

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 11/15/2024
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>31846</p> <p>Based on review of facility policy, record reviews and interviews, the facility failed to ensure resident rights were upheld related to voting in the Presidential Election, for 8 of 8 residents reviewed for Resident Rights.</p> <p>Finding include:</p> <p>Review of the undated facility policy titled, Resident Rights documented, 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: g. Exercise his or her rights as a resident of the facility and as a resident or citizen of the United States; h. Be supported by the facility in exercising his or her rights. i. Exercise his or her rights without interference, coercion, discrimination or reprisal from the facility, j. Be informed about his or her rights and responsibilities.</p> <p>During interviews with residents at a Resident Council Meeting at an unspecified date and time, three residents verbalized that they did not get the opportunity to vote in the Presidential Election on 11/05/24. The residents also stated that they filled out the voter registration form, but never got to vote.</p> <p>Review of the South Carolina Voter Registration Forms dated 10/21/24, revealed eight resident completed the South Carolina Voter Registration Forms and the forms were emailed to the Greenville County Voter Registration office 7 days after the deadline of 10/14/24.</p> <p>During an interview on 11/14/24 at 9:35 AM, the Social Service Director (SSD) stated that residents have been coming to her upset because they did not get to vote. The SSD further stated that the forms for registration to vote were completed on the last day and they should have been completed sooner.</p> <p>During an interview on 11/14/24 at 10:30 AM, the Administrator stated he was upset that the residents that wanted to vote did not get to. The Administrator stated that he spoke with the Activity Director (AD) months before the voter registration form was to be completed, if the residents were going to vote. They were completed after the cut off date.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/14/24 at 11:00 AM, the AD provided signed voter registration forms for eight residents. The eight residents are still residing in the facility and signed the South Carolina Voter Registration form on 10/16/24, 2 days after the deadline to complete registration to vote.</p>

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50085</p> <p>Based on record review, observation and interviews, the facility failed to ensure Resident (R)79's Protected Health Information (PHI) was maintained in a private manner, for 1 of 9 residents observed during medication administration.</p> <p>Findings included:</p> <p>Review of the facility policy titled Confidentiality of Information and Personal Privacy with a revision date of February 2021, documented, Our facility will protect and safeguard resident confidentiality and personal privacy . 1. The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records . 4. Access to resident personal and medical records will be limited to authorized staff and business associates.</p> <p>Review of R79's Face Sheet revealed R79 was admitted to the facility on [DATE], with diagnoses including but not limited to: paraplegia, diabetes mellitus type two, morbid obesity, post traumatic stress disorder, schizoaffective disorder, and major depressive disorder.</p> <p>During an observation on 11/14/24 at 10:18 AM, revealed the Unit Two Medication Cart (A) was unattended, while R79's Electronic Medication Administration Record (EMAR) was visible on the computer screen. Additionally, there were two cups of a white topical cream on the medication cart. The Unit Two Medication Cart (A) was located at the far end of the hall, away from the nurses station. The nurse assigned to the Unit Two Medication Cart (A) was not in sight. R79's EMAR was visible to other residents, staff, visitors and anyone else who walked by the medication cart.</p> <p>During a second observation on 11/14/24 at 10:27 AM, revealed R79's EMAR still open to view and the cart unattended. Registered Nurse (RN)2 was observed going to the treatment cart located next to nurse's station while the medication cart was still located at the end of the hall.</p> <p>During an interview on 11/14/24 at 10:36 AM, RN2 revealed that it is expected that the nurse hit the lock button to hide the screen. RN2 further stated, It is done for HIPPA purposes, so no-one can see residents' information. RN2 stated that she was in a rush due to patient care. RN2 concluded that treatment medications should not be left on the medication cart unattended for no length of time.</p> <p>During an interview on 11/15/24 at 8:57 AM, the Director of Nursing (DON) stated, this is an issue, and, in the past, I have grabbed their cart, make them come and explain to me why the screen was not hidden. The DON stated, My expectation is if you pull a medication give the medication, and in an emergency lock up the medication. Pull one, give and then pull the other, not two treatments for different patients at one time.</p> <p>During an interview on 11/15/24 at 2:02 PM, RN1 revealed the expectation to use the system, to lock your screen, or use control, alt, delete so no one can have access to the resident's medical records. RN1 further stated, I have seen this being an issue currently and I have been reminding staff to not have private information exposed.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>50085</p> <p>Based on review of facility policy, observation, and interviews, the facility failed to remove expired medication cards in 1 of 6 medication carts reviewed.</p> <p>Findings include:</p> <p>Review of the facility policy titled, Storage of Medications revised on November 2020, documents, The facility stores all drugs and biologicals in a safe, secure, and orderly manner. 3. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 4. Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to dispensing pharmacy or destroyed.</p> <p>During an observation on 11/14/24, of the Medication Cart B on Unit 3, revealed three cards of expired Tramadol 50 mg (milligram) half tablets. Card one had an expiration date of 8/2024 and had 13 half tablets remaining, card two (full card) had an expiration date of 10/2024 and card three (full card) had an expiration date of 10/2024.</p> <p>During an interview on 11/14/24 at 11:07 AM, Licensed Practical Nurse (LPN)1 revealed that the nurse is responsible for ensuring the medications are in date. LPN1 stated, As I am doing the medication administration, I review the dates on the medications. I check mostly the scheduled and as needed medications. When I encounter expired narcotics or expired medications, I take it out the cart and take them to the Director of Nursing (DON) or the Unit Manager. I then get a new script from the physician. I check medication's dates every shift I work, but I did not do it today. I did not see these expired narcotics and I did not give them my shift. The last time I worked on this cart was around three weeks ago because I am as needed (PRN) staff.</p> <p>During an interview on 11/14/24 at 11:12 AM, LPN2 revealed the unit does monthly audits on medications and the pharmacy also perform monthly audits. Pharmacy came about two weeks ago and went through the narcotic book for expired medications and issues with medications. Medication reconciliation is also done at that time by the pharmacy. We also update the medication as it is changed. Thursdays are the medication reconcile date for Unit 3, to ensure that changes promptly noted, and medications are ordered. This ensures medications are accessible throughout. LPN2 stated, The three cards of Tramadol 50 mg half tablets are expired, they will be taken off the cart and given to the DON to return safely. I will contact the Nurse Practitioner to get an order so the patient can have them when needed.</p> <p>During an intervention on 11/15/24 at 8:49 AM, the DON revealed going forward the facility will continue to do medication cart audits on Thursdays. The DON stated since there is an identified issue, we will now be color coding medication cards to ensure there is no further issue with expired narcotic medications. We do not want any expired medications given.</p>		