of bread, uncovered the tuna salad in a deep 1/8 acrylic pan covered with plastic wrap, and placed tuna salad on the bread with a spoon. Cook 1 then opened the lettuce container, picked up two slices of lettuce and placed it on top of the tuna, cut the sandwich with a knife, and placed it on to a plate. Cook 1 then uncovered the pickle spears, picked up a spear and placed it on the plate, turned back by the griddle and removed the plastic wrap from a 1/3 deep steam table pan that contained potato chips, used his gloved hands, and then placed potato chips onto the plate with gloved hands. Cook 1 then retrieved a large jar of peanut butter from the shelf above the cold deli items, opened it, spread peanut butter on the bread while held in gloved hand, put the bread down, put the lid back on the peanut butter, opened the two-door refrigerator under the deli item cooler and retrieved a Smucker's grape squeezable jelly. The Cook then squeezed the jelly onto a slice of bread, spread the jelly with a spoon, picked up the knife, turned on the water in the sink to the right of the deli cooler items, rinsed the knife under the water, dried the knife with a towel at his waist, cut the sandwich, placed it on a plate, and served potato chips with his gloved hands onto plate. At 11:41 AM, Cook 1 changed his gloves and served the next plate which was sweet & sour shrimp. Cook 1 removed three shrimp from the steam table pan, chopped the shrimp and placed them in a bowl with his hand, ladled in sauce and mix, and then poured onto a plate. Next Cook 1 removed two pot stickers with tongs and chopped them with the same knife on the same cutting board, placed the chopped pot stickers onto the plate with gloved hands and knife, then chopped egg rolls in the same place with the same knife. All plates were garnished with orange slices and scallions via gloved hands. At 11:50 AM, Cook 1 left the steam table area to retrieve tongs, then opened a black zippered bag with orange handles, withdrew a squeeze bottle, used the tongs to open a steam table pan to pick up a hamburger, place it on the griddle, cover with a stainless-steel bowl, and squirt water (confirmed by Cook1) to steam the burger. Cook 1 then opened a bag of hamburger buns, removed one, squirted oil onto the griddle, opened the bun and placed down onto the oiled griddle. Cook 1 then opened the bread wrapper and removed two slices, laid them on the shelf by the deli cooler, commented if there were a lot of sandwiches ordered he would prep them in advance and keep them in the refrigerator, if not a lot he will make to order. At 11:52 AM, the Cook served a plate with stir fry vegetables using a spoodle (a serving utensil) and placed two egg rolls onto the plate by hand. Cook 1 proceeded to slice a serving of chicken with gloved hands, placed the sliced chicken on plate, and garnished with scallions and an orange slice. At 11:55 AM, Cook 1 removed lettuce and tomato with gloved hands, placed them onto a bun, held the other half of the bun in his other hand, added the hamburger patty, placed the hamburger onto a plate, and then added a pickle spear and potato chips with gloved hands. The last plate was served with two egg rolls placed on the plate by the gloved hand, sliced a serving of chicken, placed the chicken on plate with the same gloved hand and garnished the plate with scallions and a orange slice with same gloved hands. The service ended at 11:56 AM.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 03/20/24 at 12:42 PM, the CDM stated it was her expectation staff, depending on their station, if working prep or plating, [then staff] require a hair restraint. Dining room servers do not need a hair restraint, and the dishwashers usually wear a hat - but he (UHC3) had a lot of hair. The CDM also stated it was her expectation When handling ready to eat, cutting/chopping meat, using gloved hands to put food on plate, ready to eat defined anything not going to be cooked further, would be picked up with gloved hands or tongs. When queried if touching the bread product wrappers and door handles contaminated gloves, the CDM stated, if touching handles of things should definitely change gloves. The CDM did not confirm that touching bread wrappers would contaminate gloves.</p> <p>During an observation on 03/20/24 at 3:15 PM, of the first-floor kitchen prepping the evening meal items for the second floor Rehab, revealed UHC2 was preparing cantaloupe with no hair restraint. When mentioned to the EC at 3:19 PM, the EC stated the fruit was for the Rehab unit. The EC told UHC2 to go put his cap on and explained to him that whenever out here [kitchen area] [you] need that [hat] on when working with food.</p> <p>During an interview on 03/20/24 at 4:31 PM, regarding the number of Rehab residents that receive meals from the kitchen, the Director of Nursing (DON) stated, All residents on rehab receive their meals from the kitchen; nobody is NPO [nothing by mouth] or receiving tube feedings.</p>		

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<p>F 0841</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25335</p> <p>Based on observation, record review, staff interview, manufacturer' guidelines and review of the facility's policy and procedures, the facility failed to ensure the Medical Director worked with the facility to completely assess 1 of 5 residents (Resident (R)75) for unnecessary medications. Specifically, an antipsychotic and psychoactive medication was used by the facility without an attempted gradual dose reduction (GDR), proper medical rationale or proper indication for use.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Psychotropic Medication Guideline revised March 2022 revealed, The Medical Director will act in an administrative and supervisory capacity by A. Contributing to the establishment of the Medical Policies in to the establishment of the Medical Policies B. Supervising the medical care given C. Ensuring that the medical policies are carried out D. Participating in the Quality Improvement Program to identify areas of improvement of patient care E. Approving medical care procedures as set forth in the procedures Manual. and The Medical Director shall act as a liaison between attending physicians and the Directors of the respective healthcare areas, assuring compliance with regulations.</p> <p>Review of the Centers for Medicare and Medicaid S&Q Memo Ref 13-35-NH dated May 24, 2013 revealed, . The problematic use of medications, such as antipsychotics, is part of a larger, growing concern. This concern is that nursing homes and other settings (i.e., hospitals, ambulatory care) may use medications as a quick fix for behavioral symptoms or as a substitute for a holistic approach that involves a thorough assessment of underlying causes of behaviors and individualized, person-centered interventions . When antipsychotic medications are used without an adequate rationale, or for the purpose of limiting or controlling behavior of an unidentified cause, there is little chance it will be effective. In addition, they commonly cause complications such as movement disorders, falls, hip fractures, cardiovascular events (cardiovascular accidents and transient ischemic events) and increased risk of death .</p> <p>Review of the manufacturer's guideline for the use on Seroquel last updated 03/27/20 revealed under the section titled, Indications, Seroquel is used specifically for the treatment of bipolar disease and schizophrenia with a Black Box Warning Increased mortality in elderly patients with dementia-related psychosis.</p> <p>Review of R75's Face Sheet revealed R75 was admitted to the facility on [DATE] with diagnoses including but not limited to: pneumonia, unspecified organism, (idiopathic) normal pressure hydrocephalus and unsp (unspecified) dementia, unspecified severity, without beh/psych/mood/anx (behaviors/psychiatric/mood/anxiety).</p> <p>(continued on next page)</p>		

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<p>F 0841</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R75's Electronic Medical Record (EMR), Physician Orders and Medication Administration Record (MAR) dated March 2024, revealed orders dated 03/12/24 for Seroquel 25 mg (milligram) tablet (Quetiapine) 1 tablet ORAL Twice a Day for UNSPECIFIED MOOD [AFFECTIVE] DISORDER being administer daily starting 03/13/24, as prescribed, at 09:00 (9:00 AM) and 16:00 (4:00 PM); Seroquel 25 mg (Quetiapine) - 2 tablets ORAL Hour of Sleep. (Take with Quetiapine 200 mg to equal 250mg) For UNSPECIFIED MOOD [AFFECTIVE] DISORDER and Seroquel 200mg [Quetiapine] - 1 tablet ORAL Hour of Sleep. (Take with Quetiapine 50mg to equal 250mg) For UNSPECIFIED MOOD [AFFECTIVE] DISORDER being administered daily starting 03/12/24, as prescribed, at 21:00 (9:00 PM) with the exception of not having been administered on 03/13/24.</p> <p>On 03/19/24 at approximately 1:52 PM review of the [NAME] St. [NAME] Physician Partners discharge plan revealed continue .Seroquel .</p> <p>Review of R75's entry Minimum Data Set (MDS) did not indicate R75 had a psychiatric/mood diagnosis or that R75 was receiving a psychotherapeutic agent .</p> <p>Review of R75's March 2024 EMR failed to reveal the physician's rationale for prescribing Seroquel and there were no behaviors or psychosis documented on the MAR or in progress notes.</p> <p>On 03/19/24 at approximately 4:02 PM and on 03/20/24 at 11:55 AM, attempts were made to contact the Medical Director but were unsuccessful.</p> <p>On 03/20/24 at approximately 1:15 PM review of R75's Baseline Careplan revealed Administer medications as ordered and Dementia Care with no reference to a specific medication.</p> <p>During an interview on 03/20/24 at approximately 1:21 PM, the Administrator and Director of Nursing (DON) confirmed that R75 was receiving high doses of Seroquel during his recent hospitalization and subsequent to his admission to the facility on [DATE] and that this particular Medical Director was not working with the facility to have a complete assessment for continued use of psychotherapeutic agents. The reason being not wanting to mess with orders for long standing psychotherapeutic medications during a short term stay at the facility. The Administrator and DON stated that their expectation was for a complete and documented assessment by the Medical Director or prescribing physician to occur.</p>		