STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425341	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Moultrie Nursing Home	1038 McGill Lane Saint Stephen, SC 29479

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on facility policy review, record review, observation, and interview, the facility failed to ensure the medication error rate was less than 5 percent (%). The facility made 3 medication errors out of 27 opportunities, affecting 1 (Resident (R)4) of 6 residents reviewed during the medication administration task, resulting in a medication error rate of 11.11%. Findings included: Review of the facility policy titled, Administration Procedures for All Medications, revised on 02/25/2025, indicated the purpose was, To administer medications in a safe and effective manner. The policy also indicated, Q. Notification of attending physician: 1) Consistent refusal of medications or as clinically indicated. Review of the facility policy titled, Enteral Tube Medication Administration, revised on 02/25/2025, indicated, The facility assures the safe and effective administration of enteral formulas and medications via enteral tubes. Selection of enteral formulas, routes and methods of administration, and the decision to administer medications via enteral tubes are based on nursing assessment of the resident's condition, in consultation with the physician, dietician, and consultant pharmacist. Review of R4's admission Record revealed the facility admitted R4 on 02/18/2025. According to the admission Record, the resident had a medical history that included but was not limited to diagnoses of, Parkinson's disease (a progressive neurological disorder that primarily affects movement), encounter for attention to gastrostomy (a feeding tube inserted directly into the stomach), dysphagia (difficulty swallowing), personal history of pulmonary embolism (a blood clot in an artery of the lungs), and an encounter for Palliative Care. Review of R4's March 2026 physician Order Summary Report contained the following active orders: 1. An order dated 11/06/2025 for apixaban (a medication to thin the blood) 5 milligrams (mg), one tablet by mouth every morning and at bedtime; 2. An order dated 11/06/2025 for carbidopa-levodopa (a medication used to treat Parkinson's disease) 25 mg-100 mg, two tablets by mouth three times a day; and 3. An order dated 08/19/2025 for lorazepam (a medication used to reduce anxiety) 0.5 mg, one tablet by mouth or sublingual every morning and at bedtime. Review of R4's electronic medical record (EMR) clinical report revealed Special Instructions that indicated peg tube [G-tube] in place for flushing only. During a concurrent observation of medication administration and an interview with Registered Nurse (RN)1 on 03/11/2026 at 8:12 PM, the RN removed one lorazepam 0.5 mg tablet, two carbidopa/levodopa 25 mg-100 mg tablets, and one apixaban 5 mg tablet from their packaging and placed each medication in a separate medication cup. The observation revealed that RN1 crushed each medication and kept the medications in individual medication cups. RN1 stated she usually administered R4's medications by mouth, but the resident also had a G-tube, and she could administer R4's medication either route. RN1 stated she did not know the route that was ordered for the medications and indicated she gave R4's medications by mouth when the resident was awake and by G-tube when they were asleep since the resident was at high risk for aspiration. The observation revealed RN1 then entered R4's room and placed the cups of crushed carbidopa/levodopa 25 mg-100 mg, lorazepam 0.5 mg, apixaban 5 mg, on a bedside table, obtained water from the sink, filled each medication cup with 15 milliliters (ml) to 25 ml of water, and administered each of the medications via R4's G-tube. During an interview on 03/11/2026 at 8:41 PM, RN1 stated that she gave R4's lorazepam, carbidopa/levodopa, and apixaban via G-tube, although the order indicated to administer the medications by mouth. RN1 stated R4 took their medications by (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

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mouth during the day, and she administered the resident's medications via G-tube at night when they were sleeping. RN1 stated she did not clarify the route ordered for R4's medications because R4 had a G-tube. During a telephone interview on 03/12/2026 at 10:56 AM, RN1 stated that R4's medications should be given according to the route ordered by the physician and that she should have called the physician to get an order to give the medication via G-tube. During a telephone interview on 03/12/2026 at 11:08 AM, the Consultant Pharmacist stated she visited the facility monthly and had access to view R4's medication physician orders from her computer. She stated that R4's apixaban and carbidopa/levodopa were both ordered to be given by mouth, and lorazepam was ordered to be given by mouth or sublingual. The Consultant Pharmacist stated her expectations were that medications be given per physician orders. She stated she was not aware that staff were administering R4's medications by mouth during the day and via G-tube at night. During an interview on 03/12/2026 at 12:22 PM, the Director of Nursing (DON) reviewed R4's physician-ordered medications on her computer and stated R4's physician order for apixaban and carbidopa/levodopa revealed the medications should be given by mouth, and lorazepam was ordered to be given by mouth or sublingual. The DON stated her expectations were that all medications be administered according to the physician orders. During an interview on 03/12/2026 at 12:38 PM, the Administrator reviewed a copy of R4's physician orders and stated her expectation was for R4 to receive lorazepam 0.5 mg by mouth or sublingual, apixaban 5 mg by mouth, and carbidopa/levodopa 25 mg-100 mg by mouth as per the physician orders. The Administrator stated that medications should be given as physician ordered or when needed, nursing staff should obtain a new physician order to change the route of medication administration. During a telephone interview on 03/12/2026 at 1:22 PM, the Nurse Practitioner (NP) stated she was not aware that the facility was administering R4's daytime medications by mouth and nighttime medications via G-tube. The NP stated her expectation was that staff administer R4's lorazepam 0.5 mg by mouth or sublingual, apixaban 5 mg by mouth, and carbidopa/levodopa 25 mg -100 mg by mouth as per the physician orders. The NP stated RN1 should have contacted her or the physician on call about the route of administration for the night medications or should have followed the physician's order.