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	09/08/2022

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

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 0806 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 46991 Based on review of facility policy, record review, and interviews, the facility failed to ensure Resident (R)6 was served meals in accordance with allergies, intolerances, and preferences for 1 of 2 residents reviewed for Nutrition. Specifically, the facility served R6 shrimp, which had the potential of resulting in a life threatening incident. Findings include: Review of the facility's policy titled, Nutrition dated 08/01/20, revealed The Nutrition Service Director (NSD) or designee is responsible for training culinary staff on how to handle foods to avoid any inappropriate foods being served to patients or residents with food allergies. This may include special designated food preparation space in the case of life threatening food allergies. If using the MEALTRACKER computerized tray tickets, the word allergic to may be printed on the ticket using dietary notes, as well as recorded in the allergy section of the system. Food allergies are clearly communicated to culinary personnel. The facility admitted R6 on 10/07/20, with diagnoses included but not limited to; Alzheimer's disease, dysphasia, anaphylactic shock, and heart disease. Review of R6's Face Sheet located in the Electronic Medical Record (EMD) indicated R6 had known allergies to; Donzepil (medication used to treat Alzheimer's disease), seafood, shrimp, and shellfish. Review of R6's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/04/22 revealed R6 has a Brief Interview for Mental Status (BIMS) score of 0 out of 15, which indicates R6 is rarely or never understood. Review of R6's Care Plan dated 04/08/22, located in the EMR, revealed R6 has moderately impaired vision and is allergic to Donzepil, seafood, shellfish, and shrimp. (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 0806 Level of Harm - Actual harm Residents Affected - Few	Review of R6's Progress Note dated 06/10/22 revealed, Director of Nursing was called to the room by CNA because [R6] was throwing up. While entering the room resident vomited on himself. After checking [R6's] vital signs, lung sounds was assessed. It was discovered that [R6] had received food during lunch time that had shrimp on it. It was noticed that resident had allergies to seafood, shrimp and shellfish. Nurse Practioner was notified and ordered [R6] to have a one time dose of Benadryl 25mg, to do neuro checks and monitor for any reactions. Resident's sister was notified of incident and DON. Review of R6's Progress note dated 08/19/22 revealed, Review of Residential Progress Note dated 8/19/22 (but late entry on 8/22/22) states on Friday 8/19/2022 after lunch, resident was sent out to ER after eating shrimp which he is allergic. Unit Manager was notified and two 25mg tabs of Benadryl was administered. Physician Assistant was notified in the building and she went to evaluate. Resident starting swelling and he is semi-verbal but could not express himself. Two more 25mg Benadryl and 20 mg Pepcid was administered. Resident's family was notified. Review of R6's Meal Ticket for multiple dates revealed R6 in on a mechanical altered diet and has allergies to chocolate, seafood, shrimp, shellfish, and fish. Review of the facility's week at a glance menu for week 1, revealed the following food items were served on Friday; shrimp scampi, spinach salad, oatmeal peanut bar, fresh baked roll, and roasted red potatoes. Further review of the facility's menu did not indicate any other days that shrimp was served. In an interview on 09/08/22 at approximately 12:50 PM with the Kitchen Manager (KM), revealed she was aware R6 had received shrimp on his meal tray on 08/19/22. The KM stated the Cook did not read the ticket. It says alternate food, she failed to follow through. The KM further stated, this is an ongoing process and they keep reminding workers to review the ticket. In an interview on 09/08/22 at approximately 12:56 PM with Cook (C1), revealed she is responsible for serving and plating food. C1 verified R6 had shrimp on his meal plate (during the day of the incident). C1 further stated she is aware that R6 is allergic to shrimp and followed up with, It was busy. I made a mistake. I went to see if [R6] ate it and asked another CNA if she saw his tray. I told them I made a mistake and gave him shrimp. C1 concluded that later R6 had a reaction (itching and scratching) and the nurse gave him an allergy pill. An attempted interview on 09/08/22 at approximately 4:26 PM with R6 was unsuccessful. In an interview on 09/08/22 at approximately 4:28 PM with the Administrator, revealed she was aware of the incident and the kitchen was ultimately responsible. The Administrator stated she was walking down the hall and saw staff around R6. She asked what happened and someone said he (R6) was having a reaction. They decided to send him out to the hospital. The Administrator further stated he couldn't communicate and they called 911. Follow up with the kitchen revealed C1 admitted she served him shrimp. The Administrator concluded the kitchen is ultimately responsible and should have known he is allergic.