STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425102	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Village Post Acute	8 North Texas Avenue Greenville, SC 29611

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure beverages were served in a safe and sanitary manner to residents who ate in their rooms. This deficient practice had the potential to affect all residents who received beverages from the facility. Findings include: During an observation on 01/12/26 at 11:41 AM, staff on Unit 3 dispensed tea from a container on top of the food delivery cart, then carried the food tray with the uncovered cup of tea from the food delivery cart outside room [ROOM NUMBER] past the nurses' station to room [ROOM NUMBER]. During an observation on 01/12/26 at 5:30 PM, staff on Unit 1 poured tea from a container on top of the food delivery cart near the nurses' station, then walked the tray with the uncovered tea to room [ROOM NUMBER]. Staff then poured tea into another cup, placed it on a tray, and carried the uncovered tea to room [ROOM NUMBER].^ During an observation on 01/15/26 at 11:32 AM, Certified Nursing Assistant (CNA)1 poured tea and coffee from the container on top of the food delivery cart, then carried the uncovered tea and coffee down the hall past the medication cart to room [ROOM NUMBER]. During an observation on 01/15/26 at 11:34 AM, CNA2 carried an uncovered cup of tea from the food delivery cart near room [ROOM NUMBER] approximately 36 feet, past a medication cart and past five opened resident room doors to room [ROOM NUMBER]. During an interview on 01/15/26 at 11:35 PM, CNA1 stated she had training on how to deliver meal trays. CNA1 stated the cover over the food protected it from germs. CNA1 stated if the tea was not covered it could get germs in it, but the kitchen had not provided them with lids for the tea. During a concurrent interview and observation on 01/15/26 at 11:38 AM, CNA2 poured tea from the container on top of the food delivery cart on the 500 Hall, then carried the tea past the nurses' station and the medication cart and delivered the tea to room [ROOM NUMBER]. CNA2 stated if the tea was uncovered it could get germs in it, but the kitchen had not sent any lids for the tea. During an interview on 01/15/26 at 11:46 AM, Licensed Practical Nurse (LPN)3 stated if staff poured tea and carried it down the hallway uncovered, it would be an infection control issue. During an interview on 01/16/26 at 10:21 AM, the Director of Nursing (DON) stated all food and beverages should be covered when being transported down the hall for infection control purposes. During an interview on 01/16/26 at 11:37 AM, the Administrator stated there should be lids on the tea when it was being passed on the halls.

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, record review, and facility policy review, the facility failed to follow the planned menu. Specifically, the facility served the incorrect portion size for the pureed diets for the lunch meal on 01/13/26. This failure had the potential to affect 13 residents who received pureed diets. Findings include: Review of a facility policy titled Menus, revised 10/2017, indicated, Menus are developed and prepared to meet resident choices including religious, cultural and ethnic needs while following established national guidelines for nutritional adequacy. Review of the facility menu for the lunch meal served on 01/13/26, indicated the pureed baked salmon should be a 4-ounce (oz) portion, pureed chicken should be a 4 oz portion, and the pureed collard green should be a 1/2 cup portion. During observations of the lunch meal on 01/13/26 beginning at 11:22 AM revealed, [NAME] 4 plated the lunch meal. [NAME] 4 used a green #12 (2.67 oz) scoop to serve the pureed salmon and the pureed collard greens, and a 2-oz serving spoon to serve the pureed chicken. During an interview on 01/13/26 at 12:06 PM, [NAME] 4 stated she knew what portions to serve from looking at the production sheet. [NAME] 4 reviewed the scoops that were used for the meal service. [NAME] 4 confirmed she used a 2 oz serving spoon to serve the pureed chicken. [NAME] 4 stated she could not find the size on the green scoops in the pureed salmon and pureed collard greens but based on the color of the scoop, they were #12 scoops. [NAME] 4 then reviewed the production sheet and confirmed that she should have served 4 oz of pureed chicken, 4 oz of pureed salmon, and 1/2 cup of pureed collard greens. [NAME] 4 stated the scoops that she used were not the correct portion sizes. The Dietary Director (DD), who was present during the interview, confirmed the #12 scoop was slightly over a 2 oz portion. During a follow-up interview on 01/15/26 at 1:46 PM, the DD stated they should follow the menu and the portion sizes to make sure that residents received the correct nutrition daily. During an interview on 01/14/26 at 3:27 PM, the Dietitian stated she expected the kitchen staff to follow the menu and serve the correct portions so that residents received nutritionally sound meals that met their nutritional needs. During an interview on 01/16/26 at 10:21 AM, the Director of Nursing (DON) stated the staff should follow the portion sizes on the menu. The DON stated it was important to serve the correct portion sizes for nutrition and weight management. During an interview on 01/16/26 at 11:37 AM, the Administrator stated the staff should follow the menu and serve the correct portion sizes so that residents received the right number of calories to maintain their health.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview, record review, review of facility policy, and review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to ensure a Minimum Data Set (MDS) assessment accurately reflected the status of 1 (Resident (R)81) of 2 residents reviewed for pressure ulcers. Specifically, R81's Quarterly MDS, with an Assessment Reference Date (ARD) of 12/09/25, did not reflect that the resident had intravenous (IV) access, specifically a peripherally inserted central catheter (PICC). Findings include: Review of the facility policy titled Resident Assessments revised on 10/2023, indicated, . 12. Information in the MDS assessments will consistently reflect information in the progress notes, plans of care, and resident observations/interviews. Review of the CMS Long-Term Care Facility RAI 3.0 User's Manual, version 1.19.1, dated 10/2024, revealed, Chapter 3: MDS Items, O0110: Special Treatments, Procedures, and Programs specified, O0110O1, IV Access Code IV access, which refers to a catheter inserted into a vein for a variety of clinical reasons, including long-term medication administration, large volumes of blood or fluid, frequent access for blood samples, intravenous fluid administration, total parenteral nutrition (TPN), or, in some instances, the measure of central venous pressure. The manual instructed, O0110O4, Central (e.g. [exempli gratia, for example], PICC, tunneled, port) Check when IV access was centrally located. Review of R81's admission Record indicated the facility admitted R81 on 11/16/23. According to the admission Record, the resident had a medical history that included diagnoses of, but was not limited to: paraplegia, osteomyelitis, mild protein-calorie malnutrition, and personal history of other infections and parasitic diseases. Review of R81's Order Recap [Recapitulation] Report contained an active order dated 08/22/25 to place a PICC line for antibiotic therapy. Review of R81's Care Plan Report included a RESOLVED focus area, initiated on 08/25/25 and resolved on 12/04/25, that indicated the resident was at risk for complications due to the presence of a PICC line for the long-term treatment with IV antibiotic therapy. Review of R81's Progress Notes revealed an Infection Note, dated 11/30/25, that indicated the resident's PICC line in the right upper arm remained patent (open, unobstructed, and functioning properly). Review of R81's Quarterly MDS, with an ARD of 12/09/25, revealed the assessment did not reflect the presence of IV access within the 14-day look-back period. Section O was not checked to reflect the presence of IV access, including central access. During a concurrent interview and record review on 01/15/26 at 9:22 AM, the Registered Nurse (RN) MDS Coordinator stated that Section O of R81's MDS did not reflect that the resident had a PICC line but should have. During an interview on 01/16/26 at 9:13 AM, the Director of Nursing (DON) stated she expected MDS assessments to be accurate. The DON stated it was important for MDS assessments to accurately reflect each resident's current condition (at the time of the assessment). The Administrator and the Regional Director of Clinical Services (RDCS) were interviewed on 01/16/26 at 10:32 AM. The Administrator stated he expected MDS assessments to be accurate. The RDCS confirmed R81 utilized a PICC line and stated she expected Section O of the resident's MDS to be accurate.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, record review, and facility policy review, the facility failed to ensure a care plan was in place to address the care needs associated with the use of a peripherally inserted central catheter (PICC) line for 1 (Resident (R)81) of 2 sampled residents reviewed for pressure ulcers. Specifically, the facility resolved a care plan addressing R81's PICC line on 12/04/25 and one was never re-initiated, despite ongoing PICC line use and access. Findings include: Review of the facility policy titled Care Plans, Comprehensive Person-Centered, revised in 03/2022, indicated, 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The policy further indicated, . 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The policy revealed, . 11. Assessments of the residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. Review of R81's admission Record indicated the facility admitted R81 on 11/16/2023. According to the admission Record, the resident had a medical history that included diagnoses of, but not limited to: paraplegia, osteomyelitis, mild protein-calorie malnutrition, and personal history of other infections and parasitic diseases. Review of R81's Order Recap [Recapitulation] Report contained an active order dated 08/22/25 to place a PICC line for antibiotic therapy. Review of R81's Care Plan Report included a RESOLVED focus area, initiated on 08/25/25 and resolved on 12/04/25, that indicated the resident was at risk for complications due to the presence of a PICC line for the long-term treatment with IV antibiotic therapy. The Care Plan Report revealed no active focus areas addressing the resident's ongoing use of the PICC line or interventions that directed staff on the needed care and services related to the resident's PICC line. During an observation on 01/12/26 at 10:15 AM, R81 was in their room, and a PICC line was observed in the resident's right upper arm. R81's PICC line dressing was visibly soiled; the transparent dressing, dated 01/02/26, was almost detached from the resident's skin; dried blood was observed on the Biopath (a small, sterile antimicrobial foam disk placed around the PICC insertion site to reduce the risk of infections); and the central line itself was exposed and not covered. During an interview on 01/14/26 at 9:57 AM, the Admissions Nurse (AN) stated R81 had a central line for antibiotic therapy to treat osteomyelitis (infection of the bone). During a concurrent interview and record review on 01/15/26 at 9:22 AM, the Registered Nurse (RN) Minimum Data Set (MDS) Coordinator stated care plans were updated daily. The RN MDS Coordinator stated that the Licensed Practical Nurse (LPN) MDS Nurse was responsible for updating the care plans for long-term residents. The RN MDS Coordinator stated that if R81 still had a PICC line, the care plan should have indicated the PICC line was in use. During an interview on 01/15/26 at 11:47 AM, the LPN MDS Nurse stated the RN MDS Coordinator participated in daily clinical meetings where she received and gathered information regarding each resident from staff reports, assessments, and orders and then relayed new information to the LPN MDS Nurse so that she could update residents' care plans. The LPN MDS Nurse confirmed she was responsible for updating long-term care residents' care plans. During an interview on 01/16/26 at 9:13 AM, the Director of Nursing (DON) stated care plans must be updated in a timely manner. The DON stated she expected if a resident had a PICC line inserted, their care plan should reflect it. The DON stated R81's PICC line care plan should not have been resolved if the resident still had a PICC line in place. The Administrator and the Regional Director of Clinical Services (RDCS) were interviewed on 01/16/26 at 10:32 AM. The Administrator and RDCS both stated they expected care plans to be accurate and reflect each resident's needs.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, record review, and facility policy review, the facility failed to provide Resident (R)45 with an ordered oral nutritional supplement and failed to serve the correct portion size to the resident during the lunch meal on 01/13/26. This deficient practice affected 1 of 5 sampled residents reviewed for nutrition. Findings include: Review of a facility policy titled Food and Nutrition Services, revised 10/2017, indicated, Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. The policy specified, . 7. Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident. Reivew of R45's admission Record indicated the facility admitted R45 on 05/17/16. According to the admission Record, the resident had a medical history to include diagnoses of, but not limited to: dysphagia, speech and language deficits following cerebral infarction, and dementia. Review of R45's Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/19/25, revealed R45 had a Staff Assessment for Mental Status (SAMS) that indicated the resident had severely impaired cognitive skills for daily decision. The MDS indicated R45 had no significant weight loss and received a mechanically altered diet. Review of R45's Care Plan included a focus area initiated 09/14/22, that indicated the R45 required a mechanically altered diet texture related to swallowing concerns. Interventions directed the staff to provide supplement as ordered (initiated 03/20/2023). Review of R45's Order Summary Report with active orders as of 01/12/26, revealed an order dated 06/07/24, for a regular diet with pureed texture and thin liquids; an order dated 10/06/23, for ice cream daily with dinner for weight stability; an order dated 10/08/25, for an eight-ounce high protein oral nutritional supplement with lunch for weight stability; and an order dated 10/08/25, for an oral nutritional supplement two times daily with breakfast and dinner for weight stability. During an observation of the lunch meal on 01/12/26 beginning at 12:48 PM, R45 was served a pureed meal with an oral nutritional supplement. The resident was not served an eight-ounce high protein oral nutritional supplement for weight stability as ordered. During an observation of the dinner meal on 01/12/26 at 5:37 PM, R45 received a pureed diet with ice cream; however, there was no oral nutritional supplement on the resident's meal tray. During an observation of the lunch meal on 01/13/26 at 11:22 AM, [NAME] 4 plated the lunch meal and used a green #12 (2.67 oz) scoop to serve the pureed salmon and the pureed collard greens and a 2-oz serving spoon to serve the pureed chicken. During an interview on 01/13/26 at 12:06 PM, [NAME] 4 stated she knew what portions to serve from looking at the production sheet. [NAME] 4 reviewed the scoops that were used for the meal service. [NAME] 4 confirmed she used a 2 oz serving spoon to serve the pureed chicken. [NAME] 4 stated she could not find the size on the green scoops in the pureed salmon and pureed collard greens but based on the color of the scoop, they were #12 scoops. [NAME] 4 then reviewed the production sheet and confirmed that she should have served 4 oz of pureed chicken, 4 oz of pureed salmon, and 1/2 cup of pureed collard greens. [NAME] 4 stated the scoops that she used were not the correct portion sizes. The Dietary Director (DD), who was present during the interview, confirmed the #12 scoop was slightly over a 2 oz portion. During an interview on 01/14/26 at 3:04 PM, Registered Nurse 6 stated dietary was supposed to place the supplement on the resident's tray. During an interview on 01/14/26 at 3:27 PM, the Dietitian stated she expected the kitchen staff to follow the menu and serve the correct portions so that residents received nutritionally sound meals that met their nutritional needs. The Dietitian further stated if eight-ounce high protein oral nutritional supplement was ordered, dietary should purchase it and place it on the resident's tray. During an interview on 01/15/26 at 1:46 PM, the DD stated they should follow the menu and the portion sizes to make sure that residents received the correct nutrition daily. The DD stated that when a resident had an oral nutritional supplement ordered, they needed to receive it so they got the extra protein and nutrition they needed if their appetite was poor. During an interview on 01/16/26 at 10:21 AM, the (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Nursing (DON) stated staff should follow the portion sizes on the menu. The DON stated it was important to serve the correct portion sizes for nutrition and weight management. The DON stated if the Dietitian recommended an oral nutritional supplement it should be given as ordered for the health and well-being of the resident, whether that was wound healing or weight management. During an interview on 01/16/26 at 11:37 AM, the Administrator stated the staff should follow the menu and serve the correct portion sizes so that residents received the right amount of calories to maintain their health. The Administrator stated he expected any ordered nutrition supplement to be given to the resident so the resident received the right amount of calories to maintain their health.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observation, interview, record review, and facility policy review, the facility failed to provide care and treatment according to professional standards for peripherally inserted central catheter (PICC) lines (long thin flexible tube inserted through a peripheral vein in the upper arm and advanced to the large vein near the heart) for 1 (Resident (R)81) of 2 residents reviewed for PICC lines. Specifically, the facility failed to ensure R81's PICC line dressing was secure and changed per physician order and facility policy. Findings include: Review of a facility policy titled Central Venous Catheter Care and Dressing Changes, revised June 2025, indicated, . 5. Change the dressing if it becomes damp, loosened, or visibly soiled and: a. at least every 7 [seven] days for TSM [transparent semi-permeable membrane] dressing; b. at least every 2 [two] days for sterile gauze dressing (including gauze under a TSM unless the site is not obscured); or c. immediately if the dressing or site appears compromised. The policy also specified under a section titled Documentation that, The following information should be recorded in the resident's medical record: 1) Date and time dressing was changed; 2) Location and objective description of the insertion site; 3) Any complications, interventions that were done; 4) Condition of sutures (if present); 5) Any questions, education given to the resident, resident's statement regarding IV [intravenous] therapy, and response to the procedure; and 6) Signature and title of the person recording the data. Review of R81's admission Record indicated the facility admitted R81 on 11/16/23. According to the admission Record, the resident had a medical history that included diagnoses of, but not limited to: osteomyelitis, mild protein-calorie malnutrition, and personal history of other infections and parasitic diseases. Review of R81's Order Recap [Recapitulation] Reportˆcontainedˆan active order dated 08/22/25 to place a PICC line for antibiotic therapy. During an observation on 01/12/26 at 10:15 AM, R81 was observed with a PICC line in their right upper arm. R81's PICC line dressing was visibly soiled, the transparent dressing was dated 01/02/26, was almost detached from the skin, dried blood was on the Biopath (a small, sterile antimicrobial foam disk placed around the PICC insertion site to reduce the risk of infections), and the central line itself was exposed and not covered. During a concurrent observation and interview on 01/12/26 at 11:45 AM, in R81's room, Licensed Practical Nurse (LPN)21 inspected R81's PICC access line with gloved hands. LPN21 stated the PICC line dressing looks terrible and was barely hanging on. LPN21 stated the date on the PICC line dressing was 01/02/26. LPN21 stated that the insertion site was exposed and not covered by a transparent dressing. LPN21 stated that the PICC line was at risk of coming out. During an interview on 01/14/26 at 3:53 PM, Licensed Practical Nurse Manager (LPNM)22 stated she observed R81's PICC line dressing. LPNM22 stated R81's PICC line dressing was coming off, and the PICC line was coming out. LPNM22 stated PICC line dressings should be changed every seven days or whenever soiled. LPNM22 stated R81's soiled dressing had potential to cause infection. During an interview on 01/14/26 at 12:44 PM, Registered Nurse (RN)23 stated soiled PICC dressings were not acceptable. She stated she saw R81's PICC line dressing on 01/12/26 and had the PICC line removed the same day. She stated that the dressing was dated 01/02/26 and should have been changed on 01/09/26. RN23 stated that PICC line dressings should be intact and should be changed every seven days to help prevent infections to the resident, as the PICC line went directly into the patient's heart. During an interview on 01/16/26 at 9:13 AM, the Director of Nursing (DON) stated PICC line dressings should be changed per physician's order. The DON stated nurses should be looking for redness, discharge, and ensuring the dressing's integrity. The DON stated RNs and IV certified LPNs were responsible for maintaining and managing PICC lines.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, record review, and facility policy review, the facility failed to ensure staff used the proper personal protective equipment (PPE) during the care of a resident on Enhanced Barrier Precautions (EBPs) for 1 (Resident (R)81) of 2 residents reviewed for infection control. Findings include: Review of the facility policy titled Enhanced Barrier Precautions, revised in December 2024, indicated, 1. Enhanced barrier precautions (EBPs) refer to infection prevention and control interventions designed to reduce the transmission of multi-drug-resistant organisms (MDROs) during high contact resident care activities. 2. Enhanced barrier precautions apply when: and indicated, b. A resident is NOT known to be infected or colonized with any MDRO, has a wound or indwelling medical devices, and does not have secretions or excretions that are unable to be covered or contained; and c. Contact precautions do not otherwise apply. The policy continued, 5. Indwelling medical devices include central lines, urinary catheters, feeding tubes, and tracheostomies. The policy continued, 7. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gowns are applied prior to performing high contact resident care activity (as opposed to before entering the room). The policy continued, 8. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: and indicated, i. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc. [et cetera, and so on]; and j) wound care (any skin opening requiring a dressing). Review of R81's admission Record indicated the facility admitted R81 on ^11/16/23^. According to the admission Record, the resident had a medical history that included diagnoses of, but not limited to: osteomyelitis, mild protein-calorie malnutrition, and personal history of other infections and parasitic diseases. Review of R81's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/09/25, revealed R81 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated the resident had intact cognition. The MDS indicated R81 had an indwelling catheter. Review of R81's Care Plan Report, included a focus area initiated on 11/05/24, that indicated the resident required EBP during high-contact resident care activities due to the presence of wounds and suprapubic catheter. Interventions directed staff to utilize PPE (gown and glove; face-shield as indicated) during high-contact resident care activities (initiated 11/05/2024). Review of R81's Order Recap [Recapitulation] Report, dated for the timeframe 01/01/23 through 01/31/26, contained an order for EBP related to wounds with start date of 11/18/25 with no end date. During anˆobservation and interview on 01/12/26 atˆ10:15ˆAM,ˆR81 wasˆobservedˆwithˆa peripherally inserted central catheter (PICC) lineˆin theirˆright upper arm and a suprapubic catheter. R81 stated they also had a wound on their left foot. R81 said that when the staff came in to provide care, they only wore gloves and did not wear a gown. During an observation on 01/12/26 at 11:36 AM, Certified Nursing Assistant (CNA)2 entered R81's room wearing only one glove, and emptied R81's catheter bag. CNA2 did not don a gown during the observation. During an interview on 01/15/26 at 2:36 PM, CNA2 stated when emptying a resident's catheter, she should have worn gloves and a gown and confirmed she did not wear a gown. She stated the PPE bins were empty, and she did not know where to obtain the supplies. During an observation on 01/12/26 at 11:45 AM, Licensed Practical Nurse (LPN)21 entered R81's room, LPN21 handled and inspected R81's PICC access line with gloved hands. LPN21 did not don a gown during the observation. During an interview on 01/14/26 at 12:31 PM, Registered Nurse (RN)23 stated EBP was used for residents with Percutaneous Endoscopic Gastrostomy (PEG) (a tube used to deliver food or medicine directly into the stomach), catheters, open wounds, and ostomies. RN23 stated that the purpose of EBP was to prevent the spread of infection. RN23 stated that when emptying catheter bags or handling central lines, the CNAs and nurses should have worn gowns and gloves. During an interview on 01/14/26 at 3:53 PM, Licensed Practical Nurse Manager (LPNM)22 stated residents with hemodialysis catheters, suprapubic catheters, PICC lines, and feeding tubes (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425102	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Village Post Acute	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were placed on EBP. The purpose of EBP was to reduce the spread of infections from residents to staff or staff to residents. LPNM22 stated that anytime CNAs or nurses entered a resident room that was on EBPs, the staff must wear gloves and gowns. LPNM22 said this included emptying R81's suprapubic catheter and touching the resident's PICC line. During an interview on 01/16/26 at 9:13 AM, the Director of Nursing (DON) stated residents with catheters, wounds, ostomies, and any type of IV required EBPs. The DON stated staff should have worn gowns and gloves when performing direct patient care such as emptying catheters or handling central lines. The DON stated CNA2 and LPN21 should have worn gowns when providing care for R81. The DON stated wearing gowns and gloves served to prevent infections from spreading from one individual to another. During a joint interview on 01/16/26 at 10:32 AM, the Administrator (ADM) and the Regional Director of Clinical Services (RDCS), the ADM stated EPBs protected staff and residents from spreading respiratory or contacting illnesses from one another. The ADM stated they expected staff to follow EBP guidelines. The ADM stated CNA2 and LPN21 should have worn a gown when providing patient care to R81. The RDCS stated CNA2 and LPN21 should have worn a gown when providing patient care to R81.