

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425102	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2025
NAME OF PROVIDER OR SUPPLIER West Village Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 8 North Texas Avenue Greenville, SC 29611	
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** 47914</p> <p>Based on interview, record review, facility document review, and facility policy review, the facility failed to report an allegation of abuse to the state survey agency timely for 1 (Resident #1) of 3 residents reviewed for abuse/neglect.</p> <p>Findings included:</p> <p>A facility policy titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, revised 08/2022, indicated, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. The policy further indicated, If resident abuse (staff to resident and/or resident to resident), neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator. a. All allegations of staff to resident abuse must be reported immediately but no later than 2 hours. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. the state licensing/certification agency responsible for survey/licensing the facility. The policy also specified the term, immediately was defined as, a. within two hours of an allegation involving abuse or result [sic] in serious bodily injury. b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.</p> <p>An Initial Report, dated 01/25/2025, indicated Resident #1 stated a certified nursing assistant (CNA) on third shift was rough during care. The report indicated Resident #1 named CNA #11 as the staff member who had been rough, and the CNA was suspended pending the investigation. The police, physician, and responsible party were notified. The report indicated the operations manager was notified of the allegation on 01/25/2025 at 9:00 AM.</p> <p>An e-mail dated 01/25/2025 revealed the facility sent the initial report to the state survey agency on 01/25/2025 at 1:48 PM, a period of four hours and 48 minutes after being informed of the allegation, which was not in compliance with the required two-hour reporting timeframe.</p> <p>(continued on next page)</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/13/2025 at 5:21 PM, the Operations Manager stated he currently was the only one who could complete allegation submissions to the state agency. He indicated most of the facility's weekend staff were agency, and they did not have the same access as facility staff did. He stated he understood that the reports needed to be submitted within two hours and that when he got to the facility on [DATE], he immediately started gathering all of the information before sending the report to the state.</p> <p>During a follow-up interview on 03/14/2025 at 12:35 PM, the Operations Manager stated he tried to send the initial report in via fax, but it did not go through. He stated he did not have fax confirmation sheets to show those attempts. The Operations Manager stated when the report was faxed, it showed up in the queue, but by the time he got home, he remembered staff saying that the fax had failed. The Operations Manager stated he had staff continue to try to fax the report but they ultimately had to submit it via eFax, which was the e-mail documentation dated 01/25/2025 that he had previously provided.</p> <p>During an interview on 03/14/2025 at 3:55 PM, the Operations Manager stated that moving forward, he would have a manager on duty who would be able to send in an initial allegation report and he would communicate with staff to make sure they reported abuse immediately.</p>		