SCALA's 2022 Spring Conference

JoMonica Taylor, MHA ,APM, Director

April 19, 2022 4:00pm

Columbia Metropolitan Convention Center

South Carolina Department of Health and Environmental Control

Healthy People. Healthy Communities.

OVERVIEW

- ❑Healthcare Quality “HQ”
- ❑CRCF Data
- ❑Top 10 Violations
- ❑Licensing Requirements
- ❑Reporting
- ❑Enforcement
- ❑Plan of Correction
- ❑Red Cap
- ❑COVID-19

HEALTHCARE QUALITY

Gwendolyn Thompson, Director of Healthcare Quality

dhec
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Healthcare Quality

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HQ HEALTHCARE QUALITY

Community Care

- Nursing Homes
- Community Residential Care Facilities
- Intermediate Care Facilities for Individuals with Intellectual Diabilities
- Residential Treatment Facilities for Children & Adolescents

Healthcare Systems & Services

- Athletic Trainers
- EMS
- Hearing Aid Specialists
- Midwives
- Hospitals
- Stroke Centers
- Trauma Centers
- Abortion Clinics
- Adult Day Care Facilities
- Ambulatory Surgical Facilities
- Birthing Centers
- Body Piercing Facilities
- Substance Abuse Disorder Facilities
- CLIA Laboratories
- Freestanding & Mobile Technology
- Home Health Agencies
- Hospice
- In-Home Care Providers
- Renal Dialysis Facilities
- Tattoo Facilities

Planning & Construction

- Health Facilities Construction
- Certificate of Need
- Certificate of Public Advantage

Drug Control

- Prescription Monitoring Program
- Controlled Substances Registrants

Radiological Health

- Radioactive Materials
- X-Ray Equipment
- Tanning Facilities

Policy & Communications

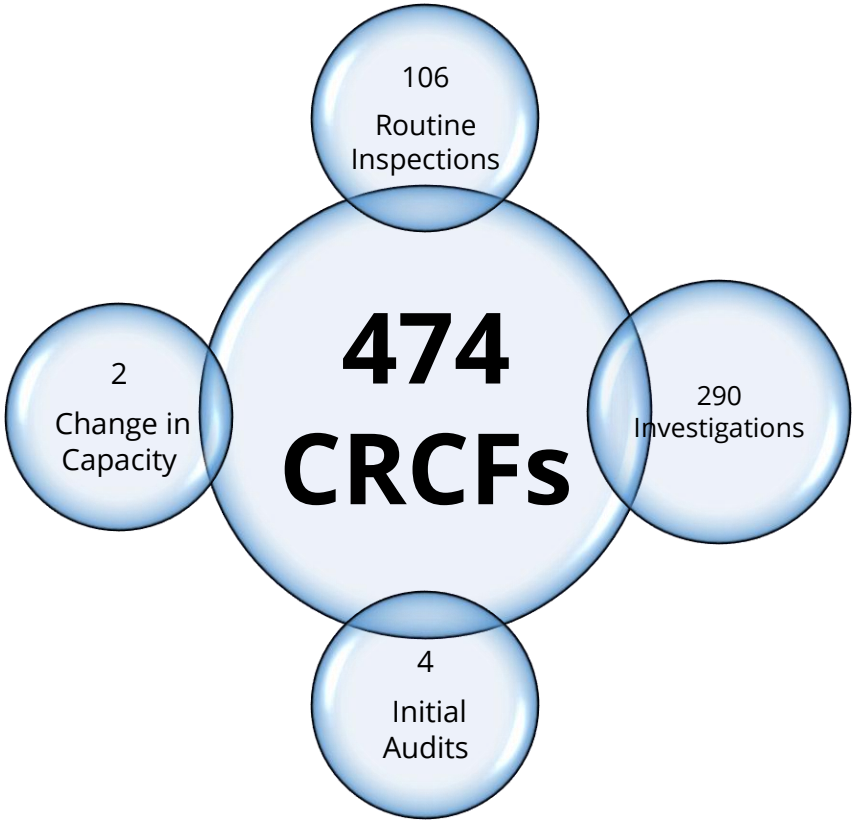
Training & Compliance

Administrative Services

RESIDENTIAL FACILITIES DIVISION

- **Division Director-** JoMonica Taylor
- **Field Managers-** Pamela Williams & Sandra Johnson
- **Support Manager-** Everette Williams
- **Facility Types**
  - Community Residential Care Facilities (CRCFs)
  - Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs)
  - Residential Treatment Facilities for Children & Adolescents (RTFs)
  - Crisis Stabilization Unit Facilities

CRCF DATA



Data October 1, 2021- April 1, 2022

Top 10 Citations

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2301.B
WATER SUPPLY/HYGIENE

- **Hot water** at plumbing fixtures
- **Accessible** to residents
- Temperature range of **at least 100 degrees Fahrenheit** and **not to exceed 120 degrees Fahrenheit**

1206.A MEDICATION STORAGE

- Stored and safeguarded from unauthorized persons.
  - **Locked and secured**
- Expired or discontinued medications
- Refrigerated medications 36-46 degrees F
  - Thermometers required
  - Secured refrigerator for medications only OR secured manner separate from other items in the refrigerator

1703 HOUSEKEEPING

- Clean and free of vermin & offensive odors
- Equipment- cleaned and disinfected
- Safe storage of chemicals and cleaning products/materials/supplies
  - Orders required for resident use

1703 HOUSEKEEPING cont.

- Clean exterior areas
- Free of weeds, rubbish, overgrown landscaping and potential breeding sources for vermin
- Safe storage of chemicals

1206.C CONTROLLED SUBSTANCES

- **1206.C.1**
  - Separate control sheets for **each controlled substance**
  - Required information
    - Date
    - Time administered
    - Resident's name
    - Dose
    - Signature of individual administering
    - Ordering physician or authorized healthcare provider's name

1206.C CONTROLLED SUBSTANCES

- **1206.C.2**
  - **Required** at **each** shift change
  - **Documented review** of the control sheets
  - **Outgoing with incoming staff** will verify medications were:
    - Properly administered
    - Documented
    - Errors/omissions indicated, addressed and corrected

MEDICATION ADMINISTRATION RECORD (MAR)

NARCOTICS SHIFT CHANGE
(Two Shifts Only)

SAMPLE

Month/Year: _____

Purpose: At each shift change, a documented review of the control sheets by outgoing staff members with incoming staff members including verification, indicating they have properly administered medications in accordance with orders by a physician or other authorized health care provider and have documented the administrations. Errors/omissions indicated on the control sheets shall be address and corrective action taken at that time.

Date	Shift	Incoming Signature (PLEASE PRINT CLEARLY)	Outgoing Signature (PLEASE PRINT CLEARLY)	Count Correct Y/N
1	7am – 7pm			
	7pm – 7am			
2	7am – 7pm			
	7pm – 7am			
3	7am – 7pm			
	7pm – 7am			
4	7am – 7pm			
	7pm – 7am			
5	7am – 7pm			
	7pm – 7am			
6	7am – 7pm			
	7pm – 7am			

1101.A RESIDENT PHYSICAL EXAMINATION

- Completed within **30 days prior** to admission
- Physicians licensed in **other states**
  - **Permitted for new admissions**
  - Resident must obtain a SC licensed physician **within 30 days of admission**
  - Physical must be updated if changes from the previous examination

1101.A RESIDENT PHYSICAL EXAMINATION cont.

- Physical examination requirements:
  - Appropriateness of placement in a CRCF
  - Medications/treatments ordered
  - Self-administration status
  - Identification of special conditions/care required
  - The need of (or lack thereof) for the continuous daily attention of a licensed nurse

Sample Admission Physical Examination Form

ADMISSION/ANNUAL MEDICAL EXAMINATION

Name of Resident:	Age:	Sex:	Uses: ( )Walker ( )Cane ( )Wheelchair

1. General Diagnosis:

2. Any contagious or infectious disease? Yes/No

3. Any conditions or habits which would adversely affect the well being of others in the facility? Yes/No If "Yes," please explain:

4. Is this person able to self-administer medications? Yes/No

5. Does this person have the physical ability to engage in light, specially designed, low-level, geriatric exercises? Yes/No

6. Is this person ambulatory; able to enter and exit the facility unassisted? Yes/No

7. Does this person require the daily care of a registered or licensed practical nurse? Yes/No

8. A Community Residential Care Facility provides room, board, a degree of personal assistance in the activities of daily living. Can this person be cared for in such a facility? Yes/No

9. Diet:

Physician's Signature:	Address:	Telephone:	Date:

901.C RESIDENT CARE/SERVICES

- Render care and services
- Orders by a physician or authorized healthcare provider
- Take precaution for residents with special conditions
- Assist with ADLs as needed and appropriate

1203.F MAR REVIEW

- **Required** at **each** shift change
- **Documented review** of the MAR
- **Outgoing with incoming staff** will verify medications were:
  - Properly administered
  - Documented
  - Errors/omissions indicated, addressed and corrected

MEDICATION ADMINISTRATION RECORD (MAR) SHIFT CHANGE

(Two Shifts Only)

SAMPLE

Month/Year: _____

Purpose: There shall be a documented review of the MAR by incoming and outgoing staff which indicates that they have properly administered medications in accordance with orders of a physician or other authorized health care provider and have documented the administrations.

Date	Shift	Incoming Signature (PLEASE PRINT CLEARLY)	Outgoing Signature (PLEASE PRINT CLEARLY)
1	7am – 7pm		
	7pm – 7am		
2	7am – 7pm		
	7pm – 7am		
3	7am – 7pm		
	7pm – 7am		
4	7am – 7pm		
	7pm – 7am		

SAMPLE

MEDICATION ADMINISTRATION RECORD (MAR) SHIFT CHANGE

(First, Second, Third Shifts)

Month/Year: _____

Purpose: There shall be a documented review of the MAR by incoming and outgoing staff which indicates that they have properly administered medications in accordance with orders of a physician or other authorized health care provider and have documented the administrations.

Date	Shift	Incoming Signature	Outgoing Signature
1	7am – 3pm		
	3pm – 11pm		
	11pm – 7am		
2	7am – 3pm		
	3pm – 11pm		
	11pm – 7am		

1601 MAINTENANCE

- **ALL** equipment and building components
  - Good repair and operating condition
- Document preventive maintenance
- SC Building Codes and SC State Fire Marshal

703.A
INDIVIDUAL CARE PLAN

- Developed within **7 days of admissions**
  - Resident, administrator (or designee) and/or sponsor or responsible party
  - Signature and date required
- Reviewed and/or revised **as changes occur** but **not less than semi-annually**
  - Signature and date required by participants

Sample ICP Form

INDIVIDUAL CARE PLAN (ICP)

Resident Name _____ Date of Admission_____

Diagnosis: _____

Advanced Directives: YES ___ NO ___ Power of Attorney: YES ___ NO ___ Responsible Party: _____

Primary Physician: _____ Dietary Requirements: _____

Transportation Arrangement for Visits to Physician(s) and/or Other Healthcare Provider: Family: ____Facility: ____Other: _____

Will resident require someone to remain with them throughout the physician's appointment? Y____ N____ Staff____ Family____

Other (explain):_____

TASK / NEED	HOW MUCH ASSISTANCE	FREQUENCY	GOAL/ACHIEVEMENT DATE	RESPONSIBLE PARTY
DRESSING	___Independent (no assistance required) ___Reminder (needs reminders/cues) ___Minimum (lay out articles/buttons, laces/zippers/hooks) ___Moderate (full hands on assistance with all articles of clothing/shoes) ___Maximum (frequent clothing changes needed throughout day or at night due to incontinence) ___Other (explain):	___Daily ___AM ___PM ___PRN ___As Requested ___Other (explain):	____ Next 6 months ____ Other (details): To insure that the resident is appropriately dressed	___Self ___Staff ___Family/Sponsor ___Other (explain):
BATHING	___Independent (no assistance required) ___Reminder (remind/cues/monitor) ___Minimum (lay out supplies, set water temp. assist in/out) ___Moderate (in addition to minimum, assist with washing back, feet, "hard to reach areas") ___Maximum (in addition to moderate, full assist with washing/drying) ___Assist with certain areas/special needs (explain): ___Other (explain):	___Daily Circle: Mon. Tues. Wed. Thurs. Fri. Sat. Sun. ___AM ___PM ___PRN ___As requested ___Other (explain)	____ Next 6 months ____ Other (explain): To insure that the resident is clean, fresh and odor free.	___Self ___Staff ___Family/Sponsor ___Other (explain):

1203.A ADMINISTERING MEDICATION/TREATMENT

- Administer by the same staff who prepped
  - Prep no earlier than 1 hour prior to administration
- **Initial on the MAR as the medication is administered or treatment record as rendered**

HONORABLE MENTION CITATIONS

- **1001.A-** Bill of Rights
- **1201.A-** Medication available and properly managed
- **504.A.4**- Medication management training

Sample STAFF ORIENTATION & IN-SERVICE RECORD
Community Residential Care Facilities (CRCF)
Bureau of Health Facilities Licensing

NAME _____

HIRE DATE _____

INITIAL RESIDENT CONTACT DATE _____

The following training shall be provided to all staff members/direct care volunteers, prior to resident contact, and at least annually:

Topic	Date	Staff Signature	Trainer Signature	Training Resource
Basic First Aid				
Checking and Recording Vital Signs (Designated Staff Members Only)				
Management/care of contagious or communicable disease				
Medication Management(i.e. storage, administration, receiving orders, securing)				
Special Care** (e.g., dementia; cognitive disability; mental illness; or aggressive, violent, and/or inappropriate behavioral symptoms)				
Restraint Techniques				
OSHA (including blood-borne pathogens)				
CPR (Designated Staff Members Only)				
Confidentiality				
Bill of Rights for Long Term Care Facilities/ Resident Rights				
Fire Response Training (within 24 hours of first day on the job)				
Emergency Procedures/Disaster Preparedness (within 24 hours of first day on the job)				
Facility Organization and Environment/ Orientation (within 24 hours of first day on the job)				
Activities***				

**Depending on Type of Residents in Facility

***Staff Members responsible for providing/coordinating recreational activities

LICENSING REQUIREMENTS

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LICENSE RENEWAL

- Notifications are sent **via e-mail to the contact e-mail address on file 60 days prior to the expiration date**.

- Complete and submit via e-mail (preferably) **prior to the expiration of your license.**
  - CRCF license application (DHEC 0217)
  - Applicable supporting documentation
  - Emergency evacuation plan (REDCap)
  - Online payment receipt

AMENDED LICENSE

- Facility shall request an issuance of an amended license to the Department for the following circumstances:
    1. **Change of Ownership (CHOW)**
    2. **Change of licensed bed capacity**
    3. **Change of facility location from one geographic site to another**
    4. **Changes in facility name or address**

CHANGE OF OWNERSHIP (CHOW)

- **Completed** Application DHEC-0217
- FBI background check for new licensee
- Licensing fee
  - **$10 per bed or**
  - **$75 for facilities with 7 beds or less**
- New Emergency Evacuation Plan (EEP)
- Administrator's License
- Evidence of a CHOW/transaction (Bill of Sale, agreement etc)
- Articles of Incorporation/Organization/Partnership documents

CHANGE IN LICENSED BED CAPACITY

- **Completed** Application DHEC-0217
- Licensing Fee
- Updated Emergency Evacuation Plan
- Notice of Completion (NOC)- contact Construction Division

FACILITY NAME CHANGE

- **Completed** Application DHEC-0217 **or**
- Letter from the licensee
  - On official letterhead

REPORTING

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604
ADMINISTRATOR CHANGE

- **Licensee** notifies DHEC within **72 hours** of any change in administrator status
    - Via telephone or e-mail
- **Licensee** has **10 days after notification** to provide the following:
    - **Name of the newly appointed administrator**
    - **Effective date**
    - **Copy of administrator's license**
    - **Hours the individual will be working each day**
- **Change can be submitted online or via e-mail.**

https://scdhec.gov/healthcare-quality/healthcare-facility-licensing/community-residential-care-facilities

601. ACCIDENTS/INCIDENTS

- Report every serious accident and/or incident within **24 hours**
  - Physician, next of kin/responsible party & DHEC
  - Telephone, e-mail, or **online portal** (preferred)
- Written report of the facility's investigation due within 5 days of the serious accident and/or incident
  - **Online portal** (preferred)
- **Retain records for 6 years**

601. ACCIDENTS/INCIDENTS cont.

Serious accidents and/or incidents requiring reporting include, but are not limited to:

1. Crime(s) against resident
2. Confirmed or suspected cases of abuse, neglect, or exploitation
   - Contact SC LTC Ombudsman
3. Medication error with adverse reaction
4. Hospitalization as a result of the accident and/or incident;
5. Severe hematoma, laceration or burn requiring medical attention or hospitalization
6. Fracture of bone or joint
7. Severe injury involving use of restraints
8. Attempted suicide; or
9. Fire.

Elopement

ENFORCEMENT ACTION

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300 ENFORCEMENT ACTIONS

When the **Department determines** that a facility is in violation of **any statutory provision, rule, or regulation relating to the operation or maintenance of such facility**, the Department, upon proper notice to the licensee, may **impose a monetary penalty, deny, suspend, or revoke licenses**.

300 ENFORCEMENT ACTION

- Specific conditions and their impact or potential impact on health, safety or well-being of the residents
- Repeated failure to pay charges for utilities/services resulting in repeated or threats to terminate
- Efforts to correct cited violations
- Overall conditions of the facility
- History of compliance
- Any other pertinent conditions that may be applicable to current statutes and regulations

300 ENFORCEMENT ACTION

Frequency of violation of standard within a 36-month period:

MONETARY PENALTY RANGES

FREQUENCY	CLASS I	CLASS II	CLASS III
1st	$500-1,500	$300-800	$100-300
2nd	1000-3000	500-1500	300-800
3rd	2000-5000	1000-3000	500-1500
4th	5000	2000-5000	1000-3000
5th	5000	5000	2000-5000
6th	5000	5000	5000

PLAN OF CORRECTION

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202.D INSPECTIONS/INVESTIGATIONS

- Noncompliance with licensing standards requires a Plan of Correction (POC):
  - Actions taken to **correct each cited deficiency**
  - Actions take to **prevent recurrences**
  - The **actual or expected completion date** of those actions

REDCap

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Resize font:

Emergency Evacuation Plan Summary - CRCFs

Please complete the information below regarding your facility's emergency evacuation plan.

If you administer multiple facilities, you must complete a separate form for each inpatient facility in Beaufort, Charleston, Colleton, Georgetown, Horry and Jasper counties.

You only need to save your progress if you need to finish the form at a later time. If you have issues completing this form, please contact Everette Williams at williael@dhec.sc.gov or JoMonica Taylor at taylorjj@dhec.sc.gov.

License Number: [redacted]
* must provide value

Facility Name: [redacted]
* must provide value

Licensed Bed Capacity: 80
* must provide value

Average Daily Census: 60
* must provide value

Please enter the following information for your facility's designated Emergency Evacuation Planner:

First Name: [redacted]
* must provide value

Last Name: [redacted]
* must provide value

E-mail: [redacted].com
* must provide value

COVID-19

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COVID-19 UPDATES

- NO VISITATION RESTRICTIONS
- Adhere to Core Principles of COVID-19 Infection Prevention
- DHEC COVID-19 guidelines located within the visitation guidance previously issued (click the applicable links within the document)

COVID-19 UPDATES cont.

- **R. 61-84 section 1701**: *Staff/volunteer practices shall promote conditions that prevent the spread of infectious, contagious, or communicable diseases and provide for the proper disposal of toxic and hazardous substances.* ***These preventive measures/practices shall be in compliance with applicable guidelines*** *of the Blood borne Pathogens Standard of the Occupational Safety and Health Act (OSHA) of 1970;* ***the Centers for Disease Control and Prevention (CDC); and R.61-105; and other applicable Federal, State, and local laws and regulations****.*

- *CDC Infection Prevention & Control*

https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-home-long-term-care.html

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CONTACT US

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QUESTIONS???

THANK YOU SCALA !!!

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