

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  425419	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/11/2024
NAME OF PROVIDER OR SUPPLIER  Veteran Village		STREET ADDRESS, CITY, STATE, ZIP CODE  1200 E National Cemetery Rd Florence, SC 29506	

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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42070</b></p> <p>Based on interviews, record review, and review of facility policy, facility staff failed to implement the corrective actions as indicated in the facility's investigative report for an allegation of abuse. This deficient practice affected one (1) of two (2) residents reviewed for abuse from a total of 19 sampled residents. (Resident (R)48).</p> <p>Findings include:</p> <p>Cross Reference to F607 - Develop/Implement Abuse/Neglect Policies</p> <p>Review of the undated facility policy titled Abuse Investigation documented, An immediate investigation is warranted when abuse is suspected or reported, and a thorough investigative result will be documented. Step 11 of the policy directed staff to analyze the occurrence and implement changes to prevent further occurrences.</p> <p>Review of R48's medical record revealed an initial admitted [DATE]. R48's primary medical diagnosis was Congestive Heart Failure. Review of the most recent Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/16/24, revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating R48's cognition was intact. The assessment identified the resident as having functional limitation in range of motion to one upper extremity and both lower extremities. R48 was also dependent on staff for bed mobility.</p> <p>Review of the facility's Investigative Report revealed that an allegation of physical abuse was voiced by R48 to facility staff on 09/09/24 at 4:45 PM. The report indicated that R48 reported to the Director of Nursing (DON) and the Registered Nurse (RN) Supervisor that Licensed Practical Nurse (LPN)4 entered his/her room and pushed him/her on the shoulder. R48 also stated that no one had been in his/her room for several hours during the shift and that his/her call light was not working. The report narrative also indicated that R48 stated this alleged incident occurred on 09/08/24.</p> <p>Review of a Summary Report of Facility Investigation narrative within the Investigative Report indicated that LPN4 would be reeducated on the facility's abuse policy and would be moved to another unit upon return from suspension.</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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/10/24 at 3:25 PM, R48 explained that the alleged incident transpired after a Certified Nursing Assistant (CNA) assisted him/her to bed and forgot to place his/her call light within reach. R48 explained that he/she realized the call light was not within reach and began to yell out for the nurse so that he/she could have his/her call light placed within reach. R48 went on to explain that the nurse (LPN4) responded to his/her room and immediately began to lecture him/her for about five minutes about other, more important people that he/she was taking care of, and that R48 would need to wait for help. R48 stated that after LPN4 finished the lecture LPN4 pushed R48 on his/her right shoulder and then left the room. R48 added that [LPN4] had a good story. [LPN4] tried to say that [he/she] was moving me around in the bed but I was already in the bed. When asked to clarify how he/she was laying in the bed when LPN4 entered the room, the resident confirmed that he/she was lying in the bed as he/she would normally with his/her head at the head of the bed and his/her feet at the foot of the bed. R48 also added that he/she had been cared for by LPN4 a couple of times since this happened but not in the last two weeks or so. R48 described the overall encounter as intimidating and explained that he/she felt LPN4 should not have been working with older people.</p> <p>Review of R48's Medication Administration Record for September 2024 revealed documentation that LPN4 administered medications and provided nursing care to R48 after returning to work from suspension on 09/11/24 and 09/12/24.</p> <p>During an interview on 10/10/24 at 4:38 PM, the Director of Nursing (DON) confirmed that LPN4 returned to work on 09/11/24, and that LPN4 did provide nursing care to R48 on 09/11/24 and 09/12/24, despite the facility's corrective actions as alleged in the Summary Report of Facility Investigation to relocate LPN4 to a different nursing unit. According to the DON, he/she received notification to move LPN4 late.</p> <p>During an interview on 10/11/24 at 11:33 AM, the Administrator confirmed that he/she and the DON were responsible for the facility's investigation and that, as a result of the investigation, it was determined that LPN4 would be relocated to a different nursing unit upon return to work. The Administrator acknowledged that LPN4 returned to work on 09/11/24 and that he/she provided care for R48 on 09/11/24 and 09/12/24. The Administrator went on to explain that notification to the DON to relocate LPN4 was delayed.</p>		