

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425062	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2025
NAME OF PROVIDER OR SUPPLIER Brookview Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</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>(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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425062	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2025
NAME OF PROVIDER OR SUPPLIER Brookview Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, record review, interview and observation, the facility failed to ensure Resident (R)4 was provided appropriate supervision to prevent an elopement from the facility for 1 of 3 resident reviewed. On 09/05/25 at 11:21 AM, the surveyor provided the Administrator with a copy of the CMS Immediate Jeopardy (IJ) Template, informing the facility IJ existed as of 09/03/25. The IJ was related to 42 CFR 483.25 - Freedom from Accidents Hazards/Supervision/Devices. On 09/05/25, the facility provided an acceptable IJ Removal Plan. On 09/05/25, the survey team validated the facility's corrective actions and determined the facility put forth due diligence in addressing the non-compliance. The SA is considering this IJ at Past Non-compliance as of 09/04/25. An Extended Survey was conducted in conjunction with the Complaint Survey for noncompliance at F689, constituting substandard quality of care. Review of the facility policy titled Elopement Response Guidelines with an effective date 05/01/06 states, It is the responsibility of all staff to provide a safe environment for all residents. The following guidelines will be followed in the event that a resident is missing. Responding to an actual elopement: 1. 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 unit. 3. When a resident is determined to be missing: Note the time that the resident is/was determined missing. The staff members assigned to the unit where the resident resides will verify that the resident has not been signed out. Staff members will do a thorough search to locate the resident. If the resident is not located, proceed with the following: The Charge Nurse will notify the Director of Nursing that a resident is missing. Staff members from other departments will search the entire facility and grounds. Prior to beginning the search, the resident's photograph will be viewed by all staff involved in the search. Review of R4's Face Sheet revealed R4 was admitted to the facility on [DATE] with diagnoses including but not limited to other seizures (History of), vascular dementia, moderate, with anxiety (History of), and dementia. Review of R4's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/05/25 revealed the assessment is in process. Review of R4's Care Plan with a start date of 08/30/25 revealed, Resident has disorganized thinking or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject) R/T [related to] dementia diagnosis. This Care Plan directed staff to, Orient to person, place, and time as appropriate [sic]. Protect from injuring self and others during delirious state. provide a quiet, well-lit, calm environment. Surround resident with familiar objects. Remove potentially dangerous objects from environment. Further review of the Care Plan dated 08/30/25 revealed, Resident has socially inappropriate/disruptive behavioral symptoms as evidenced by: verbal and physical threats to staff. This Care Plan directed staff to, Avoid over-stimulation (e.g., noise, crowding, other physically aggressive residents). Maintain a calm environment and approach to the resident. Review of a document titled Addressing Decisional Capacity, signed by the Attending Physician on 09/02/25 revealed, This patient DOES NOT meet all the criteria for decisional capacity, therefore is not able to make healthcare decisions for self. Further review of this document revealed, Criteria not met: Oriented to person place time, Understands the nature of his/her illness, Ability to understand that decisions need to be made, Ability to communicate a decision, Ability to understand and use information logically to reach a decision, Ability to be realistic in decision making. Review of R4's Progress Notes, revealed the following notes: 08/30/25 at 10:30 AM Resident arrived via stretcher. Resident exit seeking. 08/30/25 at 7:07 PM Resident continues to exit seek. 08/31/25 at 11:02 AM Resident up this am ambulating. Continues to exit seek pushing on doors. 09/01/25 at 2:00 PM Resident continues to exit seek. 09/01/25 at 5:57 PM. Noted exit seeking and has made door alarm go off in dining room and long peach hall door. 09/01/25 at 6:24 PM Resident attempting to leave this nurse was trying to redirect resident. 09/03/25 at 9:00 PM Recorded as late entry on 09/04/25 at 1:59 PM During Shift change this nurse and day shift nurse was counting NARCS. 7P-7a CNA asked where [R4], her resident was. Another CNA spoke up and said she is on Peach unit sitting on the couch. The 7P- 7a CNA went to Peach. Resident was not there. All staff from all units began looking for [sic] [R4] around 7:15-7:17pm. As the staff was outside looking for the resident [R4]. The kitchen lady pulled up with [R4]. she reported she had seen her at [local grocery store]. She was able to bring her back to the facility in her car. During an interview on 09/04/25 at 2:45 PM, Dietary 1 stated, I have worked here for three years now. I clocked out at 7:20 PM yesterday. I called my daughter to pick me up from work. I told her to bring my wallet with her so I could go to [local grocery store]. As soon as we pulled up at [local grocery store], I saw [R4] standing in front of [local</p>		