STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425082	A. Building B. Wing	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Health and Rehab	2375 Baker Hosp Blvd Charleston, SC 29405

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility policy, the facility failed to: 1.) promote the resident's right to dignity for 128 of 147 residents who ate food from the kitchen when meals were served in Styrofoam containers, and 2.) protect the resident's right to physical privacy during medication administration for one of 34 sampled residents (Resident (R)77), reviewed for resident rights. These failures had the potential to affect the dignity and psychosocial wellbeing of the residents. Findings include: A request for a meal service policy was requested on 04/14/25 at 3:45 PM and on 04/15/25 at 11:30 AM. The policy was not provided prior to the survey exit. 1. During an observation of meal service on 04/13/25 at 9:15 AM, residents received their breakfast trays served on Styrofoam containers. During an interview on 03/13/25 at 9:30 AM, the [NAME] stated she arrived at work to find dirty pots, pans, and dishes from the previous evening meal service and did not have enough time to wash dishes prior to serving the breakfast meal. The [NAME] stated she also served resident meals in Styrofoam containers for the breakfast and lunch meals on Saturday 04/12/25, because she was running behind schedule. During an interview on 04/16/25 at 10:45 AM, the Dietary Manager (DM) stated that serving meals to residents in Styrofoam containers was not acceptable and that the evening kitchen staff on 04/12/25 should have cleaned and prepared the kitchen for the morning meal service. Review of the facility's undated policy titled, Resident Rights revealed, . The facility protects and promotes the rights of each resident in our care . Each resident has the right to privacy with regard to accommodations, treatment, communications, personal care, visits and meetings of family and resident groups. 2. Review of R77's admission Record, located in the Profile tab of the electronic medical record (EMR), revealed R77 was admitted to the facility on [DATE], with diagnoses that included but was not limited to: congestive heart failure and neuromuscular dysfunction of bladder. (continued on next page)

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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R77's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/06/25 and located in the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. Review of R77's Physician Orders, located in the Orders tab of the EMR, revealed R77 was to receive insulin glargine (a long-acting insulin) 100 unit/mL, 28 units once a day and Renacidin (citric ac-gluconolact-mag Carb, a sterile irrigating solution), 1980.6 mg-59.4 mg-980.4mg/30mL; 30 ml irrigation to his suprapubic catheter for 10 minutes and drain once a day. During an observation on 04/14/25 at 9:10 AM, Licensed Practical Nurse (LPN)2 entered R77's room, left the door wide open, approached R77, and did not close the privacy curtain. R77 could be seen from the hallway. LPN2 raised R77's shirt above his abdomen and administered R77 his long-acting insulin to the lower left quadrant, while R77 lowered the waistband of his pants to access his suprapubic catheter. LPN2 then administered the Renacidin irrigation solution into the catheter tube. R77 used one hand to hold both the tube and the top sheet up for privacy. R77 used other hand to pour the irrigation solution. During an interview on 04/14/25 at 9:25 AM, LPN2 stated, I had to leave [R77]'s door open so that I could watch my unlocked med cart and laptop screen. [R77] held up the top sheet so no one could see. But normally I would pull the privacy curtain to give them their privacy. During an interview on 04/14/25 at 10:20 AM, Registered Nurse (RN)1 stated, All the staff know that you must provide patient privacy. My expectation is that nurses lock their med carts and minimize their laptop screens so that they can provide privacy. That's what [LPN2] should have done. During an interview on 04/14/25 at 10:24 AM, the Director of Nursing (DON) stated, All the staff know to always provide privacy during all patient care no matter what it is. That is my expectation too, with no exceptions. [LPN2] . should have provided privacy.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Review of R108's Face Sheet, located in the EMR under the Profile tab, revealed R108 readmitted to the facility on [DATE], with diagnoses that included but was not limited to: End Stage Renal Disease, urinary tract infection, diabetes mellitus, and essential hypertension. Review of R108's quarterly MDS, with an ARD of 02/28/25 and located in the EMR under the RAI tab, revealed R108 had a BIMS score of 15 out of 15, which indicated R108 was cognitively intact. Review of R108's Physician's Orders, located under the Orders tab of the EMR, revealed no order for self-administration of medication. During an interview and observation on 04/14/25 at 1:00 PM, R108 was observed lying in bed. A medication cup containing eight medications was noted on her overbed table. R108 was asked why her medications were left and had not been taken. R108 stated, I had fallen asleep and forgot to take them. R108 picked up her medications and took them. During an interview on 04/14/25 at 1:09 PM, LPN2 confirmed that she had administered R108 medications and did not observe the resident taking them. The surveyor asked LPN2 to verify the medications that were left. LPN2 stated, Vitamin C, Aspirin, Vitamin B, Vitamin B 12, Iron Pill, Keppra, Methocarbamol, Metoprolol and Neurontin. LPN2 stated R108 had not been assessed for self-administration and it was not facility policy to leave medications unattended. During an interview on 04/15/25 at 3:03 PM, the DON confirmed R108 had not been assessed for self-administration of medications. The DON stated it was her expectation that medications are not left unattended with any residents. She stated nursing staff were to monitor all residents taking medications. Based on observation, interview, record review, and facility policy review, the facility failed to assess a resident's ability to self-administer medications for two of two residents (Resident (R)77 and R108) reviewed for self-administration of medications out of a total sample of 34. This had the potential to cause medication administration errors and adverse consequences. Findings include: Review of the facility's policy titled, Pharmacy Services Policies and Procedures, revised on 04/17/24, revealed, . The resident may choose to self-administer medication(s) according to applicable state and federal law and regulation upon completion of an assessment by the Interdisciplinary Care Team (IDT). 1. Review of R77's admission Record, located in the Profile tab of the electronic medical record (EMR) revealed R77 was admitted to the facility on [DATE], with diagnoses including but not limited to: congestive heart failure. Review of R77's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/06/25 and located in the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R77's Physician Orders, located in the Orders tab of the EMR, revealed R77 was to receive: Amlodipine (a calcium channel blocker to treat hypertension), five mg once a day, Amiodarone (an antiarrhythmic), 200 mg once a day, Atorvastatin (a statin), 10 mg once a day, Docusate sodium (a laxative), 100 mg twice a day, Diazepam (a benzodiazepine), two mg three times a day, Loratadine (an antihistamine), 10 mg once a day, Magnesium oxide (a minerals/electrolyte), 500 mg once a day, Methenamine hippurate (an anti-infective), one gram once a day, Metoprolol tartrate (a beta blocker to treat hypertension), 25 mg twice a day, Famotidine (an H2 blocker (acid reducer)), 20 mg twice a day, Actobacillus acidophilus (a probiotic), 1.5 mg (250 million cell) twice a day, Ergocalciferol (vitamin d2, a dietary supplement), 1,250 mcg (50,000 unit) once a day on Monday, and Cyanocobalamin (vitamin B-12, a dietary supplement), 500 mcg once a day. During an observation and interview on 04/14/25 at 9:10 AM, Licensed Practical Nurse (LPN) 2 placed a medicine cup containing 13 pills on R77's bedside table and left the room prior to R77 consuming the medications. R77 was observed to have a half bottle of Tums on his bedside table. LPN2 stated, We're not allowed to leave meds at the bedside, but [R77] likes to take his meds with his breakfast. So, I go pass the next room's meds and come back to check on [R77] to make sure he took all his meds. He likes to do things his way. He has that bottle of Tums whenever he needs them, but I don't think he takes them regularly. I'll have to look to see if he has an order for them. He orders a lot of his own meds from Amazon. I know he doesn't have an assessment to self-administer his own meds, but like I said, [R77] likes to do things his way. During an interview on 04/14/25 at 9:35 AM, R77 stated, The Tums just sit there, and I take them as an emergency in case the Pepcid doesn't work. I bought them on Amazon. The doctor has seen them on my bedside table every time they come to see me and have never said a word about them. I haven't had one in four months. I dropped most of them on the floor and that's why they're gone. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 04/14/25 at 10:20 AM, Registered Nurse (RN)1 stated, The nurses don't leave meds at the bedside. We don't have any residents that are assessed to self-administer their own meds. [LPN2] should have watched R77 take his meds or return with them when he was ready to take them. We do have a few residents that order their own meds from Amazon. We make rounds checking for meds in rooms, remove them, and educate them. RN1 entered R77's room, informed R77 that he was not allowed to have medications in his room, and she would need to remove them. RN1 informed R77 that they could call the doctor to get orders for the medications to be left at the bedside. During an interview on 04/14/25 at 10:24 AM, the Director of Nursing (DON) stated, Nurses are not supposed to leave meds at bedside with any resident. [LPN2] knows that is the policy and she will be reeducated immediately. The DON stated, We don't have any residents that self-administer their own meds. We do have a few residents that try to order their own over the counter meds from Amazon and we must monitor for that. We remove the meds and reeducate them that they are not allowed to because other residents could come and take them.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility policy, the facility failed to implement therapy recommendations for the use of hand splints for three of three residents (Resident (R)40, R102, and R15) reviewed for contractures out of a total sample of 34. This failure had the potential to increase limited range of motion, deformities, and pain. Findings included: Review of the facility's policy titled, Restorative Nursing Policies and Procedures, revised 10/25/24, revealed, . The Nurse completes the Restorative monthly summary to include overall status in the program, progress toward care plan goals, and program recommendation. Documentation must be completed as per state specific guidelines . documents on all programs during look back of Minimum data set (MDS) . Patients/Residents in a Joint Mobility/Splint Program are reassessed on a regular basis (quarterly), and as needed (significant change). The plan of care is reviewed by the interdisciplinary team and revised as needed. Reassess as per nursing assessment and follow trigger guidelines . appropriate candidates for the Nursing Restorative (range of motion) ROM Program may include, but are not limited to, patients/residents with the following conditions: Contractures . 1. Review of R40's Face Sheet, located in the electronic medical record (EMR) under the Face Sheet tab, revealed R40 was readmitted to the facility on [DATE], with diagnoses that included but was not limited to: cerebral palsy, quadriplegia, unspecified and contracture, unspecified joint. Review of R40's Care Plan, located in the EMR under the RAI tab and initiated on 05/08/24, revealed, . [R40] has, requires assistance with ADL's [activities of daily living] r/t [related to] Cerebral Palsy . LUE [Left Upper extremities] d/t [due to] contracture. Review of R40's Occupational Therapy (OT) Discharge Summary, provided by the facility and dated 03/05/25, revealed, . Discharge Recommendations: LHS [Left right hand splint] three hours a day as tolerated to prevent worsening contractures . Review of R40's EMR, including Orders, Medication Administration Records (MARs), Treatment Administration Records (TARs), and Care Plan tabs revealed no orders or treatments for R40's left hand contracture per OT discharge recommendations. The Care Plan had not been updated to reflect the OT discharge recommendations for the use of a left hand splint. During an observation and interview on 04/13/25 at 10:49 AM, R40 was resting in his room. A blue hand splint was noted on the resident's dresser. R40 stated that while on therapy services, therapy staff would place the splint on his left hand, but since I do not have therapy anymore, no one puts it on me. R40 confirmed that he was unable to put the brace on without assistance. 2. Review of R102's Face Sheet, located in the EMR under the Face Sheet tab, revealed R102 was admitted to the facility on [DATE], with diagnoses that included contracture, unspecified joint. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R102's Occupational Therapy Discharge Summary, provided by the facility and dated 03/04/25, revealed, . Discharge Recommendations: Continue use of RHS [right hand splint] with nursing staff . It was recorded R102 was to use the splint three hours per day as tolerated to prevent worsening contractures. Review of R102's Care Plan, located in the EMR under the RAI tab and dated 03/04/25, revealed, . [R102] has (L) hand splint . [R102] requires assistance with ADL's R/T COPD, Muscle wasting and atrophy . R hand contracture . The care plan did not address use of the right hand splint. Review of R102's EMR, including Orders, MARs, and TARs tabs revealed no order or treatments for R102's right hand contracture per OT discharge recommendations. During an observation on 04/13/25 at 12:36 PM and 04/14/25 at 1:49 PM, R102's right hand was noted to be contracted inwards at the wrist at a 90-degree angle. R102's splint was observed laying on the resident's bedside table at each observation. During an interview on 04/14/25 at 3:49 PM, the Rehabilitation Director stated the tracking and placement of splints had been a concern. The Rehabilitation Director stated that once a resident was discharged from rehabilitation services, orders were not implemented related to the therapist's recommendations. During an interview on 04/14/25 at 4:10 PM, the Director of Nursing (DON) confirmed that there had been a communication failure between nursing and therapy. The DON stated her expectation was for orders to be placed to reflect therapy recommendations. During an interview on 04/15/25 at 10:20 AM, the Regional Director of Rehabilitation revealed she was aware of the disconnect between the therapy department and nursing and the concern was currently being addressed. 3. Review of R15's Face Sheet, located under the Resident tab of the electronic medical record (EMR), indicated the resident was admitted to the facility on [DATE], with diagnoses that included but was not limited to: epilepsy, right hand contracture, and aphasia following cerebral infarction. Review of R15's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/18/25 and located in the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 99 out of 15, which indicated the resident was severely cognitively impaired. The assessment indicated the resident had functional limitation in range of motion to the upper extremity on one side and that R15 was dependent on staff for self-care and mobility and did not reject care. Review of R15's Physician Orders, located under the Resident tab of the EMR and dated 07/12/23, indicated, [R15] splint to right hand daily with hand hygiene. Review of R15's Care Plan, initiated 07/01/21 and located in the Care Plan tab of the EMR, revealed the resident was at risk for skin impairment related to impaired mobility, incontinence, orthotic use, contracture. Interventions, dated 12/27/24, revealed, orthotic as ordered. An additional intervention, dated 04/15/25, was to splint to right hand daily. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R15's Observations, located under the Resident Documents tab of the EMR and dated 01/01/25, revealed a Therapy Screening Form, which was documented by the Occupational Therapist (OT), that R15, currently has towel roll used in hand contracture with nursing . Review of R15's Observations, located under the Resident Documents tab of the EMR and dated 03/18/25, revealed a Therapy Screening Form, which was documented by the OT, that R15 . was at baseline. Review of R15's Observations, located under the Resident Documents tab of the EMR and dated 04/14/25, revealed a Therapy Screening Form, which was documented by the OT, that R15 had joint limitations/contractures and . would benefit from new R [right] palm guard. During an observation on 04/13/25 at 12:14 PM, R15 was asleep in bed with her right hand in a fist. No splinting was observed in place. During an additional observation on 04/14/25 at 3:30 PM, R15 was observed in bed with her right hand in a fist without splinting. During an interview on 04/14/25 at 4:12 PM, the DON stated that the facility kept a book on the nursing floor to identify the ambulation needs of the residents. She stated that the information was also verbalized to the staff. The DON confirmed they needed to do a better job documenting. She stated that her expectation was that if there was a need for splinting for a resident, there would be a physician order in place with directions on how to use it. During an interview on 04/15/25 at 9:20 AM, the Regional Director of Rehab (RDR) stated that R15 required the use of a small right-handed palm guard. During an observation on 04/15/25 at 9:28 AM, R15 was observed in bed with her right hand in a fist, with no splinting in place. During an interview on 04/15/25 at 9:30 AM, Licensed Practical Nurse (LPN)3 stated that she was not aware if R15 required a splint or not but confirmed the resident was not currently using one. During an additional interview on 04/15/25 at 9:39 AM, the RDR stated that OT had rescreened R15 on 04/14/25 and had noted she did not have a splint or palm guard in use. She stated that after searching, the facility staff could not find one in her room for use. The RDR stated that the last assessment had been completed on 03/18/25, and that the assessments were completed by the OT. At 10:31 AM, the RDR confirmed there should be better communication between nursing and therapy. During an additional interview and resident observation on 04/15/25 at 11:00 AM, the DON confirmed R15 was in bed and not actively wearing a splint or palm guard to her right hand. The DON stated that the use of the splint could help prevent decline or pain. She again confirmed that she would want to see a care plan and physician order for the splinting. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/15/25 at 11:24 AM, the OT stated that she evaluated new residents on caseload, new or old, and did quarterly screening for residents with contractures. OT stated that since R15 had a contracture, she would see her quarterly. OT confirmed R15 had a right-handed contracture and had been treated with passive range of motion last year and had a palm guard that she was tolerating. OT stated that R15 had not had any changes since last year according to the nursing staff. She stated that after speaking with nursing, the facility staff could not find her palm guard and told her they were using a towel. OT stated that she believed that R15 should wear the palm guard daily because it was a flatter design.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interview, the facility failed to post current nurse staffing information daily. Specifically, the facility had a nurse staffing posting displayed in a common area accessible to residents and visitors; however, the information was not current for the date reviewed. This practice has the potential to mislead all residents and visitors regarding staffing levels and may impact transparency and trust in the facility's operations. Findings include: Review of the facility's 24 Hour Posting of nursing staffing data on 04/13/25 at 9:00 AM, located in the facility front lobby revealed, Riverside Health and Rehab .Census 147 .date 04/10/25 . During an interview on 04/13/25 at 10:13 AM, the Assistant Administrator confirmed the posting was dated 04/10/25 and should have been dated 04/13/25. He further stated that the staffing data was to be current, accurate, and posted daily. During an interview on 04/13/25 at 10:22 AM, the Director of Nursing (DON) confirmed that the 24-hour posting nurse staffing data should reflect the current 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 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 and interview, the facility failed to ensure food stored in the refrigerator was labeled and dated; failed to ensure dietary equipment was clean; failed to ensure dry storage bins were free of a Styrofoam cup directly touching the flour and sugar instead of a scoop; and failed to ensure dirty dishes and trays were not stored in the dietary prep area. This deficient practice had the potential to affect 128 of 147 residents who received meals prepared in the facility and had the potential to affect the spread of food borne illness. Findings include: A request for a kitchen cleaning and service policy was requested on 04/14/25 at 3:45 PM and on 04/15/25 at 11:30 AM. The policy was not provided prior to the survey exit. During the initial kitchen tour on 04/13/25 at 8:30 AM, with the Dietary [NAME] (DA) the following observations were made: The reach in refrigerator contained food items of gravy, roast beef, a block of opened cheese, and three packages of opened sliced sandwich meat, that were not dated or labeled. The large bins that contained sugar and flour contained a Styrofoam cup inside the bin. The Styrofoam cup was in direct contact with the flour and sugar. In the prep area of the kitchen, there was a six-tiered rack that held dirty trays, and on the floor were crumbs and scraps of paper. The oven's cooktop and the sides of the oven had the appearance of thick grease and food debris. During the second kitchen tour on 04/13/25 at 4:00 PM, with the Dietary Manager (DM), the following observations were made: The large bins containing dry goods containers of sugar and flour still contained a Styrofoam cup inside the bin. The oven's cooktop and sides of the oven still had the appearance of thick grease and food debris. During an interview with the Dietary [NAME] (DA) on 04/13/25 at 9:15 AM, she stated she arrived to discover dirty pots, pans, and trays left by the previous staff that prepared dinner on 04/12/25. She stated she was not aware of the Styrofoam cups in the dry food bins that appeared to be used as scoops. She stated there should be a proper scoop available for the dry food bins. During an interview with the Dietary Manager (DM) on 04/16/25 at 10:45 AM, she provided a cleaning schedule for cleaning the appliances, floors, and dirty kitchen ware. She stated that the staff should have labeled and dated the food in the reach in refrigerator, that it was not acceptable to have the Styrofoam cup in the flour and sugar bins, and the oven should have been cleaned.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425082	A. Building B. Wing	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Health and Rehab	2375 Baker Hosp Blvd Charleston, SC 29405

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation and interview, the facility failed to dispose of garbage in a sanitary manner in the kitchen. Specifically, the garbage container was overflowing with garbage on the floor. This deficient practice had the potential to affect 128 of 147 residents who received meals prepared in the kitchen. Findings include: During the initial kitchen tour on 04/13/25 at 8:30 AM, with the dietary cook (DA), the following observation was made: The garbage container near the food preparation area was uncovered and overflowing with garbage of paper towels and gloves on the floor. During an interview with the Dietary Manager (DM) on 04/16/25 at 10:45 AM, she stated that it was unacceptable, and that garbage should be contained or emptied before it overflowed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425082	A. Building B. Wing	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Health and Rehab	2375 Baker Hosp Blvd Charleston, SC 29405

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and review of facility policy, the facility failed to ensure staff properly handled soiled linen. Specifically, Licensed Practical Nurse (LPN)1 carried unbagged soiled linen out of one of one resident's room (Resident (R) 102) and placed the linen in the soiled linen cart. Failure to properly handle soiled linen can lead to cross contamination. Findings include: Review of the facility's policy titled, Laundry, dated 05/2006 revealed, Soiled linens are handled minimally . collection bags, carts or other containers should be strong and large enough to contain the contents of the soiled linens . personnel is instructed in the proper disposition of linens . Review of R102's Face Sheet, located in the electronic medical record (EMR) under the Face Sheet tab, revealed R102 was readmitted to the facility on [DATE], with diagnoses that included but was not limited to: urinary tract infection (UTI) and dysphagia. Review of R102's Physician Orders, located in the EMR under the Resident tab, revealed, . [R102] is on Enhanced Barrier Precautions, r/t [related to] Enteral Feeding tube . During an observation and interview on 04/13/25 at 12:39 PM, revealed Licensed Practical Nurse (LPN)1 exited R102's room after providing activities of daily living (ADL) care. LPN1 was carrying a large bundle of unbagged soiled linen and placed the linen in the laundry cart which was located 60 to 75 feet away from R102's room. Interview with LPN1 immediately after this observation confirmed that she did not bag the soiled linen per facility policy and failed to follow facility's procedures for handling soiled linen. During an interview on 04/13/25 at 12:40 PM, Certified Nurse Aide (CNA)1 confirmed soiled linen is to be placed in a clear bag prior to exiting a resident's room per facility policy and procedures to reduce the spread of infections. CNA1 stated soiled linen which is unbagged is not to exit a resident's room. During an interview with the Infection Preventionist (IP) on 04/14/25 at 10:04 AM, revealed her expectation is that all staff should adhere to the facility's soiled linen policy.