Top Violations in Community Residential Care Facilities

JoMonica Taylor, MHA, Director

SCALA Fall Conference 2022

South Carolina Department of Health and Environmental Control

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OVERVIEW

- ❑Residential Facilities Division
- ❑CRCF Data
- ❑Top Violations

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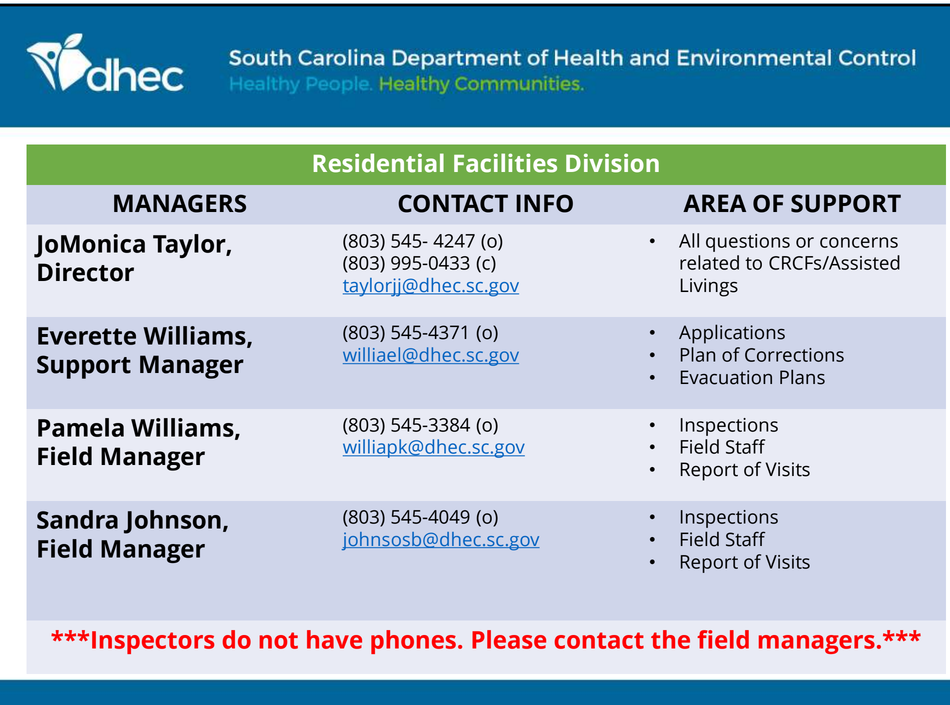

Residential Facilities Division		
MANAGERS	**CONTACT INFO**	**AREA OF SUPPORT**
JoMonica Taylor, Director	(803) 545- 4247 (o) (803) 995-0433 (c) taylorjj@dhec.sc.gov	• All questions or concerns related to CRCFs/Assisted Livings
Everette Williams, Support Manager	(803) 545-4371 (o) williael@dhec.sc.gov	• Applications • Plan of Corrections • Evacuation Plans
Pamela Williams, Field Manager	(803) 545-3384 (o) williapk@dhec.sc.gov	• Inspections • Field Staff • Report of Visits
Sandra Johnson, Field Manager	(803) 545-4049 (o) johnsosb@dhec.sc.gov	• Inspections • Field Staff • Report of Visits

Inspectors do not have phones. Please contact the field managers.

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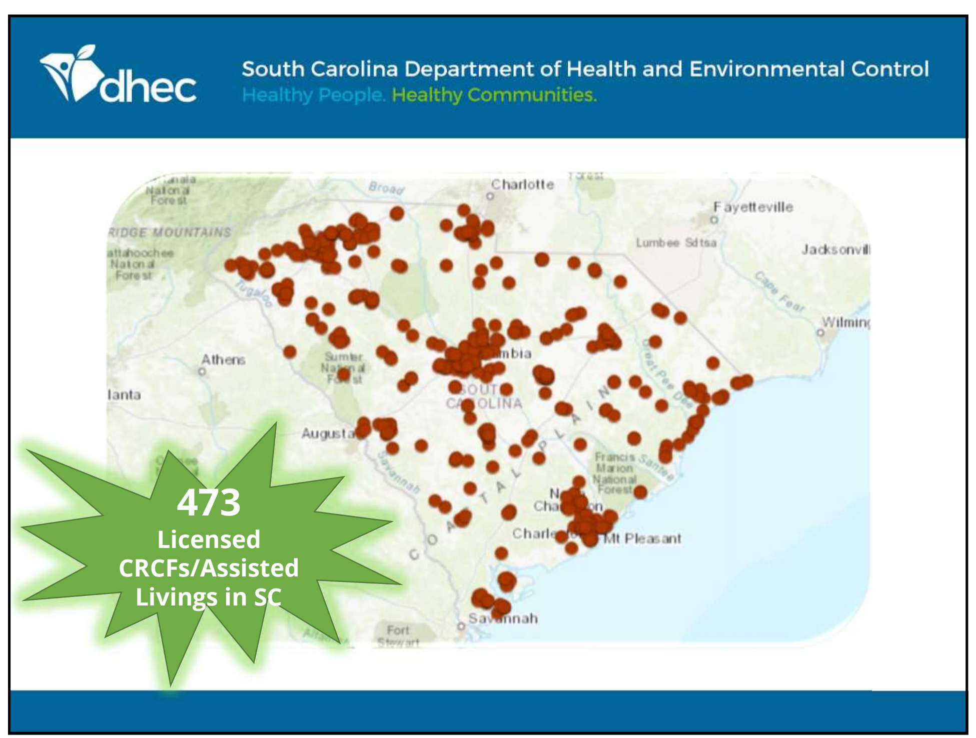

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Top Violations

January 1 – August 31, 2022

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1203.A ADMINISTERING MEDICATION/TREATMENT

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

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1601 MAINTENANCE

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

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MEMORANDUM

TO: Administrators, Licensed Facilities

FROM: Gwen C. Thompson, Chief
Bureau of Health Facilities Licensing

SUBJECT: Reporting Loss of Utilities/Services

Extreme weather conditions may severely impact the safety of residents, patients or clients in facilities that are licensed by the Bureau of Health Facilities Licensing (BHFL). Temperature extremes place a heavy burden on air conditioning and heating equipment. Associated increased electrical needs may overwhelm the power supply resulting in brown outs or complete loss of power. Facilities must plan ahead to address these issues and are expected to have emergency plans to accommodate disruptions in power.

As a reminder, should a facility licensed by the Department experience a loss of cooling or heating, interruption of potable water supply, loss of electrical power, or other conditions affecting the continuity of essential services, the facility must notify the Department immediately after ensuring the safety of the residents, patients, or clients. You may contact the Department at (803) 545-4370. After hours, please contact the Department at (803) 606-0767.

Failure to notify the BHFL promptly may result in sanctions from the Department.

GCT/lkw

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901.C RESIDENT CARE/SERVICES

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

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703.A INDIVIDUAL CARE PLAN

- Developed within **7 days of admissions**
  - Participation of the 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

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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):

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Disclaimer: Facilities are NOT required to use this form.

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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

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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

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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

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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

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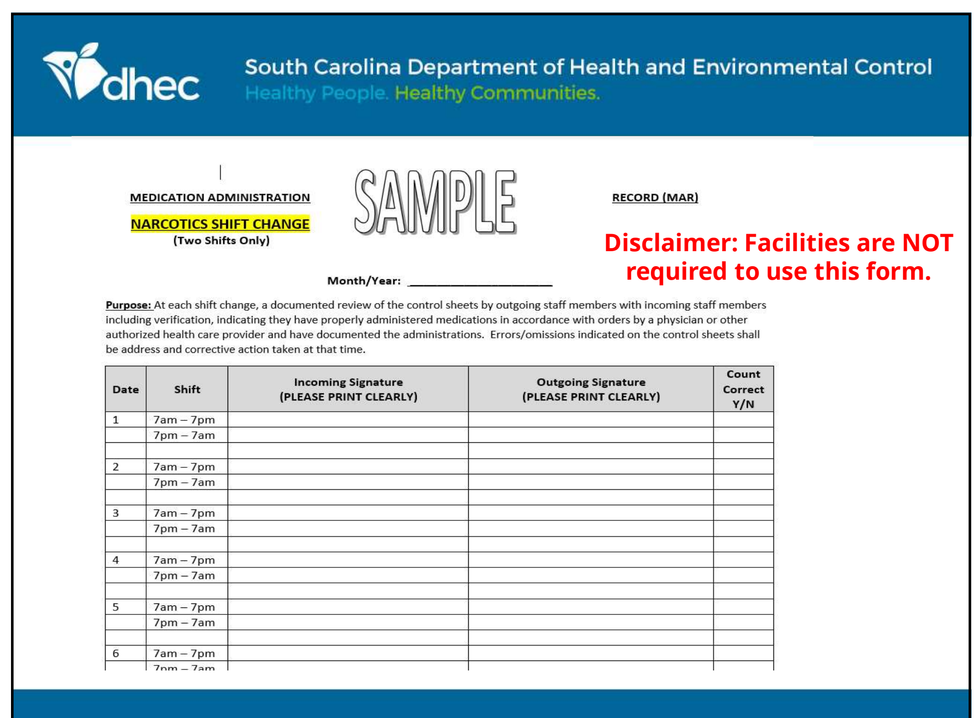

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MEDICATION ADMINISTRATION SAMPLE RECORD (MAR)

NARCOTICS SHIFT CHANGE
(Two Shifts Only)

Disclaimer: Facilities are NOT required to use this form.

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			

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1206.A MEDICATION STORAGE

- Properly stored and safeguarded
- Do not store expired & discontinued medications with current medications
- Storage area must be locked, clean and orderly
- Refrigerated medications
  - Secured refrigerator or
  - Secured manner separated from other items

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504.A.1-12 STAFF INSERVICE TRAINING

- **Required for all staff**
- **Prior to** resident contact & **annually** thereafter
- Documented, signed and dated by the individual providing and receiving training
- Provided by appropriate resources

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REQUIRED INSERVICE TRAINING

- Basic first aid
- Checking and recording vital signs (designated staff)
- Management/care of persons with contagious and/or communicable disease
- Medication Management
- Depending on the type of residents, care of persons specific to the physical/mental condition being cared for in the facility
- Restraint techniques
- OSHA standards
- CPR (designated staff/direct care volunteers)
- Confidentiality
- Bill of Rights for Long Term Care
- Fire response
- Emergency procedures/disaster preparedness
- Activity training (designated staff)

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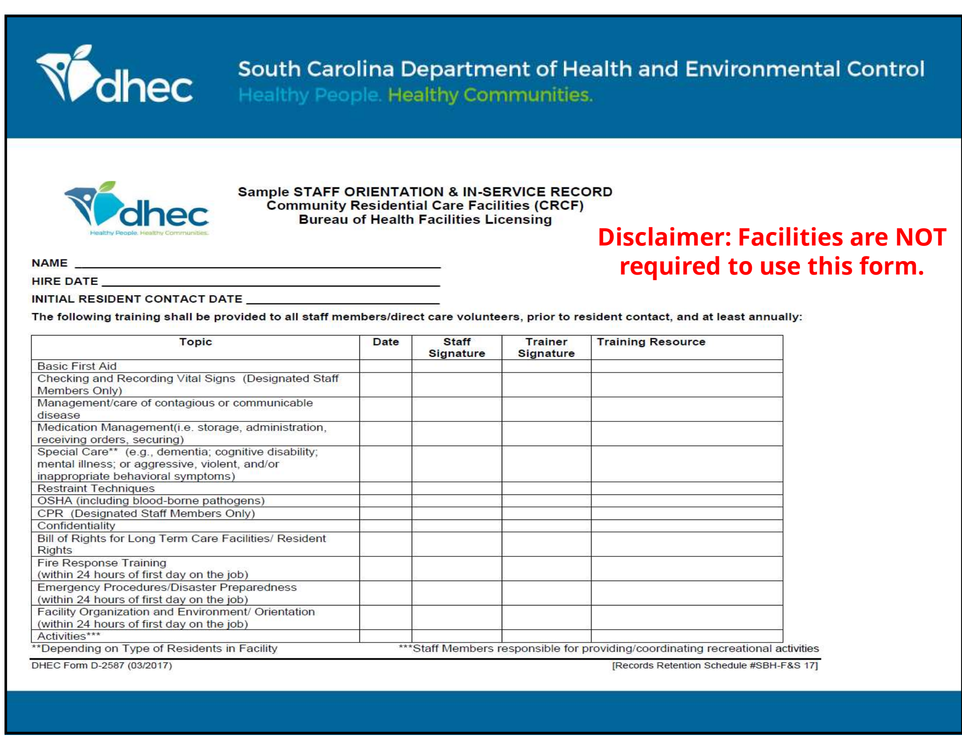

Sample STAFF ORIENTATION & IN-SERVICE RECORD
Community Residential Care Facilities (CRCF)
Bureau of Health Facilities Licensing

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

DHEC Form D-2587 (03/2017)

[Records Retention Schedule #SBH-F&S 17]

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