STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425392	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linville Court at the Cascades Verdae	30 Springcrest Court Greenville, SC 29607

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on review of facility policy, record review, observation, and interview, the facility failed to ensure that Resident (R)17 had an active order for the use of a Cervical Thoracic Orthosis (CTO) neck brace, for 1 of 1 resident reviewed for positioning/range of motion (ROM). Findings include: Review of the facility policy titled, Medication and Treatment Orders, with a last revision date of July 2016, documented, Orders for medications and treatments will be consistent with principles of safe and effective order writing. Review of the facility policy titled, Assistive Devices and Equipment, with a last revision date of February 2014, documented, Our facility maintains and supervises the use of assistive devices and equipment for residents. The policy also documented, The following factors are addressed to the extent possible to decrease the risk of avoidable accidents associated with devices and equipment: a. Appropriateness for resident condition; b. Personal fit; c. Device condition; d. Staff practices. Review of R17's Face Sheet revealed that R17 was admitted to the facility with diagnoses including, but not limited to: Traumatic Subarachnoid Hemorrhage Without Loss of Consciousness, Intracranial Injury with Loss of Consciousness, Epidural Hemorrhage with Loss of Consciousness, Nontraumatic Subarachnoid Hemorrhage, Nondisplaced Fracture of the 2nd Cervical Vertebra, Multiple Fractures of Ribs, Left Side, Stable Burst Fracture of the Fourth Thoracic Vertebra, and Stable Burst Fracture of the Third Thoracic Vertebra. Review of R17's undated Care Plan documented ADL - [R17] relays a goal to improve her abilities in self-care. She has difficulties with movement, generalized weakness, and unsteady balance due to a recent hospitalization from a fall from her attic (about 15 feet) directly onto her head. This caused significant injuries, including subarachnoid hemorrhage, scalp laceration, left frontoparietal cranial fracture, epidural hematoma, left C2 lamina fracture, left rib fractures (1st, 3rd, 4th, 9th), left pneumothorax, L4 pars defect of unknown chronicity, and a three-column fracture at T3-T4. She has a CTO brace that should remain in place to prevent extreme changes in the position of the neck. She also prefers to lie flat for comfort, but this causes headaches. She was treated for her acute needs at the hospital but remains fatigued and restricted in her movements, requiring staff assistance with transfers, toileting, and incontinence care. She was referred to rehab to improve her functional activities without physical assistance, address impaired dynamic and static balance, and improve strength and balance. (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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Prisma Health Progress Note with a visit date of 02/24/25, revealed the patient was admitted to the hospital for multiple traumas, including Traumatic Brain Injury (TBI), Subdural and Subarachnoid Hemorrhage (brain bleed), multiple broken ribs, and a spinal fracture. Additionally, the document revealed, 2/24/25 Continue CTO [Cervical Thoracic Orthosis] brace for 3 months. Review of R17's Orders on 03/10/25 at 3:00 PM, did not reveal an active order for the use and/or indication for a CTO brace. During an interview on 03/09/25 at 12:42 PM, R17 revealed that she suffered a head-first fall at home, resulting in multiple fractures to her spine, neck, and ribs. The resident stated she was hospitalized for treatment and sent to the facility for rehab. She was told to leave her neck brace on until she sees her spinal doctor and neuro team later in the week. The resident indicated that she wears the brace at all times except when bathing. During an interview on 03/11/25 at approximately 4:30 PM, with Registered Nurse (RN)1 and Interim Director of Nursing (DON). RN1 stated that it was her understanding that R17 should have her CTO brace on at all times. An observation was made with RN1 and the DON of the resident's current order set, and no active order could be found in regard to the use and rationale for the use of R17's CTO brace. The DON acknowledged that the lack of an order could potentially lead to safety concerns and possible harm to the resident. The DON also stated that an order should have been placed for the CTO brace use. During an interview on 03/11/25 at 5:23 PM, the Medical Director (MD)1 stated based on R17's hospital discharge instructions, the CTO brace should be worn at all times until the resident is seen by the neurosurgeon on 03/13/25. MD1 thought there was an order in place for R17's CTO brace in the electronic health record (EHR). MD1 explained that the resident should have an order for the CTO brace to ensure resident safety and protect the resident from further injury. MD1 further explained that typically, the admissions nurse is responsible for reviewing hospital discharge paperwork and transferring any relevant orders to the resident's EHR under the medical director's name. During an interview on 03/11/25 at 5:32 PM, RN2, who serves as the admissions nurse, stated that when a resident is admitted from the hospital, she is responsible for ensuring that any medications and treatment orders specified by hospital providers are entered into the resident's EHR. The admissions nurse will place the orders under the MD's name. RN2 recalled reading a note from the hospital that stated the resident needed to wear the brace at all times. RN2 explained that when the resident was admitted , she was handling four other admissions simultaneously, and the order for the CTO brace was not entered into the system, possibly because it was overlooked. RN2 believes the order for the CTO brace should have been placed upon admission. During an interview on 03/11/25 at 5:44 PM, the Executive Director (ED) confirmed that, based on the admissions nurse's role in ensuring that orders are properly placed during admission, proper procedures were not followed, and the order for R17's CTO brace should have been placed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observation, and interview, the facility failed to ensure proper handling and transportation of resident laundry for 1 of 1 residents observed. Findings include: Review of the facility policy titled, Laundry and Bedding, Soiled, documents, Policy Interpretation and Implementation Transport . 5. Separate carts are used for transporting clean and contaminated linen. Otherwise, carts that are used for transport of dirty linen are thoroughly cleaned and disinfected before being used to transport clean linen. 6. Clean linen is protected from dust and soiling during transport and storage to ensure cleanliness . Storage 1. Clean linen is stored separately, away from soiled linens, at all times. During an observation on 03/11/25 at 11:35 AM, the Laundry Attendant removed covered dirty linen basket from room [ROOM NUMBER]. Laundry Attendant took the dirty linen basket to the hallway outside of the laundry room. The laundry attendant donned gloves and removed clean linen from the dryer. She folded a pair of pants and a blanket and placed the clean laundry on top of the resident's dirty linen basket. The laundry attendant did not clean and disinfect the dirty linen basket before placing the clean linen on top of the dirty laundry basket. The Laundry Attendant removed her gloves. She donned an apron and a new pair of gloves. She removed the soiled laundry from the dirty linen basket and placed it in the washing machine. The washing machine was started. The clean linen was transported back to the resident's room uncovered, on top of the dirty linen basket. The Laundry Attendant confirmed that she always transports linen like this. During an interview on 03/11/25 at 12:13 PM, the Director of Facilities revealed that dirty linen should be bagged, sealed off and transported. There should be a separate cart for dirty linen and a separate cart for clean linen. Both the clean and the dirty linen should be covered for transport because you do not know what kind of viruses are floating around. During an interview on 03/11/25 at 12:36 PM, the Executive Director revealed their expectations are that clean linen should never come in contact with dirty linen or dirty surfaces. Clean linen and dirty linen should be covered during transport.