

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 12/12/2025
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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interviews, and facility policy review, the facility failed to assess the ability to manage and self-administer medications in 1 out of 5 residents, (Resident (R)13), reviewed for unnecessary medications out of a total sample of 31 residents. This failure increased the risk of medication errors for R13. Findings include: The facility's Self-Administration of Medications policy, with a revision date of February 2021, states, Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. The policy also confirms that the (MAR) should indicate if a dose is self-administered. Review of a Progress Note dated 05/25/23 in the electronic medical record (EMR) revealed R13 was admitted to the facility on [DATE], following a hospitalization for a left leg fracture and respiratory failure. The EMR Orders also revealed that the resident had a tracheostomy with no ventilator and required the use of a Percutaneous Endoscopic Gastrostomy (PEG) tube for nutrition and administration of medications. During an observation of medication administration, R13 was found to be self-administering his medications. The resident was observed on 12/11/25 at 11:00 AM crushing his own medications and administering them via his PEG tube. This was confirmed by Registered Nurse (RN)7. Review of R13's care plan revealed an area of focus related to Medication - Self-Administration Per the focus, R13 prefers to self-administer medication and is capable of doing so as assessed/determined by the IDT. Interventions for the focus were initiated on 04/20/24 and included: assessing cognitive ability, encouraging assistance from the nurse, periodic review, and physicians' order for specific medications for self-administration. A review of the Orders tab in the EMR revealed R13's December physician's orders included two orders that indicated self-administration: 1) Pro-Stat Oral Liquid, 30 milliliters (mL) twice daily and 2) Enteral Feed, 474mL twice daily with 120 mL water flush via PEG tube. During an interview on 12/11/25 at 4:10 PM, RN7 confirmed that she had been working at the facility for four months and since she started R13 had been self-administering all his medications. RN7 added that the resident was watched to confirm the medications were properly crushed and administered via the PEG tube most times. She also confirmed that she documented in the medication administration record (MAR) like any other administered medication. Review of the Assessment tab of the EMR revealed a Nursing - Self-Administration of Medication Observation dated 04/19/24. Under section A, Self-Determination it indicated that R13 did self-administer some Meds. The list of medications included: Sodium Chloride Inhalation Nebulization Solution 6%. The notice also advised how the medications would be stored and it indicated Resident Room. During an interview with the Director of Nursing (DON) on 12/12/25 at 8:39 AM, the DON stated that she was not aware that R13 was self-administering all his medications. She did confirm that she was aware of the nebulizer treatments and that the administering nurse should be providing visual oversight and documenting only what they witnessed.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interviews, and document review, the facility failed to provide physician-ordered adaptive equipment for 1 resident, (Resident (R)16), out of the sample of 31 residents. The facility's failure to provide the adaptive utensils increased the risk that R16 would lose his independence in eating. Findings include: The facility provided a form titled Best Practice: Adaptive Feeding Equipment dated 12/20/23. Per the document, the process for getting adaptive equipment included a therapy referral, followed by an order if necessary. The nursing department confirmed the order and communicated it to the dietary department and appropriate nursing staff and updated the care plan. Once notified, the dietary department updated the tray card. A review of R16's Face Sheet, found under the Census tab of the electronic medical record (EMR), revealed the resident was admitted to the facility on [DATE], with diagnoses including but not limited to: encephalopathy (brain dysfunction), dysphagia (difficulty swallowing), and dementia. On 12/10/25 at 12:13 PM, R16 was observed in the dining room, seated in his wheelchair. There was an untouched meal tray on a table nearby. Certified Nurse Assistant (CNA)6 was interviewed on 12/10/25 at 12:19 PM and she confirmed that the meal did belong to R16. CNA6 added that R16 typically did not eat much of his provided meal, but that he will drink and request coffee throughout the day. The meal ticket for the R16 was requested, but CNA6 confirmed that it was not on the meal tray. Review of most the recent nutritional assessment, dated 11/21/25, revealed Nutrition/Goals/Monitoring and Evaluation: 87 yo [year old] feeding self, eating 50-100% of meals. Has adaptive feeding equipment to aid in self-feeding. Diet upgraded to mechanical soft from puree 11-21-25 per ST [speech therapy] . A review of R16's care plan, found under the Care Plan tab of the EMR, revealed that the resident is at risk for malnutrition due to abnormal labs.mechanically altered diet, poor intake. Interventions for this care plan focus included upgrading the resident's diet to mechanical soft, initiated 11/21/25 and adaptive feeding equipment initiated 11/17/25. A review of the R16's EMR, under the Orders tab, it revealed an order for Adaptive Feeding Equipment (Adaptive Utensil: built up handled utensils) to be provided during all meals to facilitate independence with self-feeding, with a start date of 11/19/25. The meal ticket was requested from the Dietary Manager (DM), who provided the ticket on 12/11/25 at 2:30 PM. The DM confirmed that the meal ticket did not indicate the resident had adaptive equipment and that the dietary staff was not aware of the order. He added that he did not have access to physician orders and that the therapy staff would have to inform the dietary department of updates. During an interview with the Rehabilitation Director, on 12/12/25 at 9:20 AM, he confirmed that the dietary department would not receive electronic notification of changes to diets or an addition of adaptive equipment. He added that they would typically hand deliver the changes to the dietary department. He was asked about the missing information for R16 and he stated that he could not explain it, but that someone missed the order and it did not make it to the dietary department.</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the Daily Staff Posting contained the facility name, the actual hours of the nurses in each cottage, and whether or not the nurse was an RN (Registered Nurse) or LPN (Licensed Practical Nurse). This failure made visitors, families, and residents unaware of the current staffing levels in each cottage. Findings include: The facility had no written policy for staff posting. During an observation on 12/10/25 at 9:30 AM in Dogwood Cottage, the staff posting was observed on the wall in the day room. The staff posting did not show the name of the facility, had included one nurse and one CNA (Certified Nurse Assistant) on duty for both the 7:00 AM to 7:00 PM shift and the 7:00 PM to 7:00 AM shift. The posting did not include whether the nurse on duty was a Registered Nurse (RN) or a Licensed Practical Nurse (LPN). During an interview on 12/11/25 at 8:45 AM, Licensed Practical Nurse (LPN) 15 was asked if she worked in her cottage for the entire shift. LPN 15 stated, No, I am responsible for two cottages. The CNA is in this cottage for the whole shift. LPN 15 was asked who was responsible for the Daily Staff Postings LPN 15 stated, The nurse is. I put it up every morning. LPN 15 was asked if you were not in this cottage from 7:00 AM to 7:00 PM then you are here only half the time. LPN 15 stated, Yes. LPN 15 was asked if the 7:00 PM to 7:00 AM shift has one cottage. LPN 15 stated, No, they sometimes have three cottages. During an interview on 12/11/25 at 9:12 AM, the Director of Nursing (DON) was told about the lack of information on the Daily Staff Postings. The DON acknowledged that the current Daily Staff Postings did not meet the regulatory requirements.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>(continued on next page)</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure residents were free from unnecessary psychotropic medications for 3 (Residents (R)10, R51, and R127) of 6 residents reviewed for unnecessary medications in a total sample of 31. The facility failed to ensure adequate monitoring had occurred for R10's use of an antipsychotic medication. In addition, the facility failed to ensure psychotropic medications had a stop date in excess of 14 days. These failures placed the residents at risk of having unmet care needs and a decreased quality of life. Findings Include: Review of the facility policy titled, Psychotropic Medication Use, dated February 2025 revealed, . Residents do not receive psychotropic medications that are not clinically indicated and necessary to treat a specific condition documented in the medical record .When determining whether to initiate, modify, or discontinue medication therapy the interdisciplinary team conducts and documents and evaluation of the resident. The evaluation includes the residents: physical, behavioral, mental, and psychosocial status; comorbid conditions; expressions or indicators of distress; changes in functional status; resident complaints, behaviors, and symptoms .PRN [as needed] .For psychotropic medications that are NOT antipsychotics; If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, they will document the rationale for extending the use and include the duration for the PRN order .1. Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R10 was admitted to the facility on [DATE]. During her stay, R10 had diagnoses that included but was not limited to dementia without behavioral disturbance, psychotic disturbance, mood disturbance and delusional disorders, dated 11/18/22 and a diagnosis of schizoaffective disorder on 04/25/24. Review of the Order Summary located in the Orders tab of the EMR revealed, Aripiprazole 2 mg [milligram]. Give one tab every morning for schizoaffective disorder [a mix of hallucinations, delusions, and disorganized thinking], dated 05/04/24. Review of the 04/09/21 and revised on 09/05/24 Comprehensive Care Plan located in the Care Plan tab of the EMR revealed, Mood and Behavior: Resident exhibits the following mood or behavior issues, not using call light due to yelling out 'help me' I need to call 911, using remote as a phone, feels like she is falling out of bed related to a diagnosis of dementia, depression, paranoid, schizoaffective disorder. Review of the 02/28/25 Behavioral Nurse Practitioner (BNP) Visit Note revealed, Patient is a [AGE] year-old long-term resident at the facility .Patient reports she is feeling pretty good . Some confusion noted . Patient reports she is anxious to get out of the wheelchair, which makes her depressed . Sleep is good. Appetite is good . Denies auditory hallucinations . Patient says she sees 'little things' in her eyes. She says that the eye doctor told her they were floaters. Denies suicidal ideations. On 02/17/25 the patient's urinalysis and culture were positive . I did not notice any paranoia during today's visit. Staff reports that the patient has improved with the antibiotic regimen for the UTI [urinary tract infection] Hallucinations: By history denies today. Review of the February 2025, March 2025, April 2025, May 2025, June 2025, and July 2025 MAR (Medication Administration Record) for behaviors revealed no documented behaviors. Review of the quarterly Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 10/08/25 revealed R10 had a Brief Interview of Mental Status (BIMS) score of 15 out of 15 which indicated R10 was cognitively intact, had no behaviors, and was administered an antipsychotic medication during the observation period. During an interview on 12/12/25 at 11:16 AM, Registered Nurse (RN)16 was asked if she had noticed any delusions or paranoia for R10. RN16 stated, Not that I have seen. She does get restless, but that is about all I see. During an interview on 12/12/25 at 11:27 AM, Certified Nurse Assistant (CNA)13 stated, She is very easy to work with. She is alert and can tell me what is going on with her. CNA13 was asked if R10 has times in which she sees things that are not there or hears things that are not in reality. CNA13 stated, No, not at all. During an interview on 12/12/25 at 12:27 PM, the Social Services Director (SSD) stated, We have our behavioral weekly meetings on Thursdays. R10 had not had any behaviors and has not been reviewed as nothing has changed. During an interview on 12/12/25 at 1:30 PM, R10 was asked if she has had any hallucinations such as seeing things that are not in reality. R10 stated, I used to way in the past, but not now. During an interview on 12/12/25 at 1:36 PM, the Director of Nursing (DON) stated, We have done education as the nurses' just put zeros [on the behavior documentation], because they are not acting out. We had an IDT [interdisciplinary team] meeting, and we discussed her antipsychotic and antidepressants, but she has not had any behaviors documented ? Review of the admission Record located in the Profile tab of the EMR revealed that R51 was</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and facility policy review, the facility failed to administer medications in a manner to prevent cross-contamination for 1 (Resident (R)36) and to implement Enhanced Barrier Precautions (EBP) for 2 residents (R115 and R105) in a total sample of 31. These failures placed the residents at risk for cross-contamination and/or worsening health concerns. Findings include: Review of the facility policy titled Enhanced Barrier Precautions dated December 2024 revealed, . Enhanced Barrier Precautions (EBPs) are utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents . Indwelling medical devices include central lines, urinary catheters, feeding tubes, and tracheotomies . Examples of secretions or excretions include wound drainage, fecal incontinence or diarrhea, or other discharged from the body that cannot be contained and pose an increased potential for extensive environmental contamination and risk transmission of a pathogen . Review of the facility policy titled Administering Medications dated April 2019 revealed, . Staff follows established facility infection control procedures (e.g., handwashing, techniques, gloves, isolation procedures, etc.) for the administration of medications, as applicable .1. Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R36 was admitted to the facility on [DATE] with diagnoses including but not limited to a stroke and diabetes. During a medication pass observation on 12/11/25 at 7:59 AM, Registered Nurse (RN)7 was observed to use her fingers, without using hand hygiene, to obtain medications from a bottle and from medications cards. RN7 placed the medications into the medication cup for administration. At 8:05 AM, RN7 put on gloves (without hand hygiene) and obtained an insulin pen from the top drawer of the medication cart. At 8:07 AM, RN7 entered R36's room and administered the oral medications. RN7 was observed to have placed the insulin pen on R36's bed linens prior to and after administration. During an interview on 12/11/25 at 8:08 AM, RN7 stated, I am aware that I should have put the medication on the lid when dosing from the bottle and punch the medications from the card without using my fingers to pull them out, but I witnessed other nurses' when being trained as they were using their fingers to put medications in the cup. I guess I just followed along. RN7 was asked why she placed the resident's insulin pen on the bed linens prior to and after administration of the insulin before going back to the medication cart and placing the insulin pen in the drawer. RN7 acknowledged that practice could cause cross-contamination and was a break in infection control. During an interview on 12/11/25 at 9:15 AM, the Director of Nursing (DON) was informed of the medication pass with R36. The DON stated, That should have never happened. 2. Review of the admission Record located in the Profile tab of the EMR revealed R115 was admitted to the facility on [DATE] with diagnoses including but not limited to sepsis (life-threatening response to an infection) due to Methicillin Susceptible Staphylococcus Aureus (MRSA-antibiotic resistant bacteria). Review of the Order Summary located in the Orders tab of the EMR revealed, Cefazolin [an antibiotic] 500 mg [milligrams] IV every eight hours. During an observation on 12/11/25 at 1:03 PM, RN1 was observed to administer the IV medication without wearing a gown. During an interview on 02/11/25 at 2:00 PM, RN1 was asked why she did not wear a gown, as the EBP precautions were posted on the door to R115's room. RN1 stated, I thought the EBP precautions were only used for his wound care. RN1 left the room, looked at the signage outside the door, and stated, I should have used a gown for the IV medications also. 3. Review of the admission Record located in the Profile tab of the EMR revealed R105 was admitted to the facility on [DATE] with diagnoses including but not limited to, dementia and an open wound to the right lower leg and coccyx. Review of the 09/22/25 Order Summary located in the Orders tab of the EMR revealed, Enhanced Barrier Precautions related to wounds. Prior to observing wound care on 12/11/25 at 10:43 AM, with RN9 and Licensed Practical Nurse (LPN)2 stated that R105 had a bowel movement and needed to be cleaned up prior to providing wound care. LPN2 did not wear a gown during incontinent care. LPN2 was asked why she did not wear a gown for incontinent care for a resident on EBP precautions. LPN2 stated, I did not see the sign. RN9 and LPN2 then observed the EBP signage outside R105's door and confirmed that gowns were to be used for incontinent care. On 12/11/25 at 10:50 AM, the Staff Development Coordinator (SDC) approached this surveyor and stated, They [nurses] don't have to wear a gown when changing linens or providing care. EBP is only for wound care or if they had a PICC [Peripherally inserted central catheter-a long thin tube inserted into the vein] line or indwelling urinary catheter. The SDC further stated, Current CDC [Center for Disease Control and Prevention] guidelines do not require a gown for personal care. The SDC was asked then why</p>		