SUMMARY SHEET
SOUTH CAROLINA BOARD OF HEALTH AND ENVIRONMENTAL CONTROL

September 7, 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 July 1, 2023, through July 31, 2023.

**III.** **FACTS:** For the period of July 1, 2023, through July 31, 2023, Healthcare Quality reports 4 Consent Orders totaling $15,600 in assessed monetary penalties.

| Bureau | Facility, Service, Provider, or Equipment Type | Administrative Orders | Consent Orders | Assessed Penalties | Required Payment |
|---|---|---|---|---|---|
| **Community Care** | Nursing Home | | 2 | $15,000 | $15,000 |
| **Healthcare Systems and Services** | In-Home Care Provider | | 2 | $600 | $600 |
| **TOTAL** | | | **4** | **$15,600** | **$15,600** |

Submitted By:

Gwendolyn C. Thompson

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Gwen C. Thompson
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Healthcare Quality

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

September 7, 2023

## Bureau of Community Care

| Facility Type | Total Number of Licensed Facilities | Total Number of Licensed Beds |
|---|---|---|
| Nursing Home | 194 | 20,204 |

### 1. Vivant Healthcare of Hanahan, Hanahan (135 beds)

**Investigation and Violations:** On June 7, 2022, Aug. 30, 2022, Sept. 2, 2022, Mar. 6, 2023, Mar. 14, 2023, and Apr. 12, 2023, the Department representatives made unannounced visits to the Facility to conduct inspections, follow-up inspections and complaint investigations. During those inspections, the Department found the Facility in violation of Regulation 61-17 as follows:

- The Facility failed to afford a resident the opportunity to formulate an advanced directive.
- The Facility failed to ensure there were adequate staff in number and skill.
- The Facility failed to provide the minimum 1.63 hours of direct care per resident per day from the non-licensed staff.
- The Facility failed to provide the staff members with the necessary training.
- The Facility failed to ensure all staff were provided in-service training that identified training needs related to problems, needs, resident care and infection control.
- The Facility failed to have documentation of a resident's advance directive upon admission.
- The Facility failed to ensure complete and accurate medical records for a resident's files that contained written records of month weights.
- The Facility failed to review and revise residents' Individual Care Plan.
- The Facility Failed to ensure treatment and services were rendered effectively and safely.
- The Facility failed to provide residents with assistance in self-care and activities of daily living.
- The Facility failed to ensure that residents were neat, clean and appropriately/comfortably dressed in clean clothes.
- The Facility failed to institute measures to prevent and treat wounds.
- The Facility failed to provide a resident with assistance with addressing social, emotional and related problems.
- The Facility failed to notify a family member of a resident's discharge/transfer.
- The Facility failed to maintain a resident's privacy by knocking before entering the room.
- The Facility failed to store and safeguard medications to prevent access by unauthorized individuals.
- The Facility failed to ensure the proper storage and labeling of blood glucometer testing strips and vials of insulin.
- The Facility failed to ensure that schedule II controlled substances were properly stored and secured.
- The Facility failed to make provisions for proper maintenance of food temperatures.
- The Facility failed to ensure food is properly prepared and sufficient in quantity and quality.

- The Facility failed to ensure that the storage, preparation, serving and transportation of food was in accordance with R. 61-25.
- The Facility failed to employ a qualified dietitian or other qualified nutrition professional.
- The Facility failed to ensure that fire protection and suppression systems were maintained and tested annually.
- The Facility failed to ensure that staff practices promote conditions that prevent the spread of infectious, contagious or communicable diseases and provide for the proper disposal of toxic and hazardous substances.
- The Facility failed to have documentation that direct care staff and/or residents had an annual flu vaccine or were offered and declined the vaccination.
- The Facility failed to implement an infection prevention and control program.
- The Facility failed to have documentation of residents who were vaccinated for Streptococcus pneumoniae or those who were offered and declined.
- The Facility failed to ensure the facility and its grounds were uncluttered, clean and free from vermin and offensive odors.
- The Facility failed to keep the structure, component parts, amenities and equipment in good repair and operating condition.
- The Facility failed to properly secure oxygen tanks.
- The Facility failed to ensure the facility free of fire hazards or impediments.
- The Facility failed to ensure a call button was available to allow residents to call for assistance.
- The Facility failed to have a system in place to ensure all financial obligations are met to guarantee care and services are provided to residents.

**Enforcement Action:** The parties agreed to resolve the matter with a Consent Order. The Facility paid the $10,000 monetary penalty.

**Remedial Action:** The facility agreed to initiate action to correct those violations and ensure that they are not repeated.

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

**2. Vivant Healthcare of Charleston – Charleston (125 beds)**

**Investigation and Violations:** On Jan. 31, 2022, Mar. 7, 2023, and Apr. 12, 2023, Department representatives made unannounced visits to the Facility to conduct inspections. During those inspections, the Department found the Facility in violation of Regulation 61-17 as follows:

- The Facility failed to ensure treatment and services were rendered effectively and safely.
- The Facility failed to have documented reviews of the control sheets at each shift change.
- The Facility failed to ensure that fire protection and suppression systems were maintained and tested.
- The Facility failed to keep the structure, component parts, amenities and equipment in good repair and operating condition.
- The Facility failed to have a system in place to ensure all financial obligations are met to guarantee care and services are provided to residents.

**Enforcement Action:** The parties agreed to resolve the matter with a Consent Order. The Facility paid the $5,000 monetary penalty.

**Remedial Action:** The facility agreed to initiate action to correct those violations and ensure that they are not repeated.

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

## Bureau of Healthcare Systems and Services

| Facility Type | Total Number of Licensed Facilities |
|---|---|
| In-Home Care Provider | 933 |

**1. S & S Sure Care, LLC**

**Investigation and Violations:** The Facility failed to submit a timely renewal application and licensing fees by the license expiration date.

**Enforcement:** The Department and the Facility decided to resolve the matter through a Consent Order. The Facility paid the $300 monetary penalty.

**Remedial Action:** none

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

**2. Alpha Health Services**

**Investigation and Violations:** The Facility failed to submit a timely renewal application and licensing fees by the license expiration date.

**Enforcement:** The Department and the Facility decided to resolve the matter through a Consent Order. The Facility paid the $300 monetary penalty.

**Remedial Action:** none

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