Ghosts of Citations Past: Vanishing Violations

South Carolina Assisted Living Association (SCALA)

Fall Conference

October 1, 2025

SPOOKY OVERVIEW

- **THE HAUNTED HOUSE:** *Residential Facilities Section Overview*
- **DON'T GET SPOOKED BY AUDITS:** *Maintaining Compliance*
- **BEWARE OF THE BLACK CAT**: *Top Citations of Regulation 60-84 (Quarter 2)*
- **POTION OF PRODUCTIVITY**: *Department & Regulatory Reminders*
- **TRICK OR TREAT**: *Q & A*

THE HAUNTED HOUSE:
Residential Facilities Section

Residential Facilities Section Management

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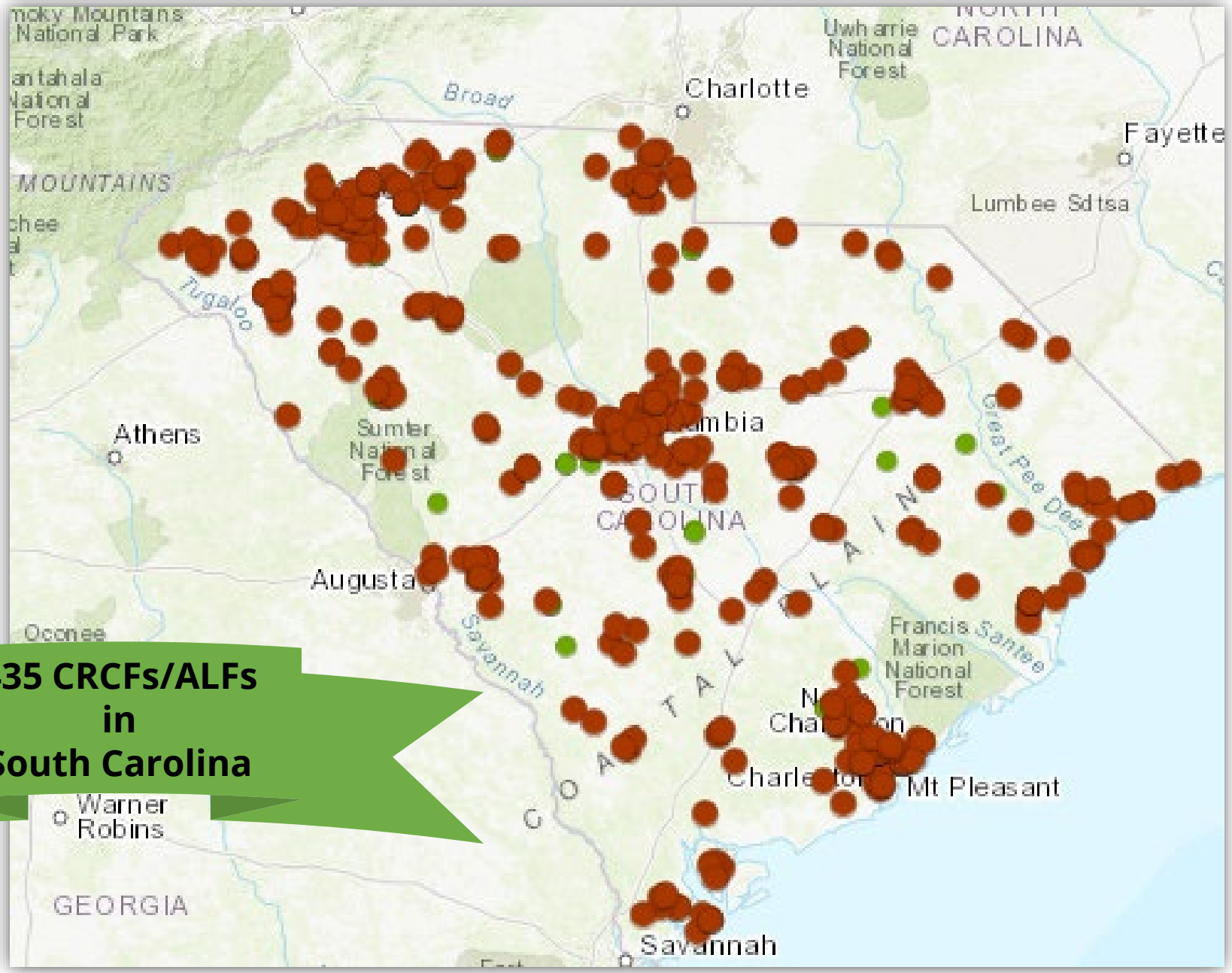
ransdedt@dph.sc.gov

Residential Facilities Section

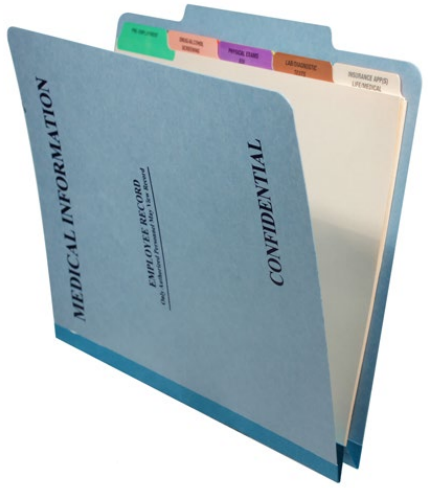
- Enforce regulatory standards, inspect and license the following:
  - Community Residential Care Facilities/Assisted Livings
  - Crisis Stabilization Units
  - Adult Day Cares
  - Facilities for Chemically Dependent or Addicted Persons



435 CRCFs/ALFs in South Carolina

DON’T GET SPOOKED BY AUDITS:
Maintaining Compliance

Items Needed



INDIVIDUAL CARE PLAN (ICP)

Resident Name _____ Date of Admission _____

Diagnosis: _____

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

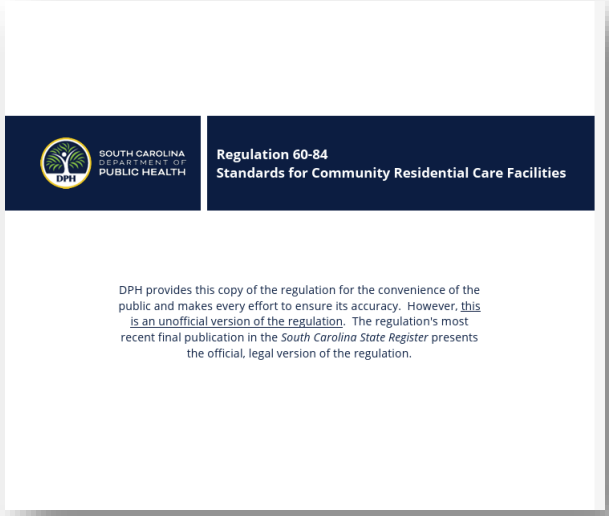
Primary Physician: _____ Dietary Requirements: _____

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): _____

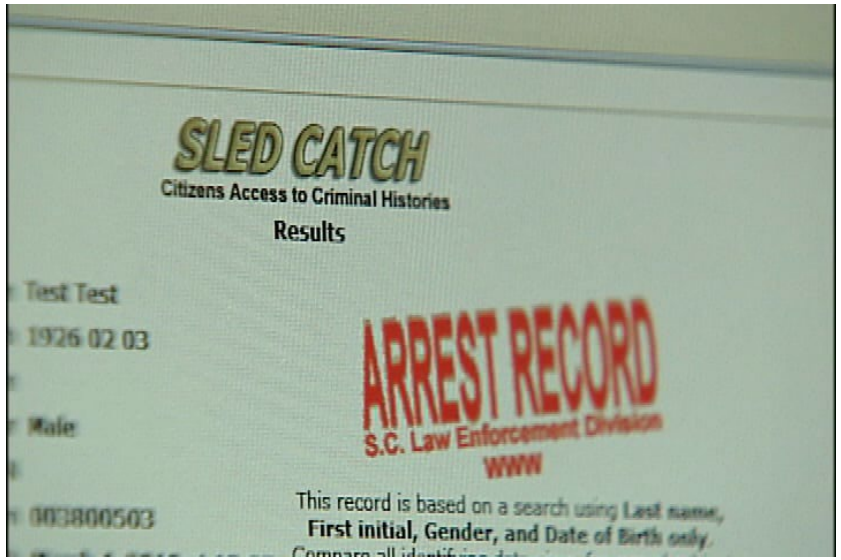
TASK / NEED	HOW MUCH ASSISTANCE	FREQUENCY	GOAL/ACHIEVEMENT DATE	RESPONSIBLE PARTY
DRESSING	___Independent (no assistance required) ___Reminder (needs reminders/cues) ___Minimum (lay out articles/buttons, laces/zippers/hooks) ___Moderate (full hands on assistance with all articles of clothing/shoes) ___Maximum (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 (reminds/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):



Staff Record Review

Criminal Background Check

- Include staff member's name
- Date of completion
- Must be completed prior to the **hire date**



- No prior conviction or pled no contest to **abuse, neglect, or exploitation of a child or vulnerable adult**

Current/Accurate Information

- Staff/Volunteer information must include:
  - Address
  - Phone Number
  - Personal/work/training background

Job Description

Job Description - Company name

Job title: Insert job title
Location: Where is job located? Any travel etc?
Terms: Perm/contract? Hours? Full/part time?
Salary/rate: Include remuneration if possible
Requirements: Any special requirements such as weekend work

About us: Brief description of your organisation, such as what markets they operate in, products and services offered, mission statement, culture and values etc.

About the role: High level summary of the role including an overview of the job's main purpose, who the job holder will report to and how the job contributes to the organisation's success. In larger firms, some information about the department the role sits within would be helpful.

Responsibilities:

- Bullet pointed list of the job holder's main responsibilities
- Focus more on broad responsibilities than specific tasks
- Who will they liaise with? What will they manage?
- What work or results will they be accountable for?
- Aim for 6 – 10 concise bullet points in this section

Candidate requirements:

- Bullet pointed list of skills, experience and qualifications successful candidates will need
- Be specific as possible, using numbers where possible (e.g. experience managing teams of 10 or more)
- Don't ask for anything that discriminates against personal traits such as age or sex

Contact us to apply

Write a call-to-action to encourage readers to apply for the job, telling them who to contact and how – including the email address of the recruiter or hiring manager

In-Service Training

- Must be **documented, signed and dated** by the trainer and trainee

- Appropriate resources
  - Licensed/registered certified persons
  - Books
  - Electronic media

- Timeframe to complete training
  - Prior to resident contact for new hires
  - Annually thereafter (every 12-13 months)

In-Service Training

- Basic 1st Aid
- **Vital Signs**
- Contagious/Communicable Disease
- Medication Management
- Care of Persons (physical/mental condition)
- Restraint Techniques
- OSHA
- **CPR**
- Confidentiality
- Bill of Rights for LTC
- Fire Response
  - *Within 24 hours of 1st day on the job*
- Emergency Procedures/Disaster Prep
  - *Within 24 hours of 1st day on the job*
- **Activity**

******Bolded trainings** are for designated staff members.****

In-Service Training & Orientation

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

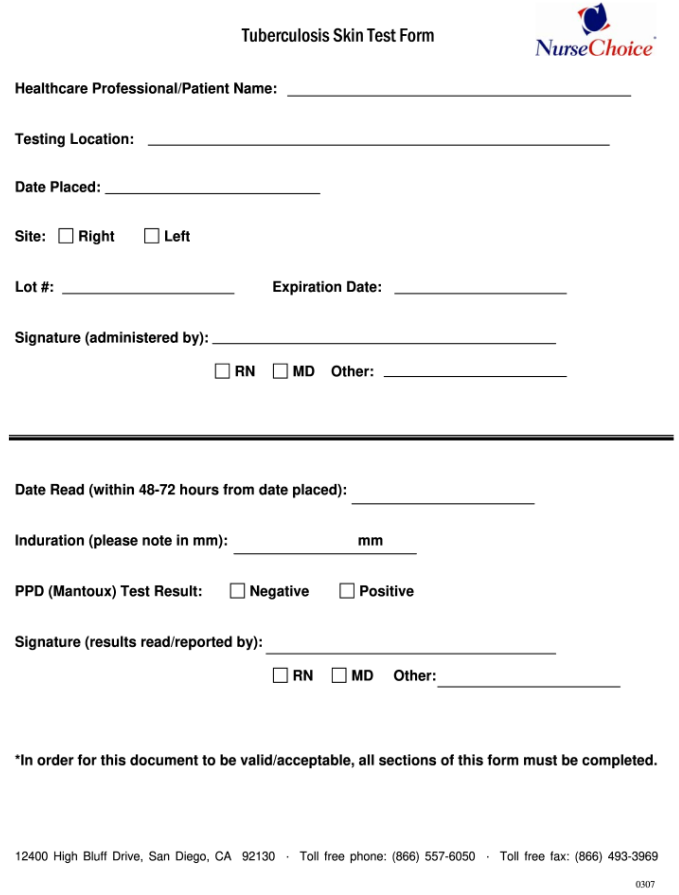
***Staff Members responsible for providing/coordinating recreational activities

Health Assessment

- Evaluation of the health status
- Required for all staff who have contact with residents
- **Completed within 12 months prior to resident contact**
- Must include a TB Test
- Completed by physician/authorized healthcare provider
  - A written standing order and/or protocol signed by a physician is required for a Registered Nurse (RN) to perform the assessment
  - Must be reviewed annually

Tuberculin Skin Test

- Completed within 3 months prior to resident contact
- Tuberculin Skin Test or BAMT
- Single TST/BAMT is acceptable if the employee has a documented negative result within the previous 12 months



Tuberculosis Skin Test Form

NurseChoice

Healthcare Professional/Patient Name: _____

Testing Location: _____

Date Placed: _____

Site: ☐ Right ☐ Left

Lot #: _____ Expiration Date: _____

Signature (administered by): _____

☐ RN ☐ MD Other: _____

Date Read (within 48-72 hours from date placed): _____

Induration (please note in mm): _____ mm

PPD (Mantoux) Test Result: ☐ Negative ☐ Positive

Signature (results read/reported by): _____

☐ RN ☐ MD Other: _____

*In order for this document to be valid/acceptable, all sections of this form must be completed.

12400 High Bluff Drive, San Diego, CA 92130 · Toll free phone: (866) 557-6050 · Toll free fax: (866) 493-3969

0307

Tuberculin Skin Test

- Examined within 48-72 hours of injection
- Measurement recorded in millimeters (including 0mm)
  - “Negative” is not acceptable
- Performed by authorized healthcare provider
  - Licensed in South Carolina (MD, APRN, PA)

Private Sitters

- Private contractor who provides sitter or companion services to a resident

- Orientation prior to contact
  - Resident rights
  - Confidentiality
  - Disaster Prep
  - Emergency Response Procedures
  - Safety Procedures & Precautions
  - Infection Control

Private Sitters

- Record must contain:
  - Documented Orientation
    - Resident rights, regulation compliance, policies/procedures, training and duties
  - Current Information
    - Name, address and telephone number
  - Health assessment
    - Within 12 months prior to resident contact or 1st day working
  - Criminal Record Check
    - Prior to working as a private sitter
  - TB Test
    - Prior to resident contact or 1st day working

Private Sitters

- Not included in the minimum staffing requirements
- Must sign in and out of the facility
- Display identification that is visible

Resident Record Review

Residents Records

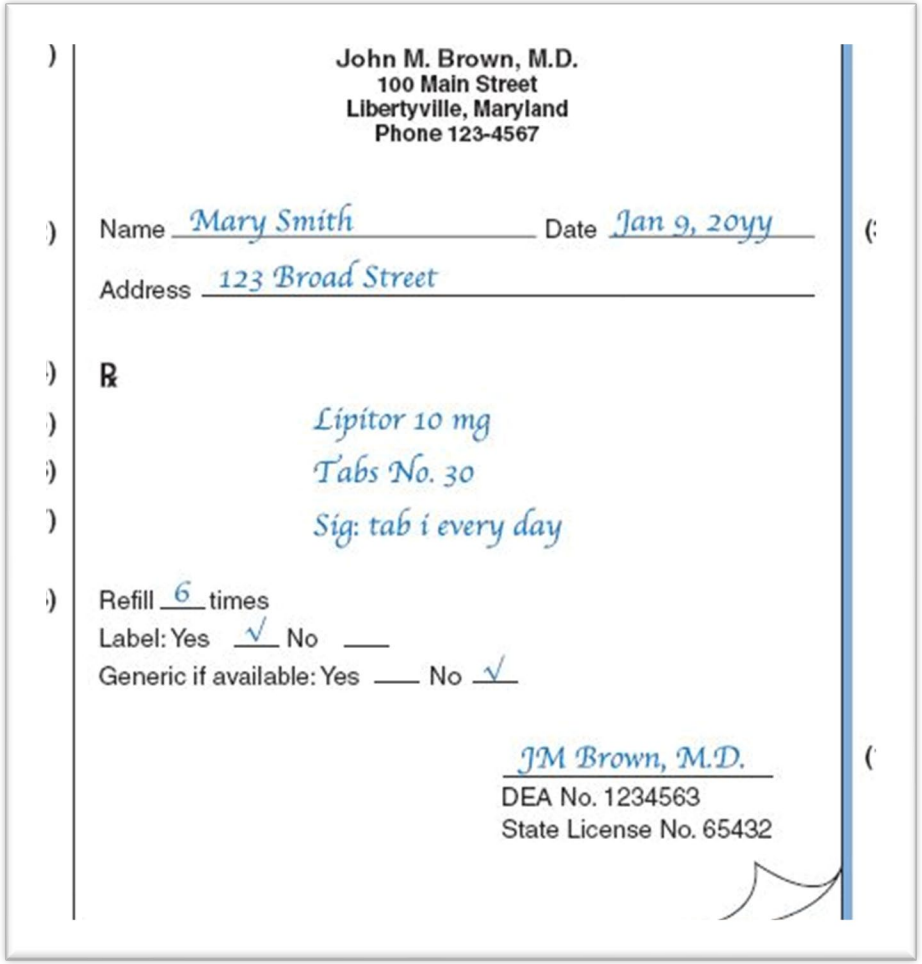
- Required entries/documentation
  - Signed & dated entries
  - Orders by physician/authorized healthcare provider
  - Documentation for care/services
  - Observation Notes

Residents Records

- Required entries/documentation
  - Provisions for emergency medical care, payments for medications
  - Special care info (DNR, allergies etc.)
  - Resident photo
  - 72 Hour assessment
  - Individual Care Plan (ICP)
  - Written Service Agreement
  - Fiscal Management
  - Physical Exam & TB Test

Orders

- Orders required for all medication, care, services, procedures and diets
- Signed by physician or authorized healthcare provider
- Completed prior to or at the time of admission and subsequently



John M. Brown, M.D.
100 Main Street
Libertyville, Maryland
Phone 123-4567

Name Mary Smith Date Jan 9, 20yy

Address 123 Broad Street

℞

Lipitor 10 mg
Tabs No. 30
Sig: tab i every day

Refill 6 times
Label: Yes √ No ___
Generic if available: Yes ___ No √

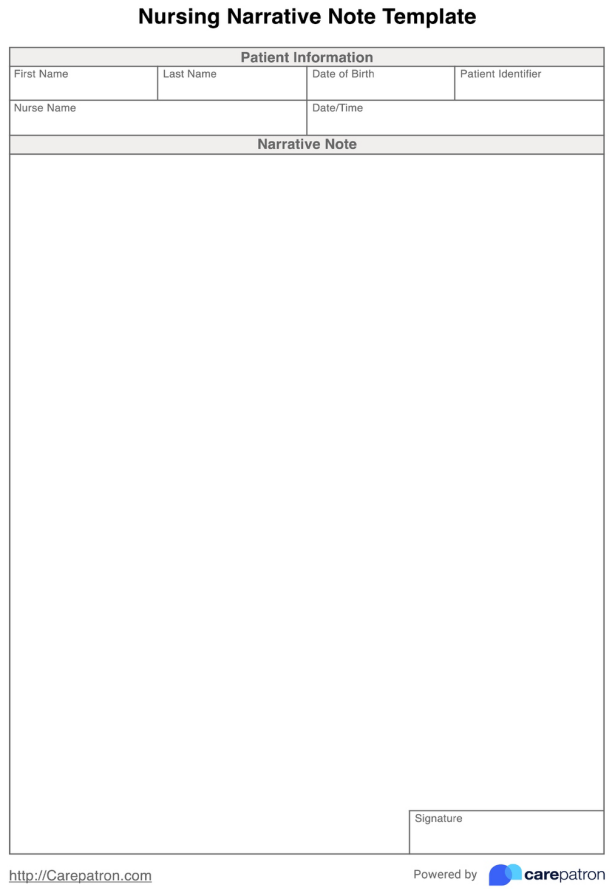
JM Brown, M.D.
DEA No. 1234563
State License No. 65432

Documentation of Care/Services

- If a resident receives services such as home health, hospice, physical therapy and/or occupational therapy, documentation of the services must be provided.

Observation Notes

- Frequency of completion:
  - Monthly
  - Daily **if there is a change in the resident's medical condition or a serious incident occurs**.
    - Resume monthly once the condition is stabilized or the incident is resolved



Nursing Narrative Note Template

Patient Information			
First Name	Last Name	Date of Birth	Patient Identifier
Nurse Name		Date/Time	

Narrative Note
Signature

http://Carepatron.com

Powered by carepatron

Provisions for Emergency Medical Care

IROQUOIS NURSING HOME
4600 Southwood Heights Drive
Jamesville, NY 13078 (315) 469-1300 • (315) 469-5545 FAX

APPLICATION FOR ADMISSION

ALL information requested on pages 1 and 2: **Date ___/___/___:**

Name of Applicant_____
Last First Middle
Is placement considered Short term _____ or Long term_____ (check one)
Does Applicant have wandering _____ (yes or no) or aggressive behaviors____ (yes or no)?
-Please explain

Home Address _____ Telephone No. _____
Street
_____
City State County Zip Code
Birth Date_____ Age_____ Sex _____ Citizenship _____
Marital Status: ☐ Single ☐Married ☐Widowed ☐Separated ☐Divorced
Name of Spouse _____ Spouse SS #_____
Present Location of Applicant (if other than home address) _____
Address_____
Street City State Zip Code
Former Residence in a Nursing Home or Adult Care Facility?: ☐Yes ☐No If so where_____
Do Not Resuscitate Order: ☐ Yes ☐ No Organ Donation: ☐ Yes ☐ No

Social Security No. _____ Veteran: ☐Yes ☐ No Spouse Veteran: ☐ Yes ☐ No
Medicare No. _____ ☐ Part A ☐ Part B Effective Date _____
Medicaid Case No. _____ CIN No. _____ County _____
Effective Date _____ Pending Application/Date Submitted _____
Medical Insurance Name and No. _____ Insurance Prescription Card No. _____
Attending Physician _____
Address _____ Telephone No._____
Street City State Zip Code
please supply copies of all insurance cards

Designated Representative(s):

Name Address and Zip Code Home Phone Work Phone Relationship
_____
_____
Responsible Party: E-Mail Address _____Cell Phone No. _____
Funeral Home _____
Name Address Phone #

Power of Attorney/Guardian)s)/Conservators

(Attach copies of Power of Attorney, Guardianship and Conservator Court Orders)
Name_____ Telephone No._____
Address _____
Street City State Zip Code

(Continued on page 2)

Special Information

dhec

Emergency Medical Services
Do Not Resuscitate Order

SOUTH CAROLINA
EMERGENCY MEDICAL SERVICES

RESUSCITATE

DO NOT RESUSCITATE ORDER

NOTICE TO EMS PERSONNEL

This notice is to inform all emergency medical personnel who may be called to render assistance to

_____ that he/she has a terminal condition which has been diagnosed by me and is at
(Name of Patient)

least eighteen (18) years of age, and has specifically requested that no resuscitative efforts including artificial stimulation of the cardiopulmonary system by electrical, mechanical, or manual means be made in the event of cardiopulmonary arrest.

REVOCATION PROCEDURE

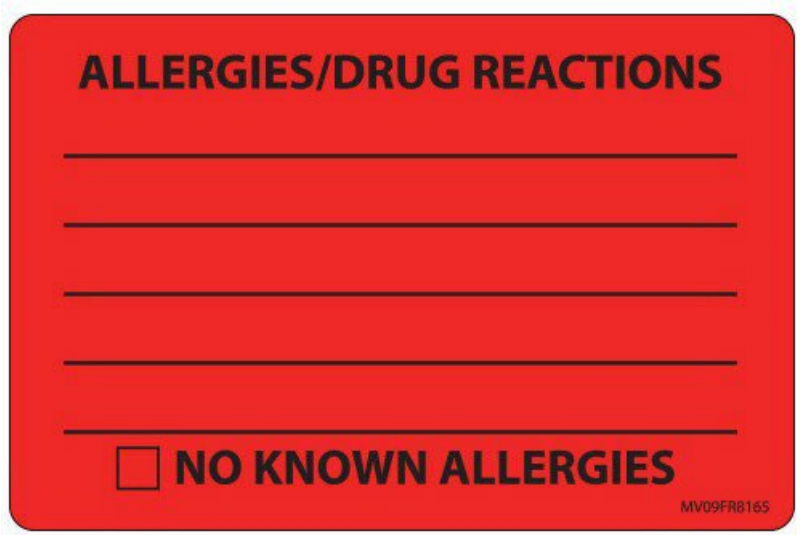
THIS FORM MAY BE REVOKED BY AN ORAL STATEMENT BY THE PATIENT TO EMS PERSONNEL, OR BY MUTILATING, OBLITERATING, OR DESTROYING THE DOCUMENT IN ANY MANNER.

Date _____ Patient's Signature (or Surrogate or Agent) _____

Physician's Name (Please Print) _____ Physician's Signature _____

Physician's Address _____ Physician's Telephone Number _____

DHEC 3462 (06/2015) **SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL**



SOUTH CAROLINA HEALTH CARE POWER OF ATTORNEY

INFORMATION ABOUT THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

1. THIS DOCUMENT GIVES THE PERSON YOU NAME AS YOUR AGENT THE POWER TO MAKE HEALTH CARE DECISIONS FOR YOU IF YOU CANNOT MAKE THE DECISION FOR YOURSELF. THIS POWER INCLUDES THE POWER TO MAKE DECISIONS ABOUT LIFE-SUSTAINING TREATMENT. UNLESS YOU STATE OTHERWISE, YOUR AGENT WILL HAVE THE SAME AUTHORITY TO MAKE DECISIONS ABOUT YOUR HEALTH CARE AS YOU WOULD HAVE.

2. THIS POWER IS SUBJECT TO ANY LIMITATIONS OR STATEMENTS OF YOUR DESIRES THAT YOU INCLUDE IN THIS DOCUMENT. YOU MAY STATE IN THIS DOCUMENT ANY TREATMENT YOU DO NOT DESIRE OR TREATMENT YOU WANT TO BE SURE YOU RECEIVE. YOUR AGENT WILL BE OBLIGATED TO FOLLOW YOUR INSTRUCTIONS WHEN MAKING DECISIONS ON YOUR BEHALF. YOU MAY ATTACH ADDITIONAL PAGES IF YOU NEED MORE SPACE TO COMPLETE THE STATEMENT.

3. AFTER YOU HAVE SIGNED THIS DOCUMENT, YOU HAVE THE RIGHT TO MAKE HEALTH CARE DECISIONS FOR YOURSELF IF YOU ARE MENTALLY COMPETENT TO DO SO. AFTER YOU HAVE SIGNED THIS DOCUMENT, NO TREATMENT MAY BE GIVEN TO YOU OR STOPPED OVER YOUR OBJECTION IF YOU ARE MENTALLY COMPETENT TO MAKE THAT DECISION.

4. YOU HAVE THE RIGHT TO REVOKE THIS DOCUMENT, AND TERMINATE YOUR AGENT'S AUTHORITY, BY INFORMING EITHER YOUR AGENT OR YOUR HEALTH CARE PROVIDER ORALLY OR IN WRITING.

5. IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A SOCIAL WORKER, LAWYER, OR OTHER PERSON TO EXPLAIN IT TO YOU.

6. THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS TWO PERSONS SIGN AS WITNESSES. EACH OF THESE PERSONS MUST EITHER WITNESS YOUR SIGNING OF THE POWER OF ATTORNEY OR WITNESS YOUR ACKNOWLEDGMENT THAT THE SIGNATURE ON THE POWER OF ATTORNEY IS YOURS.

THE FOLLOWING PERSONS MAY NOT ACT AS WITNESSES:

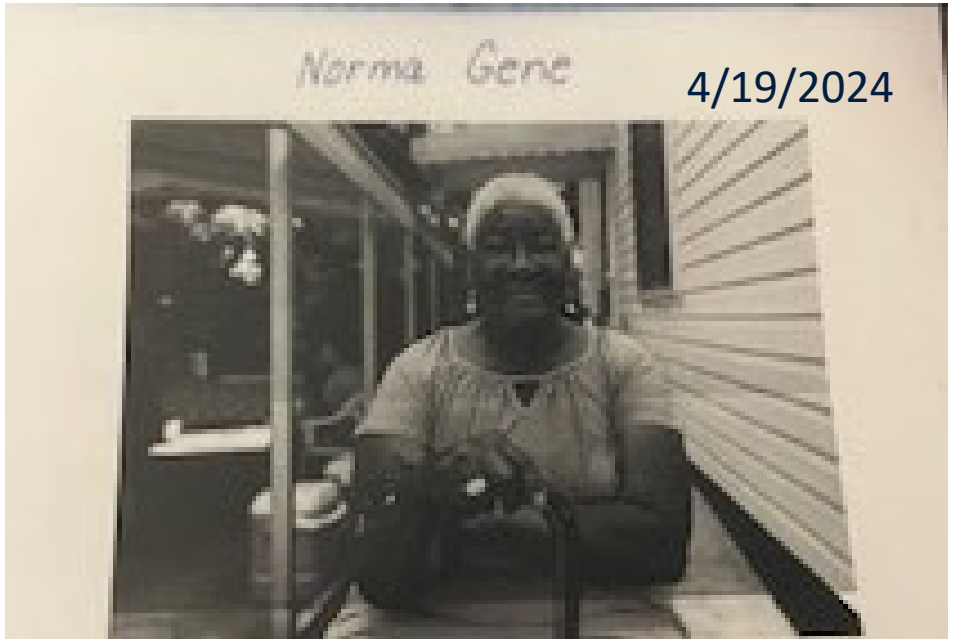
A. YOUR SPOUSE, YOUR CHILDREN, GRANDCHILDREN, AND OTHER LINEAL DESCENDANTS; YOUR PARENTS, GRANDPARENTS, AND OTHER LINEAL ANCESTORS; YOUR SIBLINGS AND THEIR LINEAL DESCENDANTS; OR A SPOUSE OF ANY OF THESE PERSONS.

B. A PERSON WHO IS DIRECTLY FINANCIALLY RESPONSIBLE FOR YOUR MEDICAL CARE.

C. A PERSON WHO IS NAMED IN YOUR WILL, OR, IF YOU HAVE NO WILL, WHO WOULD INHERIT YOUR PROPERTY BY INTESTATE SUCCESSION.

Resident Photograph

- Size must be a minimum of 2 ½ by 3 ½ inches
- Dated
- Updated every 24 months unless a significant change in appearance



72 Hour Assessment

- Conducted by a direct care staff member
- Must be signed and dated by the direct care staff member
- Completed no later than 72 hours after admission
- Assessment is NOT the same as an Individual Care Plan (ICP)

72 Hour Assessment

- Assessment evaluates the following:
  - Physical
  - Emotional
  - Behavioral
  - Social
  - Spiritual
  - Nutritional
  - Recreational
  - Vocational, educational, legal status/needs of a resident when appropriate

72 HOUR COMMUNITY RESIDENTIAL CARE FACILITY ASSESSMENT

Resident's Name _____ Date of Assessment: _____

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(s): 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		TASK/NEED	HOW MUCH ASSISTANCE
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)		**GROOMING**	___Independent (No assistance required) ___Reminder (remind/cues) ___Minimum (lay our supplies, monitor) ___Moderate (in addition to minimum, assist with brushing teeth, combing hair) ___ Maximum (in addition to moderate, resident frequently removing/misplacing/losing assistive devices noted below): Does resident wear assistive devices: Eyeglasses: Y___ N___ Dentures: Y ___ N___ Hearing Aide(s): Y ___ N ___
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		**FEEDING/ NUTRITION**	___Independent (no assistance required) ___Reminder (reminder of meals times/menu choices) ___Minimal (cut food into pieces) ___Moderate (chop food in blender, explain what is one plate, possible finger foods) ___Maximum (requires continual monitoring throughout

Individual Care Plan (ICP)

- Documented regimen of appropriate care/services or written action plan based on resident's needs and preferences
- Developed using the 72-hour assessment
- **Must be developed within 7 days of admission**
  - Resident and/or the sponsor or responsible party
  - Administrator or designee
- **Signed & dated**
- **Reviewed semiannually or revised as changes in resident needs occur**

Individual Care Plan (ICP)

- ICP must describe:
  - Needs of the residents including ADLs which assistance is required
    - What assistance, how much, who will assist, how often and when
  - Arrangements to medical appointments
  - Advance directives/healthcare power of attorney
  - Recreational and social activities
  - Nutritional needs

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):

Written Service Agreement

- Completed prior to admission
- Agreement between the resident and/or responsible party & the facility
- Revised upon any changes

Written Service Agreement

- Explanation of the specific care, services and/or equipment provided by the facility
- Disclosure of fees for all care, services and/or equipment provided
- Advance notice requirement not less than 30 days to changes in fees for care, services and/or equipment provided
- Refund policy
- Date residents receive personal needs allowance (*monthly allowance for Medicaid recipients*)
- Transportation policy
- Discharge/transfer provisions

Fiscal Management

- The administrator may maintain resident's personal monies upon written request only
- Accurate accounting of personal monies & written evidence of purchases
- Quarterly reports of the balance of resident finances must be provided to the resident
  - Documentation must be readily available

Physical Examination

- Examination of a resident performed by a physician or authorized healthcare provider
- Must be completed within 30 days prior to admission
- Annually thereafter (12-13 months)

Physical Examination

- Must address the following:
  - Appropriateness of placement in a CRCF
  - Medications/treatments ordered
  - Self administration status
  - Identification of special conditions/care required
  - Need of or lack there for the continuous daily attention of a licensed nurse

ADMISSION / ANNUAL MEDICAL EXAMINATION

Name Of Resident	Age	Sex	Uses:
_____	_____	_____	( ) Walker ( ) Cane ( ) Wheelchair

1. General Diagnosis:

2. Any contagious or infectious disease? **Yes / No** If "Yes" please explain:

3. Any condition 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 exercise? **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 (CRCF) provides room, board, and a degree of personal assistance in the activities of daily living. A community resident care facility by South Carolina law cannot provide daily nursing care or care to individuals in need of care appropriately provided by a nursing home or hospital.

   Can this person be cared for in this type of facility? Yes _____ No _____

9 Diet: _____

Physician' Signature:	Address:	Telephone #	Date: (Please Print Clearly)

New Admission Tuberculin Test

- Tuberculin skin test (TST) or BAMT
  - 1st step must be completed within 30 days prior to admission
  - 2nd step completed 7 to 21 days following the 1st step
  - Documented negative test within the previous 12 months, a single TST/BAMT can be administered within 1 month prior to admission
- Chest x-ray is **ONLY** acceptable if:
  - History of positive results (with proof)
  - Emergency placement by Adult Protective Services (SC DSS) or Department of Behavioral Health & Development Disabilities (formerly DMH)

TB Screening for Residents Admitted from the Hospital

On May 20, 2024, Governor McMaster signed into law S.558 which adds Section 44-31-40 to the S.C. Code of Laws regarding the tuberculosis screening of nursing home or community residential care facility ***residents admitted from a hospital***.

Prior to admission of such residents, the nursing home or community residential care facility (CRCF) must:

1) Request and receive a written declaration, which can be in a hospital progress note or discharge summary, from an authorized healthcare provider that, based upon medical examination, the resident has no signs or symptoms of active tuberculosis;
2) Within 3 days of admission of the resident, administer the first step of the two-step tuberculin skin test (TST) to the resident; and
3) Within 14 days of admission of the resident, administer the second step of the two-step TST to the resident.

Additionally, a nursing home or CRCF may substitute a single blood assay for mycobacterium tuberculosis (BAMT) for a two-step TST. Further, if the facility has documentation that within the 12-month period prior to admission the resident obtained a negative tuberculin skin test or a negative single BAMT, then it may administer a single TST or single BAMT within 14 days of the resident's admission.

Record Maintenance (704)

- Records of residents must be **maintained for six (6) years** following discharge

- Records of **current residents are the property** of the facility and **cannot be removed without a court order EXCEPT:**
  - A resident moves from one licensed facility to another by the same licensee, then the original record may follow the resident

- Change of Ownership (CHOW)
  - All active resident records or copies **must be transferred to the new owners**

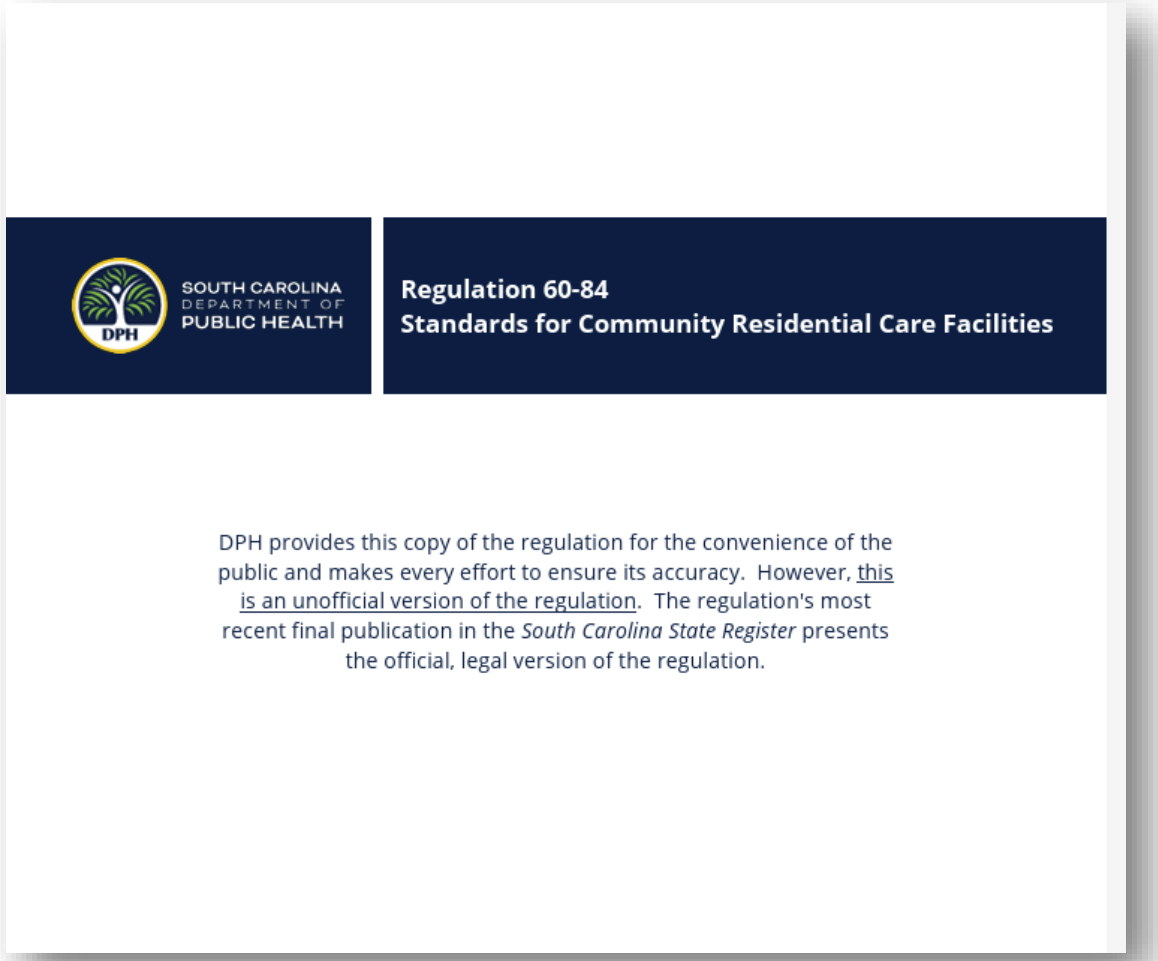
Documentation Review

DOCUMENTATION REVIEW
(CRCF) Community Residential Care Facilities
Regulation 61-84

Facility:	Permit #:	Date:

Section/ Class	Inspection Items	Notes
103.B (II)	Copy of current DHEC Regulation 61-84	
202.E (III)	Copies of recent inspections and investigations reports	
401(II)	Written policies & procedures addressing each section of the regulation	
	Staffing/Training/Background Checks/Health Assessments/PPDs	
	Accidents/Incidents/Elopments	
	Private Sitters	
	Fire/Disaster Preparedness/Emergency Procedures/Continuity of Essential Services	
	Medication Management/Medication Administration and Treatments	
	Resident Rights and Assurances/Grievance Procedures/Care and Services	
	Fire Prevention/Fire Drills/Fire Response Training	
	Meal Service	
	Maintenance	
	Infection Control/Infectious Waste/Clean-Soiled Linen and Clothing/Housekeeping	
	Quality Improvement	
	Provisions of any Special Care Offered (ex: Alzheimer's/Dementia)	
	Time Period Established for Review (recent date)	
502.A (II)	Administrator licensed as a CRCF administrator	
502.C (II)	Individual designated in writing to act in the absence of the administrator	
500 (I)	Personnel records: ____ New ____ Maintenance ____ Total ____ Old ____ Housekeeping ____ Administrator ____ Dietary ____ Nurse ____ Activity Director ____ Sitters ____ Volunteers To include: background checks, health assessments, tuberculosis screening, orientation, annual in-service training, accurate/current info, date of hire, date of first resident contact, and job descriptions for all staff.	
501.G (II)	Contracts with qualified sources outside the facility	
601.A (III)	Incident/accident reports for the previous year	
700 (II)	Resident records: ____ New admissions ____ Old ____ Home Health ____ Hospice ____ Total To include: all physician visits and orders, documentation of care/services provided, notes of observation, provisions for medical care, photo, assessments, ICPs, service agreement, financial records, physicals and tuberculosis screening	
1201.B (I)	Medication reference materials published within the previous three years (published date)	
1203.B (I)	Evidence of a CLIA Waiver (if the facility staff monitors blood-sugars)	

Regulation 60-84



SOUTH CAROLINA DEPARTMENT OF PUBLIC HEALTH

Regulation 60-84
Standards for Community Residential Care Facilities

DPH provides this copy of the regulation for the convenience of the public and makes every effort to ensure its accuracy. However, this is an unofficial version of the regulation. The regulation's most recent final publication in the *South Carolina State Register* presents the official, legal version of the regulation.

Inspection and Investigation ROVs

dhec
S.C. Department of Health and Environmental Control

INSPECTION RESULTS

Facility Information		Audit Information	
Permit:	CRC-[redacted]	Audit Name:	CRC GENERAL ROV 20190924
Facility Name:	[redacted] COMMUNITY RESIDENCE	Type:	L01 Routine
Address:	[redacted]	Start Date:	26 Aug 2024 12:45 PM
City/State/Zip:	[redacted]	End Date:	26 Aug 2024 02:45 PM
Phone 1:	[redacted]	Inspector:	[redacted]
Email:	[redacted]	Score:	0.0%
Contact Name:	[redacted]		
Contact Email:	null		
Contact Phone:	[redacted]		

Overall Score
0.0%

Audit Level Notes:

ROV sent via e-mail 8/27/24. {JT}

Report Notice

Question	Answer	Percent
Bureau of Health Facilities Licensing 2600 Bull St Columbia SC 29201-1708	Report Notice	

REPORT NOTICE: If applicable, this Report of Visit includes a detailed description of the conditions, conduct or practices that were found to be in violation of requirements. This inspection or investigation is not to be construed as a check of every condition that may exist, nor does it relieve the licensee (owner) from the need to meet all applicable standards, regulations and laws. The South Carolina Code of Laws requires this Department to establish and enforce basic standards for the licensure (permitting), maintenance, and operation of health facilities and services to ensure the safe and adequate treatment of persons served in this State. It also empowers the Department to require reports and make inspections and investigations as considered necessary. Furthermore, the Code authorizes the Department to deny, suspend, or revoke licenses (permits) or to assess a monetary penalty against a person or facility for (among other reasons), violating a provision of law or departmental regulations or conduct or practices detrimental to the health or safety of patients, residents, clients, or employees of a facility or service. If applicable to the type of report being made, the signature of the activity representative indicates that all of the items cited were reviewed during the exit discussion. If this Report of Visit is required by regulation to be made available in a conspicuous place in a public area within the facility, redaction of the names of those individuals in the report is required as provided by Sections 44-7-310 and 44-7-315 of the S.C. Code of Laws, 1976, as amended.

Totals

Administrator's Signature - Plan of Correction

dhec
S.C. Department of Health and Environmental Control

INSPECTION RESULTS

Facility Information		Audit Information	
Permit:	CRC-[redacted]	Audit Name:	CRC GENERAL ROV 20190924
Facility Name:	[redacted]	Type:	L07 Investigation
Address:	[redacted]	Start Date:	26 Aug 2024 11:30 AM
City/State/Zip:	[redacted]	End Date:	26 Aug 2024 01:30 PM
Phone 1:	[redacted]	Inspector:	[redacted]
Email:	[redacted]	Score:	100.0%
Contact Name:	[redacted]		
Contact Email:	null		
Contact Phone:	[redacted]		

Overall Score
100.0%

Report Notice

Question	Answer	Percent
Bureau of Health Facilities Licensing 2600 Bull St Columbia SC 29201-1708	Report Notice	

REPORT NOTICE: If applicable, this Report of Visit includes a detailed description of the conditions, conduct or practices that were found to be in violation of requirements. This inspection or investigation is not to be construed as a check of every condition that may exist, nor does it relieve the licensee (owner) from the need to meet all applicable standards, regulations and laws. The South Carolina Code of Laws requires this Department to establish and enforce basic standards for the licensure (permitting), maintenance, and operation of health facilities and services to ensure the safe and adequate treatment of persons served in this State. It also empowers the Department to require reports and make inspections and investigations as considered necessary. Furthermore, the Code authorizes the Department to deny, suspend, or revoke licenses (permits) or to assess a monetary penalty against a person or facility for (among other reasons), violating a provision of law or departmental regulations or conduct or practices detrimental to the health or safety of patients, residents, clients, or employees of a facility or service. If applicable to the type of report being made, the signature of the activity representative indicates that all of the items cited were reviewed during the exit discussion. If this Report of Visit is required by regulation to be made available in a conspicuous place in a public area within the facility, redaction of the names of those individuals in the report is required as provided by Sections 44-7-310 and 44-7-315 of the S.C. Code of Laws, 1976, as amended.

Totals

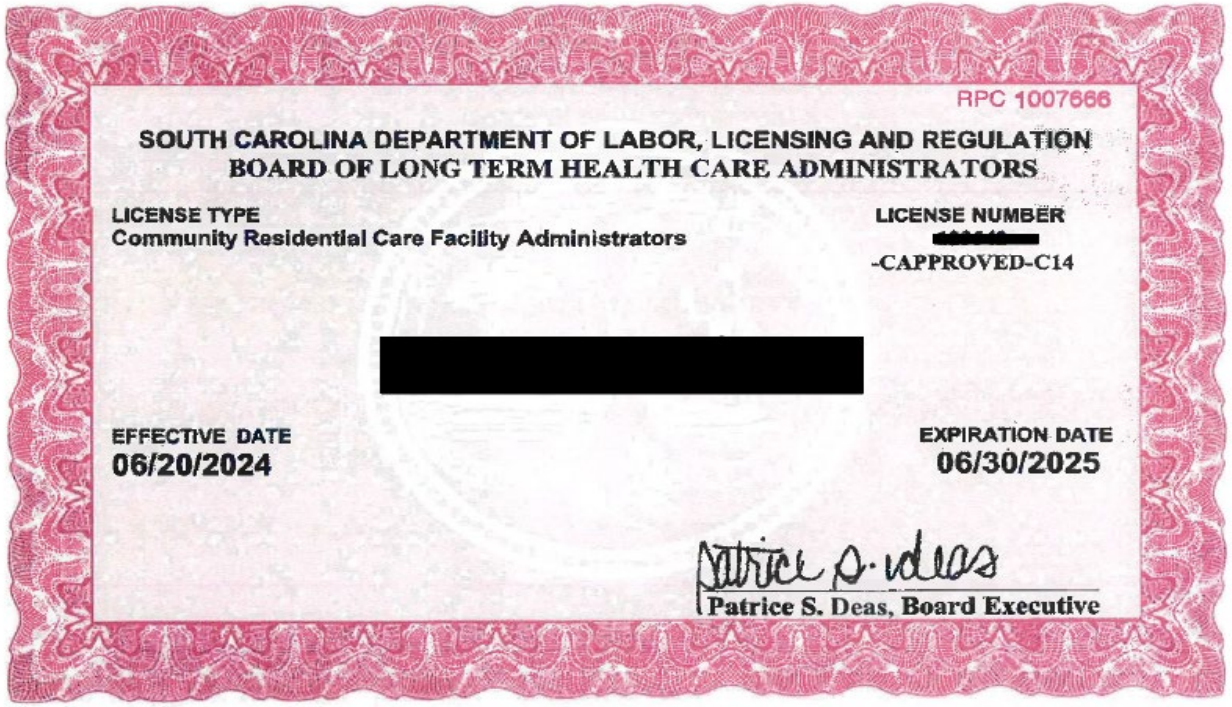
Inspection Information

Question	Answer	Percent
Inspection Includes Licensing:	YES	
Inspection Includes Food/Sanitation:	NO	
Inspection Includes Fire & Life Safety:	NO	
Is this an On-Site Visit?	YES	

Policies and Procedures

- Must address each section regarding resident care, rights and facility operations.
- Established time period of review
  - Reviews must be documented
- Must be accessible to staff, residents/responsible parties

Licensed Administrator



RPC 1007666

SOUTH CAROLINA DEPARTMENT OF LABOR, LICENSING AND REGULATION
BOARD OF LONG TERM HEALTH CARE ADMINISTRATORS

LICENSE TYPE
Community Residential Care Facility Administrators

LICENSE NUMBER
[redacted]
-CAPPROVED-C14

[redacted]

EFFECTIVE DATE
06/20/2024

EXPIRATION DATE
06/30/2025

Patrice S. Deas, Board Executive

Absence of Administrator

Administrator's Designee

In the absence of _____ (administrator), the following may fulfil the duties of my role.

Ashley Brown, Assistant Administrator	803-545-2323	abrown@seniorliving.com
Bryant Williams, Director of Nursing	803-545-4233	bwill2@seniorliving.com
Coco Jones, Residential Care Coordinator	803-545-4822	cjones@seniorliving.com

Personnel Records

- Request records to include:
  - **New staff-** Employed less than a year
  - **Old staff-** Employed more than a year
  - **Variety of Roles**
    - Administrator
    - Kitchen Manager
    - Med Tech
    - Nurses (if applicable)
    - Sitters
    - Housekeeping
- Records must include:
  - Background checks
  - Health assessments
  - Tuberculosis Tests
  - Orientation & In-service Training
  - Documented date of hire & resident contact date
  - Accurate Information
  - Job Description

Contracts

- Copies of written agreements with outside services:
  - Staffing
  - Training
  - Recreation
  - Food Service
  - Professional Consultant
  - Maintenance
  - Transportation
- Must describe the following
  - How services are provided
  - When services are provided
  - Exact service(s) to be provided
  - Services provided by qualified individuals

Accidents/Incident Reports

- Facility must maintain a record of each accident/incident that occurred in the facility or on its grounds
- Must be documented, reviewed, investigated (if necessary)
- Retained by the facility for 6 years

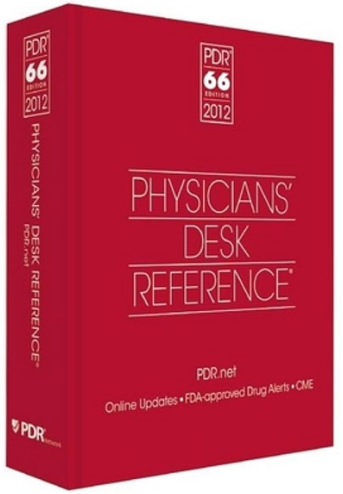
Resident Records

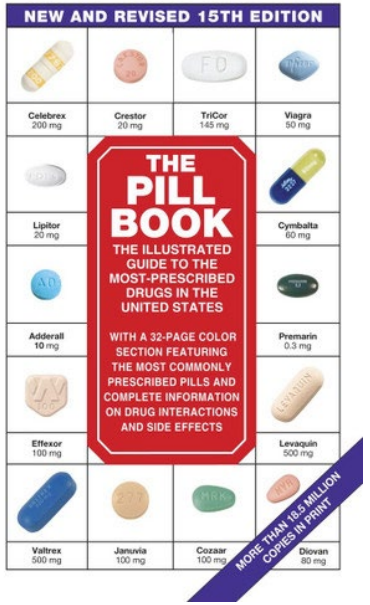
- Request the following records:
  - **New admissions**- less than a year
  - **Old admissions-** greater than a year
  - **Home Health**
  - **Hospice**

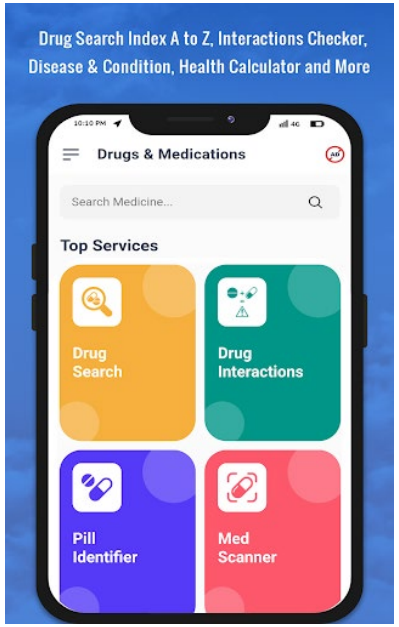
- Records must include:
  - Orders
  - Documents of care/services
  - Tuberculosis screening & Physical exams
  - Observation Notes
  - Assessments & ICPs
  - Photo
  - Provisions for care
  - Agreements
  - Financial Records

Reference Materials

- Hard copy or digital version
- Published within the previous 3 years
- Adequate information concerning medications







CLIA Waiver

CENTERS FOR MEDICARE & MEDICAID SERVICES

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

CERTIFICATE OF WAIVER

LABORATORY NAME AND ADDRESS

[redacted]

CLIA ID NUMBER

[redacted]

EFFECTIVE DATE

01/24/2020

LABORATORY DIRECTOR

[redacted]

EXPIRATION DATE

01/23/2022

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

This certificate shall be valid until the expiration date above, but is subject to revocation, suspension, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder.

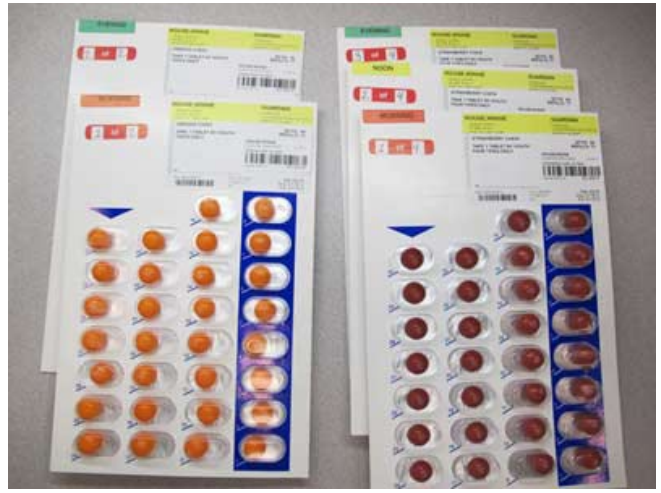
CMS

CENTERS FOR MEDICARE & MEDICAID SERVICES

Karen W. Dyer, Director
Division of Laboratory Services
Survey and Certification Group
Center for Clinical Standards and Quality

Pharmacy Reports

- Quarterly reports are required for the following facilities:
  - Utilize unit/multi dose system
- Onsite review of the medications
  - Program properly implemented and maintained
- Conducted by a **pharmacist at least quarterly**



Medication Destruction Record

- The following must be documented:
  - Signatures of witness
  - Mode of destruction
- Records retained for 2 years

DRUG DESTRUCTION LOG

RESIDENT NAME	DRUG NAME AND STRENGTH	AMOUNT DESTROYED	DATE OF DISPOSITION	METHOD OF DISPOSITION	SIGNATURE OF NURSES WITNESSING DISPOSITION	

www.BriggsCorp.com
©SAMPLE
(800) 247-2343

BRIGGS Healthcare

DRUG DESTRUCTION LOG

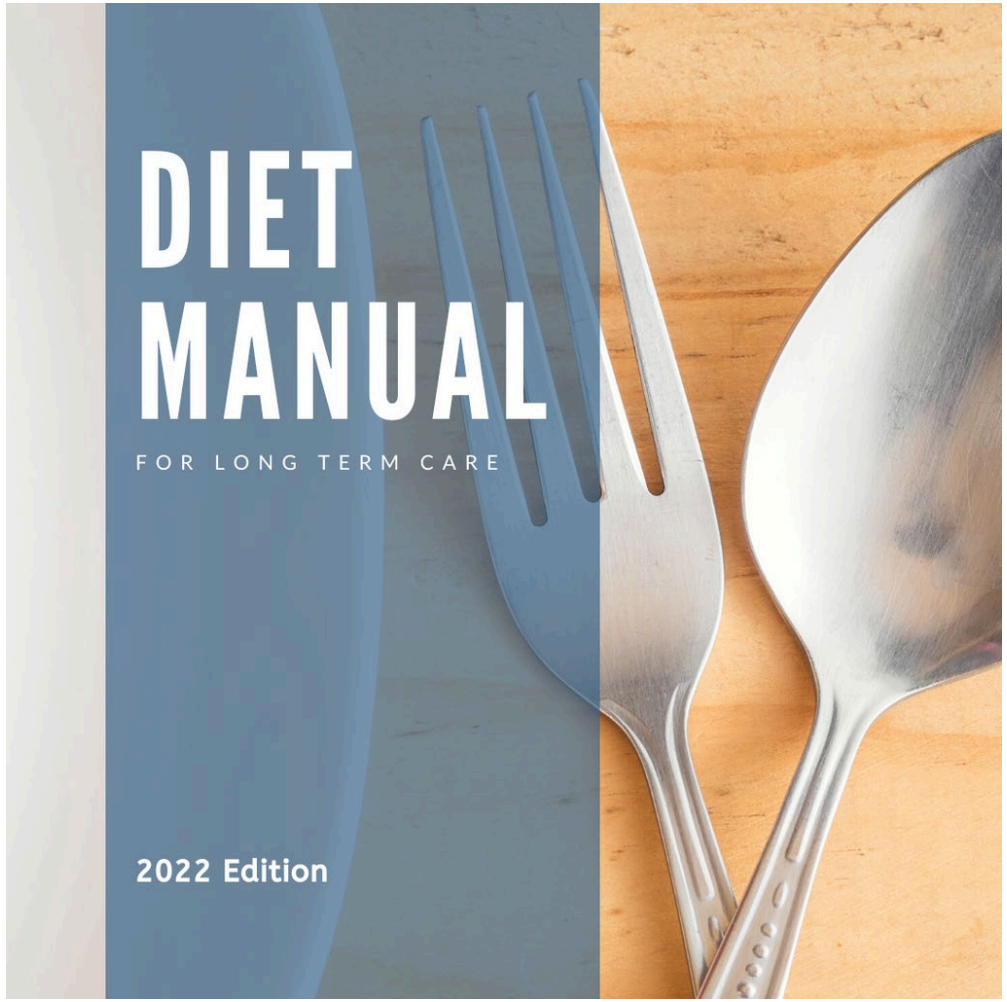
Menus

- Menus signed by a physician/authorized healthcare provider for medically prescribed diets
- Planned and written a week in advance and dated as served
- Current week's menu must be posted
- Records of menus maintained for at least 30 days

Diet Manuals

- Published within the previous 5 years
  - Food sources & quality
  - Protection, storage, preparation & services
  - Worker health & cleanliness
  - Recommended dietary allowances
  - General menu planning
  - Menu planning to special needs

- Hard copy or digital copy acceptable



Continuity of Essential Services

- Written plan that addresses the continuation of essential services to residents if the following occurs:
  - Power outage
  - Water shortage
  - Short staff due to inclement weather or other causes

Annual TB Risk Assessment

dhec
S.C. Department of Health and Environmental Control

TB Risk Assessment (Short Form)

ONLY APPROVED FOR USE BY THE FOLLOWING FACILITY TYPES:
(Please check the appropriate box)

- ☐ Ambulatory Surgical Facility
- ☐ Day Care Facility for Adults
- ☐ In-Home Care
- ☐ Community Residential Care

Date: _____

Facility Name: _____ Permit Number: _____

Number of Licensed Beds or Clients: _____

Address: _____

City: _____ Zip: _____ County: _____

Phone: _____

Name of Person Completing Form: _____

Title of Person Completing Form: _____

Part A – Incidence of TB

1. Number of TB cases identified **in your facility** in the past year? (*Check only one box)*

   - ☐ No cases within the last 12 months.
   - ☐ Less than 3 cases identified in the past year.
   - ☐ 3 or more cases identified in the past year.
   - ☐ Evidence of ongoing M. tuberculosis transmission.

2. Number of TB cases identified in your County in the last year?
   (This information may be obtained from the TB Control Section of the South Carolina Department of Health and Environmental Control's website.)

3. Number of TB cases identified in the State of South Carolina the last year? _____
   (This information may be obtained from the TB Control Section of the South Carolina Department of Health and Environmental Control's website.)

Veterinarian Records

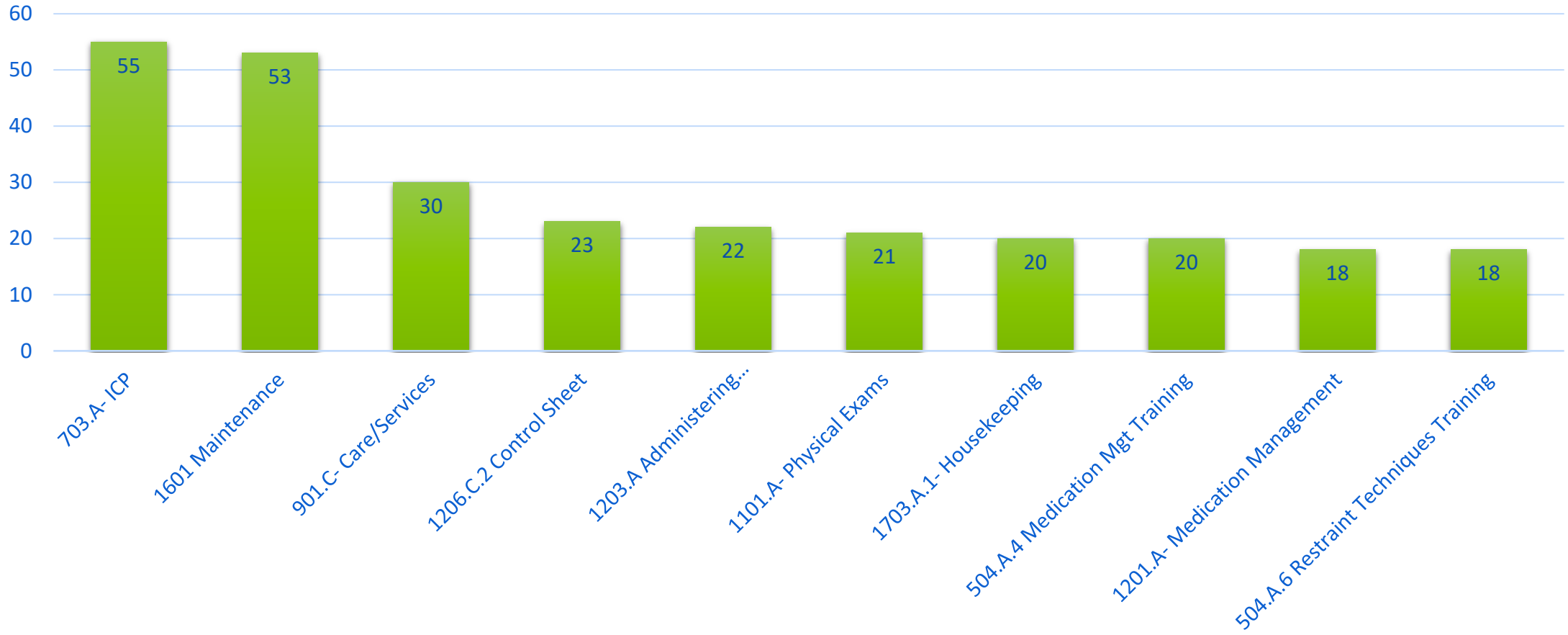
- If the facility allows pets, the following compliance must be met:
  - Screening by a veterinarian **prior to resident contact**
  - Required inoculations
  - Present no apparent threat to the health, safety and well being of the residents
  - Pet’s housing area must be kept clea

Quality Improvement Plan

Written and implemented program that provides effective self assessment and implementation of changes designed to improve the care/services provided by the facility.

BEWARE OF THE BLACK CAT:
Top Citations of R.60-84

Frequency of Citations



Helpful Tips

- **Audit staff and resident files at a frequency determined by the administrator.**
  - Document findings and corrective actions
  - Assure all files are available and completed in a timely manner
  - Verify signatures have been attained
  - Confirm all files are onsite

- **Administrator or designee should perform walkthroughs of the facility at a frequency determined by the administrator.**
  - Document findings and corrective actions
  - Check for medications and chemicals in resident rooms without orders to self-administer
  - Check for maintenance and housekeeping issues
  - Check facility temperatures and water temperatures
    - Maintain a temperature log
  - Assure all required signage is posted conspicuously
  - Assure oxygen cylinders are properly secured

Helpful Tips

- **Audit the medication cart and MARs** at a frequency determined by the administrator.
  - Document findings and corrective actions.
  - Assure all medications with orders are present in the facility and ready to be administered at the scheduled time(s)
  - Verify no medications have expired and are stored correctly
  - Check for blanks on the MARs, control sheets and **both** shift change sheets
  - All staff have received appropriate training
  - Have a backup pharmacy if you're unable to get medications filled or received in a timely manner

POTION OF PRODUCTIVITY:
Department & Regulatory Reminders

Transfer of Regulations to New Chapter

- All regulations have been transferred to a new chapter of the S.C. Code of Regulations

- DPH Regulations were transferred from Chapter 61 to **Chapter 60**

- **NO SUBSTANTIVE** changes were made to Regulation 60-84

Reminders

- Update facility information
- Report administrator changes
- Loss of Service Memorandum
- TB Screening Memorandum
- Changes to Department e-mail addresses **@dph.sc.gov**
- Residential Care Committee: Virtual meeting tentatively scheduled for Nov. 5th @10am
- Emergency Evacuation Plans (EEPs)

Survey for CRCFs & Nursing Homes

Be on the lookout for a survey at the end of the month regarding Alzheimer's special care programs and/or memory care units.

TRICK OR TREAT:
Q & A

CONTACT ME

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taylorjj@dph.sc.gov

https://dph.sc.gov/professionals/healthcare-quality/healthcare-facility-licensing/community-residential-care