STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425117	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carlyle Senior Care of Kingstree	401 Nelson Boulevard Kingstree, SC 29556

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 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** 36190 Based on review of the facility policy, record review, observation, and interviews, the facility failed to document bruising for one of two residents (Resident (R)11) reviewed for quality of care of 23 sample residents. This failure could have caused a missed opportunity to distinguish accidents from inflicted injuries. Findings include: Review of the facility's policy titled, Skin Assessment revised 09/30/24, revealed A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, daily for three days, and weekly thereafter. The assessment may also be performed after a change of condition . h. Note any skin conditions such as redness, bruising . Documentation of skin assessment . b. Document observations (e.g., skin conditions). Review of R11's annual Minimum Data Set (MDS) with an Assessment reference date (ARD) date of 02/03/25, revealed R11 had an admitted [DATE] and a BIMS score of 11 out of 15, indicating R11's cognition was moderately impaired. R11 received an antiplatelet medication, and had diagnoses of heart failure, diabetes mellitus, and stroke. Review of R11's Orders revealed the following: 08/21/24 Clopidogrel Bisulfate (an antiplatelet medication) 75 MG [milligrams] 1 tablet [tab] by mouth [PO] one time a day. 08/21/24 Aspirin (an antiplatelet medication) Tab 325 MG 1 tablet by mouth one time a day. With instructions to observe closely for significant side effects including .bruising . every shift and to document: Y[yes] if side effects noted and notify MD if indicated; N[no] if no side effects noted. Document side effects observed in progress note. Review of R11's March 2025 Medication Administration Record (MAR) revealed, monitoring of anticoagulant side effects such as bruising documented with an N or 0 for 03/01/25 through 03/26/25 indicating no side effects were present. Review of R11's Skin Only Evaluations dated 03/03/25 and 03/18/25, revealed no current skin issues noted. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R11's Progress Notes, dated 01/10/25 through 03/25/25, revealed no documentation of bruising. During an observation and interview on 03/25/25 at 11:10 AM, R11 was awake in bed dressed in a night gown. Several purple bruises were noted on both of R11's forearms. R11 was asked about her bruises. R11 stated she didn't know how she got them, and it was concerning her. R11 stated she was not mistreated, and the bruises were not painful. R11 then revealed more bruises on her right neck and shoulder. R11 stated she didn't remember bumping anything. During an interview on 03/26/25 at 1:26 PM, Licensed Practical Nurse (LPN) 1 was asked about R11's bruises. LPN1 stated she was aware of R11's bruises, but she wasn't sure why R11 had them as she wasn't receiving an anticoagulant medication. During an interview on 03/26/25 at 1:56 PM, the DON was asked why R11 had bruises and why the section of the March 2025 MAR included 0 or N indicating no side effects were present. The DON stated she didn't know but R11 was out of the facility last weekend. The DON stated R11 had bumps things on her way to the bathroom and that sometimes causes bruises. The DON confirmed the MAR section for documenting side effects and the skin assessment were noted as none present. During an interview on 03/27/25 at 11:23 AM, the Nurse Practitioner (NP) was asked about R11's bruises. The NP stated she found out about R11's bruises on Monday, 03/24/25 and they looked like purpura. The NP stated she documented the bruises but didn't always tell the staff. The NP was asked what her expectation was for staff in documenting bruises. The NP stated, it depends on the bruise. 52323

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52323 Based on review of the facility policy, record reviews and interviews, the facility failed to ensure services were provided to prevent and treat pressure ulcers by not following professional standards of practice to evaluate and document initiating wound assessment and following the wound doctor's care recommendation for four of six residents (Resident (R) 12, R27, R30, and R47) reviewed for pressure ulcers out of a total sample of 23 residents. These failures placed all four residents at risk of pressure ulcers worsening. Findings include: Review of the facility's policy titled, Pressure Injury Prevention and Management, dated 09/30/23, revealed documentation as follows: Licensed nurses will conduct a full body skin assessment on all residents upon admission/readmission and weekly. Findings will be documented in the medical record .Assessments of pressure injuries will be performed by a licensed nurse and documented in the electronic charting. 1. Review of R12's Admission Record revealed, R12 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including but not limited to: chronic respiratory failure and need for assistance for personal care. Review of R12's Care Plan, revised on 03/26/25, included the following: Potential for alterations in skin integrity related to comorbidities, incontinence, impaired mobility, weakness, and history of pressure ulcers. 02/26/25 - unstageable pressure ulcer to the left medial foot with treatment noted. 03/04/25 - unstageable pressure ulcer left heel with treatment changed. 03/11/25 - treatment changed to left heel and left medial foot. 03/25/25 - treatment changed to left medial foot. Review of R12's Treatment Administration Record (TAR) dated from 01/01/25 to 03/27/25, revealed R12 was receiving wound care orders, that included: Start date 02/26/25, offload heels/ heel protectors two times a day on everyday shift and night shift. May offload heels or apply heel protectors. Start date 03/26/25, wound care to cleanse distal medial foot wound with normal saline. Pat dry. Apply Medi honey and border gauze, do daily. everyday shift. Review of R12's Progress Notes titled VohraProgressNote dated 03/04/25 and 03/25/25, documented three pressure ulcers as follows: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Site two, UNSTAGEABLE (DUE TO NECROSIS) OF THE LEFT, DISTAL, MEDIAL FOOT FULL THICKNESS. The plan of care included recommendations: Cleanse with saline at time of dressing change; Off-Load Wound; Reposition per facility protocol; Pressure Off-Loading Boot. b. Site three, UNSTAGEABLE (DUE TO NECROSIS) OF THE LEFT, MEDIAL FOOT FULL THICKNESS. The plan of care included recommendations: Cleanse with saline at time of dressing change; Off-Load Wound; Reposition per facility protocol; Pressure Off-Loading Boot. c. Site four, UNSTAGEABLE DTI OF THE LEFT HEEL UNDETERMINED THICKNESS The plan of care included recommendations: Cleanse with saline at time of dressing change; Off-Load Wound; Reposition per facility protocol; Pressure Off-Loading Boot. Review of R12's record revealed, no initial wound assessment documentation to include: start date, wound size and wound conditions. Review R12's TAR revealed no documentation that the wound doctor's plan of care recommendations was implemented. During an interview on 03/26/25 at 11:06 AM, the Director of Nursing (DON) stated R12's pressure ulcers' start date was 02/26/25, a Certified Nurse Aide (CNA) verbally reported this to the Infection Preventionist/ Wound Nurse (IP/WN) IP /WN. She said that IP/WN did not document the initial measurements, and the conditions of the pressure wounds in R12's record. 2. Review of R27's Admission Record revealed R27 was admitted to the facility on [DATE] with diagnoses including but not limited to diabetes. Review of R27's Nurse's Note dated 03/05/25 at 1:17 PM, documented, Open area noted to right buttock. TX [treatment] put in place. RP [responsible party] made aware. No s/s [signs and symptoms] of distress noted. Call light is within reach. Review of R27's Progress Notes titled VohraProgressNote dated 03/11/25 included the following: Site two, STAGE 2 PRESSURE WOUND OF THE RIGHT BUTTOCK PARTIAL THICKNESS. Review of R27's Care Plan, revised on 03/24/25, included the following: Stage II pressure ulcer to right buttock with potential for further alterations in skin integrity related to decreased mobility, incontinence, history of healed wounds, comorbidities, and edema. 03/11/25 and stage II pressure ulcer noted to the right buttock with treatment noted. Resolved on 03/22/25. Review of R27's record revealed no initial wound assessment to include: the stage II pressure ulcer's size and wound conditions. During an interview on 03/26/25 at 11:06 AM, The DON stated that a nurse verbally reported the wound to IP/WN and the IP/WN did not document the initial measurements and conditions of the pressure wound in R27's record. 3. Review of R30's Admission Record revealed R30 was admitted to the facility on [DATE] with diagnoses including but not limited to: chronic obstructive pulmonary disease, and pressure-induced deep tissue damage of left heel. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R30's Care Plan, revised on 03/26/25 included the following: Existing stage IV to sacrum & Deep Tissue Injury (DTI) left heel with potential for further alternations in skin integrity related to comorbidities, weakness, & impaired mobility, 12/10/24 - Bactrim for fourteen days and cefepime intravenous (IV) for 14 days rated to Methicillin-resistant Staphylococcus aureus (MRSA, a type of staph bacteria resistant the antibiotics) in wound and 12/20/24 - Cefepime IV for fourteen days related to MRSA in wound. Review of R30's Progress Notes titled, VohraProgressNote dated 03/25/25, included the following: Site six, STAGE 4 PRESSURE WOUND SACRUM FULL THICKNESS, wound size 0.4 x 0.7 x 0.3 cm. The plan of care included recommendations: Group-2 Mattress: Continue; Cleanse with saline at time of dressing change; Off-Load Wound; Reposition per facility protocol; Check bed pump q [every] shift to ensure working properly. Review of R30's TAR dated 01/01/25 to 03/26/25 revealed, R30 was receiving wound care by physician's order as follows: Start date 08/06/24, apply heel protectors as tolerated two times a day every day and night shift May offload heels or apply heel protectors. Start 08/14/24, air mattress to bed every shift for aid in wound healing. Check every shift. Start date 03/27/25, wound care for sacral wound, cleanse with wound cleanser. Apply barrier cream on skin directly around the wound. Apply small amount of saline to small piece of Hydrofera Blue, wring out. Tuck in wound and cut off excess. Cover with a dry dressing every day shift, every Tuesday, Thursday, and Saturday, for stage IV pressure ulcer to sacrum. Replace if soiled. Review of R30's record revealed no documentation that the wound doctor's plan of care recommendations was implemented. During an interview on 03/27/25 at 9:53 AM, the DON reviewed R30's record and stated there was no documentation that indicated that the wound doctor's care recommendation was implemented or recorded in R30's record and it should have been implemented, documented in the MAR, and care planned. 4. Review of R47's Admission Record revealed R47 was admitted to the facility on [DATE] with diagnoses including but not limited to: diabetes, stage three pressure ulcer of sacral region, onset date 12/10/25. Review of R47's Care Plan, revised on 03/20/25, included, documentation on 10/28/24 R27 had a stage III pressure ulcer to sacrum. Review of R47's TAR dated 01/01/25 to 03/27/25 revealed that R12 was receiving wound care by physician order as follows: Start date 02/18/25, mattress to bed as tolerated. Check functional every shift. Start 02/21/25, wound care for stage III pressure ulcer to sacrum, clean with wound cleanser, normal saline. Then apply calcium alginate and cover with dry dressing, two times a day on every day and night shift. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R47's Progress Notes titled VohraProgressNote dated 10/29/24, included the following: Site seven, STAGE 3 PRESSURE WOUND SACRUM FULL THICKNESS. The plan of care included recommendations: Cleanse with wound cleanser at time of dressing change; Off-Load Wound; Reposition per facility protocol; Turn side to side in bed every 1-2 hours if able; Group-2 Mattress. Review of R47's Progress Notes titled VohraProgressNote dated 02/21/25 and 03/18/25 included the following: Site seven, STAGE 4 PRESSURE WOUND SACRUM FULL THICKNESS Peri Wound Treatment: Zinc ointment apply twice daily and as needed for 30 days. The plan of care included recommendations: Group-2 Mattress: Continue; Cleanse with saline at time of dressing change; Off-Load Wound; Reposition per facility protocol; Turn side to side in bed every 1-2 hours if able; Check bed pump q [every] shift to ensure working properly. Review of R47's record revealed no initial wound assessment was documented to include when the stage III pressure ulcer, now stage IV, began and the initial assessed size. There was no documentation that the treatment order of Zinc ointment twice daily and as needed for 30 days. was given, and if the plan of care recommendation was implemented and what was the pump pressure requirement for the air mattress. During an interview on 03/26/25 at 11:06 AM, the DON stated staff usually verbally reported new wounds to the IP/WN and the IP/WN did not have any documentation of the initial measurements and the condition of the pressure wound. During an interview on 03/27/25, at 9:53 AM, the DON stated a wound assessment would have included size, color, drainage, odors. The DON reviewed R47's record and stated no documentation indicating that the wound doctor's care recommendation was implemented or recorded, and it should have been documented in the MAR, and care planned. During a follow up interview on 03/27/25 at 11:30 AM, the DON stated that the facility's air mattresses were in group two. She said per the manufacturer's manual; the pressure setting would adjust based on the resident's weight. The DON said she would include the pressure setting for air mattress in the monitoring orders in the future.

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F 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36190 Based on review of the facility policy, record review, observation and interview the facility failed to effectively manage pain for one of one resident (Resident (R) 58) reviewed for pain out of 23 sample residents. The facility failed to order R58's Morphine (an opioid pain medication) in a timely manner, resulting in an escalation of pain levels and decreased oral intake. Findings include: Review of the facility's policy titled Pain Management revised 08/30/24, revealed, 1. In order to help a resident attain or maintain his/her highest practicable level of physical, mental and psychosocial well-being and to prevent or manage pain, the facility will . c. Manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences . i. Facility staff will notify the practitioner, if the resident's pain is not controlled by the current treatment regimen. Review of the facility's policy titled Ordering Medications from the Pharmacy, revised 08/10/21, revealed 3. Schedule II controlled substances should be reordered seven (7) days in advance of need. Review of R58's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 12/23/24 revealed R58 was admitted to the facility on [DATE] with diagnoses that include but are not limited to: acquired absence of the right leg above the knee, cardiomyopathy and peripheral vascular disease. R58 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R58 was cognitively intact. Review of R58's Care Plan, revised 03/12/25 revealed Pain: Resident is at risk for alteration in comfort related to weakness, decreased mobility, peripheral arterial occlusion with ischemia to the LLE [lower left extremity] with chronic pain, Rt [right] AKA [above the knee amputation], GERD [gastroesophageal reflux disease], BPH [benign prostatic hyperplasia], Dysphagia and pain Constipation. Amputation was recommended to LLL [lower left leg] but has been declined by the resident. 2/17/25-readmitted to facility, Neurontin & morphine sulfate in place . Interventions included Administer medication as ordered and PRN [as needed] pain meds when non-pharmacological pain interventions are ineffective .Provide alternative comfort measures (relaxation, positioning etc) prn as ordered, and Report uncontrolled pain to MD [Medical Doctor] as needed. Review of R58's Orders revealed: 02/17/25 Morphine Sulfate Tab ER [extended release] 15 MG [milligrams] by mouth [by mouth] three times a day [TID] for pain. 02/17/25 Gabapentin Cap 400 MG 1 capsule orally two times [BID] a day for pain in legs. 03/03/25 Tylenol Oral Tablet 325 MG (Acetaminophen) 2 tablet by mouth every 6 hours as needed for pain. 3/13/25 Acetaminophen Oral Tablet 325 MG 2 tablet by mouth in the afternoon for Chronic Pain. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of a medication request located in the Nurse Practitioner's book at the nurse's station, revealed, a request completed on 03/10/25 for R58's morphine ER 15 MG PO three times a day for pain and noted the number on hand as three. On 03/17/25 and 03/22/25 the number on hand was left blank. Review of R58's Pain assessment dated [DATE], revealed R58 occasionally had pain with a Numeric Rating of 3 on a Scale (00-10). R58's pain was managed with Tylenol daily, Gabapentin BID, Morphine TID. Review of R58's Medication Administration Record (MAR) revealed R58's morphine was not administered on 03/21/25 at 2:00 PM, on 03/22/25 and 03/23/25 at 6:00 AM, 2:00 PM, and 10:00 PM, and on 03/24/25 at 6:00 AM. A total of eight doses of morphine were not administered. Review of R58's administration note, dated 03/25/25 revealed Tylenol Oral Tablet 325 MG Give 2 tablet by mouth every 6 hours as needed for pain. Resident c/o [complain of] pain 10/10. During an interview on 03/25/25 at 11:01 AM, R58 stated he had been out of his morphine for five days and suspected the facility ran out. R58 stated his morphine came in yesterday [03/24/25] and it was taking a while for his body to catch up. R58 was asked how it made him feel to be without the morphine and he stated he couldn't describe it, but he couldn't get out of bed or move about in bed because he had a lot of pain. R58 was asked if he was given something else to help with his pain. R58 said Tylenol. R58 was asked if the Tylenol helped and he stated, No, not really, it took a little of the edge off. During an observation and interview on 03/26/25 at 8:34 AM, R58 was observed awake in bed eating breakfast. R58 stated he felt much better now his pain was more controlled. R58 also stated during the time he was without the morphine and in pain he wasn't able to eat. Review of R58's Amount Eaten revealed, on 03/24/25 R58 refused breakfast and lunch. On 03/25/25 R58 ate 26-50 % at breakfast and lunch. R58's usual consumption was 51-100%. During an interview on 03/26/25 at 8:37 AM, Licensed Practical Nurse (LPN) 1 was asked if R58's morphine was out over the weekend. LPN1 stated, Yes. LPN1 stated the prescription was sent to the pharmacy with no response. LPN1 stated, Finally the unit manager called the pharmacy. LPN1 was asked how much time in advance the process needed to be started to refill the morphine. LPN stated they ordered when they saw the morphine getting low, about four days out. LPN1 stated they physically placed the order request in the Nurse Practitioner's (NP) book at the nurse's station and the NP sent it. LPN1 was asked if the prescription for R58's morphine was sent timely and LPN1 stated, No. During an interview on 03/26/25 at 3:09 PM, the Director of Nursing (DON) was asked if she was aware R58 was out of his morphine over the weekend. The DON stated, No, she just became aware. The DON stated she reviewed the medication request book; pharmacy was called, and the NP said she sent it in. The DON went on to say, But it [morphine] didn't come in until we requested it on Monday [03/24/25]. The DON stated it should have come Friday night, 03/21/25. The DON was asked what should be done when the medication didn't come in as planned. The DON stated, Notify the physician. The DON was asked if another pain medication or intervention was utilized in the meantime. The DON stated she would have to check. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 03/27/25 at 11:20 AM, the NP was asked if she was aware R58 was out of morphine over the weekend. The NP stated, No. The NP stated on 03/21/25, the medication was supposed to be filled and sent to the facility that night. The NP stated R58 informed her 03/24/25 during her visit that the morphine wasn't given. The NP stated the staff on-call should have been notified. The NP checked her computer and confirmed she didn't get notification the on-call staff were called.