STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425176	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medford Nursing Center	105 Medford Drive Darlington, SC 29532

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 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 observation, interview, and facility policy review, the facility failed to ensure staff trimmed the fingernails of 1 (Resident (R)57) of 3 sampled residents reviewed for activities of daily living.Findings included:Review of an undated facility policy titled, Activities of Daily Living revealed, Policy: Staff assists or performs activities of daily living as indicated.Review of a facility policy titled, Nail Care, dated 04/2008, revealed, Policy: Resident's [sic] will receive proper nail care.Review of R57's admission Record revealed the facility admitted R57 on 06/12/2025. According to the admission Record, the resident had a medical history that included but was not limited to, diagnoses of, vascular dementia and cognitive communication deficit.Review of R57's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/10/2026, revealed R57 had a Brief Interview for Mental Status (BIMS) score of 0 out of 15, which indicated the resident had severe cognitive impairment. The MDS indicated the resident required substantial/maximal assistance with personal hygiene.Review of R57's Care Plan Report included a focus area revised on 08/11/2025, that indicated the resident required assistance with activities of daily (ADL) care. Interventions directed staff to check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse (initiated 07/30/2025).During an observation on 03/16/2026 at 10:02 AM and 03/17/2026 at 1:45 PM, R57 was resting in bed with their hands placed on her chest. R57's fingernails were long and extended past their fingertips.During an interview on 03/17/2026 at 2:40 PM, Certified Nursing Assistant (CNA)4 stated she was assigned to provide care to R57 and gave the resident a shower on 03/17/2026. CNA4 stated residents were usually offered nail care if the resident requested. CNA4 stated she did not observe R57's fingernails when she gave the resident a shower and explained that she did not even look at the resident's fingernails.During a concurrent observation and interview on 03/17/2026 at 2:48 PM, R57 was resting in bed with their hands placed on their chest. CNA4 observed R57's fingernails on both hands and stated the resident's fingernails needed to be trimmed.During an interview on 03/18/2026 at 11:09 AM, Licensed Practical Nurse (LPN)8 stated a resident's fingernails should be trimmed, if needed, as part of the resident's shower. LPN8 stated she would expect for the CNA staff to ensure a resident's fingernails were trimmed.During an interview on 03/19/2026 at 2:03 PM, the Director of Nursing (DON) stated the CNA staff primarily provided showers and bed baths to the residents at the facility. The DON stated nail care would typically be offered outside of the shower time because it could be too much for a resident to handle all at one time, so they would usually offer it in between shower days if it was needed. The DON stated R57 depended on the CNA staff to assist them with ADL care.During an interview on 03/19/2026 at 2:31 PM, the Executive Director (ED) stated residents could be offered nail care any time they requested. The ED stated if a resident was not able to make their needs known, the CNA staff should evaluate the resident's need for nail care during routine care. The ED stated resident's fingernails that extended past the resident's fingertips would be a good indicator the resident's fingernails needed to be trimmed, and she would expect CNA staff to keep the resident's fingernails trimmed, as long as the resident approved.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview, record review, and facility policy review, the facility failed to ensure a resident's medical record accurately reflected the resident's use of a hearing amplifier (a device designed to amplify environmental sound that was not prescribed by a professional or intended to treat hearing loss) for 1 (Resident (R)61) of 1 sampled resident reviewed for communication and sensory issues.Findings include:Review of a facility policy titled, Maintenance of Clinical Records, dated 07/2023, revealed, . 2. In accordance with accepted professional standards of practices, the facility must maintain medical records on each resident's that are: a. Complete b. Accurately documented.Review of R61's admission Record revealed the facility admitted R61 on 04/29/2024. According to the admission Record, the resident had a medical history that included but was not limited to, diagnoses of, need for assistance with personal care and cognitive communication deficit.Review of R61's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/17/2026, revealed R61 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated the resident had intact cognition. The MDS indicated the resident used a hearing aid or other hearing appliance.Review of R61's Care Plan Report included a focus area revised on 07/08/2025, that indicated the resident was at risk for complications/injury related to difficulty hearing and wore bilateral hearing aids as tolerated. Interventions directed staff to assist the resident with placement of and removal of hearing aids as needed (initiated 07/07/2025) and turn hearing aids on and off as indicated (initiated 07/07/2025).Review of R61's Physician Orders revealed an order dated 11/27/2024 that directed the staff to remove the resident's hearing aids every night and place them on the nurses' cart, and an order dated 11/28/2024 that directed staff to place the resident's hearing aids in the resident's ear every morning.Review of R61's Treatment Administration Record [TAR] for the timeframe 03/01/2026 - 03/31/2026, revealed the transcription of a physician's order that specified remove the resident's hearing aid every night and place on the nurses' cart and place the resident's hearing aids in their ear every morning. According to the TAR, staff placed their initials on the TAR to indicate they placed R61's hearing aids in the resident's ear every morning and removed the hearing aids every night and placed them on the nurses' cart on 03/01/2026 to 03/16/2026.During an interview on 03/18/2026 at 9:07 AM, Licensed Practical Nurse (LPN)2 stated R61 did not have hearing aids and never had hearing aids.During an interview on 03/18/2026 at 9:15 AM, the Social Services Director (SSD) stated R61 had hearing amplifiers. Per the SSD, she was not sure why R61 had orders or a care plan that directed staff to put hearing aids in the resident's ear every morning and take them off at night.During an interview on 03/18/2026 at 12:49 PM, the Director of Nursing (DON) stated R61 and their responsible party were given options, but the responsible party did not wish to go forward with hearing aids for the resident. The DON stated the facility ordered amplifiers for the resident, and there was a noticeable difference when the resident had the amplifiers in and when they did not have them in. The DON stated she expected a resident's care plan to be accurate.During a follow-up interview on 03/19/2026 at 10:25 AM, the DON stated she expected information contained within a resident's medical record to accurately reflect the care provided.During an interview on 03/19/2026 at 10:30 AM, the Executive Director stated all information contained within the resident's medical record should be accurate.