STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425143	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St George Healthcare Center	905 Duke Street Saint George, SC 29477

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and facility policy review, the facility failed to keep the kitchen's large manual can opener, a kitchen oven, stove top spill pan, and four kitchen drawers which had food preparation and service equipment stored inside clean. These failures had the potential to create an environment for food-borne illnesses which could affect 80 residents who consumed food prepared from the facility's kitchen.Findings include:Review of the facility's policy titled, Sanitation & Food Safety in Food and Nutrition Services, dated 10/15/25, specified, . Policy: The Certified Dietary Manager (CDM) will assume responsibility for the food safety and sanitation of the Nutrition Culinary Department. Procedures: 1. Infection control and sanitation practices are followed to minimize the risk of contamination of food and prevent food borne illness . 4. The CDM monitors food safety and sanitation of the Food and Nutrition Department daily. 5. The CDM develops, implements, and monitors a cleaning schedule that assigns specific cleaning responsibilities to specific individuals .1. Observation during the initial kitchen inspection on 02/15/26 from 8:25 AM to 8:50 AM, revealed the following unclean food preparation and service equipment that was stored and ready for use: a. The kitchen's large manual can opener was unclean with dried and sticky substances on its blade and table base attachment. b. A kitchen oven was unclean with accumulated dried and burned food spills in its inner cooking compartment.c. The kitchen's stove top spill pan was unclean with a heavy accumulation of dried food and burned food spills.d. The inner storage compartments of four kitchen drawers which had food preparation and service equipment stored in them including serving scoops, serving spoons, spatulas, ladles, tongs, adaptive eating utensils, and measuring cups were unclean with accumulated dried substances and loose food debris.During observation on 02/15/26 from 8:50 AM to 9:00 AM, the Dietary Manager (DM) was shown the above unclean kitchen equipment, and she confirmed the four kitchen drawers which housed food preparation and service equipment, the kitchen oven, the stove top's spill pan, and the kitchen's large manual can opener's blade and its table base attachment were unclean. During an interview on 02/15/26 at 9:00 AM, the DM stated the kitchen's drawers, kitchen oven, and stove top spill pan should be cleaned by staff weekly or as needed. The DM also stated the kitchen's large manual can opener, and its table base attachment should be cleaned after each use.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interviews, and policy review, the facility failed to implement processes to ensure: 1. staff verified and signed that the controlled substance count was correct at each shift change in the narcotic count books, and 2. controlled medications were maintained in a safe and secure manner to prevent loss or diversion. These failures were identified in four of four medication carts ([NAME] Unit - Medication Carts #1 and #2; Stone Unit - Medication Carts #1 and #2) observed for medication storage and labeling. This deficient practice created the potential for drug diversion, medication theft, and improper handling of controlled substance returns, which could impact patient safety and the facility's compliance with medication management requirements.Findings include:Review of the facility policy Section 2 - Controlled Substances, revised 04/17/2024, revealed, Policy: 1. The Facility will have systems in place to ensure the safe and secure storage of controlled substance medications. 2. The Facility will conduct routine reconciliations of all Controlled Substances to prevent any potential loss or diversion. Procedures: 4. A scheduled reconciliation (shift change count) of controlled substance inventory should be completed at every nursing shift change and documented as required by state regulations. H. Both staff members (off going and oncoming) sign the Controlled Substance Shift Change Sheet with the date and time of the shift change. K. In counting Controlled Substance drugs, the nurse/authorized staff member is alert for any evidence of a substitution or tampering by closely inspecting all tablets, solutions, and packages. If the oncoming nurse/authorized staff member, notices any defects in a drug container or products, they shall immediately report any suspicion of substitution or tampering with controlled drugs to the Director of Nursing.1. During an observation on 02/15/26 at 10:38 AM of Medication Cart #1 on [NAME] Unit with Licensed Practical Nurse (LPN)1, it was revealed the shift change sheet of controlled substance inventory was missing the signature of the oncoming nurse (LPN1) verifying that the medication count was correct. During audit of the controlled drug count, five blister cards containing controlled substances revealed punched, ripped, torn, or taped foil on the back of the card that secured the pill in the blister. The following was observed:- Chlordiazepoxide (benzodiazepine used to treat acute alcohol withdrawal, severe anxiety) 25 milligram (mg) capsules blister #13, #18, and #20 were ripped, torn, or punched open.- Oxycodone IR (immediate release) 5 mg tablets blister #14 was ripped, torn, or punched open.- Tramadol 50 mg tablets blister #14 was punched open and secured with a piece of transparent tape.- Lorazepam 0.5 mg tablets blister #7 was punched open and secured with a piece of transparent tape and blister #4 was ripped, torn, or punched open.- Tramadol 50 mg tablets blister #8 and #18 was ripped, torn, or punched open.During an interview on 02/15/26 at 10:45 AM, LPN1 said that she was required to sign the inventory count sheet with the off-going nurse after the narcotics were counted to verify that the count was done and the count was correct. LPN1 said that the exposed pills could be less effective, could fall out, or someone could take the pills for personal use. LPN1 said the procedure would be to ask another nurse to witness the destruction of the pill and sign that the pill was wasted.2. During an observation on 02/15/26 at 11:23 AM of Medication Cart #2 on [NAME] Unit with LPN2, it was revealed the shift change sheet of controlled substance inventory was missing the signature of the oncoming nurse (LPN2) verifying that the medication count was correct. During audit of the controlled drug count, three blister cards containing controlled substances revealed punched, ripped, torn, or taped foil on the back of the card that secured the pill in the blister. The following was observed:- Hydrocodone/APAP (acetaminophen) 5/325 mg tablets, blister #27 was punched open and secured with a piece of transparent tape.- Tramadol 50 mg tablets, blister #18 was punched open.- Tramadol 50 mg tablets, blister #1 was ripped, torn, or punched open.During an interview on 02/15/26 at 11:30 AM, LPN2 said that she forgot to sign the narcotic inventory sheet when she finished counting with the off-going nurse. LPN2 said there was a potential for loss or theft (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of controlled medications when the package was not secured. LPN2 said that she would notify the Director of Nursing (DON) of the unsecured medications.3. During an observation on 02/15/26 at 1:03 PM of Medication Cart #1 on Stone Unit with Registered Nurse (RN)3, it was revealed the shift change sheet of controlled substance inventory was missing the signature of the oncoming nurse (LPN3) verifying that the medication count was correct. During audit of the controlled drug count, two blister cards containing controlled substances revealed punched, ripped, torn, or taped foil on the back of the card that secured the pill in the blister. The following was observed:- Tramadol 50 mg tablets, blister #28 was punched open and secured with a piece of transparent tape.- Tramadol 50 mg tablets, blister #5 was ripped, torn, or punched open.During an interview on 02/15/26 at 1:07 PM, LPN3 said that she was supposed to sign the narcotic inventory sheet when she finished counting with the off-going nurse. LPN3 said that she did not check the back of the cards when she counted to hold the off-going nurse responsible for any discrepancies. LPN3 said that the blister cards appeared to be tampered with when there was any break in the seal.4. During an observation on 02/15/26 at 1:13 PM of Medication Cart #2 on Stone Unit with RN2, it was revealed three blister cards containing controlled substances with punched, ripped, torn, or taped foil on the back of the card that secured the pill in the blister. The following was observed:- Lorazepam 0.5 mg tablets, blister #12 was ripped, torn, or punched open.- Oxycodone/APAP 5/325 mg tablets, blister #7 was ripped, torn, or punched open.- Oxycodone/APAP 5/325 mg tablets, blister #8 was ripped, torn, or punched open.During an interview on 02/15/26 at 1:20 PM, RN2 said that it did not look like the back of the blister was punched all the way through. RN2 said that it was a risk of drug diversion whenever a seal was broken. RN2 said that she would notify the DON right away.During an interview on 02/15/26 at 1:45 PM, the DON said that the nurses and Unit Manager were responsible for overseeing procedures that prevented drug diversion such as monitoring the inventory log sheets and actual narcotic count.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on record review, interviews, and review of the Resident Assessment Instrument (RAI) Manual 3.0, the facility failed to ensure Minimum Data Set (MDS) assessments were transmitted within the required timeframes specified for one of 23 sampled residents (Resident (R) 68) reviewed for MDS. This failure had the potential for inaccurate or incomplete care planning and/or provision to the residents, and/or a lack of appropriate payment for services to the facility.Findings include:Review of the RAI Manual 3.0, dated 10/2019, revealed . OBRA [Omnibus Budget Reconciliation Act] required comprehensive assessments include the completion of both the MDS and CAA process, as well as care planning. Comprehensive assessments are completed upon admission, annually, and when a significant change in a resident's status has occurred or a significant correction to a prior comprehensive assessment is required . The MDS completion date (item Z0500B) must be no later than 14 days from the ARD [Assessment Reference Date] . and no later than 14 days after the determination that the criteria for an SCSA [Significant Change in Status Assessment] were met. This date may be earlier than or the same as the CAA(s) completion date, but not later than .Review of R68's undated Face Sheet from the electronic medical record (EMR) Resident tab revealed a facility admission date of 04/24/23 with medical diagnoses that included type II diabetes mellitus, chronic kidney disease, and altered mental status.Review of R68's annual MDS with an Assessment Reference Date (ARD) of 01/10/26, located in the EMR under the RAI tab and the MDS 3.0 Assessments tab, revealed it was signed by the Minimum Data Set Coordinator (MDSC)2 as completed on 01/16/26. However, the status of this assessment was noted as Production Rejected. Further review of R68's MDS assessments revealed the resident's quarterly MDS assessment, with an ARD of 10/10/25, was R68's most recent assessment that had been successfully transmitted to the Centers for Medicare and Medicaid Services (CMS).During an interview on 02/17/26 at 10:10 AM, MDSC1 and MDSC2 reviewed R68's annual MDS, with an ARD date of 01/10/26, and confirmed the assessment's status was Production Rejected and had not been transmitted to CMS. MDSC2 confirmed that she signed the resident's annual MDS as complete on 01/16/26 but did not know why it was noted as rejected and was not transmitted to CMS.During an interview on 02/17/26 at 10:45 AM, MDSC1 stated she rejected R68's annual MDS, with an ARD of 01/10/26, and failed to transmit this assessment to CMS. MDSC1 stated she could not recall why she rejected this assessment but would transmit this MDS to CMS on 02/17/26. During an interview on 02/17/26 at 5:05 PM, the Administrator stated she expected MDS assessments to be transmitted to CMS on time. The Administrator stated the facility did not have MDS policies but used the RAI Manual for their MDS procedures.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and policy review, the facility failed to ensure nursing staff were competent in gastric tube (GT) management, including verifying tube placement prior to flushing and performing GT replacement, for one of three residents (Resident (R) 6) reviewed for tube feeding management out of a total sample of 23. The facility failed to ensure staff competency was validated through return demonstration of GT-related skills, use of a competency checklist, and evaluation of staff performance following training prior to providing direct resident care. This failure placed R6 at risk for aspiration, respiratory distress, and injury if fluids were administered into a GT that was not correctly positioned or if the tube was improperly replaced at the bedside.Findings include:Review of the facility policy titled, Staff Development for Nursing Employees, revised 01/01/24, revealed Policy: 1. Staff development and learning through ongoing education including in-servicing, training, and other activities that improve staff's competence will be offered according to Facility Policies and Procedures . 2. The nursing staff will receive initial job training and an assessment of their ability to perform specific job duties as well as an understanding of the Facility . Purpose: To ensure that all nursing staff possess the appropriate competencies and skills sets necessary to provide nursing and related services to meet the residents' needs safely and in a manner that promotes each residents' rights, physical, mental, and psychosocial well-being.Review of the facility policy titled, Gastrostomy Tue Replacement (Balloon Type), revised May 5, 2023, revealed Policy: The qualified nursing staff will replace balloon type gastrostomy tube as guided by: State specific nurse practice acts . 15. Feeding/Medication administration is held until placement has been verified and documented by the physician, his/her designee (Nurse Practitioner, Enterostomal Therapist experienced in Gastrostomy Tube replacement, or qualified licensed nurse) as determined by attending physician. The feeding is held for a clinically appropriate time as determined by the attending physician in order to prevent dehydration/loss of nutrition. 16. Document.Review of R6's Resident Face Sheet, located under the Resident tab of the electronic medical record (EMR), revealed R6 was admitted to the facility on [DATE], the latest return to facility was 11/29/23. R6 had diagnoses that included dysphagia following cerebral infarction (trouble swallowing after stroke), gastroesophageal reflux disease ([GERD] chronic acid reflux) without esophagitis (inflammation, irritation, or swelling of the esophagus lining), and gastrostomy (G-tube) status. R6 received hospice services as of 11/21/25.Review of R6's Orders, located under the Resident tab of the EMR, reflected the following orders:Order date: 11/18/22 - Enteral Feeding: Placement Verification - Check Residual Special Instructions: If residual 150 ml [milliliters] or less reinsert volume into stomach and continue feeding. If greater than 150 ml, hold feeding and notify physician.Order date: 10/12/23 - Enteral Feeding: Flush tube with 30 cc's [cubic centimeters] warm water before and after medication administration Every ShiftOrder date: 08/13/25 - Eternal Tube: 16 Fr [French] g-tube with 5cc balloon may change for displacement, damage, occlusion As NeededOrder date: 01/27/25 - 30 mL of water before and after medication administration via gtube Every ShiftOrder date: 02/15/26 - Enteral Feeding: May change NG/G (nasogastric/gastric) Tube for displacement/damage/occlusion As NeededReview of R6's Care Plan, dated 02/18/22 and located under the RAI (Resident Assessment Instrument) tab of the EMR, reflected a category for Category: Feeding Tube [R6] requires tube feeding R/T [related to] history of oral cancer. Interventions included Check placement and patency of feeding tube before each feeding or medication administration. During an observation on 02/15/26 at 9:51 AM, Licensed Practical Nurse (LPN)1 disconnected the formula tubing from R6's GT feeding port. LPN1 did not verify GT placement by checking gastric residual as ordered prior to attempting to flush the tube. LPN1 poured approximately 30 cc of water into a syringe connected to the feeding port; however, the water did not infuse, indicating the GT was not patent. LPN1 then poured the water from the syringe (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	into a cup, detached the syringe, replaced the cap on the feeding port, and left the room.During an interview on 02/15/26 at 10:08 AM, prior to re-entering R6's room, LPN1 stated she had spoken with the Director of Nursing (DON), who instructed her to use the syringe plunger to push the water through the GT. LPN1 stated that she would verify tube placement by pushing air into the GT with a syringe while listening to the stomach with a stethoscope near the insertion site, explaining this was the method she learned in school. LPN1 acknowledged that pushing water through the GT without verifying placement could place R6 at risk for aspiration. LPN1 then left to retrieve a stethoscope.During observation and interview on 02/15/26 at 12:34 PM, LPN1 attached a 60-cc syringe to R6's GT feeding port and withdrew gastric contents to check residual, then returned the residual. LPN1 removed the plunger from the syringe, reattached the syringe to the feeding port, poured approximately 30 cc of water into the syringe, and the water infused by gravity through the GT without difficulty. LPN1 stated the water flowed without a problem because the DON had replaced the gastric tube. When asked to clarify, LPN1 confirmed the DON had removed the previous gastric tube and inserted a new gastric tube. LPN1 said that she was not sure if it was scheduled to replace the GT and confirmed that no other interventions were tried to unclog the GT before replacing it.During an interview on 02/15/26 at 2:07 PM, the DON verified that he replaced R6's GT and was going to document as soon as possible. The DON said that R6 had an order to replace the GT as needed. The DON said that he received training, was checked off for competence, and replacing the GT was within his scope of practice. The DON said that it was the facility protocol to replace a resident's GT at the bedside if it would avoid sending a resident to the hospital unnecessarily.Review of R6's Treatment Administration Report (TAR), located under the Resident tab of the EMR, reflected LPN1's initials on 02/15/26 at 2:12 PM, next to the order for Eternal Tube: 16 Fr g-tube with 5cc balloon may change for displacement damage occlusion. In the comment section, LPN1 wrote blockage for the reason the GT was replaced.Review of R6's Progress Notes, located under the Resident tab of the EMR, dated 02/15/26 at 6:10 PM, and written by LPN1, revealed, G tube was blocked and not flushing. PRN [as needed] order administered by DON, resident tolerated well. G tube change effective and flushing well. No distress noted.During an interview on 02/16/26 at 12:17 PM, the Assistant Director of Nursing (ADON) stated she served as the nurse educator and was responsible for ensuring nursing staff competency skills checkoffs were completed during new-hire orientation, annually, and as needed. The ADON stated nurses were not permitted to perform skilled care without demonstrating competency. The ADON stated training and competency documentation were maintained in personnel files by the Human Resources (HR) department.Review of LPN1's personnel file, provided by the Administrator, revealed a date of hire of 10/28/25. Documentation showed LPN1 completed competency validation on 10/28/25 for Isolation - Standard and Transmission-Based Precautions, Handwashing, and Perineal Care, evaluated by Registered Nurse (RN) 1. The personnel file did not include training transcripts, graded tests, or competency validation for GT management or GT replacement.Review of the DON's personnel file, provided by the Administrator, revealed a promotion from LPN to RN DON on 05/10/24. The DON's file included competency documentation for multiple nursing skills; however, there was no documentation of training or competency validation for gastric tube management or replacement. The DON's competencies had been evaluated by the ADON.Review of the ADON's personnel file, provided by the Administrator, revealed a promotion from LPN to ADON on 03/15/23. The ADON's file did not include documentation of training or competency validation for gastric tube management or replacement.