

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425302	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER Rehab Center of Cheraw		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45108</p> <p>Based on observation, interview, and policy review, the facility failed to maintain infection prevention and control practices designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. This was evidenced by medication administration observations of Resident (R)1 and R18.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Hand Hygiene/Handwashing dated 5/15/23 documented, Procedures: 1. Hand hygiene/hand washing is done: Before: A. Before patient/resident contact .After: .B. After patient/resident contact. C. After contact with a contaminated object or source where there is a concentration of microorganisms, such as, mucous membranes, non-intact skin, body fluids, blood or wounds .J. Contact with environmental surfaces in the immediate vicinity of patients/residents.</p> <p>Review of the facility policy titled, Blood Glucose Monitoring dated 5/5/23 documented, .If the manufacturer doesn't specify how the device should be cleaned and disinfected, then it shouldn't be shared.</p> <p>Review of the facility policy titled, Infection Prevention and Control Policies and Procedures dated 5/15/23 documented, Subject: Transmission Based/Standard Precautions, and Enhanced Barrier Precautions, Standard Precautions vs. Transmission</p> <p>(continued on next page)</p>

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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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based Precautions .B. Personal Protective Equipment: determined by the nature of staff interaction, extent of anticipated blood, body fluid or pathogen exposure. Appropriate use of PPE includes but is not limited to: Gloves .4) Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another patient/resident .E. Patient/Resident-Care Equipment .2) Verify that reusable equipment is cleaned, disinfected, and reprocessed appropriately.</p> <p>Review of R1's electronic medical records, revealed an admitted [DATE], and diagnosis list that consisted of Type Two (2) Diabetes Mellitus with Diabetic Neuropathy, Acute Osteomyelitis unspecified femur, Acquired Absence of Right Leg Above the Knee, Cardiomyopathy among other conditions not listed. Resident #1 Physician's Orders showed an order for Insulin Aspart U-100 solution; per sliding scale to be given subcutaneously four (4) times a day.</p> <p>In an observation on 10/7/24 at 11:31 a.m. made during medication administration of R1, Registered Nurse (RN)1 was seen placing the gauze, an open alcohol swab, the glucometer and gloves on the seat of a chair in the resident's room, with no barrier underneath, while donning Personal Protective Equipment (PPE) gown after performing hand hygiene. Then RN1 put on gloves and gathered the supplies. Next RN #1 placed the same supplies on the resident's bed, wiped the resident's finger with the opened alcohol swab and performed the finger stick to check R1's blood glucose. The first attempt was unsuccessful, so RN1 wiped the resident's finger with the same swab and made a second attempt to collect a blood sample. After collecting the sample and getting the resident's blood glucose reading, RN1 took off her gloves and set them on the resident's bed, doffed the PPE gown, returned to their assigned medication cart and placed the glucometer inside without cleaning or disinfecting it.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R18's electronic medical records, revealed a current admitted of 9/1/21, and also the latest return admitted [DATE] and diagnosis list that consisted of Type Two (2) Diabetes Mellitus without complications, Chronic Kidney Disease, Squamous Cell Carcinoma of Skin among other conditions not listed. R18's Physician's Orders showed an order for Humalog U- 100 solution Insulin: per sliding scale to be given subcutaneously three (3) times a day.</p> <p>An observation on 10/7/24 at 11:38 AM, made during medication administration of R18 revealed RN1 performed hand hygiene, walked into the resident's restroom to get a pair of gloves, and was seen placing the gauze, an open alcohol swab, the glucometer and gloves on the resident's bedside table with no barrier underneath. RN1 wiped the resident's finger with the opened alcohol swab and performed the finger stick to check R18's blood glucose. The first attempt was unsuccessful, so RN1 wiped the resident's finger with the same swab and made a second attempt to collect a blood sample. After collecting the sample and getting the resident's blood glucose reading, RN1 returned to their assigned medication cart and placed the glucometer inside without cleaning or disinfecting it. RN1 returned to R18's room to administer the resident's medication. RN1 performed hand hygiene, then touched the resident's restroom door, donned gloves, then with gloved hands touched the restroom door to close the door and administered insulin injection to R18.</p> <p>In an interview with RN1 on 10/7/24 at 11:45 AM, she stated that there was no reason why they placed the items down without a barrier underneath, only used one alcohol swab, or did not clean glucometer between residents. RN1 did state that they understood the reason for infection control, but felt that the facility layout made it difficult, saying, It's kind of hard here, I get it, but it is nit-picky.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 10/9/24 at 8:56 AM with Licensed Practical Nurse (LPN)1, the current unit nurse manager on</p> <p>they stated that the expectation was to improve on infection control, putting down barriers, hand sanitizer use, for the safety of residents and staff and to re-educate.</p> <p>In an interview on 10/9/24 at 9:17 AM with the Director of Nursing (DON) and the Administrator, the DON stated that the expectation was to do better, and that RN1 said that they knew better and should not have exhibited those behaviors. The Administrator stated that re-education with staff had already occurred.</p>		