STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425297	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carlyle Senior Care of Williston	5721 Springfield Road Williston, SC 29853

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, observation, and interview, the facility failed to ensure residents' right to reside in a safe, clean, comfortable, and homelike environment, related to routine cleaning of resident rooms and bathrooms. The deficient practice affected 8 (Rooms 1, 2, 7, 8, 9, 10, 11, and 12) of 9 resident rooms reviewed for environmental concerns. Findings included: Review of an undated facility policy titled, Routine Bathroom Cleaning indicated, It is the policy of this facility to establish policies, procedures and guidelines to provide a clean and sanitary environment for residents, staff and visitors in order to prevent cross contamination and transmission of healthcare associated infection (HAI). The policy's Procedure included 1. Working from clean areas to dirty areas, which included d. Clean inside and outside the sink, sink faucets and mirror. Wipe plumbing under the sink. Apply disinfectants to interior of sink and allow sufficient contact time with disinfectant according to manufacturer's recommendations. Rinse sink and dry fixtures; e. Clean all dispensers and frames; and i. Clean entire toilet including handle and underside of flush rim. Apply disinfectant and allow sufficient contact time according to manufacturer's recommendations. During an initial tour of the facility on 04/17/26 at 9:10 AM, the following was observed: - room [ROOM NUMBER]'s bathroom- A white, milky substance clouded the bottom third of the bathroom mirror. The soap dispenser did not have any soap in it. The soap dispenser appeared to have been replaced, but damage to the wall behind it was not repaired prior to hanging the new soap dispenser. - room [ROOM NUMBER]'s bathroom- A white, milky substance was observed on the mirror, the soap dispenser appeared to have been replaced, but damage to the wall behind it was not repaired prior to hanging the new soap dispenser, and a plastic bag was hanging over the toilet paper dispenser. - room [ROOM NUMBER]'s and room [ROOM NUMBER]'s shared bathroom- A broken toilet paper dispenser with sharp edges, rusted-colored stains inside the toilet bowl, the soap dispenser appeared to have been replaced, but damage to the wall behind it was not repaired prior to hanging the new soap dispenser. - room [ROOM NUMBER]'s and room [ROOM NUMBER]'s shared bathroom- There were rust-colored stains in the toilet bowl, a brown smudged substance about the size of a quarter on the back of the toilet, the soap dispenser appeared to have been replaced, but damage to the wall behind it was not repaired prior to hanging the new soap dispenser. - room [ROOM NUMBER]'s bathroom- Both the sink and toilet had rust colored stains, and there was resident equipment being stored in the bathroom. The mirror in the bathroom had milky residue obscuring the bottom third of the mirror. The soap dispenser appeared to have been replaced, but damage to the wall behind it was not repaired prior to hanging the new soap dispenser. - room [ROOM NUMBER]'s bathroom- A white, milky substance was observed on the mirror, the soap dispenser appeared to have been replaced, but damage to the wall behind it was not repaired prior to hanging the new soap dispenser, and a roll of toilet paper was inside the toilet bowl. During a follow-up observation on 04/17/26 beginning at 8:45 AM, the following was observed: - room [ROOM NUMBER]'s bathroom- The damage to the wall behind the soap dispenser remained. - room [ROOM NUMBER]'s bathroom- The same milky substance was observed on the mirror, the damage to the wall behind the soap dispenser remained, and a plastic bag was hanging over the toilet paper dispenser. - (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room [ROOM NUMBER]'s and room [ROOM NUMBER]'s shared bathroom- The broken toilet paper dispenser with sharp edges, rusted-colored stains inside the toilet bowl, and the damage to the wall behind the soap dispenser remained. - room [ROOM NUMBER]'s and room [ROOM NUMBER]'s shared bathroom- Rust colored stains in the toilet bowl, brown smudged substance about the size of a quarter on the back of the toilet, and the damage to the wall behind the soap dispenser remained. - room [ROOM NUMBER]'s bathroom- The rust-colored stains in the toilet and sink, resident equipment being stored in the bathroom, the mirror in the bathroom had the same milky residue obscuring the bottom third of the mirror, and the damage to the wall behind the soap dispenser remained. - room [ROOM NUMBER]'s bathroom- The same milky substance on the mirror, the damage to the wall behind the soap dispenser, and a roll of toilet paper inside the toilet bowl remained. During an interview on 04/17/26 at 11:35 AM, the Maintenance Director stated that the expectation was that every resident room and bathroom was to be cleaned at least once a day and more often if needed. He stated that even if the room was empty, it was still an expectation that the bathroom was to be cleaned. The Maintenance Director stated that there was a maintenance logbook for anything that needed to be fixed, and he expected any staff to report items that needed attention in the maintenance logbook. The Maintenance Director revealed that every couple of months he conducted facility rounds with the Administrator (ADM) and identified areas needing cleaning or fixed, which they called Angel Rounds. The Maintenance Director stated that each resident's room was their own apartment, and it should feel like home. He stated that all residents allowed housekeeping staff into their rooms to clean both the room and the bathroom. An observation of Rooms 1 through 12 on 04/17/26, beginning at 11:45 AM, was completed with the Maintenance Director and the ADM and revealed the following: - room [ROOM NUMBER]'s bathroom- The Maintenance Director stated that the mirror was dirty and the toilet had stains. He stated that the bathroom did not appear to have been cleaned in a while. - room [ROOM NUMBER]'s and room [ROOM NUMBER]'s shared bathroom- Per the Maintenance Director and the ADM, no one had reported the broken toilet paper dispenser, and it was stated that at least two of the four residents who shared the bathroom were capable of using the toilet on their own. The damage to the wall behind the soap dispenser remained, and the bottom third of the bathroom mirror was clouded by a white, milky substance. In regard to how often the Maintenance Director made round of the resident rooms, he stated, Not enough. - room [ROOM NUMBER]'s and room [ROOM NUMBER]'s shared bathroom- A brown substance smeared on the back of the toilet and rust-colored stains were observed. The Maintenance Director stated that if staff could not remove the stains, then the toilet should be replaced. - room [ROOM NUMBER]'s bathroom- The damaged wall behind the soap dispenser remained, and the mirror had the same white milky residue. A toilet paper roll remained in the toilet. The main part of the resident room had scuff marks along the lower part of the wall and paint chips about the size of half a dollar. The Maintenance Director stated that the wall behind the soap dispenser should have been repaired prior to the new soap dispenser being hung up. The ADM stated he expected the room to be in better condition if it was his own loved one moving in. - room [ROOM NUMBER]'s bathroom- The resident's equipment being stored in the bathroom remained. The Maintenance Director observed the rust-colored stains in the sink and toilet and stated, It is obvious that it has not been cleaned. During an interview on 04/17/26 at 4:06 PM, Housekeeper #5 revealed being aware of the broken toilet paper dispenser in room [ROOM NUMBER]'s and room [ROOM NUMBER]'s shared bathroom but could not recall when she had reported it; and stated having written it in the maintenance book. Housekeeper #5 stated that if something was broken, she reported it to maintenance staff or her supervisor. During an interview on 04/17/26 at 3:47 PM, the Maintenance Director stated that he had met with the housekeepers, who denied not cleaning the restrooms. He revealed he had conducted education with the housekeepers on room cleaning back in January of 2026. During an interview on 04/17/26 at 12:17 PM, the ADM stated his expectation was that they would get everything fixed and to come up with a system to increase rounds; maybe develop some type of check-off list for rooms.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on facility policy review, record review, and interview, the facility failed to ensure Minimum Data Set (MDS) assessments were accurately coded to reflect residents' status, which affected 1 (Resident (R)32) of 2 residents reviewed for tube feeding and R40, 1 of 1 resident reviewed for edema. Findings included: An undated facility policy titled, MDS [Minimum Data Set] 3.0 Completion, revealed Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan. The policy revealed, 1. According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI [Resident Assessment Instrument] specified by the State. The policy revealed, 4. Care Plan Team Responsibility for Assessment Completion included a. Interdisciplinary Responsibility for Completion of MDS Sections, which included i. The responsibility of all sections of the MDS will be clearly assigned; ii. Persons completing part of the assessment must attest to the accuracy of the section they completed by signature and indication of the relevant sections; and iii. The R.N. (Registered Nurse) Coordinator signs, dates, and attests (in section Z0500A) to timely completion of the RAI, once all other disciplines have completed their sections. The policy revealed, d. Care Area Assessment (CAA's) included iii. Based on the CAA review, key findings regarding a resident's status are documented, including the nature of the condition, complications and risk factors that affect the care planning decision, factors that must be considered in developing care plan interventions, and the need for referrals or evaluation by appropriate health professionals. The policy revealed, 5. Corrections of Errors on the Assessment included i. Modification, which included i. A Modification Request is used when an MDS record (assessment, entry tracking record, or death in facility tracking record) is in the QIES [Quality Improvement and Evaluation System] ASAP [Assessment and Submission and Processing] system (already transmitted and accepted by CMS [Centers for Medicare and Medicaid Services]), but the information in the record contains clinical or demographic errors. It must be corrected within 14 days after identifying errors. 1. An admission Record revealed the facility admitted R32 on 01/11/24. According to the admission Record, the resident had a medical history that included diagnoses of adult failure to thrive, unspecified protein-calorie malnutrition, Alzheimer's Disease, dysphagia, and gastrostomy status. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/16/26, revealed R32 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The MDS further indicated the resident had a feeding tube (nasogastric or abdominal) while a resident of the facility and within the last seven days of the look-back period. The MDS also indicated R32's received 51 percent (%) or more of their total calories through parenteral or tube feeding and 501 cubic centimeter (cc)/day or more of their average fluid intake by intravenous (IV) or tube feeding within the last seven days of the look-back period. R32's Care Plan Report included a focus area initiated 10/08/24, that indicated the resident required tube feeding. Per the Care Plan Report, the focus area revealed, 12/4/25 RESIDENT TUBE D/C. R32's Order Recap [Recapitulation] Report, for the timeframe from 12/01/25 through 04/16/26, revealed the enteral feed order for Jevity (a liquid supplement that provides nutrition) 1.5 at 55 milliliters (ml)/hour (hr) for 12 hrs was discontinued on 12/04/25. The reason indicated dc'd [discontinued] feeding tube. During an interview on 04/16/26 at 8:35 AM, the MDS Nurse stated she was responsible for checking the entire MDS for accuracy and department directors were responsible for their individual sections. She stated that the Certified Dietary Manager (CDM) was responsible for Section K of the MDS, that documented dietary needs. The MDS Nurse stated the R32's annual MDS was incorrect because the resident's tube feeding was discontinued on 12/04/25. The MDS Nurse stated that she should have double checked the MDS and caught the error. During an interview on 04/16/26 at 9:08 AM, the CDM stated that Section K of the MDS was her responsibility. The CDM confirmed R32's tube feeding was discontinued on 12/04/25, and she had (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	marked that the resident was still receiving tube feeding on their 01/16/26 annual MDS. The CDM said she did not know how she missed that. During an interview on 04/16/26 at 1:33 PM, the Corporate Clinical Consultant (CCC) stated that the MDS assessment should accurately reflect the resident's status. During an interview on 04/16/26 at 1:51 PM, the Administrator (ADM) stated his expectation was for the MDS to be correct, and that it mirror the residents and their care needs. 2. An admission Record indicated the facility admitted R40 on 02/17/25. According to the admission Record, the resident had a medical history that included a diagnosis of lymphedema. A quarterly MDS, with an ARD of 02/21/26, revealed R40 had a BIMS score of 14, which indicated the resident had intact cognition. The MDS further revealed the resident's diagnosis of lymphedema was not included under the section titled, Section I- Active Diagnoses. R40's Care Plan Report included a focus area initiated 02/19/25, that indicated the resident had edema related to a history of lymphedema. Interventions directed staff to elevate extremities as needed, position to aid in reducing edema, and follow diet as ordered. R40's Order Summary Report with active orders as of 04/16/26, contained an order dated 02/18/26 to apply lymphatic boot to the resident's right leg for one hour twice a day for lymphedema.During an interview on 04/16/26 at 4:15 PM, the MDS Nurse stated she was responsible for updating residents' MDS assessments. The MDS Nurse stated R40 had a diagnosis of lymphedema and it should have been represented in the resident's 02/21/2026 MDS. She stated she must have missed it, but that it should have been there. During an interview on 04/17/26 at 11:43 AM, the Director of Nursing (DON) stated she expected the MDS to be accurately coded. The DON stated that an inaccurate MDS had the potential to affect resident care as it could result in inaccurate care plans. CCDuring an interview on 04/17/26 at 11:46 AM, the CCC stated she expected the MDS to be accurate.

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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. Based on observation, interview, record review, and facility policy review, the facility failed to ensure treatment in accordance with professional standards of practice for 1 (Resident (R)25) of 2 sampled residents reviewed for wound dressing changes. Specifically, R25's wound dressing was not changed on 04/13/26 as ordered. Findings included: Review of the facility policy titled, Documentation of Wound Treatments, dated 08/01/2025, indicated, Wound treatments are documented at the time of each treatment. Review of the facility policy titled, Clean Dressing Change, dated 11/30/2025, indicated, Physician's orders will specify type of dressing and frequency of changes. An admission Record indicated the facility admitted R25 on 10/24/25. According to the admission Record, the resident had a medical history that included a diagnosis of a chronic non-pressure ulcer of the right lower leg with unspecified severity (a persistent sore or wound not caused by pressure). A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/23/26, revealed R25 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. R25's Care Plan Report included a focus area, initiated 10/27/25 and resolved 12/22/25, that indicated the resident had a non-pressure wound to the right lower shin. Interventions directed staff to refer R25 to a wound care doctor, to follow the facility's and doctor's orders, to avoid friction/shearing, and to offer appropriate wound healing supplements. R25's Order Summary Report, with active orders as of 04/16/26, included: Clean area to right lower shin with wound cleanser, apply xerofoam [a medicated gauze dressing] and cover with bordered gauze dressing and change daily and PRN [pro re nata, as-needed] until healed, every day shift for stasis ulcer, dated 04/12/2026. R25's Treatment Administration Record [TAR], dated 04/26, included the transcription of a physician's order that indicated, Clean area to right lower shin with wound cleanser, apply xerofoam and cover with bordered gauze dressing. Change daily and PRN until healed. [sic] every day shift for stasis ulcer - Start Date - 04/13/2026 0700. The TAR revealed the entry space for R25's dressing change on 04/13/2025 was blank which indicated the dressing change had not been done. During an interview on 04/14/26 at 11:16 AM, R25 stated the resident had a sore on their right leg, it had been an ongoing problem, and they had the wound before being admitted into the facility. R25 stated the dressing was supposed to be changed daily, but the nurses did not change the wound dressing daily. During a concurrent observation and interview on 04/14/26 at 11:34 AM, Licensed Practical Nurse (LPN)1 stated R25 had a vascular wound (an open sore related to poor circulation) on the right leg. The observation revealed R25's right lower leg shin dressing was dated 04/12/26, and LPN1 confirmed the date on the dressing was 04/12/26. LPN1 stated R25's dressing changes were supposed to be performed daily. During an interview on 04/17/26 at 11:54 AM, the Director of Nursing (DON) stated she expected nurses to adhere to and follow the physician's orders exactly to ensure the best care was provided to the residents. The DON stated R25's dressings should have been changed on 04/13/26. During an interview on 04/17/26 at 11:56 AM, the Corporate Clinical Consultant (CCC) stated she expected physician's orders to be followed. The CCC stated it was a standard of practice to follow physician's orders. The CCC stated if physician's orders were not followed, it should have been documented as to why they were not followed. The CCC stated not following orders could have resulted in the worsening of the wound that could have potentially led to an amputation. During an interview on 04/17/26 at 12:09 PM, the Administrator (ADM) stated he expected physician's orders to be followed, and R25's dressing should have been changed daily.

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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 facility policy review, facility document review, observation, and interview, the facility failed to ensure drugs and biologicals were labeled in accordance with professional principles. Specifically, the facility failed to date a multi-dose vial of tuberculin purified protein derivative (PPD) (a solution used to detect tuberculosis infection) with an opened date and a discard date and failed to discard an expired multi-dose vial of tuberculin PPD. The facility also failed to date a semaglutide (an antidiabetic) injection pen with an opened date and discard date. The deficiencies were identified in 1 of 2 medication storage refrigerators observed. Findings included: Review of a facility policy titled, Medication Management, dated 04/10/2019, indicated, All medications and biologicals used in the facility will be labeled in accordance with current state and federal regulations to facilitate consideration of precautions and safe administration of medications. The policy indicated, 4. Labels for individual drug containers must include, which included f. The date the drug was dispensed; and h. The expiration date when applicable. The policy further indicated, 6. Labels for each floor/unit's stock medications must include, which included c. The expiration date when applicable. The policy revealed, 8. Labels for multi-use vials must include, which included a. The date the vial was initially opened or accessed (needle-punctured); b. All opened or accessed vials should be discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial; and c. Unopened or unaccessed (needle-punctured) vials should be discarded according to the manufacturer's instructions. Review of a facility policy titled, Medication Administration, dated 10/22/2022, indicated, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manger to prevent contamination or infection. The policy revealed, 12. Identify expiration date. If expired, notify nurse manager. Review of a facility document titled, Medication with shortened expiration dates, dated 2025-2026, included Tuberculin PPD, diluted injection, which instructed to Discard vial 30 days after opening. The document revealed, Semaglutide injection, which instructed Keep refrigerated until dose given OR each multi-dose pen can be stored at 59-86 F [degrees Fahrenheit] or refrigerated for up to 56 days after first use. The document revealed, How to use, which included 1. Pick the month you first opened (punctured/used) the vial/medication; and 4. Write on auxiliary sticker/product (not Rx label) ?Date opened' and ?Date Expired' (Do not use medication beyond this date). Review of a quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/07/26, revealed the facility admitted R1 on 09/22/23. According to the MDS, the resident had active diagnoses that included diabetes mellitus. The MDS indicated the resident had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. An observation with the Director of Nursing (DON) on 04/16/26 at 1:14 PM in the facility's medication storage room revealed that in a medications storage refrigerator there was an opened and used vial of a tuberculin PPD was observed that did not have an opened or date expired written on the bottle or vial. Another tuberculin PPD vial was observed that had a discard date of 04/15/25 written on the bottle. An opened and used semaglutide injection pen that belonged to R1 was observed without an opened or discard date written on the box. During an interview at the time of the observation, the DON stated she expected used medications to have an opened date and discard date on all the medications. The DON stated it was important to have medications dated so residents did not receive expired medications. The DON stated expired medications were not effective and had the potential to cause severe side effects. During an interview on 04/16/26 at 3:42 PM, the Corporate Clinical Consultant stated that the dates on the multi-dose vials had to have dates when it was opened along with the expiration dates. During an interview on 04/16/26 at 2:19 PM, the Infection Preventionist (IP) stated that once medications were opened, nurses should label them with an (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	opened date and discard-by date. The IP stated that the medication in Resident #1's injector pen only lasted a month and should have been discarded after a month. The IP stated residents should not be given expired medications. She added that expired medications had the potential to cause adverse reactions and would not be therapeutic. During an interview on 04/16/26 at 3:41 PM, the Administrator (ADM) stated he deferred to the nurse and nurse consultant regarding the labeling of dates of medications.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, record review, and facility policy review, the facility failed to ensure enhanced barrier precautions (EBP) were implemented for 2 (Resident (R)25 and R40) of 4 residents reviewed for EBP. Specifically, staff failed to don gowns prior to high contact resident care activities for R25 and R40. Additionally, Licensed Practical Nurse (LPN)2 failed to dispose of worn gloves prior to leaving R40's room. Findings included: 1. Review of the facility policy titled, Enhanced Barrier Precautions, dated 05/30/2024, indicated, It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms [MDRO]. The policy also indicated, ?Enhanced barrier precautions [EBP] refer to an infection control intervention designed to reduce transmission of multidrug resistant organisms that employs targeted gown and gloves use during high contact resident care activities. The policy also indicated, Wounds (e.g. [exempli gratia, for example], chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC [peripherally inserted venous catheter] lines, midline catheters) even if the resident is not known to be infected or colonized with a MDRO. The policy also indicated, PPE [personal protective equipment] for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. It continued, Position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room. The policy also indicated, High-contact resident care activities include, and h. Wound care: any skin opening requiring a dressing. Review of the facility policy titled, Standard Precautions Infection Control, dated 06/30/2025, indicated, All staff are to assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. Therefore, all staff shall adhere to Standard Precautions to prevent the spread of infection to residents, staff and visitors. The policy also indicated, Standard Precautions refers to the infection prevention practices that apply to all residents, regardless of suspected or confirmed diagnosis or presumed infection status. This includes hand hygiene, selection and use of PPE (e.g., gloves, gowns, facemask, respirators, eye protection), respiratory hygiene and cough etiquette, safe injection practices, environmental cleaning and disinfection, and reprocessing of reusable resident medical equipment. The policy also indicated, All staff who have contact with residents and/or their environments must wear personal protective equipment as appropriate during resident care activities and at other times in which exposure to blood, body fluids, or potentially infectious materials is likely. Review of the facility policy titled, Standard Precautions Infection Control Protocol, dated 2025, indicated in the section Personal Protective Equipment that gloves were for the practices of, touching blood, body fluids, secretion, excretions, contaminated items; for touching mucous membranes, non-intact and intact resident skin, and gowns were for practices, During the procedures and resident-care activities when contact of clothing/exposed skin with blood/body fluids, secretions, and excretions is anticipated. Review of an admission Record indicated the facility admitted R25 on 10/24/25. According to the admission Record, the resident had a medical history that included a diagnosis of a chronic non-pressure ulcer of the right lower leg with unspecified severity (a persistent sore or wound not caused by pressure). Review of a quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/23/26, revealed R25 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS indicated R25 had no venous ulcers present. Review of R25's Care Plan Report included a focus area, initiated 10/27/25 and resolved 12/22/25, that indicated the resident had a non-pressure wound to the right lower shin. R25's Care Plan Report also included a focus area, initiated 12/01/25 and resolved 12/08/25, that indicated the resident had a non-pressure wound to the left shin. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425297	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carlyle Senior Care of Williston	5721 Springfield Road Williston, SC 29853

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions directed staff to refer R25 to a wound care doctor, to follow the facility's and doctor's orders, to avoid friction/shearing, and to offer appropriate wound healing supplements. Review of R25's Order Summary Report, with active orders as of 04/16/2026, included: Clean area to right lower shin with wound cleanser, apply xerofoam [a medicated gauze dressing] and cover with bordered gauze dressing. Change daily and PRN [pro re nata, as-needed] until healed, every day shift for stasis ulcer, dated 04/12/2026 and- Enhanced barrier precautions every shift for chronic wound, dated 04/15/2026. An observation, on 04/14/26 at 11:16 AM, revealed R25's room had EBP signage on the door, and a supply cart filled with gowns and gloves was outside the door. During a concurrent interview, R25 stated the resident had a wound on their right leg. An observation, on 04/14/26 at 11:34 AM, revealed Licensed Practical Nurse (LPN)1 removed R25's right lower leg shin dressing while wearing gloves. During a concurrent interview, LPN1 stated she did not wear a gown but should have worn one. During an interview on 04/16/26 at 2:56 PM, the Infection Preventionist (IP) stated that if a resident had an open wound, whether acute or chronic, the resident had to be placed on EBPs, and gowns and gloves were required when performing patient care. The IP stated LPN1 should have worn a gown while caring for R25's wound dressing. The IP stated it was important that gowns had to be worn to prevent any spread of pathogens. During an interview on 04/17/26 at 11:32 AM, the Director of Nursing (DON) stated it was her expectation for staff to adhere to EBP guidelines. The DON stated that when nurses had direct patient care such as wound care, they had to wear gowns and gloves. The DON stated it was important to follow EBP guidelines so as not to spread infections. During an interview on 04/17/26 at 11:41 AM, the Administrator (ADM) stated he expected staff to follow standards of practice. During an interview on 04/17/26 at 3:54 PM, LPN3 stated residents who had open wounds had to be placed on EBPs. LPN3 stated staff had to wear gowns and gloves whenever direct patient care was done. 2. An admission Record indicated the facility originally admitted R40 on 08/14/23, with the most recent admission date on 02/17/25. According to the admission Record, the resident had a medical history that included a diagnosis of lymphedema. Review of a quarterly MDS, with an ARD of 02/21/26, revealed R40 had a BIMS score of 14, which indicated the resident had intact cognition. Review of R40's Care Plan Report included a focus area, initiated 01/06/2026, that indicated the resident had wounds to the right leg and foot due to lymphedema. Interventions directed staff to provide wound care to the right leg and foot as ordered until resolved. Review of R40's Order Summary Report with active orders as of 04/16/2026, included: - Enhanced barrier precautions, dated 02/18/2026; - dorzolamide HCL (hydrochloride) - timolol ophthalmic solution, 2%/- 0.5%, one drop in both eyes two times a day for glaucoma, started 11/11/2025; - Cleanse wounds to right lateral calf, right lateral thigh, right lateral foot, right distal calf with wound cleanser, apply calcium alginate (a wound dressing) to the wound bed only, cover with rolled gauze, two times a day for wound care, as needed, dated 04/15/2026; - Cleanse wounds to right distal thigh, apply calcium alginate to the wound bed only, cover with rolled gauze, two times a day for lymphedema, dated 04/16/2026; - Cleanse wounds to right lateral foot, apply calcium alginate to the wound bed only, cover with rolled gauze, as needed dated 04/16/2026; and - Cleanse wounds to right lateral foot, apply calcium alginate to the wound bed only, cover with rolled gauze, two times a day for wound care, dated 04/16/2026. An observation on 04/15/26 at 8:25 AM revealed LPN2 went into R40's room to administer morning medications. The observation revealed R40 was in a room that required enhanced barrier precautions (EBPs). The observation revealed LPN2 performed hand hygiene and donned gloves. The observation revealed LPN2 pulled down R40's conjunctiva (a thin, transparent mucous membrane that lines the inside of the eyelids) and instilled one eye drop in each eye and wiped away an extra drop. The observation revealed LPN2 exited the room without removing gloves and performing hand hygiene. The observation revealed LPN2 returned to the medication cart and removed her gloves there. During an interview on 04/15/26 at 8:25 AM, LPN2 stated she should have worn a gown when administering R40's eye drops. LPN2 stated she should not have worn gloves in the hallway after providing care to R40. LPN2 stated she should have removed the gloves and (continued on next page)

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	425297	A. Building B. Wing	04/17/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	performed hand hygiene before leaving the room. During an interview on 04/16/26 at 2:56 PM, the Infection Preventionist (IP) stated that if a resident had an open wound, whether acute or chronic, they had to be placed on EBPs, and gowns and gloves were required when performing patient care. The IP stated hand hygiene had to be performed before and after patient care. The IP stated LPN2 should not have worn gloves in the hallway and should have removed them inside R40's room. The IP stated wearing gloves in the hallway posed a contamination risk. The IP stated they did not think a gown needed to be worn when administering eye drops to residents on EBP who did not have a wound near their eyes, but that gloves were necessary. During an interview on 04/17/26 at 11:32 AM, the DON stated it was her expectation for staff to adhere to EBP guidelines. The DON stated LPN2 should not have been walking in the hallway while wearing gloves. The DON stated PPE should have been disposed inside the room before exiting. The DON stated it was important to follow EBP guidelines so as not to spread infections. During an interview on 04/17/26 at 11:41 AM, the ADM stated he expected staff to follow standards of practice. During an interview on 04/17/26 at 3:54 PM, LPN3 stated residents who had open wounds had to be placed on EBPs. LPN3 stated staff had to wear gowns and gloves whenever direct patient care was done.