

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER Brushy Creek Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29015</p> <p>Based on observations, interviews, record review, and policy review, the facility failed to ensure that two Residents(R)93, and R107) of two residents sampled for restraints, were free from restraints. Specifically, R93 and R107 were observed seated in Broda chairs with chair alarms on, and with bed alarms situated on both of these beds. Additionally, there was no documentation that less restrictive methods were attempted. Continued use of the position alarms has the potential to cause a decline in physical functioning, including an increased dependance in activities of daily living (e.g., ability to walk), impaired muscle strength and balance, decline in range of motion, and risk for development of contractures.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Restraint Policy dated 04/21, revealed, Policy Statement .restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls .Physical restraints are defined as any manual method, or physical, or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily .When the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for need for restraints will be documented . Restrained individuals shall be reviewed regularly to determine whether they are candidates for restraint reduction, less restrictive methods of restraints, or total restraint elimination.</p> <p>1. Review of R93's undated Admission Record located in the EMR under the Profile tab, indicated the resident was admitted to the facility on [DATE], with diagnoses including dementia, muscle weakness, unsteadiness on feet, difficulty walking, and history of falling.</p> <p>Review of R93's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/24/24, located in the EMR under the MDS tab with a Brief Interview of Mental Status (BIMS) score two out of 15, indicating the resident is severely cognitively impaired. Further review indicates resident was assessed as having chair and bed alarms.</p> <p>Review of R93's Physician Orders dated 02/14/24, located in the EMR under the Orders tab documented, Bed and chair alarms, check placement and function every shift and prn [as needed].</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 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R93's Care Plan dated 11/25/23 located in the EMR under the Care Plan tab documented, Falls: Resident is at risk for falls with or without injury related to antihypertensive medication, and history of falls. Interventions: .bed/chair alarms for poor safety awareness, check placement and function every shift and PRN.</p> <p>Observations on 10/29/24 at 2:30 PM and 10/31/24 at 12:30 PM, R93 was seated in a Broda wheelchair with a chair position alarm attached to the chair.</p> <p>During an interview on 10/31/24 at 1:39 PM, Registered Nurse (RN)2 was questioned concerning why R93 had position alarms located on his chair and bed. RN2 stated the resident is very impulsive and has had multiple falls. The alarms were put into place to prevent his falling. RN2 confirmed that there was no documentation in the EMR of the monitoring and assessment of the alarms.</p> <p>During an interview on 10/31/24 at 2:06 PM, the Nurse Practitioner (NP) was questioned why R93 had chair and bed alarms ordered. The NP responded that the resident has poor safety awareness, and has tried assorted sizes and shapes of wheelchairs, unsuccessfully.</p> <p>2. Review of R107's undated Admission Record located in the EMR under the profile tab, indicated R107 was admitted to the facility on [DATE], with diagnoses including fracture of right humerus, muscle weakness, Parkinson's disease with dyskinesia with fluctuations, and dementia.</p> <p>Review of R107's admission MDS with an ARD of 10/10/24, located in the EMR under the MDS tab with BIMS score of seven out of 15, indicating the resident was severely cognitively impaired. The resident required substantial/maximal assistance for all mobility activities.</p> <p>Review of R107's Physician Orders dated 10/11/24, located in the EMR under the Orders tab revealed an order for bed/chair alarm to bed/chair at all times, every shift.</p> <p>Review of R107's Care Plan dated 10/07/24, located in the EMR under the Care Plan tab documented, Falls: Resident is at risk for falls with or without injury related to weakness, medications. Interventions: initiated 10/11/24 Bed/chair alarm every shift. Check positioning and functioning every shift.</p> <p>Observation's on 10/29/24 at 1:17 PM, and 10/31/24 at 1:32 PM, R107 was seated in a Broda wheelchair with a chair position alarm attached to chair.</p> <p>During an interview on 10/31/24 at 1:32 PM, RN2 was questioned why did R107 have a chair and bed position alarms in place. RN2 responded that R107 has Parkinsons and dementia, he gets very impulsive and tries to stand and falls. When asked if the resident has the ability to stand, RN2 stated, No. RN2 added the alarms are to help keep him from falling. RN2 confirmed that there was no documentation in the EMR of the monitoring and assessment of the alarms.</p> <p>During an interview on 10/31/24 at 2:02 PM, the NP was questioned on why R107 has the chair/bed alarms. The NP stated the resident has Parkinsons and dementia, he is very impulsive and has a complete lack of safety awareness. The resident is a fall risk and is not a candidate for removal of alarms.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/31/24 at 2:26 PM, the Director of Nursing (DON) was questioned concerning the use of the chair and bed alarms for R93 and R107. The DON responded that she expected the alarms to be care planned, the interventions and monitoring to be conducted and documented. The DON confirmed that there were no assessments, monitoring, or other interventions attempted related to the alarms. The DON stated that fall prevention was not a valid use for the alarms.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440</p> <p>Based on record review, interview, and document review, the facility failed to revise the Preadmission Screening and Resident Review (PASARR) Level I for one of three residents (Resident (R) 34) reviewed for PASARR out of a sample of 29 residents when there was a new diagnosis of mental illness. This had the potential for a failure to identify what specialized or rehabilitative services the resident needed and whether placement in the facility was appropriate.</p> <p>Findings include:</p> <p>Review of R34's Profile tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses which included major depressive disorder, single episode, and generalized anxiety disorder. A new diagnosis of schizoaffective disorder was added on 09/01/23.</p> <p>Review of R34's PASARR Level 1 Screening Form, with review date of 03/25/24 and located in the Misc tab of the EMR, revealed mental illness diagnoses of anxiety and depression. Psychotropic medications listed included quetiapine 25 milligrams (mg) and Zoloft 50mg.</p> <p>Review of R34's Progress Notes tab of the EMR revealed a Nurse Practitioner (NP) Encounter note dated 06/16/23 where the NP ordered Abilify (aripiprazole- an antipsychotic medication) 2mg daily for delusions and paranoia. Review of NP Encounter note dated 09/01/23 stated to give aripiprazole 2mg daily for schizoaffective disorder.</p> <p>Review of the Orders tab of R34's EMR revealed an order for aripiprazole 2mg daily for schizoaffective disorder dated 09/01/23.</p> <p>Review of R34's Care Plan in the EMR under the Care Plan tab revealed a focus area initiated on 12/05/23 for antipsychotics.</p> <p>Review of R34's quarterly Minimum Data Set (MDS) with an Assessment Review Date (ARD) of 10/01/24, located in the MDS tab of the EMR, revealed Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated moderate cognitive impairment. R34 had a diagnosis of schizophrenia (e.g., schizoaffective, and schizophreniform disorders) and received antipsychotic medication.</p> <p>Review of R34's EMR revealed there was no evidence of a new PASARR I screening after the facility added the schizoaffective disorder diagnosis.</p> <p>During an interview on 10/30/24 at 3:55 PM, the MDS Coordinator (MDSC) stated she entered the schizoaffective disorder diagnosis into the MDS when the NP documented it in a Progress Note. The MDSC reported she failed to inform the Social Services Director (SSD) who did the PASARRs of the new diagnosis and did not know if a new PASSAR screening was completed.</p> <p>During an interview on 10/30/24 at 4:34 PM, the SSD stated the facility was expected to complete a new PASARR Level I with a new diagnosis of schizoaffective disorder. The SSD was unable to locate a PASSAR completed by the facility which included the schizoaffective diagnosis.</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/31/24 at 1:45 PM, the Director of Nursing (DON) stated she expected a new PASARR Level I to be completed when a resident had a new diagnosis of schizoaffective disorder.</p> <p>Review of the facility provided PASRR Training for Providers, dated 06/20/23, revealed, Referral to Level II for mental illness is not required for all applicants exhibiting behavior or adaptation problems. Only applicants who have or are suspected of having a serious mental illness must be referred to Level II. The checklist for mental illness indicators included diagnoses (confirmed or suspected): schizophrenia, . , and other mental disorder that may lead to a chronic disability In cases where the individual is admitted to the nursing facility without the appropriate screening, the nursing facility will be responsible for completing the required screening and for arranging any specialized services or specialized rehabilitative services deemed necessary.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29015</p> <p>Based on interviews, record review, and policy review the facility failed to ensure for one Resident(R)295 of six residents sampled for accidents, maintained a safe, hazard free environment. Specifically, staff left a wooden chair next to the resident's bed and R295 supposedly hit her head on the arm of the chair, resulting in a laceration to her forehead that required sutures. Failure to ensure that residents have a safe and hazardous free environment could result in further accidents with injuries.</p> <p>Findings include:</p> <p>Review of R295's undated Admission Record located in the electronic medical record (EMR), under the Profile tab indicated the resident was admitted to the facility on [DATE], with diagnoses including Alzheimer's disease, difficulty in walking, and muscle weakness.</p> <p>Review of R295's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/25/24 and the Brief Interview of Mental Status (BIMS) score was three out of 15, indicating the resident was severely cognitively impaired and was assessed as not exhibiting behaviors. The resident was wheelchair bound and dependent on staff for all activities of daily living (ADLs), including mobility in and out of bed. Further review of the MDS indicated the resident had sustained a fall with fracture within six months of admission to facility.</p> <p>Review of R295's Fall Risk assessment dated [DATE], located in the EMR under the Evaluation tab, indicated the resident's fall score was 32, indicating the resident was a high fall risk. The assessment indicated a score of 16-42 indicated high fall risk.</p> <p>Review of R295's Care Plan dated 05/16/24 and revised on 06/20/24 indicated, resident is at risk for falls with or without injury related to altered mental status, antihypertensive medication, antipsychotic medication, history of falls, and unsteady gait. Interventions included: keep bed in low position with brakes locked, keep call light within reach, keep personal items frequently used within reach, keep within supervised view as much as possible, safety devices as ordered: fall mat beside low bed when resident is in bed.</p> <p>Review of the Initial Report, dated 09/05/24 at 1:35 PM, revealed, Resident observed with a small left eyebrow laceration and hematoma. Resident was sent to the emergency room (ER) for evaluation and treatment. Resident returned to facility with six sutures to her left eyebrow. The 5-day investigation report, submitted by the Director of Nursing (DON) indicated, On the morning of September 5, 2024, Administrator, Assistant DON (ADON), and DON went into R295's room to evaluate her and her room. The resident was in bed. She was noted to have sutures intact to her left eyebrow. Her bed was in a low position with a fall mat beside her bed. There was a wooden chair at her bedside with the arm of the chair at the level of the blood, there was noted to be a small amount of blood on the right chair arm. CNA (Certified Nurse Aide) stated she used the chair to feed the resident if she is still in bed, and never thought it would be a potential problem. The wooden chair was removed from the room and a recliner was placed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/31/24 at 11:33 AM, CNA2 stated that the night shift CNA (CNA1's name) noticed the bruise on R295. CNA2 was questioned concerning R295's mobility, and behaviors. CNA2 stated R295 could be combative at times and was a total assist. The resident spoke incoherently, and sometimes CNA2 fed R295 her meal in her room.</p> <p>During an interview on 10/31/24 at 11:57 AM, Registered Nurse (RN)1 was questioned about the incident with R295. RN1 stated that she was in another cottage, and just left there, approximately 9-9:30 AM. CNA1 stopped her and told her (R295's name) had blood all over her head and that she (CNA1) had called the supervisor and left a voice mail. RN1 stated that she entered F295's room and the resident was lying in bed with her head tilted a little bit. RN1 stated that she assessed her wound, called emergency medical services (EMS), and that a wooden chair was sitting in front of resident, facing the resident. RN1 stated R295 was not alert and oriented, was incomprehensible, and that she has never seen her get up.</p> <p>During an interview on 10/31/24 at 12:30 PM, CNA1 stated that she was making rounds, and when she entered the resident's room, she saw that R295 had blood all over her face, clothing, and sheet. She immediately called the supervisor, there was no answer, she left a voicemail and went to get the nurse. Stated she did not recall if there was a chair in the room or not.</p> <p>During an interview conducted on 10/31/24 at 3:21 PM, the DON stated she went to see the resident who was lying in bed and unable to tell her what had happened. There was a wooden chair right at the level of the bed. The DON stated that she started an investigation, interviewed staff and other residents. CNA1 told her she found the resident like that and that she had notified the supervisor. When asked why the chair was at the bedside, CNA1 told her it was used to feed the resident. The DON noticed a small amount of blood on the chair's arm. CNA1 told her she doesn't remember leaving the chair there. The DON reached the conclusion that the resident pulled the chair onto her causing the laceration to the eyebrow.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29015</p> <p>Based on interviews, record review, and policy reviews the facility failed to ensure that one Resident(R)93 of five residents sampled for unnecessary medications was monitored for behaviors, side effects and efficacy of an antipsychotic medication. The failure to monitor for adverse effects and efficacy does not ensure the safe administration and dosing of the resident's antipsychotic medications.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Antipsychotic Medication Use dated 07/22 indicated, staff will observe, document, and report to the attending physician information regarding the effectiveness of any interventions, including antipsychotic medications. Nursing staff shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medications to the attending physician: general/anticholinergic: constipation, blurred vision, dry mouth urinary retention, sedation. Cardiovascular: orthostatic hypotension, arrhythmias. Metabolic: increase in total cholesterol triglycerides, unstable or poorly controlled blood sugar, weight gain; or Neurologic: akathisia, dystonia, extrapyramidal effects, akinesia; or tardive dyskinesia, stroke, or TIA [Transient Ischemic Attack].</p> <p>Review of R93's undated Admission Record located in the electronic medical record (EMR) under the Profile tab, indicated the resident was admitted to the facility on [DATE], with diagnoses including anxiety disorder, Parkinson's disease with dyskinesia, and dementia.</p> <p>Review of R93's Physician Orders dated 10/19/24, located in the EMR under the Orders tab, revealed an order for Quetiapine Fumarate (an antipsychotic medication) 25 milligram (mg) at bedtime for Parkinson's psychosis.</p> <p>Review of R93's October Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed there was no monitoring of behaviors, efficacy, or side effects related to the antipsychotic medication administered.</p> <p>During an interview on 10/31/24 at 1:37PM, Registered Nurse (RN)2 confirmed there was no documentation of the monitoring of behaviors, efficacy, or side effects for R93's use of antipsychotic medication, and that there should have been.</p> <p>During an interview on 10/31/24 at 2:20 PM, the Director of Nursing (DON) was questioned concerning what the expectation of staff was monitoring for behaviors, efficacy, and adverse reactions to antipsychotic usage. The DON responded that the orders for antipsychotic medications are to be flagged for behavioral monitoring and side effects. The DON stated it was missing during chart audits.</p>		