STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425014	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carlyle Senior Care of Aiken	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to honor a resident's right to be free from unnecessary physical restraint for one of three residents (Resident (R)5) reviewed for abuse out of seven sampled residents. This had the potential to effect residents functional status.Findings include:Review of the facility's policy titled Resident Rights dated 04/2025 revealed that the facility will inform the resident both orally and in writing, in a language that the resident understands, of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The resident has a right to be treated with respect and dignity, including the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms.Review of R5's Face Sheet located in the electronic medical record (EMR) under the Profile tab revealed the resident was readmitted to the facility on [DATE] with diagnoses which included dementia and anxiety disorder.Review of R5's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/31/25 and located in the EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of 99 out of 15, which indicated the resident was unable to complete the assessment.Review of R5's Care Plan dated 01/25/25 and located in the EMR under the Care Plan tab revealed, At risk for potentially physically and verbally aggressive related to dementia and agitation. Interventions included approach in a non-threatening manner and approach from the front in a calm manner.During an interview on 09/11/25 at 4:52 PM, Registered Nurse (RN)1 stated that on 06/30/25 she observed R5 walk into the lobby and walked over to R21 and hit R21 in the head with the plate cover. She said there was absolutely no provocation by R21. R5 simply hit R21 for no reason. She said Certified Nurse Aide (CNA)2 came over and bear hugged R5 by putting both of her arms around him from the back to prevent him from moving his arms. RN1 said CNA2 guided R5 to a wing chair and sat him down in it. She stated R5 remained in the chair until police and Emergency Medical Service (EMS) arrived. She stated that staff have not received any type of training on this type of technique, but she felt it was appropriate for CNA2 to restrain R5 at that time.During an interview on 09/11/24 at 5:50 PM, CNA2 said she did not see when R5 struck R21 in the head with the plate lid, but she heard the interaction which made her look up. She observed R5 attempting to hit R21 again and she went over to R5 and grabbed him from behind and putboth her arms around him. She stated at first he was trying to still move forward but he stopped resisting, and she was able to walk him over and sit him down in the chair. She waited with him until EMS arrived. She said that she has not received any training by the facility to use that type of technique on a resident and it was not an approved use of restraint.During an interview on 09/11/25 at 7:10 PM, the Director of Nursing (DON) stated she was familiar with abuse and restraint regulations and that CNA2 should not have grabbed and held R5 in the way she did. The DON said it was not appropriate for CNA2 to bear hug R5. She stated that staff should have tried other diversional techniques to try and calm him. She said the bear hug technique could be considered a restraint and was not an approved technique. She stated that staff have not been trained on doing those types of holds.

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, document review and review of the Resident Assessment Instrument (RAI) manual, the facility failed to ensure timely completion and submission of the Minimum Data Set Assessments (MDSs) for one of one (Resident (R) 81) reviewed out of 21 sampled residents. This failure had the potential to adversely affect care planning and care provision or payment to other facilities for any residents that may not have had a discharge assessment transmitted.Findings include:Review of the October 2024 RAI Manual revealed, . MDS assessments for Significant Change must be completed no later than 14 days from the ARD and no later than 14 days from the determination date of the significant change. MDS assessments for Entry the MDS completion date must be no later than seven days from the event date. and . Comprehensive assessments must be transmitted electronically within 14 days of the completion of the MDS. For Entry information must be transmitted within 14 days of the event date.Review of R81's undated admission Record located in the electronic medical record (EMR) under the Profile tab indicated an admission date of 12/05/23 and diagnoses of respiratory insufficiency, muscle weakness, and difficulty in walking.Review of R81's entry MDS located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 11/25/24 revealed the MDS was completed on 12/04/24 and accepted on 12/05/24. The MDS should have been completed and accepted on 12/01/24.Review of R81's discharge return anticipated MDS located in the EMR with an ARD of 02/08/25 was completed on 03/05/25 and accepted on 03/05/25. The MDS should have been completed and submitted on 02/21/25.Review of R81's entry MDS located in the EMR with an ARD of 02/11/25 was completed on 03/05/25 and accepted on 03/05/25. The MDS should have been completed and submitted on 02/24/25.Review of R81's significant change MDS located in the EMR with an ARD of 04/24/25 was completed on 05/08/25 and accepted on 05/08/25. The MDS should have been completed and submitted on 05/07/25.During an interview on 09/12/25 at 2:30 PM, the MDS Coordinator (MDSC)confirmed R81's MDSs were completed and submitted late. The MDSC also stated the facility did not have a specific policy for following the MDS and that the MDS nurses follow the MDS manual for coding.During an interview on 09/12/25 at 3:30 PM, the MDSC provided the MDS validation report for R81 from [DATE] until her discharge in June 2025. The validation report was reviewed and the MDSC confirmed the 11/25/24 and 04/24/25 MDSs reflected a warning message that stated .submitted values listed do not match the IQIES database. The February 2025 MDSs confirmed the .submission date is more than 14 days after the ARD. No corrections or modifications were completed for the 11/25/24 or 04/24/25 MDSs. The MDSC stated she saw the warning messages, but the MDSs were accepted.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review, and policy review, the facility failed to ensure that urinary catheter care was performed for one of one resident (R)65) reviewed for catheters and urinary tract infection. This failure placed the resident at risk for transmission of infection to the urinary tract.Findings include:Review of the facility's policy titled, Catheter Care dated 02/17/24 revealed, .Male:.16. With a new moistened cloth, starting at the urinary meatus moving down, cleanse the shaft of the penis.Review of the Census tab in R65's electronic medical record (EMR) revealed he was admitted to the facility on [DATE] with diagnoses including urinary tract infection (UTI) and neuromuscular dysfunction of bladder.Review of R65's Orders tab of the EMR revealed a physician's order dated 07/29/25 which documented, Catheter-Provide catheter care every shift.During catheter care observation with Certified Nursing Assistant (CNA)1 and Licensed Practical Nurse (LPN) 1 on 09/11/25 at 9:06 AM, R65 was lying in his bed. CNA1 removed R65's incontinence brief After doffing gloves, CNA1 took a wipe and retracted the foreskin. CNA1 wiped around the head of the penis, three different times, with three different wipes and changing gloves between each time. After the final wipe, CNA1 then wiped the tubing, removed her gloves, and replaced the same incontinence brief on R65.There was no evidence that the shaft of the penis was cleaned during the care.During an interview on 09/12/25 at 9:30 AM, CNA1 confirmed that she was trained to clean the shaft of the penis and stated that she did not clean the shaft of the penis.During an interview on 09/12/25 at 9:55 AM, the Director of Nursing (DON) stated that the shaft of the penis does not need to be cleaned during catheter care. The DON could not confirm the procedure she stated in the facility's policy.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to ensure a resident's nasal cannula was stored properly when not in use for one of two residents reviewed for oxygen therapy (Resident (R) 65) out of a total sample of 21 residents. This failure had the potential to increase the risk of a respiratory infection for residents receiving respiratory therapy.Findings include:Review of the facility's policy titled Oxygen Safety dated 04/2025 revealed, it is the policy of this facility to provide a safe environment for residents, staff, and the public. This policy addresses the use and storage of oxygen and oxygen equipment.Review of R65's admission Record located in the electronic medical record (EMR) under the Profile tab revealed the resident was readmitted to the facility on [DATE] with diagnosis which included quadriplegia.Review of R65's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/06/25 in the EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was not cognitively impaired. The resident was coded as receiving oxygen therapy.Review of R65's Physician Order dated 02/27/25 in the EMR under the Orders revealed an order for oxygen at 2 Liters per Minute (lpm) via nasal cannula as needed for shortness of breath.Observation on 09/11/25 at 2:35 PM, revealed R65's oxygen nasal cannula was wrapped around the top of the resident's oxygen concentrator and on 09/12/25 at 12:00 PM, R65's nasal cannula was lying at the foot of the resident's bed uncovered.During an observation and interview on 09/11/25 at 2:40 PM, Licensed Practical (LPN)3 verified R65's nasal cannula was left out uncovered and that the nasal cannula should be stored in a bag.During an interview on 09/12/2025 at 11:52 AM, LPN4 verified R65's nasal cannula was lying on the floor uncovered. He stated R65 only used oxygen at night and not during the day and it should not be on the floor LPN4 stated that he did not notice the cannula was on the floor and stated it should be stored in a bag.During an interview on 09/12/25 at 4:35 PM, the Director of Nursing (DON) stated a resident's nasal cannula should be stored in a bag when not in use.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and review of facility policy, the facility failed to ensure the daily nurse staffing information was posted in a manner that residents and visitors had access to the information. This deficient practice has the potential to affect all residents and visitors.Findings include:Review of the facility's policy titled Nurse Staffing Posting Information dated May 2025 revealed, . It is the policy of this facility to make nurse staffing information readily available in a readable format to residents. staff and visitors at any given time.Upon entrance to the facility on [DATE] at 9:00 AM, the daily nurse staffing information was observed posted on a glass bulletin board, with multiple notices behind it inside the case, approximately six feet high. The posting was current for the day, all three shifts, however, was not readable, or accessible, for residents in a wheelchair or with vision problems.Observations on the subsequent survey days of 09/11/25 at 2:30 PM, and 09/12/25 at 10:00 AM revealed the daily nurse staffing information posted on a glass bulletin board, with multiple notices behind it inside the case, approximately six feet high. The posting was current for the day, all three shifts, however, was not readable, or accessible, for residents in a wheelchair or with vision problems.During an interview on 09/12/25 at 3:00 PM, the Director of Nursing (DON) stated she was responsible for posting the daily nurse staff information. She also stated she was not aware it had to be posted in an accessible area for residents and visitors.