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	03/12/2026

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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on review of facility policy, record review, and interview, the facility failed to ensure and document annual performance evaluations were completed for 5 out of 5 Certified Nursing Assistants (CNAs) reviewed.Findings include:Review of the undated facility policy titled Skill Competency Evaluations, revealed, All Nurse's and CNA's will have competency evaluations performed during orientation, annually, and prn (as needed) by designated staff.Review of personnel records for 5 of 5 CNAs, revealed no documentation of an annual performance evaluation within the required timeframe.During an interview on 03/12/2026 at 11:21 AM, the Human Resource Director confirmed that annual competency evaluations have not been completed for the CNAs reviewed.During an interview on 03/12/2026 at 3:34 PM, the Administrator confirmed that although competency evaluations are required to be completed annually for nurses and CNAs, they have not been completed as required.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on review of facility policy, record review, observation and interview, the facility failed to ensure Resident (R)5 received the needed care and services related to activities of daily living. Specifically R5, was not provided routine hair and nail care, for 1 of 1 resident reviewed for activities of daily living.Findings include: Review of the facility policy titled, Activities of Daily Living (ADL) Supporting, with a revision date of March 2018, revealed as the policy statement, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. The policy interpretation and implementation revealed, . 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care. Care and services to prevent and/or minimize functional decline will include appropriate pain management, as well as treatment for depression and symptoms of depression. 3. If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time, or having another staff member speak with the resident may be appropriate. 6. The resident's response to interventions will be monitored, evaluated and revised as appropriate. Review of R5's Face Sheet revealed the facility admitted R5 with diagnoses including, but not limited to, anxiety disorder, cerebral infarction, and history of urinary tract infections. Review of R5's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/21/2026, a return after a hospital stay, revealed a Brief Interview for Mental Status (BIMS) score of 4 out of 15, which indicated R5 suffered from severe cognitive deficits. Review of R5's Care Plan dated 02/02/2025, revealed a focus area that states, The resident has an ADL self-care performance deficit related to fatigue, impaired balance and stroke. The goal states, The resident will improve current level of function in ADLS through the review date. The interventions include, Bathing/showering: The resident requires extensive assistance from staff to provide a bath and a shower. [R5] requires extensive assistance with bed mobility, dressing and transfer. Personal hygiene, The resident requires partial/moderate assistance by staff for personal hygiene and oral care.During an observation on 03/10/2026 at 11:22 AM, revealed R5 in bed, her fingernails were dirty and her hair was in need of a wash.During an observation on 03/11/2026 at 10:26 AM, revealed R5 resting in bed, her clothes were changed from 03/10/2026, but her fingernails and hair are still in need of cleaning.During an observation on 03/12/2026 at 8:04 AM, I entered R5's room and her Responsible Party (RP) was in the room feeding R5. R5's fingernails remained dirty and her hair was dirty and matted to her head.During an interview on 03/11/2026 at 12:50 PM, the Administrator stated, she would talk with the nurse and see why the resident was not bathed and clean daily. During an interview on 03/12/2026 at 3:41 PM, Licensed Practical Nurse (LPN)2, who was assigned to provide care for R5 on all 3 days, stated, if this resident refuses a bath or shower they will tell her and she will attempt to encourage the resident to bathe. LPN2 stated she was not aware that R5 had not received a bath on any of the three days mentioned. Upon entering R5's room LPN2 showed me her hands and fingernails which had been cleaned and her hair had been shampooed today, after this surveyor brought the concern to their attention.

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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 review of facility policy, record review and interview, the facility failed to attempt a gradual dose reduction (GDR) for Resident (R)10, who has a diagnoses of Alzheimer's Dementia and is receiving 200 milligrams of Quetiapine at bedtime, for 1 of 5 residents reviewed for unnecessary medications. Findings include:Review of the undated facility policy titled, Unnecessary Medications, revealed, Purpose: To ensure residents are free from unnecessary medications and that all medications are prescribed and administered only when clinically indicated. The policy states, The facility will ensure that each resident's medication regimen is free from unnecessary medications. An unnecessary medication is defined as any medication used in excessive dose, excessive duration, without adequate monitoring, without adequate clinical indication, in the presence of adverse consequences, or without adequate attempts at dose reduction when indicated. 4. Residents receiving medications such as psychotropic medications will receive gradual dose reductions when clinically appropriate unless contraindicated. Documentation must support when dose reductions are attempted or when clinical rational exists for not attempting a reduction. 5. Psychotropic medications will be used when necessary to treat a specific diagnosed condition. Non-pharmacological interventions will be attempted when appropriate and monitoring for effectiveness and side effects will be documented.Review of R10's Face Sheet revealed the facility admitted R10 with diagnoses including, but not limited to, cognitive communication deficit, anxiety and Alzheimer's dementia.Review of R10's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/23/2026, revealed a Brief Interview for Mental Status (BIMS) score of 4 out of 15, indicating severe cognitive deficit.Review of R10's Physician Order revealed an order for: Quetiapine 200 milligrams to be given at bedtime each night, which was ordered by the physician on 05/22/2025 on admission.Review of R10's Medical Record revealed a weight on 03/04/2026 of 86 pounds and according to the Care Plan Report dated 02/23/2026 states, resident has a history of significant weight changes. Review of R10's Care Plan Report dated 05/25/2025, revealed a fall with minor injuries. The Care Plan Report dated 06/03/2025 ,revealed a fall with a fracture of her left femur. The Care Plan revision dated 09/02/2025, revealed a fall with minor injuries and again on 01/16/2026, a fall with a minor injury and a complaint of right hip pain.Review of R10's Note To Attending Physician/Prescriber with a MRR (Medication Regimen Review) date of 11/21/2025, revealed, The resident has been taking the antipsychotic Quetiapine 200mg at bedtime since May 2025. please evaluate the current dose and consider a dose reduction. The physician indicated, Resident with good response, maintain the current dose. The next section of the document stated, IMPORTANT: Please add resident specific documentation to support the above action or check below if information was added to physician progress notes this section was left blank and did not include clinical rationale nor physician progress notes. During an interview on 03/12/2026 at 9:38 AM, the Pharmacist stated she had recommended a reduction in the Seroquel on 11/21/2025 and the physician declined. She stated that the physician makes the decision whether to reduce the medications or not. I informed her that the physician has checked the area that stated, Resident with good response. there was no documentation on the dose reduction recommendation as to specific rationale for no dose reduction.During an interview on 03/12/2026 at 10:35 AM, the attending physician for R10, she stated that 200 milligrams of Seroquel was a large dose for an [AGE] year old weighing 86 pounds. I brought to her attention the weight loss and the falls. She also agreed that the weight loss and the falls could have been attributed to the Quetiapine. She stated she look at the chart and make a decision.

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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 on review of facility policy, observation and interview, the facility failed to ensure expired medications were removed from, and not in use with in-date medications for residents, in 1 of 4 medication carts.Review of the facility policy titled, Medication Labeling and Storage, states, . 2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner. During an observation on 03/12/2026 at approximately 4:00 PM, of the South Hall medication cart #1, revealed one bottle of Aspirin, 325 milligram tablets, with Lot #921X06 was expired on 01/26/2026. During an interview on 03/12/2026 at 4:06 PM, Licensed Practical Nurse (LPN)1 confirmed the expired medication and removed the bottle of Aspirin from the medication cart.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure temperatures were in range for safe food storage to prevent foodborne illness, in 1 of 2 nourishment room refrigerators.Findings include:Review of the undated facility policy titled, Policy: Resident Nourishment Refrigerator Temperature Monitoring, revealed, Purpose: To ensure all nourishment room refrigerators maintain safe temperature to prevent foodborne illness. Policy: All refrigerators used for resident nourishment storage will be maintained at 41 degrees F (5 degrees C) or below. Monitoring: Refrigerator temperature will be checked and documented daily by designated staff. Thermometers: Each refrigerator must contain a visible thermometer. Corrective Action: If temperature exceeds 41 degrees F, staff will recheck with 30 minutes and notify dietary or maintenance. Audits: Dietary manager or designee will conduct monthly audits to ensure compliance.During an observation on 03/12/26 at 8:40 AM, of the North Unit Hall-100 nourishment room refrigerator revealed the temperature gauge reading at 46 degrees Fahrenheit, which was verified by the kitchen manager. The refrigerator contained the following: nine (9) Mighty Shakes (strawberry and chocolate) 4FL oz., two (2) Medpass supplements drinks 32 FL oz., five (5) Glucerna Shake 10 FL oz., and eight (8) Ardmore 100% Orange Juice 4FL oz. The refrigerator also contained residents' personal food items. Review of the Daily Refrigerator/Freezer Temperature Checks Month February 2026-North Nourishment dated 02/24 revealed refrigerator temperature was 52 degrees Fahrenheit on 02/25 refrigerator temperature 52 degrees Fahrenheit, on 02/26 refrigerator temperature 50 degrees Fahrenheit, on 02/27 refrigerator 50 degrees Fahrenheit, on 02/28 refrigerator temperature 50 degrees Fahrenheit. Review of the Daily Refrigerator/Freezer Temperature Checks Month March 2026-North Nutrition dated 03/01 revealed refrigerator temperature 44 degrees Fahrenheit, on 03/02 refrigerator temperature 42 degrees Fahrenheit, on 03/04 refrigerator temperature 42 degrees Fahrenheit, on 03/09 refrigerator temperature 42 degrees Fahrenheit, on 03/10 refrigerator temperature 48 degrees Fahrenheit, on 03/11 refrigerator temperature 46 degrees Fahrenheit, on 03/12 refrigerator temperature 44 degrees Fahrenheit. During an interview on 03/12/26 at 9:12 AM, the Kitchen Manager (KM) revealed the unit nourishment rooms are maintained by the nursing staff. The refrigerator was recently replaced because the previous refrigerator was too small and was not big enough for nourishments and the residents' personal food. The refrigerator temperatures are normally checked before she gets into work. The nourishments are refilled by the kitchen staff, and they are expected to monitor the temperature readings and report to maintenance when the temperature is out of range. During an interview on 03/12/26 at 9:46 AM, the Maintenance Director revealed it was reported to him last week that the refrigerator temperature gauge was reading out of range. The temperature control was reset. The current refrigerator is new and was replaced on 02/19/26. The Maintenance Director believed it was the thermometer, so he changed it out, however, the temperature remained out of range. The Maintenance Director still didn't believe the thermometer is accurate and proceeded to switched out the thermometer again. During an interview on 03/12/26 at 10:00 AM, the Administrator revealed she was not aware the refrigerator temperatures were out of range. The Administrator stated they just found out and she asked maintenance to replace the thermometer and place it in the back of the refrigerator. The Administrator stated her expectation is for the temperature to be checked and when it is out of range to notify maintenance. The regulated temperature range is on the bottom of the temperature log and when to notify maintenance.