SUMMARY SHEET
SOUTH CAROLINA BOARD OF HEALTH AND ENVIRONMENTAL CONTROL

August 10, 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 June 1, 2023, through June 30, 2023.

**III.** **FACTS:** For the period of June 1, 2023, through June 30, 2023, Healthcare Quality reports 3 Consent Orders totaling $35,060 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) | | 2 | $34,760 | $17,900 |
| **Healthcare Systems and Services** | In-Home Care Provider | | 1 | $300 | $300 |
| **TOTAL** | | | **3** | **$35,060** | **$18,200** |

Submitted By:

Gwendolyn C. Thompson

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Gwen C. Thompson
Deputy Director
Healthcare Quality

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

August 10, 2023

## Bureau of Community Care

| Facility Type | Total Number of Licensed Facilities | Total Number of Licensed Beds |
|---|---|---|
| Community Residential Treatment Facility (CRCF) | 463 | 21,655 |

**1. Palmetto Ridge Assisted Living & Memory Care – Cheraw (106 beds)**

**Investigation and Violations:** On Jan. 13, 2022, May 24, 2022, June 27, 2022, July 29, 2022, Aug. 31, 2022, Sep. 6, 2022, Oct. 13, 2022, and Nov. 10, 2022, the Department representatives made unannounced visits to the Facility to conduct inspections, follow-up inspections and an investigation. During those inspections, the Department found the Facility in violation of Regulation 61-84 as follows:

- The Facility failed to implement their policies addressing resident abuse.
- The Facility failed to employe a licensed CRCF administrator.
- The Facility failed to have at least one staff member for each eight residents during peak hours.
- The Facility failed to report a serious incident or accident to the Department.
- The Facility failed to report abuse or suspected abuse to the SC long-Term Care Ombudsman Program.
- The Facility failed to notify the Department of any change in administrator status.
- The Facility failed to review and/or revise a resident's ICP at least semiannually.
- The Facility failed to render care and services to residents in accordance with physician orders.
- The Facility failed to ensure a resident was free from mental abuse.
- The Facility failed to have residents' physician order medications available for administration.
- The Facility failed to initial residents' medication administration records as medications were administered.
- The Facility failed to keep medications in the original containers and, instead, stored loose pills in medication carts.
- The Facility stored discontinued medications with current medications.
- The Facility failed to maintain records of controlled substances in sufficient detail to enable an accurate reconciliation.
- The Facility failed to keep 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 Facility agreed to the assessment of a $22,960 monetary penalty. The facility agrees to pay $12,000 in four equal payments. Two payments have been received by the Department. The Department agrees to hold the remaining $10,960 in abeyance upon a six-month period of substantial compliance.

**Remedial Action:** The facility attended a compliance assistance meeting with the Department on July 19, 2023.

**Prior Orders:** The Department issued a Consent Order in Dec. 2021. The Facility agreed to pay $10,300 in assessed monetary penalties. The violations were primarily medication related.

**2. Reid House – Wellford (42 Beds)**

**Investigation and Violations:** On Apr. 19, 2021, and Dec. 13, 2022, Department representatives made unannounced visits to the Facility to conduct inspections. During those inspections, the Department found the Facility in violation of Regulation 61-84 as follows:

- The Facility failed to properly initial Medication Administration records.
- The Facility failed to keep all equipment and building components in good repair and operating condition.
- The Facility failed to keep the facility free of vermin and offensive odors.
- The Facility failed to ensure that each specific interior area of the facility was clean.
- The Facility failed to ensure soiled linen/clothing were kept in enclosed containers.
- The Facility failed to properly secure oxygen cylinders.

**Enforcement Action:** The parties agreed to resolve the matter with a Consent Order. The Facility agrees to pay $5,900. The remaining $5,900 will be held in abeyance for a six-month period of substantial compliance.

**Remedial Action:** The Facility met with the Department on July 10, 2023, for a compliance assistance meeting.

**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 | 935 |

**1. Olive Branch Home Care 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.