STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425004	A. Building B. Wing	12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brushy Creek Post Acute	101 Cottage Creek Circle Greer, SC 29650

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility policy, record review, and interviews, the facility neglected to provide services and care to Resident (R)1. Specifically, the facility failed to monitor and provide medications as ordered by the physician, resulting in R1 suffering a hypertensive crisis.On [DATE] at 11:30 AM, the State Agency (SA) determined that the facility's non-compliance with one or more federal health, safety, and/or quality regulations could cause psychosocial harm.On [DATE] at 1:15 PM, the survey team provided the Administrator with a copy of the Centers for Medicare and Medicaid Services (CMS) Immediate Jeopardy (IJ) Template, informing the facility IJ existed as of [DATE]. The IJ was related to 42 CFR 483.12 - Freedom from Abuse, Neglect, and Exploitation.On [DATE], the facility provided an acceptable IJ Removal Plan. On [DATE], the survey team validated the facility's corrective actions and determined the facility put forth due diligence in addressing the noncompliance. An extended survey was conducted in conjunction with the Complaint Survey for non-compliance at F600 constituting substandard quality of care.Findings include:Review of the facility's procedure copyrighted 2001, titled Blood Pressure, Measuring, stated, The purpose of this procedure is to measure the pressure exerted by the circulating volume of blood on the walls of the arteries, veins, and chambers of the heart. General Guidelines . 4. Hypertension is usually defined as blood pressure over 140/90 mm/hg (although the elderly often have persistent systolic readings from 140 to 160 mm/Hg. 5. Hypertension should be reported to the physician. If a resident has a hypertensive reading, staff should record several readings taken at different times of the day. Staff should note any pertinent medications and/or recent changes of condition when reporting to the physician.Review of R1's Face Sheet revealed R1 was admitted to the facility on [DATE] with diagnoses including, but not limited to, hypertensive crisis, likely acute Intracranial hemorrhage, left PCA occlusion, Dementia with word-finding difficulties, and ambulatory dysfunction.Review of R1's vital signs (VS) revealed on [DATE], at 19:56 [7:56 PM] BP [Blood Pressure] 192/103 HR [Heart rate] 73 Resp 21 O2 sat [Oxygen Saturation] 96% Temp [Temperature] 97.5 F [Fahrenheit].Review of R1's Medication Administration Record (MAR) revealed an order for AmLODIPine Besylate tablet 5 mg [milligrams], Give 1 tablet by mouth every 24 hours as needed for the SPB [Systolic Blood Pressure] greater than 160; start date [DATE] 0645PM, discharge date [DATE] at 0820 AM. Documentation did not reveal that a dose was given on [DATE] following R1's blood pressure reading of 192/103.Review of R1's Care Plan with a start date of [DATE] documented, Medication - Antihypertensive: Resident requires antihypertensive medication related to Hypertension. Further review of the Care Plan revealed the following approach: Observe for side effects of medication (i.e., bradycardia, dizziness, fatigue, bronchospasm, hypotension, edema, nausea, diarrhea, rash, etc.) and notify the physician promptly if observed.Review of R1's 2-hour rounds revealed on [DATE] at 22:45 [11:45 PM] the resident was in the chair. No other documentation noted. On [DATE] at 3:27 AM, R1 was on left side, and back. R1 expired at 03:20 AM.Review of R1's OnSite Healthcare & Wellness report of communication did not reveal a message of when R1's BP was taken.Review of BP machine revealed a sign attached stating vital signs to report temp above 100.4, heart rate (HR) below 50 or above 100, respiration below 14 or above 22, and BP systolic -below 90 or above 190. Diastolic below 40 or above 90.Review of progress notes on [DATE] at 4:13 AM by Registered Nurse (RN)1 revealed The resident was slumped over bathroom sink leaning forward with head over sink and legs were buckled with weight on vanity. No pulse, respiration effort. Do Not Resuscitate (DNR) confirmed. R1 placed in the wheelchair and transferred to bed. No acute findings. Postmortem care assisted with primary [Certified Nursing Assistant] CNA1. Called the resident daughter first on contact and left a voicemail to return a call. Called the son he was on his way to the facility. Primary nurse notified on call NP via live chat number.Review of late entry progress note on [DATE] at 6:37 AM revealed CNA1 found R1 cyanotic, no pulse, no respirations. R1 was warm, cyanotic no palpable [NAME]. RN1 notified. RN1 pronounced R1 at 03:20 AM.During an interview on [DATE] at 12:24 PM, LPN1, stated I was in another cottage. I was called by another CNA. She stated she was at the sink, standing and I think she is dead. When I arrived, I tried to get a pulse. I didn't get anything. I called the supervisor, and the supervisor came over and pronounced to her. I had to get a wheelchair cause she was upright standing. It was three employees who manually lifted her up and placed back in bed. She was a new admission. We got report that she could not get out of bed. She would not stay in bed. She was not evaluated by PT [Physical Therapy]. Depending on the time of the day, PT would come out to do an assessment or the next day. She was found

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility policy, record review, and interviews, the facility failed to ensure that cardiopulmonary resuscitation (CPR) was initiated to Resident (R)1, Specifically, not responding in a timely manner and initiating CPR per the physician's order.On [DATE] at 11:30 AM, the State Agency (SA) determined that the facility's non-compliance with one or more federal health, safety, and/or quality regulations could cause psychosocial harm. On [DATE] at 1:15 PM, the survey team provided the Administrator with a copy of the CMS Immediate Jeopardy (IJ) Template, informing the facility IJ existed as of [DATE]. The IJ was related to 42 CFR 483.24-Quality of Life.On [DATE], the facility provided an acceptable IJ Removal Plan. On [DATE], the survey team validated the facility's corrective actions and determined the facility put forth due diligence in addressing the noncompliance. An extended survey was conducted in conjunction with the Complaint Survey for non-compliance at F678 constituting substandard quality of care. Findings include:Review of the facility's policy titled, Advance Directives, no revision or copyright date, revealed advanced directives will be respected in accordance with state law and facility policy. Policy . 8. If the resident indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives. a. The resident will be given the option to accept or decline the assistance, and care will not be contingent on either decision. b. Nursing staff will document in the medical record the offer to assist and the resident's decision to accept or decline assistance . 13. If the resident or representative refuses treatment, the facility and care providers will: f. Offer pertinent alternative treatments; and g. Modify the care plan as appropriate, providing all other appropriate services (i.e., those that will allow him or her to maintain the highest practicable physical, mental and psychosocial well-being).Review of R1's Face Sheet revealed R1 was admitted to the facility on [DATE] with diagnoses including, but not limited to, hypertensive crisis, likely acute Intracranial hemorrhage, left PCA occlusion, Dementia with word-finding difficulties, and ambulatory dysfunction.Review of R1's face sheet does not reveal a code status.Review of R1's Medication Administration Record (MAR) revealed an order for full code with a discharge date [DATE] at 08:20 AM. Review of R1's Care Plan did not reveal code status.Review of a progress note dated [DATE] at 4:13 AM by Registered Nurse (RN)1, revealed The resident was slumped over bathroom sink leaning forward with head over sink and legs were buckled with weight on the vanity. No pulse, respiration effort. Do Not Resuscitate (DNR) confirmed. R1 placed in the wheelchair and transferred to bed. No acute findings. Postmortem care assisted with primary [Certified Nursing Assistant]CNA1. Called the resident daughter first on contact and left a voicemail to return a call. Called the son he was on his way to the facility. Primary nurse notified on call NP [Nurse Practitioner] via live chat number.Review of late entry progress note dated [DATE] at 6:37 AM revealed, CNA1 found R1 cyanotic, no pulse, no respirations. R1 was warm, cyanotic no palpable [NAME]. RN1 notified. RN1 pronounced R1 at 03:20 AM.During an interview on [DATE] at 02:18 PM, the Director of Nursing (DON) stated, We used what we had on file from the hospital. If the daughter were here, we would have updated the information received. We do not have DNR choices; that is a living will.During an interview on [DATE] at 10:08 AM, Licenses Practical Nurse (LPN)2, The orders are put in by the unit managers. When they are first admitted . We will refer to the computer of code status. Every cottage we keep a yellow binder with the demographics and code status. The orders are populated as soon as they are admitted . On admission, I talked to her and her daughter. R1 was oriented x2. She was able to hold a conversation. I got a history from my daughter. I performed my assessment. In report from the hospital and EMT's she did run high Blood Pressures (BP)'s. The daughter told me that had been the norm for her. I explain to the daughter it would be a full code until we have a signed DNR in the patient info book.Review of R1's Electronic Medical Record (EMR) did not reveal documentation related to the nurse discussing code options with the daughter. During an interview on [DATE] at 10:25 AM, the NP stated, I learned about the incident the next day. I ask the family about the Do Not Resuscitate (DNR), because sometimes they will change their minds. Then I will complete the standard form for Brushy Creek and have the physician sign. I think the facility honors the DNR from the hospital until we can see them. I think it is a standing order until we can see them. We have a standard DNR form. I have never seen the other form with the choices here at Brushy Creek. The medical administration order and the DNR form should be the same. Since I have been having problems entering the code status, I have the supervisor, Assistant Director of Nursing (ADON), or the nurses enter the code status. I reach out to the supervisor or ADON, or some nurses will enter the code status. Unfortunately, I am