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	01/14/2026

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on review of the facility's policy entitled, Activity Policies and Procedures, record review, observations, and interviews, the facility failed to provide an ongoing program of activities to meet the needs and interest of each resident for one (1) of three (3) residents reviewed for activities (Resident (R)18).Findings include:Review of the facility's policy entitled, Activity Policies and Procedures, stated, POLICY: Based on a comprehensive assessment, individualized care plan and the preferences of each resident, the Activity/Recreation Director and staff will provide an ongoing Activity/Recreation program to support resident personal choice of activities, facility-sponsored group, one to one activities, and independent activities designed to meet the interests of and support the physical, intellectual, psychosocial, emotional and spiritual well-being of each resident, encouraging both independence and community interaction.Purpose: To implement an ongoing resident centered activities program that incorporates the resident's needs, interests, hobbies, and cultural preferences which is integral to maintaining and/or improving physical, Intellectual, psychosocial, emotional, spiritual wellbeing and independence. To create opportunities for each resident to have a meaningful life by supporting the domains of wellness (security, autonomy, growth, connectedness, identity, joy and meaning).R18 was admitted to the facility on [DATE] with diagnoses that included; displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing, arthritis, right hip, muscle weakness, depression, anxiety disorder, and schizoaffective disorder.Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed R18 had a Brief Interview for Mental Status (BIMS) score indicating moderate cognitive impairment. The MDS further indicated rejection of care behaviors were not exhibited, and the resident required dependent assistance with bathing.During an observation on 01/11/26 at 2:20 PM, R18 was in her bed, in her room, with no staff present, no books or other reading materials observed.During an observation on 01/13/26 at 8:41 AM, R18 was observed in her bed.During an observation on 01/13/26 at approximately 10:15 AM, R18 was observed in her room alone, in her bed, no activities or reading materials were observed.During an interview on 01/11/26 at 2:20 PM, R18 stated she does not participate in one-on-one or group activities. R18 stated she would like to get out of bed and participate; however, staff do not come to assist her. She further stated the facility has not provided her with reading materials for independent activity or provide any other one on one activities.During an interview on 01/13/26 at 8:41 AM, R18 stated staff did not get her out of bed the previous day. The resident reported that although she would like to attend group activities, she did not attend in-room or group activities and stated no staff notified her of scheduled activities for that day.During an interview on 01/14/26 at 11:03 AM, the Assistant Director of Nursing (ADON) stated that it is her expectation that activities staff coordinate with nursing staff and certified nursing assistants (CNAs) to ensure residents that would like to attend group activities are able to attend scheduled (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	activities.During an interview on 01/13/26 at 11:14 AM, Certified Nursing Assistant (CNA)1 stated she did not remember asking R18 if she wanted to get out of bed or participate in activities.During an interview on 01/14/26 at 12:55 PM, the Activities Assistant stated, while reviewing the activity log with the surveyor, that her previous statement indicating R18 had been invited to group activities was not supported by documentation in the activity log.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on record review, Payroll-Based Journal (PBJ) staffing data, Resident Council interview responses, and a staff interview, the facility failed to ensure sufficient nursing staff to meet the needs of residents as evidenced by low weekend staffing and missing Registered Nurse (RN) hours, affecting residents' timely access to care on a facility-wide basis. Findings include:Record review of the Payroll-Based Journal (PBJ) staffing data for Fiscal Year (FY) 2025, Quarter Four (Q4) identified excessively low weekend staffing levels. The submitted PBJ data for Q4 is consistent with undocumented licensed Registered Nurse (RN) hours and required shifts for facilities with greater than 60 residents.Record review of Resident Council Meeting Minutes dated for 07/22/2025 identify an unresolved Nurse call out issue and reference late medication administration and unspecified disturbances.Record review of the Daily Licensed and Unlicensed Direct Care Staff hours between November 11, 2025 and December 30, 2025 reveal ten (10) instances of missing RN coverage and only document Licensed Practical Nursing (LPN) and Certified Nursing Assistant (CNA) hours. During a Resident Council meeting on 01/13/2026, at 10:30 AM with eleven (11) resident attendees, residents were asked: Do you get the help and care you need without waiting a long time, and does staff respond to your call light in a timely manner? All residents in attendance reported concerns regarding delays in assistance, indicating potential impacts related to insufficient staffing. During an interview on 01/14/2026, at approximately 2:40 PM, the Mobile Administrator was asked about the missing RN hours identified in the PBJ report. In response, she stated that the missing RN hours were covered by a Minimum Data Set (MDS) Nurse functioning as a Unit Charge Nurse, however, there was no documentation to prove the MDS Nurse was working in the capacity of the facility's RN during this time period.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, record reviews and the facility's policy entitled, Nursing Policies and Procedures, the facility failed to provide Activities of Daily Living, (ADLs) for Resident (R)18 related to hair and dental care, and for R90 related to nail care, for two (2) of five (5) residents reviewed for activities. Findings include: Review of the facility policy titled, Staff Education /Orientation Polices and Procedures, revised 1/12/2024, states performance criteria as follows: 5. Fills basin with warm water 6. Soak nails 7. Clean under nails with orange stick. Review of R90's face sheet revealed R90 was admitted to the facility on [DATE] with diagnoses including but not limited to contracture of the left wrist, other pericardial effusion (non-inflammatory), other abnormal involuntary movements, other lack of coordination, muscle weakness (generalized), and flaccid hemiplegia affecting the left nondominant side. Review of the Physician Orders written on 08/11/25 revealed (Nursing) Nail Check Completed Special Instructions: Document results using KEY below: A. No intervention needed B. Toenails Trimmed C. Fingernails Trimmed D. Podiatry Consult requested Once A Day on Mon NAIL CHECK 07:00 - 19:00 08/28/2025 Review of R90's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 11/18/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating cognition is intact. Review of R90's Care Plan, with a start date of 09/08/25, reveals a risk of deterioration in personal hygiene due to the resident's preference for long fingernails and refusal for staff to cut their nails. During an observation on 01/11/26 at approximately 11:48 AM, observed R90 lying in bed with contractures of bilateral hands, long fingernails with visible brownish-black debris under nails. During an observation on 01/12/26 at approximately 2:30 PM, R90 was observed in bed, supine (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	position, both upper extremities resting on top of covers. R90 continues to have visible brownish-black debris under nails. During an observation on 01/13/26 at approximately 3:35 PM, R90 was observed lying in bed, upper extremities lying on top of the covers. There was visible brownish-black debris was under the nails of both contracted hands. During an observation on 01/14/26 at approximately 9:00 AM, R90's contracted hands were observed, nails cut and clean; however, jagged edges were noted. Licensed Practical Nurse (LPN)5 was notified and stated she would file R90's nails. During an interview on 01/13/26 with LPN4 at 2:31 PM, LPN4 revealed R90's nails should be checked and cleaned during ADLs, which included to check nails and cut nails as needed. During an interview on 01/13/26 with Certified Nursing Assistant (CNA)4 at 2:37 PM, revealed that during ADLs, she uses soap on washcloths and washes R90's hands, but does not do nail care. The facility has never told her she has to do nail care. CNA4 states she has never clipped nails. She uses a washcloth, antibacterial soap, and pulls it through the resident's hands. At this time, CNA4 observed R90's hands and acknowledges visible debris underneath R90's nails. During an interview on 01/13/26 with the Director of Nursing (DON) at 3:45 PM, she revealed her expectations regarding hand contractures and nail care/ADLs with residents with contractures is for it to be done daily. The DON revealed when R90 is bathed, hands should be cleaned, and underneath nails daily. Residents have the right to have long nails if they desire. The DON stated the activities staff has R90 on the list for painting and filing nails. During an interview on 01/13/26 at 3:15 PM, the Occupational Therapist Registered (OTR) reports that upon evaluation, R90 has deformities in the bilateral upper extremities, right flexion contracture of the right hand, and shoulder deformity of the right shoulder. The OTR reported R90 does not have active finger extension and confirmed R90's fingernails were dirty with debris under the fingernails. 2. R18 was admitted to the facility on [DATE] with diagnoses that include but were not limited to; displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing, arthritis, right hip, Muscle weakness, depression, anxiety disorder, and schizoaffective disorder. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed R18 had a Brief Interview for Mental Status (BIMS) score indicating moderate cognitive impairment. The MDS further indicated rejection of care behaviors were not exhibited, and the resident required dependent assistance with bathing. During an observation on 01/11/26 at 2:20 PM, R18 was observed lying in bed. The resident's hair appeared disheveled and greasy. The resident's teeth were observed to have visible plaque buildup. During an observation on 01/13/26 at 8:41 AM, R18 was observed lying in bed wearing the same shirt observed on 01/11/2026. The resident's hair appeared greasy and unkempt. The residents' teeth were observed to have visible, yellow-colored plaque buildup. During an observation on 01/13/26 at approximately 10:15 AM, R18 was observed lying in bed in her (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room. The resident's hair appeared disheveled and greasy. The resident's teeth continued to have visible, yellow-colored plaque buildup. During an interview on 01/11/26 at 2:20 PM, R18 revealed she prefers bed baths and not showers. She does not remember the last time her hair was washed. She has requested on numerous occasions to have her hair shampooed and it is not done. The last time she recalled getting it done was months ago. She did not have a bed bath yesterday or today. She also does not get to brush her teeth daily and should like them to be brushed daily. During an interview on 01/13/26 at 8:41 AM, R18 stated she was in bed all day yesterday, she did not get a bed bath or have her hair shampooed or brushed her teeth. During an interview on 01/14/26 at 11:03 AM, the Assistant Director of Nursing (ADON) stated that it is her expectation that staff will offer residents twice daily the opportunity to brush their teeth. Hair washing should be included in bed baths. R18's shower days are Tuesdays, Thursdays and Saturdays. During interview on 01/13/26 at 11:14 AM with Certified Nursing Assistant (CNA)1 revealed that she is assigned to R18 today. She has provided ADL for her today; she gave her a bed bath. She did not ask R18 if she wanted her teeth brushed today, although that is a part of providing ADLs to residents.

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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** Based on record review, interview, and observation, the facility failed to ensure Resident (R)32's wound dressing was changed daily in accordance with physician orders. The resident's bandage had not been changed for five (5) days and was observed to be visibly soiled with dried blood. Findings include:R32 was admitted to the facility on [DATE], with diagnoses including, but not limited to, cerebral palsy, functional quadriplegia, psychosis, mild intellectual disability, and left hand contracture.R32 was assessed as having a 0.5 cm x 0.5 cm wound on the right upper arm.Review of Physician Orders revealed orders including, but not limited to: Wound R[right] Arm Upper: Clean the wound with wound cleanser or normal saline, pat dry, apply honey, and cover with a bordered gauze dressing (BGD) to be changed daily and as needed (PRN).Review of R32's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/07/2025 revealed R32 had a Brief Interview of Mental Status (BIMS) score of 2 out of 15, indicating the resident was severely cognitively impaired.An observation of R32 on 01/11/2026 at 11:05 AM revealed the resident had an unclean bandage on the right upper arm, dated 01/06/2026, indicating the dressing had not been changed for five (5) days. The bandage was observed to be visibly soiled with excessive dried blood.During an interview with Licensed Practical Nurse (LPN)5 on 01/13/2026 at 1:40 PM, it was stated that R32 has a behavior of biting when upset and that this behavior caused the wound. LPN5 confirmed the wound dressing should have been changed daily and as needed per physician orders.During an interview with the Director of Nursing (DON) on 01/13/2026 at 2:30 PM, the DON stated the facility has a wound care nurse who works Monday through Friday. The DON further stated that when the wound care nurse is not present, it is the responsibility of the assigned nurse to provide wound care. The DON confirmed the wound dressing should have been changed daily and stated dressings are dated so staff can identify when the dressing was last changed.

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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. Based on the facility policy, medical records, observations and interviews, the facility failed to ensure a medication administration error rate of less than 5 percent for 2 out of 25 opportunities for error. The med error rate was 8 percent. Findings include: Review of the facility policy titled, Medication Management Program, under Policy states,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.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. Review of the facility policy titled, Staff Education/Orientation Policies and Procedures, under the competency, Medication Administration - Insulin Pen, states under the Performance Criteria, Priming the Pen, 1. Remove the outer needle cap and dial 2 units. 2. Points the pen up and presses the plunger button to expel 2 units of insulin. 3. Repeats these steps as needed until a drop or stream of insulin appears at the needle tip. An observation on 01/12/2026 at 10:06 AM of med pass by Licensed Practical Nurse (LPN)1 revealed LPN1 pulled the Miralax 17 grams from the medication cart, and placed the 17 grams in a plastic cup. LPN1 then filled the cup with water. The cup did not contain the 6 to 8 ounces as prescribed by the physician. LPN1 then administered the cup of Miralax with the small amount of water to Resident (R)41. Review of the medical record on 01/12/2026 at 10:30 AM for R41 revealed an order for Miralax 17 grams dissolved in 6 to 8 ounces of water or a liquid of the resident's choice, by mouth each day. During an interview on 01/12/2026 with LPN1, he confirmed the amount of water was not the ordered 6 to 8 ounces. During a observation on 01/12/2026 at 11:25 AM, LPN1 placed a needle on a Degludec Insulin Pen, then held the pen in the downward position toward the trash can and pushed the dose button expelling the 2 units used to prime the pen in the trash can. LPN1 confirmed that he had held the insulin pen downward to prime the pen and not in the correct upward position. LPN1 could not confirm that R50 had received the correct amount of insulin as ordered by the physician. Review of R50's Physician Orders indicated, Degludec Insulin Pen- Inject 15 units subcutaneously, twice a day.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on the facility policy, observation and interview, the facility failed to ensure a significant medication error did not occur for Resident (R)50, when Licensed Practical Nurse (LPN)1 failed to correctly prime an insulin pen before administering a dose of insulin for 1 of 1 residents observed, receiving insulin via a pen during med pass. Findings include: Review of the facility policy titled, Staff Education/Orientation Policies and Procedures, under the competency, Medication Administration - Insulin Pen, states under the Performance Criteria, Priming the Pen, 1. Remove the outer needle cap and dial 2 units. 2. Points the pen up and presses the plunger button to expel 2 units of insulin. 3. Repeats these steps as needed until a drop or stream of insulin appears at the needle tip. During a observation on 01/12/2026 at 11:25 AM, LPN1 placed a needle on a Degludec Insulin Pen, then held the pen in the downward position toward the trash can and pushed the dose button expelling the 2 units used to prime the pen in the trash can. LPN1 confirmed that he had held the insulin pen downward to prime the pen and not in the correct upward position. Review of R50's Physician Orders indicated, Degludec Insulin Pen- Inject 15 units subcutaneously, twice a day. LPN1 could not confirm that R50 had received the correct amount of insulin as ordered by the physician causing a significant medication error.

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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 record review, observation, and staff interviews, the facility failed to ensure medications were properly stored in one (1) of two (2) medication storage rooms at safe and appropriate temperatures in accordance with facility policy and manufacturer recommendations.Findings include:Review of procedure number 10.A.1 of the facility policy titled Pharmacy Services Policies and Procedures, last revised on 04/01/2022, revealed that facility staff are required to monitor and record refrigerator and freezer temperatures twice daily, with medication refrigerator temperatures maintained between 36-46 F (2-8 C). On 01/13/2026 at approximately 09:15 AM, review of medication storage areas was conducted. The facility was observed to have one medication storage room and two medication carts each located on the North and South wings. Review of the South Med Room refrigerator temperature logs revealed multiple documented dates with temperatures outside of the acceptable range.On 01/13/2026 at approximately 01:20 PM, the Mobile Director of Nursing (DON) was interviewed regarding the out-of-range temperature logs in the South Med Room refrigerator and the facility's process for managing medications and resolving temperature discrepancies. The Mobile DON was unable to provide an explanation regarding the management of medications stored in the refrigerator during periods of out-of-range temperatures and referred the surveyor to other staff members, who stated they would need to revisit the issue.On 01/13/2026 at approximately 02:00 PM, the Regional Environmental Services (EVS) staff member met with the surveyor regarding the South Med Room refrigerator thermometer. The staff member presented an infrared thermometer and stated that the infrared reading differed by approximately five (5) degrees from the refrigerator thermometer, noting the infrared thermometer measured 35 F while the refrigerator thermometer measured 30 F. The acceptable refrigerator temperature range of 36-46 F was discussed. The Regional EVS staff member stated that the old thermometer would be replaced; however, no further explanation was provided to address out-of-range temperature resolution to ensure medication safety.