STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425014	A. BUILDING _____ B. WING _____	**03/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARLYLE SENIOR CARE OF AIKEN	**123 DUPONT DR NORTHEAST 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 0623 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility failed to provide written notice of facility-initiated transfer to Resident Representative or Ombudsman for 2 of 4 sampled residents reviewed for hospitalization . (Residents #6 and #76) Findings included: The facility admitted resident #6 on 3/28/2018 with the [DIAGNOSES REDACTED]. On 03/09/20 04:49 PM, the medical record review revealed that resident had a fall on 11/13/2019. Resident fell out of bed onto the floor. Resident #6 was sent to Aiken Regional Medical Center for observation. Further review revealed there was no written notice of transfer to resident representative. An interview with the social worker on 3/11/20 stated that she did not send out the transfer forms because resident was sent to emergency room and returned the same day. The facility admitted resident #76 on 8/19/19 with [DIAGNOSES REDACTED]. On 03/10/20 04:40 PM resident #76 was sent to hospital due to fall out of Wheelchair. At 9:30 a.m. on 3/7/2020 Resident #76 was on the floor in front of her wheelchair. Laceration approximately 2.5-3 cm in length noted to forehead. Ice packed applied; neuro checks initiated MD notified. Orders obtained to send resident to emergency room for lacerations and evaluation. Resident returned to facility at 3:00 p.m. via stretcher. Resident was assessed, lacerations were noted on forehead with 8 sutures and small hematoma. Further review revealed there was no written notice of transfer to resident representative. Interview with social worker on 3/11/20 stated that she did not send out the transfer forms because resident was sent to emergency room and returned the same day.
F 0625 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Record review and interview, the facility failed to provide written notice of Bed-Hold to Residents Representative upon facility-initiated transfer for 2 of 4 sampled residents reviewed for hospitalization . (Residents #6 and #76) Findings Include: Resident #6 was admitted to facility on 3/28/2018 with the [DIAGNOSES REDACTED]. Resident #6 was sent to Aiken Regional Medical center emergency roiagnom on [DATE] after a fall. Further chart review revealed that resident representative did not receive written Bed Hold Notice. Interview with social worker on 3/11/20 stated that she did not send out the transfer forms because resident was sent to emergency room and returned the same day. The facility admitted resident #76 on 8/19/19 with [DIAGNOSES REDACTED]. On 03/10/20 04:40 PM Resident #76 was sent to hospital due to fall out of Wheelchair. Interview with social worker on 3/11/20 stated that she did not send out the transfer forms because resident was sent to emergency room and returned the same day.
F 0637 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Assess the resident when there is a significant change in condition** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, and review of the RAI (Resident Assessment Instrument), the facility failed to conduct a Significant Change in Status Assessment (SCSA) upon discharge from Hospice for Resident #4, 1 of 1 residents reviewed for Hospice. The findings include: The facility admitted Resident #4 on 03/29/18 with [DIAGNOSES REDACTED]. On 03/11/29 at 11:16 AM, a review of the physician orders [REDACTED]. Review of the Minimal Data Set (MDS) assessments revealed no SCSA had been conducted within 14 days after hospice services were discontinued as required. During an interview on 03/11/20 at 02:32 PM, the MDS Coordinator confirmed Resident #4 was discharged from Hospice Services on 01/26/20. The RN (Registered Nurse) stated that s/he thought a SCSA only had to be done if a significant improvement had occurred that warranted the discontinuation of services. Review of the CMS's (Resident Assesment Instrument) RAI Version 3.0 Manual CH 2: Assessments for the RAI October 2018 Page 2-24 revealed A SCSA is required to be performed when a resident is receiving hospice services and then decides to discontinue those services (known as revoking of hospice care). The ARD must be within 14 days from one of the following: 1) the effective date of the hospice election revocation (which can be the same or later than the date of the hospice election revocation statement, but not earlier than); 2) the expiration date of the certification of terminal illness; or 3) the date of the physician's or medical director's order stating the resident is no longer terminally ill.
F 0641 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of the CMS's (Centers for Medicare/Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 Manual, October, 2018, the facility failed to accurately code the presence of a PASARR (Pre-Admission Screening and Resident Review) for Resident #69, 1 of 4 residents reviewed for Resident Assessments and failed to accurately code the functional status for Resident #26, 1 of 2 residents reviewed for a Significant Change in Status. The findings include: Resident #69 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 03/09/20 at 10:26 AM, review of the (Minimal Data Set) MDS indicators for Resident #69 revealed the resident had no Level II PASARR (pre-admission screening and resident review) but had a diagnosis. At that time, record review revealed a Level II PASARR dated 11/02/17 in the resident's physical record. During an interview on 03/11/20 at 02:32 PM, the MDS Coordinator, Brittany Jeffcoat, RN, confirmed the Annual MDS assessment dated [DATE] coded the resident as not having a PASARR. The RN further confirmed the PASARR in the chart had a date of 11/02/17 indicating that was the date it was received by the facility. The facility admitted Resident #26 on 06/10/14 with [DIAGNOSES REDACTED]. On 03/09/20 at 11:49 AM, review and comparison of the 10/06/19 Annual MDS and the 12/22/19 Quarterly MDS revealed a decline in transfers from limited to extensive assistance and a decline from supervision to total care for bathing on the 12/22/19 Quarterly Assessment. During an interview on 03/11/20 10:29 AM, the CNA (Certified Nursing Assistant) assigned to the resident stated that Resident #26 required assistance of 2 for transfer from the bed to the wheelchair. The resident lifts his/her body using the trapeze bar then the 2 CNAs, one on each side, slide the resident over to the wheelchair. The CNA also stated that Resident #26 washes his/her upper body and the CNA washes the back and lower body. The CNA further indicated the resident had not had a decline and that s/he had required the same amount of assistance for a long time. A review of the CNA documentation for transfers revealed Resident #26 required limited assistance 3 times during the lookback period for the 10/06/19 MDS assessment which was coded correctly. Review of the CNA documentation for the lookback period for the 12/22/19 MDS assessment indicated the resident required supervision 3 times and limited assistance 3 times. Based on the Rule of 3, the resident should have been coded limited assistance, but was coded as requiring extensive assistance. Review of the documentation for bathing indicated the resident was coded as being total dependence once, required physical help with part of the bathing activity once, and physical assistance with transfers only 4 times during the lookback period for the 10/06/19 assessment. Based on

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

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.

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F 0641 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) the instructions in the RAI Manual, to be coded as total dependence requires the resident be totally dependent every time on every day during the lookback period. The instructions otherwise indicate, the assessment should be coded for the most dependent and should have been coded as requiring physical help with the bathing activity but was inaccurately coded as requiring supervision. The CNA documentation for the 12/22/19 assessment indicated the most dependent the resident was during the lookback period was also physical help in bathing, since the resident was only totally dependent one day, but was inaccurately coded as being totally dependent. During an interview on 03/11/20 at 04:10 PM, the MDS Coordinator confirmed the inaccuracy on both MDS assessments and stated I see what you mean and I understand. Review of the CMS's RAI Version 3.0 Manual, October, 2018, CH 3: MDS Items (G), Page G-7 revealed the following: Instructions for the Rule of 3: When an (Activities of Daily Living) ADL activity has occurred three or more times, apply the steps of the Rule of 3 below (keeping the ADL coding level definitions and the above exceptions in mind) to determine the code to enter in Column 1, ADL Self-Performance. These steps must be used in sequence. Use the first instruction encountered that meets the coding scenario (e.g., if #1 applies, stop and code that level). 1. When an activity occurs three or more times at any one level, code that level. 2. When an activity occurs three or more times at multiple levels, code the most dependent level that occurred three or more times. 3. When an activity occurs three or more times and at multiple levels, but not three times at any one level, apply the following: a. Convert episodes of full staff performance to weight-bearing assistance when applying the third Rule of 3, as long as the full staff performance episodes did not occur every time the ADL was performed in the 7-day look-back period. It is only when every episode is full staff performance that Total dependence (4) can be coded. Remember, that weight-bearing episodes that occur three or more times or full staff performance that is provided three or more times during part but not all of the last 7 days are included in the ADL Self-Performance coding level definition for Extensive assistance (3). b. When there is a combination of full staff performance and weight-bearing assistance that total three or more times-code extensive assistance (3). c. When there is a combination of full staff performance/weight-bearing assistance, and/or non-weight-bearing assistance that total three or more times-code limited assistance (2). If none of the above are met, code supervision. Further review revealed Page G-25 under Bathing indicated Coding directions for bathing state, code for most dependent in self-performance and support.
F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to obtain in a timely manner a positioning device the resident requested from his/her physician for Resident #55, 1 of 1 sampled residents reviewed for positioning devices. The findings include: The facility admitted Resident #55 with [DIAGNOSES REDACTED]. In an interview during the Resident Group meeting on 03/09/20 at approximately 3:00 PM Resident #55 stated that her neurologist had ordered a neck collar over a month ago and s/he had asked facility staff on multiple occasions when she would receive it. Review of the medical record on 03/11/20 at approximately 12:40 PM revealed a consultation with a neurologist on 01/08/20, the consultation notes stated the physician discussed and agreed to allow resident to have a hard cervical collar. Further review revealed a telephone order dated 01/30/20 for a collar to be worn at Resident #55's discretion. In an interview on 03/11/20 at approximately 3:42 PM the Director of Nursing provided a copy of email showing the collar was ordered on [DATE] but was unable to provide a reason why it took over 30 days to submit the order. In an interview on 03/11/20 at approximately 1:15 PM, the Director of Rehabilitation and Therapy stated that Resident #55 was evaluated and it was determined soft cervical collar would be of more benefit but did not know when it was ordered. S/he also did not document in Resident #55's health record because the order did not originate from therapy and there were no ongoing therapy services being provided. S/he provided in invoice dated 03/09/20. The collar was delivered on 03/10/20.