

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425319	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/22/2025
NAME OF PROVIDER OR SUPPLIER Carlyle Senior Care of Blackville		STREET ADDRESS, CITY, STATE, ZIP CODE 1612 Jones Bridge Road Blackville, SC 29817	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, document review, and facility policy review, the facility failed to timely report an allegation of sexual abuse to the state survey agency that involved 1 (Resident #5) of 3 sampled residents reviewed for abuse. Findings included: A facility policy titled, Abuse, Neglect and Exploitation, revised 10/24/2022, revealed, 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 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. An admission Record revealed the facility admitted Resident #5 to the facility on [DATE]. According to the admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease, muscle weakness, anxiety disorder, depression, and adult failure to thrive. A significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/03/2025, revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The Medical Records (MR) Clerk's Incident Witness Statement dated 12/10/2025, revealed On 12-10-25 @ [at] approximately 3:30 pm I was on back hall near back hall nurses station, [Resident #5] said I have something to tell you. Resident said you know that guy right there he raped me. Per the Incident Witness Statement, the MR Clerk revealed she immediately notified the Administrator of the allegation. Licensed Practical Nurse (LPN) #9's Witness Statement dated 12/10/2025, revealed that at 3:35 PM, she saw the MR Clerk and Certified Nurse Aide (CNA) #6 coming up the middle hall and both stated that Resident #5 accused CNA #6 of rape. Per the Witness Statement, LPN #9 stated she notified the Abuse Coordinator, the Administrator. Contained within the facility investigation file was a facsimile report which indicated the facility notified the state survey agency of Resident #5's allegation sexual abuse perpetrated by CNA #6 on 12/11/2025 at 4:52 PM. During an interview on 12/20/2025 at 2:56 PM, the Administrator, who served as the Abuse Coordinator, stated she was notified of the allegation of sexual abuse on 12/10/2025 when CNA #6 notified her that Resident #5 alleged he raped them. The Administrator stated she did not submit a facility reportable incident to the state survey agency on 12/10/2025. Per the Administrator, the resident's allegation was reported to the state survey agency on 12/11/2025, but it should have been reported immediately.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview, record review, document review, and facility policy review, the facility failed to ensure certified nurse aides (CNAs) notified a nurse of a resident's fall before the staff assisted the resident off the floor. Specifically, on 09/17/2025, CNA #6 and CNA #7 placed Resident #3 back in bed after the resident was found on the floor and did not inform Licensed Practical Nurse (LPN) #8 that the resident had fallen. This failure contributed to a lack of assessment for any injuries the resident might have sustained as the result of the fall. The resident was assessed on 09/18/2025 and had no injuries at the time of the incident on 09/17/2025 or post incident on 09/18/2025. This deficient practice affected 1 (Resident (R)#3) of 3 sampled residents reviewed for accidents. Findings included: A facility policy titled, Fall Prevention Program, revised 09/01/2023, indicated, A fall is an event in which an individual unintentionally comes to rest on the ground, floor, or other level, but was not as a result of an overwhelming external force. The event may be witnessed, reported, or presumed when a resident is found on the floor or ground, and can occur anywhere. The policy specified, 8. When any resident experiences a fall, the facility will: a. Assess the resident including full body audit. An admission Record revealed the facility admitted Resident #3 on 09/11/2025. According to the admission Record, the resident had a medical history that included diagnoses of need for assistance with personal care and muscle weakness. A 5-Day Minimum Data Assessment (MDS), with an Assessment Reference Date (ARD) of 09/18/2025, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated that the resident was dependent on staff for sit to lying, lying to sitting on the side of the bed, sit-to-stand, and chair/bed-to-chair transfers. The MDS revealed the resident had one fall with no injury since admission. Resident #3's Care Plan Report included a focus area initiated 09/12/2025, that indicated the resident was at risk for falls related to confusion, deconditioning, gait/balance problems, occasional incontinence, unaware of safety needs, chronic obstructive pulmonary disease, chronic kidney disease, hypertension, and congestive heart failure. Resident #3's incident report prepared by LPN #8 and dated 09/18/2025 at 10:00 AM, revealed on 09/17/2025, LPN #8 was called to the Resident #3's room to check on resident. The incident report indicated when LPN #8 asked the resident what happened, Resident #3 responded they were alright. Per the incident report, on 09/18/2025, Resident #3 reported to the treatment nurse they had a fall on 09/17/2025 when they slid out of bed and a staff member assisted them back to bed. The incident report indicated the resident had no injuries at the time of the incident on 09/17/2025 or post incident on 09/18/2025. During an interview on 12/21/2025 at 3:05 PM, Resident #3 stated they recalled falling out of their bed a few months prior and were on their knees with their hands on the bed after attempting to get back in bed independently. Resident #3 stated CNA #6, along with CNA #7 placed them back in bed. During an interview on 12/21/2025 at 3:17 PM, CNA #6 stated he recalled that a month or two prior as he passed out the evening meal trays, CNA #7 requested assistance to get Resident #3 into their wheelchair. CNA #6 stated when he and CNA #7 entered Resident #3's room, they saw the resident on the floor in a kneeling position, slightly crunched down, and holding onto their bed with their arms. CNA #6 stated he assisted CNA #7 to lift Resident #3 back into the bed safely. CNA #6 said that after getting the resident to bed, CNA #7 alerted the nurse on duty, LPN #8, and he returned to his routine duties. CNA #6 stated LPN #8 was not notified of the resident's fall prior to him assisting the resident back to bed because Resident #3 insisted on being placed back in the bed immediately. During an interview on 12/21/2025 at 3:37 PM, CNA #7 stated when she entered Resident #3's room to deliver their meal, she noticed Resident #3 on the floor on their knees by the bed. CNA #7 stated the resident's feet were on the floor and their arms were on the bed at the time. CNA #7 stated she and CNA #6 assisted the resident back to bed then completed passing out the meal trays to other residents. CNA #7 stated that after the trays were passed, she notified LPN #8 that she needed to check on Resident #3. CNA #7 stated she knew she was to alert a nurse before moving a resident after a fall and that she should have alerted LPN #8 before moving the resident. During an interview on 12/21/2025 at 3:55 PM, LPN #8 stated CNA #7 approached her and informed her that Resident #3 needed to be checked but did not notify her why the resident needed checked. LPN #8 stated she went to see Resident #3, who was lying in their bed at the time and the resident stated they did not need anything so she returned to her duties. LPN #8 stated on the following day, 09/18/2025, LPN #9 asked her about a fall Resident #3 reported to her. LPN #8 stated both she and LPN #9 went to Resident #3's room to inquire further about the fall, and Resident #3 stated they had not notified the nurse of the fall on 09/17/2025. During an interview on 12/22/2025 at 1:03 PM, the Director of</p>		