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	02/14/2019

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 39206 Based on observation, record review, and interview the facility failed to ensure residents remained free from abuse. Resident #73, who required 1:1 supervision due to aggressive/agitated behaviors, grabbed Resident #2 by the wrists causing a skin tear and bruises to both of his/her wrists. Resident #3 who was on 1:1 supervision due to wondering/elopement grabbed Resident #38's cane and struck Resident #38 on the head. Two of 6 residents reviewed for abuse. The findings included: Review of the facility 5-day investigation report dated 12/17/18 revealed that on 12/12/18 Resident #2 was having an aggressive outburst towards staff when Resident #73 stood up to intervene. Resident #73 made contact with Resident #2 arms. Care plan followed. Observed with skin tear to right write and Skin tear to left wrist. The facility admitted Resident #73 on 4/3/18 with diagnoses including but not limited to Alcohol Use, Bipolar Disorder, Alzheimer's disease, and Depression. During an observation on 2/11/19 at approximately 11:32 AM Resident #73 was observed in his/her wheelchair in his/her room accompanied by a sitter and wearing a wonder guard on his/her right foot. During an interview on 2/11/19 at approximately 11:32 AM Resident #73 was asked by the surveyor if s/he has had an issue with another resident s/he stated no. Resident #73 was asked by the surveyor if s/he has had any issue with Resident #2 s/he stated no. During an observation on 2/11/19 at approximately 10:55 AM Resident #2 was observed walking throughout the facility's hallways by him/herself. Resident #2 had a small skin tear (healing) on his/her left wrist and small bruises to his/her forearms. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #73's nurse's notes on 2/12/19 at 2:29 PM revealed a nurse's note dated 10/1/18 [Resident #73] was belligerent in the hallway; screaming, yelling, and cursing up and down the hall. Aggressive to other residents and staff. Nurse's note dated 12/6/18, during the second shift, [Resident #73] has been aggressive towards others, when awake, called the sheriff department and had to be redirected from other female residents. Nurse's note dated 12/12/18 at 6:12 AM [Resident #73] continued on 1:1 supervision and was up in [his/her] wheelchair rolling around the unit. Nurse's note dated 12/12/18 at 2:07 PM [Resident #73] was noted yelling at another resident, jumped up out of his/her wheelchair shouting aloud. Review of Resident #73's Social Service notes revealed a Social Service note dated 12/12/18 at 1:07 PM [Resident #73] was seen by psychosocial support following concerns related to a resident to a resident altercation and that the resident was unable to recall the event and showed no signs of distress or injury. Review of Resident #73's care plan revealed that Resident #73 was care planned for 1:1 supervision r/t (related to) risk for adverse/unprovoked behavior towards other residents date initiated 6/7/18. During an interview with the LPN #1 (witness) on 2/12/19 at 2:54 PM LPN #1 that the incident happened on12/12/18 at around lunchtime (11:30 AM to 12:00 PM). LPN #1 stated that s/he was sitting at the first table facing the door and window in the dining room. S/he heard noises and saw the commotion as Resident #73 approached Resident #2, who was walking down the hall, cursing at him/her and making motions as if s/he was going to fight Resident #2. LPN #1 stated that Resident #73 tried to get up from his/her wheelchair but was not able to sustain his/her body and leaned to the side of the wall and held on to the handrail. The nursing assistant put Resident # 73 back to his/her wheelchair. LPN #1 stated that Resident #2 also made motions as if s/he was going to fight back Resident #73. LPN #1 stated that s/he believed that there was no physical contact between the residents and cannot remember if anyone (staff) grabbed Resident #2. During an interview with Certified Nursing Assistant (CNA) #1(not interviewed by the facility) on 2/13/19 at approximately 9:00 AM CNA #1 stated that s/he was in Resident #3's room (resident not involved) when s/he heard/saw Resident #2 eliminating (urinating) on the floor of Resident #3's room. CNA #1 stated that s/he told Resident #2 not to do that, then the resident fixed him/herself up and started walking down the hallway. CNA #1 stated that s/he looked down the hall to see if the resident was going to enter another resident's room, but saw was Resident #2 coming back charging at him/her. CNA #1 stated that s/he screamed for help and walked backward, trying to get out of Resident #2's way, and walked into the back door making a loud sound. At that time, Resident #2 turned around and started walking down the hall as if nothing has happened. CNA #1 stated that Resident #2 walked back and for the hallway a couple of times, and at one point, when Resident #73 was coming out of the dining room, they met. Resident #73 stood up from his/her wheelchair and grabbed Resident #2 by both wrists. Resident #2 pulled his/her arm back and continued walking his/her usual way. Resident #73 than, lost his/her balance but held on to the handrail, the staff assisted him/her back to his/her wheelchair. Resident #2 ended up with skin tear and bruises on his wrists. During an interview with CNA # 2 on 2/13/19 at 9:14 AM CNA #2 stated s/he did not see the whole incident, however, s/he saw Resident #73 trying to stand up and acting as if s/he was going to fight Resident #2. S/he said that Resident #73 was mad. S/he added that Resident #73 gets upset from time to time and can be physically and verbally aggressive. (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview with CNA #3 on 2/13/19 at 9:26 AM CNA #3 stated that s/he saw Resident #73 propelling his/her wheelchair, with his/her feet, out of the dining room very fast. S/he did not expect Resident #73 to confront Resident #2 but as Resident #2 walked down the hallway and as Resident #73 was coming out to the dining room s/he stood up but could not tell if Resident #73 grabbed Resident #2, but saw Resident #2 pulled his/her arms back and Resident #73 lost his/her balance. During an interview with the Administrator and the Director of Nursing (DON) on 2/13/19 at 4:56 PM it was confirmed that CNA #1 who witness the resident to resident altercation was not interviewed. Review of the facility 5-day investigation report dated 11/2/18 revealed that on 10/28/18 Resident #38 was eating dinner in the dining hall when staff saw Resident #3 grab Resident #38's cane and make contact with Resident #38. The facility admitted Resident #3 on 4/3/18 with diagnoses including but not limited to Lack of Coordination, Vascular Dementia with Behavioral Disturbance, Violent Behavior, Anxiety, Cognitive Communication Deficit, Depression, and Muscle Weakness. Review of Resident #3's care plan revealed that Resident #3 was care planned to be on 1:1 related to wandering/elopement, intervention dated 7/4/18. Review of Resident #38's Progress notes review on 2/12/19 at approximately 4:00 PM revealed that on 10/28/18 the certified nursing assistant report to a registered nurse that another resident (Resident #3) hit [Resident #38] in the top of [his/her] forehead and back of [his/her] head with resident's cane causing [him/her] a hematoma to the front of [his/her] forehead. During an interview on 2/14/19 at 2:49 PM CNA #5 stated that Resident #38 has always threatened Resident #3 with his/her cane but s/he never acted on and that Resident #3 has never before responded to Resident #38's threats. CNA #5 stated that s/he was the 1:1 sitter for Resident #3 on the date of the incident but since no one was bringing out Resident #3's meal tray CNA #5 asked CNA #6 to keep an eye on Resident #3 while s/he went to go get Resident #3's meal tray. CNA #5 sated that when s/he turned around s/he saw Resident #3 holding Resident #38's cane and when Resident #38 tried to get his/her cane back s/he saw Resident #3 strike Resident #38 on his/her forehead. During an interview with Registered Nurse #3 on 2/14/19 at 3:58 PM, RN #3 stated that s/he only knows what the nursing assistant told her/him. Resident #3 hit Resident #38 on the forehead with a cane. RN #3 stated that during his/her assessment of Resident #38 s/he saw some swelling on his/her forehead but no severe trauma.

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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 0607 Level of Harm - Actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 39206 Based on observation, record review, including the facility's abuse policy, and interview the facility failed to implement the components of its abuse policy that prohibit and prevent abuse for two of 6 residents reviewed for abuse and for conducting a thorough investigation for one of 6 residents reviewed for abuse. Resident #73, who required 1:1 supervision due to aggressive/agitated behaviors, grabbed Resident #2 by the wrists causing a skin tear and bruises to both of his/her wrists. CNA #1 was not interviewed as a witness for the incident involving Resident #73 and Resident #2. Resident #3 who was on 1:1 supervision due to wondering/elopement grabbed Resident #38's cane and struck Resident #38 on the head. The findings included: Review of the facility 5-day investigation report dated 12/17/18 revealed that on 12/12/18 Resident #2 was having an aggressive outburst towards staff when Resident #73 stood up to intervene. Resident #73 made contact with Resident #2 arms. Care plan followed. Observed with skin tear to right write and Skin tear to left wrist. The facility admitted Resident #73 on 4/3/18 with diagnoses including but not limited to Alcohol Use, Bipolar Disorder, Alzheimer's disease, and Depression. Review of Resident #73's nurse's notes on 2/12/19 at 2:29 PM revealed a nurse's note dated 10/1/18 [Resident #73] was belligerent in the hallway; screaming, yelling, and cursing up and down the hall. Aggressive to other residents and staff. Nurse's note dated 12/6/18, during the second shift, [Resident #73] has been aggressive towards others, when awake, called the sheriff department and had to be redirected from other female residents. Nurse's note dated 12/12/18 at 6:12 AM [Resident #73] continued on 1:1 supervision and was up in [his/her] wheelchair rolling around the unit. Nurse's note dated 12/12/18 at 2:07 PM [Resident #73] was noted yelling at another resident, jumped up out of his/her wheelchair shouting aloud. Review of Resident #73's care plan revealed that Resident #73 was care planned for 1:1 supervision r/t (related to) risk for adverse/unprovoked behavior towards other residents date initiated 6/7/18. During an interview with the LPN #1 (witness) on 2/12/19 at 2:54 PM LPN #1 that the incident happened on12/12/18 at around lunchtime (11:30 AM to 12:00 PM). LPN #1 stated that s/he was sitting at the first table facing the door and window in the dining room. S/he heard noises and saw the commotion as Resident #73 approached Resident #2, who was walking down the hall, cursing at him/her and making motions as if s/he was going to fight Resident #2. LPN #1 stated that Resident #73 tried to get up from his/her wheelchair but was not able to sustain his/her body and leaned to the side of the wall and held on to the handrail. The nursing assistant put Resident # 73 back to his/her wheelchair. LPN #1 stated that Resident #2 also made motions as if s/he was going to fight back Resident #73. LPN #1 stated that s/he believed that there was no physical contact between the residents and cannot remember if anyone (staff) grabbed Resident #2. (continued on next page)

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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 0607 Level of Harm - Actual harm Residents Affected - Few	During an interview with Certified Nursing Assistant (CNA) #1(not interviewed by the facility) on 2/13/19 at approximately 9:00 AM CNA #1 stated that s/he was in Resident #3's room (resident not involved) when s/he heard/saw Resident #2 eliminating (urinating) on the floor of Resident #3's room. CNA #1 stated that s/he told Resident #2 not to do that, then the resident fixed him/herself up and started walking down the hallway. CNA #1 stated that s/he looked down the hall to see if the resident was going to enter another resident's room, but saw was Resident #2 coming back charging at him/her. CNA #1 stated that s/he screamed for help and walked backward, trying to get out of Resident #2's way, and walked into the back door making a loud sound. At that time, Resident #2 turned around and started walking down the hall as if nothing has happened. CNA #1 stated that Resident #2 walked back and for the hallway a couple of times, and at one point, when Resident #73 was coming out of the dining room, they met. Resident #73 stood up from his/her wheelchair and grabbed Resident #2 by both wrists. Resident #2 pulled his/her arm back and continued walking his/her usual way. Resident #73 than, lost his/her balance but held on to the handrail, the staff assisted him/her back to his/her wheelchair. Resident #2 ended up with skin tear and bruises on his wrists. During an interview with CNA # 2 on 2/13/19 at 9:14 AM CNA #2 stated s/he did not see the whole incident, however, s/he saw Resident #73 trying to stand up and acting as if s/he was going to fight Resident #2. S/he said that Resident #73 was mad. S/he added that Resident #73 gets upset from time to time and can be physically and verbally aggressive. During an interview with CNA #3 on 2/13/19 at 9:26 AM CNA #3 stated that s/he saw Resident #73 propelling his/her wheelchair, with his/her feet, out of the dining room very fast. S/he did not expect Resident #73 to confront Resident #2 but as Resident #2 walked down the hallway and as Resident #73 was coming out to the dining room s/he stood up but could not tell if Resident #73 grabbed Resident #2, but saw Resident #2 pulled his/her arms back and Resident #73 lost his/her balance. During an interview with the Administrator and the Director of Nursing (DON) on 2/13/19 at 4:56 PM it was confirmed that CNA #1 who witness the resident to resident altercation was not interviewed. Review of the facility policy titled Abuse Investigation and Reporting Revealed all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management . Under Role of the Investigator revealed Interview any witnesses to the incident Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident Review of the facility 5-day investigation report dated 11/2/18 revealed that on 10/28/18 Resident #38 was eating dinner in the dining hall when staff saw Resident #3 grab Resident #38's cane and make contact with Resident #38. The facility admitted Resident #3 on 4/3/18 with diagnoses including but not limited to Lack of Coordination, Vascular Dementia with Behavioral Disturbance, Violent Behavior, Anxiety, Cognitive Communication Deficit, Depression, and Muscle Weakness. Review of Resident #3's care plan revealed that Resident #3 was care planned to be on 1:1 related to wandering/elopement, intervention dated 7/4/18. (continued on next page)

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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 0607 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #38's Progress notes review on 2/12/19 at approximately 4:00 PM revealed that on 10/28/18 the certified nursing assistant report to a registered nurse that another resident (Resident #3) hit [Resident #38] in the top of [his/her] forehead and back of [his/her] head with resident's cane causing [him/her] a hematoma to the front of [his/her] forehead. During an interview on 2/14/19 at 2:49 PM CNA #5 stated that Resident #38 has always threatened Resident #3 with his/her cane but s/he never acted on and that Resident #3 has never before responded to Resident #38's threats. CNA #5 stated that s/he was the 1:1 sitter for Resident #3 on the date of the incident but since no one was bringing out Resident #3's meal tray CNA #5 asked CNA #6 to keep an eye on Resident #3 while s/he went to go get Resident #3's meal tray. CNA #5 sated that when s/he turned around s/he saw Resident #3 holding Resident #38's cane and when Resident #38 tried to get his/her cane back s/he saw Resident #3 strike Resident #38 on his/her forehead. During an interview with Registered Nurse #3 on 2/14/19 at 3:58 PM, RN #3 stated that s/he only knows what the nursing assistant told her/him. Resident #3 hit Resident #38 on the forehead with a cane. RN #3 stated that during his/her assessment of Resident #38 s/he saw some swelling on his/her forehead but no severe trauma. Review of the facility policy titled Abuse and Neglect - Clinical Protocol revealed under Treatment/Management The facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect.

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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 0610 Level of Harm - Actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 39206 Based on observation, record review, and interview the facility failed to thoroughly investigate an allegation of resident to resident abuse for one of six resident review for abuse. Resident #73 who required supervision due to aggressive/agitated behaviors, grabbed Resident #2 by the wrists causing a skin tear and bruises to both of his/her wrists. The facility did not interview the certified nursing assistant that witnessed the altercation. The findings included: The facility admitted Resident #73 on 4/3/18 with diagnoses including but not limited to Alcohol Use, Bipolar Disorder, Alzheimer's disease, and Depression. Review of the facility 5-day investigation report dated 12/17/18 revealed that on 12/12/18 Resident #2 was having an aggressive outburst towards staff when Resident #73 stood up to intervene. Resident #73 made contact with Resident #2 arms. Care plan followed. Observed with skin tear to right write and Skin tear to left wrist. During an observation on 2/11/19 at 11:32 AM Resident #73 was observed in his/her wheelchair in his/her room accompanied by a sitter and wearing a wonder guard on his/her right foot. Review of the facility 5-day investigation revealed that the social worker and Licensed Practical Nurse (LPN) #1 witness the altercation. However, during an interview with the Social Worker (witness) on 2/12/19 at 2:34 PM s/he stated that s/he was at the nurse's station faxing some documents and did not see what had happened between the residents. The Social Worker stated that s/he heard the commotion and heard the staff (CNA) screaming. During an interview with the LPN #1 (witness) on 2/12/19 at 2:54 PM LPN #1 that the incident happened on12/12/18 at around lunchtime (11:30 AM to 12:00 PM). LPN #1 stated that s/he was sitting at the first table facing the door and window in the dining room. S/he heard noises and saw the commotion as Resident #73 approached Resident #2, who was walking down the hall, cursing at him/her and making motions as if s/he was going to fight Resident #2. LPN #1 stated that Resident #73 tried to get up from his/her wheelchair but was not able to sustain his/her body and leaned to the side of the wall and held on to the handrail. The nursing assistant put Resident # 73 back to his/her wheelchair. LPN #1 stated that Resident #2 also made motions as if s/he was going to fight back Resident #73. LPN #1 stated that s/he believed that there was no physical contact between the residents and cannot remember if anyone (staff) grabbed Resident #2. (continued on next page)

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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 0610 Level of Harm - Actual harm Residents Affected - Few	During an interview with Certified Nursing Assistant (CNA) #1(not interviewed by the facility) on 2/13/19 at approximately 9:00 AM CNA #1 stated that s/he was in Resident #3's room (resident not involved) when s/he heard/saw Resident #2 eliminating (urinating) on the floor of Resident #3's room. CNA #1 stated that s/he told Resident #2 not to do that, then the resident fixed him/herself up and started walking down the hallway. CNA #1 stated that s/he looked down the hall to see if the resident was going to enter another resident's room, but saw was Resident #2 coming back charging at him/her. CNA #1 stated that s/he screamed for help and walked backward, trying to get out of Resident #2's way, and walked into the back door making a loud sound. At that time, Resident #2 turned around and started walking down the hall as if nothing has happened. CNA #1 stated that Resident #2 walked back and for the hallway a couple of times, and at one point, when Resident #73 was coming out of the dining room, they met. Resident #73 stood up from his/her wheelchair and grabbed Resident #2 by both wrists. Resident #2 pulled his/her arm back and continued walking his/her usual way. Resident #73 than, lost his/her balance but held on to the handrail, the staff assisted him/her back to his/her wheelchair. Resident #2 ended up with skin tear and bruises on his wrists. During an interview with CNA # 2 on 2/13/19 at 9:14 AM CNA #2 stated s/he did not see the whole incident, however, s/he saw Resident #73 trying to stand up and acting as if s/he was going to fight Resident #2. S/he said that Resident #73 was mad. S/he added that Resident #73 gets upset from time to time and can be physically and verbally aggressive. During an interview with CNA #3 on 2/13/19 at 9:26 AM CNA #3 stated that s/he saw Resident #73 propelling his/her wheelchair, with his/her feet, out of the dining room very fast. S/he did not expect Resident #73 to confront Resident #2 but as Resident #2 walked down the hallway and as Resident #73 was coming out to the dining room s/he stood up but could not tell if Resident #73 grabbed Resident #2, but saw Resident #2 pulled his/her arms back and Resident #73 lost his/her balance. During an interview with the Administrator and the Director of Nursing (DON) on 2/13/19 at 4:56 PM it was confirmed that CNA #1 who witness the resident to resident altercation was not interviewed.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 41300 Based on record review and interview, the facility failed to include the amounts to be paid for reserve bed payment or the private pay daily rate on the bed hold policy sent to residents/resident representatives upon transfer for 2 of 3 sampled residents reviewed for hospitalization s. (Residents #47 and #98) The findings included: The facility admitted Resident #98 with diagnoses including, but not limited to, End Stage Renal Disease. Record Review of Resident #98's medical record on 02/13/19 at approximately 9:30 AM revealed Resident #98 was sent to the hospital on 11/27/18. The Nurses Note stated, Resident states [s/he] does not feel well, that [s/he] is dizzy, and would like be sent to the hospital. Record Review of Resident #98's medical record on 02/13/19 at approximately 9:30 revealed that on 01/02/19, the Communication with Family Note stated that the resident was sent to the emergency room for altered mental status and elevated blood pressure. Record Review of Resident #98's medical record on 02/13/19 at approximately 9:30 AM revealed that on 01/17/19, the Hospital Summary Note stated, Nurses Assistant notified this nurse that resident had large stool burgundy in color, odd and appeared to look like blood. The resident stated s/he had had a colonoscopy in the hospital. The physician was called, notified of change in status, and orders were obtained to transfer to the emergency room for evaluation. Review of the Bed Hold Policy on 02/13/19 at 1:00 PM revealed that the policy sent to the resident/representative did not include the amounts to be paid for reserve bed payment or the private pay daily rate. The facility admitted Resident #47 with diagnoses including, but not limited to, Depressive Disorder, Osteoporosis, Anxiety, Retinopathy, Hypertension, and Asthma. Record Review of Resident #47's medical record on 02/14/19 at 08:50 AM revealed that Resident #47 was sent to the hospital on 11/18/18. The General Note from the eRecord stated, Resident complained of headache at 15:15. Tylenol was given. Staff told this nurse at 17:45 that resident did not eat much supper, this nurse went to check on resident at 18:10. Resident lethargic, sternum rub was performed. This nurse was still unable to arouse resident. Vitals checked blood pressure 100/62. Temperature 98.0 Respiration 17, Oxygen saturation 92%. Nurse Practitioner and Responsible Party notified. Emergency Medical Service (EMS) called at 18:25. Resident left facility via EMS at 18:45. Review of the Bed Hold Policy on 02/13/19 at 1:00 PM revealed that the policy sent to the resident/representative did not include the amounts to be paid for reserve bed payment or the private pay daily rate. (continued on next page)

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	425102	A. Building B. Wing	02/14/2019

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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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/13/19 at 1:00 PM, Medical Records confirmed the Bed Hold Policy did not include the payment amounts.

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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. 39206 Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan to address Resident #2's behavior of urinating and defecating in resident rooms and throughout the facility hallways. One of 4 residents review for behavior. The findings included: The facility admitted Resident #2 on 8/01/2018 with diagnoses including but not limited to Dementia with Behavioral Disturbances, Cognitive Communication Deficit, Depression, Recurrent Mild Weakness, Age-related Physical Disability, Altered Mental Status, Wondering, Psychosis ad violent behaviors. During an interview with the certified nursing assistant (CNA) #1 on 2/13/19 at approximately 9:00 AM. CNA #1 stated that Resident #2 defecates and urinates in other residents' room (on the floor), throughout the facility's hallways, or in any other place where s/he feels s/he would not be seen. During an interview with CNA #2 on 2/13/19 at 9:14 AM. CNA #2 stated Resident #2 refuses care including shower and has a bowel movements and urinates anywhere in the facility. During an interview with CNA #3 on 2/13/19 at 9:26 AM. CNA #3 stated that Resident #2 walks around the hallways non-stop. Resident #2 goes into the resident rooms and defecates/urinates on the floor but usually does not bother any person/resident. On 2/13/19 at 11:03 AM during the residents' council meeting more than one resident voiced concerns about the resident (Resident #2) who walks all around the building, goes into their rooms and uses the floor as a bathroom. Review of Resident #2's Care Plan on 2/14/19 at approximately 9:30 AM revealed that the facility did not develop/implement a plan of care to address and prevent the resident's behavior of defecating and urinating in inappropriate places. During an interview with the Director of Nursing and the Administrator, the Administrator stated that s/he did not know that Resident #2 was urinating and defecating on the floor of hallways and in resident rooms.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. 41300 Based on record review and interview, the facility failed to provide appropriate care and services for one of one resident reviewed for dialysis. Staff failed to consistently monitor Resident #98's dialysis access site for bleeding, thrill and bruit. The findings included: The facility admitted Resident #98 with diagnoses including, but not limited to, End Stage Renal Disease. Review of Resident #98's treatment sheets on 02/12/19 at approximately 4:00 PM revealed that on 12/11/18 night shift, 12/25/18 day and evening shift, 01/22/19 night shift, 02/02/19 day shift, 02/03/19 day shift, and 02/11/19 night shift were missing initials, indicating that Physician's Orders were not followed for: Monitor right arm for signs and symptoms of bleeding every shift. If bleeding noted apply pressure and call 911. Review of Resident #98's treatment sheets on 02/12/19 at approximately 4:00 PM revealed that 12/11/18 night shift, 12/25/18 day and evening shift, 01/22/19 night shift, 02/02/19 day shift, 02/03/19 day shift, and 02/11/19 day and night shift were missing initials, indicating Physician's Orders were not followed for: Right arm fistula, auscultate bruits and palpate thrills every shift. During an interview on 02-13-19 at 11:50 AM, the Director of Nursing verified that the treatments had not been initialed to indicate the order had been followed.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 39206 Based on record review and interview the facility failed to administer Ativan, psychotropic medication, as prescribed and did not document medication administration consistently. Resident #73's Ativan prescribed for seizure was given for behaviors. The findings included: The facility admitted Resident #73 on 4/3/18 with diagnoses including but not limited to Epilepsy, Alcohol Use, Bipolar Disorder, Alzheimer's disease, Depression, Review of Resident #73's Physician's order on 2/12/19 at 2:06 PM revealed that on 8/29/18 the doctor prescribed 1mg of Ativan (psychotropic medication) to be given intramuscularly (IM) every six hours as needed for Seizure activity for 60 days. Review of Resident #73's Progress Note dated 10/13/18 at 8:00 AM revealed resident became violently agitated with staff this am, refusing to be redirected, kicking at staff, putting hands back as to punch staff. This nurse administered 1 mg IM Ativan in left arm . Review of Resident #73's Progress Note dated 10/13/18 at 9:04 AM revealed Ativan tablet 1 MG Inject 1 mg intramuscularly every 6 hours as needed for seizure activity for 60 days threating and swinging at staff Review of Resident #73's Progress Note dated 1/1/19 at 1:57 AM revealed at 1230 am resident started yelling out at staff and being aggressive with sitter. Staff approached resident and resident stated [s/he] was going to leave here. Staff tried to redirect resident without any success. Resident then started cursing out loud. Nurse administered PRN Ativan IM in resident right arm . According to the nurse's notes, the resident received Ativan PRN on 1/1/19 for behavior; however, the facility did not provide a physician's order, and the resident's Medication Administration Record (MAR) does not reflect that s/he received the Ativan on 1/1/19. Review of Resident #73's Medication Administration Record (MAR) revealed an order dated 1/3/19 Ativan Solution 2 MG/ML (LORazepam) Inject 0.5 ml intermuscular every 6 hours as needed for seizures. Review of Resident #73's Progress Note dated 2/12/18 at 3:38 AM revealed Ativan Solution 2 MG/ML Inject 0.5 ml intramuscularly every 6 hours as needed for seizures patient agitated woke up cursing and attempting to awaken other patients. During an interview with the Physician and the Director of Nursing (DON) on 2/14/19 at approximately 11:00 AM the physician stated that the resident's seizures are successfully controlled with the scheduled Ativan and that the PRN Ativan is for his/her aggressive behaviors. The Physician and the DON believed that the Ativan PRN for Seizure might have carried over from an old order, but they were not able to provide documentation to support their claim.

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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** 39206 Based on observation and interview the facility failed to ensure that the dietary staff-maintained walk-in-cooler and walk-in-freezer free from expired, spoiled and freezer burned foods. The facility also failed to ensure that the ice-maker and walk-in-cooler were kept clean for one of one kitchen review/observed. The findings included: During an observation of the kitchen with the Food and Nutrition Director on [DATE] at 9:52 AM the walk-in-cooler contained a 3lbs bag of deli ham expired, two large spoiled onions, and two large spoiled cucumbers. The walk-in cooler's floor had trash/food debris and dark, unclean spots on it. The walk-in-freezer contained an opened box with several pieces of fish filet that appeared freezer burned. The door of the ice-machine, located in the dining room, was soiled. The filter and mat in front of the ice-machine located in the dining room was dirty. The Food and Nutrition Director acknowledged the above findings and removed the food items immediately.