

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425163	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER Carlyle Senior Care of Florence		STREET ADDRESS, CITY, STATE, ZIP CODE 133 West Clarke Road Florence, SC 29501	

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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902</p> <p>Based on interview and record review, the facility failed to ensure a resident's representative (RP) was informed of the risks and benefits associated with the resident taking psychotropic medications for one of three residents (R) Resident 72) reviewed for unnecessary medication use out of a total sample of 28. This failure had the potential to affect residents receiving psychotropic medications.</p> <p>Findings include:</p> <p>Review of R72's Face Sheet located in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnosis which included strange and inexplicable behavior.</p> <p>Review of R72's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/03/25 and located in the resident's EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated the resident was cognitively intact.</p> <p>Review of R72's Certification of Inability to Make Healthcare Decisions located in the electronic medical record (EMR) under the Misc tab and dated 07/27/23 revealed two physicians certified the resident was unable to make healthcare decisions for himself.</p> <p>Review of R72's Informed Consent for psychoactive medication Use located in the electronic medical record (EMR) under the Misc tab and dated 03/20/25 revealed the resident signed the document that indicated the risk and benefits of receiving a psychotropic medication. Further review revealed the nurse completing the form was the Director of Nursing (DON).</p> <p>During an interview 03/27/25 at 9:52 AM the Director of Nursing (DON) said she was unaware that R72 had been deemed incapable of making health care decisions. She agreed the RP should have signed the form and not R72. She said she only looked at the resident's BIMS score. She said she spoke with R72 about the medication. He said okay, so she assumed he understood. But she agreed that if a physician had deemed him incapable it was inappropriate to discuss the risk and benefits of the medications with him and have him sign the document.</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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>40902</p> <p>Based on review of the facility policy, observation and interviews, the facility failed to ensure medical records containing personal health information (PHI) were not accessible to 16 of 16 residents. This failure had the potential to allow inappropriate access to residents' records.</p> <p>Findings include:</p> <p>Review of the facility policy titled HIPAA Security Measures last revised 09/30/24 revealed, it is the facility's policy to implement reasonable and appropriate measures to protect and maintain the confidentiality, integrity, and availability of the resident's identifiable information and /or records that are in electronic format .</p> <p>During an observation on 03/25/25 at 10:44 AM, the east unit nursing medication cart was in the hallway and the cart was locked but the computer screen was on and revealed six resident names. Four residents and three staff walked past the medication cart and computer screen before Licensed Practical Nurse (LPN)7 returned to the cart.</p> <p>During an interview on 03/25/25 at 10:47AM, LPN7 stated the computer screen was locked. She said she leaves the screen open with the residents' names but there was no medical information on the screen. When asked to click on one of the residents' names, she saw that PHI immediately display on the computer screen. She said she did not know how to lock the screen and would have to close the computer to lock it.</p> <p>During an interview 03/27/25 at 9:52 AM, the Director of Nursing (DON) stated nursing staff were supposed to keep computer records out of sight and that all computer screens should have been locked when nurses were not at the medication cart. She said all medical documentation containing PHI should be kept out of view and secured.</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25232</p> <p>40902</p> <p>Based on review of facility policy, record review, document review and interviews, the facility failed to protect the residents from physical and verbal abuse by another resident or staff for four of five residents (Resident (R)72, R71, R12, and R52) reviewed for abuse. This had the potential to affect residents in the facility who were at risk for abuse.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Abuse, Neglect and Exploitation revised 10/24/22 revealed, it is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse .</p> <p>1. Review of R54's Face Sheet located in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses which include but are not limited to: autistic disorder, anxiety disorder, mental disorder, and mood disorder.</p> <p>Review of R54's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/17/25 and located in the resident's EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of seven out of 15, which indicated the resident was severely cognitively impaired.</p> <p>Review of R54's Care Plan, dated 12/05/24 and located in the EMR under the Care Plan tab revealed, Disruptive and anxious behaviors, yelling and slamming doors, restlessness, agitation and non-compliance. Interventions put in place were when resident becomes agitated intervene before agitation escalates.</p> <p>Review of R72's Face Sheet located in the EMR under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses which include but are not limited to: strange and inexplicable behavior.</p> <p>Review of R72's quarterly MDS with an ARD of 02/03/25 and located in the resident's EMR under the MDS tab, revealed a BIMS score of 13 out of 15, which indicated the resident was cognitively intact.</p> <p>Review of R72's Nurse's Note dated 02/11/25 at 3:04 PM and located in the EMR under the Notes tab written by Licensed Practical Nurse (LPN) 2 revealed, This nurse had a conversation with resident about reportable incident from the night before to get his side of the story, this resident told me that he was sitting in the lobby in his usual chair looking at the TV. He stated the accused aggressor started talking loudly and yelling, when this resident asked aggressor what was wrong, aggressor walked up to him and hit me on my right cheek. This resident stated he only hit him 1 time and then walked away. This resident denies hitting aggressor back.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Facility's Five Day Follow Up dated 02/14/25 revealed the date and time of the incident was 02/10/25 at 11:00 PM. Further, the summary indicated the residents did have a physical altercation.</p> <p>During an interview on 03/26/25 at 1:15 PM, R72 stated, on the night of 02/10/25 he was sitting on one couch and R54 was sitting on the other couch across from him. He stated R54 got up and walked over to him and hit him on the side of his face with an open hand.</p> <p>During an interview on 03/26/25 at 1:40 PM, LPN2 stated she spoke with R72 on 02/11/25 who reported on the night of 02/10/25 he was just watching TV when R54 said something to him, but he did not say anything. Then R54 hit him in the face once and walked away. He said staff were notified who separated them.</p> <p>During an interview on 03/26/25 at 3:09 PM, Certified Nurse Aide (CNA)2 stated, on the night of 02/10/25 she was coming down the hall when she saw R54 hit R72. She said they were each sitting on a couch in the TV area when R54 got up and walked over towards R72 and hit him on the side of his face. She said they were arguing about something and that R72 did not do anything.</p> <p>During an interview on 03/26/25 at 4:24 PM, the Facility Administrator (FA) stated they found that the incident did occur and that it was substantiated.</p> <p>2. Review of R71's Face Sheet revealed he was admitted to the facility on [DATE] with diagnoses that include but are not limited to: bipolar disorder, human immunodeficiency virus, and attention deficit.</p> <p>Review of R71's annual MDS with an ARD of 03/18/25, indicated a BIMS score of 15 out of 15 which indicated the resident was cognitively intact.</p> <p>Review of a Facility Related Incident Report (FRI), indicated that R71 was verbally abused by CNA9. Review of the facility investigation revealed that on 02/12/25 at 4:54 AM, CNA9 was charging her cell phone in the day room of the west unit. R71 was up and had gone to his friend's room to get his cell phone charger. R71 was returning to his room when CNA9 accused him of stealing her phone.</p> <p>Review of the facility statement from CNA9 revealed, I was charging my phone on a table in the day room. I saw R71 coming out of another residents room. I looked on the table and my phone was gone. It had to be R71. He was the only one up. I told him that I was not leaving without my phone. He stole it and ditched it in another resident's room. I did not curse at him.</p> <p>During an interview on 03/26/25 at 2:14 PM R71 stated, CNA9 said that I took her phone. I did not take her phone. I went to another room to get a phone charger. CNA9 was outside of another room when she saw me and asked what I was doing. I went back to my room. She then accused me of taking her phone. She is not her anymore. CNA9 said she was calling the police. I told her that I was calling the police. She said she was going to beat my mother f*** a**if I didn't return her phone.</p> <p>During an interview on 03/26/25 at 5:45 PM CNA10 stated, I witnessed CNA9 telling another staff that R71 took her phone. CNA9 stated that he took her [foul word] phone, and he better give it back. She did state that she would beat his a**. R71 was sitting in the corner of the day room and could hear her.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/27/25 at 6:58 PM, the FA stated, [R71] did let staff look for the phone in his room and it was not found. CNA9 was immediately suspended pending investigation and quit. She never returned to the facility. We try to prevent abuse of any kind and protect our residents.</p> <p>3. Review R12's Admission Record found in the EMR under the Profile tab, revealed R12 was admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease.</p> <p>Review of R12's annual MDS with an ARD of 02/21/25 located in the EMR under the MDS tab indicated short term and long-term memory problems. R12 was rarely/never understood. The MDS indicated that R12 wanders daily and that R12's wandering significantly intrudes on the privacy of activities of others.</p> <p>Review of a Skin Note found in the EMR under the Notes tab dated 02/20/25 revealed, .R12 noted to have red areas around after incident with other resident, no other visible injuries noted.</p> <p>Review R52's Admission Record found in the EMR under the Profile tab revealed R52 was readmitted to the facility on [DATE] with a diagnosis of dementia.</p> <p>Review of R52's quarterly MDS with an ARD of 01/09/25 located in the EMR under the MDS tab with a BIMS score of 10 out of 15, which indicated R52's cognition was moderately impaired. The MDS indicated that R52 had no behaviors.</p> <p>Review of R60's annual MDS with an ARD of 12/05/24, located in the EMR under the MDS tab with a BIMS score of 15 out of 15 which indicated R60's cognition was intact.</p> <p>Review of R60's Statement from the person alleging abuse or reportable incident dated 02/19/25 indicated, I yelled at [R12] to get out of my room. [R52] got up and tried to make her [R12] get out of the room. [R12] held onto my bed and would not turn it loose. [R12] slapped [R52] and [R52] slapped her [R12] back.</p> <p>Review of the Initial Report dated 02/19/25 indicated, On 02/19/25 at approximately 7:20 PM, residents [R12 and R52] had a physical altercation. Residents were immediately separated by staff Further review revealed, a statement from R52 saying, [R12] was in our room. We told her to get out. She would not leave; I pushed her out of the room, and she slapped me in my face. I slapped her back on her face.</p> <p>Review of LPN1's Witness Statement, dated 02/19/25, stated, I heard the two residents arguing. I went to the room and [R12] was standing in [R52's] doorway .I did not see the altercation but heard [R52] yelling.</p> <p>During an interview on 03/25/25 at 11:37 AM, R52 said R12 came into her room, went into the bathroom, came out and sat down, so R52 opened the bedroom door and told R12 to get out. R52 said that R12 pushed her, so she pushed R12 back. R52 said that an unknown nurse came into the room and removed R12 from the room and told R12 not to come back.</p> <p>During an interview on 03/26/25 at 2:15 PM, R12 was alert, but confused and unable to recall the incident.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/26/25 at 2:50 PM, LPN2 said R12 had wandered into R52's room, touching things, and R52 was yelling at R12. Staff immediately went into R52's room and removed R12.</p> <p>During an interview on 03/25/25 at 4:00 PM, LPN1 said R12 was at the doorway of R52's room. LPN1 said the residents were separated and indicated R12 wanders throughout the facility. LPN1 confirmed there were no further incidents.</p> <p>During an interview on 03/26/25 at 5:23 PM, the FA stated, The FA stated both residents should have immediately had a skin assessment after the incident; however, FA confirmed that R12's skin assessment was not completed until 02/20/25. The FA confirmed that this incident was resident to resident abuse.</p> <p>During an interview on 03/26/25 at 6:16 PM, LPN4 said she was giving report to the oncoming shift and had to go down to R52's room because R12 wandered inside. Once there in the room, R52 and R12 were separated. R52 and R60 said that R12 hit first, who had redness to one side of the neck and there was no redness to R52. LPN4 said that there have been no further incidents between these residents.</p> <p>43050</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25232</p> <p>40902</p> <p>Based on record review, interview, and policy review, the facility failed to thoroughly investigate resident to resident abuse for four of five residents (Resident (R)72, R54, R12, and R52) reviewed for abuse out of 28 sample residents. This had the potential to affect residents in the facility who were at risk for abuse.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Abuse, Neglect and Exploitation revised 10/24/22 revealed, .an immediate investigation is warranted when suspicion of abuse . or reports of abuse, .occur. Written procedures for investigations include: Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations .</p> <p>1. Review of R54's Face Sheet located in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses which include but are not limited to: autistic disorder, anxiety disorder, mental disorder, and mood disorder.</p> <p>Review of R54's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/17/25 and located in the resident's EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of seven out of 15, which indicated the resident was severely cognitively impaired.</p> <p>Review of R72's Face Sheet located in the EMR under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses which include but are not limited to: strange and inexplicable behavior.</p> <p>Review of R72's Quarterly MDS with an ARD of 02/03/25 and located in the resident's EMR under the MDS tab, revealed a BIMS score of 13 out of 15, which indicated the resident was cognitively intact.</p> <p>Review of the Facility's Five Day Follow Up Report dated 02/14/25, revealed the date and time of the incident was 02/10/25 at 11:00 PM. The summary finding indicated the residents did have a physical altercation. Further review did not indicate what occurred or who the aggressor was. There was no interview with [R72] after the incident occurred. It did not indicate what staff member witnessed the incident or an interview with that staff member. There were no interviews with any other residents who may have been in the Television (TV) room or had any knowledge of the incident or residents.</p> <p>During an interview on 03/26/25 at 4:24 PM, the Administrator stated he was the Abuse Coordinator, and it was his responsibility to ensure the completion of the investigation. He said anytime there was a resident-to-resident incident the investigation should include: statements by any staff who witnessed the incident, all residents involved and any staff in the area. He stated staff should have interviewed R72 the night of the incident to ensure he felt safe and had no concerns. He also stated he thought the Certified Nurse Aide (CNA) who witnessed the incident was interviewed. He agreed the CNA should have been identified in the investigation.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review R12's Admission Record found in the EMR under the Profile tab, revealed R12 was admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease.</p> <p>Review of R12's Annual MDS with an ARD of 02/21/25 located in the EMR under the MDS tab indicated both short term and long-term memory problems and R12 rarely/never understood. The MDS also indicated that R12 wanders daily and that R12's wandering significantly intrudes on the privacy of activities of others.</p> <p>Review R52's Admission Record found in the EMR under the Profile tab revealed R52 was readmitted to the facility on [DATE] with a diagnosis of dementia.</p> <p>Review of R52's Quarterly MDS with an ARD of 01/09/25 located in the EMR under the MDS tab with a BIMS score of 10 out of 15, which indicated R52's cognition was moderately impaired. The MDS indicated that R52 had no behaviors.</p> <p>Review of R60's Annual MDS with an ARD of 12/05/24, located in the EMR under the MDS tab with a BIMS score of 15 out of 15 which indicated R60's cognition was intact.</p> <p>Review of R60's Statement from the person alleging abuse or reportable incident dated 02/19/25 indicated, I yelled at [R12] to get out of my room. [R52] got up and tried to make her [R12] get out of the room. [R12] held onto my bed and would not turn it loose. [R12] slapped [R52] and [R52] slapped her [R12] back.</p> <p>Review of the facility's Initial Report dated 02/19/25 indicated, On 02/19/25 at approximately 7:20 PM, residents [R12 and R52] had a physical altercation. Residents were immediately separated by staff and law enforcement notified .</p> <p>Review of R60's statement from the reportable incident dated 02/19/25, indicated, I yelled at [R12] to get out of my room. [R52] got up and tried to make her [R12] get out of the room, [R12] held onto my bed and would not turn it loose. [R12] slapped [R52] and [R52] slapped her [R12] back.</p> <p>Review of R52's statement from the person alleging abuse or reportable incident dated 02/19/25, indicated, [R12] was in our room. We told her [R12] to get out. She [R12] would not leave; I pushed her out of the room, and she [R12] slapped me in my face. I slapped her [R12] back in her face.</p> <p>Review of the facility's investigative documents revealed no evidence of interview with other residents.</p> <p>During an interview on 03/25/25 at 11:37 AM, R52 said R12 came into her room, went into the bathroom, came out and sat down, so R52 opened the bedroom door and told R12 to get out. R52 said that R12 pushed her, so she pushed R12 back. R52 said that the unknown nurse came into the room and removed her from the room and told her not to come back.</p> <p>During an interview on 03/26/25 at 2:15 PM, R12 was alert, but confused and unable to recall the incident.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/26/25 at 5:23 PM, the Administrator confirmed that there were no further residents' interviews. The Administrator stated that this was an isolated incident and that was the reason why only R52 and R60 was interviewed. The Administrator confirmed that R12 has a low BIMS score and was unable to be interviewed. He confirmed that a statement was not written regarding this information about R12.</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>43050</p> <p>Based on review of facility policy, document review and interview, the facility failed to develop and implement an effective, comprehensive, data-driven Quality Assurance and Performance Improvement (QAPI) program that focuses on indicators of the outcomes of care and quality of life and addresses all the care and unique services the facility provides. Specifically, they failed to complete systematic investigations and analysis of underlying causes or contributing factors of problems affecting facility-wide processes that impact quality of care, quality of life, and resident safety related to abuse prevention. This deficient practice has the potential to affect all residents in the facility.</p> <p>Findings include:</p> <p>Review of the facility's policy titled QAPI dated 10/24/22, revealed, It is the policy of this facility to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life and addresses all the care and unique services the facility provides .The facility conducts at least one distinct performance improvement project (PIP) annually that focuses on high risk or problem prone areas. PIPs shall be designed to achieve and sustain performance improvement over time and to have an expected favorable outcome. The Quality Assessment and Assurance (QAA) shall select additional members to participate in various subcommittees based upon the PIP topic and participant expertise. Upon conclusion of the PIP, the sub-committee shall provide the QAA committee with a report, which contains a summary and analysis of activities and recommendations for improvement.</p> <p>Review of the facility ' s PIP's over the past year and interview on 03/27/25 at 6:52 PM with the Administrator, Director of Nursing (DON), and the Infection Preventionist (IP), the PIP consisted of a one page document that stated the problem to be solved was abuse prevention. This PIP was completed in two days by the Administrator. A form was filled out using F223 for abuse, which is no longer the federal regulation for abuse. The goal was there would be no abuse in the facility. There was no documentation to go along with this PIP. When the Administrator was questioned on the effectiveness of this PIP, he stated Our goal is to have zero abuse. When asked if he feels that this PIP is achievable, he did not reply. The survey team entered the facility with three abuse complaints that were all substantiated. Three weeks prior, the State Agency (SA) investigated several abuse complaints. The PIP did not contain a summary, how this was identified to QAPI, a sub-committee, or a summary and analysis of the process. When the Administrator was asked if he understood the purpose of QAPI and an annual PIP, he stated Yes.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425163	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER Carlyle Senior Care of Florence		STREET ADDRESS, CITY, STATE, ZIP CODE 133 West Clarke Road Florence, SC 29501	
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 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement a program that monitors antibiotic use.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43050</p> <p>Based on review of the facility policy, record review and interviews, the facility failed to monitor and evaluate antibiotic usage for four of five residents (Resident (R) 24, R81, R55, and R15) reviewed for antibiotic usage out of 28 sample residents. This failure had the potential to affect residents' safety related to antibiotic usage.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Antibiotic Stewardship Program dated 09/30/24 revealed, It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of this program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use .Antibiotic orders obtained from consulting, specialty, or emergency providers shall be reviewed for appropriateness .Random audits of antibiotic prescriptions shall be performed to verify completeness and appropriateness (process measure) .</p> <ol style="list-style-type: none"> 1. Review of R24's Admission Record located under the Profile tab of the electronic medical record (EMR) revealed R24 was admitted to the facility on [DATE]. R24 was sent to the emergency room (ER) on 02/18/25 for an indwelling urinary catheter. A urine analysis (UA) was completed, and an antibiotic was started. R24 returned to the facility and completed the antibiotic. A culture was not done by the ER and the Infection Preventionist (IP) did not question the antibiotic. 2. Review of R81's Admission Record located under the Profile tab of the EMR revealed R81 was admitted to the facility on [DATE]. R81 was sent to theER on [DATE] for urinary retention, was catheterized, and came back to the facility on an antibiotic. No UA or culture was completed. 3. Review of R55's Admission Record located under the Profile tab of the EMR revealed R55 was admitted to the facility on [DATE]. R55 was sent on 03/04/25 to the ER for a change in condition and came back to the facility on an antibiotic. A UA was completed by the ER; however, a culture was not ordered to be completed. 4. Review of R15's Admission Record located under the Profile tab of the EMR revealed R15 was admitted to the facility on [DATE]. R15 has a Stage IV pressure ulcer to the sacrum. The Wound Doctor was alerted to an odor coming from the sacrum and ordered an antibiotic (Doxycycline) for 14 days. No culture was order by the provider to determine if antibiotic was needed or appropriate. <p>During an interview on 03/25/25 at 12:43 PM, Licensed Practical Nurse (LPN9) revealed, I noticed a foul odor coming from the sacrum with drainage. I notified the wound doctor, and he came and evaluated the resident. A culture was not completed on the wound. Doxycycline was ordered for 14 days. I informed the IP that an antibiotic was started.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Carlyle Senior Care of Florence		STREET ADDRESS, CITY, STATE, ZIP CODE 133 West Clarke Road Florence, SC 29501	
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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 03/27/25 at 2:45 PM, the IP stated, I told LPN9 and the wound doctor that a culture should have been done on R15. The wound doctor usually does a culture, but for some reason, did not do one on this resident. I have learned that I must get cultures from the hospital to see if a resident did have a Urinary Tract Infection (UTI) and that they are on the correct antibiotic. If I do not have a culture, I will call the hospital to get one.</p> <p>During an interview on 03/27/25 at 3:43 PM, the wound doctor revealed, I normally do a culture. I am not sure why I did not do one. I understand that a culture should always be completed before an antibiotic is given.</p> <p>During an interview on 03/27/25 at 6:53 PM, the Administrator revealed, My expectation for antibiotic stewardship is to follow the Centers for Medicare and Medicaid Services (CMS) guidelines.</p>		