

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425362	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER Ashley River Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1137 Sam Rittenburg Blvd. Charleston, SC 29407	
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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>Based on review of facility policy, observation and interview, the facility failed to ensure proper storage of medications. Specifically, loose pills were found in 3 of 3 medication carts. Findings Include: Review of the facility policy with a revision date of 07/2022, titled Medication Access and Storage, E Kit Access, revealed, Procedures: 1. The provider pharmacy dispenses medication containers that meet legal requirements, including requirement of good manufacturing practices where applicable. Medications are kept and stored in these containers. Any compromised or deteriorated medications or med packs shall be discarded upon discovery, according to procedures for medication destruction. During an observation on 03/17/2026 at 2:13 PM, of North 1 medication cart, revealed six (6) loose pills not packed for resident use. During an interview on 03/17/2026 at 2:13 PM, the medications were confirmed by Licensed Practical Nurse (LPN)2 and removed from the cart. During an observation on 03/18/2026 at 7:55 AM, of East 1 medication cart, revealed one (1) loose pill not packed for resident use and one Ziploc bag containing nine 1 ounce (oz) packets of pro-stat concentrated liquid protein 15g (gram) protein in 1 fl. (fluid) oz, with liquid in the bottom of the bag. During an interview on 03/18/2026 at 7:55 AM, the medications were confirmed by LPN1 and LPN2, and removed from the cart. During an observation on 03/18/2026 at 11:44 AM, of South 2 medication cart, revealed five (5) loose pills not packed for resident use. During an interview on 03/18/2026 at 11:44 AM, the medications were confirmed by LPN3 and removed from the cart. During an interview on 03/17/26 at 2:13 PM, LPN2 revealed that if pill pack is open when she comes across it, she would discard the pill because she would be unsure if it fell out and for infection control purposes she would go to the pyxis and get a replacement. LPN2 further states that the carts are cleaned daily, with a deep clean weekly. During an interview on 03/18/2026 at 7:55 AM, LPN4 revealed that carts should be cleaned nightly, by night shift, and loose pills will be discarded once discovered. During an interview on 03/18/26 at 12:01 PM, LPN1 revealed that carts care cleaned daily and cleaned at the end of each shift. During an interview on 03/18/26 at 4:07 PM, the Director of Nursing (DON) revealed that nurses should make sure their medication carts are clean as soon as they take ownership of the cart, the medication carts should be kept tidy throughout the shifts, and they should be wiped down at the end of each shift. The DON states that as soon as loose pills are discovered they should be discarded and if medications are needed, a new pill can be retrieved from the facility's multiple backup systems or they can contact the 24-hour pharmacy service.</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on review of facility policy, observation and interview, the facility failed to follow a process when handling and transporting soiled linen to reduce the possible spread of infection. Specifically, the bins in the soiled utility room on the 200 Hall had soiled linen and resident clothes that were not bagged at the point of use and brought to the soiled utility, room for 1 of 1 soiled utility rooms observed. Review of the facility policy titled, Departmental (Environmental Services) - Laundry and Linen, states, The purpose of this procedure is to provide a process for the safe and aseptic handling, washing, and storage of linen. The General Guidelines for Bagging and Handling Soiled Linen. 1. All soiled linen must be placed directly into a covered laundry hamper which can contain the moisture . 3. Transport soiled linen in a bag to soiled utility room. During an observation on 03/18/2026 at 8:20 AM, revealed Laundry Worker 1, pushing a large covered bin in order to pick up soiled linen from Hall 2. Laundry Worker 1 entered the soiled utility room on Hall 200, the soiled linen carts were running over with soiled linen. Very few bags of soiled linen were in the bin, most of the soiled linen was unbagged and thrown into the bin. Some linens were soiled with feces and urine. During an interview on 03/18/2026 at approximately 8:25 AM, Laundry Worker 1 stated, the soiled linen should have been placed in plastic bags before leaving the residents' rooms. She went on to say that most of the time the soiled linen is just thrown into the bins, its hardly ever bagged before taking it to the soiled utility rooms.</p>		