STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425302	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehab Center of Cheraw	1150 State 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31846 Based on records reviews and interviews, the facility failed to implement the Comprehensive Plan of Care for Resident (R)24 related to a significant weight loss for 1 of 2 residents reviewed with a significant weight loss. The facility further failed to implement the Comprehensive Plan of Care related to the provision of activities of interest for R24 to attain or maintain the resident's highest practicable-physical, mental and psychosocial well being for 1 of 1 residents reviewed for activities. Findings include: The facility admitted R24 on 01/31/24 with diagnoses including, but not limited to, depression, anxiety, bipolar disorder and schizophrenia. Review on 04/22/24 at 01:55 PM of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated severe cognitive impairment. Review on 04/22/24 at 01:55 PM of the medical record for R24 revealed the following weights: On 02/01/24, R24 weighed 243.8 pounds. This was the weight on admission. On 02/05/24, R24 weighed 239.0 pounds. On 02/06/24, R24 weighed 237.6 pounds. On 02/13/24, R24 weighed 224.6 pounds. On 03/09/24, R24 weighed 215.8 pounds. On 03/11/24, R24 weighed 218.6 pounds. On 03/12/24, R24 weighed 215.6 pounds. On 03/19/24, R24 weighed 213.8 pounds. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Rehab Center of Cheraw	1150 State 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/26/24, R24 weighed 213.8 pounds. On 04/02/24, R24 weighed 211.2 pounds. On 04/09/24, R25 weighed 215.0 pounds. Total weight loss from 01/31/24 until 04/09/24 is 28.8 pounds. Review on 04/22/24 at 02:10 PM of the Comprehensive Plan of Care revealed a nutritional status problem area and states: Resident is at risk for malnutrition. She is receiving a regular diet with thin liquids. The goal dated 02/01/24 reads: Resident will maintain nutritional status as evidenced by no significant weight change through next review. The interventions listed are: Encourage to dine in dining room as is appropriate, honor food preferences as feasible, monitor and encourage intakes of foods and fluids, offer alternates if intakes are less than adequate. Monitor weights, skin report, and labs per policy, offer snacks per policy, provide assistance with meals and snack if needed and provide diet as ordered by the physician. During an interview on 04/23/24 at 10:00 AM with the Registered Dietician (RD), he stated that he put in an order for a dietary supplement today. The RD was asked what interventions were put into place to prevent significant weight loss, and he stated, R24 was obese and sometimes weight loss is a good thing. The RD was asked how he found out about weight loss and he stated that he looks at the weights in the computer by just looking them up, but no one informs him of weight loss within the residents. During an interview on 04/23/24 at 12:05 PM with the Director of Nursing concerning the weight loss, she stated that her expectations were that staff would notify the physician and the RD. She stated that she will look at weights from time to time and staff do offer the resident snacks, eventhough there is no documentation to ensure the snacks are offered or consumed. Review on 04/22/24 at 3:18 PM of the activity attendance sheets for R24 revealed no one to one activities, and no activities documented for February 24 and only socialization for March 24. Review on 04/22/24 at 3:48 PM of the Comprehensive Plan of Care R24 revealed a problem area of activities and states: Resident is non-verbal and will be receiving one to one visits with documentation by activity staff in an effort to meet her physical, emotional, and intellectual needs. The goal states: Resident will actively participate in one on one visits with activity staff until next review. The interventions start date is 03/18/24 and include, staff will provide one to one pet therapy, staff will provide one to one religious visits, one on one music hour, and one to one reading. Staff will provide one on one socialization. Staff will observe and document her participation level during activities. Staff will provide one on one outdoor activities, staff will provide one to one beauty/barber as tolerated. Staff will provide manicures as tolerated and staff will provide monthly activity calendar. No documentation could be found in the medical record for R24 to ensure R24 was receiving the one to one activities. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/23/24 at 09:00 AM with the Activity Director, this surveyor had her to take a look at the activity attendance sheets she had provided to me for January, February and March 24. She stated this resident has been in and out of the hospital. I asked her about the Comprehensive Plan of Care which had a start date of 03/18/24 for one to ones, and she did provide a sheet from 04/01/24 through 04/22/24. She confirmed that no one to one activities as listed on the plan of care were provided to R24 and no activities were offered or documented in February '24.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49801 Based on observation, interview, and record review, the facility failed to monitor behaviors and medication side effects for Resident (R)60 and 20 for 2 of 5 residents reviewed for unnecessary medications. Findings include: Review of the facility policy titled Nursing Policies and Procedures Subject: Medication Management Program revision date 05/05/23 revealed, Policy: The Facility implements a Medication Management program to meet the pharmaceutical needs of patients and residents, according to established standards of practice and regulatory requirements. Scope and Roles: 3. Licensed nurses will evaluate, assess, monitor, document and report the effectiveness of the medication regimen that includes all medications and supplements prescribed to treat illness, disease process, or enhance the patient's/resident's quality of life. Guidelines for Implementing an Efficient Medication Pass: 1B. The facility will ensure the schedules for administering medications: 1) Maximize the effectiveness of the medications. 2) Prevent potential for significant medication interactions .Preparing for the Medication Pass 8. Documentation of medications administered is completed according to State and Federal requirements. The initials and verifying signature are generally required. Administering the Medication Pass 11. Immediately after administering the medication to the resident, the authorized staff or licensed nurse will return to the medication cart and document medication administration with initials on the MAR. If a medication is not administered, the authorized staff or licensed nurse must explain why it was not given. Review of R60's Face Sheet revealed R60 was admitted to the facility on [DATE] with diagnoses including but not limited to: acute respiratory failure, chronic obstructive pulmonary disease, diabetes mellitus, major depressive disorder, and myocardial infarction. Review of R60's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/19/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R60 was cognitively intact. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R60's Care Plan with a start date of 11/05/2020 and target date 05/24/2024 documented, the problem: R60 .has potential for discomfort & adverse effects r/t [related to] use of antipsychotic & antidepressant medications. Documented goal: R60 .will be free of discomfort or adverse effects of antipsychotic & antidepressant use through next review. Documented approach revealed, Observe for muscle rigidity, increased temp, hypotension, dry mouth, sedation, tremors, tardive dyskinesia, increased confusion, change in LOC, sudden change in mood/behavior status. Additionally, the care plan documented, the problem: R60 .has potential for side effects r/t use of multiple rx [prescription]. Documented goal: R60 . will experience no drug related side effects. Documented approach revealed, Observe for inc confusions, insomnia, nervousness, tremors, changes in loc, dec appetite, wt loss. Additionally, the care plan documented, the problem: R60 .has hx [history] of verbally abusive behavioral symptoms. Documented goal: R60 .will have a decreased number of verbally abusive episodes through next review. Documented approach revealed, Assess whether the behavior endangers the resident and/or others. Intervene if necessary. The care plan had a start date of 03/15/21 and target date 05/24/24, documented the problem: R60 .has potential for difficulty falling asleep & [and] remaining asleep r/t [related to] dx [diagnosis] of Insomnia. Documented goal: R60 .will be comfortable as evidenced by verbalization of getting enough sleep most of the night through next review. Documented approach revealed, Meds as ordered per MD. Review of R60's Medication Administration Record (MAR) for 04/01/24 - 04/22/24 revealed an order for Behavior Monitoring twice daily: ANTIDEPRESSANT Drug ** DULOXETINE. CRYING/SADNESS. Special Instructions: INTERVENTIONS: A: Physical Needs Met B: Distraction C: Redirection D: Validation E: Activity Program F: Quiet Time/Rest G: Increased Observation H: Other I: No interventions needed OUTCOMES: 1. Improved, 2. Unchanged, W. Worsened Twice A Day 07:00 - 19:00, 19:00 - 07:00. The MAR also revealed an order for, Behavior Monitoring twice daily: ANTIPSYCHOTIC Drug Use **CRYING/SADNESS Special Instructions: INTERVENTIONS: A: Physical Needs Met B: Distraction C: Redirection D: Validation E: Activity Program F: Quiet Time/Rest G: Increased Observation H: Removal of Stressors J: Other K: No interventions needed OUTCOMES: 1. Improved, 2. Unchanged, Twice A Day 07:00 - 19:00, 19:00 - 07:00. The MAR also revealed an order for, Behavior Monitoring twice daily: HYPNOTIC Drug Use **MELATONIN. CHANGES IN SLEEP PATTERN. Special Instructions: INTERVENTIONS: A: Physical Needs Met B: Distraction C: Redirection D: Validation E: Activity Program F: Quiet Time/Rest G: Increased Observation H: Removal of Stressors J: Other K: No interventions needed OUTCOMES: 1. Improved, 2. Unchanged, Twice A Day 07:00 - 19:00, 19:00 - 07:00. The MAR also revealed an order for, Monitor for side effects twice daily: ANTIDEPRESSANTS Special Instructions: SIDE EFFECTS: 0. NONE 1. Dry Mouth 2. Blurred Vision 3. Constipation 4. Urinary Retention 5. Hypotension 6. Appetite Changes 7. Headache 8. Insomnia 9. Dyspepsia 10. Weight Changes 11. Suicidal ideations; Wishes of death; Attempts to harm self Twice A Day 07:00 - 19:00, 19:00 - 07:00. The MAR also revealed an order for, Monitor for side effects twice daily: ANTIPSYCHOTIC DRUG USE Special Instructions: SIDE EFFECT CODES: 0. NONE 1. Neck Stiffness 2. Confusion 3. Muscle Rigidity 4. Involuntary Movements 5. Drooling 6. Tremors 7. Restlessness 8. Sleep Disturbances 9. Dry Mouth 10. Blurred Vision 11. Constipation 12. Sedation Twice A Day 07:00 - 19:00, 19:00 - 07:00. The MAR also revealed an order for, Monitor for side effects twice daily: HYPNOTICS Special Instructions: SIDE EFFECT CODES: 0. NONE 1. Sedation 2. Dizziness 3. Confusion 4. Nightmares 5. Daytime Anxiety 6. Hallucinations 7. Fatigue 8. Headache 9. Sedation Twice A Day 07:00 - 19:00, 19:00 - 07:00. Review of R60's Physician Order with a start date of 02/13/24 documented, Behavior Monitoring twice daily: ANTIDEPRESSANT Drug ** DULOXETINE. CRYING/SADNESS. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Special Instructions: INTERVENTIONS: A: Physical Needs Met B: Distraction C: Redirection D: Validation E: Activity Program F: Quiet Time/Rest G: Increased Observation H: Other I: No interventions needed OUTCOMES: 1. Improved, 2. Unchanged, W. Worsened Twice A Day 07:00 - 19:00, 19:00 - 07:00. The MAR also revealed an order for, Behavior Monitoring twice daily: ANTIPSYCHOTIC Drug Use **CRYING/SADNESS Special Instructions: INTERVENTIONS: A: Physical Needs Met B: Distraction C: Redirection D: Validation E: Activity Program F: Quiet Time/Rest G: Increased Observation H: Removal of Stressors J: Other K: No interventions needed OUTCOMES: 1. Improved, 2. Unchanged, Twice A Day 07:00 - 19:00, 19:00 - 07:00. The MAR also revealed an order for, Behavior Monitoring twice daily: HYPNOTIC Drug Use **MELATONIN. CHANGES IN SLEEP PATTERN. Special Instructions: INTERVENTIONS: A: Physical Needs Met B: Distraction C: Redirection D: Validation E: Activity Program F: Quiet Time/Rest G: Increased Observation H: Removal of Stressors J: Other K: No interventions needed OUTCOMES: 1. Improved, 2. Unchanged, Twice A Day 07:00 - 19:00, 19:00 - 07:00. The MAR also revealed an order for, Monitor for side effects twice daily: ANTIDEPRESSANTS Special Instructions: SIDE EFFECTS: 0. NONE 1. Dry Mouth 2. Blurred Vision 3. Constipation 4. Urinary Retention 5. Hypotension 6. Appetite Changes 7. Headache 8. Insomnia 9. Dyspepsia 10. Weight Changes 11. Suicidal ideations; Wishes of death; Attempts to harm self Twice A Day 07:00 - 19:00, 19:00 - 07:00. The MAR also revealed an order for, Monitor for side effects twice daily: ANTIPSYCHOTIC DRUG USE Special Instructions: SIDE EFFECT CODES: 0. NONE 1. Neck Stiffness 2. Confusion 3. Muscle Rigidity 4. Involuntary Movements 5. Drooling 6. Tremors 7. Restlessness 8. Sleep Disturbances 9. Dry Mouth 10. Blurred Vision 11. Constipation 12. Sedation Twice A Day 07:00 - 19:00, 19:00 - 07:00. The MAR also revealed an order for, Monitor for side effects twice daily: HYPNOTICS Special Instructions: SIDE EFFECT CODES: 0. NONE 1. Sedation 2. Dizziness 3. Confusion 4. Nightmares 5. Daytime Anxiety 6. Hallucinations 7. Fatigue 8. Headache 9. Sedation Twice A Day 07:00 - 19:00, 19:00 - 07:00. During an interview on 04/23/24 at 11:42 AM, the Director of Nursing (DON) stated that her expectations are that physician orders are followed for medication administration. She reported that the facility ensures accuracy of documentation on the MAR by pulling a compliance report daily and either the DON or Assistant Director of Nursing (ADON) addresses identified issues. Education is provided to staff. She stated that unfortunately they use a lot of agency nurses, which makes it challenging. During an interview on 04/23/24 at 4:34 PM, Licensed Practical Nurse (LPN)1 verified that there was no documentation for behavior monitoring related to antidepressant use on 04/19/24 at the 7A-7P timeframe on the MAR, no documentation for side effect monitoring related to antipsychotic use on 04/19/24 at the 7A-7P and 7P-7A timeframes on the MAR, and no documentation for side effect monitoring related to hypnotic use on 04/19/24 at the 7A-7P timeframe on the MAR. LPN1 stated that the expectation is to have this documentation completed by the end of the shift. 48834 A review of the facility policy titled, Pharmacy Services Policies and Procedures- Medication Management, revised 04/01/2022, indicated the facility will ensure that each resident's entire drug/medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial wellbeing. R20 was admitted to the facility with diagnoses including but not limited to, schizoaffective disorder, generalized anxiety disorder, urinary tract infection, bipolar disorder, depressive episodes, and dementia. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R20's annual MDS with an ARD of 04/10/24, indicated R20 is ordered to take, but is not limited to, antipsychotic and antidepressant medications. A review of R20's care plan indicated a potential for discomfort & adverse effects related to the use of antipsychotic and antidepressant medications. A review of R20's care plan and progress notes did not reveal that R20 refused medications on 04/15/24 or 04/16/24. A review of R20's physician orders indicate Monitor for side effects every shift: Antipsychotic Drug Use with a start date of 07/13/2023, Monitor for side effects twice daily: Anticonvulsant with a start date of 07/26/2023, Monitor for side effects twice daily: Antidepressant with a start date of 07/13/2023. A review of R20's Behavior Monitoring Administration History, from 04/01/2024 until 04/23/2024, indicated that R20 did not receive Behavior Monitoring Every Shift: Antipsychotic Drug Use- Olanzapine, Behavior Monitoring twice daily: Anticonvulsant Drug- Depakote, Behavior Monitoring twice daily: Antidepressant- Trazadone/Paxil, Monitor for side effects every shift: Antipsychotic Drug Use, Monitor for side effects twice daily: Anticonvulsant, and Monitor for side effects twice daily: Antidepressants on 04/15/2024 during the day shift. During an interview on 04/23/24 at 03:00 PM, the DON expressed they expect nurses to document the MAR and TAR once completing a task ordered by the physician. The DON confirmed that there were several blanks on R20's TAR and MAR for April 2024, but was unsure why there were several blanks.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31846 Based on review of the facility policy titled,Weighing the Resident, records reviews and interviews, the facility failed to ensure Resident (R)24 and R91 received care and services to prevent significant weight loss or to decrease the likelihood of further weight loss for 2 of 2 residents reviewed with significant weight loss. Findings include: Review of the facility policy titled, Weighing the Resident, states as the policy statement, Patient/Resident weights will be recorded and monitored at least monthly. Under the section on titled, Procedures states, 2. If the month-to-month weight shows more than a five-percent gain or loss, the patient/resident is reweighed in the presence of licensed personnel. 3. Record all weights per facility protocol. 4. If there is an actual 5% or more gain or loss in one month, notify the patient/resident/family, physician, and the Registered Dietician. Document this notification per facility protocol. 5. The facility Dietitian reviews the patient's/resident's nutritional status and makes recommendations for intervention if significant weight change is noted. 7. Update the plan of care with goals and approaches/interventions listed. 9. Unplanned and undesired weight variance will be evaluated for significance utilizing the following guidelines: 3% in one week; 5% in 30 days; 7.5% in 90 days; 10% in 180 days. The facility admitted R24 with diagnoses including, but not limited to, depression, anxiety, bipolar disorder and schizophrenia. Review on 04/22/24 at 01:55 PM of the admission minimum data set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated severe cognitive impairment. Review on 04/22/24 at 01:55 PM of the medical record for R24 revealed the following weights: On 02/01/24, R24 weighed 243.8 pounds. This was the weight on admission. On 02/05/24,R24 weighed 239.0 pounds. On 02/06/24, R24 weighed 237.6 pounds. On 02/13/24, R24 weighed 224.6 pounds. (continued on next page)

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/09/24, R24 weighed 215.8 pounds. On 03/11/24, R24 weighed 218.6 pounds. On 03/12/24, R24 weighed 215.6 pounds. On 03/19/24, R24 weighed 213.8 pounds. On 03/26/24, R24 weighed 213.8 pounds. On 04/02/24, R24 weighed 211.2 pounds. On 04/09/24, R25 weighed 215.0 pounds. Total weight loss from 01/31/24 until 04/09/24 is 28.8 pounds. During an interview on 04/23/24 at 10:00 AM with the Registered Dietician (RD), he stated that he put in an order for a dietary supplement today. He went on to say that the resident had been in the hospital. He stated R24 was obese and sometimes weight loss is a good thing. I informed him that unless the physician orders a weight loss program then interventions should be put into place to ensure the residents do not have significant weight loss. I asked how he found out about weight loss and he stated that he looks at the weights in the computer by just looking them up. No one notifies him of weight loss. I also stated that a dietitian note had recommended a supplement but was not ordered. During an interview on 04/23/24 at 12:05 PM with the Director of Nursing (DON) concerning the weight loss, she stated that her expectations were that staff would notify the physician and the RD. She stated that she will look at weights from time to time. She stated that staff do offer the resident snacks, eventhough there is no documentation to ensure the snacks are offered or consumed. 46991 Review of R91's Face Sheet revealed R91 was admitted to the facility on [DATE] with diagnoses including but not limited to; sepsis, mycosis, pain, dysphagia, muscle weakness, long term use of opiate analgesic, nausea, constipation, major depressive disorder, urinary tract infection, diabetes, anxiety disorder, unsteadiness, lack of coordination, and cognitive communication deficit. Review of R91's Quarterly MDS with an Assessment Reference Date (ARD) of 03/18/24 revealed a BIMS score of 05 out of 15, indicating R91 has severe cognitive deficits. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R91's Nutrition note dated 04/09/24, revealed the Reason for Referral: Weight Review. Diet Order: Pureed with thin liquids. Supplements: Glucerna and Sugar free ice cream with lunch/dinner. Documented intake: Poor. Snacks provided appropriately, HS. Weight: 121.6 pounds (lbs)(4/7/24); 125 pounds (3/13/24); 142 pounds (1/23/24); 166 pounds (10/10/23). BMI: 19.04. Medications reviewed. Skin Integrity intact. Blood glucose values within target goal range X ~ 30 days. Nutrition Diagnosis: 1) Unintended weight loss related to intake as evidenced by significant decrease-CONTINUE. 2) Diet consistency difficulty related to chronic condition as evidenced by mechanically altered diet-CONTINUE. Summary: Poor intake continues, family providing Ensure - resident accepts well. Note GI referral due to persistent vomiting. Undesired weight loss continues. Recommendations/Plan: 1) Discontinue Glucerna 2) Add Ensure Plus or equivalent TID 3) RDN available PRN or when nutrition status changes; will follow as needed. 4) Weights as ordered. Goals: 1) Maintain a healthy weight status without further significant/severe change. 2) Maintain skin integrity. 3) Tolerate PO. Review R91's of Progress Note dated 03/19/24 documented, Nutrition Note. Reason for Referral: Quarterly Review and Weight Review. Diet Order: Pureed with thin liquids. Supplements: Glucerna with lunch/dinner. Documented intake: Poor. Snacks provided appropriately, HS. Weight: 125 pounds (3/13/24); 132 pounds (2/6/24); 150 pounds (12/5/23); 181.6 pounds (9/15/23). BMI: 19. 58. Medications include Cyproheptadine, Omeprazole, Mirtazapine and Vitamin D. Skin Integrity intact. Blood glucose values within target goal range X ~ 30 days. Nutrition Diagnosis: 1) Unintended weight loss related to intake as evidenced by significant decrease-CONTINUE. 2) Diet consistency difficulty related to chronic condition as evidenced by mechanically altered diet. Summary: Diet downgraded 3/15/24, which may be contributing to continued poor intake-receiving 2 appetite stimulants (second added recently and to increase mg) and supplements to encourage intake. Undesired weight loss continues, although it has slowed recently. Skin intact. Blood glucose values within target goal range. Recommendations/Plan: 1) Continue plan of care. 2) RDN available PRN or when nutrition status changes; will follow as needed. 3) Weights as ordered. Goals: 1) Maintain a healthy weight status without further significant/severe decrease. 2) Maintain skin integrity. 3) Tolerate. No changes were made even after a steady weight loss and a noted -7.04 weight loss in March. Review of R91's weights on Electronic Medical System revealed for the past six months from November 2023 to April 24, he lost -23.62 lbs. R91's weights were recorded as follows: 04/07/24 - 121.6 lbs 03/13/24 -125 lbs. 02/06/24-132 lbs. 01/23/24-142 lbs. 12/05/23-150.0 lbs. 11/04/23-159.2 lbs. Review of R91's Intake report from 11/01/2023 to 04/23/24 documented minimum intake of meals and fluids. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehab Center of Cheraw	1150 State Road Cheraw, SC 29520

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/23/24 at 9:59 AM, the RD acknowledged R91's weight loss. He stated they added ensure and sugar free ice cream, but in March '24, the RD noted weight loss, but they did not make any additional revisions to address weight loss. During an interview on 04/23/24 at 12:11 PM, the DON stated, she expects staff to notify the Doctor and RD if there is a weight loss. She stated if she is aware of a noted weight loss, she will intervene. She stated she would let the doctor know and notify the RD. She stated she pulls weights often. She stated R91 has an upcoming appointment for digestive problems.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 50087 Based on review of the facility policy, staffing documentation and interview, the facility failed to ensure that each Certified Nursing Assistant (CNA) employed by the facility received the required no less than 12 hours of in-service education based on their individual performance reviews and is calculated by their employment date with the facility during review of Sufficient and Competent Nurse Staffing. Findings include: Review of the facility policy titled Staff Education/Orientation Policies and Procedures, without a date or revision date listed. The policy states, The facility will provide orientation and training to fulfilling the organization's mission thus creating a culture that foster staff self development and continued learning. (1). Day 1: All new employees receive the general facility orientation program on day one of employment and it is completed with the designated member of the facility staff. (2). Day 2: Each new employee will receive their specific department orientation starting on day 2 and continue through to completion of the department specific orientation. Role and department specific orientation includes any state or local level requirements that are in addition to or more inclusive than federal requirements. (3). Individualized: The facility leadership has the discretion to increase the new employee's orientation if deemed necessary. (4). Annually: The employee completes the competency/performance evaluation(s) and educational requirements according to state specific regulation. Review on 04/23/24 at approximately 11:45 AM of the facility's CNA annual 12-hour in-service training based on performance reviews revealed less than the required 12 hours of training from the date of hire for CNAs. There was no documentation in the CNA's personnel files that verified the required training. There were 3 out of 5 CNAs who did not receive training in resident's rights, abuse, neglect, exploitation, and dementia training; CNA2 hire date 05/23/19, CNA3 hire date 02/01/23, and CNA5 hire date 03/10/23 revealed no training of the required areas. During an interview on 04/23/24 at approximately at 3:42 PM with the Director of Nursing (DON) revealed, to ensure the staff are competent and have the knowledge and skills to care for the residents, they attend an annual training and a skills check. If there are any concerns, we will provide additional training. DON stated staff are evaluated by the staff development coordinator to ensure competency levels. The DON confirmed the staff had not met their required hours.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31846 Based on Staff Education/Orientation for administering Insulin via an Insulin Pen, record reviews, observations and interviews, the facility failed to ensure a medication administration error rate of less than 5 percent. The medication error rate was 10.71 percent (%). Additionally, R5's medications were administered and charted late for 22 out of 31 days in March '24. Findings Include: Review of the facility's Staff Education/Orientation Policies and Procedures, the nursing,Competency: Medication Administration-Insulin Pen, states under Priming The Pen, 1. Remove the outer needle cap and dial 2 units. 2. Point the pen up and press the plunger button to expel 2 units of insulin. 3. Repeat these steps as needed until a drop or stream of insulin appears at the needle tip. NOTE: A new pen may have to be primed up to 6 times before it will expel insulin. 4. Shake the insulin off the needle top. During an observation on 04/22/24 at 08:22 AM of medication administration revealed Registered Nurse (RN)1 administering Miralax 17 grams (g) to R84. RN1 measured the 17 grams and emptied it into a 5 ounce (oz.) cup and then added water. The Miralax is to be mixed in 6 to 8 ounces of a liquid for administration. RN1 was not available for interview. An observation on 04/23/24 at 08:30 AM of medication administration revealed Licensed Practical Nurse (LPN)1 administering Lantus Insulin via an Insulin Pen to R90. The resident was to receive 45 units. The insulin pen only had 42 units after the priming of the pen so LPN1 opened a second Lantus Pen for the resident. LPN1 took an alcohol wipe and cleaned the rubber stopper on the end of the pen, then applied the insulin needle. She dialed up the 2 units for priming the pen and did not remove the cover from the needle and held the pen horizontally and pushed the dose button to expel the 2 units used to prime the pen and then dialed up the 42 units for the dosage to be administered to the resident. LPN1 then opened the new Lantus Insulin Pen and cleaned the rubber stopper on the end of the pen and applied the needle leaving the needle covered and holding the pen horizontally she pushed the dose button to expel the 2 units she had dialed up to prime the pen. Then she dialed up the 3 units needed to make up the 45 units as ordered. LPN1 then went into the resident's room and administered the 45 units of insulin with the 2 pens. During an interview on 04/23/24 at 08:40 AM with LPN1, she confirmed that she had held the 2 pens with the needle covered horizontally and expelled the 2 units used to prime the pens. She could not confirm that she saw insulin come out of the needle. She stated that pharmacy had in-serviced the staff on the correct administration of insulin via a pen and they had demonstrated holding of the pen horizontally and not vertically. 46991 (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled, Medication Management Program with a revision date of 05/05/23 documented under Preparing for Medication Pass, Section Q (4), Authorized staff must understand: (D) The 8 Rights for administering medication: (4). The Right Time (6). The Right Charting (7). Medications are administered no more than one hour before to one hour after the designated medication pass time. Review of R5's Face Sheet revealed R5 was admitted to the facility on [DATE] with diagnoses including but not limited to; chronic kidney disease, muscle weakness, peripheral vascular disease, lack of coordination, insomnia, diabetes, anxiety disorder, dementia, chronic obstruction pulmonary disease and heart failure. Review of R5's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/15/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R5 is cognitively intact. Review of R5's Medication Administration Record for March '24 revealed the following medication errors: Advair Diskus (fluticasone propion-salmeterol); two times daily (10am/9pm) for Chronic Obstructive Pulmonary disease was charted late 25% for the month. Daily multi-vitamin (multivitamin) tablet; once daily (9am) for Vitamin D deficiency was charted late 12% for the month. Eliquis 5 milligrams (mg); 2 times daily (10am/9pm) for heart failure, charted late; 29% for the month. Folic Acid 1 mg; 1 time daily (10am) for Vitamin D deficiency; charted late; 12% for the month. Furosemide 40 mg; 2 times daily (10am/9pm) for renal dialysis; charted late; 25% for the month. Lyrica 25 mg; 1 time a day (10am) for muscle weakness; charted late; 19% for the month. Melatonin 3 mg; 1 time a day (9pm) for insomnia; charted late; 12% for the month. Metoprolol tartrate 25 mg; 2 times a daily (10am/9pm) for peripheral vascular disease; charted late; 25% for the month. Pantoprazole 20 mg; 2 times daily (10am/10pm) for gastro-esophageal reflux disease; charted late; 12% for the month. Paroxetine HCl 30 mg; 1 time daily (9pm) for anxiety; charted late; 12% for the month. PreserVision AREDS-2 (vit c,e-zn-coppr-lutein-zeaxan) capsule; 250-90-40-1 mg; 1 time daily (10am); charted late; 12% for the month. Pro-Stat AWC (amino acids-protein hydrolys) liquid; 17-100 gram-kcal/30 mL; 2 times a day(10am/9pm); charted late 9% for the month. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procardia XL 30 mg; 1 time daily (10am) for hyperparathyroidism; charted late 16% for the month. Ropinirole .25 mg; 1 time daily (9pm) for cramps (hyperparathyroidism); charted late 12% for the month. Sevelamer carbonate 800 mg; 3 times daily (10am/2pm/9pm) for chronic kidney disease; charted late 29% for the month. Tradjenta 5 mg; 1 time daily (10am) for Diabetes; charted late 16% for the month. Trazodone 50 mg; 1 time daily (9pm) for anxiety; charted late 12% for the month. Tums 200 mg; 1 time daily (10am) for dependence on renal dialysis; charted late 16% for the month. Vitamin C 500 mg; 1 time daily (10am) for chronic kidney disease; charted late 16% for the month. In an interview on 04/23/24 at 3:53 PM, Director of Nursing stated her expectations is for staff to administer medications within the one-hour window before and after scheduled times and document immediately thereafter. In an interview on 04/23/23 at 4:25 PM, Administrator stated she expects medication to be given within the time frame of medication administration or one hour before or after.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31846 Based on review of the policy, Staff Education/Orientation for administering Insulin via an Insulin Pen, record reviews, observations and interviews, the facility failed to ensure Resident (R)90 received insulin via an insulin pen correctly. The facility further failed to ensure R60 received insulin as ordered, R5 received blood pressure medication as ordered and R20 received psychotropic and tremor medications as ordered and each resident was free from significant medication errors. Findings include: Review of the facility's policy titled, Staff Education/Orientation Policies and Procedures, the nursing, Competency: Medication Administration-Insulin Pen, states under Priming The Pen, 1. Remove the outer needle cap and dial 2 units. 2. Point the pen up and press the plunger button to expel 2 units of insulin. 3. Repeat these steps as needed until a drop or stream of insulin appears at the needle tip. NOTE: A new pen may have to be primed up to 6 times before it will expel insulin. 4. Shake the insulin off the needle top. An observation on 04/23/24 at 08:30 AM of medication administration revealed Licensed Practical Nurse (LPN)1 administering Lantus Insulin via an Insulin Pen. R90 was to receive 45 units. The insulin pen only had 42 units after the priming of the pen so the LPN opened a second Lantus Pen for the resident. The LPN took an alcohol wipe and cleaned the rubber stopper on the end of the pen, then applied the insulin needle. She dialed up the 2 units for priming the pen and did not remove the cover from the needle and held the pen horizontally and pushed the dose button to expel the 2 units used to prime the pen and then dialed up the 42 units for the dosage to be administered to the resident. The LPN then opened the new Lantus Insulin Pen and cleaned the rubber stopper on the end of the pen and applied the needle leaving the needle covered and holding the pen horizontally she pushed the dose button to expel the 2 units she had dialed up to prime the pen. Then she dialed up the 3 units needed to make up the 45 units as ordered. The LPN then went into the resident's room and administered the 45 units of insulin with the 2 pens. During an interview on 04/23/24 at 08:40 AM with LPN1, she confirmed that she had held the 2 pens with the needle covered horizontally and expelled the 2 units used to prime the pens. She could not confirm that she saw insulin come out of the needle. She stated that pharmacy had in-serviced the staff on the correct administration of insulin via a pen and they had demonstrated holding of the pen horizontally and not vertically. 48834 A review of the facility policy titled, Pharmacy Services Policies and Procedures- Medication Management, revised 04/01/2022, indicated the facility will ensure that each resident's entire drug/medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial wellbeing. R20 was admitted to the facility with diagnoses including but not limited to, schizoaffective disorder, generalized anxiety disorder, urinary tract infection, and dementia. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R20's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/10/24, indicated R20 is ordered to take, but is not limited to, antipsychotic and antidepressant medications. A review of R20's care plan indicated a potential for discomfort & adverse effects related to the use of antipsychotic and antidepressant medications. A review of R20's care plan and progress notes did not reveal that R20 refused medications on 04/15/24 or 04/16/24. A review of R20's physician orders indicate benztropine tablet with a start date of 07/13/23, Depakote ER tablet extended release 24 hr with a start date of 11/22/23, methenamine hippurate tablet with a start date of 12/14/23, olanzapine tablet with a start date of 03/12/24, trazodone tablet with a start date of 07/19/23, UTI-Stat liquid with a start date of 03/26/24. - blanks on 4/16/24 night shift. A review of R20's Behavior Monitoring Administration History, from 04/01/24 until 04/23/24, indicated that R20 did not receive benztropine tablet; 0.5 mg, Depakote ER (divalproex) tablet extended release 24 hr; 500 milligrams (mg), methenamine hippurate tablet; 1 gram, olanzapine tablet; 5 mg, trazodone tablet; 50 mg, UTI-Stat (cran-vitc-mannose-[NAME]-bromeln) liquid; 3,875 mg/30 mL, on 04/16/24 during the night shift. During an interview on 04/23/24 at 03:00 PM, The Director of Nursing (DON) expressed they expect nurses to document the Medication Administration Record (MAR) and Treatment Administration Record (TAR) once completing a task ordered by the physician. The DON confirmed that there were several blanks on R20's TAR and MAR for April 24, but could not give a reason why there were several blanks. 49801 Review of the facility policy titled Nursing Policies and Procedures Subject: Medication Management Program revision date 05/05/23 revealed, Policy: The Facility implements a Medication Management program to meet the pharmaceutical needs of patients and residents, according to established standards of practice and regulatory requirements. Scope and Roles: 3. Licensed nurses will evaluate, assess, monitor, document and report the effectiveness of the medication regimen that includes all medications and supplements prescribed to treat illness, disease process, or enhance the patient's/resident's quality of life. Guidelines for Implementing an Efficient Medication Pass: 1B. The facility will ensure the schedules for administering medications: 1) Maximize the effectiveness of the medications. 2) Prevent potential for significant medication interactions .3D. Insulin daily orders, sliding scale orders, and blood glucose results are documented on the same page or screen. Preparing for the Medication Pass 8. Documentation of medications administered is completed according to State and Federal requirements. The initials and verifying signature are generally required. Administering the Medication Pass 11. Immediately after administering the medication to the resident, the authorized staff or licensed nurse will return to the medication cart and document medication administration with initials on the MAR. If a medication is not administered, the authorized staff or licensed nurse must explain why it was not given. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R60's Face Sheet revealed R60 was admitted to the facility on [DATE] with diagnoses including but not limited to: Acute respiratory failure, Chronic obstructive pulmonary disease, Diabetes mellitus due to underlying condition with diabetic neuropathy, Type 2 diabetes mellitus with diabetic neuropathy, Major depressive disorder, Myocardial infarction, Ventricular tachycardia, Ischemic cardiomyopathy, Unspecified systolic (congestive) heart failure, and Peripheral vascular disease. Review of R60's Admission MDS with an ARD of 02/19/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R60 was cognitively intact. Review of R60's Care Plan with a start date of 11/09/2022 and target date 05/24/24 documented, the problem: R60 .has a dx [diagnosis] of DM [diabetes mellitus] Type 2, potential for hypo [low]/hyper [high] Glycemia [glucose]. Documented goal: R60 will adhere to diet to aide in controlling glucose and HgbA1C; will not have any acute episodes of hypo/hyper glycemia episodes through. Documented approach revealed, Insulin to be administered per MD orders. Review of R60's MAR for 04/01/24 - 04/22/24 revealed an order for Lantus Solostar U-100 Insulin (insulin glargine) insulin pen; 100 unit/mL (3 mL); amt: 10 UNITS; subcutaneous Special Instructions: NOTIFY MD/NP PRN. At Bedtime 9:00 PM. The document revealed no documentation from 04/08/24 for administration at 9:00 PM, blood sugar value, route, site, or units. Review of R60's Physician Order with a start date of 02/13/24 documented, Lantus Solostar U-100 Insulin (insulin glargine) insulin pen; 100 unit/mL (3 mL); amt: 10 UNITS; subcutaneous Special Instructions: NOTIFY MD/NP PRN. At Bedtime 9:00 PM. During an interview on 04/23/24 at 11:42 AM, the DON stated that her expectations are that physician orders are followed for medication administration. She stated the process for medication administration would include reading the order, checking the order against the medication label when pulling it up or preparing the medication and then administering the medication to the resident. Documentation of the medication being administered would be expected after the resident has received the medication on the MAR. The DON revealed she expects that there would be documentation even if the medication was not given along with notification to the Medical Doctor (MD) and to the resident responsible party if medication is not given. She reported that the facility ensures accuracy of documentation on the MAR by pulling a compliance report daily and either the DON or Assistant Director of Nursing (ADON) addresses identified issues. Education is provided to staff. She stated that unfortunately, they use a lot of agency nurses, which makes it challenging. The DON verified the missing documentation on the MAR for the Lantus insulin on 04/08/24. During an interview on 04/23/24 at 1:15 PM, contact information for the nurse working on 04/08/24 was requested. The DON stated that she would get the number but the nurse was from an agency and was not reliable in returning calls. During an interview on 04/23/24 at 3:21 PM, an attempted call was made to LPN4 but no answer was received and the mailbox was not set up to leave a message. Review of R5's Face Sheet revealed R5 was admitted to the facility on [DATE] with diagnoses including but not limited to: Chronic kidney disease, dependence on renal dialysis, peripheral vascular disease, chronic obstructive pulmonary disease, heat failure, and type 2 diabetes mellitus with diabetic neuropathy. (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R5's MDS with an AED of 03/22/24 revealed a BIMS score of 15 out of 15, indicating R5 was cognitively intact. Review of R5's Care Plan with a start date of 08/27/20 and target date 05/17/24 documented, the problem as R5 .is at risk for potential cardiac problem r/t dx of HTN [hypertension], HLD [hyperlipidemia], Hyperkalemia [elevated potassium], CHF-stable [congestive heart failure]. Documented goal R5 .will have no alteration in cardiac output through next review. Documented approaches revealed, Meds per [by] MD [medical doctor] order, Observe for c/o [complaints of] chest congestion, cyanosis, or SOB [shortness of breath], s/s [signs and symptoms] of stroke (H/A, one sided weakness, facial drooping, etc.) and notify MD prn, V/S [vital signs] per protocol. Review of R5's MAR for 04/01/24-04/23/24 revealed no documentation from 04/22/24 at 10:00 AM or 9:00 PM for metoprolol tartrate tablet 25 mg amount to administer: 1/2; oral. Review of R5's Physician Order with a start date of 03/22/24 documented, an order for Furosemide tablet; 40 mg; amt: 40 mg; oral twice a day, metoprolol tartrate tablet; 25 mg; amt: 1/2; oral twice a day, Procardia XL (nifedipine) tablet extended release 24 hr; 30 mg; amt: 1: oral once a day. Additionally dialysis every T-Thur-Sat @ 6 AM obtain vital signs after dialysis and completed dialysis sheet once a day on Tue, Thur, Sat 11:00, dialysis every T-Thur-Sat @ 6 AM obtain vital signs after dialysis and completed dialysis sheet once a day on Tue, Thur, Sat 0500, dialysis every t-thurs-sat @ 5:30 AM heartline to transport resident. Pick-up time 0530 AM once a day on Tue, Thu, Sat 05:15, Perma cath to right chest. Monitor for s/s bleeding every shift. Notify MD/NP PRN every shift days 0700-1900, Nights 1900-0700. During an interview on 04/23/24 at 10:00 AM, R5 approached surveyor to show vital signs on the dialysis flowsheet taken at the facility prior to leaving which was 182/121 and at dialysis center 158/91. The resident reported that their blood pressure was high this morning because they did not receive blood pressure medication last night at 9:00 PM. When asked if the nurse was notified, the surveyor was informed that this had not been reported because they was in the bed. The surveyor immediately went to inform the ADON, who was on the medication cart of the reported situation and was told that they would check on it as the resident was assigned on the other cart not this one where the two were standing. The surveyor then spoke with LPN1 who had come out of a room while the surveyor was walking off the unit. LPN1 was standing at the other medication cart and was asked to check the orders for the resident. Upon review of the MAR on the computer screen it was observed that the resident had a nighttime blood pressure medication scheduled: Metoprolol Tartrate 25 mg tablet was scheduled for twice a day. On Monday, April 22, 24 at 10:00 AM and 9:00 PM, there were blanks observed on the MAR. During an interview on 04/23/24 at 11:42 AM, the DON stated expectations are that physician orders are followed. The process for medication administration would include reading the order, checking order against medication when pulling up and then administering to the resident. Documentation of the medication being administered would be expected. She expects that there would be documentation if medication was not given, that the MD be made aware along with the resident or responsible party be made aware if medication is not given. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425302	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehab Center of Cheraw	1150 State 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.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/23/24 at 3:43 PM with LPN5 revealed that she came on shift at 11:00 PM and was not on duty when the 9:00 PM medication was due. She reported that the resident verbalized to her between 12:00 AM and 1:00 AM that the resident did not receive the scheduled blood pressure medication. This nurse stated she verified the order and observed that the MAR was blank and had not been signed by the previous nurse. LPN5 informed the resident that it was outside of the timeframe for it to be administered. The resident voiced a concern that there needed to be 6 hours for the medication to clear the blood stream before dialysis. This nurse reported the concern to LPN6 and stated that she was not sure what the proper next steps should have been although everyone working were agency nurses on last night. An attempted interview on 4/23/24 at 4:05 PM was made via telephone to LPN6 with no success.

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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. 31846 Based on review of the facility policy titled Medication Storage, observations and interviews, the facility failed to ensure expired medications were removed from and not stored with medications in use for residents in 2 of 4 medication carts. Findings include: Review of the facility policy titled, Medication Storage, states: 1. Medications and biological's are stored safely, securely and properly following manufacturer's recommendations or those of the supplier, The General Guidelines for Storage of Medication and Biological's, states under number 12. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled or without secure closures are immediately removed from stock, disposed of according to procedures for medication destruction, and reordered from the Pharmacy, if replacements are needed. An observation on 04/23/24 at 01:45 PM of the North Hall Medication Cart B revealed Famotidine 40 milligrams, 2 tabs, manufactured by Teva USA with Lot #7337102 was expired on 02/15/24. One Lispro Kwikpen manufactured by Lilly with Lot #D27056C was opened on 03/14/24 and expired on 04/11/24. One Novolog Flex Pen with Lot #NZF6H68 was opened on 03/25/24 and expired on 04/22/24. The expired medications were confirmed by Licensed Practical Nurse (LPN)2. An observation on 04/23/24 at 02:15 PM of the South Hall Medication Cart A revealed one pen of Toujeo with Lot #3F930A in use with no open date. LPN1 confirmed the medication did not have an open date and removed it from the medication cart.

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	425302	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehab Center of Cheraw	1150 State 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46934 Based on review of facility policy, observations, and interviews, the facility failed to ensure foods stored in the refrigerator and the main kitchen preparatory area were labeled, dated, and free from expiration. This failure had the potential to affect all 102 residents in the facility, who consumed food from the kitchen. Findings include: A review of the facility's policy titled, Nutrition Orientation and Competency Policy and Procedures on Food Storage with a complete revision date of [DATE] stated If food is not stored properly, chances are that it will spoil quickly. Remember these pointers for storage. 1. -Follow the first in, first out (FIFO) rule. a. Always cover, label, and date leftovers that are to be stored. They should be date marked with the use-by date. 2. -Throw TCS leftovers out if not used within 3 days. On [DATE] at 10:27 AM, the following observations in the kitchen were made with and verified by the Dietary Manager (DM): Main refrigerator/Cooler-Two clear bags, both with 3 heads of lettuce with no open date or use-by date listed on the bag. All 6 heads of lettuce in the bags were brown with pink build-up surrounding the entire head of lettuce. Main refrigerator/Cooler-One black crate with 2 heads of lettuce with black/brown spots. No original packing, no open date or use-by date observed. Main refrigerator/Cooler-One-half of the head of lettuce, wrapped in saran wrap, with a brown/pink substance. No label was observed, and no open date or use-by date was observed. Main refrigerator/Cooler- One metal pan, approximately 6 inches deep, labeled Stewed [NAME] Use by date [DATE]. On [DATE] at 10:39 AM observation of the main kitchen preparatory area revealed a brown cardboard box/case containing whole Idaho potatoes. 8 out of approximately 20 were rotten, containing black, grey, and green spots on potatoes. The potatoes were soft to the touch. An interview with the DM on [DATE] at 11:10 AM revealed I have been in this position since [DATE], about five months. DM stated, Staff is expected to check the coolers, freezers, and all other food storage areas for expired foods daily. DM stated, It's everyone's responsibility. Normally, her kitchen staff is to use the first in first out method. I am going to ensure that it is done and do another in-service on expired food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with the Director of Nursing on [DATE] at 3:40 PM revealed that her expectation of kitchen staff is to monitor items and dispose of items before they go bad. She stated she will talk to the kitchen staff about the monitoring and the removal of expired foods. An interview with the Administrator on [DATE] at 03:47 PM revealed My expectation of the kitchen is for all items to be labeled with open and use-by dates. Staff should label food as they go in and discard items that have expired to not compromise other foods.