STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425319	A. Building B. Wing	03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carlyle Senior Care of Blackville	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)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure correct installation, use, and maintenance of bed rails for 3 of 3 residents (Residents (R)4, R56, and R72) reviewed for bed rails out of a total of 20 sampled residents. This failure had the potential for risk of resident entrapment and injury. Findings include:Review of the facility policy titled Proper Use of Bed Rails dated 2022, revealed, It is the policy of this facility to utilize a person-centered approach when determining the use of bed rails . If bed rails are used, the facility ensures correct installation, use, and maintenance of the rails. Under Installation and Maintenance of Bed Rails Item twelve revealed, The facility will assure the correct installation and maintenance of bed rails, prior to use. This includes: a. Checking with the manufacturer(s) to make sure the bed rails, mattress, and bed frame are compatible. Rails should be selected and placed to discourage climbing over rails. B. Ensuring that the bed's dimensions are appropriate for the resident by: i. Confirming that the bed rails are appropriate for the size and weight of the resident using the bed; iii. Inspecting and regularly checking the mattress and bed rails for areas of possible entrapment; v. Checking bed rails regularly to make sure they are still installed correctly and have not shifted or loosened over time. Item 14 revealed, The facility will follow manufacturer's recommendations/instructions regarding disabling or tying rails down.Review of R4's Face Sheet located in the Profile tab of the electronic medical record (EMR) revealed R4 was admitted to the facility on [DATE], with diagnoses including but not limited to, quadriplegia, unspecified injury at cervical spinal cord. Review of R4's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/22/26, located in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. Review of R4's Care Plan dated 02/07/26, located under the Care Plan tab of the EMR, revealed that R4 was dependent on staff assistance for Activities of Daily Living (ADLs) task performance . with interventions that included 1/2 side rails to promote bed mobility and full and/or half side rails up as per physicians' order for safety during care provision and to assist with bed mobility. Review of R4's Informed Consent for Use of Bed Rails dated 01/19/26, revealed, the use of bed rails may involve risks such as: getting caught in the rails, getting caught between the rail and mattress, strangulation, suffocation, hitting against the rails causing bruising and/or skin tears, and crawling over the top of a rail risking a fall from a higher level with a risk for greater injury or death verbal consent given by R4 due to inability to sign.Review of R56's Face Sheet located in the Profile tab of the EMR revealed R56 was admitted to the facility on [DATE], with diagnoses including but not limited to quadriplegia. Review of R56's quarterly MDS with an ARD of 03/08/26, located in the EMR under the MDS tab, revealed a BIMS score of 0 out of 15, which indicated the resident's cognitive function was severely impaired.Review of R56's Care Plan dated 02/07/26, located under the Care Plan tab of the EMR, revealed that R56 was total care for ADL task performance . with an intervention of bilateral padded 1/2 side rails for positioning and bed mobility.Review of R56's Informed Consent for Use of Bed Rails dated 12/05/24, revealed, the use of bed rails may involve (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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	risks such as: getting caught in the rails, getting caught between the rail and mattress, strangulation, suffocation, hitting against the rails causing bruising and/or skin tears, and crawling over the top of a rail risking a fall from a higher level with a risk for greater injury or death verbal consent given by R56's Power of Attorney (POA).Review of R72's Face Sheet located in the Profile tab of the EMR revealed R72 was admitted to the facility on [DATE], with diagnoses including but not limited to, schizophrenia, Guillain-Barre syndrome, and disorder of the brain.Review of R72's quarterly MDS with an ARD of 02/02/26, located in the EMR under the MDS tab, revealed a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. Review of R72's Informed Consent for Use of Bed Rails dated 09/18/23, revealed, the use of bed rails may involve risks such as getting caught in the rails, getting caught between the rail and mattress, strangulation, suffocation, hitting against the rails causing bruising and/or skin tears, and crawling over the top of a rail risking a fall from a higher level with a risk for greater injury or death signed by responsible party.During an interview on 03/29/26 at 10:25 AM, R4 revealed he was being sent to the hospital on [DATE] and when the emergency medical services (EMS) came, they were trying to bring down my bedrail to transfer me into the gurney but the bed rail would not come down due to the zip tie that was holding my bedrail in the up position. He ended up cutting the zip tie so the bedrail could be lowered. During an observation and interview on 03/29/26 at 11:35 AM, Maintenance Assistant confirmed that bilateral bedrails were secured by zip ties on R72's bed, on R56's bed, and R4's bed. During an interview on 03/29/26 at 12:00 PM, the Administrator and Maintenance Assistant confirmed the facility altered the bed by using zip ties to hold the bed rails up and down without using the bed manufacturer's spare parts and recommendations.During an interview on 03/30/26 at 11:15 AM, the Maintenance Director (MD) revealed, I recently replaced the previous [MD] and some of these bed rails had already been tied up and down with zip ties by the previous maintenance staff. When they put those zip ties on, they put them on wrong because the side rails were supposed to be able to move up and down. I confirmed yesterday with the Administrator that none of the bed rails can either be moved up or down. When asked if the bed manufacturer's instructions indicate that the bed rails can be tied down by using zip ties, the MD stated, No and the bed is in disrepair when you can't bring the bed rails up or down safely. The zip tie situation was required because some of these beds are old. I placed the zip ties on [R4's] bed rails. For the other beds, it was the previous maintenance staff that did that.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to ensure 5 of 5 Certified Nursing Assistants ((CNA)5, CNA7, CNA8, CNA9, and CNA10), were provided the required 12-hours of annual in-service training. 1.Review of the facility's employment file for CNA 5 revealed a date of hire of 03/17/23. The employment file for CNA5 contained evidence that CNA5 participated in the annual skills fair provided by the facility but lacked evidence of the 12 hours of in-service training annually.2.Review of the facility's employment filed for CNA7 revealed a date of hire of 03/29/23. The employment file for CNA7 contained evidence that CNA7 participated in the annual skills fair provided by the facility but lacked evidence of the 12 hours of required in-service training annually. 3.Review of the facility's employment filed for CNA8 revealed a date of hire of 09/13/10. The employment file for CNA8 contained evidence that CNA8 participated in the annual skills fair provided by the facility but lacked evidence of the 12 hours of required in-service training annually. 4.Review of the facility's employment filed for CNA9 revealed a date of hire of 01/26/24. The employment file for CNA9 contained evidence that CNA9 participated in the annual skills fair provided by the facility but lacked evidence of the 12 hours of required in-service training annually. 5.Review of the facility's employment filed for CNA10 revealed a date of hire of 11/01/23. The employment file for CNA10 contained evidence that CNA10 participated in the annual skills fair provided by the facility but lacked evidence of the 12 hours of required in-service training annually. During an interview on 03/31/26 at 12:22 PM, the Director of Nursing (DON) revealed she was unaware the facility needed to track the hours of in-service education provided to the CNA's and failed to provide a copy of the facility policy for CNA in-service education.