

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425394	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER The Arboretum at the Woodlands		STREET ADDRESS, CITY, STATE, ZIP CODE 50 Arboretum Way Greenville, SC 29617	

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** 48835</p> <p>Based on facility policy, record review, observation, and interview, the facility failed to report an allegation of potential abuse/neglect to the abuse coordinator for hours after it was reported to a staff member for 1 of 1 resident (R)6, reviewed for abuse.</p> <p>Findings include:</p> <p>Review of the facility policy titled Abuse Prevention and Investigation reported under the policy, Neglect is the failure of the community, it's employees or service providers to provide goods and services necessary to avoid physical harm, mental anguish or emotional distress. Additionally the policy recorded, It is the policy of this Health Center to investigate different types of incidents and to identify the employees responsible for the initial reporting, investigation of alleged violations and reporting of results to the proper authorities. Each resident has the right to be from verbal, sexual, physical, physical and mental abuse .neglect . Identification; Licensed nursing home will identify events, such as .occurrence's, patterns and trends that may constitute abuse and determine the direction of the investigation. Reporting to the State Agency, and take all necessary corrective actions depending on the results of the investigation, the report of abuse should be reported no later than 2 hours after the allegation is made .</p> <p>Record review of education titled, Abuse dated 06/13/24, recorded a Staff In-Service. If you suspect any form of elder abuse, it is your duty to report it promptly. All suspected abuse and mistreatment of residents should be reported to the Abuse Coordinator immediately at, (phone number was recorded). There are no exceptions to this.</p> <p>Record review of R6's medical record revealed he was admitted to the facility on [DATE] with diagnoses that included, but were not limited to; gastro esophageal reflux disease, ulcerative colitis, respiratory failure, and alzheimer's disease.</p> <p>Review of R6's quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 10/18/24 revealed his Brief Interview of Mental Status (BIMs) score was 10, indicating moderately impaired cognition.</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>On 10/22/24 at 11:02 AM, R6 was observed in the hallway. He stated, I requested a urinal last night. I rang the bell for help, but she refused. Requested further clarification, so R6 went to his room. He then said, I asked for the urinal. She told me to urinate in my brief. I've never worked with her before, she was new. I told her to get the h*** out of here. She left and never came back. R6 stated this occurred on the night shift. He was able to describe her. R6 stated, I put my light on again, and waited and someone else came into my room. I asked for the urinal and they did get it. I did not tell the nurses, but I told that person about it. He was a male.</p> <p>On 10/22/24 at 11:15 AM, an interview with Certified Nurse Assistant (CNA)1 revealed, R6 told me about the CNA. She refused to give him the urinal last night. I reported it to the Registered Nurse Unit Manager (RN/UM), my nurse assistant manager, and Licensed Practical Nurse (LPN)1, his primary nurse. That was about 8:30 AM, he reported that to me.</p> <p>On 10/22/24 at 11:35 AM, an interview with LPN1 revealed, R6 said that he asked for his urinal and the lady would not give it to him. He said it was sometime last night, a new CNA whom he had not seen before. He likes to hang it on the bedrails, at night he likes it closer to reach it. During the day, he likes it kept in the bathroom. He is independent with it for the most part. We will help him use it when we are in there with him. I have not told my RN/UM or Director of Nurses (DON) yet, but I will tell them.</p> <p>On 10/22/24 at 11:37 AM, an interview with the RN/UM revealed, It was just reported to me that a CNA refused to give him his urinal last night. I'm getting ready to find out about it now.</p> <p>On 10/22/24 at 11:53 AM, an interview with CNA2 revealed, I am the scheduler and a med tech as well and work on the Assisted Living (AL) side. CNA1 did tell me about the urinal, about 30-40 minutes ago. I was in AL this am giving medicine.</p> <p>On 10/22/24 at 11:58 AM, an interview with LPN1 revealed, I told the DON and the UM found out at the same time, after I spoke to you. R6 told me himself about 9:30 AM. CNA1 never told me about it, until after the fact, I had already found out. We have an abuse coordinator number we call immediately. If the DON or UM was not here, we would call the abuse hotline immediately. The UM should have told somebody when he first found out. We just had an in-service on abuse about 2 weeks ago. Different scenarios, the different kinds of abuse. That was for all staff.</p> <p>On 10/22/24 at 12:29 PM, an interview with the Administrator revealed, If a staff member finds out about a reportable, they are expected to contact the Abuse Coordinator within 5 minutes. If it was an allegation of abuse, it should have been reported. Based on what R6 reported and what the staff told us, it is more of a customer service situation.</p> <p>On 10/22/24 at 12:38 PM, an interview with the DON revealed, I am conducting an investigation on R6. She stated the staff have 5 minutes after they hear or learn of an allegation to report any allegation to me. They are educated on this.</p> <p>(continued on next page)</p>		

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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>On 10/22/24 at 12:48 PM, an interview with CNA3 revealed, I work as needed, (PRN), about once a month. I was R6's CNA last night. I had not ever worked with him before. R6 rang the call bell. He said he needed to be changed. He did not ask for a urinal. When I grabbed his brief, he went off on me and told me to get the h*** out of his room. Another CNA went in and answered the call light. It was 5 minutes later. I could hear him yelling from the room. He did ask for a urinal from the CNA. The CNA told me afterward, he uses a urinal. No-one gave me a report on him. I could have asked a nurse, but I didn't. He had pull ups and regular briefs. I didn't get him a urinal, I didn't pay attention. I didn't know he used one. I did not report this to the nurse. This was between 12-1:30 am. I spoke with my DON earlier, she called me. I'm not scheduled to work until I let them know I'd like to pick up a shift.</p> <p>On 10/22/24 at 4:26 PM, an interview with the DON and the Administrator revealed, the DON stated the investigation was still on-going. I became aware at 11:57 AM. Based on the statements so far, based on what the majority of the statements by staff were they didn't feel it was enough to report. Any suspicion of abuse is reported to me within 5 minutes. They stated, We did report this to Department of Health and Environmental Control (DHEC) as an allegation of neglect.</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>48835</p> <p>Based on observation, and staff interview, the facility failed to ensure discontinued medications were removed from the treatment cart with pharmacy labels that were blacked out in marker. Additionally, open treatment items were not dated for 1 medication room and 1 of 2 treatment carts reviewed for medication storage.</p> <p>Findings include:</p> <p>Multiple requests were made at the time of the survey for a policy on medication storage, none was provided.</p> <p>On 10/22/24 at 08:09 AM, an observation of the Medication Room revealed SPS Suspension Kaexalate 60 milliliters (ml) was not open, but was in the cabinet. Most of the label has been removed and a partial piece on the left side remains.</p> <p>An observation of the treatment cart revealed a Skin Prep Pump with a label that was blacked out with ink, but a resident's name remained visible with lot #86740. Additionally, an open bottle of normal saline, 100 ml Lot #230035050, undated with an open date. A box of Tubi Grip with a resident's name blacked out on the pharmacy label, but with a marker that was written House stock.</p> <p>On 10/22/2024 at 8:35 AM, an interview with Registered Nurse Unit Manager (RN/UM) revealed, The labels should be intact. He stated, I don't know why the items remain in the cart of residents whom discharged and said he wasn't sure why house stock was written on it. All open items should be dated. The Director of Nurses (DON) came into the medication room. The DON agreed that the labels should have been intact and confirmed the resident names on the labels were blacked out with ink and continued to remain on the cart. She stated, They should have been sent back to pharmacy or given to the resident upon discharge.</p>