

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  425005	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/19/2024
NAME OF PROVIDER OR SUPPLIER  Cheraw Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  400 Moffat Road Cheraw, SC 29520	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>47914</p> <p>Based on observation, interview, record review, facility document review, and facility policy review, the facility failed to implement an appropriate fall intervention to prevent the wheelchair from rolling for 1 (Resident (R)1) of 3 sampled residents reviewed for falls.</p> <p>Findings included:</p> <p>A facility policy titled, Fall Policy and Procedures, revised 07/04/2019, indicated, Objective: To assure as safe of an environment as possible for our residents.</p> <p>R1's Face Sheet revealed the facility admitted the resident on 05/19/2021. According to the Face Sheet, the resident had a medical history that included diagnoses of abnormalities with gait and mobility, dementia, osteoporosis, osteoarthritis, and muscle weakness.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/13/2024, revealed R1 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS revealed R1 did not have any behaviors during the assessment period. The MDS revealed the resident had no range-of-motion impairment to the upper or lower extremities and the resident used a wheelchair. The MDS revealed the resident's ability to transfer, and walk was not assessed. According to the MDS, R1 was always incontinent of bowel and bladder. The MDS revealed the resident had sustained two or more falls without injury, two or more falls with minor injuries, and no falls with major injury since their prior assessment.</p> <p>R1's Care Plan included a problem statement with an onset date of 05/27/2021 that indicated the resident had the potential for falls resulting in injury related to limited mobility, poor endurance, poor judgement due to dysarthria, heart murmur, hypertension, osteoarthritis, history of prostate cancer, osteoporosis, anxiety, depression, dementia, syncope, transient ischemic attacks, and a history of urinary tract infections. Interventions directed staff to offer reminders not to arise unassisted as needed, transport to high visibility areas as needed, and to assist the resident to the bathroom every two hours and as needed.</p> <p>(continued on next page)</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An Accident/Incident Report, dated 10/12/2023, revealed R1 was eating in the dining room in their wheelchair and slid down out of the wheelchair into a sitting position on the floor. The report revealed the resident was assessed for injuries and none were noted. The report revealed an intervention for a nonskid pad on the wheelchair was crossed out. The report revealed an intervention was listed to reposition the resident in their wheelchair as needed.</p> <p>R1's Departmental Notes, dated 11/21/2023 at 4:19 PM, revealed staff were completing a body audit and heard a loud boom in the bathroom. The note revealed when the staff opened the bathroom door, R1 was sitting on the floor on their buttocks, leaning back with their head up. The note revealed that the resident stated, I hit the back of my head. The note revealed R1 was examined and slight redness was noted at the back of their head near their neck. The note revealed that no other injuries were noted, and the resident's range-of-motion was within their normal limits. The note revealed R1 was assisted by staff to their wheelchair. The note revealed the resident's vital signs were taken and within their normal limits. The note revealed the physician and resident representative were notified. The note revealed that the probable cause was R1 had gone to the restroom unassisted and the wheelchair rolled from underneath the resident before they sat down.</p> <p>An Accident/Incident Report, dated 11/21/2023, revealed preventive actions taken were to assist R1 to the bathroom every two hours and as needed, and to keep the resident in a highly visible area. The report revealed there were no documented interventions put in place to ensure the wheelchair did not roll from under the resident.</p> <p>R1's Departmental Notes, dated 12/18/2023 at 10:33 PM, revealed that at 6:45 PM, R1 was observed sitting upright on the floor in the television area after hearing a banging noise. The note revealed the resident was observed several minutes prior to the incident watching television. The note revealed the resident stated they were trying to get into their wheelchair, and it slipped from under them. The note revealed lacerations were noted to the residents right lower leg and bruising on their knee. The note revealed the resident had range-of-motion in all extremities. The note revealed the resident complained of pain but refused pain medication when offered. The note revealed the resident also refused to have their vital signs taken. The note revealed the physician and resident representative were notified, and x-rays were ordered.</p> <p>An Accident/Incident Report, dated 12/18/2023 revealed interventions that included continuing to keep R1 in visible areas and reminding the resident to ask for assistance with transfers. The report revealed that an intervention for keeping the wheelchair brakes locked was crossed out.</p> <p>An Accident/Incident Report, dated 05/09/2024, revealed R1 was trying to get in their wheelchair from the bed and the wheels were not locked, causing the resident to fall. The report revealed the resident had two bruised sites with open skin tears on their right leg and had three small pea size abrasions to their forehead. The report revealed that the preventive action put in place was to not leave the wheelchair in the resident's room when the resident was placed in bed. The report revealed that there was no intervention put in place to prevent the wheelchair from rolling from under the resident.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/18/2024 at 12:40 PM, the Director of Nursing (DON) indicated that previously there was a supervisory report completed, which had many of the same questions as the incident report. The DON stated that on this report, the supervisor could document any new interventions put into place. The DON indicated staff would not have a meeting after each fall, but falls would be discussed in the monthly quality assurance and performance improvement (QAPI) meetings.</p> <p>During an interview on 06/18/2024 at 3:18 PM, the DON stated the goal would be for a resident to not have any falls, but that was not realistic. She sated she would like to see the number of falls decrease by at least 50 percent. The DON indicated she would like to find better interventions that would decrease the number of falls while still providing the best care possible.</p> <p>During an interview on 06/19/2024 at 9:45 AM, the MDS Nurse and the DON both indicated the wheelchair skid pad was not available at the time of the fall on 10/12/2023. The MDS Nurse stated staff had been told an intervention could not be listed on the incident report if they were not able to implement it at the time. The DON stated they were not allowed to lock R1's wheelchair so the resident was free to move about. The DON also stated the intervention for more frequent toileting referred to staff checking on the resident between the two-hour intervals for rounds to make sure the resident did not need to use the restroom or be changed.</p> <p>During an interview on 06/19/2024 at 9:54 AM, the Medical Doctor stated his expectation was that interventions were done to try and make the environment safer for the resident in case they did fall.</p> <p>During an interview on 06/19/2024 at 12:34 PM, the Physical Therapy Assistant (PTA) stated that when the physical therapist performs an assessment, the goals were listed under the short-term goals or long-term goals. The PTA stated the for wheelchair mobility, the resident would usually be educated during therapy to make sure they locked the wheelchair before standing up or sitting down. The PTA stated that for R1, he did not feel the resident had the cognition to remember outside of the therapy sessions to lock the wheelchair. The PTA stated R1 was able to move around freely in the wheelchair.</p> <p>During an interview on 06/19/2024 at 1:40 PM, the DON stated she would need to get with the maintenance department to see if R1 could get a wheelchair that had automatic brakes to prevent it from rolling backwards.</p> <p>During a follow-up interview on 06/19/2024 at 3:02 PM, the DON stated education was provided to R1 on the importance of locking the wheelchair, but she realized the facility should have thought of a new intervention. The DON stated, going forward, the facility would implement additional interventions.</p>		