STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425308	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aiken Rehabilitation and Care Center	3525 Augustus Road Aiken, SC 29801

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review, interview, facility document and policy review, the facility failed to notify the physician of an elevated blood sugar over 400 milligrams per deciliter (mg/dL) as per the physician order for 1 (Resident (R)136) of 1 resident reviewed for insulin administration. Findings included: Review of the facility's undated policy titled, Timely Administration of Insulin, indicated, All insulin will be administered in accordance with physician's orders. An admission Record revealed the facility admitted R136 on 03/30/26. According to the admission Record, the resident had a medical history that included the diagnosis of type 2 diabetes mellitus with diabetic chronic kidney disease. A 5-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/03/26, revealed R136 had a Brief Interview for Mental Status (BIMS) score of 00, which indicated the resident had severe cognitive impairment. The MDS indicated the resident did not have injections of any type during the prior seven days or since admission/entry or reentry if less than seven days. Review of R136's Baseline Care Plan, undated, indicated a focus area for disease/illness management that indicated the resident was diabetic. The interventions directed staff to follow orders for treatments, monitor for complications of illness, monitor conditions and progress of illness, and report changes to the Director of Nursing (DON) and physician. Review of R136's April 2026 Order Summary Report for date range 03/30/26 through 04/30/26, contained an order, dated 04/04/26, for insulin lispro (1 unit dial) subcutaneous solution pen-injector 100 unit/milliliter (mL) per sliding scale before meals and at bedtime, with instructions to call the physician if results greater than 400 milligram (mg)/dL. In an email correspondence from Registered Nurse (RN)15 to the DON, dated 04/09/26 at 11:46 AM, revealed, On Sunday 4/5/2026 [sic] I was caring for [R136]. When I checked [his/her] evening blood sugar it was over 400. I should have called the provider but I failed to do so and I administered the top of the sliding scale which I believe was 12 units. During an interview on 04/08/26 at 10:59 AM, Nurse Practitioner (NP)2 stated she was not notified of R136's blood sugar result of 421. NP2 said she became aware through the resident's spouse. She stated there was no progress note by the nurse and no documentation in the communication book that was used by nursing to communicate to physicians. During an interview on 04/10/26 at 2:59 PM, NP16 stated she was the physician on call for the facility on 04/05/26. NP16 stated she was not notified R136's blood sugar was 421. NP16 stated she expected the nurse to call her for a blood sugar of 421 and she would give orders for insulin. She had no recollection of a call regarding this resident. During an interview on 04/11/26 at 2:46 PM, the DON stated that when R136 had a blood sugar of 421, the nurse did not notify a physician. She stated her expectation was that the nurse should have contacted the physician as the order directed. During an interview on 04/12/26 at 10:06 AM, the Administrator stated that if there was a physician's order to notify the physician, then staff should have followed the physician's order.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview, record review, and facility document and policy review, the facility failed to ensure a resident's allegation of physical abuse was reported to the state survey agency within two hours for 1 (Resident (R)95) of 3 sampled residents reviewed for abuse. Findings included: Review of an undated facility policy titled, Abuse, Neglect and Exploitation, indicated, VII. Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. [exempli gratia, for example] law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Review of an admission Record revealed the facility admitted R95 on 02/14/24. According to the admission Record, the resident had a medical history that included a diagnosis of hemiplegia and hemiparesis following a cerebral infarction affecting the non-dominant left side. Review of an annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/23/26, revealed R95 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident did not have any indication of psychosis, including hallucinations or delusions. The MDS indicated R95 was dependent on staff for rolling left and right, moving from sitting to lying, and moving from lying to sitting on the bed. The MDS indicated R95 did not attempt bed to chair transfers. Review of R95's Care Plan Report included a focus area, initiated 02/27/24, that indicated the resident had an Activities of Daily Living (ADL) self-care performance deficit related to a cerebrovascular accident (CVA) with left side hemiplegia, weakness, lack of coordination, and impaired mobility. Interventions directed staff that R95 required a mechanical lift with the assistance of two staff for transfers (initiated 02/27/24) and to monitor, document, and report as needed (PRN) any changes, any potential for improvement, reasons for self-care deficit, expected course, and declines in function (initiated 02/27/24). Review of R95's Post Fall Evaluation, dated 10/02/25 at 4:06 AM, indicated the resident experienced a fall on 10/02/25 at 2:00 AM. The Post Fall Evaluation revealed that R95 stated someone tossed the resident out of bed and onto the floor. Review of a facility document titled, [State Agency] Initial Report, dated 10/04/25, indicated, On 10/02/25 at 2:00 AM, R95 sustained a fall which resulted in a one-inch laceration to the right side of their head. The Initial Report did not include an allegation of abuse.During an interview on 04/11/26 at 12:54 PM, the Director of Nursing (DON) stated that documentation that someone threw R95 out of the bed was an allegation of abuse. The DON stated she asked the nurse who completed the Post Fall Evaluation about the resident being thrown out of bed; the nurse did not remember making that documentation, and the nurse did not report the allegation. The DON stated she became aware of the allegation the next morning. The DON stated a report of abuse was not made by the facility to the state agency. The DON stated the requirement was to report an allegation of abuse within two hours to the state agency. The DON stated her expectation was that when staff received an allegation of abuse, they were to notify her or the Administrator immediately. During an interview on 04/12/26 at 10:15 AM, the Administrator (ADM) stated that when staff received an allegation of abuse, she expected them to report immediately to the ADM or DON, and she followed the regulation to report to the state within two hours or twenty-four hours.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview, record review, and facility document and policy review, the facility failed to ensure an allegation of abuse was thoroughly investigated for 1 (Resident (R)95) of 3 residents reviewed for abuse. Findings included: Review of an undated facility policy titled, Abuse, Neglect and Exploitation, indicated, V. Investigation of Alleged Abuse, Neglect and Exploitation - A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Review of an admission Record revealed the facility admitted R95 on 02/14/24. According to the admission Record, the resident had a medical history that included a diagnosis of hemiplegia and hemiparesis following a cerebral infarction affecting the non-dominant left side. Review of an annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/23/26, revealed R95 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident did not have any indication of psychosis, including hallucinations or delusions. The MDS indicated R95 was dependent on staff for rolling left and right, moving from sitting to lying, and moving from lying to sitting on the bed. The MDS indicated R95 did not attempt bed to chair transfers. Review of R95's Care Plan Report included a focus area initiated 02/27/24 that indicated the resident had an Activities of Daily Living (ADL) self-care performance deficit related to a cerebrovascular accident (CVA) with left side hemiplegia, weakness, lack of coordination, and impaired mobility. Interventions directed staff that R95 required a mechanical lift with the assistance of two staff for transfers (initiated 02/27/24) and to monitor, document, and report as needed (PRN) any changes, any potential for improvement, reasons for self-care deficit, expected course, and declines in function (initiated 02/27/24). Review of R95's Post Fall Evaluation, dated 10/02/25 at 4:06 AM, indicated the resident experienced a fall on 10/02/25 at 2:00 AM. The Post Fall Evaluation revealed R95 stated someone tossed the resident out of bed and onto the floor. Review of a facility document titled, [State Agency] Initial Report, dated 10/04/25, indicated, On 10/02/25 at 2:00 AM, R95 sustained a fall which resulted in a one-inch laceration to the right side of their head. Review of a facility document titled, [State Agency] Five-Day Follow-Up Report, dated 10/08/25, for R95's fall on 10/02/25 at 2:00 AM did not include interviews with other residents about abuse or interviews with staff about abuse. During an interview on 04/11/26 at 12:54 PM, the Director of Nursing (DON) stated that documentation that someone threw R95 out of the bed was an allegation of abuse. During an interview on 04/12/26 at 10:15 AM, the Administrator (ADM) stated that when a resident had an allegation of abuse, she expected the investigation to be completed within five business days or request more time if needed.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on record review, interview, and facility policy review, the facility failed to provide wound treatments as ordered for 1 (Resident (R)39) of 1 resident reviewed for pressure ulcers/injuries. Findings include: Review of an undated policy titled, Pressure Injury Prevention and Management revealed, This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries.Review of an undated policy titled, Documentation of Wound Treatments revealed, The facility completes accurate documentation of wound assessments and treatments, including response to treatment, change in condition, and changes in treatment. The policy revealed, 3. Wound treatments are documented at the time of each treatment. Review of an admission Record revealed the facility admitted R39 on 12/02/25. According to the admission Record, the resident had a medical history that included diagnoses of hemiplegia and hemiparesis (paralysis and weakness) following a cerebral vascular infarction (stroke) affecting the left non-dominant side, type II diabetes mellitus with diabetic neuropathy, gout, anemia, peripheral vascular disease, and a pressure ulcer to an unspecified site. Review of a significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/23/26, revealed R39 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated the resident had one Stage 4 pressure ulcer that was not present on admission/readmission. Review of R39's Care Plan Report, included a focus area initiated 12/03/25, that indicated the resident had a pressure ulcer to the right heel. Interventions directed staff to administer treatments as ordered and monitor for effectiveness. Review of R39's Order Summary Report for active orders as of 04/11/26, revealed an order dated 03/26/26, to clean the right heel with normal saline, apply Santyl ointment (medicated ointment used^to^remove^dead^or^damaged^tissue^from^wounds) to the wound bed, and cover the area with a bordered gauze daily for wound healing. Review of R39's April 2026 Treatment Administration Record revealed no documented evidence that treatment was provided to the resident's right heel on 04/04/26 (Saturday) and 04/05/26 (Sunday). During an interview on 04/11/26 at 11:11 AM, Licensed Practical Nurse (LPN)11, who was also the Treatment Nurse, stated that she worked five days a week and provided all residents' wound treatments on weekdays. LPN11 stated that on weekends, floor nurses completed wound treatments. During an interview on 04/11/26 at 8:06 PM, LPN13 stated that she worked the day shift on 04/05/26 and did not provide wound treatment for R39. She stated that she worked for a contract agency, and 04/05/26 was the first shift that she worked at the facility. She further stated that if she had provided the treatments, she would have documented that they were provided in the resident's electronic health record. On 04/11/26 at 11:29 AM, an attempt to contact LPN12, the nurse responsible for R39's care on 04/04/26, was unsuccessful. During an interview on 04/11/26 at 1:10 PM, the Director of Nursing (DON) stated that she had spoken with LPN12 and LPN13, and they both told her that they did not provide R39's wound treatment the previous weekend. The DON stated that she expected all wound treatments to be provided as ordered. During an interview on 04/12/26 at 11:43 AM, the Administrator stated that she expected wound treatments to be completed as ordered.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview, record review, and facility policy review, the facility failed to ensure a resident's fall was investigated to include a root cause analysis and implementation of immediate or new interventions to prevent future falls for 1 (Resident (R)136) of 6 residents reviewed for falls. Findings included: Review of an undated facility policy titled, Fall Prevention Program indicated, Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. The policy revealed, 9. When any resident experiences a fall, the facility will, and a. Assess the resident; b. Complete a post-fall assessment; c. Complete an incident report; d. Notify physician and family; e. Review the resident's care plan and update as indicated; f. Document all assessments and actions; and g. Obtain witness statements in the case of injury. Review of an admission Record revealed the facility admitted R136 on 03/30/26. According to the admission Record, the resident had a medical history that included diagnoses of hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (a type of stroke) affecting left non-dominant side, and muscle weakness (generalized). Review of a five-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/03/26, revealed R136 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment. The MDS indicated the resident had one fall since admission, without injury. Review of R136's Care Plan Report included a focus area, initiated 04/02/26, that indicated the resident was at risk for falls and fall related injuries related to impaired mobility and decreased safety awareness. Interventions directed staff to anticipate and meet the resident's needs (initiated 04/02/26); ensure the resident's call light was within reach, encourage the resident to use it for assistance as needed, and promptly respond to all requests for assistance (initiated 04/02/26); follow facility fall protocol (initiated 04/02/26); and physical therapy staff to evaluate and treat as ordered and as needed (initiated 04/02/26). Review of a Nursing Note, dated 04/03/26 at 1:43 AM, indicated R136 was found on the floor, laying on [the resident's] right side beside the bed. The Nursing Note indicated: R136's bed was in the lowest position; the resident was assessed and then assisted back to bed with staff assistance; the resident did not show signs of or verbalize being in distress; the resident's blood pressure was 127/52 millimeters of mercury (mmHg), their temperature was 97.1 degrees Fahrenheit (F), their oxygen level was 94%, their pulse was 73 beats per minute, their respirations were 17 per minute; the resident was alert with confusion; a nurse practitioner, a supervisor, and the resident's family were notified; an incident report was initiated; the call light was within reach; the resident's bed was in a safe position; and staff would continue the plan of care. Review of R136's IDT [Interdisciplinary Team] Fall record, dated 04/03/26 and signed by Licensed Practical Nurse (LPN)17, indicated the resident had a fall on 04/03/26 at 12:50 AM. The IDT Fall record revealed the following portions were left blank: 4. List any diagnosis that can contribute to the residents [sic] risk for falls; 5. List any medications that put the resident at a risk for falls; 6. Are there any lab [laboratory] results that put the resident at an increased risk for falls?; 7. What is the Root Cause of the fall?; 8. What immediate interventions were put into place in response to the fall?; 9. Indicated that the IDT agreed with the immediate interventions that were implemented following the fall.; 9a. IDT Recommends a revision of the following interventions/follow up; 10. What additional interventions were put in place?: and 11. Indicated that the care plan had been reviewed and updated. During an interview on 04/10/26 at 3:40 PM, the Director of Nursing (DON) stated falls were reviewed in clinical meetings on Mondays through Fridays with the managers. The DON stated that when a fall occurred, the team reviewed progress notes, the incident report, the fall evaluation, any medication that may have changed, and any laboratory reports. During a telephone interview on 04/10/26 at 4:20 PM, LPN17 stated R136 had fallen on the floor between the window and the bed. LPN17 stated she did not determine the root cause and she did not implement new (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions following the fall. LPN17 stated there should have been a new intervention, and the care plan should have been updated. LPN17 stated she did not know why she left the root cause and interventions blank on the IDT Fall form. During an interview on 04/10/26 at 11:57 AM, the Administrator stated R136's fall had not been reviewed by the IDT team as of that day because it had happened on 04/03/26 and surveyors entered the building on 04/06/2026. During an interview on 04/11/26 at 2:16 PM, LPN/Unit Manager (LPN/UM)5 stated the IDT was in the process of reviewing R136's fall notes when surveyors entered the facility. LPN/UM5 stated that the review of R136's fall was not completed, no new interventions had been implemented, and the care plan had not been updated. LPN/UM5 stated the IDT had not met that week, and the root cause of R136's fall had not been determined because the IDT had not met. LPN/UM5 stated the nurse should not have signed the IDT Fall record, as the DON was to sign it when the IDT completed the review. LPN/UM5 stated when the IDT completed the IDT Fall record, the care plan was updated, family members were updated on new interventions for fall prevention, the root cause was investigated, and witness statements were reviewed. During an interview on 04/11/26 at 2:46 PM, the DON stated R136 did not have new interventions implemented following their fall and the care plan was not updated. The DON stated her expectation was that an intervention be implemented immediately by the nurse, and the care plan was to be updated after the IDT meeting. The DON stated the investigation for the fall, including determination of the root cause and updating the care plan, was not completed because surveyors were in the building the week after the fall occurred, and facility staff did not have a clinical meeting. During an interview on 04/12/26 at 10:11 AM, the Administrator stated her expectation was that when a resident experienced a fall, staff were to follow the facility policy.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, record review, interview, facility policy review, and review of manufacturer information, the facility failed to ensure the medication error rate did not exceed 5 percent (%). The facility had 3 medication errors out of 29 total opportunities, resulting in a medication error rate of 10.3%, affecting 1 (Resident (R)137) of 8 residents reviewed during the medication administration task. Findings include: Review of a facility policy titled, Administration of Eye Drops or Ointments, copyright 2025, revealed, Policy: Eye medications are administered as ordered by the physician and in accordance with professional standards of practice to lubricate the eye or treat certain eye conditions. The policy continued, 6. If a second medication is required in the same eye, wait appropriate amount of time per manufacturer's specifications (usually five minutes). Review of a document titled, HIGHLIGHTS OF PRESCRIBING INFORMATION, for brimonidine tartrate ophthalmic solution, revised 11/2025, revealed under DOSAGE AND ADMINISTRATION, If more than one topical ophthalmic product is being used, the products should be administered at least five 5 minutes apart (2). Review of a document titled, DORZOLAMIDE HYDROCHLORIDE - dorzolamide hydrochloride solution/ drops Alembic Pharmaceuticals Inc. [Incorporated], revised 08/2024, revealed under 2 DOSAGE AND ADMINISTRATION, Dorzolamide hydrochloride ophthalmic solution may be used concomitantly with other topical ophthalmic drug products to lower intraocular pressure. If more than one topical ophthalmic drug is being used, the drugs should be administered at least five minutes apart. Review of a document titled, HIGHLIGHTS OF PRESCRIBING INFORMATION, for timolol maleate ophthalmic solution 0.5%, revised 03/2018, revealed under 17 PATIENT COUNSELING INFORMATION, If more than one topical ophthalmic drug is being used, the drugs should be administered at least five minutes apart. Review of R137's Order Summary Report revealed the facility admitted the resident on 04/03/26. According to the Order Summary Report, R137 had a medical history that included diagnoses of macular degeneration and type two diabetes mellitus with mild non-proliferative diabetic retinopathy without macular edema. During an observation of medication pass on 04/08/26 at 9:08 AM, Registered Nurse (RN)1 administered one drop of dorzolamide-timolol eye drop, one drop of brimonidine 0.2% eye drop, and one drop of timolol 0.5% eye drop in R137's left eye. RN1 administered the three eye drops one right after the other; without waiting any time between the drops. During an interview on 04/08/26 at 9:10 AM, RN1 stated she gave each of R137's three eye drops back-to-back, without waiting any time in between because they were all due to be administered at the same time. During a follow up interview on 04/08/26 at 10:56 AM, RN1 was asked to review R137's physician orders. RN1 stated Nurse Practitioner (NP)2 had just modified the resident's orders to include instructions for waiting five minutes between different eye drops. Review of R137's Order Summary Report, reflecting active orders as of 04/09/26, revealed orders dated 04/08/26 to administer brimonidine tartrate ophthalmic solution 0.2%, one drop in left eye two times a day; dorzolamide-timolol maleate 2%- 0.5%, one drop in left eye three times a day; and timolol maleate 0.5%, one drop in left eye two times a day. The orders specified to wait 5 minutes between each different eye drop when administering. During an interview on 04/08/26 at 11:06 AM, NP2 stated R137's eye drops were prescribed for glaucoma and ocular hypertension.ˆNP2 stated the nurse should have known based on her professional nursing judgement to wait three to five minutes between each eye drop, but she had since modified the order to specify these instructions. NP2 stated not waiting three to five minutes between each eye drop could increase or decrease the eye drops' effectiveness or cancel out their effectiveness altogether. During an interview on 04/11/26 at 1:22 PM, the Director of Nursing (DON) stated she expected nurses to follow manufacturer guidelines when administering multiple eye drops in the same eye. During an interview on 04/12/26 at 11:31 AM, the Administrator stated she expected the medication error rate to be less than 5% and for nursing staff to follow manufacturer guidelines when administering multiple eye drops.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, facility document and policy review, the facility failed to ensure 1 (Resident (R)136) of 1 resident reviewed for insulin was free from a significant medication error. Findings included: Review of the facility's undated policy titled, admission Orders, indicated, A physician must personally approve, in writing, a recommendation that an individual be admitted to a facility. A physician, physician assistant, nurse practitioner or clinical nurse specialist must provide written and/or verbal orders for the residents' immediate care and needs. Review of an admission Record revealed the facility admitted R136 on 03/30/26. According to the admission Record, the resident had a medical history that included the diagnosis of type 2 diabetes mellitus with diabetic chronic kidney disease. Review of a 5-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/03/26, revealed R136 had a Brief Interview for Mental Status (BIMS) score of 00, which indicated the resident had severe cognitive impairment. The MDS indicated the resident did not have injections of any type during the prior seven days or since admission/entry or reentry if less than seven days. Review of R136's Baseline Care Plan, undated, indicated a focus area for disease/illness management that indicated the resident was diabetic. The interventions directed staff to follow orders for treatments, monitor for complications of illness, monitor conditions and progress of illness, and report changes to the Director of Nursing (DON) and physician. Review of R136's hospital Discharge Summary, dated 03/27/26, indicated the resident's discharge medications included insulin lispro 100 units/milliliter (mL) injectable solution 2-12 units subcutaneous before meals and at bedtime per sliding scale. Review of R136's April 2026 Order Summary Report for date range 03/30/26 through 04/30/26, contained an order, dated 04/04/26, for insulin lispro (1 unit dial) subcutaneous solution pen-injector 100 unit/mL per sliding scale before meals and at bedtime, with instructions to call the physician if results greater than 400 milligram (mg)/deciliter (dL). Review of R136's Progress Notes, dated 03/31/26, revealed it was the Nurse Practitioner's (NP's) initial visit with the resident. It further revealed the discharge (DC) summary, Medication Administration Record (MAR), and Plan of Care (POC) were reviewed. Insulin was not included on the resident's medication list on the Progress Note. The Progress Note was signed by NP2 on 04/01/26. Review of R136's April 2026 Medication Administration Record (MAR) revealed the resident's sliding scale insulin order was not transcribed to the MAR until 04/04/26. There was no documented evidence that the resident received insulin as ordered prior to 04/04/26 at 9:00 PM. During an interview on 04/11/26 at 3:28 PM, Licensed Practical Nurse/Unit Manager (LPN/UM)5 stated the insulin order for R136 was missed from their admission on [DATE] through 04/04/26. During an interview on 04/08/26 at 11:20 AM, NP2 stated she saw R136 on 03/31/26 for a hospital follow-up visit. She stated she overlooked the insulin during her hospital follow-up visit. During an interview on 04/09/26 at 3:37 PM, Registered Nurse/Supervisor (RN/SUP)14 stated she missed entering R136's insulin order when she entered the resident's admission orders. RN/SUP14 stated R136 missing their insulin could have resulted in the resident having elevated blood sugar levels, seizures, coma, and even death. During an interview on 04/11/26 at 2:46 PM, the DON stated R136's insulin order was missed from the hospital DC summary to the admitting orders for the facility. She stated her expectation was that orders be transcribed completely from the DC summary to the resident's medical record. During an interview on 04/12/26 at 10:06 AM, the Administrator stated her expectation was that admitting orders be transcribed to the resident's medical record from the hospital DC summary.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425308	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aiken Rehabilitation and Care Center	3525 Augustus Road Aiken, SC 29801

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review, interview, facility document and policy review, the facility failed to transcribe an insulin order upon admission from the hospital for 1 (Resident (R)136) of 1 resident reviewed for insulin administration. Findings include: Review of the facility's undated policy titled, admission Orders, indicated, A physician must personally approve, in writing, a recommendation that an individual be admitted to a facility. A physician, physician assistant, nurse practitioner or clinical nurse specialist must provide written and/or verbal orders for the residents' immediate care and needs. Review of an admission Record revealed the facility admitted R136 on 03/30/26. According to the admission Record, the resident had a medical history that included the diagnosis of type two diabetes mellitus with diabetic chronic kidney disease. Review of a 5-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/03/26, revealed R136 had a Brief Interview for Mental Status (BIMS) score of 00, which indicated the resident had severe cognitive impairment. The MDS indicated the resident did not receive injections of any type during the prior seven days or since admission/entry or reentry if less than seven days. Review of R136's Baseline Care Plan, undated, indicated a focus area for disease/illness management that indicated the resident was diabetic. The interventions directed staff to follow orders for treatments, monitor for complications of illness, monitor conditions and progress of illness, and report changes to the Director of Nursing (DON) and physician. Review of R136's hospital Discharge Summary, dated 03/27/26, indicated the resident's discharge medications included insulin lispro 100 units/milliliter (mL) injectable solution 2-12 units subcutaneous before meals and at bedtime per sliding scale. Review of R136's April 2026 Order Summary Report for date range 03/30/26 through 04/30/26, contained an order, dated 04/04/26, for insulin lispro (1 unit dial) subcutaneous solution pen-injector 100 unit/mL per sliding scale before meals and at bedtime, with instructions to call the physician if results greater than 400 milligram (mg)/deciliter (dL). Review of R136's Progress Notes, dated 03/31/26, revealed it was the Nurse Practitioner's (NP's) initial visit with the resident. The Progress Notes further revealed the discharge (DC) summary, Medication Administration Record (MAR), and Plan of Care (POC) were reviewed. Insulin was not included on the resident's medication list on the Progress Note. The Progress Note was signed by NP2 on 04/01/26. During an interview on 04/09/26 at 3:37 PM, Registered Nurse/Supervisor (RN/SUP)14 stated she missed entering R136's insulin order when she entered the resident's admission orders. During an interview on 04/08/26 at 11:20 AM, NP2 stated she saw R136 on 03/31/26 for a hospital follow-up visit. She stated if insulin was on a DC summary from the hospital, then it should have been ordered on admission. NP2 reviewed the hospital DC summary and stated insulin lispro was on the DC medications list. She stated she overlooked the insulin during her hospital follow-up visit. During an interview on 04/11/26 at 2:46 PM, the DON stated R136's insulin order was missed from the hospital DC summary to the admitting orders for the facility. She stated her expectation was that orders be transcribed completely from the DC summary to the resident's medical record. During an interview on 04/12/26 at 10:06 AM, the Administrator stated her expectation was that admitting orders be transcribed to the resident's medical record from the hospital DC summary.