SUMMARY SHEET
SOUTH CAROLINA BOARD OF HEALTH AND ENVIRONMENTAL CONTROL

August 12, 2021

( ) 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 June 1, 2021, through June 30, 2021.

III. **FACTS:** For the period of June 1, 2021, through June 30, 2021, Healthcare Quality reports four (4) Consent Orders totaling $45,600 in assessed monetary penalties.

<table>
<tr><th>Name of Bureau</th><th>Facility, Service, Provider, or Equipment Type</th><th>Administrative Orders</th><th>Consent Orders</th><th>Assessed Penalties</th></tr>
<tr><td rowspan="2">Community Care</td><td>Community Residential Care Facility</td><td>0</td><td>2</td><td>$41,600</td></tr>
<tr><td>Intermediate Care Facility for Individuals with Intellectual Disabilities</td><td>0</td><td>1</td><td>$1,500</td></tr>
<tr><td>Healthcare Systems and Services</td><td>In-Home Care Provider</td><td>0</td><td>1</td><td>$2,500</td></tr>
<tr><td colspan="2">TOTAL</td><td>0</td><td>4</td><td>$45,600</td></tr>
</table>

Submitted By:

Gwendolyn C. Thompson

Gwen C. Thompson
Deputy Director
Healthcare Quality

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

August 12, 2021

Bureau of Community Care

Facility Type	Total Number of Licensed Facilities	Total Number of Licensed Beds
Community Residential Care Facility (CRCF)	483	21,737

1. Bowles Community Care Home – McClellanville, SC

Inspections and Investigations: The Department conducted a follow-up inspection and investigation in January 2020 and a routine inspection August 2020, and found the facility repeatedly violated numerous regulatory requirements.

Violations: The Department found the facility violated Regulation 61-84, *Standards for Licensing Community Residential Care Facilities*, by failing to have a policies and procedures manual addressing each section of the Regulation regarding resident care, rights, and the operation of the facility, failing to conduct criminal background checks on staff prior to hire, and failing to have written documentation of staff members' health assessment and assigned duties and responsibilities. The facility had multiple violations regarding training including basic first aid, the care of persons with contagious or communicable diseases, medication management, care of persons specific to the physical and/or mental condition cared for in the facility, OSHA standards regarding blood borne pathogens, confidentiality of resident information, resident rights, fire response, emergency procedures, and disaster preparedness. The facility had multiple violations regarding resident records and documentation including failing to have physician orders for all resident medications, monthly resident notes of observation, current photographs of the residents, and residents' quarterly financial reports. The facility had multiple violations regarding medication administration including failing to document reviews of medication administration records at each shift change, to have quarterly on-site reviews of the medications program by a pharmacist, and failing to have documented reviews of the control sheets at each shift change by outgoing staff with incoming staff. The Department further found that the facility failed to ensure preventive measures and practices were followed according the guidelines of the Centers for Disease Control and Prevention (CDC) and infectious waste management requirements. Moreover, the facility failed to maintain its kitchen in compliance with Regulation 61-25, Retail Food Establishment, to maintain records of menus, and to have an annual tuberculosis risk assessment.

Enforcement Action: The parties agreed to resolve the matter with a consent order. The parties executed a consent order imposing a monetary penalty of $20,300 against the facility. The facility is required to pay $10,150 of the assessed monetary penalty in five payments of $1,691 and a sixth and final payment of $1,695. The facility agreed to schedule and attend a compliance assistance meeting with Department representatives within 45 days of executing the Consent Order.

Remedial Action: The facility paid the first required payment. The compliance assistance meeting was held July 23, 2021.

Prior Actions: In December 2020, the parties executed a consent order imposing a civil monetary penalty of $1,000 against the facility. The Department found the facility failed to comply with Regulation 61-84, *Standards for Licensing Community Residential Care Facilities*, by continuously failing to submit the renewal application and fees within the specified timeframe. The facility repeatedly failed to timely submit a renewal application and pay the required fees. The facility was required to pay the full amount of the penalty within 30 days of executing the Consent Order. The Department reissued the facility's renewal license upon receipt of the full monetary penalty.

2. Bowles Community Care Home 2 – McClellanville, SC

Inspections and Investigations: The Department conducted a follow-up inspection and investigation in January 2020 and a routine inspection August 2020, and found the facility repeatedly violated numerous regulatory requirements.

Violations: The Department found the facility violated Regulation 61-84, *Standards for Licensing Community Residential Care Facilities*, by failing to conduct criminal background checks on staff prior to hire, maintaining accurate and current information regarding staff members, having written documentation of staff member' assigned duties and responsibilities, and failing to maintain documentation of a staff health assessment prior to resident contact. The facility had multiple violations regarding training including basic first aid, the care of persons with contagious or communicable diseases, medication management, care of persons specific to the physical and/or mental condition cared for in the facility, OSHA standards regarding blood borne pathogens, confidentiality of resident information, resident rights, fire response, emergency procedures, and disaster preparedness. The facility had multiple violations regarding resident records and documentation including failing to have physician orders for all resident medications, monthly resident notes of observation, current photographs of the residents, reviewing and revising residents' individual care plans, and residents' quarterly financial reports. The facility had multiple violations regarding medication administration including failing to document reviews of medication administration records at each shift change, to have quarterly on-site reviews of the medications program by a pharmacist, and failing to have documented reviews of the control sheets at each shift change by outgoing staff with incoming staff. The Department further found that the facility failed to ensure preventive measures and practices were followed according the guidelines of the Centers for Disease Control and Prevention (CDC) and infectious waste management requirements. Moreover, the facility failed to maintain records of menus, to have and implement a quality improvement program, and to maintain all equipment and building components in good repair and operating condition.

Enforcement Action: The parties agreed to resolve the matter with a consent order. The parties executed a consent order imposing a monetary penalty of $21,300 against the facility. The facility is required to pay $10,650 of the assessed monetary penalty in six (6) payments of $1,775. The facility agreed to schedule and attend a compliance assistance meeting with Department representatives within 45 days of executing the Consent Order.

Remedial Action: The facility has not made the first payment. The compliance assistance meeting was held July 23, 2021.

Prior Actions: None in the past five years.

Facility Type	Total Number of Licensed Providers	Total Number of Licensed Beds
Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-ID)	66	1,632

3. Archie Drive Group Home – Columbia, SC

Inspections and Investigations: The Department conducted an investigation in February 2021 and found the facility violated regulatory requirements.

Violations: The Department found the facility violated Regulation 61-13, *Standards for Licensing Intermediate Care Facilities for Individuals with Intellectual Disabilities*, by failing to obtain a physician's order prior to using an emergency restraint procedure on a resident. The facility failed to have documentation of training in use of restraints and/or therapeutic options available for review. Moreover, the facility failed to ensure clients were protected from physical restraints and abuse as outlined in the Bill of Rights for Residents in Long-Term Care Facilities.

Enforcement Action: The parties agreed to resolve the matter with a consent order. The parties executed a consent order imposing a monetary penalty of $1,500 against the facility. The facility is required to pay the full amount of the monetary penalty. The facility agreed to schedule and attend a compliance assistance meeting with Department representatives within 45 days of executing the Consent Order.

Remedial Action: The facility paid the required monetary penalty amount. The compliance assistance meeting is scheduled to take place in early August.

Prior Actions: None in the past five years.

Bureau of Healthcare Systems and Services

Facility Type	Total Number of Licensed Providers
In-Home Care Provider	828

4. Affinity Caregivers of SC, LLC – Lexington, SC

Inspections and Investigations: The Department conducted an investigation in June 2021, at Affinity Caregivers, to determine if they were establishing, operating, maintaining, and/or representing themselves as an in-home care provider without first obtaining a license from the Department.

Violations: The Department found that Affinity Caregivers was in violation of the Licensure of In-Home Care Providers Act and Regulation 61-122, *Standards for Licensing In-Home Care Providers,* because Affinity Caregivers was operating as an unlicensed in-home care provider.

Enforcement Action: The parties agreed to resolve the matter by consent order. The parties executed a Consent Order imposing a $2,500 civil monetary penalty against Affinity Caregivers. Affinity Caregivers agreed to pay the full amount of the assessed civil monetary penalty, and to not establish, operate, maintain, or represent themselves as an in-home care provider without first obtaining a license from the Department.

Remedial Action: The in-home care provider submitted a complete and accurate application, and, on June 29, 2021, received an initial license to operate as an in-home care provider. Affinity Caregivers paid the civil monetary penalty.

Prior Actions: This is the third enforcement action against Affinity Caregivers. The parties executed a consent order in March 2021, whereby Affinity Caregivers agreed to pay a $2,500 monetary penalty and agreed to not establish, operate, maintain, or represent themselves as an in-home care provider without first obtaining a license from the Department. After an April 2021 investigation, the Department found that Affinity Caregivers continued to operate, maintain, and/or represent themselves as an in-home care provider without first obtaining a license from the Department. The parties executed a second Consent Order in May 2021, whereby Affinity Caregivers agreed to pay a $5,000 monetary penalty and agreed to not establish, operate, maintain, or represent themselves as an in-home care provider without first obtaining a license from the Department.