STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425132	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeland Nursing Center Inc	1516 Grays Highway Ridgeland, SC 29936

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility policy, observation and interview, the facility failed to ensure a successful elopement was reported timely to the State Agency (SA) within two (2) hours of its occurrence. Findings include:Review of the facility's policy titled, Abuse, Neglect, Exploitation & Misappropriation dated 10/23/2023, indicated, Neglect is the failure of the center, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Examples include but are not limited to; failure to adequately supervise a resident known to wander from the facility without the staff knowledge . Procedure: . 7. Reporting/Response- Any employee or contracted service provider who witnesses or has knowledge of an act of abuse or an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, to a resident, is obligated to report such information immediately, but no later than 2 hours after the allegation is made .On 05/10/26 between 8:45 AM- 9:15 AM, Resident (R)5 had a successful, unwitnessed elopement from the facility. R5 was found by staff members on the sidewalk, off the facility's premises, next to an active highway. Review of R5's Face Sheet revealed R5 was admitted to the facility on [DATE], with diagnoses including but not limited to cerebral infarction, traumatic subdural hemorrhage, and altered mental status. Review of R5's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/30/26, indicated R5 had a Brief Interview of Mental Status (BIMS) score of 0 out of 15, indicating he is severely cognitively impaired. Further review of the MDS indicated under Behaviors, cognitive skills for daily decision making, disorganized thinking coded as 1, indicating continuously present, does not fluctuate. Review of R5's electronic medical record (EMR) revealed progress notes that stated, 05/08/26 23:27 [11:27 PM], Note Text: Resident in wheelchair. Alert w/confusion at this time. Resident being combative during the shift. Difficult to redirect and repeatingly insisting on going home. Verbal. redirection and reassurance attempted with minimal effect. Resident monitored closely for safety at nurse station. No acute distress noted at this time. An additional note indicated, 05/10/26 09:00 Note Text: Supervisor notified of resident walking outside premises. Staff immediately located resident and assisted back to facility. No acute distress noted. Resident placed on 1:1 supervision and Q15 min monitoring; Accutech monitoring system currently unavailable. Elopement Drill Process in-service provided to staff. DON, MD, Facility Administrator and FRP notified. During a telephone interview on 05/13/26 at 10:56 AM, Registered Nurse (RN)1 indicated, [R5] was found outside by himself. He was down the road and we were not aware that he was gone. Another patient notified a staff member that the tall, white man with the blue shirt was gone. A staff member came and asked her if she knew who it was. RN1 stated she had last seen R5 previously in the hall with another staff member sitting. She stated, Yes, this was an elopement. We did not know he was gone. Once we got him back inside, I assessed him then followed the elopement protocol and began educating the staff that was in the building, on both units. During a telephone interview with R5's Resident Representative (RR) on 05/13/26 at 11:09 AM, she stated, From the minute [R5] got to this facility, he has wanted to get out. Based on his diagnosis, he doesn't always understand what's (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
	425132	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeland Nursing Center Inc	1516 Grays Highway Ridgeland, SC 29936

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	going on and sometimes tries to leave to think he is going to meet someone. I knew it was a matter of time before he got out the building successfully, because the door is always unlocked and sometimes there is no one at the desk on the weekends. During an interview with the Administrator on 05/13/26 at 11:55 AM, he stated, Yes, it's true. I was made aware of the elopement. I thought it was an assisted exit, but I just found out it was an actual elopement. I am reporting it now and will be educating staff on reporting.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425132	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeland Nursing Center Inc	1516 Grays Highway Ridgeland, SC 29936

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility policy, interview, observation, and record review, the facility failed to ensure Resident (R)5 was adequately supervised to prevent him from eloping on 05/10/26 between 8:45 AM-9:15 AM, for 1 of 3 residents reviewed for elopement. On 05/10/26 between 8:45 AM- 9:15 AM, R5 had a successful, unwitnessed elopement from the facility. R5 was found by staff members on the sidewalk, off the facility's premises, next to an active highway. On 05/13/26, the State Agency (SA) determined that the facility's non-compliance with one or more federal health, safety, and/or quality regulations has caused or was likely to cause serious injury, serious harm, serious impairment, or death.On 05/13/26 at 11:53 AM, the Centers for Medicare and Medicaid Services (CMS) IJ Template was presented to the Administrator for the identified failure at 42 CFR 483.25 Quality of Care related to R5's elopement. On 05/13/26 at 2:04 PM, the facility presented an acceptable IJ removal plan. Verification of the removal plan on 05/13/26 at 4:15 PM, indicated the facility had identified and corrected their own deficiency, indicating Past-noncompliance as of 05/11/26. Findings include:Review of the facility's undated policy titled, Exit Seeking/Elopement Policy and Procedure revealed, Definition of Elopement: Any resident who has left the building UNWITNESSED and is found to be past the RNC parameters. Parameters include: a. past the flower bed of the front door to the oak trees of hospital yard. b. past the fences at each end of the building to property line. c. past the dumpsters at the back of the building to the church yard.Review of R5's Face Sheet revealed R5 was admitted to the facility on [DATE], with diagnoses including but not limited to cerebral infarction, traumatic subdural hemorrhage, and altered mental status.Review of R5's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/30/26, indicated R5 had a Brief Interview for Mental Status (BIMS) score of 0 out of 15, indicating he was severely cognitively impaired. Further review of the MDS indicated under Behaviors, cognitive skills for daily decision making, disorganized thinking coded as 1, indicating continuously present, does not fluctuate.Review of R5's electronic medical record (EMR) revealed progress notes that stated, 05/08/26 23:27 [11:27 PM], Note Text: Resident in wheelchair. Alert w/confusion at this time. Resident being combative during the shift. Difficult to redirect and repeatingly [sic] insisting on going home. Verbal. redirection and reassurance attempted with minimal effect. Resident monitored closely for safety at nurse station. No acute distress noted at this time. An additional note indicated, 05/10/26 09:00 Note Text: Supervisor notified of resident walking outside premises. Staff immediately located resident and assisted back to facility. No acute distress noted. Resident placed on 1:1 supervision and Q15 min monitoring; Accutech monitoring system currently unavailable. Elopement Drill Process in-service provided to staff. DON, MD, Facility Administrator and FRP notified.Review of R5's Care Plan revealed a focus area, The resident has impaired cognitive function/dementia or impaired thought processes r/t altered mental status s/p CI, impaired decision making with an initiation date of 04/27/26. Interventions included, Cue, reorient and supervise as needed. The care plan also indicated a focus area, The resident is a high risk for falls r/t confusion deconditioning, gait/balance problems, poor communication/comprehension, unaware of safety needs, vision/hearing problems with an initiation date of 04/27/26. Interventions include to anticipate and meet the resident's needs.During a telephone interview on 05/13/26 at 10:56 AM, Registered Nurse (RN)1 indicated, [R5] was found outside by himself. He was down the road and we were not aware that he was gone. Another patient notified a staff member that the tall, white man with the blue shirt was gone. A staff member came and asked her if she knew who it was. RN1 stated she had last seen R5 previously in the hall with another staff member sitting. She stated, Yes, this was an elopement. We did not know he was gone. Once we got him back inside, I assessed him then followed the elopement protocol and began educating the staff that was in the building, on both units.During a telephone interview with RN2 on (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425132	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeland Nursing Center Inc	1516 Grays Highway Ridgeland, SC 29936

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	05/13/26 at 11:05 AM, she stated, I saw people running. Some staff members went out and brought him back in. We assessed him and he did not have any injuries. He was put on 1:1 with a sitter and we started documenting rounds every 15 minutes. We were going to put a monitor on him, but it was locked in the office. RN2 stated that RN1 in-serviced all staff in the building on elopements and missing patients.During a telephone interview with R5's Resident Representative (RR) on 05/13/26 at 11:09 AM, she stated, From the minute [R5] got to this facility, he has wanted to get out. Based on his diagnosis, he doesn't always understand what's going on and sometimes tries to leave to think he is going to meet someone. I knew it was a matter of time before he got out the building successfully, because the door is always unlocked and sometimes there is no one at the desk on the weekends.During an interview with the Administrator on 05/13/26 at 11:55 AM, he stated, Yes, it's true. I was made aware of the elopement. I thought it was an assisted exit, but I just found out it was an actual elopement. When asked about the availability of the Accutech monitors, he indicated the staff did not communicate that they could not access them, but this is why [R5] was placed on 1:1 until they could access them on Monday.An attempt was made to interview R5 with no success.During observations of R5 on 05/13/26 at 10:42 AM, 05/13/26 at 12:15 PM and 05/13/26 at 6:22 PM, showed R5 with a sitter. He was up walking the halls with a monitor on his left ankle.The facility presented an acceptable removal plan which indicated:Credible Allegation Compliance Plan of Correction Date 05/11/2026Resident #5 on May 10, 2026 was found outside of the facility at approximately 9:00 am. The nurse was notified and immediately brought the resident back into the facility, provided a head-to-toe assessment without injury and placed the resident on q-15 minute checks. The resident's family friend/RR was notified of the occurrence on 05/10/2026. The MD was notified on 05/10/2026. His elopement assessment was completed and identified him as a wandering resident. His care plan was updated to reflect the use of the wander guard by the MDS nurse on 05/10/26.All other residents that are at risk of elopement had their elopement evaluation updated on 05/13/2026 by the Director of Nursing. Each resident that has been identified as a high elopement risk (score of eleven or higher) has had their picture and identifying information placed in the facility's elopement risk binder which is maintained at the nurses' station and receptionist desk.Each resident identified as a high elopement risk has had a care plan developed and implemented to address the resident's elopement risk including appropriate safety interventions. Each resident identified as an elopement risk with a score of eleven or higher has now had a wander guard bracelet added to their person. The facility began educating the staff on elopement by the RN Supervisor on May 10, 2026 for all staff on the facility's elopement risk policy and procedures to ensure their knowledge level on the policy as well as to ensure the staff members understand their responsibility of ensuring that each resident's safety interventions are in place in accordance with their individualized plan of care. The nursing staff is also responsible for checking the residents wander guard placement q-shift and documenting on the MAR/TAR each shift.Residents upon admission or significant change will have their elopement evaluation completed to ensure the resident is adequately assessed for wandering behavior by the licensed nurse and reviewed by the Director of Nursing.All new hires will be educated on the elopement risk assessment and ensuring resident safety.The DON will review in the daily clinical meeting the elopement risk evaluation and care plan to ensure the proper interventions and care plan has been updated. The DON will review the Elopement binders daily for 4 weeks and weekly thereafter for 6 months to ensure the elopement binders are maintained. The Director of Nursing will review the results of the elopement audits and elopement binders with the Monthly Quality Assurance and Assessment Committee for further follow-up and recommendations as indicated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425132	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeland Nursing Center Inc	1516 Grays Highway Ridgeland, SC 29936

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 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on review of the facility policy, observation, interview, and record review, the facility failed to ensure Resident (R)7 received appropriate care and services to prevent complications related to enteral feeding, for 1 of 2 residents reviewed.On 05/13/26, R7's Gastrostomy tube (G-Tube) site was observed with a dressing dated 05/03/26 stuck to the skin and a brown, crusted substance noted around the stoma. On 05/13/26, the State Agency (SA) determined that the facility's non-compliance with one or more federal health, safety, and/or quality regulations has caused or was likely to cause serious injury, serious harm, serious impairment, or death. On 05/13/26 at 4:25 PM, the survey team provided the Administrator with a copy of the CMS Immediate Jeopardy (IJ) Template, informing the facility IJ existed as of 05/03/26. The IJ was related to 42 CFR 483.25 Quality of Care.On 05/13/26, the facility provided an acceptable IJ Removal Plan. On 05/13/26, the survey team validated the facility's corrective actions and removed the IJ. The facility remained out of compliance at F693 at a lower scope and severity of D.Findings Include:The facility did not have a policy to address these concerns.Review of R7's Face Sheet revealed the facility admitted her on 08/06/25, with diagnoses including but not limited to gastrostomy status, dysphagia and aphasia.Review of R7's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/12/26, revealed R7 had a Brief Interview for Mental Status (BIMS) score of 00 out of 15, indicating severe cognitive impairment. Further review of the MDS revealed no indications of R7's G-tube.Review of R7's Physician Orders revealed an active order dated 10/23/25 for weekly skin assessments. However, there were no physician orders addressing the care, cleaning, or management of R7's Gˆtube. Further review revealed R7 had just finished a course of Augmentin for a G-tube infection from 05/02/26 - 05/12/26.Review of R7's Electronic Medical Record (EMR) revealed a skin assessment was completed 01/29/26.Review of R7's Care Plan did not reveal any indications of care for the G-tube.Review of R7's Progress Notes revealed the following:04/12/26 23:10 Health Status Note: Nurse gave resident a shower and notice resident GTube site had drainage and odor coming from it. When dressing was removed Gtube site was red, bleeding and raw. Nurse cleaned site, and applied new dressing. ADON and weekend supervisor notified of change.04/13/26 12:03 Order Note: Bactrim DS Tablet 800-160 [milligram] MG (Sulfamethoxazole-Trimethoprim) Give 1 tablet by mouth two times a day for bacterial infection for 10 days.04/14/26 21:32 Acute Care Note: Assessment/Plan: L03.311 - Cellulitis of abdominal wall. The patient developed drainage, erythema, bleeding, and odor at the gastrostomy tube site, consistent with a localized infection, and was started on a 10-day course of Bactrim DS on 04/14/2026. There have been no adverse reactions to antibiotic therapy, and the patient remains afebrile with a temperature of 97.6 F and no systemic symptoms. The gastrostomy tube site is being monitored for signs of infection and response to therapy. Signed by the Medical Director (MD)04/25/26 14:20 Infection Note: Resident continues on antibiotics therapy for gt infection with no adverse reactions noted. Will continue to monitor for signs of infection and response to therapy.During an observation on 05/13/26 at 12:54 PM, R7's G-tube site was observed with a dressing dated 05/03, the dressing was stuck to R7's skin and her stoma had a brown crust surrounding it. R7's tube was cut off and black in color.During an interview on 05/13/26 at 1:05 PM, Licensed Practical Nurse (LPN)1 stated R7 was admitted to the facility with a Gˆtube. LPN1 stated that R7's family wanted the tube removed. LPN1 further stated that she had not observed R7's Gˆtube that day, noting that night shift cleans and changes the dressing.During an interview on 05/13/26 at 1:29 PM, LPN2 stated R7 was not receiving anything through her Gˆtube. LPN2 reported that the tube was cut at the provider's office about two months ago and that the provider did not give the facility specific instructions on what to do. LPN2 was unsure when R7's dressing was supposed to be changed. LPN2 also stated she had not looked at R7's Gˆtube site. She noted that the tube was molded from the inside, so providers were unable to remove it. She reported she was unaware of R7 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425132	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeland Nursing Center Inc	1516 Grays Highway Ridgeland, SC 29936

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 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	having an infection. She stated that whatever the Nurse Practitioner (NP) or MD orders is what they follow.During an observation and interview on 05/13/26 at 2:04 PM, the Facility Administrator confirmed the dressing on R7's site was dated 05/03. He stated the nurses should be changing the dressing but he was unsure when or how often it should be changed. He put on gloves and began to lift the dressing to assess the site. As he lifted the dressing, it was stuck to R7's skin, and R7 winced in pain.During an interview on 05/13/26 at 2:23 PM, the Director of Nursing (DON) confirmed that no orders had been entered for R7 and stated she had now placed an order. The DON stated that R7 has weekly skin audits and any concerns should have been reported to providers. She noted that R7's tube was unable to be flushed due to mold. Lastly, she stated R7 was placed on antibiotics after her last appointment.During an interview on 05/13/26 at 2:29 PM, the NP stated that there should have been orders entered to keep R7's Gˆtube site clean and dry daily. She reported that she had not been made aware of any recent concerns. The facility's removal plan included: Resident #7 had a verbal order from the MD for daily dressing change to the G-Tube site entered the orders on 05/13/2026. MD and RR were made aware of the new treatment order by the DON on 05/13/2026.The MD through virtual assessment with the DON observed the G?Tube Site with no new orders.The DON will review all residents with G-Tube orders to ensure they have the necessary orders for care and treatment of the G-Tube insertion site and feeding parameters by 05/13/2026.The Licensed nurses will be educated by the Director of Nursing on ensuring the residents that have G-Tubes will ensure the G-Tube Insertion Site Dressing is cleaned and dressed daily.The treatment nurse or DON will review the G-Tube Sites daily to ensure the dressing has been changed daily for 2 weeks weekly for 4 weeks them monthly for 4 months. Any area of concern will require the nurse to be re-educated and disciplined if applicable. The MD and NP will be notified upon any identified sign and symptoms redness, swelling, drainage, odor, or any other abnormality.All new hired nurses will be educated on G-Tube Dressing Changes upon hire.The DON will review the results of the G-Tube audit with the IDT during the weekly Ad-HOC meeting for 4 weeks then monthly and PRN.The Director of Nursing will review the results of the G-Tube Dressing Change audits with the Monthly Quality Assurance and Assessment Committee for further follow-up and recommendations as indicated. Date of Correction: 05/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425132	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeland Nursing Center Inc	1516 Grays Highway Ridgeland, SC 29936

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on review of facility policy, record review, and interviews, the facility and the pharmacy failed to provide pharmaceutical services to meet each resident's needs by not maintaining an effective system for ordering, receiving, and supplying medications, resulting in multiple missed medication doses. This failure had the potential to cause uncontrolled symptoms, worsening medical conditions, avoidable pain, and preventable decline. Findings Include:Review of the facility policy titled Ordering and Receiving Non-Controlled Medications, last revised August 2020, documented, Policy: Medications and related products are received from the pharmacy on a timely basis . Procedures . I. Ordering Medication from the Pharmacy: 1. Medications orders are written on a physician order form, telephone order sheet, or reorder from provided by the pharmacy, written in the chart by the physician, or entered into the facility's EHR systema and transmitted to the pharmacy. 2. Repeat medications (refills) are . requested via the facility's EHR system and ordered as follows: a. Reordering of medications is done in accordance with the order and delivery schedule established by the pharmacy provider . b. The refill order is called in, faxed, sent electronically, or otherwise transmitted to the pharmacy.Review of the facility policy titled Receiving Controlled Substances last revised August 2020, documented, Procedures . Controlled substances are requested when a five-day supply remains, or in accordance to facility policy, to allow for transmission of the required written prescription to the pharmacy. Review of the facility policy titled Non-Controlled Medication Orders, last revised August 2020, documented, Procedures . II. Order Clarification . 3. The prescriber is contacted by nursing for direction when the medication is not or will not be available for administration or on accordance with facility policy. Review of the facility policy titled Controlled Substance Prescriptions, last revised August 2020, documented, Policy . A chart order is not equivalent to a prescription for controlled medications. Therefore, the prescriber issuing the chart order must also provide the pharmacy with a valid prescription to ensure delivery if medication . Procedures . V. Communicating with the Prescriber . 2. The prescriber is contacted by nursing for direction when the medication is not or will not be available for administration or on accordance with facility policy . VII. Refill Requests . if one or more refills or a partial refill quantity remains, the facility must request the medication from the pharmacy. Review of R2's Face Sheet revealed the facility admitted her on 03/18/25, with diagnoses including but not limited to; hereditary and idiopathic neuropathy, chronic kidney disease, essential primary hypertension, atrial flutter, gastro-esophageal reflux disease (GERD) and gout.Review of R2's Medication Administration Record (MAR) for March, April and May 2026, revealed the following missed doses: Lyrica Capsule 75 Milligrams (mg), give 1 capsule by mouth three times a day related to Hereditary and idiopathic neuropathy. May 10.Atorvastatin Calcium Oral Tablet 80 mg, give 1 tablet orally at bedtime related to pure hypercholesterolemia. March 26, 28, 31.Lactobacillus capsule, give 2 capsules by mouth in the morning for digestive health. March 19, 21-24.Mag-Oxide Tablet, give 1 tablet by mouth in the morning related to chronic kidney disease. March 15-16, 19. April 9.Valsartan 40 mg, give 1 tablet by mouth the morning related to essential primary hypertension. March 8, 19.Eliquis 5 mg, give 1 tablet by mouth two times a day related to typical atrial flutter. March 26, 28, 31. April 5, 10, 22.Pantoprazole 40 mg, give 1 tablet by mouth two times a day related to GERD. March 15. April 15.Allopurinol 100 mg, give 1 tablet orally in the morning related to gout. April 13,16,17.Olopatadine, 1 drop in both eyes two times a day related to acute atopic conjunctivitis, left eye. April 13, 16-17. May 5.Pataday 1 drop in both eyes one time a day for dry eyes. May 6.Review of R3's Face Sheet revealed the facility admitted her on 05/10/24, with diagnoses including but not limited to; generalized anxiety disorder, primary insomnia, hyperlipidemia, primary generalized osteoarthritis, pain, major depressive disorder and GERD.Review of R3's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/15/26, revealed R3 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R3 was cognitively intact.Review of R3's Medication Administration Record (MAR) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425132	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeland Nursing Center Inc	1516 Grays Highway Ridgeland, SC 29936

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	for March, April and May 2026 revealed the following missed doses: Ambien 5 mg (Zolpidem), give 1 tablet by mouth at bedtime related to primary insomnia; March 5, May 3-4, 8-9, 12. Ezetimibe 10 mg, give 1 tablet by mouth at bedtime related to hyperlipidemia; March 5 and April 27 Hydroxyzine 25 mg, give 1 tablet by mouth at bedtime related to generalized anxiety disorder. March 1, 3, 5, 21, & 29. April 18, 21-23, 27. May 5-8.Lactobacillus capsule, give 2 capsules by mouth in the morning for abdominal health. March 9.Alprazolam 0.5 mg, give 1 tablet by mouth two times a day related to generalized anxiety disorder. March 1, 5.Diclofenac oral tablet, give 75 mg by mouth two times a day related to primary generalized osteoarthritis. March 1, 5. May 13.Buspirone 5 mg, give 1 tablet by mouth three times a day related to generalized anxiety disorder. March 1, 5, 17.Doxycycline 100 mg, give 1 tablet orally three times a day related to cellulitis. March 1, 5.Tylenol oral tablet, give 500 MG by mouth four times a day for pain. March 1, 17. April 5, 27.Nystatin Powder, apply to groin topically every shift for yeast. March 1, 4, 8-9, 13-15, 19, 21-22, 25. April 3, 6, 8-10, 16, 18-19.Citalopram 10 mg, give 1 tablet by mouth in the morning related to major depressive disorder. April 17.Lamotrigine 25 mg, give 1 tablet by mouth in the morning related to persistent mood disorders. April 17.Loratadine 10 mg, give 1 tablet by mouth in the morning for allergy symptoms. April 4.Potassium Chloride ER 10 MEQ, give 1 by mouth two times a day for taking medications for edema. April 4-8, 10, 27.Review of R6's Face Sheet revealed the facility admitted her on 04/27/26, with diagnoses including but not limited to; pure hypercholesterolemia, benign prostatic hyperplasia with lower urinary tract symptoms, long term use of anticoagulants and muscle spasms. Review of R6's Medication Administration Record (MAR) for 04/27/26 revealed the following missing doses: Atorvastatin Calcium Oral Tablet 80 mg, give 1 tablet orally at bedtime related to pure hypercholesterolemia.Tamsulosin Oral Capsule 0.4 mg, give 1 capsule orally in the afternoon related to benign prostatic hyperplasia.Apixaban Oral Tablet 5 mg, give 1 tablet orally two times a day related to long term (current) use of anticoagulants. Cyclobenzaprine Tablet 10 mg, give 1 tablet by mouth three times a day for muscle spasm relief.During an interview on 05/13/26 at 9:35 AM, Licensed Practical Nurse (LPN)1 stated that medications were sometimes not available. LPN1 reported that they would place medication orders but would not receive them until the following day. LPN1 also stated that some medications were unavailable because they required a new prescription once they reached their oneˆyear renewal date.During an interview on 05/13/26 at 11:19 AM, R3 stated that she had been without her prescribed sleep medication, Ambien, for the past five days. She further reported that some staff documented her medications as administered even though she had not received them.During an interview on 05/13/26 at 12:02 PM, the Director of Nursing (DON) stated that most missed medication doses occurred because nursing staff either failed to reorder medications, did not know how to reorder them, or did not obtain the necessary prescriptions. The DON added that the facility keeps nonˆnarcotic medications in the stockroom and receives multiple pharmacy deliveries each week. She also stated that the provider should be notified when medications are not available.During an interview on 05/13/26 at 2:29 PM, LPN2 stated that they are responsible for calling the pharmacy to reorder medications when they observe that a resident is running low.During an interview on 05/13/26 at 8:25 PM, the Medical Director stated he was unaware of the extent of the facility's medication issues. He added that he should have been notified of the missed medication doses and that the situation was not acceptable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425132	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeland Nursing Center Inc	1516 Grays Highway Ridgeland, SC 29936

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews and record review, the facility failed to ensure all drugs and biologicals were safely and securely stored. Specifically, the B-wing medication room was observed unlocked, and the treatment carts were unlocked with the key hanging in the lock. Findings Include:Review of the facility policy titled Storage of Medications last revised August 2020, documented, Policy: Medications and biologicals are stored safely, securely, and properly . The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. I. General Guidance . 2. Medication rooms, carts, and medication supplies are locked when they are not attended by persons with authorized access.Review of the undated facility policy titled Storage and Expiration of Medications, Biologicals, Syringes and Needles, documented, Medications will be securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. Only authorized, licensed facility staff will have possession of the keys to medication storage areas.During an observation on 05/12/26 at 5:55 PM, both treatment carts on A and B Wing were unlocked with the keys left in the locks and no staff present. During an observation on 05/13/26 at 9:01 AM, the treatment cart on B Wing was unlocked, with the key left hanging in the lock. Additionally, the medication storage room on B Wing was unlocked and no staff were present at the nurses station or in the medication room. During an interview on 05/13/26 at 9:05 AM, LPN1 stated that the medication storage room was supposed to be locked, but another nurse must have forgotten to lock it after leaving. LPN1 then stated, I just locked it now.During an interview on 05/13/26 at 12:02 PM, the Director of Nursing (DON) stated that the medication storage areas are required to remain locked. She reported that the facility has had previous issues with medication storage and that staff have been previously educated and are aware of the expectations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425132	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeland Nursing Center Inc	1516 Grays Highway Ridgeland, SC 29936

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 - Minimal harm or potential for 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. Based on observations and interviews, the facility failed to ensure resident preferences were honored in relation to dietary meals. Specifically, the facility did not provide residents preferences or substitutes. This deficient practice had the potential to effect all residents obtaining food items from the kitchen.Findings include:During a kitchen tour on 05/12/26 at 4:48 PM, observations revealed no posted alternative menu.During an interview conducted with Cook1 on 05/13/26 at 4:55 PM, revealed she was unaware of any alternatives for residents. Cook1 stated she was preparing the supper meal, which consisted of grilled cheese sandwiches and stewed tomatoes. When asked what the alternative was for individuals who did not eat those items, she stated, I am not sure. I do not know anything about alternative choices.During an interview with Resident (R)1 on 05/13/26 at 5:58 PM, he stated, I've been here for a few weeks. No one has asked me what I like to eat. They just serve us small helpings of food. Some of the staff here has gone and brought me Kentucky Fried Chicken (KFC), or my friends will bring me something. When I asked for something different, they told me I could only get what was served. Now, I just make peanut butter and jelly (PB&J) sandwiches in my room. Observation at this time revealed R1 actively making a PB&J sandwich during the interview.During an interview with Certified Nursing Assistant (CNA)1 on 05/13/26 at 9:05 AM, she stated, The food here is limited. We, the staff do sometimes go out and get residents different meals because that is all they have to offer, so we know they are sometimes still hungry.During an interview with R4 on 05/13/26 at 10:15 AM, he stated, See all my snacks here. The food here is horrible. There are no choices or options. The staff will sometimes bring us something they got with their own money. Observation of R4's room showed personal snacks and drinks.During an interview with the Dietary Manager (DM) on 05/13/26 at 12:10 PM, she stated, I just started. I am aware we have some issues and there are some things I want to change. We do not offer an alternate menu, or preferred options. That is something I want to start incorporating once I get things fixed. The DM confirmed there was no policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425132	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeland Nursing Center Inc	1516 Grays Highway Ridgeland, SC 29936

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility policy, observations, and interviews, the facility failed to ensure expired food items were removed from storage and food items were properly stored and labeled.Findings include:Review of the facility's policy titled, Kitchenette Policy and Procedure, dated 01/29/19 revealed, Policy: Food storage areas will be maintained in a clean, safe and sanitary manner. Food items not stored will be disposed of. Procedure: . 3. All foods requiring refrigeration will be stored in the kitchenette refrigerator behind the nurse station. Items will be marked with resident name, date and time on receipt by staff. Review of the facility's undated policy titled, Food Storage revealed . 4. Food shall be rotated as delivered and used in a first in, first out method. Items will be dated on receipt, opening and/or replaced for storage to facilitate this procedure.Review of the facility's undated policy titled, Date Marking, Potentially Hazardous Food Policy and Procedure, revealed, Procedure: . 2. Foods must be marked at the time of preparation, or in the case of a commercially processed food, at the time the container or packaging is opened in a retail facility.During a tour of the kitchen on 05/13/26 at 8:48 AM, observation of the dry storage area revealed six (6) 46 fluid ounces (oz.) cartons of [NAME] Ready Care Thickened Apple Juice with a use by date of 04/25/26. In the walk-in cooler, there was 1 - 10 count package of [NAME] B's Jumbo XL biscuits, thawed, with a manufactured notice Keep frozen until ready to use. There was also one unlabeled and undated, clear container, which contained an item that appeared to be baked beans. These items were confirmed by the Dietary Manager (DM) to be unlabeled and undated.Observation of the A Wing Nourishment Room on 05/13/26 at 9:01 AM, revealed two (2) unlabeled and undated sandwiches that appeared to be peanut butter and jelly. Observation of the resident refrigerator, located in the Nourishment room contained, two watermelon halves, that appeared to be half eaten, one to-go tray containing what appeared to be rice and grilled chicken legs, unlabeled and undated and multiple open personal cans and bottles of beverages, that were unlabeled and undated.During an interview on 05/13/26 at 9:05 AM, Certified Nursing Assistant (CNA)1 stated, Night shift keeps putting their personal items in this refrigerator. I keep trying to clean it out. Those sandwiches should be labeled and dated, but I am unsure when they were prepared. I know most of the staff here give residents bread and items for sandwiches with money out of our own pockets, to ensure they get what they want to eat.During a follow-up visit to the kitchen on 05/13/26 at 4:50 PM, an unlabeled, undated clear container containing what appeared to be diced pears was observed in the walk-in cooler. This was confirmed by the Dietary Aide.Additionally, review of the steam table on 05/13/26 at 4:55 PM, revealed the unlabeled, undated, baked beans observed earlier that morning, being served. The [NAME] was unable to confirm when the beans had been prepared.