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	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cheraw Healthcare	400 Moffat Road Cheraw, SC 29520

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49801 Based on review of facility policy, record review, and interviews, the facility failed to ensure Resident (R)11, R62, R73, R96, and R100, had the right to formulate accurate Advance Directives for 5 of 8 residents reviewed for Advance Directives. Findings include: Review of the undated facility policy titled, Advance Directives Policy documented, It is the desire of Cheraw Healthcare Inc. to inform each resident of his/her right to make an informed decision concerning their medical care including: Their right to refuse or accept medical and surgical treatment and the right to formulate advance directives . Each record will be marked to signify that Advance Directives have been made . Review of the undated facility policy titled, Procedures for Advance Directives (DNR, Living Wills, Durable/Health Care Power of Attorney) documented, Information with respect to Advance Directives (Living Wills and Health Care Power of Attorney) in the form of pamphlets Medical Treatment and Your Living Will and Your Right to make Decisions about Your Health Care will be made available upon request. The Resident/Family member or representative will be responsible to make decisions concerning: B. The right to formulate advance directives . Copies of Advance Directives will be kept in the Social Services Coordinator's office and on the medical record. To alert physicians and staff, each record will be coded with A. D. for Advanced Directives. For No Code, the initials DNR will be placed on resident's record . 1. Review of R62's Face Sheet revealed R62 was admitted to the facility on [DATE], with diagnoses including but not limited to: Alzheimer's disease and unspecified dementia. Review of R62's Physician Order with a start date of 11/13/24 documented, DNR (Do Not Resuscitate). Review of R62's Medicare 5-Day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 10/18/24, did not reveal a Brief Interview for Mental Status (BIMS) score related to section C question 0100 being coded as no (rarely/never understood). Review of R62's Electronic Medical Record (EMR) on 11/13/24 at 12:13 PM, revealed there was no code status, however a Do Not Resuscitate (DNR) written order was discovered in R62's hard chart (paper chart). (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/13/24 at 12:09 PM, Licensed Practical Nurse (LPN)2 confirmed that there was no code status order in R62's EMR. LPN2 verified a written DNR order in the hard chart. LPN2 stated she would get an order put into R62's EMR. During an interview on 11/13/24 at 2:15 PM, the Director of Nursing (DON) and the Assistant Director of Nursing (ADON), stated that their expectations would be that the nurses would enter the residents code status into the EMAR when the resident is admitted . 46934 Findings include: 2. Review of R96's Face Sheet revealed R96 was admitted to the facility on [DATE], with diagnoses including but not limited to: anxiety disorder, dementia, atrial fibrillation, hypertension, and osteoarthritis. Review of R96's Physician Order on 11/12/24, did not reveal an order for R96's Code Status. Review of R96's Care Plan with a problem onset date of 05/09/24, revealed family has chosen R96 to be DNR. 3. Review of R11's Face Sheet revealed R11 was admitted to the facility on [DATE], with diagnoses including but not limited to: chronic kidney disease, retention of urine, muscle weakness, restless leg syndrome, and type 2 diabetes mellitus without complications. Review of R11's Physician Order on 11/12/2024, did not reveal an order for R11's Code Status. Review of R11's Care Plan revealed R11 has chosen to be DNR status. During an interview on 11/14/24 at 3:38 PM, LPN2 revealed the facility transitioned systems back in September 2024. LPN2 confirmed R96 and R11 did not have an active order for code status in the EMR and an audit was done once department entered the building to ensure those residents who did not have an order, to have one put in the system to match the code status in the residents' hard chart. 49818 4. Review of R100's Face Sheet revealed that the facility admitted R100 on 01/29/24, with diagnoses including but not limited to: fracture of unspecified part of neck of left femur, subsequent encounter for closed fracture with routine healing, Alzheimer's disease, and type 2 diabetes mellitus without complications. Review of R100's quarterly MDS with an ARD of 08/02/24, revealed R100 had a BIMS of 4 out of 15, indicating R100 had severe cognitive impairment. Review of R100's Hard Chart revealed a Do Not Resuscitate Order (DNR) notice to EMS (Emergency Medical Services) Personnel dated 04/27/24. Review of R100's Physician Orders with an active date of 08/31/24, revealed a Full Code status. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R100's Care Plan revealed, family has chosen R100 to be DNR Status. Interventions directed staff to; Resident's Advanced Directives Wishes Will Be Known, Review Advanced Directives on file, if applicable. During an interview on 11/13/24 at 2:05 PM, LPN2 revealed R100's hard/paper chart showed that their code status is Do Not Resuscitate (DNR) and that there was no order in the chart to support the status. LPN2 reviewed R100's EMR and revealed that their code status was listed as Full Code. LPN2 stated that R100 is on Hospice and that if they were in distress Hospice would be notified for a Registered Nurse (RN) to come in and assess, however if there was an RN on shift they would have them to come and assess and they would provide comfort measures for the resident. LPN2 stated that they personally would go by what's on the resident's hard/paper chart, but stated some nurses look in the computer. LPN2 explained that the advanced directives are updated by Social Services. LPN2 retrieved a written order from Social Services and revealed that the order listed R100 as full code. During an interview on 11/13/24 at 2:15 PM, Social Services revealed that Hospice has only given us the Do Not Resuscitate paperwork with the doctor's signature on it. During a follow up interview on 11/15/24 at 12:19 PM, Social Services revealed that they meet with residents and family representatives during admission to discuss code status, once a code status is chosen, a sticker is placed in the resident's hard chart and the status is put in the computer. Social Services stated that if a resident and/or their representative decides on a DNR status they sign the paperwork and then either the physician or the nurse practitioner signs it and writes an order for it. Social Services further explains that the resident and/or representative has 7 days to inform them if they want to change the status from DNR back to Full Code or vice versa, and once a change is made they would update the resident's hard chart as well as the electronic chart as soon as they have an signed order from the physician. During an interview on 11/15/24 at 11:49 AM, the DON and the ADON revealed that a resident's code status is established during admission between Social Services and the residents and their family. If the resident and their family opt for DNR, the DNR is signed by the resident or resident representative, the doctor writes an order, and the order and status would be placed in the hard chart and is also scanned and added to the resident's electronic chart. The DON states that it's their expectation that the EMR is updated in a timely manner and that any changes be communicated as soon as possible as soon as they are received. The DON and ADON further explains there is sometimes a question of the real code status when a resident goes on Hospice and they have had staff call Social Services on the weekend if there needs to be clarity of the status. The DON concluded that R100 is on Hospice and that there wasn't an order for the DNR documentation and Social Services had to call the Hospice agency for an order. During an interview on 11/15/24 at 12:56 PM, the Administrator revealed that a resident's code status is to be on their hard chart identified by a sticker. The Administrator explains that the resident's code status is determined at admission and is discussed at length with the resident and their family. The Administrator further reveals that the DNR paperwork in the resident's chart is signed by the resident or the resident representative and the physician and to their understanding that is the order for the DNR. The Administrator states that their expectation is that for a resident who is DNR, is for the resident's code status to be in the hard chart as well as scanned in. 50850 (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of R73's Face Sheet revealed R73 was admitted to the facility on [DATE], with diagnoses including but not limited to: Multiple fractures of ribs, right side, subsequent encounter for fracture with routine healing, repeated falls, myasthenia gravis without (acute) exacerbation, hypo-osmolality and hyponatremia, and parkinsonism. Further review of the Face Sheet revealed R73's code status was not documented on the Face Sheet. Review of R73's Quarterly MDS with an ARD of 10/16/24, revealed R73 had a BIMS score of 15 out of 15, indicating R73 was cognitively intact. Review of R73's Physician Orders revealed no orders for advanced directives. Review of R73's Hard Chart (binder containing paper copies of medical records) revealed a document titled Cheraw Healthcare Code Status Clarification and Competency Form dated 07/09/24, revealed a DNR code status for R73. Review of R73's Hard Chart revealed a document titled SC Emergency Medical Services dated 07/15/24, which indicated R73's code status was DNR. Review of R73's Hard Chart revealed a written order dated 07/15/24, which documented, Resident's DNR Status. Review of R73's Care Plan revealed, resident has chosen to be DNR status. The interventions directed staff to; resident's Advanced Directives Wishes Will Be Known, review advanced directives on file, if applicable. During an interview on 11/13/24 at 2:09 PM, LPN4 reviewed resident's code status on the EMAR and confirmed there was no indication of the resident's code status. LPN4 also looked in the MD orders in the EMR and there was no order for code status. LPN4 stated, the hard chart contained an order for the resident to be a DNR. LPN4 concluded that she would put the DNR order in the EMR. During an interview on 11/13/24 at 2:15 PM, the DON revealed ADON stated that their expectations would be that the nurses would enter the residents code status into the EMR when the resident is admitted . The ADON stated, We have already identified that we have a problem with some of the orders for code status being brought over when we changed to PCC (Point Click Care (Electronic system for medical records)).

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46934 Based on review of facility policy, record review, observation, and interviews, the facility failed to complete a restraint assessment, for the use of trunk restraint on wheelchair, for Resident (R)47, for 3 of 4 residents reviewed for the use of restraints. Findings include: Review of the facility policy titled Restraint Assessment Policy with a revision date of [DATE], documents, 4. Orders must be obtained for any chemical or physical restraints. 5. Physical restraint assessment will be initiated to evaluate the appropriateness restraint use. Review of R47's Face Sheet revealed R47 was admitted to the facility with diagnoses including, but not limited to: Dementia, major depressive disorder, anxiety disorder, cerebrovascular disease, and overactive bladder. During an observation on [DATE] at 11:15 AM and on [DATE] at 10:06 AM, revealed R47 was sitting in her non mechanical wheelchair near the nurses station in North Unit, self-propelling with a lap n lock padded lap desk over her lap. R47's arms were crossed and the resident was leaning forward on the lap desk. Review of R47's Physician Order dated [DATE], revealed, Lap-n-lock pillow while up in w/c to help define safe perimeter due to inability to comprehend physical limitations, check q 30 minutes and release q 2 hrs. every shift. Review of R47's Electronic Medical Record (EMR) and Hard Chart (contains paper copies of medical records) did not reveal documentation to indicate R47 was assessed for the use of the lap desk, which could potentially be considered a restraint. Review of R47's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE], revealed R47 had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, indicating R47 is severely cognitively impaired. Further review of the MDS revealed R47 is coded for Trunk restraint - Used daily During an interview on [DATE] at 11:25 AM, Registered Nurse (RN)1 confirmed R47 has a trunk restraint per order, Lap N Lock Pillow. RN1 stated R47 was constantly falling at one point, getting up unassisted, so an order was placed to minimize falls. RN1 further stated CNAs (certified nursing assistant) and nurses are responsible for taking it off every 2 hours, or if she wants to eat, lay down, and brief change. RN1 revealed the use of the trunk restraint started on [DATE], after a fall she had on [DATE], where she fell attempting to get up and ambulate from wheelchair. RN1 stated since the trunk restraint was in place, it has minimized the risk of further injury, since September, no injuries. RN1 confirmed she could not locate R47's restraint assessment and restraint consent in the current EMR and resident's hard chart. RN1 concluded she would follow up with the Director of Nursing (DON), to see if she could locate the documentation. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 12:06 PM, RN1 provided a wet ink copy of a document titled Positioning Device Assessment Form which was dated [DATE]. Review of this form indicated it was completed for another resident with a similar name, who had expired in March of 2024. RN1 confirmed she, the DON and ADON could not locate the restraint assessment for R47. Furthermore, confirmed the DON produced and signed the form on [DATE], for the incorrect resident. During a phone interview on [DATE] at 12:25 PM, R47's Resident Representative revealed R47 is a fall risk, drops things and will fall while bending over to attempt to grab them. R47's Resident Representative states R47 has been there for years and he doesn't remember signing a form, or consenting via phone to his mother having a restraint. On [DATE], the DON provided a document titled Positioning Device Assessment which was dated [DATE] for R47. The assessment indicated, Late Entry done on [DATE]. The DON also provided a handwritten copy for the consent for the positioning device with a date of [DATE]. Review of the consent form revealed there was no signature and handwritten on the form was, Tel consent. The DON revealed this documentation was produced today [DATE], due to not being able to locate the original due to switching systems. During an interview on [DATE] at 1:34 PM, the DON and ADON revealed after R47's fall, a new order for Lap N lock cushion was in place because of the fall on [DATE]. Prior to [DATE], R47 was a fall risk in general. The device was used to minimize the risk of falls. The DON and ADON stated the resident can remove the restraint herself in case of an emergency. The DON stated the order was effective [DATE] and the rationale for choosing the device, the resident prefers to be out of bed in her wheelchair and often leaning forward. The DON further stated to her knowledge there were no risks when the device is in use. The DON stated if the resident wanted the restraint removed, its typically honored, if there is a staff member available. The DON and ADON concluded their expectations are for all residents to have appropriate documentation in their chart.

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F 0693 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49801 Based on review of facility policy, observation, interview, and record review, the facility failed to ensure Resident (R)107 received proper positioning during tube feeding, which had the potential for aspiration for 1 of 1 resident reviewed. Findings include: Review of the facility policy titled Gastrostomy Tube Feeding (Bolus or Continuous Feeding) with a revision date of 10/10/19, documented, Purpose: 1. To feed the resident that has obstruction or disease of the esophagus or throat. 2. To feed the residents' that are unconscious or debilitated for long periods of time. 3. To reduce the danger of aspiration. 4. To provide adequate nourishment. Procedure: 6. Place resident in fowler's position [a semi-sitting position where a patient lies on their back with their head and upper body raised at an angle of 45 to 90]. Review of R107's Face Sheet revealed R107 was admitted to the facility on [DATE], with diagnoses including but not limited to: peptic ulcer, gastroduodenitis, severe intellectual disabilities, congenital hiatus hernia, and oropharyngeal phase dysphagia. Review of R107's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 10/22/24, did not reveal a Brief Interview for Mental Status (BIMS) score related to section C question 0100 being coded as no (rarely/never understood). Review of R107's Care Plan documented, the focus . requires tube feeding. Further review of the Care Plan revealed the following goal, The resident will be free of aspiration through the review date. The interventions directed staff to: Monitor/document/report PRN any s/sx of: Aspiration- fever, SOB, Tube dislodged, Infection at tube site, Self-extubation, Tube dysfunction or malfunction, Abnormal breath/lung sounds, Abnormal lab values, Abdominal pain, distension, tenderness, Constipation or fecal impaction, Diarrhea, Nausea/vomiting, Dehydration. During an observation and interview on 11/13/24 at 11:13 AM , R107 was observed lying on their right side, with the bed flat and tube feed infusing at Jevity 1.5 cal at 40 ml/hr. Licensed Practical Nurse (LPN)1 stated the bed should be 30-45 degrees elevated. LPN1 proceeded to raise the HOB (head of bed). During an interview on 11/15/24 at 2:07 PM, the Director of Nursing (DON) stated the expectation for staff is to elevate the HOB when finished with care to a 45 to 90 degree angle.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50850 Based on review of facility policy, record review, observation, and interview, the facility failed to provide respiratory care in accordance with professional standards. Specifically, the facility failed to ensure Resident (R)33 nebulizer machine, oxygen mask and medication chamber were clean and/or bagged when not in use for 1 of 1 resident reviewed for respiratory care. Findings include: On 11/15/24 at 10:00 AM, a request was made to review the facility policy on maintenance and storage of equipment associated with respiratory therapy tasks particularly nebulizer machines. On 11/15/24 at 10:30 AM, the Director of Nursing (DON) stated that there was no policy for the cleaning and storage of a nebulizer machine. Review R33's Face Sheet revealed R33 was admitted to the facility on [DATE], with diagnoses including but not limited to: Chronic Obstructive Pulmonary Disease (COPD) and anxiety disorder. Review of R33's Physician Orders with a start date of 09/03/24 and a revision date of 09/20/24, revealed an order for Albuterol Sulfate Solution Nebulizer 0.083% (2.5 MG/3ML) 1 vial via mask every 8 hours as needed for Shortness of Breath and Oxygen at 2 liters per Minute (LPM) via nasal cannula. During an observation and interview on 11/12/24 at 12:32 PM, revealed a nebulizer machine was in the seat of a chair beside the resident's bed. The oxygen mask was propped against the nebulizer machine. The mask was attached to the medication chamber and the tubing. The mask was not bagged. There was a clear liquid in the medication chamber. The medication chamber was attached to the mask and the oxygen tubing. R33 stated she is on 2 liters of oxygen. Oxygen (O2) concentrator was set to 2.5 LPM. During an observation on 11/13/24 at 11:20 AM, revealed R33 was resting in bed with eyes closed. O2 concentrator was set at 2.5 LPM. The nebulizer was in the chair at resident's bedside. A piece of tape on the nebulizer tubing documented 11/12/24. There was a clear liquid noted in the medication chamber. The oxygen mask was propped against the nebulizer machine. The mask was attached to the medication chamber and the tubing. The mask was not bagged. The O2 concentrator was set to 2.5 LPM. During an observation 11/14/24 at 3:37 PM, revealed R33 was out of bed in wheelchair. The O2 concentrator was set to 2.0 LPM. The nebulizer was in the chair at resident's bedside. A piece of tape on the nebulizer tubing documented 11/12/24. There was a clear liquid noted in the medication chamber. The oxygen mask was propped against the nebulizer machine. The mask was attached to the medication chamber and the tubing. The mask was not bagged. During an interview on 11/15/24 at 1:22 PM, the Director of Nursing (DON) revealed the nebulizer mask and medication chamber should be cleaned with water. The DON stated the mask and the separated medication chamber should then be placed on a paper towel to air dry. The mask and the separated medication chamber should then be placed in a zip lock bag and dated.

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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. 49801 Based on observations, review of facility policy, and interviews, the facility failed to remove expired medications and biologicals from 2 of 2 medication storage rooms. Findings include: Review of the undated facility policy titled, Medication Storage In The Facility documented, Policy: Medications and biologicals are stored safely, securely and properly following manufacturers' recommendations or those of the supplier. During an observation and interview on 11/14/24 at 7:21 AM, the medication storage room on the South Unit revealed, One (1) BD Vacutainer Red Top with lot number 2258780 and expiration date 09/30/24. Licensed Practical Nurse (LPN)2 verified the item was expired and removed it from the medication room. During an observation and interview on 11/14/24 at 7:53 AM, the medication storage room on the North Unit revealed the following: -One (1) BD Vacutainer Gel and Lithium Heparin [NAME] Top with lot number 3290681 and expiration date 10/31/24. The Director of Nursing (DON) verified the item was expired and removed it from the medication storage room. -Two (2) boxes of Covidien Filac Probe Covers with lot number 930156X and expiration date 08/31/24, containing 20 probe covers in each box. -One (1) box of Covidien Filac Probe Covers with lot number 930156X and expiration date 08/31/24, containing 19 probe covers. The DON verified the items were expired and removed them from the storage. During an observation and interview on 11/14/24 at 8:42 AM, the medication storage, in the hallway, on the North Unit revealed the following: -Three (3) Covidien Kangaroo Epump Sets with Flush 1000 ml with lot number 201110107 and expiration date 03/31/23. -One (1) Covidien Kangaroo Epump Set with Flush 1000 ml with lot number 2123613664 and expiration date 07/31/24. The DON verified the items were expired and removed them from storage.