| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 425062 | A. Building<br>B. Wing | 02/28/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brookview Healthcare Center | 510 Thompson Street<br>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 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46934<br><br>Based on review of the facility policy, record review, and interview, the facility failed to protect 1 of 1 resident from sexual abuse. Specifically, Resident (R)2 wandered into R1's room and inappropriately touched R1, this was observed by two staff members. Based on the Reasonable Person Approach, R1 had the potential to suffer severe psychosocial harm.<br><br>On 02/27/25 at 6:21 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.<br><br>On 02/27/25 at 6:21 PM, the Administrator and the Director of Nursing were notified that the failure to protect a resident from sexual abuse constituted Immediate Jeopardy (IJ) at F600.<br><br>On 02/27/25 at 6:21 PM, the survey team provided the Administrator with a copy of the CMS Immediate Jeopardy (IJ) Template and informed the facility IJ existed as of 02/04/25. The IJ was related to 42 CFR 483. 12 - Freedom from Abuse, Neglect, and Exploitation.<br><br>On 02/28/25 at 1:25 PM, the facility provided an acceptable IJ Removal Plan. On 02/28/25 at 2:16 PM, the survey team validated the facility's corrective actions and removed the IJ. The facility remained out of compliance at F600 at a lower scope and severity of D.<br><br>An extended survey was conducted due to non-compliance at F600, constituting substandard quality of care.<br><br>Findings include:<br><br>Review of the undated facility policy titled Abuse and Neglect Prohibition, documented, .each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion, and misappropriation of property . Sexual Abuse - Includes, but is not limited to sexual harassment, sexual coercion, sexual assault . Prevention 2.) Facility supervisors will immediately correct and intervene in reported or identified situations in which abuse, neglect or misappropriation of resident property is at risk for occurring.<br><br>(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<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of R1's Face Sheet revealed R1 was admitted to the facility on [DATE], with diagnoses including, but not limited to: schizoaffective disorder, dementia, with other behavioral disturbance, epilepsy, and anxiety.<br><br>Review of R1's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/29/24, revealed a Brief Interview for Mental Status (BIMS) score of 4 out of 15, indicating R1 had severe cognitive impairment.<br><br>Review of R2's Face Sheet revealed R2 was admitted to the facility on [DATE], with diagnoses including, but not limited to: restlessness and agitation, psychotic disorder with hallucinations due to known physiological condition, Schizoaffective disorder, and Parkinsonism.<br><br>Review of R2's Quarterly MDS with ARD of 01/17/25, revealed a BIMS score of 10 out of 15, indicating R2 had moderate cognitive impairment.<br><br>Review of R2's Quarterly Elopement Evaluation dated 01/13/25 at 9:05 AM, documented R2 is ambulatory and/or Independent in wheelchair locomotion. R2 is cognitively impaired, has poor decision-making skills, and/or pertinent diagnosis. R2 has a history of wandering. Resident is at risk for elopement.<br><br>Review of R2's Progress Note dated 02/04/25 at 1:07 AM, documented, Resident noted being physically aggressive with staff and other residents. Resident noted going into resident's room, pulling off the covers from resident, and screaming at different resident. Resident became physically and verbally combative with staff with staff was attempting to redirect resident. DON notified. EMS called for transport to ER for psych eval. Nursing<br><br>Review of R1's Progress Note dated 02/05/25 at 11:23 AM, documented, LOA: Per daughter's (RP) request, res transported to CMC ER for exam. Res awake and alert. No s/sx of pain or distress noted. Nursing<br><br>During a phone interview with R1's Representative (RP) on 02/27/25 at 10:28 AM, revealed that on 02/05/25, between 10:30 AM and 11:00 AM, the Director of Nursing (DON) contacted R1's RP via phone and said on Monday night 02/03/24, going into 02/04/25, a male resident went missing and staff couldn't find him. When facility staff started looking for him, they heard water running from R1's room, and staff went in the room, and found the male resident. R2 was completely naked, and was actively trying to get R1's brief off. The facility staff intervened and removed him from her room. R1's RP stated the DON told her staff assessed the female resident that night, and the next morning, and she didn't have any trauma related to the event. R1's RP stated R1 has severe dementia, and will say yes as her only form of communication, and is non-ambulatory. Staff told her (R1's RP) they didn't think that it was a big enough deal and since they didn't find anything, it was not a reportable offense. The DON told the RP the male resident was sent to the psych ward. R1's RP stated, It killed me when I got the call, I requested them to send my mom to the hospital, because their assessments were not thorough enough in my opinion. R1's RP further stated that R1 went out to the hospital, no abrasions to the body or vaginal area. Police told her that R2 was interviewed and admitted to the police that R2 put it in but not all the way, not enough to make babies. I called the ombudsman, and she gave me the department's information to file a complaint.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview with the Attorney General Council for the [Local Hospital] Healthcare System via phone on 02/27/25 at 1:55 PM, revealed that the internet is down and they would not be able to send the hospital information until the internet is available. However, the Attorney General Council revealed R1's HPI (history of present illness) revealed given concerns of potential sexual consult.<br><br>Review of R1's HPI dated 02/05/25, documented, [R1] is a 77 y.o. a female who presents to the emergency department today given concerns over a potential sexual assault. History somewhat limited as patient does have a history of dementia, I am told by EMS that her care facility reported to the family that another individual with dementia may have exposed himself and had been on top her two days ago, the family had requested that she be transferred to the emergency department for further assessment. She does not have any acute complaints I am told she is mentating at baseline and does again have a known history of dementia, she will intermittently participate in the history and physical exam, and has not had any recent falls or other difficulties. ED Course Notes: SANE (Sexual Assault Nursing Examiners) has completed their evaluation, and was also able to discuss with the daughter. It sounds that the perpetrator of this event is actually not demented, but rather is a known schizophrenic. As a result SANE will contact the police department and has filed appropriate reports, we will continue to maintain patient safety until disposition can be made and we will discuss with the nursing facility prior to any plans to discharge home it sounds that this individual is also not currently at the facility so she would have a safe place to go. Police have evaluated the situation and appropriate reports filed per SANE team, patient safe to return to her care facility. Spoke with nurse at Brookview. She states the report she was given is that the event occurred at 2 am Tuesday morning. The male dementia patient at Brookview was lost for about 10 minutes. The male patient was found fully naked on top of [R1]. [R1] was also naked other than a diaper when found. Nurse states [R1's] diaper was pulled to the side and male was attempting to take it off. Nurse states unsure if there was penetration. Bed Confined-Unable to ambulate, unable to get out of bed without assistance, unable to safely sit up in a wheelchair.<br><br>Review of R2's HPI dated 02/04/25, documented, PT to ED via EMS from Brookview. Facility states pt had Aggressive behaviors. Pt is pleasant in triage. [R2] is a 56 y.o male sent from Brookview with aggressive behavior. According to EMS, the patient was being aggressive towards other occupants at the facility. Patients denies this and state he just want to smoke. Unable to perform ROS (Review of Symptoms), Psychiatric disorder. Additional MDM and Provider Notes: [AGE] year-old male brought in by EMS from Brookstone for reported aggressive behavior towards other occupants of the facility. Patient has no knowledge of this and has very tangential thoughts. He has no complaints. CBC showed no leukocytosis, mild anemia. CMP shows reassuring electrolytes, normal renal function and liver function. UDS negative. Ethanol undetectable. Urinalysis not suggestive of a urinary tract infection. Awaiting telepsychiatrist recommendations. Patient signed out to the day team. Spoke with case management regarding the patient no longer being accepted at BrookView due to sexual assault against another [NAME] of BrookView. Case management will look at the patient for placement, however, the patient will not be able to have placement at a facility with pending charges. Dr.notified.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of an Employee Statement Form written by Certified Nursing Aide (CNA)1 dated 02/04/25 at 1:00 AM stated, On 2/4/2025 at 1AM, I noticed [R2] was missing from the nurse's desk for a few minutes. I got up, I went to his room and he was not in his room. I went to Dogwood, I asked the staff if they had seen [R2], and they stated they heard him playing the piano in the dining room. [Registered Nurse (RN)2] got up, we went to the courtyard, and he was not in the courtyard. We went to the dining room, he was not in the dining room. We looked outside of the dining room, called his name, and he was not outside of the dining room. We came down the hall, I told [Licensed Practical Nurse (LPN)1] that i could not find [R2]. I went into 150 thinking he may have gone in there to look for a radio. I heard [RN2] say he was in 157. I walked back up the hall into 157, I saw [R2] putting on his shirt, and [LPN1] walked in at that time. [RN1] told [LPN1] about what was happening. I walked with [R2] back to the nurse's desk on the peach and waited on EMS to come and get him.<br><br>Review of the Employee Statement Form written by LPN1 on 02/04/25 at 1:00 AM, documented, On 2/4/25 at around 1 AM, [R2] was sitting at the nurse's desk on the couch. [R2] got up and walked down the hall. [CNA1] asked if [R2] was still sitting on the couch. This nurse said no, he walked down the hall. [CNA1] went to find the resident. [CNA1] walked over on the Dogwood unit and asked the Dogwood staff if the resident had walked by, and Dogwood staff said not recently. Dogwood staff went with [CNA1] to help locate the resident. [CNA1] came back to Peach nursing desk and informed this nurse and another cna that [R2] was not located in the initial search. This nurse and [CNA2] went to Peach Short Hall, looking in rooms, the kitchen, and the laundry room. While walking back to the peach unit, this nurse heard [RN2] talking while coming on to peach unit via long hall. Staff was noted in room [ROOM NUMBER]. Particularly 157A in [R1's] room. This nurse noted [R2] standing beside of 157A'a bed with no pants on. [R2] was yelling at staff and being aggressive. [RN1] explained she saw [R2] on top of [R1] when she entered the room then [R2] got up and got dressed. This nurse took [R2] to the nurses desk. This nurse notified the DON and called EMS to transport resident to the hospital. [CNA] stayed with [R2] while this nurse went back to 157A's room to assess [R1]. [R1] was laying in bed on back. Upon inspection, resident noted to have brief intact, still adhered to both sides. The brief was pulled up the front, with the brief creating a thong like appearance, within the labia majoria. This nurse removed the brief. No redness, injuries, or bruising noted to the vulva or vagina area. Resident denied pain to that area. EMS arrived and escorted [R2] to ER.<br><br>During an interview, via phone, with LPN1 on 02/27/25 at 2:24 PM, LPN1 confirmed her statement. LPN1 stated she is familiar with both residents. LPN1 stated she spoke to the DON, she and another nurse, and since her brief was intact, they didn't believe she was penetrated, or sexually assaulted which is why she was not sent to the hospital. LPN1 stated she spoke to the DON first, and informed she would take care of it all the following morning. LPN1 stated she did not notify R1's family. LPN1 stated the assessments were visual. No documentation was filled out. Typically it should have been done on paper, and filled out to its entirety.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of an undated Employee Statement Form written by RN1, states, I was sitting at Dogwood desk working when [CNA1] from peach asked if I saw [R2]. I told her not in the last little bit, but I heard him playing the piano about 15 minutes ago. I went to help [CNA] look for the resident. After looking on Dogwood and in the dining room, the cna went to see if the other staff had seen the resident. Upon walking onto Peach Unit, I heard water running in 157 and knew neither resident could turn it on. When I opened the door the water in the sink was on and about to over flow. I then saw [R2] naked on top of [R1] 157A. I told him to get off of her right now. [R1] was laying flat in bed with cover pulled off, Gown pulled up and brief slightly pulled to the side. At this time, other staff was in the room. This nurse asked [R1] if she was okay and she just looked at me and finally said yes. [LPN1] took [R2] out of the room to the desk. [LPN1] then called DON and EMS.<br><br>Attempt to interview, via phone, CNA1 on 02/27/25 at 1:05 PM, was unsuccessful and unable to leave a voicemail.<br><br>Attempt to interview, via phone, RN1 on 02/27/25 at 3:19 PM, was unsuccessful.<br><br>During an interview with the Director of Nursing (DON) on 02/27/25 at 12:19 PM, the DON she is aware of a situation between two residents, R1 and R2. LPN1 called her on 02/04/25 at 1 AM stating R2 walked out of [LPN] and [CNA's] sight and they got up and started looking for him down the hall. They walked around the building to ensure he didn't make it out of the building. Dogwood nurse, located him in R1's room, completely naked, on top of female resident. Female residents covers were pushed back, brief still on. The DON stated LPN1 yelled at him to get off her, and yelled for back up, and another nurse came in to assist the RN. LPN1 told me she assessed the resident. There was no evidence that he penetrated her. No redness, no discharge, no bruises. Female resident has dementia, and is not cognitive enough to say what would have happened to her. Male resident has psychosis issues, he had behavioral issues, however, not sexual, physical and verbal. The DON stated she hadn't had any issues with R2. The DON stated it was her decision to not send R1 to the hospital because R1 did not have redness, or injury. The DON stated her fear was that if R2 tried to do it and wasn't successful, he would try that with somebody else and didn't want him back at the facility. The DON stated R1's niece, who is a nurse in the facility and works on that unit messaged her on the following night, it was on 02/04/24, and she found out upon getting the report. She asked me if R1's daughter had been notified, and the nurse confirmed she hadn't called. The DON stated she would notify her the following day on 02/05/25. The DON further stated on 02/05/25, she called the daughter and apologized in regards to her not being notified the day it happened. The DON told the daughter, R2 walked in R1's room, had gotten in bed with R1, and her brief was still on. The DON stated R1's daughter requested R1 to be sent out. The DON stated she told the daughter that she was assessed twice by facility staff and there were no injuries and that the male resident was sent out that night. The daughter still wanted her mother to get sent out.<br><br>During an interview with the Administrator on 02/27/25 at 3:40 PM, revealed she is familiar with both residents. The Administrator stated the DON told her that R2 went into R1 room. R2 wandered off from LPN1's sight and ended up in R1's room. R2 was found naked, at R1's bedside. The Administrator stated he was removed from the room. R2 was sent out to the hospital for further evaluation. R1 did not go, there was no indication it occurred. She was fine. She didn't remember anything having happened.<br><br>On 02/28/25 at 1:25 PM, the facility provided an acceptable IJ Removal Plan, which included the following:<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | - Resident #2 was sent to the Hospital Psychiatric Unit.<br><br>- Resident #1 was checked for any signs and symptoms of abuse. She was sent to hospital for further evaluation.<br><br>- Resident #1 did not recall the incident occurring.<br><br>- All staff will receive additional training on Sexual Abuse by the Staff Development Coordinator starting 2/28/25 and will be completed by March 3, 2025.<br><br>- The DON was provided with additional training on reportable incidents by the Administrator on 02/27/25.<br><br>- The Administrator will be notified in addition to the Director of Nursing of all unusual occurrences involving two residents.<br><br>- All staff will be educated to the update of this procedure by the Staff Development starting 02/28/25 and will be completed by March 3, 2025.<br><br>- All incident reports will be brought to the Morning Meeting for review.<br><br>- The Administrator will monitor these incidents to ensure that any resident/resident incidents were reported to her.<br><br>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.<br><br>The facility alleges that we were in compliance on 02/28/25. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46934<br><br>Based on review of the facility policy, record review, and interview, the facility failed to report to the State Survey Agency (SSA) an alleged incident involving sexual abuse, that occurred on 02/04/25.<br><br>Findings include:<br><br>Review of the undated facility policy titled Abuse and Neglect Prohibition, documented, Prevention 2.) Facility supervisors will immediately correct and intervene in reported or identified situations in which abuse, neglect or misappropriation of resident property is at risk for occurring. The facility will report allegations and substantiated occurrences of abuse, neglect and misappropriation of resident property to the state agency and law enforcement officials designated by state law. The facility will report to the company management and legal departments in accordance with company reporting procedures. The facility will report any occurrences of abuse by registered or certified staff to the State Board as required by state law. Policies and facility procedure will be analyzed and modified as necessary by the QA&A Committee so as to meet the full intent of the law.<br><br>Review of R1's HPI (History of Present Illness) dated 02/05/25, documented, [R1] is a 77 y.o. a female who presents to the emergency department today given concerns over a potential sexual assault. History somewhat limited as patient does have a history of dementia, I am told by EMS that her care facility reported to the family that another individual with dementia may have exposed himself and had been on top her two days ago, the family had requested that she be transferred to the emergency department for further assessment .<br><br>Review of R2's HPI dated 02/04/25, documented, PT to ED via EMS from Brookview. Facility states pt had Aggressive behaviors. Spoke with case management regarding the patient no longer being accepted at BrookView due to sexual assault against another [NAME] of BrookView.<br><br>Review of the Employee Statement Form written by Licensed Practical Nurse (LPN)1 on 02/04/25 at 1:00 AM, documented, On 2/4/25 at around 1 AM, . Staff was noted in room [ROOM NUMBER]. Particularly 157A in [R1's] room. This nurse noted [R2] standing beside of 157A'a bed with no pants on. [Registered Nurse (RN)1] explained she saw [R2] on top of [R1] when she entered the room then [R2] got up and got dressed. This nurse notified the DON and called EMS to transport resident to the hospital. [R1] was laying in bed on back. Upon inspection, resident noted to have brief intact, still adhered to both sides. The brief was pulled up the front, with the brief creating a thong like appearance, within the labia majoria. This nurse removed the brief. No redness, injuries, or bruising noted to the vulva or vagina area. Resident denied pain to that area. EMS arrived and escorted [R2] to ER.<br><br>Review of an undated Employee Statement Form written by RN1, documented, Upon walking onto Peach Unit, I heard water running in 157 and knew neither resident could turn it on. When I opened the door the water in the sink was on and about to over flow. I then saw [R2] naked on top of [R1]. I told him to get off of her right now. [R1] was laying flat in bed with cover pulled off, gown pulled up and brief slightly pulled to the side. [LPN1] then called the DON and EMS.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a phone interview with the Ombudsman on 02/27/25 at 10:34 AM, revealed she is aware of the complaint involving Resident R1 and R2. The Ombudsman stated that R1's daughter had contacted her to make a complaint and told her that the police were investigating the complaint. The Ombudsman stated she could not recall the exact date; however, it was February 2025. The Ombudsman stated she came to the facility on [DATE], and no one at the facility reported anything to her regarding the incident that occurred between R1 and R2. The Ombudsman also stated she gave R1's daughter the department's information to submit an online submission.<br><br>During a phone interview with R1's Representative (RP) on 02/27/25 at 10:28 AM, revealed that on 02/05/25, between 10:30 AM and 11:00 AM, the Director of Nursing (DON) contacted R1's RP via phone and said on Monday night 02/03/24, going into 02/04/25, R2 was completely naked, and was actively trying to get R1's brief off. The facility staff intervened and removed him from her room. Staff told her (R1's RP) they didn't think that it was a big enough deal and since they didn't find anything, it was not a reportable offense.<br><br>During an interview, via phone, with LPN1 on 02/27/25 at 2:24 PM, LPN1 confirmed her statement. LPN1 stated she spoke to the DON, she and another nurse, and since her brief was intact, they didn't believe she was penetrated, or sexually assaulted which is why she was not sent to the hospital. LPN1 stated she spoke to the DON first, and informed she would take care of it all the following morning. LPN1 stated she did not notify R1's family.<br><br>During an interview with the Director of Nursing (DON) on 02/27/25 at 12:19 PM, the DON stated she is aware of a situation between two residents, R1 and R2. LPN1 called her on 02/04/25 at 1:00 AM, stating RN1 located R2 in R1's room, completely naked, on top of the female resident. The female residents covers were pushed back, brief still on. There was no evidence that he penetrated her, no redness, no discharge, no bruises. The DON stated on 02/05/25, she called the daughter and apologized in regards to her not being notified the day it happened.<br><br>During an interview with the Administrator on 02/27/25 at 3:40 PM, the Administrator stated the DON told her that R2 went into R1 rooms, R2 was found naked, at R1's bedside. The Administrator stated the DON is responsible for reporting, and this incident should have been reported, and is unsure as to why the DON did not. |