SUMMARY SHEET
SOUTH CAROLINA BOARD OF HEALTH AND ENVIRONMENTAL CONTROL

April 13, 2023

( ) ACTION/DECISION
( X ) INFORMATION

**I.** **TITLE:** Healthcare Quality Administrative and Consent Orders.

**II.** **SUBJECT:** Healthcare Quality Administrative Orders and Consent Orders for the period of February 1, 2023, through February 28, 2023.

**III.** **FACTS:** For the period of February 1, 2023, through February 28, 2023, Healthcare Quality reports 5 Consent Orders totaling $71,700 in assessed monetary penalties.

| Bureau | Facility, Service, Provider, or Equipment Type | Administrative Orders | Consent Orders | Assessed Penalties | Required Payment |
|---|---|---|---|---|---|
| **Community Care** | Community Residential Care Facility (CRCF) | 0 | 4 | $43,000 | $35,000 |
| | Residential Treatment Facility for Children and Adolescents (RTF) | 0 | 1 | $28,700 | $20,000 |
| **TOTAL** | | **0** | **5** | **$71,700** | **$55,000** |

Submitted By:

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HEALTHCARE QUALITY ENFORCEMENT REPORT
SOUTH CAROLINA BOARD OF HEALTH AND ENVIRONMENTAL CONTROL

April 13, 2023

## Bureau of Community Care

| Facility Type | Total Number of Licensed Facilities | Total Number of Licensed Beds |
|---|---|---|
| Community Residential Care Facility (CRCF) | 471 | 22,049 |

### 1. Carriage House of Florence (80 beds) – Florence

**Investigation and Violations:** The Department conducted routine follow-up and food and sanitation follow-up inspections and complaint investigations at the facility in February, March, April, and May 2022, and cited numerous and repeated violations.

The Department found the following violations, of which many were repeated:

- Failing to render care in accordance with orders from physicians or other authorized healthcare provider regarding medication administration.
- Failing to initial medication administration records ("MARs") as medications were administered.
- Failing to have documented reviews of MARs at shift changes.
- Failing to maintain residents' medications in the original packaging.
- Storing discontinued medications with current medications.
- Failing to document reviews of controlled sheets at shift changes.
- Storing medication in a resident' room who has an order to not self-administer over-the-counter medications.
- Failing to keep equipment and building in good working repair and operating condition.
- Failing to keep the grounds clean and free of vermin and offensive odors.
- Failing to clean each specific area of the building.
- Failing to provide window treatments for privacy in residents' bathrooms.
- Failing to maintain plumbing fixtures that require hot water and which are accessible to residents to supply water at a temperature of at least 100 degrees Fahrenheit.
- Failing to equip a resident room with a comfortable single bed with water-proof linens.
- Failing to provide liquid soap and a sanitary hand drying method in a shared bathroom.
- Failing to provide toilet paper in a shared bathroom.
- Leaving medication unsecured and accessible in a resident's room.
- Failing to ensure its kitchen and food preparation were in compliance with Regulation 61-25.
- Failing to keep its grounds free of weeds, rubbish, overgrown landscaping, and other potential breeding sources for vermin.
- Failing to maintain documentation of staff initial and annual trainings.
- Failing to have a health assessment for staff member.
- Failing to have monthly notes of observation for residents.
- Retaining a resident who required daily care of a licensed nurse and was inappropriate for a CRCF.
- Failing to have medication available for administration.

- Failing to safely store harmful chemicals in a manner that makes them inaccessible to residents.
- Failing to keep soiled clothing in proper containers.
- Failing to take safety precautions against fire and other hazards when oxygen is dispensed, administered, or stored.
- Failing to keep supplies and equipment off the floor.
- Failing to at least semi-annually review a resident's individual care plan.

**Enforcement Action:** In June 2022, the parties met for an enforcement conference and discussed the abovementioned violations. The Department requested, and received, photographs in response to the violations discussed at the enforcement conference. In August 2022, the Department issued an Administrative Order to the facility revoking its license to operate. Carriage House of Florence submitted a request for final review (RFR) of the Department's administrative order in August 2022, and then filed a request for a contested case hearing with the Administrative Law Court in October 2022. In November 2022, the Department received an application for an amended license for Carriage House of Florence as a result of a change of ownership. The parties agreed to resolve this matter with a Consent Order, whereby the facility agreed to the assessment of a $10,000 monetary penalty to be paid in two payments of $5,000. The parties' agreement and signing of the Consent Order of Dismissal dismissed the pending contested case in the Administrative Law Court. The Department further agreed to rescind its revocation, and upon payment of the required fees (not including the payment of the $10,000 monetary penalty) and submission of required documentation, the Department agreed to issue an amended license in accordance with the licensure application regarding a change of ownership for the facility.

For a period of five years, the shareholders and officers of Carriage House of Florence, either individually or through entities or organizations formed by or on behalf of the shareholders or officers, agree not to seek licensure as a CRCF and not to manage or operate a CRCF in South Carolina. Additionally, for a period of five years, Carriage House of Florence agrees to not seek licensure as a CRCF in South Carolina and to not manage or operate a CRCF in South Carolina.

**Remedial Action:** The facility has made the first payment of $5,000. The facility has completed their change of ownership and have new owners and a new name, Patriot Living of Florence. Residents did not have to be relocated as a result.

**Prior Orders:** In November 2020, The Department and Carriage House of Florence executed a Consent Order imposing a $5,000 monetary penalty based upon violations relating to infection control standards. In February 2022, the Department and Carriage House of Florence executed a second Consent Order imposing a $10,000 monetary penalty based on various regulation violations including failing to have a licensed administrator, failing to notify the Department of a change in administrator's status, failing to maintain sufficient staff, failing to maintain resident medical and financial records, failing to maintain and properly store resident medications, failing to maintain kitchen compliance, failing to safely store chemicals, allowing smoking in a resident room, failing to keep the facility clean and free from vermin and failing to promote conditions the prevent the spread of infection. Following the second Consent Order, the Department visited the facility numerous times to conduct follow-up inspections and investigations. The Department was cited for failing to render care in accordance with orders from physicians, maintain resident records, maintaining resident medications, maintain and clean the building's interior and exterior and plumbing fixtures, and failing to provide soap and toilet tissue in a shared bathroom. As a result, the Department issued an Administrative Order revoking the license to operate Carriage House Senior Living of Florence as a CRCF.

**2. Carriage House of Sumter (60 beds) - Sumter**

**Investigation and Violations:** The Department conducted routine general, food and sanitation, fire and life safety, and routine follow-up inspections at the facility in April, May, and June 2022, and cited numerous and repeated violations.

The Department found the following violations, of which many were repeated:

- Failing to have monthly notes of observation for residents.
- Failing to review and/or revise residents' individual care plans ("ICPs") at least semi-annually, by failing to develop residents' ICPs within seven days of admission, and by failing to have a resident's ICP signed by the resident and/or the resident's sponsor or responsible party.
- Retaining a resident that received a sliding scale insulin.
- Failing to have documentation of a resident's current annual physical examination and by failing to complete a resident's physical examination within 30 days prior to admission.
- Failing to properly initial medication administration records ("MARs") as medications were administered to residents.
- Failing to have documented reviews of MARs and control sheets at shift changes.
- Failing to maintain its food service area in compliance with Retail Food Establishment, Regulation 61-25.
- Failing to keep all equipment and building components in good repair and operating condition.
- Failing to ensure the facility was free of vermin and offensive odors.
- Failing to ensure that each specific interior area of the facility was cleaned.
- Failing to ensure that harmful chemicals in the interior of the facility were stored safely and inaccessible to residents.
- Failing to provide liquid soap at each lavatory used by more than one resident and by allowing communal use of bar soap.

**Enforcement Action:** The Department and Carriage House of Sumter met for an enforcement conference in August 2022, to discuss the abovementioned violations, the facility's efforts to obtain and maintain regulatory compliance, and discussed resolution of the enforcement action. In November 2022, the Department received an application for an amended license for Carriage House of Sumter as a result of a change of ownership. The facility agreed to a $10,000 assessed monetary penalty to be paid in two installments of $5,000. In addition, upon payment of the required fees (which does not include payment of the monetary penalty) and submission of required documentation, the Department will issue an amended license in accordance with the licensure application regarding a change of ownership for the facility.

Furthermore, the facility agrees to not seek licensure as a CRCF in South Carolina and to not manage or operate a CRCF in South Carolina for a period of five years. Additionally, the shareholders and officers of Carriage House of Sumter, either individually or through entities or organizations formed by or on behalf of the shareholders or officers, agreed to not seek licensure as a CRCF in South Carolina and to not manage or operate a CRCF in South Carolina for a period of five years.

**Remedial Action**: Carriage House of Sumter has paid the first $5,000 payment. The facility has completed their change of ownership and have new owners and a new name, Patriot Living of Sumter. Residents did not have to be relocated as a result.

**Prior Orders:** In February 2022, the Department and Carriage House of Sumter executed a Consent Order imposing a $5,000 monetary penalty against the facility as a result of violations of various provisions of Regulation 61-84. The facility failed to have proper documentation for residents, maintain equipment and building components, promote conditions that prevent the spread of infectious diseases, ensure the facility was fee from vermin and/or offensive odors, properly store chemicals, ensure the interior and exterior of the facility was clean.

**3. Seneca Residential Care (33 beds) - Seneca**

**Investigation and Violations:** The Department conducted multiple inspections and investigations at the facility and cited numerous and repeated violations.

The Department found the following violations, of which many were repeated:

- Failing to submit to the Department timely acceptable written plans of correction.
- Failing to have at least one staff member/direct care volunteer on duty for each eight residents or fraction thereof during periods of peak hours.
- Failing to maintain documentation to ensure the Facility had at least one staff member/direct care volunteer on duty for each eight residents during peak hours and at least one staff member/direct care volunteer on duty for each 30 residents during non-peak hours.
- Failing to ensure the Facility completed a written assessment of a resident no later than 72 hours after the resident's admission.
- Admitting a resident that needed treatment for a stage two decubitus ulcer.
- Failing to render care and services to residents in accordance with physicians' orders.
- Failing to ensure a resident was free from mental abuse.
- Failing to ensure a resident's admission physical included a two-step tuberculin skin test.
- Failing to initial the medication administration records ("MARs") as medications were administered.
- Failing to have documented reviews of the MARs at each shift change.
- Failing to ensure medications were kept in their original containers or packaging.
- Storing discontinued and expired medications with current medications, by failing to have a thermometer in the refrigerator storing medications, and by failing to properly store and safeguard medications to prevent access by unauthorized persons.
- Failing to maintain records of controlled substances in sufficient detail to enable an accurate reconciliation.
- Failing to have documented reviews of the control sheets at each shift change.
- Failing to maintain its kitchen and food preparation in compliance with Retail Food Establishment, Regulation 61-25.
- Failing to record in writing substitutions made on the master menu.
- Failing to maintain all equipment and building components in good repair and operating condition.
- Failing to ensure the Facility was free of vermin and offensive odors.
- Failing to ensure that each specific interior area of the Facility was cleaned.
- Failing to ensure soiled linen/clothing were kept in enclosed/covered containers.
- Failing to have window treatments for privacy in residents' rooms.
- Failing to properly secure in place an oxygen cylinder and by failing to post a "No Smoking" sign in a resident room that had an oxygen concentrator.
- Failing to maintain plumbing fixtures that require hot water and are supplied to residents at a temperature of at least 100 degrees F. and not to exceed 120 degrees F.
- Failing to ensure a resident's room is furnished with a comfortable bed and a mattress with a moisture-proof cover.
- Failing to have liquid hand soap in public restrooms and by allowing communal use of bar soap.

**Enforcement Action:** The parties met for an enforcement conference and agreed to resolve this matter with a Consent Order. The facility agreed to the assessment of a $18,000 monetary penalty, and to pay $10,000

in two installments of $5,000. The remaining $8,000 will be stayed upon a six-month period of substantial compliance with Regulation 61-84 and this Consent Order. The Facility attended a compliance assistance meeting with representatives of the Department on March 21, 2023.

**Remedial Action:** The facility has made the first payment of $5,000. The Department and the facility met for the compliance assistance meeting in March 2023.

**Prior Orders:** None in the past five years.

**4. Palmetto Village of Chester (100 beds) - Chester**

**Investigation and Violations:** The Department conducted multiple inspections and investigations at the facility and cited numerous and repeated violations.

The Department cited the facility for the following violations, of which many were repeated:

- Failing to have documentation of staff in-service training in basic first aid.
- Failing to have documentation of staff in-service training in management/care of persons with contagious and/or communicable disease.
- Failing to have documentation of staff in-service training in medication management.
- Failing to have documentation of staff in-service training in care of persons specific to the physical/mental condition(s) being cared for in the Facility.
- Failing to have documentation of staff in-service training in use of restraint techniques.
- Failing to have documentation of staff in-service training in OSHA standards regarding blood-borne pathogens.
- Failing to have documentation of staff in-service training in confidentiality of resident information and records.
- Failing to have documentation of staff in-service training in the Bill of Rights for Residents of Long-Term Care Facilities, S.C. Code Ann. Sections 44-81-10, et. seq.
- Failing to have documentation of staff in-service training in fire response.
- Failing to have documentation of staff in-service training in emergency procedures/disaster preparedness.
- Failing to have documentation of residents' individual care plans ("ICPs") that have been reviewed and/or revised at least semi-annually and by failing to revise a resident's ICP as changes in the resident's needs occurred.
- Failing to render care in accordance with physician's orders for administering medications and by Failing to take special precautions for a resident with special conditions.
- Failing to have documentation of a resident's physical examinations that addresses the need (or lack thereof) for the continuous daily attention of a licensed nurse.
- Failing to initial the medication administration records ("MARs") as medications were administered.
- Failing to have documented reviews of the MAR.s at each shift change by outgoing staff with incoming staff.
- Failing to have documented reviews of the control sheets at each shift change by outgoing staff with incoming staff.
- Failing to maintain all equipment and building components in good repair and operating condition.
- Failing to ensure that the Facility was free of vermin.
- Failing to ensure that the plumbing fixtures that require hot water and are accessible to residents are maintained between 100 degrees F and 120 degrees F.

**Enforcement Action:** The parties met for an enforcement conference and agreed to resolve this matter with a Consent Order. The facility agreed to an assessment of $5,000 monetary penalty to be paid in ten installments of $500.

**Remedial Action:** The facility has paid all of the required $5,000 to the Department. The facility agreed to correct the violations that initiated this enforcement action and shall submit invoices to support repairs and purchases made, to ensure that all violations of Regulation 61-84 are not repeated. The facility agreed to ensure that all repairs are completed within the ten-month period.

**Prior Orders:** None in the past five years.

| Facility Type | Total Number of Licensed Facilities | Total Number of Licensed Beds |
|---|---|---|
| Residential Treatment Facility for Children and Adolescents (RTF) | 8 | 518 |

**5. New Hope Carolinas, Inc. (150 beds) - Rock Hill**

**Investigation and Violations:** The Department conducted a complaint investigation at the facility and cited the following violations:

- Failing to implement its policies and procedures regarding resident care, rights, and operation of the Facility.
- Not reporting a serious accident and/or incident to the Department within 24 hours of the serious accident and/or incident.
- Failing to submit a written report of its investigation of serious accidents and/or incidents to the Department within five calendar days of the serious accidents and/or incidents.
- Failing to revise the residents' individual treatment plans as changes in the residents' needs occurred.
- Failing to delineate the responsibilities of the sponsor and of the Facility in meeting the needs of the resident, including provisions for the sponsor to monitor the care and effectiveness of the Facility in meeting those needs.
- Failing to afford each resident the right to be treated with consideration, respect, and dignity.
- Failing to ensure that residents were free from harm, abuse, or neglect.
- Not maintaining the Facility's building components in good repair and operating condition and/or by failing to comply with the codes adopted by the South Carolina Building Codes Council and the South Carolina State Fire Marshal.
- Failing to clean each area of the interior of the Facility.
- Failing to submit plans and specifications to the Department for new construction or projects that have an effect on the life safety system of the residents.
- Failing to maintain plumbing fixtures that require hot water and are accessible to residents, at least 100 degrees Fahrenheit.

**Enforcement Action:** The Facility is responsible for a monetary payment to the Department of $28,700. The Facility shall make payment of $20,000 within 30 days of execution of this Consent Order. Payment was received on Feb. 10, 2023. Payment of the remaining $8,700 will be stayed upon a six-month period of substantial compliance with Regulation 61-103 and this Consent Order.

**Remedial Action:** The Facility attended a compliance assistance meeting with representatives of the Department on April 5, 2023, and agrees to initiate action to remedy deficient conditions identified by the Department.

**Prior Orders:** None in the past 5 years.