

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 07/14/2026
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)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, interviews, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible. Specifically, the facility failed to identify risks and hazards, failed to implement processes and failed to implement and monitor person-centered interventions for smokeless tobacco use for 3 of 3 Residents reviewed, (R)51, (R)71, and (R)77. Findings include: Review of R77's admission Record revealed the facility admitted R77 on 11/11/25. According to the admission Record, the resident had a medical history that included but was not limited to diagnoses of cognitive communication deficit, alcohol-induced persisting dementia, and acute cough. Review of R77's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/10/26, revealed R77 had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated the resident had moderate cognitive impairment. Review of R77's Care Plan Report, included a problem area initiated on 01/05/26, that indicated the resident had a behavior of spitting on floor, uses chewing tobacco provided by family. Approaches directed staff to provide spit cup, created, 01/22/26. Review of R71's admission Record revealed the facility admitted R71 on 04/15/19. According to the admission Record, the resident had a medical history that included but was not limited to diagnoses of vascular dementia, moderate with other behavioral disturbance, cognitive communication deficit, schizoaffective disorder, and anxiety disorder. Review of R71's Annual MDS with an ARD of 05/07/26, revealed R71 had a BIMS score of 08 out of 15, which indicated the resident had moderate cognitive impairment. Review of R71's Care Plan Report, included a problem area initiated on 04/23/19, that indicated the resident uses nicotine pouches. Review of R51's admission Record revealed the facility admitted R51 on 06/13/24. According to the admission Record, the resident had a medical history that included but was not limited to diagnoses of vascular dementia and chronic obstructive pulmonary disease. Review of R51's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/20/26, revealed R71 had a Brief Interview for Mental Status (BIMS) score of 06 out of 15, which indicated the resident had severe cognitive impairment. Review of R51's Care Plan Report, included a problem area initiated on 06/20/24, that resident uses nicotine pouches. During observation on 07/12/26 at 10:34 AM of R77's room, revealed his door was opened and a white Styrofoam cup without a lid was observed on R77's bedside table, with a white napkin and tobacco spit in it. During observation on 07/12/26 at 3:12 PM, R77 was sitting alone on the sunporch behind the South Day Room, a cup was on the floor beside the resident, no staff were present on the porch. During observation on 07/13/26 at 1:07 PM, R77 was in his wheelchair on the sunporch. He was spitting into a cup. Two other residents were also present on the porch at this time; no staff were present on the porch. During an observation on 07/14/26 at 10:41 AM with R77 revealed he was on the sun porch listening to music, sitting in his wheelchair, with the spit cup on the floor beside the wheelchair. During an interview on 07/12/26 at 10:34 AM, R77 stated that the cup on his (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bedside table was where he spits. He stated that he chews tobacco and that the facility is aware of his use. He further stated that he keeps the tobacco on his person, though he did not show it to the surveyor. During an interview on 07/12/26 at 3:12 PM, R77 again stated that he uses tobacco and that the facility is aware of it. When asked how long he had been using it, he stated it began shortly after he was admitted to the facility. When asked how he obtains the tobacco, he stated that someone brings it to him. When asked if the person gives the tobacco to the facility staff, he stated that the person gives it directly to him. During an interview on 07/13/26, Certified Nursing Assistant (CNA)3 stated that the facility is strictly non-smoking but noted that certain residents use chewing tobacco. CNA3 reported seeing chewing tobacco in the drawer of R77 about a week prior, guessing that the resident receives money from the Activities department to purchase it at the store. CNA3 further noted that a nurse holds the tobacco for R71, though they were unsure if a nurse also holds tobacco for R77. On multiple occasions over the course of a week, CNA3 witnessed R77 chewing tobacco out of his pocket and putting it into his mouth, inside the facility. CNA3 reported these incidents to the nurse on duty, who was an agency shift nurse. Upon checking the facility matrix to see if any residents had valid orders for chewing tobacco, CNA3 did not see R77's name listed. Additionally, CNA3 stated that R71 uses tobacco products and receives them directly from the nurse. During an interview on 07/13/26, time unspecified, CNA2 stated that the facility is a non-smoking property, which also prohibits the use of other tobacco products. CNA2 verified that R77 chews tobacco and became aware of this habit on the resident's admission date because spit would be found all over his room floor. CNA2 reported R77's tobacco use to Licensed Practical Nurse (LPN)2. Additionally, CNA2 stated that R51 chews snuff and keeps it in his pockets and dresser drawer. During an interview on 07/13/26 at 2:04 PM, Unit Nurse/LPN2 revealed this is a non-smoking facility. She stated that R51, R71 and R77 use tobacco products. To her knowledge R51 and R77 are care planned for using tobacco. R71 uses tobacco chews, which are kept and administered by the Activities Director. LPN2 also stated that tobacco is not considered smoking products. She stated that staff have been educated on the use of tobacco products. Surveyor requested the documentation on the education on 3 separate occasions, first during the interview, then on 07/14/26 at approximately 1:15 PM and approximately 2:30 PM, each time she stated, Oh yes, I do owe you that. During a follow-up interview on 07/14/26 at 10:41 AM with R77 revealed his family brings tobacco to him when they visit him. He stated he keeps the tobacco in his dresser drawer and on him when he has it. He has been chewing it since his was little and he goes crazy without it. He stated that his doctor has not discussed his tobacco use. He stated staff knows that he uses it, however he did not identify any staff. When asked when he chews the tobacco, he states when he has some. He refused to show the tobacco to the surveyor. During an interview with R71 on 07/14/26 at approximately 10:55 AM, R71 revealed that he uses tobacco, and he keeps it in his dresser drawer. During an observation with CNA2 on 07/14/26 at approximately 10:58 AM of R77's nightstand drawer, revealed there were fragments of tobacco. During an interview on 07/14/26 at 12:34 PM, the Activities Director stated she has held her position since November 2025 and is responsible for purchasing, storing, and administering tobacco products for R71. She noted that R71 uses ON! 2mg [milligram] Nicotine Pouches, three times daily following morning snack, lunch, and dinner. The Activities Director further stated that families bring tobacco products into the facility for R77 and R51. Specifically, R77 uses Stoker's Red Supreme Chewing Tobacco. This product is provided to R77 in a Ziplock bag, which he keeps on his person or in his top nightstand drawer, allowing him to use it unsupervised. Finally, the Activities Director stated she has never received education or training to monitor R51 and R71 during tobacco product use and confirmed that the facility does not maintain a product inventory log. At the time of the interview, an (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observation was conducted with the Activities Director. She revealed the key to the black locked box is kept in her office in a drawer that cannot lock; the black box is kept in a cabinet that was not locked, and all of the tobacco products for R71 and R77 were labeled and in the box, R51 did not have any tobacco products in the black locked box. During an interview on 07/14/26 at approximately 1:31 PM, CNA1 stated the facility maintained a smoke- and tobacco-free policy, meaning tobacco products were prohibited. However, she noted that some residents still possessed chewing tobacco. Specifically, she stated R71 and R77 both used chewing tobacco products. She noted that R71's tobacco was kept by the Activity Director and that R71 received two chewing tobacco pouches after every meal, which were provided in a small plastic cup like a medicine cup. CNA1 stressed that it was possible for other residents in the facility to access the spit cups, the containers where the resident spits fluid generated during the tobacco chewing process, presenting a significant safety and contamination risk. Finally, she stated that if she observed a resident with unauthorized tobacco products, she would report it to the nurse to ensure staff could safely remove the items from the resident. An interview was conducted on 07/14/26 at 2:16 PM with the Director of Nursing (DON) regarding facility assessment protocols and smoking safety policies. The DON stated that the nursing team assesses residents using the BIMS score, while the therapy department is responsible for assessing residents for swallowing issues. Regarding tobacco use, the DON stated that the facility has no designated areas or designated times for residents to use tobacco products. When asked about wandering residents entering rooms or areas where tobacco or spit cups are stored by tobacco-using residents, the DON stated this scenario would be no different than a resident grabbing food off another resident's plate, putting it in their mouth, and choking on it. When asked directly if this situation constitutes a safety issue, the DON stated, she guesses. DON stated regarding training/education on residents using tobacco products, that this takes place verbally. No proof of the education was provided to surveyor. During an interview on 07/14/26 at 2:49 PM, the Administrator and Mobile Administrator stated that although the facility is officially a non-smoking facility, they are aware of three residents who currently use chewing tobacco products. They noted that this tobacco use is managed directly through the Activities Director. When questioned about the risk of tobacco or spit cups falling into the hands of other residents, the administrators stated this scenario would be no different than residents grabbing food from another resident and potentially choking. Furthermore, both administrators acknowledged that the facility lacks any official facility policy regarding the use or oversight of tobacco products. During interviews on 07/14/26 at approximately 3:07 PM-3:10 PM, multiple CNAs confirmed never receiving training or education regarding resident tobacco use at the facility.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on review of the facility policy, observations and interviews, the facility failed to ensure expired/outdated medications and biologicals were not stored with, and removed from storage away from other medications and biologicals in use for residents in 1 of 2 treatments carts and 1 of 4 medication carts. Findings Include: Review of the facility policy titled, Pharmacy Services Policies and Procedures, Section 8-Medication Storage, General Guidelines for Storage of Medication and Biologicals. last revised 04/01/22 revealed, Policy: Medications and biologicals are stored safely, securely and properly following manufacturer's recommendations or those of the supplier. In accordance with State and Federal Laws, the facility will store all drugs and biologicals in locked compartments under proper temperatures and other appropriate environmental controls to preserve their integrity. Procedures: 5. Medications with manufacturer's expiration date expressed in month and year will expire on the last day of the month. 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 07/13/26 at 1:35 PM, with Licensed Practical Nurse #1 (LPN1), of the North Treatment Cart revealed the following: One tube of Remedy Zinc Oxide Paste, 4 ounces, Manufactured by Medline, with Lot #24A1025, NDC-53329-156-44, was expired on February 2026. One tube of Remedy Antifungal Ointment, skin protectant 2.5 ounces, Manufactured by Medline, with Lot #2401133, was expired on April 2026. Eleven Catheter Stabilization Devices, Manufactured by Greystone Medical, with Lot #20230418 were expired on April 17, 2026. The outdated/expired medications and biologicals were confirmed by LPN1 and removed from storage with other medications and biologicals. An observation on 04/13/26 at 2:30 PM of the South B medication cart revealed: One bottle of UTI Stat, Cranberry, 30 fluid ounces, 887 milliliters partially used, with Lot #2501368-5566 was expired on 07/07/2026. The expired bottle of UTI Stat was confirmed by the Director of Nursing and removed from the South B medication cart.		