STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425027	A. Building B. Wing	11/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountainview Nursing Home	340 Cedar Springs Road Spartanburg, SC 29302

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 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 interview, record review, and facility policy review, the facility failed to ensure Resident (R)1 received adequate supervision to prevent an elopement on 11/01/25 at approximately 6:00 AM. Specifically, R1 was located by staff outside the facility lying on the ground. R1 was dressed in bedtime clothing (pajamas and slippers). According to weather reports on 11/01/25 at 5:55 AM, the weather was 36 Degrees Fahrenheit (F). On 11/07/25 at 1:34 PM, the survey team provided the Administrator and Assistant Administrator with a copy of the CMS IJ Template and informed the facility IJ existed as of 11/01/25. The IJ was related to 483.24 Quality of Care.On 11/07/25 at 4:12 PM, the facility provided an acceptable IJ Removal Plan. On 11/07/25 at 5:00 PM, the survey team validated the facility's corrective action and determined that the facility put forth due diligence in addressing this non-compliance. The SA is considering this IJ at Past Non-Compliance (PNC) as of 11/05/25.An Extended Survey was conducted in conjunction with the Compliant Survey, constituting substandard quality of care. Findings include:Review of the facility policy titled Elopement, Risk Prevention, and Management of Missing Residents revealed, The facility strives to promote resident safety and protect the rights and dignity of the residents. The facility maintains a process to assess all residents for risk for elopement, implement prevention strategies for those identified as an elopement risk, institute measures for resident identification at the time of admission, and conduct a missing resident procedure. Intervention: responding to an actual elopement. It is the responsibility of all staff, regardless of the department they work in, to respond to activated door alarms and to return residents to their units. When a resident is determined to missing: note the time and date the resident is/was determined missing; the staff member assigned to the unit where the resident residents verify that the resident has not signed out; the staff notify the Director of Nursing Services that a resident is missing; staff members in accordance with the facility's search team plan, conduct a thorough search to locate the resident.Review of R1's Face Sheet revealed R1 was admitted to the facility on [DATE] with diagnoses including but not limited to, Alzheimer's Disease, Dementia with psychotic mood disturbance, repeated falls, and unsteadiness on feet.Review of R1's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/28/25 revealed that R1 had a Brief Interview for Mental Status (BIMS) score of 8 out of 15, which indicated R1 had moderate cognitive impairment. Further review of the MDS revealed R1 did not exhibit wandering behaviors or other behavioral symptoms during the look-back period. Further review revealed, R1 utilizes a walker for mobility and requires supervision or touching assistance with walking and staff utilize a bed alarm - it was used less than daily to notify staff when movement is detected from R1.Review of R1's Physician Orders revealed an order dated 04/13/25 which stated, Ambulatory with rolling walker.Review of R1's Physician Orders revealed an order dated 07/08/25 which stated, Code alert related to wandering secondary to dementia.Review of R1's Physician Orders revealed an order dated 07/12/25 which stated, Bed alarm related to poor safety awareness secondary to falls.Review of R1's Progress Notes dated 11/01/25 at 8:20 AM revealed, This nurse was making patient rounds at approximately 6:10 AM and noted that the resident was not in her bed. This nurse then checked the resident's bathroom; she was not there. All Certified Nursing Assistants (CNAs) were summoned to assist in looking for [R1]. All other rooms were checked - no [R1]. This nurse then went to the back door where the resident was seen lying on the ground.Review of R1's Progress Notes dated 11/01/25 at 9:05 AM revealed Registered Nurse called to unit at 6:22 AM due to resident elopement. Resident discovered by Licensed Practical Nurse (LPN) in charge of care lying outside facility on the ground. 911 had already been activated, resident was supine covered in multiple blankets, resident was shivering with eyes closed. [R1] did open eyes to sound of nurse's voice but did not speak. Emergency Medical Services (EMS) arrival 6:40 AM, resident taken to local Emergency Department for evaluation and treatment, Director of Nursing (DON) notified by RN at 6:38 AM, Resident Representative notified by LPN left message. Review of R1's Progress Notes dated 11/02/25 at 8:50 PM Late entry, resident was alert to name and location. Resident was able to life [sic] her legs up, no injuries was noted at the time of her fall. Resident denies any pain at this time, resident was complaining of being cold.Review of R1's Quarterly Elopement assessment dated [DATE] revealed R1 scored a 0-elopement score indicating she was not at risk for elopement.Review of R1's Care Plan last revised on 10/22/25 revealed R1 is at risk for wandering and safety concerns. Interventions included, clearly identify resident's room and bathroom; code alert in place related to wandering; engage resident in purposeful activity; identify if there is a certain time of