STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425361	A. Building B. Wing	06/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southpointe Healthcare and Rehabilitation	35 Southpointe Drive Greenville, SC 29607

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 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** Based on review of facility policy, record review, observation, and interview, the facility failed to properly assess Resident (R)1 for the appropriateness of the self-administration of prescription chlorhexidine mouthwash, for 1 of 3 residents reviewed. Findings include:Review of the facility policy titled Self-Administration of Medications with a revision date of 04/17/24, revealed, Policy: 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). Procedures: 1. A Resident choosing to self-administer medications will be assessed and evaluated by the Interdisciplinary Care Team (IDT) in order to determine if it is safe for him/her to self-administer medication. Review of R1's Face Sheet revealed she was admitted to the facility on [DATE], with diagnoses included, but not limited to, dental caries (cavities), hemiplegia (paralysis on one side of the body) affecting her right dominant side, visual loss in the right eye, cognitive communication deficit, and personal history of traumatic brain injury. Review of R1's active orders did not show a current order for chlorhexidine mouthwash. Review of R1's Medication Administration Record (MAR) for 06/2026, revealed three past orders for chlorhexidine gluconate 0.12% mouthwash 15 cc. The first order read, Chlorhexidine gluconate mouthwash 0.12% swish 15 cc for 30 seconds twice a day for 7 days. The first order started on 05/31/26 and ended on 06/03/26. The second order read, Chlorhexidine mouthwash 0.12% swish 15 cc for 30 seconds three times a day after meals. May keep at bedside. The second order started on 06/03/26 and ended on 06/08/26. The third order read, Chlorhexidine mouthwash 0.12% swish 15 cc for 30 seconds three times a day after meals. May keep at bedside. The third order started 06/10/26 and ended 06/17/26. Review of R1's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/14/26, revealed R1 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating she had no cognitive deficits.Review of R1's Care Plan revealed she had a focus on requiring an antibiotic related to dental pain/infection starting 05/14/26. The goal was to have decrease in pain and improvement of condition through end of treatment. Interventions included, but were not limited to, antibiotic as ordered; assess condition of oral cavity, teeth, tongue, lips; dental evaluation and intervention as needed; and encourage fluids to keep oral cavity moist. A second focus was related to R1 experiencing mouth pain related to probable cavity starting on 03/24/26. The goal was for R1 to not exhibit mouth pain or infection. Interventions included, but were not limited to, antibiotic started for tooth pain; assess condition of oral cavity, teeth, tongue, lips; dental evaluation and intervention as needed; and provide mouth care every day and PRN (as needed). No focus items, goals, or interventions were found in R1's care plan related to the self-administration of medications, including chlorhexidine gluconate mouthwash. During a random observation on 06/29/26 at approximately 3:00 PM, revealed a bottle of chlorhexidine mouthwash on R1's bedside table. The resident was not present in the building at the time of the observation. No lock box or lock on her bedside table drawer was observed. During an interview on 06/29/26 at approximately 3:15 PM, Licensed Practical Nurse (LPN)1 revealed R1 was alert and oriented x4. He stated R1 had nine teeth pulled at one time and was ordered two different mouthwashes. The first mouthwash was lidocaine mouthwash, which was kept (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
	425361	A. Building B. Wing	06/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southpointe Healthcare and Rehabilitation	35 Southpointe Drive Greenville, SC 29607

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on the medication cart. The second mouthwash was chlorhexidine mouthwash for R1 to use after each meal. This mouthwash was kept at the bedside. LPN1 revealed R1 wanted to have the chlorhexidine mouthwash at her bedside to make it easy for her to use after she was finished eating her meals. He stated R1 wanted to ensure she did not get any complications from the extractions. LPN1 revealed the chlorhexidine mouthwash was re-ordered a couple of times. He stated R1 would keep the mouthwash at her bedside in the top drawer of her nightstand next to her bed. He revealed R1 has had no problems with self-administering the mouthwash. He stated he has not worked in the facility for a few days, so he is not sure why the mouthwash was not removed from R1's bedside when the order ended on 06/17/26.During an interview on 06/29/26 at 5:30 PM, the Director of Nursing (DON) provided a copy of Self-Administration of Medication Observation Detail dated 05/31/26 at 11:45 AM. She revealed they have morning meetings where the administration talks about all residents and any changes to their care. She stated the meetings include the Administrator, herself, Assistant DON, and department heads. She described the meeting as an interdisciplinary team (IDT) meeting. She stated they would have discussed R1 requesting to self-administer her chlorhexidine mouthwash in this meeting and then the care plan would have been updated by the Minimum Data Set (MDS) Nurse. Surveyor requested to see the written records or notes of the meeting when R1's request to self-administer chlorhexidine mouthwash was discussed.During an interview on 06/29/26 at 6:00 PM, the MDS Nurse revealed she makes notes at every morning meeting where they discuss all the residents and any changes. She stated her process is to notate anything that indicates a change is needed to a resident's care plan or MDS. During the interview, the MDS Nurse looked through her morning meeting notes for June. She did not find any notes indicating they discussed R1's request to self-administer her prescription mouthwash. She stated if the discussion happened, she would have written a notation of the discussion and the need to revise the care plan.During an interview on 06/26/26 at 6:10 PM, the Administrator revealed no medications should be left at the bedside. He stated if a resident wants to self-administer medications, the nurse should complete an assessment and get a physician's order. He revealed the request would typically be discussed in the morning meeting where all disciplines attend, and the self-administration of medication would need to be added to the resident's care plan.During an interview on 06/29/26 at 6:30 PM, the DON confirmed no IDT meeting or discussion had occurred regarding R1 self-administering her prescribed chlorhexidine mouthwash.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425361	A. Building B. Wing	06/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southpointe Healthcare and Rehabilitation	35 Southpointe Drive Greenville, SC 29607

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on review of facility policy, record review, observation, and interview, the facility failed to ensure resident health information was properly concealed from unauthorized viewing during a random observation of medication administration.Findings include:Review of the facility policy titled Safeguarding Electronic Protected Health Information with an email revision date of 04/29/22, revealed, Procedures: . 1. F. Access to electronic protected health information is limited to employees who need the information for treatment, payment or facility operations purposes. H. Employees log off the network or, at a minimum, lock their workstation when leaving the work area.During a random observation on 06/29/26 at 11:25 AM, revealed an unattended medication cart that was unlocked with the narcotics book open and the computer showing a resident's information, clearly visible. Registered Nurse (RN)1 verified this observation. During an interview on 06/29/26 at 11:26 AM, RN1 revealed the medication cart should have been locked, and the narcotics book and the computer should have been closed so that patient information was not visible. She stated she was going back and forth to a resident's room giving the resident her medications, and the resident asked several questions. RN1 revealed she was going back and forth from the cart to the room to look at the resident's information, to gather the information the resident was asking for, and she forgot to lock the medication cart and close the narcotics book and computer. During an interview on 06/29/26 at 11:26 AM, the Unit Manager (UM)1 verified the medication cart should have been locked, and the computer and narcotics book should have been closed to prevent resident health information from being visible. She stated the electronic medical record is sometimes difficult to log out of. During an interview on 06/29/26 at 12:17 PM, the Director of Nursing (DON) revealed RN1 is an agency nurse. She stated RN1 was well aware surveyors were in the building. The DON revealed she was glad RN1 acknowledged she knew the cart should have been locked and the computer closed. The DON stated they only use one agency, and their nurses get the same education as the facility staff does. She revealed when they have something they need to educate the staff on, they call ShiftKey (staffing agency) and upload the documents. She further stated the agency staff have to sign that they reviewed the information before they are allowed to work another shift.During an interview on 06/26/26 at 6:10 PM, the Administrator revealed the medication carts should be locked at all times when not attended, and resident information should be covered and not visible to anyone passing by.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425361	A. Building B. Wing	06/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southpointe Healthcare and Rehabilitation	35 Southpointe Drive Greenville, SC 29607

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, interview and record review, the facility failed to ensure Resident (R)12's right to be free from misappropriation of resident property by failing to prevent or protect the resident's three rings from being taken without the resident's consent. This deficient practice was identified in 1 of 4 residents reviewed for misappropriation of property.Findings include:Review of the facility's policy titled Abuse, Neglect, Exploitation, or Mistreatment, revised on 11/01/17, revealed that the facility's leadership prohibits neglect, mental, physical, and verbal abuse, involuntary seclusion, corporal punishment, and misappropriation of a resident's property or funds. The policy states that alleged violations involving abuse, neglect, exploitation, mistreatment, injuries of unknown origin, and misappropriation of resident property must be reported immediately. The policy defines misappropriation of resident property as the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent.Review of R12's Face Sheet revealed the resident was admitted to the facility on [DATE] at 11:36 AM, with diagnoses including, but not limited to, senile degeneration of the brain, unspecified dementia, cognitive communication deficit, and urinary tract infection.Review of R12's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/10/26, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 10 out of 15, indicating moderate cognitive impairment.Review of R12's admission Inventory Sheet dated 05/05/26 revealed the resident was admitted with three gold rings.Review of the Grievance Summary dated 05/14/26, categorized as Missing items and reported by R12's responsible party, revealed the grievance was resolved on 05/26/26. The grievance stated that three goldˆtone rings were missing, including one worn on the resident's left pointer finger and two worn on the resident's left ring finger. On 05/14/26, the resident's daughter notified the facility that the three rings were missing, describing them as two gold bands and one gold band with diamondˆlike stones, and identifying the items as family heirlooms. She reported that the rings were present on the resident's hand on the evening of admission and observed they were no longer present during a visit the following week. The daughter stated she contacted local law enforcement prior to notifying the facility administrator on 05/14/26. The facility's investigation included interviews with the resident, family, and staff; searches of the resident's room, belongings, and laundry; review of admission observations; and communication with law enforcement. The facility was unable to determine how or when the rings became missing, and no evidence was identified to substantiate misappropriation by facility staff. An addendum dated 05/26/26 documented that the Sheriff's Department reported the three rings had been located at a local pawn shop and had been sold by an agency nurse.During an interview with R12's Responsible Party (RP), the resident's daughter and Power of Attorney (POA), was conducted on 06/29/26 at 4:44 PM, following a returned call. The RP reported the resident was admitted on [DATE] from the hospital and had been wearing three rings at the time of admission, including two solid gold bands and one solid gold band with diamonds. The RP stated the resident was still wearing all three rings upon admission; however, during a visit on 05/09/26, she observed the resident was no longer wearing any of the rings. She reported notifying the nurse on duty, who informed her that because it was a Saturday, no administrative staff were available to address the concern. When she returned to the facility the following Monday, she was again unable to meet with administrative staff. On Tuesday, she spoke with the facility's Social Worker, who stated she would file a grievance. The RP reported she later contacted administration and the Director of Nursing, both of whom stated they were unaware of the missing rings and would initiate an investigation. The RP stated she became frustrated with the lack of information from the facility and subsequently contacted law enforcement and filed a police report. According to the RP, staff informed her that interviews were conducted but no one reported knowledge of what happened to the rings. The RP reported that law enforcement later (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425361	A. Building B. Wing	06/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southpointe Healthcare and Rehabilitation	35 Southpointe Drive Greenville, SC 29607

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified an agency staff member, subsequently confirmed to be an agency Licensed Practical Nurse (LPN)5, as the individual who sold the resident's rings to a local pawn shop after comparing photographs of the rings with pawn shop transaction records. The pawn shop had collected a photo ID from the seller, which matched LPN5. The RP stated she was able to recover all three rings with the assistance of law enforcement and reported that the facility informed her they would report the staff member to the appropriate licensing board. The RP voiced no additional concerns during the interview.During an observation and attempted interview of R12 on 06/19/26 at approximately 5:50 PM, revealed the resident was sleeping. Due to the resident's dementia diagnosis and condition at the time of observation, the resident was unable to be interviewed.During an interview with the Facility Administrator (FA) was conducted on 06/29/26 at 6:03 PM. The FA reported he had been in his role for less than one year and was familiar with R12, who was admitted on [DATE]. The FA stated that on 05/14/26, he and the Director of Nursing (DON) met with the resident's daughter regarding concerns that the resident's three rings were missing. One daughter was present in person. During the discussion, the daughter described the missing items as two gold bands and one gold band with diamondˆlike stones, and reported the rings were visible on the resident's hand on the evening of admission. She provided a cell phone video that appeared to show the resident wearing the rings. The FA stated the daughter was asked whether the rings could have been removed by family due to the resident's cognitive impairment and risk for losing valuables; however, the daughter reported the rings remained in the resident's possession following the visit. The daughter stated that during a visit the following week, she observed the rings were no longer present and contacted law enforcement on 05/13/26 before notifying the Assistant Director of Nursing (ADON), DON, and FA on 05/14/26. The FA stated that on 05/14/26, the facility contacted the local police department regarding the missing property and was informed a report had already been initiated. Facility staff were instructed to follow up with the assigned officer the next day. On 05/15/26, the FA reported the responding officer requested a list of all employees working at the facility, and it was through this list that the identified perpetrator was later matched to pawn shop records. The FA stated that during this followˆup communication, the Sheriff's Office reported they had the information needed at that time and advised the facility to report any additional findings if they arose. The FA further stated that several days later, the police officer returned to the facility and reported that an agency staff member, later identified as LPN5, matched the individual who pawned the resident's rings. Upon receiving this information, the FA contacted the staffing agency to request the employee be placed on the agency's doˆnotˆreturn list and provided law enforcement with the agency's contact information. The FA stated an addendum was then submitted to the Department of Public Health (DPH) regarding the new findings. The FA stated his expectation is zero tolerance for misappropriation of resident property, noting that no situation is too small or too big when it comes to protecting residents and their belongings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425361	A. Building B. Wing	06/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southpointe Healthcare and Rehabilitation	35 Southpointe Drive Greenville, SC 29607

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based facility policy review, observation, and interview, the facility failed to ensure housekeeping chemicals were securely locked and stored outside of resident areas. Findings include:Review of the facility's Maintenance/Housekeeping policy titled Micro-organisms with an original date of 03/2006, revealed, Maid Carts: . 4. Never leave maid carts unattended with chemicals exposed for patient/resident safety. Chemicals should be kept with housekeeper. During a random observation on 06/29/26 at 11:20 AM, revealed two housekeeping carts unattended in the Resident lounge of the 100 Hall. Six residents were noted to be seated in the lounge watching tv. Both housekeeping carts were unlocked and contained a liquid smelling of bleach in the mop bucket. Inside the unlocked compartment of the first cart was a can of air freshener. A bottle of liquid soap was on the lower shelf. Inside the unlocked compartment of the second cart was: Tylex spray, Xotic Team air freshener spray, Pure Bright RTU germicidal spray, and Glass cleaner spray. Both Housekeeping Aide (HA)1 and HA2 verified the housekeeping carts were left unattended and unlocked in a resident area. During an interview on 06/29/26 at 11:23 AM, HA1 and HA2 revealed they were short-staffed today, and HA2 had just arrived to fill in. Both housekeeping aides stated they knew the carts should be locked at all times. HA1 showed this Surveyor the keys she had for the housekeeping carts. HA1 and HA2 revealed they were in the housekeeping office for only a few minutes to discuss the schedule for the day.During a phone interview on 06/29/26 at 12:43 PM, the Housekeeping Director revealed his expectation was for staff to never leave a housekeeping cart unattended. He stated if the housekeeping aide is not using the cart, the cart should be back in the hallway locked away or pushed out onto the dock. The Housekeeping Director revealed the carts should never be left open within a resident's reach. He further stated the cart should remain locked. Housekeeping Director stated it is rare for this to happen, but regardless, housekeeping carts should never be left open within resident areas.During an interview on 06/29/26 at 1:43 PM, the Director of Nursing (DON) stated she educated the housekeeping personnel on locking housekeeping carts when the cart is not attended. During an interview on 06/29/26 at 6:10 PM, the Administrator revealed the housekeeping carts should be locked at all times or be placed out on the dock. He confirmed the carts should not be stored in resident areas.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425361	A. Building B. Wing	06/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southpointe Healthcare and Rehabilitation	35 Southpointe Drive Greenville, SC 29607

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, record review, observation, and interview, the facility failed to ensure medication was discontinued after the physician's ordered end date. Specifically, the facility failed to remove chlorhexidine mouthwash from Resident (R)1's bedside, for 1 of 3 residents reviewed. Findings include:Review of the facility policy titled Self-Administration of Medications with a revision date of [DATE], revealed, Procedures: . 4.G. The nursing staff will rotate bedside stock and will remove expired, discontinued, or recalled medications. Review of R1's Face Sheet revealed she was admitted to the facility on [DATE], with diagnoses included, but not limited to, dental caries (cavities), hemiplegia (paralysis on one side of the body) affecting her right dominant side, visual loss in the right eye, cognitive communication deficit, and personal history of traumatic brain injury. Review of R1's active orders did not show a current order for chlorhexidine mouthwash. Review of R1's Medication Administration Record (MAR) for 06/2026 revealed three past orders for chlorhexidine gluconate 0.12% mouthwash 15 cc. The first order read, Chlorhexidine gluconate mouthwash 0.12% swish 15 cc for 30 seconds twice a day for 7 days. The first order started on [DATE] and ended on [DATE]. The second order read, Chlorhexidine mouthwash 0.12% swish 15 cc for 30 seconds three times a day after meals. May keep at bedside. The second order started on [DATE] and ended on [DATE]. The third order read, Chlorhexidine mouthwash 0.12% swish 15 cc for 30 seconds three times a day after meals. May keep at bedside. The third order started [DATE] and ended [DATE]. Review of R1's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE], revealed R1 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating she had no cognitive deficits.During a random observation on [DATE] at approximately 3:00 PM, revealed a bottle of prescription chlorhexidine mouthwash on R1's bedside table. The resident was not present in the building at the time of the observation. No lock box or lock on her bedside table drawer was observed. During an interview on [DATE] at approximately 3:15 PM, Licensed Practical Nurse (LPN)1 revealed R1 would keep the mouthwash at her bedside in the top drawer of her nightstand next to her bed. He stated he has not worked in the facility for a few days, so he is not sure why the mouthwash was not removed from R1's bedside when the order ended on [DATE].During an interview on [DATE] at 3:35 PM, the Director of Nursing revealed R1 asked to have the mouthwash continued after the initial order ran out. The DON verified no current order for the mouthwash was in place. She revealed the last order for the chlorhexidine mouthwash ended on [DATE].During an interview on [DATE] at 6:10 PM, the Administrator revealed there should have been an order to continue the mouthwash after [DATE] or the mouthwash should have been removed from R1's bedside. The Administrator stated they will have to discuss the process for removing medications from a resident's bedside once a medication that is self-administered is discontinued. During an interview on [DATE] at 6:30 PM, the DON confirmed no new order was obtained to continue the chlorhexidine mouthwash past [DATE], and the medication should have been removed from R1's room when the last order expired.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425361	A. Building B. Wing	06/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southpointe Healthcare and Rehabilitation	35 Southpointe Drive Greenville, SC 29607

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 - Few	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 facility policy review, record review, observation, and interview, the facility failed to ensure medication was properly and securely stored during two random observations. Findings include:1. Review of the facility policy, Medication Management Program with an email revision date of 01/15/25, revealed, Security and Safety Guidelines: . 3. The medication cart is locked when not in use and in direct line of sight.During a random observation on 06/29/26 at 11:25 AM, revealed an unattended medication cart that was unlocked with the narcotic book open. Registered Nurse (RN)1 verified the observation. During an interview on 06/29/26 at 11:26 AM with RN1, she revealed the medication cart should have been locked. She stated she was going back and forth to a resident's room giving the resident her medications. RN1 revealed she was going back and forth from the cart to the room to look at the resident's information and she forgot to lock the cart and close the narcotics book and computer. During an interview on 06/29/26 at 11:26 AM, the Unit Manager (UM)1 verified the medication cart should have been locked. During a random observation on 06/29/26 at 4:18 PM, revealed an unattended medication cart that was unlocked on the Blue Unit. Licensed Practical Nurse (LPN)2 verified the observation. During an interview on 06/29/26 at 12:17 PM, the Director of Nursing (DON) revealed she was glad RN1 acknowledged she knew the cart should have been locked. During an interview on 06/26/26 at 6:10 PM, the Administrator revealed the medication carts should be locked at all times when not attended.2. Review of the facility policy, Self-Administration of Medications with a revision date of 04/17/24, revealed, Procedures: . 5. Facility should provide a secured compartment for storage of such medications in accordance with facility policy (see BEDSIDE STORAGE OF MEDICATION). Surveyor requested the document, Bedside Storage of Medication that was referenced in the policy but was told by the DON that the document did not exist. Review of R1's active orders did not show a current order for chlorhexidine mouthwash. Review of R1's medication administration record for 06/2026 revealed three past orders for chlorhexidine gluconate 0.12% mouthwash 15 cc. The first order read, Chlorhexidine gluconate mouthwash 0.12% swish 15 cc for 30 seconds twice a day for 7 days. The first order started on 05/31/26 and ended on 06/03/26. The second order read, Chlorhexidine mouthwash 0.12% swish 15 cc for 30 seconds three times a day after meals. May keep at bedside. The second order started on 06/03/26 and ended on 06/08/26. The third order read, Chlorhexidine mouthwash 0.12% swish 15 cc for 30 seconds three times a day after meals. May keep at bedside. The third order started 06/10/26 and ended 06/17/26. During an observation on 06/29/26 at approximately 3:00 PM, revealed a bottle of prescription chlorhexidine mouthwash on R1's bedside table. No lock box or lock on her bedside table drawer was observed. During an interview on 06/29/26 at approximately 3:15 PM, Licensed Practical Nurse (LPN)1 revealed R1 would keep the mouthwash at her bedside in the top drawer of her nightstand next to her bed.During an interview on 06/29/26 at 3:35 PM, the Director of Nursing (DON) revealed she believed R1's bedside table had a lock on it for her to store the chlorhexidine mouthwash in. During an interview on 06/26/26 at 6:10 PM, the Administrator revealed no medications should be left at the bedside. He stated the resident would be given a lock box to keep the medication in, or they can keep it in their bedside table if there is a lock.