STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425062	A. Building B. Wing	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookview Healthcare Center	510 Thompson Street Gaffney, SC 29340

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50085 Based on review of the facility policy, record review, and interviews, the facility failed to provide appropriate supervision to prevent Resident (R)1's elopement from the facility. Resident (R)1 had a successful elopement from the facility on 01/25/2025 and was without supervision for a period of time. R1 was last seen ambulating in the hall around 6:00 PM by a Certified Nursing Assistant (CNA). Approximately around 7:00 PM, CNA1 noticed that R1 was not in her room and alerted a nurse. The unit and facility was searched, R1 was not found to not be on the premises. R1 obtained a ride from college students located at the neighboring apartment and went to her friend's house. R1 was returned to the facility by local police with a bruise to her right eye, right hand, and right arm. On 01/29/2025 at approximately 5:34 PM, the State Agency (SA) determined that the facility's non-compliance with one or more federal health, safety, and/or quality regulations has caused or was likely to cause serious injury, serious harm, serious impairment, or death. On 01/29/2025 at 5:52 PM, the Administrator was notified that the allegation of elopement for R1 constituted Immediate Jeopardy (IJ) at F689 and the IJ template was presented. On 01/29/2025 at 7:07 PM, the facility provided acceptable plans of removal for the IJs. Review of the facility's removal plan and verification of implementation determined the facility had corrected their own deficiency, related to the IJ being identified as Past-noncompliance. An extended survey was completed on 01/31/2025 due to the failure constituting substandard quality of care. Findings include: Review of the facility's policy titled, Elopement Response Guidelines, effective date 05/01/2006 stated, It is the responsibility of all staff to provide a safe environment for all residents. Review of R1's Face Sheet revealed R1 was admitted to the facility on [DATE], with diagnoses including but not limited to: generalized anxiety disorder, vascular dementia, and unspecified dementia with other behavioral disturbance. (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	Review of R1's Elopement Evaluation dated 01/23/2025 revealed R1 had no elopement risk factors, and an elopement care plan was not required. Review of R1's Admission Minimum Data Set (MDS) with an Assessment Reference Date of 11/02/2024 revealed R1 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating no cognitive impairment. Further review of the MDS revealed there were no wandering behaviors exhibited. Review of R1's Progress Note dated 01/25/2025 at 9:00 PM revealed, Resident noted to be upset about a dress that belonged to another resident. Resident was last seen by this nurse on the peach unit around 5:30 pm - 6:00 pm talking to staff. At 7:00 pm, certified nursing assistant (CNA) alerted staff that she was unable to find resident. Staff immediately searched all rooms and the entire facility. Upon searching staff noticed resident's walker on the hill, next to apartment buildings. While staff continued to search, some college students stated they had seen the resident and gave her a ride to her preferred address. Resident's family was updated throughout the process. Director of Nursing (DON) and administrator notified. DON notified provider staff. Review of R1's Progress Note dated 01/25/2025 at 9:41 PM revealed Resident returned to facility in the custody of local police authorities. Resident returned with bruising around eye, bruising noted to back of right hand and right forearm, and a kerlix wrapped around her left forearm. DON present during this time and is aware. DON walked resident to her room and spoke with resident outside of her room in the hallway prior to leaving facility for the night. Resident took her medications whole without difficulty, vital signs stable. No complaints of pain or discomfort noted. Notified responsible party of patient return. Review of Blue Ridge Palmetto Elopement Event Sheet dated 01/25/2025 revealed, Resident left the facility. Contributing factors: Dementia and Anxiety Disorder. Yes, was selected to there being recent events, trauma, new diagnosis, or other stressors/losses. Description given; resident was upset about a dress that does not belong to her. During an interview on 01/29/2025 at 1:17 PM, Licensed Practical Nurse (LPN)1 revealed, I am familiar with the incident. It was my first time on that unit. As I walked in and getting report, the oncoming CNA did rounds and noticed that the resident was not there. The day shift nurse was still there, and we were in the middle of report. We started searching for the resident. We went in all the rooms on the unit, then the facility. We walked outside and the nurse noted the walker on the hill going toward the apartments. The nurse notified every one of her rollator. Staff member went and knocked on doors and ended speaking with college students. They said we seen her out here and we gave her a ride. She told them where she wanted to go. The college kids took her to the address. When she got there the occupants of the house let the resident in and they left. I went back into the facility to see that the police and the Director of Nursing (DON) was in the facility. When the resident returned, she had bruising on her right hand and right arm. She had an eye that was bruised, and kerlix wrapped on the left arm. I assessed what I seen and the DON walked her to her room. The resident was rowdy about an incident that happened prior to her leaving. She was upset and wanted to leave because of it. It was about a dress, but she was going on about other things. The DON is the person who calmed her down and we assisted her to bed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 01/29/2025 at 1:55 PM, the DON revealed, Yes, I am familiar with the incident. I received a phone call saying they were unable to find R1. They checked the unit and facility. Code Dr Hunt (the elopement code) was started, and a nurse found her walker that was on the hill towards the apartment building. The police were already notified. I went to the Magnolia unit then to the apartments. A girl stated that an elderly lady came to her door and said her car broke down. Police officer was there and got the address and went to the address given. Resident had on Sketchers tennis shoes, a long sleeve shirt, a sweater, and a pocketbook, upon her return. She never had signs of elopement and we never had an issue prior to the dispute about a dress. She stated, She did not want to be here anymore, and her daughter told her to leave this place then. R1 was last seen around 6 PM and she returned to the facility at 9:15 PM. We changed the wander guards because of the door will alarm. If they hold the door, it will open, but it will alarm. During an interview on 01/29/2025 at 2:17 PM, CNA1 revealed, I came in and I started picking up trays. I went to her (R1) room, and I seen that it was dark, and her tray was not touched. I asked the nurse where R1 was located. I was told that she was in her room. I checked the rooms on the floor. We did a Dr. Hunt, she was not in the facility, so we went outside and searched. It was cold that day. The last CNA to see her was around 6 pm. We found her walker on the hill going up towards the college apartments. I spoke with the college kids, and they told me that she asked them for help to go to (a friend's house). They gave her a ride to her friend's home. We got the address to where she was. It took the sheriff a while to bring her back. She was determined not to return, and she stated that if she gets another chance she will not come back. There is a problem with the door lock on the Peach Unit. It has been reported, and they told me that it has been checked by maintenance. I told them that it is a problem and that is where she got out at. During an interview on 01/29/2025 at 2:31 PM, R1 revealed, I left the facility because I went to the section to play some games. People steal here and I asked a good friend to watch my purse. They keep stealing my food, my clothes and my money. I told the three nurses at the nurse's station. A man punched the door code, and I went out. The only reason they knew to find me was because of my daughter. It was dark and my way was lit by the moon. I went up the hill to not be seen by the people at this facility. I tried to push the rollator up the hill but could not, so I tried to pick it up and I hit my eye. I left because they do nothing for you. I did not see anyone and then I seen a man. I asked him to take me to my girlfriend's house. He got another boy and girl, and they told me they go to Limestone College. They drove me to my girlfriend's house. I will not answer the question if I will try to leave again. The facility's plan of removal included the following: The immediate action taken for this deficient practice include the following: -A body audit was done on Resident #1 upon return to the facility. -Resident was placed on 15 minute checks. -Emotional support was provided to resident by the Director of Nursing. -Inservice was completed 1/25/25-1/26/25 to all staff by the Staff Development Coordinator and Director of Nursing on CMS guidelines regarding elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Maintenance staff checked and recorded that all doors on units with residents who are at risk for elopement were found to be in working order. Facility recognizes that all residents have the potential to be affected by this deficient practice. Measures put into place to ensure that this deficient practice does not reoccur include the following: -A professional contractor was brought into the building to inspect all alarms and provide any work required if issues were found. -The facility requested a quote from the contractor to upgrade all door monitoring alarms in the facility. Monitors to be put in place to ensure the deficient practice does not reoccur include: -Door alarms inspections were increased from weekly to daily by the maintenance staff. -Inservice will be provided to staff regarding any issues with the doors/alarms must be reported directly to the Director of Nursing or Administrator. -The facility has set the TELS system, used to document the completion of the monitoring, to alert the administrator via e-mail and mobile application that the task was completed. Administrator will take findings of this monitoring tool to the QAPI committee monthly for three months and quarterly thereafter until the issue is deemed to require no further review. The facility alleges compliance on 1/26/2025.