

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425014	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/15/2025
NAME OF PROVIDER OR SUPPLIER Carlyle Senior Care of Aiken		STREET ADDRESS, CITY, STATE, ZIP CODE 123 Dupont Dr Northeast Aiken, SC 29801	

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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, resident records, and interviews, the facility failed to provide adequate supervision to prevent Resident (R)1 from eloping. Specifically, on 10/13/25 R1 had a successful elopement from the facility where he was found across the street, placing the resident at serious risk for injury or harm. On 10/15/25 at 2:15 PM the State Agency (SA) determined that the facility's non-compliance with one or more federal health, safety, and/or quality regulations has caused or was likely to cause serious injury, serious harm, serious impairment, or death. On 10/15/25 at 2:15 PM, the Facility Administrator was notified that the failure to protect R1 from having a successful elopement from the facility constituted Immediate Jeopardy (IJ) at F689. On 10/15/25 at 2:15 PM, the survey team provided the Facility Administrator with a copy of the Immediate Jeopardy (IJ) Template and informed the facility IJ existed as of 10/13/25. The IJ was related to S483.25 Quality of Care at F689: Free of Accident Hazards/Supervision/Devices. On 10/15/25 at 2:30 PM, the facility provided an acceptable IJ Removal Plan. On 10/15/25, the survey team validated the facility's corrective actions and determined the facility made good faith attempts at correcting the non-compliance. The IJ is considered at Past Non-Compliance as of 10/14/25. The survey team concluded all corrective actions were put in place prior to arrival onsite. An extended survey was conducted in conjunction with the Complaint survey for non-compliance at F689, constituting substandard quality of care. Review of the facility policy titled, Elopements and Wandering Residents, last revised 10/13/25 revealed, This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Review of R1's Face Sheet revealed R1 was admitted to the facility on [DATE] with diagnoses including but not limited to vascular dementia with behavioral disturbance, psychotic disorder with hallucinations due to a known physiological condition, delusional disorder, psychophysiological insomnia, and auditory hallucinations. Review of R1's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/02/25 revealed R1 had a Brief Interview of Mental Status (BIMS) score of 5 out of 15, indicating R1 was severely cognitively impaired. Further review revealed R1 wears a wander/elopement alarm daily. Review of R1's Elopement Risk Evaluation dated, 12/04/24, revealed a score of three indicating R1 was at risk for elopement. Review of the facility's statement dated 10/13/25 revealed, 0530 AM Resident was changed by CNA in his room. 0543 AM Resident went out of the building from the service hall doorway. 0615 AM it was noted that the resident was missing and a search began immediately of the entire building. During a second outdoor search the nurse noted the resident across (facility) at the school. After talking to him for a few minutes he agreed to come back to the facility (he said he had to go to work). She returned with him at 0645 AM (no injury was noted). The investigation indicates that Mr. [NAME] exited through the service hall door, with video evidence supporting this claim. Review of a progress note dated 10/13/25 by Licensed Practical Nurse (LPN) 1 revealed, Resident was noted to not be pacing the hallway by his nurse. She then began to look down her hallway. When she did not see him, she called the back to check if he was in the back lobby. When he was not noted there, staff began searching the building. While available staff did a triple check of the building, another nurse started an exterior perimeter check. After the perimeter check she then began walking further down the street. She then observed resident across the street, attempting to go in the door of the school. When asked what he was doing, he stated I'm going to work. He was easily redirected and assisted back into the building. MD aware. Attempted to call RP, it went to voicemail and the voicemail was full. Email was to be sent. Resident was then placed on one on one. Interview with LPN 1 on 10/15/25 at 12:24 PM revealed, R1 is known to pace and frequently walks up and down the facility hallways. He exhibits confusion and decreased safety awareness due to his dementia and other disease processes. R1 has demonstrated some inadvertent exit-seeking behaviors, such as attempting to open closed doors, which staff attribute to his curious nature. However, there were no prior elopement incidents before the current event. Staff report that R1 has consistently worn a functioning WanderGuard for as long as they can recall. On the day of the incident, LPN 1 was informed by another nurse that R1 could not be located and was due for his morning blood sugar check. Nursing staff immediately initiated a search using the facility's triple-check method, inspecting all hallways and resident rooms. R1 was not found inside the facility. LPN 3 expanded the search perimeter and located R1 across the street on high school grounds. When asked why he left the building, R1</p>		