STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425005	A. Building B. Wing	11/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cheraw Healthcare	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)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility policy, record review, and interview, the facility failed to ensure a significant medication error did not occur when Resident (R)1 received medications intended for her roommate, resulting in R1 suffering from a low heart rate, low blood pressure, and becoming diaphoretic (excessive sweating), which required a hospital stay in intensive care from 08/23/25 until 08/26/25, for 1 of 1 resident reviewed for significant medication errors.On 11/06/25 at 1:35 PM, the survey team provided the DON with a copy of the CMS Immediate Jeopardy (IJ) Template and informed the facility IJ existed as of 08/23/25. The IJ was related to 483.45-Pharmacy Services.On 11/06/25 at 6:45 PM, the facility provided an acceptable IJ Removal Plan. The survey team validated the facility's corrective actions and determined that the facility put forth due diligence in addressing the non-compliance. The SA is considering this IJ at Past Non-Compliance as of 08/25/25.An Extended Survey was conducted in conjunction with the Complaint Survey for non-compliance at F760, constituting substandard quality of care. Findings include:Review of the facility policy titled Medication Error Reporting and Adverse Drug Reaction Prevention and Detection states under the Guidelines and Definitions: 1. Medication Error/Variance shall be defined as any preventable event that may cause or lead to inappropriate medication use or resident harm while the medication is in the control of the health care professional, resident or consumer.Review of R1's medical record on 11/06/25 revealed R1 was admitted to the facility with diagnoses including, but not limited to, stroke, aortic valve stenosis, seizure disorder, hypertension, depression, heart failure with atrial fibrillation and cognitive communication deficit. Review of R1's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/14/25 revealed a Brief Interview for Mental Status (BIMS) score of 5 out of 15, indicating R1 had severe cognitive deficits. Review of the Progress Notes for R1 dated 08/23/25 (2 notes) revealed, At around 09:30 PM, I heard [R1] calling for help. I, the RN on duty, went to the resident's bedside. She was found laying in the bed and asking for help to get up. She stated she felt sick. I adjusted the resident in bed and fanned her. While assessing her I found her pulse to be weak. I took the resident's blood pressure and she was found to be hypotensive. The Nurse Practitioner was notified of the resident's status, and she advised to call EMS for transport to send [R1] to the ER. EMS was called and the resident was picked up around 10:30 PM by EMS and transported to the hospital. The resident's family was contacted and informed of the transfer to the ER. Review of R1's Emergency Department (ED) Provider Notes with a Date of Service on 08/23/25 revealed the following: Chief Complaint: Drug Overdose (Pt form CHC after being given 15mg morphine among some other meds that was not hers). History of Present Illness: Patient brought to the emergency room from Cheraw health care after receiving multiple medications from another patient's medication list. She received a single dose of morphine sulfate extended release 15 mg a single dose of quetiapine fumarate 300 mg a single dose of Eliquis 5 mg a single dose of clonidine 0.1 mg a single dose of docusate sodium 100 mg a single dose of carvedilol 25 mg a single dose of atorvastatin 40 mg a single dose of hydralazine 100 mg and a single dose of gabapentin 100 mg. Patient's blood pressure is low and mental status is somewhat subdued. The patient received Narcan and 1 L of LR by EMS and 1 mg of Narcan by EMS.During an interview on 11/03/25 at 10:03 AM, Registered Nurse (RN)1 stated it all started when R1 was in the restroom yelling for help. I had already pulled the medications for her roommate, and they were in a cup. I carried the cup of medication into the room and helped R1 get up from the toilet and then gave her the medications that were for her roommate. When I realized it was a mistake, I started monitoring her. She became diaphoretic and her heart rate decreased. So, I notified my Unit Manager and she called the Nurse Practitioner and got an order to transport the resident to the ER.During an interview on 11/06/25 at 12:03 PM the DON stated she could not find in the medical record where the vital signs were monitored. She stated that she would expect the nurse to monitor the vital signs so that she could report them to the physician.During an interview on 11/06/25 at 12:10 PM, the Unit Manager stated that she knew the nurse was monitoring the vital signs. RN1 had come to her and told her she thought she gave the wrong medications to the resident and I told her to call the physician and give him the information and go from there. The Unit Manager confirmed that the vital signs were not in the medical record and stated that she would expect the nurse to document them in the medical record. On 11/06/25 at 6:45 PM, the facility provided an acceptable IJ Removal Plan, which included the following:1. MD notified, and Resident was sent to the hospital on [DATE]. Returned to facility on 08/26/2025. Resident returned with no adverse effects.2. All residents were assessed by the Director of