

PROTECTION AND  
ADVOCACY FOR  
PEOPLE WITH  
DISABILITIES, INC.

*The Protection and Advocacy System for South Carolina*

## **No Place To Call Home:**



## **How South Carolina Has Failed Residents of Community Residential Care Facilities**

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# **EXECUTIVE SUMMARY**<sup>1</sup>

Community Residential Care Facilities (CRCFs) are the homes of last resort for as many as 16,700 South Carolinians.<sup>2</sup> These poorly overseen facilities, which range in size from two to more than one hundred beds, provide housing, food, and care to individuals who are unable to live independently but who do not need institutional or skilled nursing care.<sup>3</sup> Residents of CRCFs have physical, emotional, or intellectual disabilities. Many cannot manage their own funds. These vulnerable individuals often do not have family members or friends who can advocate for them. The SC Department of Health and Environmental Control (DHEC) currently licenses over 480 separate community residential care facilities in South Carolina.<sup>4</sup>

Since 1986, Protection and Advocacy for People with Disabilities, Inc. (P&A) has conducted unannounced visits to more than 1000 CRCFs through the Team Advocacy Program.<sup>5</sup>

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<sup>1</sup> This report was prepared by attorneys and other staff members of Protection and Advocacy for People with Disabilities, Inc. It was funded in part by the US Department of Health and Human Services (Substance Abuse and Mental Health Services Administration and the Administration on Developmental Disabilities) and by the US Department of Education (Rehabilitation Services Administration).

<sup>2</sup> The Department of Health and Environmental Control licenses and regulates CRCFs, DHEC R. 61-84. As of May 2009, there were 16,741 licensed CRCF beds in South Carolina. A licensed CRCF may also refer to itself as an assisted living facility. The facilities discussed in this report are those that serve residents with disabilities and low incomes, usually with government funding, including Supplemental Security Income, Social Security Disability Income or veterans' benefits. For CRCFs willing to accept a monthly cap of \$1100 for all fees, SC Health and Human Services also has an Optional State Supplementation (OSS). It supplements a resident's other earnings or benefits so that a total of \$1100 a month is available to pay CRCF charges. See: <http://www.dhhs.state.sc.us/dhhsnew/insidedhhs/bureaus/EligibilityPolicyAndOversight/oss.asp>. The CRCFs included in this report are predominantly operated by individuals as sole proprietorships or small corporations. Boarding homes, providing only food and shelter without personal care, do not have to be licensed as CRCFs and were not included in this report.

<sup>3</sup> DHEC R. 61-84.101.L defines a CRCF as: A facility which offers room and board and which, unlike a boarding house, provides/coordinates a degree of personal care for a period of time in excess of 24 consecutive hours for two or more persons, 18 years old or older, not related to the licensee within the third degree of consanguinity. It is designed to accommodate residents' changing needs and preferences, maximize residents' dignity, autonomy, privacy, independence, and safety, and encourage family and community involvement. Included in this definition is any facility (other than a hospital), which offers or represents to the public that it offers a beneficial or protected environment specifically for individuals who have mental illness or disabilities. These facilities may be referred to as "assisted living" provided they meet the above definition of community residential care facility.

<sup>4</sup> DHEC listing of Community Residential Care Facilities: <http://www.scdhec.gov/health/licen/hrcrcf.pdf>.

<sup>5</sup> S.C. Code § 43-33-350. The Team Advocate uses a number of factors to develop the list of CRCFs to inspect throughout the year, including balancing the different regions of the state, the number of facilities in each area/region, how many of those have a Memorandum of Agreement with DMH, the date of Team's last inspection

P&A is the state and federally mandated protection and advocacy system for South Carolina. P&A was established as a nonprofit corporation in 1977 by S.C. Code §§ 43-33-310 *et seq.* to protect the rights of people with disabilities. Each year P&A serves thousands of South Carolinians who have been abused, neglected or denied their rights to equal treatment and access to services. P&A has broad authority under state and federal law to advocate for the rights of individuals with disabilities and to investigate allegations of abuse and neglect when such incidents are reported or when probable cause exists to determine that abuse and neglect has occurred.

**P&A has found that many CRCFs are filthy, do not provide adequate food and heat, do not safely administer medications or arrange for needed medical care, and do not provide protection from abuse, neglect and exploitation. Inspectors have found infestations of cockroaches in facilities, blood on the walls, and food which is out of date and rotting. Some residents routinely lack prescribed medications or are given the wrong amounts of medications, and some residents have been physically harmed by staff or other residents due to lack of supervision. These CRCFs are no place to call home.**

Oversight of CRCFs is fragmented, slow to respond, and ineffective in protecting residents. In fact, as anyone who followed the story of Peachtree Manor in Winnsboro until its closing knows, the current system protects the owners of the facilities more than the residents.

During 2007 and 2008 P&A received many reports about increasing frequency and severity of abuse and neglect at some CRCFs.<sup>6</sup> The reports included deaths, sexual and physical abuse and neglect, including the failure to appropriately administer medication and to provide basic necessities such as food, heat and basic care. P&A has filed a complaint with DHEC about conditions in CRCFs in about 40% of the facilities inspected under the Team Advocacy program. While many CRCF owners are committed to operating facilities that provide a good quality of care, the lack of effective oversight puts all residents of CRCFs at risk of harm.

This report presents six case studies<sup>7</sup> that illustrate common problems found in CRCFs throughout the state, as well as the inability of the current system to prevent or cure these

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of that facility (if any), the availability of volunteers, the size of the facility, travel time, concerns or problems reported with facilities, etc.

<sup>6</sup> See Appendix for a brief description of the methodology used to select the six facilities included in the report.

<sup>7</sup> In order to protect the privacy of residents, these facilities are referred to by pseudonyms, except Peachtree Manor, which received widespread publicity throughout 2008.

problems in a timely fashion. Even though the shocking conditions at these six CRCFs have been widely known among state agencies, five of the six remain open. The single closure discussed here took an overwhelming amount of time and resources from several state agencies and P&A, despite the facility's repeated failure to comply with regulations and a lengthy series of investigations that routinely confirmed the presence of deplorable, unsafe conditions.

**As a result of P&A's review of hundreds of facility and agency documents and conversations and interviews with CRCF staff and residents and agency personnel, P&A recommends:**

1. The statutes and regulations governing CRCFs should be revised to give licensing agencies **more enforcement options against frequently cited facilities and administrators**, such as:

- The power to **suspend new admissions to CRCFs with repeated, uncorrected violations** that significantly jeopardize residents' life or health while the appellate process to suspend or revoke a license is pending;<sup>8</sup>
- The power to **make suspension of operations automatic when a license has been revoked**, followed by an emergency hearing to determine whether the facility should remain closed during the appeal or be allowed to resume operations;
- The ability to suspend the license of an administrator, prior to a hearing, based upon frequent or egregious violations that significantly jeopardize residents' life or health;
- The creation of an **expedited appeal process** to review license suspensions or bars to new resident admissions;
- The **consideration** of information relating not only to the current licensing period, but of **all pertinent information regarding the facility and the applicant** when considering applications and renewals of licenses;

2. DHEC should **inform the public and concerned parties about problem facilities**. Facility inspection reports, including corrective actions, should be made available to the public on the agency's website (without personal information identifying residents)<sup>9</sup> and posted at the facility.

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<sup>8</sup> Nursing homes that accept Medicaid payments are barred from accepting new admissions pending appeal of revocation of their operating license, 42 C.F.R. 488.414. Also, the statute could be expanded to include suspensions for prolonged periods of substandard conditions and repeated, uncorrected violations that present an unhealthy living environment. A third option would be to make suspensions automatic when a license has been revoked, followed by an emergency hearing to determine whether the facility should remain closed during the appeal or be allowed to resume operations. A fourth alternative would be to include an option for the licensing agency to request an expedited appeal process as well as injunctive relief pending appeal, if conditions so warrant. This injunctive relief could include a bar on the admission of new residents.

<sup>9</sup> In its 2005 Annual Report, the Adult Protection Coordinating Council (APCC), a group created by the Omnibus Adult Protection Act, recommended that DHEC post inspection reports on its website.

3. The state should **create an Adult Abuse Registry** of individuals who have substantiated allegations of abuse or neglect of vulnerable adults against them. Facilities should be required to check the Registry before hiring a prospective employee.
4. The General Assembly should **fully fund enough DHEC inspection staff** to provide for periodic unannounced visits and full, timely investigation of allegations of regulatory violations.
5. The General Assembly should adequately fund the SC Department of Labor, Licensing and Regulation (LLR) to enable **prompt investigation of complaints against CRCF administrators.**<sup>10</sup>

**Current procedures provide only an illusion of oversight.** The General Assembly, the Department of Health and Environmental Control, the Long Term Care Ombudsman and the other responsible agencies must act before more residents continue to live in squalor, suffer abuse and neglect or even die, and before more state and federal funds are wasted on grossly inadequate care. **CRCF residents deserve to have a place to call home.**

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<sup>10</sup> CRCF administrators are licensed by the Board of Long Term Health Care Administrators, located in LLR; complaints are investigated by LLR's Office of Investigation and Enforcement.

**NO PLACE TO CALL HOME:  
HOW SOUTH CAROLINA HAS FAILED RESIDENTS OF  
COMMUNITY RESIDENTIAL CARE FACILITIES**

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## **Introduction**

Community Residential Care Facilities (CRCFs) are the homes of last resort for as many as 16,700 South Carolinians. These poorly overseen facilities, which range in size from two to more than one hundred beds, provide housing, food, and care to individuals who are unable to live independently but who do not need institutional or skilled nursing care.<sup>11</sup> Residents of CRCFs have physical, emotional, or intellectual disabilities. Many cannot manage their own funds. These vulnerable individuals often do not have family members or friends who can advocate for them. The SC Department of Health and Environmental Control (DHEC) currently licenses over 480 separate community residential care facilities in South Carolina.<sup>12</sup>

This report initially provides information regarding the fragmented regulation and oversight of CRCFs in South Carolina. Information is provided about six CRCFs, including one known as Peachtree Manor. After two years of operation, Peachtree Manor was finally closed by Administrative Law Court decision in April 2008, due to its poor and unsafe conditions.

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<sup>11</sup> DHEC R. 61-84.101.L defines a CRCF as: A facility which offers room and board and which, unlike a boarding house, provides/coordinates a degree of personal care for a period of time in excess of 24 consecutive hours for two or more persons, 18 years old or older, not related to the licensee within the third degree of consanguinity. It is designed to accommodate residents' changing needs and preferences, maximize residents' dignity, autonomy, privacy, independence, and safety, and encourage family and community involvement. Included in this definition is any facility (other than a hospital), which offers or represents to the public that it offers a beneficial or protected environment specifically for individuals who have mental illness or disabilities. These facilities may be referred to as "assisted living" provided they meet the above definition of community residential care facility.

<sup>12</sup> DHEC listing of Community Residential Care Facilities: <http://www.scdhec.gov/health/licen/hrcrecf.pdf>

## **Fragmented Regulation and Oversight of CRCFs**

Oversight of CRCFs is split among many agencies:

The South Carolina Department of Health and Environmental Control (DHEC), Division of Health Licensing licenses and inspects CRCFs through regulation DHEC R. 61-84.<sup>13</sup> The regulation covers most aspects of facility management, including reporting of abuse, neglect, and injuries; physical safety; nutrition; administration of medicine; residents' rights; and enforcement of regulations. DHEC has authority to make unannounced inspections, although they are rare. DHEC has the authority to levy fines up to \$10,000 for repeated serious violations, although in practice fines are usually substantially reduced.<sup>14</sup>

The South Carolina Department of Health and Human Services (HHS) provides financial supplementation to Social Security Disability Insurance/Supplemental Security Income (SSDI/SSI) benefits through Optional State Supplementation (OSS), a state-funded program administered by HHS. OSS payments, which provide additional funds to pay for the cost of the poorest residents in CRCFs, are made directly to the facility.<sup>15</sup> HHS also is responsible for the administration of Medicaid, which most residents receive.

The Attorney General is responsible for prosecuting Medicaid fraud and other issues.

**Ms. A is a 65-year-old woman, with diagnoses of traumatic brain injury, dementia, and seizure disorder. She uses leg braces, a walker, and occasionally wears adult incontinency products. Ms. A can communicate very little verbally. Ms. A has lived in the same CRCF for over twenty years. Team Advocacy's inspection found an overwhelming odor of urine in the bedroom; no shower curtain and dangerously loose handrails in the bathroom; and dangerously low lighting in the bedroom. Ms. A's clothing was dirty and had holes. The residents had to ask for toilet paper, which was difficult for Ms. A to communicate. When asked where she stored her toilet paper, she reached through a small hole in her walker and pulled out a few sheets which she was hoarding.**

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<sup>13</sup> <http://www.scdhec.net/administration/regs/docs/61-84.pdf>

<sup>14</sup> DHEC R. 61.84.302; <http://www.scdhec.net/administration/regs/docs/61-84.pdf>

<sup>15</sup> CRCFs currently receive \$1100 per month for individuals receiving OSS. <http://www.dhhs.state.sc.us/Internet/pdf/ossadvJanuary2009.doc>



The Department of Labor, Licensing, and Regulation (LLR) licenses and disciplines CRCF administrators<sup>16</sup> through the Board of Long Term Health Care Administrators. The Board does not have the power to suspend a license before a hearing, regardless of the seriousness of the misconduct.

The Long Term Care (LTC) Ombudsman in the Office of the Lieutenant Governor is responsible for investigation of reports of abuse and neglect of residents of CRCFs.<sup>17</sup> Local law enforcement or SLED may also receive reports.

**Mr. B is a 46-year-old man who has diagnoses of schizophrenia and hypertension. He had been living at a CRCF in the Charleston area for a month. His family could not visit him because they lived over 200 miles away. He did not know why he had been placed so far from his family. Team Advocacy's inspection found: bedrooms were overheated at 81°F and 82.6 °F; several of the residents were wearing dirty and worn clothing; residents were not allowed to sit in the front living room area because a sign written by the administrator stated that they wanted to keep that area clean and smelling good; Mr. B stated that other residents were using illegal drugs; the only snack offered was one Mr. B was allergic to; and the facility did not always have clean bath towels or enough toilet paper.**

Some CRCF residents receive services from the Department of Mental Health (DMH), including individuals discharged from DMH facilities who move into CRCFs because they have no family or cannot afford to live anywhere else. Some CRCFs contract with DMH for an enhanced rate to serve residents with mental illness. A staff member of DMH has responsibility for oversight of these contracts. Some DMH community mental health centers directly operate CRCFs in order to provide supplemental mental health services to residents. DMH also contracts with P&A to make 75 unannounced inspections of CRCFs per year through P&A's Team Advocacy program to ensure that DMH clients have access to safe facilities.

The Social Security Administration is responsible for oversight of SSDI/SSI disability or retirement benefits paid to a representative payee for a person who cannot manage funds. Many residents of CRCFs appoint the CRCF as their representative payee.

<sup>16</sup> <http://www.scstatehouse.gov/coderegs/c093.htm>

<sup>17</sup> As part of the Omnibus Adult Protection Act, <http://www.scstatehouse.gov/code/t43c035.htm>.

Their entire income is assigned to the CRCF, leaving them a net income of only \$57.00 (SSI) or \$77.00 (SSDI) per month.<sup>18</sup> From these funds, residents must pay for prescription and over the counter drugs, physician copayments, and personal items such as adult incontinency products, soap, shampoo, clothing, etc.

The Veterans Administration has fiscal oversight responsibility for recipients of veterans' benefits.

The State Fire Marshal is responsible for enforcing fire safety.

The Department of Social Services (DSS) has responsibility for any residents who have been placed in its custody through the Family Court.<sup>19</sup>

The Department of Disabilities and Special Needs (DDSN) has responsibility for any residents who it may have placed in the CRCF or for clients placed there by others.

The U.S. Department of Homeland Security has placed individuals in CRCFs, apparently with little or no oversight.

**Ms. C is a 62-year-old woman with schizophrenia and diabetes. The Department of Mental Health placed her in the CRCF where she had lived for five years. While Team Advocacy members were speaking with the facility administrator, Ms. C approached Team Advocacy members and said that she was afraid of another resident who attacked her and other residents. Immediately, the administrator responded by shouting and yelling at Ms. C. The administrator called the resident a "liar" and accused her of being "jealous" because the other resident had more money. At one point in the argument, the administrator was close to Ms. C's face. Ms. C became upset and tearful, screaming that she wanted to move. She packed all of her belongings in one garbage bag within minutes. Team Advocacy contacted her case worker at DMH, and the resident was immediately moved to another CRCF.**

This report documents the history of enforcement efforts at six CRCFs throughout the state. As shown in the accounts of individual facilities, several agencies may conduct investigations into the same incident without prompt improvement of the violations and without any meaningful sanctions to the owner, the administrator or the perpetrators of abuse or neglect.

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<sup>18</sup> <http://www.dhhs.state.sc.us/Internet/pdf/ossadvJanuary2009.doc>

<sup>19</sup> As part of the Omnibus Adult Protection Act, <http://www.scstatehouse.gov/code/t43c035.htm>

# **WHAT DID INSPECTORS FIND AT THE**

## **SIX CRCF FACILITIES?**<sup>20</sup>

### **FACILITY A**

Facility A is located in a rural county. Serious problems have been noted at Facility A since at least February, 2006. The facility's deficiencies included errors or carelessness in handling medication; failure to fill prescriptions and provide needed health care for residents; interference with DMH services to residents; incomplete or missing admission papers, medical assessments, TB tests, and level of care evaluations to ensure residents' needs can be met in a CRCF. Other serious and recurring problems were inadequate staff documentation and training; poor sanitation, health care deficiencies (medications out of stock, the need for higher level of care than a CRCF); altercations between residents; safety issues such as food improperly stored/labeled and/or lacking completely; financial mismanagement of residents' funds; and inadequate utility maintenance. Some of the most significant deficiencies were:

- Failure to obtain medical care for a resident who had an open lesion on his arm, which was bleeding through his sweatshirt, and on his forehead;
- Administration of discontinued medications;
- Failure to assess residents within 72 hours of admission, which DHEC cited as a violation; and
- Interference with residents' access to services at the local community mental health center.

Due to continuing problems with this CRCF, P&A made three visits to the facility in January, September and October of 2007 and one visit in 2008. DHEC made at least two inspections between February and December of 2007, and two more in May and June of 2008. DMH made two visits in February and March of 2006, and two joint visits with P&A in January and October of 2007. The local Community Mental Health Center also

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<sup>20</sup> More detailed information about each facility may be found in the Appendices.

made visits. The Long Term Care Ombudsman visited in February, September, and October of 2007.

In 2006, the administrator had been fined \$5,000 by DHEC for operating a separate unlicensed facility, in addition to her operation of Facility A. This amount was later reduced by mutual agreement between the parties upon the condition that the administrator cease operating the unlicensed facility. Despite the terms of the agreement, DMH discovered during a visit on October 30, 2007, that the administrator was operating an unlicensed home. This home contained an unvented heater with no apparent carbon monoxide detector in the house. The wall had become discolored above the heater due to the heat. Bedrooms, bathroom, and kitchen were not heated. A resident stated that the ceiling leaked when it rained. The floor in the bathroom was sinking in.

This case illustrates the need for DHEC and other agencies to be able to consider the entire history of an owner or administrator. The operator of Facility A was allowed to continue its operation in spite of her failure to comply with the previous agreement with DHEC and in spite of the continuing lack of compliance in operation of Facility A.

## **FACILITY B**

Facility B is a 10-bed facility located in an urban county. It has a history of violations, and was briefly shut down in 2001 after the death of a resident. Recent renovations have made significant improvements to the physical condition of the facility, but as recently as July 24, 2008, the LTC Ombudsman's office performed an unannounced inspection and found numerous problems.

A review of the records from DHEC, DMH, the State LTC Ombudsman and P&A reveals a history of physical abuse by staff; the facility's requiring residents to perform work in the facility; errors or carelessness in handling medication; failure to perform medical tests as required upon admission; and a resident who continued to live at the facility after being committed to a state mental hospital, by court order, as a danger to himself or others.<sup>21</sup> Some of the most significant deficiencies were:

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<sup>21</sup> The July 24, 2007, inspection also found that one resident was on probation for committing a crime and had been court ordered into a state mental facility after being determined to be a danger to himself and others. He had been placed at Facility B when the facility had a 24-hour Department of Mental Health presence. This was no longer the case, but the resident had not been relocated to an appropriate facility.

- On July 3, 2007, a resident was removed to a Crisis Stabilization Center after alleging a staff member had severely beaten him, to the point of vomiting blood, with a two-by-four board.<sup>22</sup>
- When the LTC Ombudsman staff inspected the facility later in July 2007, they found that residents were being assigned many duties not consistent with their care plans. Residents were being required to wash their own laundry and cook and serve their own meals; one resident was required to mow the facility's lawn.
- The March 29, 2008, Team Advocacy inspection discovered numerous inconsistencies in residents' medical records and available medications. Thirteen medications prescribed to different residents were not available, including major prescription pain medications. Other residents' medications had not been properly administered or were past their expiration dates.
- Residents did not receive needed clothing, dentures, adult incontinency supplies, and medical care. A complaint was filed with DHEC.
- DHEC inspected and cited Facility B for violations for unavailability of staff, medications out of stock, food preparation violations and unlocked chemicals. DHEC required Facility B to submit a plan of correction.

Team Advocacy inspected this facility in March 2008; the LTC Ombudsman inspected it in July 2007 and April 2008; and DHEC inspected Facility B in April 2008.

The ongoing problems with this facility reveal the inability of existing state agencies to remedy problem conditions in a timely manner.

## **FACILITY C**

Facility C is a small (licensed for five beds) CRCF in an urban county. Throughout the time period reviewed for this report, significant problems were noted with resident documentation and care; staff documentation and supervision; sanitation,

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<sup>22</sup> Charleston/Dorchester Community Mental Health Center removed resident to a Crisis Stabilization Center and reported the incident to the LTC Ombudsman, DHEC, DMH, the state attorney's office, and several other entities. The LTC Ombudsman performed an unannounced facility inspection on July 20, as per next paragraph. DHEC also did a report, dated August 16, 2007.

health and safety; medication administration; and food. Some of the most significant deficiencies were:

- Exceeding the number of residents for which the facility was licensed;
- Staff sleeping on the job;
- Inadequate background checks of staff;
- Residents had no Medication Administration Records (MARs)<sup>23</sup> or MARs were incorrect or unsigned;
- Medicines were not kept locked;
- Insulin was not refrigerated;
- Residents did not receive medication or appropriate medical treatment: residents did not receive medication for over a week;
- At least one resident had been performing cleaning duties at the facility for \$5 per day.

P&A inspected this facility in July 2007; DMH inspected it in July and twice in August of 2007 and then in January, February, and June 2008; and DHEC inspected it in September, 2007; and January, February, and April 2008.

Again, the ongoing problems with this facility reveal the inability of existing state agencies to remedy problem conditions in a timely manner.

## **FACILITY D**

Facility D is located in a rural area of an urban county. The five-bed facility is a converted house in a local neighborhood. It has had persistent compliance problems for several years going back to 2005. As early as 2006, the administrator had entered into a probation agreement with the Department of Labor, Licensing, and Regulation based on

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<sup>23</sup>DHEC R. 61-84.1203. A. "Each medication dose administered or supervised shall be properly recorded by initialing on the resident's medication administration record (MAR) as the medication is administered. Recording medication administration shall include medication name, dosage, mode of administration, date, time, and the signature of the individual administering or supervising the taking of the medication."

problems from prior inspections. Since that time there were multiple complaints and multiple emergency inspections. P&A inspected Facility D in December 2007; DMH inspected it in February 2007 and January, March, May and August of 2008; the LTC Ombudsman inspected the facility twice in January 2007 and once in March 2007. The LTC Ombudsman's office responded to seven complaints there between March 21, 2007, and January 11, 2008; DHEC has made four inspections; and P&A has inspected and responded to numerous complaints from December, 2007 to February 2008. In May 2008, after the facility repeatedly failed to meet inspection requirements, DHEC held a consultation with the CRCF staff. When problems were still not remedied in a final inspection, DHEC recommended an enforcement action in August 2008.

Among the many deficiencies at this facility, some of the most serious were:

- Inadequate documentation and storage of prescription medications;
- An administrator was consistently absent;
- No way to contact the administrator in an emergency;
- Refusing to allow P&A and DHEC to inspect the facility;
- Blood found on the walls;
- Cockroaches crawling on the walls;
- Pushing a DMH inspector;
- Rotten food;
- Filthy walls, carpets and furnishings;
- Debris and beer cans in the yard;
- Inadequate documentation of staff and training.

The protracted difficulty that state organizations had reforming this facility-- despite almost total abandonment by the licensed administrator, consistently foul conditions, and open defiance of state inspectors by staff-- demonstrates how difficult it is to deal with problem facilities in a timely fashion under our current system.

## FACILITY E

Facility E is a facility in a rural county. On June 4, 2007, the Department of Labor, Licensing, and Regulation brought an action against the administrator before the Board of Long Term Health Care Administrators (the Board) for substandard conditions in his facility. A consent agreement was signed whereby the administrator's license was suspended for one year and a \$1,000 fine was assessed. The suspension was stayed, and the license was put on probationary status for a year. The administrator was also required to report all complaints and inspections to the Board. **All of the incidents listed below occurred after this consent order took effect while the license was in probationary status, yet the administrator's license remained in place.** Some of the significant deficiencies in Facility E included:

- Failure to dispose of medication properly;
- Exploitation of some residents by others;
- Residents leaving the facility without staff's knowledge;
- No privacy at tubs or toilets in bathrooms;
- Urine-soaked sweatpants worn by a resident and urine on the floor of a bedroom;
- A resident covered in dried blood lying on a bare mattress;
- Roaches in the bedrooms and bathroom;
- Mouse droppings in a dresser drawer;
- A resident who had not had a bath from June until November;
- Inadequate documentation of criminal background checks.

P&A inspected Facility E in October 2007; the LTC Ombudsman inspected it in November 2007; DMH inspected it in November and December 2007 and January 2008; DHEC inspected Facility E in June, September, October and November 2007 and then requested and received a plan of correction for all violations. In January 2008, when



DHEC inspected again, over 30 violations were found (many of which were repeat violations).

The ongoing problems with this facility again reveal the inability of existing state agencies to remedy problem conditions in a timely manner.

## **PEACHTREE MANOR<sup>24</sup>**

Peachtree Manor, although an extreme case, illustrates the deficiencies of the current system for oversight of CRCFs. It is now closed. At times during its operation:

- A resident was killed in traffic while unsupervised;
- Residents did not receive their medications or medical care;
- Residents did not have heat;
- The facility had no gas for cooking;
- The facility had consistently filthy conditions, including roaches in the kitchen.

Peachtree received its license to operate as a CRCF in Winnsboro, South Carolina, in Fairfield County on January 18, 2006. DHEC inspectors first noted problems at Peachtree before the facility even opened, and multiple inspections over the next two years uncovered a pattern of ongoing and progressive deterioration. Peachtree proved consistently unable to appropriately document the administration of residents' required medications, ensure basic sanitation, or maintain finances stable enough to consistently provide for basic necessities like food, heat, phone service, and garbage removal.

Additionally, at least one resident died due to lack of supervision. On the evening of Saturday, October 29, 2006, two residents were walking on the road in front of the facility. A vehicle struck and killed one of the two residents, who used a wheelchair. The other resident sustained minor injuries as he leapt to safety. A complaint was made

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<sup>24</sup> Because the facts surrounding Peachtree were the subject of widespread media coverage and the facility is no longer operating, the report uses the facility name, rather than a pseudonym.

concerning resident monitoring, staffing and training, resident's records, and facility safety. The individual care plan for the deceased resident had not been reviewed or revised every six months; the initial care plan (ICP) had been performed on March 3, 2006. His admission assessment was incomplete, and did not contain all items required by DHEC R. 61-84.101.I. There was no care plan available for review for the surviving resident. He had been admitted on October 6, 2006; DHEC regulations require an ICP be completed within seven days of admission.<sup>25</sup> His assessment stated that he "wanders" but the DHEC inspector determined the resident was not properly supervised. (According to hearing testimony by the operator of Peachtree, the two residents were on a "buddy system" with each other, and were also supervised by staff.)

DMH, the LTC Ombudsman's Office, P&A and DHEC all conducted inspections throughout Peachtree's period of operations, although primary responsibility fell on DHEC as the licensing agency. DHEC cited Peachtree for regulatory violations on numerous occasions, beginning on January 5, 2006 (before the facility even opened), again on May 31, 2006, and again on June 21 and 22, 2006. By letter dated July 21, 2006, DHEC imposed a total monetary penalty in the amount of \$20,100.00 for the assorted regulatory violations (reduced to a total fine of \$6,325.00 by order of the Administrative Law Court dated Sept. 14, 2007).<sup>26</sup>

A DHEC complaint investigation in response to the death mentioned above was made on October 30, 2006, and a DHEC general sanitation inspection and complaint investigation was made on November 14, 2006. Pursuant to the results of those inspections, DHEC revoked Peachtree's license to operate by letter dated December 5, 2006. Peachtree appealed that revocation to the Administrative Law Court. While the action was pending, the facility remained open and continued to admit new residents. In the meantime, conditions continued to deteriorate and the residents' lives and health were daily placed at greater and greater risk.

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<sup>25</sup> DHEC R. 61-84 703. Individual Care Plan (II) A. The facility shall develop an ICP with participation by, as evidenced by their signatures, the resident, administrator (or designee), and/or the sponsor or responsible party when appropriate, within seven days of admission.

<sup>26</sup> S.C. Dep't of Health & Envtl. Control v. Peachtree Manor Residential Care, LLC, 06-ALJ-07-0765-CC (S.C. Admin. Law Ct., Sept. 14, 2007) (Kittrell, C.J.). Online at <http://www.scalc.net/decisions.aspx?q=4&id=10347>

Finally, on March 28, 2008, after several warnings regarding non-payment, Palmetto Long Term Care Pharmacy terminated its contract with Peachtree and ceased to supply the facility with medications. The pharmacy then notified DHEC of this action and stated that it therefore believed the residents were no longer receiving necessary medications. As a result, DHEC performed an emergency inspection that same afternoon, which confirmed that residents were not receiving required medications, cited several other violations as well, and finally determined that an “imminent threat to the health, safety, and welfare of the residents” existed, which allowed DHEC to immediately suspend Peachtree’s license under S.C. Code § 44-7-320(A)(3). Five days later, an emergency hearing was held, and on April 1, 2008, an Administrative Law Court judge confirmed both the license suspension and the earlier revocation action. **Finally, after over two years, almost the entirety of which had been spent in noncompliance with regulatory requirements, Peachtree was closed and the remaining residents were moved.**

Peachtree’s eventual closure was not a success, but the outcome of systemic failure. Its residents suffered, and even died, over a period of years because of the lack of an adequate and competent system to approve initial licenses, inspect facilities, and revoke licenses. Efforts to make Peachtree comply with DHEC’s regulations cost hundreds of hours of many agencies’ time and tens of thousands of state dollars. While Peachtree represents the extreme of noncompliance, the other facilities discussed in this report, as well as many others across the state, continue to pose health and safety hazards to residents.

## **FINDINGS**

1. Unsafe, unsanitary, and unacceptable conditions prevail at many residential care facilities throughout the state.
2. Staff and administrators are often unaware, untrained, or apathetic about compliance with the regulations that govern the facilities.
3. Since inspection results are not public and no central database of facility reports exists, it is difficult for agencies and others that serve vulnerable adults to easily access information regarding complaints and actions taken against facilities.

4. Different agencies have varying degrees of oversight and reporting responsibilities.
5. State regulatory agencies have only limited tools, typically monetary penalties that are often reduced significantly, to address problems in CRCFs.<sup>27</sup> Fines imposed on facilities, however, often result in worse resident care rather than curing the problem.
6. There is no process to stop admissions to a deficient facility short of license revocation.
7. The level of noncompliance required for revocation of a facility's license is too high to ensure protection to residents, and the legal process required for facility closure can take years. Meanwhile, residents continue to live in substandard and unsafe conditions.

## **Conclusion**

The history of the efforts to obtain compliance with the law in these six Community Residential Care Facilities shows the complete ineffectiveness of our state's efforts to protect these people with disabilities, who are usually poor and without family. Facilities that continue to operate with numerous and repeated violations over a long period of time show the callousness with which many administrators and operators treat the people in their care. Such pervasive violations signify a blatant disregard for the law and discredit the ability of agencies and advocacy organizations to compel compliance.

Residents in the facilities in this report lived in unsanitary environments where they were provided no opportunity for activities and were often expected to perform housekeeping duties that should be designated for staff only. These residents often did not receive vital medications, medical treatment in a timely matter, food, heat, and care by an adequate number of properly trained staff with no criminal history. Many of the residents have been threatened, exploited, neglected, and even abused by the staff entrusted with their care.

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<sup>27</sup> See, e.g. <http://www.scalc.net/decisions.aspx?q=4&id=10347>, S.C. ALC 06-ALJ-07-0765-CC, original fine imposed by DHEC against Peachtree \$20,100, final total fine imposed by court; \$6,325. Often, however, DHEC negotiates with the owner instead of taking it through the court: see, e.g., <http://www.scalc.net/decisions.aspx?q=4&id=5515>

Violations of CRCF regulations must be enforced more consistently and more stringently. Administrators and operators must understand that noncompliance will be punished and that repeat offenses will not be tolerated without serious consequences. Public awareness of substandard facilities and of negligent staff should also support decreasing admissions to substandard facilities, a primary goal in any effort to ensure facilities provide quality care and comply with regulatory requirements. Until South Carolina reinforces its commitment to ensuring that Community Residential Care Facility operators are accountable for their actions, administrators will have little incentive to improve the standard of care, residents will not receive the care to which they are entitled, and residents and the state will continue to financially reward operators who fail to meet the most basic standards of care. **CRCF residents deserve to have a place to call home.**

## RECOMMENDATIONS

1. The statutes and regulations governing CRCFs should be revised to give licensing agencies **more enforcement options against frequently cited facilities and administrators**, such as:
  - The power to **suspend new admissions to CRCFs with repeated, uncorrected violations** that significantly jeopardize residents' life or health while the appellate process to suspend or revoke a license is pending;<sup>28</sup>
  - The power to **make suspension of operations automatic when a license has been revoked**, followed by an emergency hearing to determine whether the facility should remain closed during the appeal or be allowed to resume operations;

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<sup>28</sup> Nursing homes that accept Medicaid payments are barred from accepting new admissions pending appeal of revocation of their operating license, 42 C.F.R. 488.414. Also, the statute could be expanded to include suspensions for prolonged periods of substandard conditions and repeated, uncorrected violations that present an unhealthy living environment. A third option would be to make suspensions automatic when a license has been revoked, followed by an emergency hearing to determine whether the facility should remain closed during the appeal or be allowed to resume operations. A fourth alternative would be to include an option for the licensing agency to request an expedited appeal process as well as injunctive relief pending appeal, if conditions so warrant. This injunctive relief could include a bar on the admission of new residents.

- The ability to suspend the license of an administrator, prior to a hearing, based upon frequent or egregious violations that significantly jeopardize residents' life or health;
- The creation of an **expedited appeal process** to review license suspensions or bars to new resident admissions; and
- The **consideration** of information relating not only to the current licensing period, but of **all pertinent information regarding the facility and the applicant** when considering applications and renewals of licenses.

2. DHEC should **inform the public and concerned parties about problem facilities**. Facility inspection reports, including corrective actions, should be made available to the public on the agency's website (without any personal information identifying residents)<sup>29</sup> and posted at the facility.

3. The state should **create an Adult Abuse Registry** of individuals who have substantiated allegations of abuse or neglect of vulnerable adults against them. Facilities should be required to check the Registry before hiring a prospective employee.

4. The General Assembly should **fully fund enough DHEC inspection staff** to provide for periodic unannounced visits and full, timely investigation of allegations of regulatory violations.

5. The General Assembly should adequately fund the SC Department of Labor, Licensing and Regulation (LLR) to enable **prompt investigation of complaints against CRCF administrators**.<sup>30</sup>

These measures would significantly improve protection for our state's vulnerable adults who have no choice but to live in these facilities. State law and regulations provide for oversight of Community Residential Care Facilities, but many South Carolinians are harmed every year because the oversight is ineffective and fragmented. We cannot afford to continue the current practice of minimal accountability for serious and continual transgressions. A few of the most serious incidents have been reported by the press; this report illustrates that many others have not. The State and individual

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<sup>29</sup> In its 2005 Annual Report, the Adult Protection Coordinating Council (APCC), a group created by the Omnibus Adult Protection Act, recommended that DHEC post inspection reports on its website.

<sup>30</sup> CRCF administrators are licensed by the Board of Long Term Health Care Administrators, located in LLR; complaints are investigated by LLR's Office of Investigation and Enforcement.  
<http://www.llr.state.sc.us/POL/LongtermHealthCare/> <http://www.scstatehouse.gov/coderegs/c093.htm>

residents are paying for services that do not meet the standard of care established by regulation. **It is past time to ensure safety and accountability in these facilities.**



## **APPENDICES**



## METHODOLOGY OF THIS REPORT

This report originally began with a focus on one CRCF, Peachtree Manor. However, shortly after Peachtree's doors finally closed, the report was expanded to examine conditions in other CRCFs since P&A's Team Advocacy inspections and other information indicated that problems existed in many CRCFs across the state.

P&A's Team Advocate provided a list of every CRCF inspected from June 29, 2007, through April 3, 2008.<sup>31</sup> From this list, 28 of 67 inspections were selected for further review because the Team Advocacy findings had been sufficiently serious that complaints had been filed with DHEC. Consideration was also given to other information from previous encounters with these facilities while working with clients.

Each of the 28 facilities was then graded by applying a uniform performance scale to the Team Advocacy reports. That scale was based upon three categories:

- Medication. It included the accuracy of MARs, the availability of all prescribed medication on site, the proper storage and labeling of medications, and evidence of appropriate distribution of medication as prescribed.
- Sanitation. This category included overall appearance and condition of the facility, odors, proper food labeling and storage, sufficient cleaning and paper supplies, and insect infestation, as well as the appearance of the residents' cleanliness.
- Other Issues. Some examples include lack of supervision of both staff and residents, incomplete residents' records, lack of staff training documentation, violations of residents' rights, and utilities not working properly.

P&A then requested information on ten facilities from DHEC, the Department of Mental Health (DMH), and the LTC Ombudsman. Based on review of these materials P&A selected five facilities plus Peachtree for inclusion in the report.

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<sup>31</sup> However, an inspection which occurred before the start of the Team Advocacy contract year July 1, 2007 through June 30, 2008 was excluded.

# **LEGAL RIGHTS OF CRCF RESIDENTS**

## **RESIDENT'S BILL OF RIGHTS**

<http://www.scdhec.gov/health/licen/hlboreng.pdf>

South Carolina Code of Laws, Section 44-81-20 et seq.

**As a resident of this facility, YOU have or your legal guardian has, the right to:**

### **MEDICAL TREATMENT**

- Choose your own personal physician;
- Receive from your physician a complete and current description of your medical condition in terms you understand;
- Participate in planning the care and treatment you receive;
- Participate in any changes to your care and treatment;
- Be fully informed in advance of any changes in your care and treatment that may affect your well-being;
- Refuse to participate in any type of experimental tests or research;
- Have privacy during treatment;
- Have your medical records treated with confidentiality;
- Approve or refuse release of your medical records to anyone outside this facility, unless you are transferred to another health care facility, or it is required by law or by other third party contracts;

### **PERSONAL POSSESSIONS**

- Have security in storing your personal possessions;
- Approve or refuse release of your personal records to anyone outside the facility, except as provided by law;
- Keep and use personal clothing and possessions as long as they do not affect other residents' rights;
- Manage your personal finances. If the facility has been delegated in writing to manage your finances for you, it must provide you with a quarterly report of your finances;

### **PERSONAL TREATMENT**

- Be treated with respect and dignity;
- Be free from mental or physical abuse;
- Be free from being restrained either physically or with drugs, unless your doctor has ordered them;
- Be free from working or performing services for the facility unless they are part of your plan of care;
- Be discharged or transferred to another facility against your wishes only for: your welfare; the welfare of the other residents; medical reasons; or for nonpayment. You must be given written notice at least 30 days prior to discharge or transfer, unless your discharge or transfer is for your welfare or the welfare of other residents; in that case the facility must provide you with written notice within a reasonable time under the circumstances.

## COMMUNICATION

- Have your legal guardian, family members, and other relatives see you when they visit;
- Refuse to see your legal guardian, family members, and other relatives;
- Send and receive mail with freedom and privacy;
- Associate and communicate privately with persons of your choice;
- Meet with your legal guardian, family members, or other resident's family members to discuss this facility;
- Meet with and participate in social, religious, and community group activities, unless a written medical order prohibits such activity;

## PERSONAL PRIVACY

- Have privacy when receiving personal care;
- Have privacy when visiting with your husband or wife;
- Share a room with your husband or wife, unless your doctor forbids this in your medical record;
- Have your personal records treated confidentially;
- Employ a sitter from outside this facility to come and provide you with sitter services, unless you have already agreed in writing with this facility not to hire a private sitter. You must choose a sitter from an approved agency or list and that sitter must be approved by the facility. The sitter must also abide by the policies and procedures of this facility. You must agree not to hold the facility liable for any matters involving your private sitter.

**By the time you were admitted to this facility, a representative of this facility must have explained to you:**

**Your Rights:** You must have been told and given a written explanation of your rights as explained in this poster, what to do if you believe your rights have been violated, and how to enforce your rights under state law. You must have acknowledged that you received these explanations in writing, and they must be part of your file.

**Services:** You must have been given a written list of the services that are available to you and their cost. If the services or their costs change, you must be notified of those changes in writing.

**Refund Policy:** This facility must have a policy on giving refunds to residents. The policy must be based on the actual number of days you were in the facility or a bed was held there for you. You must have been given a copy of this policy in writing and you must be notified in writing again of any changes that are made to this policy.

If you contact a member of the facility staff, but no action is taken on your behalf, contact:

**South Carolina Department of  
Health & Environmental Control, Health Licensing, 2600 Bull Street, Columbia, SC  
29201. Or call: (803) 545-4370.**

# INSPECTIONS AT THE SIX CRCF FACILITIES

## **FACILITY A**

### **Resident Care and Documentation**

From 2006 through 2008 the following problems in handling medication and failing to fill prescriptions were noted at Facility A: unsecured medications; residents' medications prepared the previous day to take to their day program,<sup>32</sup> in violation of regulations;<sup>33</sup> controlled drug count sheets listed more pills than were actually in stock; Medication Administration Records (MARs) were not signed; MARs were signed even though medications were not in stock and had not been administered; residents were not given appropriate dosages of medicine; an Albuterol Inhaler was not labeled with resident's name or instructions; medicines were prescribed and in residents' medication drawers but not listed on their MARs; medications which were discontinued were still being administered; expired medicines without instructions or the name of residents were in the medication cart; the MAR did not match the prescription; medicines of residents who had left the facility were still in the cart; and resident files did not contain the 72 hour assessment as required. Additionally, staff reported that they sometimes did not administer the medications by the date indicated on the package, and would take medications from other dates to administer it.

DHEC conducted a complaint investigation on February 14, 2007, regarding medication administration, resident and staff records, and sanitation issues. One violation was cited because two residents had no 72-hour assessment available for review.

On January 2, 2007, the CRCF Coordinator at DMH received a call from the county detention center. The staff person there informed her that there had been an

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<sup>32</sup> On September 29, 2007, a resident who attended the Disabilities and Special Needs Board (DSN) day program had come to the day program from the CRCF with medication in her pants pocket. The DSN staff directed the individual to take the medication and soon after found her sleeping on the lawn, unable to be roused. She was transported to the hospital where her stomach was pumped. She had taken an excess of Seroquel. It could not be determined when and where the resident had procured the Seroquel.

<sup>33</sup> DHEC R. 61-84 1203. Administering Medication (I) A. Doses of medication shall be administered by the same staff member who prepared them for administration. Preparation shall occur no earlier than one hour prior to administering. Preparation of doses for more than one scheduled administration shall not be permitted.

altercation between two residents of Facility A; one of the residents was arrested for disorderly conduct. The resident arrived at the detention center with her medications, but they had been prescribed for her the previous August. The staff person believed that the resident had not been receiving the correct medications (psychotropic drugs), which may have led to her problems. The detention center staff stated that it was not the first time they had had residents from Facility A there. She said the residents typically reported not receiving their medications and that staff were “mean” to them. The resident had to remain at the detention center until a new living arrangement was made and bail was posted. The resident had no family to assist her in this process.

In 2006, Facility A sent a letter to the local Mental Health Center (MHC) informing the MHC that a number of residents wanted their mental health cases closed.<sup>34</sup> The CRCF administrator had gathered the signatures of eight residents on this letter to demonstrate their consent. When DMH and MHC employees attempted to visit the residents to speak with them about this letter, the director denied them admission to the facility. The director tried to force the residents to state that they did not want to speak with DMH or the MHC. DMH and MHC finally obtained access to the residents when the administrator arrived at the facility. DHEC was notified of this situation.

DMH and P&A advocates who visited the facility also repeatedly found admission papers, medical assessments and TB tests incomplete or lacking at Facility A during this time period. In February and March of 2006, DMH found residents who had not been given a PPD test for TB and whose admission papers, medical assessments, and TB tests had not been conducted before the move to the CRCF, as regulations require.<sup>35</sup>

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<sup>34</sup> Some of these residents could not read so they would not have understood the letter closing their case unless it had been read to them. Two of the residents had previously asked that their cases be transferred to another county since they intended to move. One of these residents had recently requested that the MHC help her move closer to her family. Although an employee of the MHC was helping her in this process, when the employee came to help her move a week later, the resident was upset and claimed she no longer wanted to move. However, the following day, the day DMH went to the facility in response to the letter, the resident stated that she definitely wanted to move, to be close to her family and to get away from the “yelling and fighting” at Facility A.

<sup>35</sup> DHEC Regulation R. 64-81 1101. General (I)  
A. A physical examination shall be completed for residents within 30 days prior to admission and at least annually thereafter. The physical examination shall address the appropriateness of placement in a CRCF, medications required and self-administration status, and identification of special conditions/care required,

When P&A's Team Advocacy staff and volunteer inspected the facility in September 2007, they could not locate documentation of a physical exam for two residents and four of the five resident care plans needed to be updated. On December 18, 2007, DHEC cited the facility for several violations, including lack of documentation regarding resident care plans and services provided.

The information reviewed also shows Facility A's failure to procure health care for residents. During the Team Advocacy inspection in September 2007, the Team advocate found that none of the resident records reviewed contained documentation of a podiatry exam over the past year, yet three residents reported needing to see a podiatrist. Three residents reported needing an eye exam, two reported needing a dental exam, and one reported needing a gynecological exam. One resident had open lesions on his forehead and his arm. His arm lesion was bleeding onto his sweatshirt. He had a closed lesion on his other arm.

The information reviewed also shows the failure to obtain level of care evaluations to ensure residents' needs could be met at a CRCF. During an inspection by DMH and Team Advocacy on October 30, 2007, the director of the facility explained that one of the residents had been discharged directly from a hospital to the CRCF. She stated that the resident needed assistance with dressing, bathing, and toileting. The resident wore "pull-ups" and could not change them on her own. She could not get in the shower due to her unsteadiness and size. The staff cleaned her with a wet cloth. This resident was not appropriate for placement in a CRCF. Another resident was placed there by DSS, but the director said he was "very ill" and required more care than they could provide.

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*e.g.*, if a resident has a communicable disease, dental problems, podiatric problems, Alzheimer's disease and/or related dementia, etc.

B. The admission physical examination shall include a two-step tuberculin skin test, as described in Section 1702, unless there is a documented previous positive reaction.

1702. Tuberculin Skin Testing (I)

A. Tuberculin skin testing, utilizing a two-step intradermal (Mantoux) method of five tuberculin units of stabilized purified protein derivative (PPD), is a procedure recommended by the CDC Guidelines for Preventing Transmission of Mycobacterium Tuberculosis in Healthcare Facilities to establish baseline status. The two-step procedure involves one initial tuberculin skin test with a negative result, followed 7-21 days later by a second test.

Other problems with resident care and documentation<sup>36</sup> include a failure to provide organized activities, residents receiving a lower monthly personal allowance than they were entitled to, and not having enough furniture for resident seating.

### **Staff, Documentation and Supervision**

Throughout this same time period, problems were also noted with staff documentation of training, supervision, and abuse of residents. Staff reported that the administrator was rarely present. They were unable to tell inspectors what the usual hours were for the administrator, and it was noted that some of the administrator's hours overlapped with her hours at the Mental Health Center where she was also employed.

Incidents of physical altercations between residents often occurred at night while no staff was present.

Training documentation for staff members was not current.

During a January 22, 2007 visit by P&A and DMH, one resident told a P&A staff person that she would like to live with her boyfriend. He apparently lived near the facility and she stated that he used to work at Facility A. She said that when he worked at the home, they would kiss and hug on the back porch. According to the resident, the director found them kissing and prohibited it because he was an employee. The resident reported that he still came to see her and they hug and kiss. The resident had a 9<sup>th</sup> grade education and a diagnosis of psychotic disorder. DMH reported this incident to the Attorney General's office, the Ombudsman, DHEC, LLR, and DSS.

On January 23, 2007, P&A visited a client who had previously lived at Facility A. This resident stated that she had been having sex with a staff person almost every day of her six month stay at Facility A. She stated that he told her to keep their activities a secret and not to tell anyone she was pregnant. He told her they could get in trouble and he would lose his job. She stated that he had been calling her at her new CRCF to check on her. P&A confirmed with staff at the new CRCF that he had indeed been calling the

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<sup>36</sup> In February 2006, DMH found that two residents of a separate unlicensed facility which the administrator of Facility A ran at the time used to walk from that facility to Facility A to have their medications administered, according to the residents and staff. One resident did this three times a day. The records and medications for both facilities were kept at the licensed facility. Upon observation of these records, it was noted that the prescription labels stated that the residents of the unlicensed facility lived at Facility A, not the unlicensed facility. Their mail from Social Security and Food Stamps also had the residence listed as the licensed facility. One resident's hospital discharge papers stated that the patient would go to a community care home but apparently was sent to the unlicensed facility.

resident at the facility. The resident's file noted a serious psychiatric diagnosis and also limited cognitive functioning. DMH reported this incident to the Attorney General's office, the Ombudsman, DHEC,<sup>37</sup> LLR, and DSS. P&A reported the alleged abuse to SLED.<sup>38</sup>

According to a report by the Ombudsman, the staff of a local disabilities and special needs board contacted Facility A on February 5, 2007, after a resident had become agitated at the Work Activity Center. They asked a staff person at Facility A to come transport her back to the CRCF. When the staff person came to pick her up, the resident's frustration had been subdued, yet the Facility A staff person placed her in handcuffs. It is unclear whether these handcuffs were real or a toy. While the resident and staff at Facility A stated this action was performed as a joke, it was unclear whether the resident had the mental capacity to understand the violation of her rights. The complaint was found to be substantiated.

On September 11, 2008, a resident of Facility A came to the Mental Health Center with a scratch on one side of his nose and a bandage on the other side. His eyeglasses were missing. He reported that another resident (his roommate) had knocked him down that morning and taken his glasses. He said the resident pushed him out of bed and stomped on his foot. The resident stated that his roommate had broken two pairs of eyeglasses and harasses him daily. The MHC employee contacted the administrator, who stated that the resident was "lying" and "vindictive." She stated that he did not like his roommate and was trying to get him in trouble with his lies. Another Facility A resident verified what the first resident had told the MHC employee. This resident also reported that the same male who had attacked the resident had previously touched her inappropriately. She stated that the staff had reprimanded him, but he would not listen. When the administrator was contacted again, she responded by saying that the female should not put herself in a position where she could be touched by him. Neither resident

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<sup>37</sup> On February 14, 2007, DHEC visited the facility to follow up on the complaint regarding sexual relations between a staff member and a resident. They interviewed the staff member who had been accused of the conduct and, based upon his interview, no violations were cited. There is no documentation by DHEC that any further inquiry was made.

<sup>38</sup> SLED staff advised P&A they "took the report as information only" because they understood the Attorney General's office had an ongoing investigation.



wanted to press charges. These allegations were reported to the appropriate agencies including DHEC and the LT Care Ombudsman.

### **Sanitation, Health, and Safety**

Between February 2006 and October 2007, the following problems were found during inspections at Facility A: a smoke detector needed a battery replacement; a dryer vent screen was ripped; the bathroom had a rancid odor and its exhaust fan was covered with dust and dirt; in both bathrooms, the safety bars were attached to the toilet seats, but neither the seat nor the bars were attached to the toilet; a bathroom sink was not secured to the wall properly; both bathrooms were dirty; the blankets on the bed were unclean and worn; a fly strip hanging from the ceiling contained many insects; the floor was unlevel, soft, and sinking in places throughout the facility; some items with labels that indicate refrigeration is required after opening were stored improperly in the cabinets; the handrail in the hallway was not adequately secured; the men's bathroom did not have toilet paper, paper towels or liquid soap, there was a hole in the wall, there was urine on the floor and the shower curtain was dirty; the women's bathroom did not have paper towels or liquid soap; neither bathroom was wheelchair accessible; two residents had dirty bed linens; residents reported needing several items, such as socks, underwear, feminine napkins, toiletries, eyeglasses, and canes; the mattresses were worn and sagging. On December 18, 2007, DHEC cited the facility because some of the mattresses needed to be replaced.

### **Food**

Throughout this time period inspectors noted meat defrosting in the sink, in violation of regulations;<sup>39</sup> insufficient food and drink: meals served consisted of only a sandwich and did not match the menu posted; foods in the freezer were not dated or labeled; and food was improperly stored and unsealed, causing discoloration.

### **Financial Management & Utility Maintenance**

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<sup>39</sup>DHEC R. 61-25.II.D.7. Thawing potentially hazardous food.

Potentially hazardous food shall be thawed as follows:

- a. In refrigerated units at a temperature not to exceed 45°F. (7.2°C.); or
- b. Under potable running water from the cold water supply with sufficient water velocity to agitate and float off loose food particles into the overflow; or
- c. In a microwave oven only when the food will be immediately transferred to conventional cooking facilities as part of a continuous cooking process or when the entire uninterrupted cooking process takes place in the microwave oven; or
- d. As part of the conventional cooking process.

At the visit conducted by DMH and Team Advocacy on October 30, 2007, the thermostat read 56 degrees. Residents were observed wearing sweaters and jackets. One older resident wearing a short sleeved shirt stated that she was cold, but said she was not able to get a sweater. A staff person then obtained a sweater for her. The director stated that the heat had broken the day before and that it was to be repaired the day of the visit. When asked to contact the heating company for a specific time, she did so and informed the Team Advocate and the DMH inspector that it would be after lunch.<sup>40</sup> DHEC was contacted and notified of the temperature in the facility. The facility director said it was fixed the next day.

On June 10, 2008, P&A complained to DHEC regarding a P&A client who had been sent a substantial pharmacy bill after leaving the facility. The client had been led to believe by Facility A that payments were being made toward this bill every month because she had been putting her personal funds toward these costs. The pharmacy bill showed that payment amounts varied each month and many months no payment was made at all. When P&A visited Facility A to check on this matter, the administrator was unable to provide a personal needs ledger or any sort of documentation to show how much the resident had been paying each month for her medications. She was also unable to show what kind of benefits the client had received or the amount of benefits. DHEC regulations require records.<sup>41</sup> When DHEC followed up on this complaint on June 23, 2008, they found no violations.

## **FACILITY B**

Facility B is a 10-bed facility located in an urban county. It has a history of violations, and was briefly shut down in 2001 after the death of a resident. Recent

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<sup>40</sup> A staff person confided in the DMH inspector her gratitude at the request to contact the heating company. She stated that the heat had been broken for at least three days and the residents were cold.

<sup>41</sup> DHEC R. 61-84 902.G. There shall be an accurate accounting of residents' personal monies and written evidence of purchases by the facility on behalf of the residents to include a record of items/services purchased, written authorization from residents of each item/service purchased, and an accounting of all monies paid to the facility for care and services. Personal monies include all monies, including family donations. No personal monies shall be given to anyone, including family members, without written consent of the resident. If a resident's money is given to anyone by the facility, a receipt shall be obtained. H. A report of the balance of resident finances shall be physically provided to each resident by the facility on a quarterly basis in accordance with the Resident's Bill of Rights, regardless of the balance amount, e.g., zero balance.

renovations have improved the physical condition of the facility, but as recently as July 24, 2008, the State LTC Ombudsman's office performed an unannounced inspection and found numerous problems.

A review of the records from DHEC, DMH, the State LTC Ombudsman and P&A reveals: a history of physical abuse by staff; the facility's requiring residents to perform work in the facility; errors or carelessness in handling medication; failure to perform medical tests as required upon admission; and a resident who continued to live at the facility after being committed to a state mental hospital, by court order, as a danger to himself or others.

### **Resident Care and Documentation**

On July 3, 2007, a resident was removed to a Crisis Stabilization Center after alleging a staff member had severely beaten him, to the point of vomiting blood, with a two-by-four.

When the LTC Ombudsman staff inspected the facility later in July 2007, they found that residents were being assigned many duties not consistent with their care plans. Residents were being required to wash their own laundry and cook and serve their own meals; one resident was charged with mowing the facility lawn.

The July 24, 2007, inspection also found that one resident was on probation for committing a crime and had been court ordered into a state mental facility after being determined to be a danger to himself and others. He had been placed at Facility B when the facility had a 24-hour Department of Mental Health presence. This was no longer the case, but the resident had not been relocated to an appropriate facility.

The March 29, 2008, Team Advocacy inspection also discovered numerous inconsistencies in the residents' medical records and available medications. Thirteen medications prescribed to different residents were not available on hand, including the prescription pain medications. One resident could not have been receiving his anti-anxiety medication as prescribed (there were five full blister packages and one blister pack with 31 tablets remaining, despite the fact that the resident's medication count sheet noted only six remaining tablets). Additionally, five over-the-counter medications had passed their expiration dates.

That March 29<sup>th</sup> inspection found many additional problems with resident records. Contrary to DHEC regulation, two resident records noted tuberculin skin tests had been performed significantly after admission (sixteen days and three months, respectively).<sup>42</sup> None of the resident care plans had been updated within the past six months as required by regulation.<sup>43</sup> Although a resident reported problems with incontinency, there was no reference to this in the resident's records.

Only one resident stated he had enough clothing; two of four residents interviewed were wearing clothes that did not fit appropriately and had holes, stains, or tears. Two of four residents interviewed were observed to have inadequate clothing.<sup>44</sup> Several residents had body odor; several reported needing soap, deodorant, and other toiletries.

Two residents reported needing eyeglasses; one resident reported needing dentures and adult incontinency products as well.<sup>45</sup>

One resident reported that he sometimes went without clean bedclothes for several nights running due to incontinency problems and that his sheets were not washed

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<sup>42</sup> DHEC R 61-84. 1101. A. A physical examination shall be completed for residents within 30 days prior to admission and at least annually thereafter. The physical examination shall address the appropriateness of placement in a CRCF, medications required and self-administration status, and identification of special conditions/care required, e.g., if a resident has a communicable disease, dental problems, podiatric problems, Alzheimer's disease and/or related dementia, etc.  
B. The admission physical examination shall include a two-step tuberculin skin test, as described in Section 1702, unless there is a documented previous positive reaction.

<sup>43</sup> DHEC R 61-84.703. A. The ICP shall be reviewed and/or revised as changes in resident needs occur, but not less than semi-annually by the above-appropriate individuals.

<sup>44</sup> DHEC R 61-84 901 D. "Residents shall be neat, clean, appropriately and comfortably dressed in clean clothes, and provided the necessary items and assistance, if needed, to maintain their personal cleanliness, e.g., bar soap." And, 1706. Clean/Soiled Linen and Clothing (II) A. Clean Linen/Clothing. "A supply of clean, sanitary linen/clothing shall be available at all times."

<sup>45</sup> CRCFs are to provide residents with food and shelter from the monthly assessment. They are to ensure that other needs of residents such as clothing, medical care, personal toiletries and transportation are met by coordinating Medicaid, any personal needs allowances and other funding sources. The relevant regulation is DHEC R 61-84 §901 (B) "Residents shall receive care, including diet, services, i.e., routine and emergency medical care, podiatry care, dental care, counseling and medications, as ordered by a physician or other authorized healthcare provider. Such care shall be provided and coordinated among those responsible during the process of providing such care/services and modified as warranted based upon any changing needs of the resident. Such care and services shall be detailed in the ICP." And (D) "Residents shall be neat, clean, appropriately and comfortably dressed in clean clothes, and provided the necessary items and assistance, if needed, to maintain their personal cleanliness, e.g., bar soap. (II)"

in a timely fashion; that resident also reported that the facility administrator ridiculed him for “wetting the bed.”

A DHEC inspection on April 24, 2008, found three prescription medications listed on resident MARs that were not in stock at the facility. One resident’s MAR indicated that his pain medication had been discontinued, but, at the time of inspection, the facility could not provide an order from a physician discontinuing that medication.

### **Staff, Documentation and Supervision**

Inspections over the past two years have noted ongoing and continuous problems with staff as well. The July 24, 2007, LTC Ombudsman’s inspection found only one staff member on duty to supervise eleven residents, which is well below DHEC regulations for staffing.<sup>46</sup> The March 29, 2008, Team Advocacy inspection noted insufficient staff present on hand to care for residents. When the inspection team arrived, the facility administrator was just arriving at the facility; no staff members were on duty inside the facility. The team received conflicting information as to how long the residents had been without supervision, but it was clear that there was generally only one staff member on duty with residents during the day.

### **Sanitation, Health, Safety, Maintenance**

The July 24, 2007, visit by the Ombudsman’s office found two broken chairs and a broken couch, and found that the facility furnishings were worn, torn and broken. A subsequent P&A visit on March 29, 2008, noted significant ongoing renovations,<sup>47</sup> but also found dust from drywall construction and some incomplete electrical work. Additionally, the facility was in some disarray; several tools, including a power sander, nails, and a circular saw, were left lying on the floor of the sunroom; several light fixtures throughout the facility were exposed leaving open electrical sockets; several smoke detectors were not secure and were hanging from the ceiling; **an open gallon container three-fourths full of used hypodermic needles was found on the floor of the facility living room**; several bedrooms had torn, worn, thin, and dirty bed linens, and smelled

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<sup>46</sup> DHEC R. 61-84. 503. A. 1. In each building, there shall be at least one staff member/volunteer for each eight residents or fraction thereof on duty during all periods of peak hours.

<sup>47</sup> According to DHEC the deadline for completion of the renovations was July 1, 2008. However, as of June 16, 2008, the facility administrator confirmed to the State Ombudsman that the renovations were not complete.

strongly of urine; several bathrooms lacked paper towels or liquid soap; cleaning supply closets had been left unlocked and residents had unrestricted access to cleaning chemicals and hand tools.

The April 24, 2008, DHEC inspection found two residents' mattresses sunken in. A closet containing chemicals was unlocked during the walkthrough. The facility was cited for a violation and required to have a plan of correction.

### **Food**

Residents were observed cooking and serving all their own food. Other observations were: open containers of food labeled "refrigerate after opening" in the pantry; decomposing fruit in a basket in the kitchen; and empty boxed lunches that had reportedly been donated by a local distributor on the dining room table. An April 24, 2008, DHEC inspection found five rolls of turkey sausages thawing in the sink in violation of DHEC regulations.<sup>48</sup>

### **Finances, Utilities, and Other Issues**

Conflicting information was provided about the management of resident funds. The administrator's son stated that the resident funds were kept in a "locked petty cash box," but when they asked to see the box to count the residents' money both the administrator and son stated that the box was not at the facility. When the P&A Team Advocate expressed concerns regarding the residents' money, the administrator then pulled out a FedEx envelope with a pile of one dollar bills and mentioned that he stored residents' money in the envelope. The money was not organized or sorted by resident, raising concerns about the safe management of resident funds and ability to provide proper accounting to residents for their personal funds.<sup>49</sup>

At that time, one of the four residents interviewed stated "sometimes people [here] want to harm me[.]" That resident also stated he did not feel safe talking to anyone and that he had no freedom. Two of the four residents reported they were not allowed to go outside the property's front gate.

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<sup>48</sup> See DHEC R 61-25 II C 2b, banning thawing of food except under running water, in refrigerator, or in microwave.

<sup>49</sup> S.C. Code § 44-81-40 (Bill of Rights) (E) "...Each resident ...may manage the resident's personal finances unless the facility has been delegated in writing to carry out this responsibility, in which case the resident must be given a quarterly report of the resident's account."

## **FACILITY C**

Facility C is a small (licensed for five beds) CRCF in an urban county. The administrator and her husband operate several CRCFs in North and South Carolina. Throughout the time period reviewed for this report, significant problems were noted with resident care and documentation; staff documentation and supervision; sanitation, health and safety; medication administration; and food.

### **Resident Care and Documentation**

From 2007 through 2008, inspections showed multiple violations of procedures for medication administration: there were no MARs or other records for some residents; MARs were not signed; residents had incorrect dosages listed on their MARs; prescribed medications were not listed on MARs; medicines were in unlocked storage; insulin was not refrigerated; MARs were taken home by the administrator; medications were not administered for over a week; staff could not recall who had administered medications; medications were not in stock; medications for former residents were still in the medicine cart/drawer. Some residents did not have documentation of TB tests prior to admission. Some residents did not have care plans in their files. Some residents reported needing dental exams and visits to doctors such as cardiologists

At least one resident had been performing cleaning duties at the facility for \$5 per day, according to residents and the administrator's husband.<sup>50</sup>

One resident needed a higher level of care than authorized for residency in a CRCF, as he could not bathe or dress himself and was incontinent.

One resident was sleeping on a cot.

DMH made a visit to Facility C on August 3, 2007. In addition to some of the problems mentioned above, DMH also found the facility had six residents at the time of the visit, although the facility is only licensed for five residents. There was also a male in the facility who was a resident of an unlicensed facility with the same operators. The administrator's husband told the DMH inspector that he was moving three residents to his unlicensed facility and that DHEC had stated that he could have up to three residents

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<sup>50</sup> SC Code § 44-81-40 (Bill of Rights) Section I (I): Each resident must be assured that no resident will be required to perform services for the facility that are not for therapeutic purposes as identified in the plan of care for the resident.

without requiring a license. Regulations allow for up to only two residents without a license.<sup>51</sup>

He also said he had told two residents they were moving that day and that he had given them prior notice. He stated that the residents wanted to move. One of the residents informed the inspector that he did not want to move because there was no furniture in the other facility. He and the residents left without their medications or property. These residents had not been given their medication that morning.

When DMH noted that some of the residents' records did not contain a two-step PPD test for tuberculosis, the husband of the administrator stated that he had been confused about the two-step requirement.<sup>52</sup> He said he had recently taken residents to get their injections and produced paperwork for a one-step PPD. He could not produce records of their previous PPD tests; he stated he had discarded them.

The Department of Homeland Security (DHS) had placed three residents in the facility. DMH contacted DHS about the conditions at the facility, including the fact that the residents had not received any personal needs allowances since they arrived at the facility, and requested DHS's help in moving two residents. DHS informed DMH that it was in the process of sending another person there, but that in light of the information provided they would not send any more residents.<sup>53</sup> Homeland Security pays \$1100 per month for room and board, and administrators are not required to give the residents spending money out of this amount. The DHS employee told DMH that DHS staff are not allowed to visit these facilities, but only to check licensure. The employee stated that she would contact the immigration office in Charlotte to seek alternative placement for these residents; if alternative placement could not be located, the residents would be returned to the detention center until a placement was located.

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<sup>51</sup> DHEC R 61-84 103. A. License. No person, ...shall ... operate...a community residential care facility/assisted living facility in S.C. without first obtaining a license from the Department. ....When it has been determined by the Department that room, board, and a degree of personal care to two or more adults unrelated to the owner is being provided at a location, and the owner has not been issued a license ... the owner shall cease operation immediately.....

<sup>52</sup>Pursuant to federal Center for Disease Control, TB testing involves an under skin injection and then a reading of any reaction 2-3 days later. [http://www.cdc.gov/tb/faqs/qa\\_latentbinf.htm#latent2](http://www.cdc.gov/tb/faqs/qa_latentbinf.htm#latent2)

<sup>53</sup> More residents placed there by Homeland Security were discovered during later visits to this facility.



DMH also called the Veterans Administration to inform them that two of the residents they had placed at Facility C were transferred to the unlicensed home.

On August 6, 2007, DMH filed a complaint with LLR, stating that the administrator and her husband were moving residents to an unlicensed boarding home with only mattresses on the floor.

On August 22, 2007, DMH conducted a follow-up visit. Along with the problems concerning medications which were noted above, they discovered seven residents at the facility rather than the five for which Facility C was licensed. The facility had converted one staff bedroom into a resident room. The facility also converted the pantry into a resident room by removing the shelves and cabinets from the pantry and placing a cot-sized bed, small dresser and TV in the room. The resident of this room did not have a bed pillow but had to use two pillows from the couch instead. The DMH inspection also raised concerns about health care. A new resident had not been given a PPD test. Another resident appeared to require nursing facility level of care.<sup>54</sup> A home health aide came to the facility to dress an ulcer on the resident's hip. One resident who reported having pain in all of his joints had requested to visit a doctor; it did not appear that any arrangements had been made to address this resident's pain. On August 23, 2007, DMH sent an email to the Attorney General's Office and LLR to report the problems found at the facility on her August 3 and August 22, 2007, visits.

DHEC conducted a complaint investigation of the facility on January 30, 2008. They found that the facility had six residents, while only licensed for five. One resident had no physical examinations available for review; one resident had no TB skin test record available.

DMH conducted a site visit to Facility C again on February 26, 2008. In addition to many of the medication problems already mentioned, there were, again, six residents at the facility. The staff person reported that the sixth resident had arrived on February 22<sup>nd</sup> and would be moving to a facility in North Carolina operated by the administrator and her husband. The husband of the administrator arrived and stated that he would move the resident to NC that day if it was a problem. He then told the resident to pack his

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<sup>54</sup> The resident with the hip ulcer used a wheelchair, but could not transfer himself. He also could not bathe, toilet, or dress himself and was incontinent.

belongings. The resident had been moved to the facility by the US Department of Justice and had a Medical Summary of Federal Prisoner/Alien in Transit. There was no record of a PPD tuberculosis test in his file. The administrator's husband stated that the resident's crime was stabbing someone with a knife.

The DMH inspector was told that another resident who had previously resided there had been moved to a work camp by the Department of Homeland Security. The administrator and her husband had transferred him to their NC facility. The resident with limited self-care abilities needed a higher level of care and was still residing at the facility.

Despite the serious allegations raised by the DMH inspection February 26, 2008, DHEC did not conduct another inspection for two months, on April 29, 2008. At that time four of five residents did not have physician's orders on file; four of five residents had no assessment within 72 hours after admission; and four of five residents' Individual Care Plans had not been updated every six months. DHEC required the facility to submit a plan of correction.

### **Staff, Documentation and Supervision**

Team Advocacy's visit to the facility on July 11, 2007, revealed that there was no staff documentation of Cardiopulmonary Resuscitation (CPR) training. In addition, there was an incident report where one resident had struck another resident on the head. The incident had been reported to the Sheriff's office and a report was made. When DMH arrived for their visit on August 3, 2007, at 8:40 a.m., both staff members were asleep on couches even though the residents were awake. The residents had not been provided with breakfast or their morning medications. Staff records contained no documentation of criminal background checks, DHEC trainings, physical examinations, two-step PPD tuberculosis tests, job responsibilities, or job applications.

The husband of the administrator stated that one of the males at the facility was not a resident; he claimed that the resident was a staff person "in training" who was paid \$5 a day; his goal was to work. The resident explained that he helped with bathing and cleaning a resident with a higher level of care when he goes to the bathroom. He also cleaned the facility. Other residents said he is supposed to be paid for these duties, but has not received any money. The resident/staff in training confirmed these statements.

He said he did not want to clean the resident anymore. This person was placed by Homeland Security, which was paying \$1,100 to stay at the facility. His records stated that he was in need of supervision and treatment. Homeland Security confirmed that he was a resident.

On the August 22, 2007, visit by DMH, both staff persons were sleeping upon arrival at 4:02 p.m., while all of the residents were awake. One staff person stated that the administrator would be there to make dinner for the residents between 4-5 p.m. The administrator had not arrived at the conclusion of the visit at 4:31 p.m., nor had she called. This staff person also explained that he lives at the facility but does not receive a salary. The residents sponsored by Homeland Security had not received any personal needs funds since they moved to the facility. They reported that they would like some money to purchase a cup of coffee or soda.

A fire marshal inspection was done by DHEC on September 21, 2007. Five violations were cited for mandated corrections.

DMH went back to the facility on January 23, 2008. A previous resident was now, apparently, a staff person. He provided direct care to residents, including bathing, dressing, and toileting assistance to a resident who needed a higher level of care. This “staff person” had a lengthy criminal background report, and DMH was informed by the administrator’s husband that DHEC was aware of the person’s history and had approved his employment there. The report included assault and battery charges, but after the visit it was noted that this person is also on South Carolina’s sex offender registry website. The address for the facility was listed on the website as his current address. His training and physical exam documents were not signed by the appropriate persons, calling into question their validity. He could not describe the trainings indicated in his file. There was no signature on his CPR form and he had no card.<sup>55</sup> The dates on the forms indicated the trainings were given while the person was still a resident. The Resident’s Bill of Rights was present in his file. DMH sent an email to DHEC and the LTC Ombudsman that day informing them of the live-in staff person’s conviction of assault and battery of a high and aggravated nature on a twelve year old victim.

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<sup>55</sup> DMH also found that the CPR form was not signed by a trainer or staff and had expired. His physical exam report was not signed by a doctor.

During DHEC's complaint investigation on January 30, 2008, the facility was cited for having a staff member who had been convicted of assault and battery.<sup>56</sup>

During the visit by DMH on February 26, 2008, it was noted that there was an insufficient criminal background check for an employee; this employee's health record was not signed by a physician.<sup>57</sup> The CPR certificates for this employee and the administrator's husband were not signed by the trainer. Neither staff person could present a CPR card.<sup>58</sup>

The administrator's license expired February 29, 2008, and a late fee was assessed by DHEC. The application contained incomplete or inaccurate information.

DHEC cited violations on April 29, 2008, in the following areas in staff documentation: no current first aid training for all four employees; no current OSHA standards/blood borne pathogens training; no current training on the confidentiality of resident records; no documentation of physicals within 12 months prior to initial resident contact for three of four employees. Many of these violations were repeat violations. DHEC required the facility to submit a plan of correction.

On a June 6, 2008, DMH visit, a staff member could not recall all of the residents' names. When the administrator's husband arrived, the inspector asked him to produce a record for an employee who was working in the kitchen. He presented the record for someone with a different name. When shown that this record was incorrect, he insisted that it was not and identified the staff person in question. The inspector informed him of

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<sup>56</sup> DHEC R 61-84 501 B. Staff members/direct care volunteers of the facility shall not have a prior conviction or pled no contest (*nolo contendere*) for child or adult abuse, neglect, or mistreatment. The facility shall coordinate with applicable registries should licensed/certified individuals be considered as employees of the facility. For those staff members/volunteers who are licensed/certified, a copy shall be available for review. (I)

<sup>57</sup> DHEC R 61-84.101. X. Health Assessment. An evaluation of the health status of a staff member/volunteer by a physician, other authorized healthcare provider, or registered nurse, pursuant to written standing orders and/or protocol approved by a physician's signature. The standing orders/protocol shall be reviewed annually by the physician, with a copy maintained at the facility.

<sup>58</sup> DHEC R 6-84.504. Inservice Training (I)  
A. The following training shall be provided by appropriate resources, *e.g.*, licensed/registered persons, video tapes, books, etc., to all staff members/direct care volunteers in context with their job duties and responsibilities, prior to resident contact and at a frequency determined by the facility, but at least annually:  
8. Cardiopulmonary resuscitation for designated staff members/volunteers to insure that there is a certified staff member/volunteer present whenever residents are in the facility;

the staff person's name. The administrator's husband then questioned the staff person and the staff person confirmed the name stated by the DMH inspector. The only record for this employee that the husband was able to present was a one-step PPD test. DMH also noted in its report that the name on the record that the administrator's husband originally presented to the inspector was the name of a staff person who on a previous occasion had been identified as a relative of the administrator's. **The staff person who was present at the facility was on the S.C. Sex Offender Registry.** The conviction was for Criminal Sexual Conduct, First Degree. The address on the registry was not the same as the CRCF, in violation of the Sex Offender Registry Act.<sup>59</sup>

Another staff person present had a medical form in his file that was not dated nor signed by a physician. The record contained no CPR card. A third staff person did not have a record on file. The administrator's husband stated that a record was not needed because that staff member only takes care of the lawn; however, this staff person was observed coming from the staff sleeping quarters and socializing with the residents. The staff person was present at the facility despite the fact that he told the administrator's husband he would not be mowing the lawn again until later in the week.

### **Sanitation, Health, and Safety**

In 2007, bedrooms in the facility were not clean--a foul smell came from dirty clothes piled up in a closet; there were no hangers available in the closets; sheets were soiled; residents did not have towels; residents reported obtaining sheets from the garbage; a Team Advocacy volunteer was locked inside a bedroom because the door had no doorknob; residents did not have toiletries; there were no paper towels, liquid soap, or toilet paper in either of the residents' bathrooms; one resident reported having to wipe himself with his hands when he had no access to toilet paper; the facility contained dirty couches, bedrooms, and bathrooms; one of the couches had a plastic tablecloth on it for the residents who were incontinent; residents who were incontinent were sleeping on plastic tablecloths; cleaning supplies were stored in unlocked cabinets.

In 2008, DMH reported that the bedroom for the resident who was incontinent smelled of urine, with sheets stained with urine on the floor. There was ill-fitting plastic on the mattress, and the mattress was stained with urine and smelled bad. The bathroom

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<sup>59</sup> SC Code §§ 23-3-400 et seq.

in this resident's bedroom was not accessible for his wheelchair. Again, several other residents had dirty sheets and pillows.

On the February 26, 2008, visit by DMH, exposed wires in a wall socket were covered with paper stapled over it. Chemicals were not in secure storage. Extension cords were going out of windows to other parts of the property. Dirty clothes were lying on the floor; there were also clean clothes on the floor because there were not enough hangers. There were dirty linens and dirty mattress and box spring. An overhead exhaust fan was clogged with dust. The tub was very dirty as well.

During DHEC's general inspection on April 29, 2008, the facility staff could not produce the latest electrical inspection documentation. The DHEC report also noted broken glass in a storage area, a pile of leaves on the patio, standing water in front of the garage, and fire ant mounds and empty beer cans around the yard. There was a torn window screen on an open window, allowing insects to enter. The facility also had numerous cracks in the sheetrock, dirty floors and drapes, dusty vents, cobwebs, a soiled tub, and no paper towels in the bathroom. DHEC required the facility to submit a plan of correction.

On the June 6, 2008, DMH visit, wires were observed exposed from an opening in the wall. There were two sheets tacked over windows as curtains.

### **Food**

Throughout 2007 and 2008, inspections by various agencies found there were no beverages for residents; menus did not indicate any special dietary accommodations, although there were residents who needed diabetic diets and other special diets; bags of brown decomposing vegetables and moldy bread were found; meat with no expiration date was leaking in the refrigerator; food was prepared in an unlicensed area of the facility, which also served as staff living quarters; and cleaning supplies were stored in the same compartments as food.<sup>60</sup>

On August 3, 2007, DMH reported that the refrigerator was locked with a large chain and padlock, so that the only beverage available was water: no food was available. The administrator's husband stated inaccurately that locking the refrigerator was a DHEC

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<sup>60</sup> P&A July 2007; DMH January, February, and June 2008, twice in August 2007; DHEC April 2008. Each of these inspection noted food/diet problems.

requirement. No current menu was posted as required by DHEC regulation.<sup>61</sup> The staff reported that grits would be served for breakfast, but the administrator's husband gave a resident \$20 and told him to buy breakfast for everyone at Hardee's. The resident returned with a sausage biscuit for each resident. Again, no drinks were provided. Residents repeatedly reported that they were usually served cereal for breakfast, a sandwich at lunch, and rice and gravy for dinner. They reported that they rarely received chicken and were never served red meat or fish. Again, food was not stored or labeled properly.

During the August 22, 2007, DMH visit, residents reported they had not received anything to drink during the previous night's dinner. Menu items posted for dinner the night of DMH's visit were not available at the facility that day. Again, foods were not stored or labeled properly.

On the January 23, 2008, visit by DMH, residents were observed making their own breakfasts. The menu calendar was inaccurate, and minimal food was in the refrigerator. One refrigerator was inoperable, and the other refrigerator contained a leak from the freezer that was dripping into the refrigerator compartment below. There was half an inch of water in the bottom drawer, along with two plastic containers on the top shelf nearly filled with water.

There was not enough food on site for six people during DMH's February 26, 2008, inspection. Unlabeled meat was leaking in the freezer. The one operable refrigerator was still leaking water inside.

DHEC conducted a food/sanitation inspection on April 29, 2008. They discovered expired food in the refrigerator and an improper use of chemical cleaning products. They also noted that several surfaces in the kitchen were soiled. DHEC required a plan of correction.

During the DMH visit on June 6, 2008, very little food was observed in the facility. There were no fruits and vegetables on site. The posted menu was inaccurate. The meat in the freezer was stored in freezer bags that were neither labeled nor dated.

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<sup>61</sup> DHEC R. 61-84 1307. Menus A. Menus shall be planned and written at a minimum of one week in advance and dated as served. The current week's menu, including routine and special diets and any substitutions or changes made, shall be readily available and posted in one or more conspicuous places in a public area

## **FACILITY D**

Facility D is located in a suburban area of an urban county. The five-bed facility is a converted house in a local neighborhood. It has had persistent compliance problems for several years, including a general absence of trained staff. As early as 2006 the administrator had entered into a probation agreement with Labor, Licensing, and Regulation based on problems from prior inspections.<sup>62</sup> Since that time there have been multiple complaints and multiple emergency inspections. The Ombudsman's office has responded to seven complaints there between March 21, 2007, and January 11, 2008; DHEC has made four inspections; and P&A has inspected and responded to numerous complaints. In May 2008, after the facility repeatedly failed to meet inspection requirements, DHEC held a consultation with staff. When problems were still not remedied in a final inspection, DHEC recommended an enforcement action in August 2008.

### **Resident Records and Documentation**

Through 2007 and 2008, numerous problems with resident medical records and medications were noted.

- One resident was prescribed an anti-anxiety drug, but there was no available control count sheet for that medication.
- Another resident's MAR was not present in the MAR book; when located, the resident's sheet had not been initialed for a week for an anti-psychotic prescription and had not been initialed for a month for a sleep medication.<sup>63</sup>
- No physician's orders were available documenting residents' medication needs. Staff could not locate the required orders when asked.
- A DHEC inspection on January 3, 2008, noted that medications were being kept unsecured in an office to the rear of the facility and that

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<sup>62</sup> While DHEC licenses long term care facilities, the administrators of such facilities are separately licensed by the Board of Long Term Health Care Administrators, within the Department of Labor, Licensing, and Regulation. See: <http://www.llr.state.sc.us/>. DHEC R. 61-84; S.C. Code Ann. §40-35-110(1),(2), and (4) (Supp. 2004) and S.C. Code of Regulations 93-230(2), (4), and (6)(Supp. 2004)

<sup>63</sup> None of the records noted whether or not the resident in question had an advance medical directive or health care power of attorney.



prescription medications were being administered without a doctor's order on file. DHEC required a plan of correction.

- Chromium tablets and vitamins were observed in one resident's refrigerator, but no MAR was available for that resident.
- One resident did not have evidence of a PPD (tuberculosis) test in her record.
- There was a shortfall in the controlled medication count for one resident, as the count sheet specified that 24 diazepam pills were on hand for a resident but only 18 tablets were in fact available.

The Policy and Procedures manual did not contain any indication of annual or other regular review.

Twice in February 2008, DMH and P&A noted problems with residents' files when they were assisting residents in moving from the facility. One resident had items missing from her records, including her Medicaid card. Another resident's records were not provided to him; this resident had to relocate without his medical records, Medicaid number, or any form of personal identification.

At the same time, the DMH team helping with the move discovered a new resident in the facility; apparently this resident had been transferred from a facility owned by another CRCF operator. The resident had been discharged from the other CRCF due to the administrator's belief that he needed a higher level of care; the administrator at the former facility had been told that there was a bed available for this resident at another CRCF, but the resident was in fact relocated to Facility D that same day.

The August 6, 2008, DHEC inspection found no dietary orders from a physician in two out of three residents' records. All three residents' records reviewed lacked a resident photo. All three Individual Care Plans had been signed and dated by staff, but the care plans contained no information and were otherwise blank (this was a repeat violation).<sup>64</sup> Among other problems, this meant that the care plan did not contain dietary

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<sup>64</sup>DHEC R. 61-84 703. B. The ICP shall describe:

1. The needs of the resident, including the activities of daily living for which the resident requires assistance, *i.e.*, what assistance, how much, who will provide the assistance, how often, and when;
2. Requirements and arrangements for visits by or to physicians or other authorized health providers;
3. Advanced care directives/healthcare power-of-attorney, as applicable;

requirements; no one was listed as responsible for monitoring care and effectiveness of the plan; there was no documentation of how residents preferred their funds managed; arrangements for doctors' visits had not been filled out; advance medical directives had not been completed; and no recreational or social activities were listed.

Additionally, as noted above this inspection found a shortfall in the controlled medication count for one resident's diazepam pills.

### **Staff, Documentation and Supervision**

The December 19, 2007, Team Advocacy inspection noted that all four staff members reported living at the facility. One resident reported being locked out of the facility sometimes when returning from work.

On December 21, 2007, a P&A Advocate met with a female client at Facility D who had expressed a desire to move out. During this meeting, P&A staff discovered information of a possible incident of sexual abuse. Repeated calls to the staff and administrators over the next several weeks were unable to determine whether the possible aggressor had been a staff member, resident, or neither. Staff refused to speak with P&A representatives, refused to give basic information, and accused advocates of being "nosey."

On December 27, 2007, the P&A advocate went to the facility to attempt to meet with her client again, but only a young man (between 14 and 17 years old, estimated) answered the door and said the client was with his grandmother.

On January 3, 2008, two P&A advocates went to the facility for a meeting with that same client in order to consult with her about a potential move out of the facility. When the advocates knocked on the front door, they at first were met with only silence, but then heard muffled laughter inside the home. When the door was cracked open, a man came to the door, identified himself as a staff member named "Mr. X",<sup>65</sup> and told the P&A advocates that their client was not present in the home. Moments later, however, the P&A advocates heard their client's voice shouting for help – as best the advocates

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4. Recreational and social activities which are suitable, desirable, and important to the well-being of the resident;

5. Dietary needs.

<sup>65</sup> To preserve privacy for him and the facility, he will be identified in the report simply as "Mr. X.":

could tell, the client was shouting “they won’t let me out.” “Mr. X” continued to deny that the client was there, however, and the police were called by P&A advocates.

While awaiting the police, an inspector with the State Ombudsman’s office arrived to inspect a different situation. P&A advocates entered the facility, along with the Ombudsman inspector, and met with their client. The client stated that a staff member had refused to let her out of her room and had placed her hand over the client’s mouth so she could not yell. (It should be noted that there is some question as to whether or not this person was, in fact, a staff member; DSS records indicate she is also a resident, placed there by DSS. Future references will refer to her as “staff.”) When the inspector from the Ombudsman’s office asked “Mr. X” who he was, he initially claimed to be staff. He later changed his story repeatedly, claiming first he was just staying there for a while and then that he did not stay there but was only visiting for the day.

Resident interviews conducted by P&A indicated “Mr. X” had been living at the facility since September 2007. The facility administrator that was listed in DHEC records was not at the facility that day, apparently due to illness. During previous calls by P&A staff, the “staff” person refused to provide a contact number for the administrator; when other staff were asked, they gave a number that had been disconnected. Facility staff therefore apparently had no way to contact the administrator in an emergency.

The next day (January 4, 2008), in response to a complaint by the Ombudsman’s office and P&A, DHEC made an emergency inspection. That inspection cited Facility D for a number of violations, among them “501.B/I – Staff members / direct care volunteers of the facility should not have a prior conviction or pled no contest (*nolo contendere*) for child abuse, adult abuse, neglect or mistreatment.” DHEC also cited Facility D on this occasion for apparently providing services to non-residents, for the lack of a designated staff member to act in the absence of the administrator, and for having an altered SLED report on file (former SLED Chief Robert Stewart’s name was apparently pasted onto the report).

On January 11, 2008, a P&A advocate called the CRCF to attempt to speak with her client. The “staff” person answered, stated the residents were away at a medical appointment, and asked that P&A call again later in the day. When the P&A advocate

called again later that day, a man answered who sounded like “Mr. X,” but who gave his name as “Mr. Z.”<sup>66</sup> When asked if he was staff, he said yes, but the P&A advocate did not recall any staff members by that name at the facility. When P&A asked for the client, “Mr. Z” replied that she was not there; repeated calls over the course of the day were not answered. Finally, the P&A advocate managed to get in touch with her client and the client confirmed that “Mr. X” was still living with them at the facility.

On February 7, 2008, a P&A advocate traveled to Facility D, along with a DMH inspector, in order to review client records. A P&A client opened the door, and the “staff” person yelled at her for doing so. Two other persons were present; both claimed to be staff, “Mr. X” and “Mr. Y.”<sup>67</sup> Mr. Y claimed to be an employee of another facility who had merely stayed at Facility D the night before.

The female “staff” person contacted the operator of Mr. Y’s facility, as that facility’s operator was supposedly the only person with a working contact number for the listed administrator of Facility D. This administrator from the other facility arrived at Facility D shortly thereafter and demanded that the P&A and DMH representatives leave. She claimed she had “worked it out with DHEC” and had papers stating the DMH inspector was not allowed on her property and was trespassing. She also stated she was “over everything here” and that she pays the bills and “[does] everything;” she said that she was the acting administrator due to the ongoing illness of the administrator listed in the records. The P&A advocate and the DMH inspector refused to leave, insisting that they be allowed to review their client’s records. The police were called and when they arrived, they explained to the acting administrator that the P&A advocate and DMH inspector had authority to be there. Approximately ten minutes after that, the listed administrator arrived and stated that the other administrator was actually the owner of Facility D; she allowed both P&A and DMH to access their clients’ records. The P&A advocate and the DMH staff did so and left immediately when finished. The police officers remained with the P&A and DMH staff until they left.

During this visit, the P&A advocate noted that the female “staff” member who was believed to be a resident appeared to be administering medications, cooking all

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<sup>66</sup> To protect privacy of the individual and the CRCF, the name given will be referenced as “Mr. Z.”

<sup>67</sup> To protect his privacy and that of the CRCF, he will be referred to as “Mr. Y.”

meals, and cleaning the home. When asked if she had spoken with anyone from DSS, she said she had not. She continued to share a room with a client (the same client she had reportedly restrained during the prior P&A visit on January 11, 2008).

When the DMH inspector spoke with her client, he showed her a paper that he said the other administrator had made him sign. The top of the paper read “Special Power of Attorney.” The document stated that the resident “does hereby appoint [blank] as [his] lawful attorney” and that she would “Represent [him] to all state, local, and federal agencies and to make decisions regarding [his] care to social agencies.” The document was signed by the resident, a witness and by the other administrator on the line above “special attorney.”

On February 11, 2008, the same P&A advocate and DMH inspector made a final visit to the facility in order to assist the P&A client with moving out and to speak with a DMH client residing there. “Mr. X” was outside when the team arrived but went inside and closed the door when he saw them. The P&A advocate knocked on the door and heard her client yelling from inside that they would not let her open the door. The P&A advocate asked to be allowed inside, but a male voice told her she would have to wait until the other administrator arrived. Her client continued to yell for help, shouting that she was not being allowed out, and asked the P&A advocate to call the police.

The police were called and the same two police officers arrived as on the February 7th visit. As they arrived, the front door of the facility opened and the P&A advocate went inside to meet with the client, who was in her room. The “staff” person began to shout at the P&A client for letting the advocates inside the facility. The P&A advocate explained to her client that she needed to gather her belongings because everything was ready for her to leave, and began helping her pack. A man approached the P&A advocate and demanded she leave immediately, claiming she was “trespassing on his property.” One of the officers came into the room and told the man to back away from the P&A advocate or he could be removed from the premises; the man replied “remove me then.” While the P&A advocate continued to help her client pack, the “staff” person continued to yell and demand that everyone leave the room, despite repeated explanations that the advocate was only there to assist her client with leaving and would depart as soon as they were finished packing.

On February 27, 2008, a DMH inspector visited Facility D, along with a case manager from the local Mental Health Center, and an official from DMH Quality Management, in order to assist a DMH client with a planned move out of the facility. On their arrival, the front door was open, but was immediately slammed shut. The group knocked on the front door but there was no answer; and when tried, the door was locked. The back door was unlocked, however, and the team therefore opened it and announced themselves and their agency. A large man came to that door and shook his finger in the DMH inspector's face, approximately two inches away, stating she was not allowed in their facility. He then physically pushed the inspector out of the doorway and locked the back door.

The police were called and arrived a few minutes later. While waiting, the Quality Management official called the facility and asked that the client be sent out. The staff person said he was not allowed to send him out and refused to comply with the request. When the police officer arrived, he banged on the door several times. Initially no one answered, but then another male opened the door. When the officer asked to see the client who wanted to move, the man shut the door in the officer's face. The officer knocked again on the door and told him not to close the door and to get the client. The client came to the front door with a bag containing his belongings and prescription medication. No paperwork was provided, including important documents such as the Medicaid number, personal ID, etc. The client put his belongings in the car and said he was happy to be moving.

On March 6, 2008, DHEC investigators made a visit to investigate a complaint. As they pulled up to the facility, they noticed that no vehicles were present. The inspectors knocked on the front and rear doors many times and telephoned the facility, but no one answered. No emergency contact number was posted. The administrator's cell phone was called numerous times, but the voicemail box was full. Over the course of the day the DHEC inspectors made numerous attempts to contact the administrator to gain access to the facility, but were unsuccessful. Shortly after 1:00 p.m., the inspectors returned to their office. A staff person did return their calls around 4:00 p.m., but the administrator never did.

On May 1, 2008, DHEC inspectors reviewed staff records. In one of the five staff records reviewed they were unable to find documentation of training in management and care of persons with contagious or communicable diseases, training in care specific to the conditions of facility residents, job orientation training, or staff health assessments and tuberculin skin testing. No signature page to note annual or other regular review was observed in the Policy and Procedures manual. The facility still lacked a posted notice of a contact phone number where the facility administrator could be contacted when staff or residents were away. While there was a quality improvement plan, it did not address all previously cited issues. Staff were given an opportunity to remedy the missing information, but they did not provide further information.

On May 23, 2008, DHEC officials met with Facility D staff for a consultation to review the last two inspections and to discuss responses, correction, and prevention. Kitchen maintenance, housekeeping, required documentation, and resident records including physicals, TB tests, care plans, finances, observational notes, and doctor's orders were all discussed. Staff record requirements were reviewed, including the need to document annual training, background checks, and TB training.

The August 6, 2008 inspection by DHEC found the Policies and Procedures manual was not updated or revised as required to reflect actual operation. A cat with no veterinary records was observed on the property (a repeat violation). No current shift change log sheet was available for review (also a repeat violation).

### **Sanitation, Health, Safety, Maintenance**

Throughout 2007 and 2008, inspectors and advocates found multiple serious problems: the facility was extremely dirty, including the walls and floors, and there were persistent foul odors. Specifically, there were spots of blood on the wall of residents' bedrooms and the carpet in the living room was stained and dirty. The bathroom floors were dirty and sticky; the bathtub was dirty; toilets and bathtubs needed caulking; and water temperatures were dangerously high. One bathroom had a hole in the wall above the sink with cockroaches crawling in and out; cockroaches were in residents' bedrooms as well; food safety issues including cabbage decomposing on the kitchen counter and several items in the refrigerator not appropriately wrapped or labeled; the shelves in the kitchen cabinets were filthy with stained foods and dirt; the pots and pans were dirty and

greasy. A couch was covered in plastic (the facility administrator reported that this was due to one resident's incontinence problems); the dining room table was dirty, with dried food stuck to the tablecloth and table mats; bathrooms lacked liquid soap, paper towels, and toilet paper; there was no laundry detergent in the facility; residents lacked sheets on their beds; one bedroom was missing a door; the smoke alarm in the women's bedroom was chirping to indicate it needed a new battery, and the emergency light in the hallway was inoperable. The floor was slanted and soft in some areas.

On January 3, 2008, a DHEC inspection noted the same hole in the wall above the bathroom sink remained after being noted in an earlier inspection. The sink and bathtub needed caulking and the toilet in one bathroom was inoperable; and paint was peeling from the facility exterior. There were ladders, rubbish, and a toilet in the back and side yards. Stray dogs and a stray cat were observed on the facility grounds (no veterinary records existed for these animals at the facility).

A March 6, 2008, DHEC inspectors were able to examine only the exterior of the facility because no one appeared to be at the facility. Nevertheless, several problems were noted, among them trash and debris such as beer cans littering the yard, a bucket of standing water and cigarette butts, and numerous physical maintenance issues, including a large hole in the wall behind the exterior dryer.

A May 1, 2008, DHEC inspection noted the following violations, many of which were repeat violations: the carpet in the den was stained; the residents' bathroom window was broken with sharp glass exposed and no insect screen; the sink and tub still needed re-caulking; a loose board was covering a hole behind the bathtub faucet; and the bathroom door would not lock for privacy. Cleaning agents and other chemicals accessible to residents were observed under the sink in the residents' bathroom.

An August 6, 2008, DHEC inspection found a large space at the side of an air conditioner was open with no screen to keep out insects; drawers in resident bedrooms were missing knobs; and there was a hole in the wall behind the laundry appliance on the back porch (repeat violation). Housekeeping issues found were dirty carpet in the living room and food debris and a heavy accumulation of dust in the room closest to the kitchen (repeat violation). The yard was still littered with beer cans (repeat violation). A memorandum was prepared for enforcement action.



## **Food**

During this time period, many problems with residents' food were noted. The facility had difficulty providing adequate food for residents; the strong odor of rotten food permeated the facility; filthy food and drink containers were found in the refrigerator; expired foods and discolored containers were in the refrigerator and cabinets; and jars containing filmed-over food and condiments were in kitchen. The DHEC inspection on January 3, 2008, noted open and unlabeled chicken in the freezer.

## **FACILITY E**

### **Resident Care and Documentation**

From 2006 through 2008, the following problems were found in Facility E: medications were out of stock and insufficient for the residents' evening dosages as required; medications were expired; medications were listed on the MARs twice and initialed as being given twice, even though the indications on the bottles were to take one tablet daily; medications were listed on MARs, but times of administration were not listed; and medications were not administered. Also several residents had not been given their TB test until after admission; medications for residents who were no longer at the facility, including vials of insulin, were still in the medication drawers and carts; sample medications were in some of the residents' bins, but they were not labeled; discontinued, expired, and empty bottles of medications were in the medication cart; expired vials of an anti-psychotic drug and TB vaccine injections were in the medication refrigerator; staff did not know when/how to administer insulin; medications in the bin were not listed on the MARs; and packages of Albuterol Sulfate were not stored in protective pouches as indicated on the package.

Additional problems included residents who reported that the administrator made them do the dishes if staff failed to come to work; reports the administrator was angry and mean to residents; residents wearing clothes which were too small and which also had holes in them; residents selling their winter coats, clothes and sheets to other residents in exchange for cigarettes with no other coats or appropriate clothing or bed linens available (the residents involved in these transactions had different levels of intellectual abilities); bathrooms without shower curtains and no doors on the stalls in the

bathrooms. Also, resident files contained either blank, but signed care plans or care plans which did not have the residents' signatures. Files often lacked the 72-hour assessments required after initial admission to the facility.<sup>68</sup>

On June 22, 2007, DHEC investigated a complaint regarding sanitation, food, and medications. As a result of the investigation, Facility E was cited for the following medication violations: one resident indicated she was not receiving her medications, and her doctor's orders were not available; and three medications listed on the MAR from the transferring facility were not available. Three pills were in a container, but the MAR indicated that they had been administered. Outgoing staff had not signed the review sheet for MARs during the entire month. DHEC required submission of a plan of correction.

DHEC returned to the facility on September 15, 2007, due to a complaint that the facility had inappropriately admitted a resident. The complaint stated that the administrator contended that the resident was not officially admitted, but spent one night at the facility. The following day, after the resident was taken to an appointment at the Mental Health Center the facility refused to allow the resident to return. A violation was cited for the 72-hour post-admission assessment not being signed by the individual who completed it. DHEC required submission of a plan of correction.

On September 18, 2007, DHEC conducted another investigation based upon a complaint that a resident was being verbally abusive, exposing himself, and harassing neighbors of the CRCF.

According to one staff person, residents frequently eloped from the facility without informing staff of their location. In spite of this, no incident reports had been given to DHEC.<sup>69</sup> These tendencies to elope were not mentioned in the residents' files,

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<sup>68</sup> DHEC R. 61-84 702. Assessment (II) A complete written assessment of the resident in accordance with Section 101.I. shall be conducted by a direct care staff member within a time-period determined by the facility, but no later than 72 hours after admission.

<sup>69</sup> DHEC R. 61-84 601. C. Incidents where residents have left the premises without notice to staff members/volunteers of intent to leave and have not returned to the facility within 24 hours, shall be reported to the next-of-kin, sponsoring agency or any agency providing services to the resident and local law enforcement immediately. When residents who are cognitively impaired leave the premises without notice to staff members/volunteers, regardless of the time-period of departure, law enforcement, next-of-kin, and sponsoring agency shall be contacted immediately. DHL [Division of Health Licensing] shall be notified not later than 10 days of the occurrence.

nor were care plans updated to address this problem. A staff person stated that one resident knocked on the neighbors' doors and sat on their porch, another resident went to the store and begged for money, and a third resident waited at the edge of the road and rode away with different men.

DHEC visited the facility again on November 7, 2007, to investigate a complaint that Team Advocacy had filed two weeks before. The complaint stated that a resident claimed she had not been receiving her personal needs money, needed a cream for lesions on her feet, and that her clothes were dirty and had holes in them. She also stated that she was not allowed to get her hair cut. The men in the facility had shaved heads, but did not want to have their hair cut this way. The complaint also referred to a resident who had been crying and appeared to be upset during Team Advocacy's visit. The staff ignored her for several minutes and then yelled at her and told her to go outside. She wanted to use the telephone, but needed assistance reaching and dialing because she was in a wheelchair. The staff did not provide assistance to her. A male resident complained he had been hit by a staff person. Violations were cited by DHEC as follows:

- One resident's file did not contain written authorization for the facility to manage his funds.
- Medications, that included controlled substances, were not listed on the MAR.
- Expired medications were stored with current medications.
- One medication was listed and initialed on the MAR twice.
- No privacy was available at the tubs or toilets in the men's or women's bathroom.

On November 12, 2007, DHEC again investigated a complaint about this facility. Three resident records were reviewed. Each of these residents received insulin, but no special diet orders were available as would be appropriate for individuals with diabetes. One resident was diagnosed with alcohol dependency, yet this issue, along with his

seizures/falling tendencies, was not addressed in his care plan. There was no incident report for a fall that resulted in a resident's admission to the hospital.<sup>70</sup>

During DHEC's January 9, 2008, visit, problems with residents' records accounted for seven violations. These violations included no documentation that a quarterly report of the balance of funds had been provided to the residents, no accounting of a resident's personal funds for two months, lack of a detailed service agreement, and no documentation of a resident's annual health assessment. Two of these violations were repeats.

Five medications on the MARs were not available during the inspection. None of the MARs had been signed for that day's 8 a.m. medication administration. One resident's MAR indicated that he had not been given his nightly medication for the previous week. The second shift had not signed the MAR for shift change on three days for January. One controlled drug did not have a control sheet. Residents' medications were not stored separately and expired and discontinued medications were stored with current medications. All of the medication citations were repeat violations.

### **Staff, Documentation and Supervision**

On the date of the September 18, 2007, DHEC inspection, three people were assisting 26 residents at the facility.<sup>71</sup> One was a staff person who was assigned to laundry, one was the administrator's sister, and one was a DSS volunteer. Further, there was no documentation for two volunteers regarding their background checks, necessary training, a health assessment, or basic identifying information.

One resident's sweat pants were soaked in urine during the inspection. She remained wet from 11:45 a.m. to 3:00 p.m.

During a November 8, 2007, inspection DMH and the LTC Ombudsman noted one resident lying on a bare mattress. The left side of his face, the back of his head, and

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<sup>70</sup> DHEC R. 61-84 601. Incidents/Accidents...1. Incidents/accidents and/or serious medical conditions as defined below and any illness resulting in death or inpatient hospitalization shall be reported via telephone to the next-of-kin or responsible party immediately and the sponsoring agency at the earliest practicable hour, but not to exceed 12 hours of the occurrence, and in writing to the Department's Division of Health Licensing (DHL) within 10 days of the occurrence.

<sup>71</sup> At least one more staff member would have been required: DHEC R. 61-84 503. Staffing (I)...1. In each building, there shall be at least one staff member/volunteer for each eight residents or fraction thereof on duty during all periods of peak hours.

his scalp and ear were covered in dried blood. He was wearing a dirty sweatshirt and jeans that were covered with stains and dried blood. His jacket and cap were in the room and were also stained with blood. There were two bloodied bandages on the floor. There were flies in the bedroom and on the resident. The staff person in charge was asked to call 911. The staff person explained that he had fallen and she had cleaned him up sometime after 6:00 p.m. the evening before. She indicated that he had fallen a few more times that evening. She said she asked the administrator about calling 911 and he directed her not to do so. The staff person stated that the resident had used his allowance to buy alcohol and had gotten drunk. She felt this was the cause of his falls. Other residents reported that the individual had been banging on the tables and walls very loudly the previous night. One resident stated that the man had come in the dining room and eaten while blood was dripping down his face. During the inspection, the resident was taken by ambulance to the hospital.

On January 9, 2008, DHEC cited the facility for nearly twenty violations of staff documentation, many of them repeat violations. One staff person was missing training in medication management, specific person care, communicable diseases, OSHA safety standards, confidentiality, and fire response. Another employee had this documentation, but none of the forms was dated. Two employees did not have documentation of annual emergency training. One had not been given a pre-employment physical or an annual PPD tuberculosis test. Two employees did not have documentation of a criminal background check in their files. One employee had been trained in medication management by the administrator, who himself was not licensed to administer medications.

### **Sanitation, Health, and Safety**

During the June 22, 2007, DHEC inspection, several sanitation violations were noted. These violations included dusty ventilation units; cobwebs throughout the facility; debris in an air conditioning unit; unpleasant odors in four bedrooms; stained floors at three of the toilets; soiled walls at two sinks; soiled floors; chewing gum pieces on a window; stained sheets; and a soiled tub mat. Also, inadequate storage for residents' clothing was noted, as clothes were stored in cardboard boxes or on the floor. The

housekeeping cart with toxic agents was left unsecured and unattended. Flies were observed throughout the facility.

Throughout 2007 and 2008, Facility E staff reported that the administrator was not concerned with the residents' welfare; residents indicated that they had to buy their own soap and toothpaste or go without; roaches were observed in the bedrooms; linens were worn, dirty and not changed frequently; the facility did not always have clean towels and washcloths, and staff had been told to clean residents using tee shirts; bathrooms were missing shower curtains; the bathrooms had no toilet paper; all of the bathrooms and some of the bedrooms had a strong urine odor; some of the bedrooms smelled strongly of cigarette smoke; there were loose handrails in the women's bathroom; residents were wearing clothing with holes or tears; residents appeared to have dirty hair; residents reported bathing only four to six times a month; residents stated they did not have any bath towels and one stated that he received a clean bath towel once every three to four months; there were flies throughout the facility and an open window with no screen; residents had no containers in which to store their dirty clothes; there were oxygen machines with no filter; there were mice droppings in residents' drawers; the mattresses were very worn; there were also several broken chairs sitting on the front lawn; one lounge area seemed to serve as a storage area for unused items and furniture; shower heads were missing so that only a tube was coming from the wall causing the water to come out at a very high pressure, stinging the skin; the ceiling above the shower had water damage, and there was a hole in the wall; bathrooms had inoperable cold water faucets on the bathtubs/showers; toilets leaked when flushed, leaving a puddle of water on the floor; and empty food cans were found under a cabinet in a bathroom.

On September 18, 2007, DHEC investigated a complaint and cited the facility for several sanitation issues. Sheets and pillow cases were soiled on several beds and urine odors were noted in three bedrooms. Urine was observed on the floor in one of the bedrooms. Flies were observed in six resident rooms and in the hallway. Cigarette butts were observed in one bedroom. No clean towels were available in the facility.

A fire marshal inspection was conducted on September 19, 2007. The report cited that cigarette lighters were located in the same bedroom where oxygen was in use. A certain type of fire extinguisher was needed for the kitchen. Two staff members did not

have fire response training. A bedroom door was propped open, in violation of fire safety standards. Two smoke detectors did not activate the fire alarm when tested, which is considered a serious, Class I<sup>72</sup> violation.

On DHEC's November 7, 2007, visit, bedrooms contained worn or torn mattresses and soiled sheets or bedspreads and had an unpleasant odor; vents were clogged with dust; flies were seen throughout the facility; there were no clean towels in the facility; and bathrooms had no toilet paper or liquid soap.

When DHEC conducted its general inspection on January 9, 2008, several housekeeping and maintenance issues were cited. There was a leaking washing machine in the laundry room; a water-stained floor in a bathroom; a broken window pane covered with cardboard; a hole in the wall of a bedroom; and an open window with no screen. Several roaches were found in the cabinet of a resident's restroom, a repeat violation. Soiled carpet, floors, and bed linens were cited as repeat violations. Toxic cleaning agents were stored unlocked and unattended. None of the fire extinguishers had documentation to indicate monthly inspections. There were no paper towels in five restrooms and no toilet paper in the men's bathroom. Several closets were overflowing with clothes. Most of these citations were repeat violations.

During a DMH and Ombudsman visit to the facility on November 8, 2008, one resident had very dry, flaky skin on both legs. She had sores that were healing on her legs. The tops of her feet were a purple-black color and were swollen. Her toenails were yellow and very thick and dirty. Her feet had a very strong odor. She stated that the last time she had been in a shower was June 1<sup>st</sup>, over five months earlier, when she lived at another facility. The staff gave her a small tub of water to wipe herself off because she was too large for the bathtub. She could not reach many parts of her body, such as her back and feet. A staff person had helped wash her back three weeks before this inspection. Her wheelchair was dirty and the upholstery was ripped.

## **Food**

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<sup>72</sup> DHEC R. 61-84 302. Violation Classifications...

Violations of standards in this regulation are classified as follows: A. Class I violations are those that the Department determines to present an imminent danger to the health, safety, or well-being of the persons in the facility or a substantial probability that death or serious physical harm could result therefrom.

Throughout 2007 and 2008, the following problems were noted repeatedly: there was very little food in the refrigerator; there was no milk, despite the fact that cereal with milk was listed as the breakfast meal; orange juice was the only beverage available; packages of expired bologna were in the refrigerator; packages of meat had not been resealed properly, causing the meat to become discolored; a thick layer of ice in the freezer had a blackish-brown color; foods were not labeled and dated; staff stated that the residents were given fruit for snacks, but the fruit on site was not fresh; chicken was defrosting in the sink, in violation of regulations;<sup>73</sup> and employees admitted they did not cook at the facility. The staff stated that lunch and dinner were catered by Senior Catering. However, when DMH contacted Senior Catering to confirm this, they were told that Senior Catering provided only lunch to the facility. Senior Catering stated that they provided 26 lunches and no special diets; there were 27 residents at the facility. Senior Catering did not serve meals on weekends.

The DHEC inspection of June 22, 2007, investigated a report that the stove had been broken for some time. The administrator stated that a part had been ordered and the stove was to be repaired that day. Resident meals for breakfast and dinner had been provided from local fast food restaurants. Lunch was catered by Senior Catering. The facility was also grilling some items. Substitutions were not being noted on the posted menu, nor were special diets being observed.

On November 12, 2007, DHEC noted that the items listed on the posted menu were not available in the facility.

DHEC cited several problems with the kitchen on January 9, 2008, including accumulated food debris on several kitchen surfaces, dead insects in cabinet, and roach droppings. Many of the violations were repeats.

DHEC received a complaint on September 14, 2008, stating that leftovers from dinner and lunch were being served for breakfast.

### **Financial Management & Utility Maintenance**

On the November 8, 2007, DMH visit, the heat did not appear to be working in one of the wings. These rooms did not contain individual heaters and were very cold.

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<sup>73</sup> DHEC R. 61-25 II. D. 7 governs thawing of foods and prohibits thawing in this manner.



## **PEACHTREE MANOR**

### **Resident Records and Documentation**

From 2006 until 2008, when it was closed by court order, problems with resident records and documentation were repeatedly noted at Peachtree. For instance, throughout this time period, records did not contain documentation of the required initial 72-hour admission assessments; records frequently failed to contain a care plan; care plans were not signed by the resident or responsible party; records contained only one-step TB tests and some of the two-step TB tests were not performed within 30 days of admission; at least one of the residents had a chest x-ray, but no documentation of a positive TB test or an emergency admission. There was generally a lack of rosters of residents.<sup>74</sup>

Some of the most serious concerns about Peachtree, beginning in 2006 and continuing until the date of closure, involved medication. Throughout this time period, medication was given later than the time prescribed; medications prescribed for residents were out of stock while the MAR was signed as though they had been administered every day; medication that had been discontinued or belonged to prior residents was stored with current medications; controlled drug count sheets displayed an inaccurate number of pills remaining while there was no drug count sheet for other controlled substances; controlled drug count sheets were initialed by one staff member while the MARs indicated that other staff members had actually administered the drugs; MARs indicated that some medications were not being administered as prescribed (too often or not enough); the number of pills remaining in pill containers suggested that some medications were not administered on a regular basis; some medications that had been prescribed were not listed on the MARs; destruction of medication was not properly performed or witnessed; medication destruction records were not available at times; unidentifiable initials and markings were observed on MARs; numerous blanks were observed throughout MARs; there were no MARs for some residents; some residents' medications had been marked "administered" despite the fact that the residents in question had been in the hospital since the day before and were not present to take medications; staff indicated that they

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<sup>74</sup> The administrator repeatedly had problems producing rosters for inspections and keeping track of new admissions. On April 4, 2008, several days after the facility was closed for other reasons, the Board of Labor, Licensing and Regulations finally suspended the license of the Peachtree administrator.

monitored resident blood sugar levels and administered insulin injections, but no Clinical Laboratories Improvement Amendments (CLIA) waiver was available for review;<sup>75</sup> and there was no record of review of MARs by outgoing staff members with incoming staff members.

### **Financial**

The facility records also showed no documentation of residents' personal allowances and how their money was handled. One resident reported that the CRCF owner had taken that resident's personal checkbook home, but had since returned it. Residents also had complaints of non-receipt of personal funds and that their mail had been opened. During a P&A inspection January 28, 2008, another resident stated that she was supposed to be receiving \$55 a month in personal allowances, but she had not been given any money. Again during a P&A inspection February 28, 2008, a resident stated that she was supposed to be receiving \$55 a month in personal allowances, but she had not been given any money.

### **Level of care**

Also throughout this time period, several residents at Peachtree needed a higher level of care than could be provided at a CRCF. One such resident received hospice care for end stage coronary artery disease. Discharge notes from a hospitalization earlier that year indicated that "patient is stable for transition into nursing home." Her former CRCF stated that the resident had left because she needed skilled level of care. Another resident had difficulty swallowing and choked several times during the observed meal. He had suffered a stroke the previous year, and at the time of the visit was incontinent, needed physical therapy, and had other serious medical issues. The records of another resident showed that the admission physical did not address the appropriateness of residential care placement or whether or not the resident could self-medicate. A resident who had a Foley (indwelling) catheter and a percutaneous endoscopic gastrostomy (PEG) feeding tube needed care beyond what the facility was licensed to provide, but there was no documentation that the facility had made arrangements to transfer this resident to an

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<sup>75</sup> DHEC R. 61-84 § 1203.B allows CRCF staff to monitor blood sugar levels if they have a CLIA waiver, but specifically prohibits staff from administering insulin injections.

appropriate level of care.<sup>76</sup> Another resident did not meet the required level of care for a community residential care facility, as she could not dress or bathe herself or ambulate using her wheelchair. Another resident had cancer and received hospice care at Peachtree until she moved.

### **Medical care**

Other problems included failure to take residents to medical appointments;<sup>77, 78</sup> failure to perform fasting blood sugar tests three times a week as required; failure to perform blood tests for residents on Depakote; allowing residents to prepare charts for new admissions, thereby allowing residents access to the personal information of all the other residents.

On January 2, 2008, DMH and P&A noted during an inspection that a resident had a red, scaly rash on both of his arms. The rash had scabs where he had been scratching, and the resident stated that he needed to go to the doctor. The staff person stated that he had visited the doctor, but the staff could not access the resident records to provide the documentation.

In January 2008, the administrator could not produce a January resident roster. She first said that there had been no new residents admitted, but later recanted this statement. P&A discovered one resident who was not on the December roster. This resident was in need of dialysis; the owner stated he was waiting on a home health

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<sup>76</sup> At one point, four residents who had moved to another CRCF upon Peachtree's license revocation were to be returned to Peachtree because they needed a Nursing Facility level of care and so could not stay at the new CRCF. Adult Protective Services (APS) was contacted to address this situation.

<sup>77</sup> One P&A client complained that staff were not taking her to a doctor. When she complained about missing her appointments with her doctor and psychiatrist twice each, she said the owner had told her she was whining and called her a "druggie" when she asked for her medication

<sup>78</sup> For residents who are Medicaid recipients, no-cost transportation may be obtained through SC Department of Health and Human Services, "the Medicaid van." See: <http://www.dhhs.state.sc.us/dhhsnew/TransportationFAQ.asp?ID=83&pType=Transportation>.

DHEC Regulation R. 61-84 904 requires the facility to secure or provide medical transportation: Transportation (I) The facility shall secure or provide transportation for residents when a physician's services are needed. Local (as defined by the facility) transportation for medical reasons shall be provided by the facility at no additional charge to the resident. If a physician's services are not immediately available and the resident's condition requires immediate medical attention, the facility shall provide or secure transportation for the resident to the appropriate health care providers such as, but not limited to, physicians, dentists, physical therapists, or for treatment at renal dialysis facilities.

agency to return his call about when to schedule it. He also stated that he was going to transport the resident to the emergency room that night. The resident had a prescribed medication that was not listed on the MAR. Another resident had a permanent pacemaker that was due to be checked on February 9, 2007, but there was no indication in her record that this had occurred.

P&A conducted another monitoring visit to Peachtree on January 18, 2008. During this visit, one resident, who was diabetic, told P&A she had not received her medication for two weeks. She stated that she did not receive a diabetic diet and that she had high blood pressure. When asked how often the staff checked her blood pressure, she responded that they did not do so.<sup>79</sup> One resident was supposed to receive dialysis three times a week and the staff person stated that was taking place, but there was no documentation to verify. Again, there was no staff roster, so the owner had to write one for P&A.

On an Ombudsman visit on February 13, 2008, a resident was wheezing. When asked about her medication, she was told the staff could not administer her inhaler, and she would have to wait until the administrator returned.

During a P&A inspection on February 28, 2008, a resident stated she missed a medical appointment on February 8, 2008; the last time she had gone to the Mental Health Clinic was September, 2007. Another resident reported that he needed to go to the dentist very badly.

### **Transfers to and from other facilities**

When one resident was moved from Peachtree to a nursing home in Hopkins on February 14, 2008, the nursing home operator reported that the individual was not provided any paperwork including information on his medical providers or his medications. He was also transferred with no medications.

A P&A inspection on February 28, 2008, found even more problems. Staff was initially unable to find one resident's chart when requested, but did eventually locate an incomplete chart that contained no information as to the placing agency. Other residents' records had no resident admission date. One resident stated that he had been homeless

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<sup>79</sup> She had lost her right leg below the knee due to her diabetes.

and a Mental Health client, but since his arrival on February 24, 2008, he had not been taken to a psychiatrist, and he did not have any medication. The resident's file contained very little information about the resident or how he was placed at Peachtree.

### **Staff Documentation and Supervision**

Prior to the licensure of Peachtree, DHEC conducted an initial site inspection on January 5, 2006, and cited Peachtree for several violations regarding staff training and health screenings. DHEC could find no documentation which showed that staff had been trained for care of persons with communicable disease, in the use of restraints, in OSHA standards regarding blood borne pathogens, in fire safety, or in recreational activities. Also, Peachtree failed to provide documentation that two staff members had taken physical exams prior to hiring and that two staff members had completed the Tuberculin (TB) Skin Test.

Another inspection was conducted by DHEC on May 31, 2006. Seven different types of documentation failures were noted in regards to staff training and background, including a failure to document a SLED background check for two of four staff records reviewed.<sup>80</sup>

DHEC responded to a complaint at Peachtree by conducting an unannounced inspection on June 21, 2006. They discovered that Peachtree did not have sufficient staff on duty during peak hours. Two staff members were present for 18 residents.

There were deficiencies in staff background checks and training. On June 22, 2006, DHEC returned to Peachtree. Four of the five employee records reviewed contained no SLED background checks and there was no FBI check in the file of a staff member who moved to South Carolina in July 2005 (Peachtree asserted that it was not aware of the FBI check requirement);<sup>81</sup> the Administrative Law Court did not fine Peachtree for these failures as there was no evidence Peachtree had in fact hired any

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<sup>80</sup> Because the Administrative Law Court later found that the regulations do not require documentation of background checks and first aid training be maintained, but only that the background checks be performed, Peachtree was not fined for these documentation failures.

<sup>81</sup> SC Code § 44-7-2920 requires state criminal background checks on direct health care staff at direct care entities (included CRCFs) and if applicant cannot produce proof of at least 12 months residency in SC, a federal background check must be initiated after employment, unless a state check can be completed in a prior state of residence.

individuals who had a prior conviction or pled no contest for child or adult abuse, neglect, or mistreatment, ALC opinion # 06-ALJ-07-0765-CC.<sup>82</sup> DHEC found seven different training documentation failures. Although the ALC found that some of this training had been completed, the facility failed to maintain this information in its records in accordance with the regulations. There were also several issues related to proper documentation of TB testing for staff.

From 2006 to 2008, problems included: lack of documentation for staff training in CPR and first aid; lack of proper assessments and health testing prior to admission or upon arrival to the facility; lack of appropriate staff to resident ratio.

On October 30, 2006, when DHEC conducted an inspection in response to the death of an unsupervised resident who had wandered away and was killed when struck by a car, DHEC found several problems with staff documentation. The documentation of in-service training in one staff member's record indicated that it was not done prior to resident contact. For two staff members, there was no documentation of in-service training in the care of residents specific to their needs. Four individuals (three paid staff and one volunteer) on duty at the time of this incident did not have a criminal background check on file. There was no documentation of a two-step TB skin test in two employees' records reviewed, and there was no physical examination in one employee's record. One employee's record did not contain documentation of orientation.

A DHEC inspection on November 14, 2006, again cited Peachtree for many problems, including those cited in prior inspections. The inspection team found there was no established written time period for review of all policies and procedures, and policies and procedures had not been reviewed as needed. Also, the three persons designated to admit, discharge, and transfer residents no longer worked at the facility. Out of five employee records reviewed at that time, none showed documentation of an appropriate criminal background check. Three of five employee records reviewed failed to show vital signs training, and no one was designated in writing to receive this training. Again, out of the five employee records reviewed, two did not contain evidence of basic

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<sup>82</sup>SCDHEC vs. Peachtree Manor Residential Care Home, LLC 06-ALJ-07-0765-CC Hearing of February 12 and 15, 2007, <http://www.scalc.net/decisions.aspx?q=4&id=10347>

first aid training; two did not contain evidence of training in contagious or communicable disease.

Two did contain documentation of “medicine training” by Palmetto Long Term Care pharmacy; however, there was no documentation for any of the other three employees showing that they had passed a competency test as required by the Nurse Practice Act, S.C. Code § 40-33-43.

Two employee records did not contain adequate documentation of specific personal care training, and two employee records lacked documentation of training in OSHA standards for blood borne pathogens. Two employee records did not contain evidence of fire response training and two did not contain evidence of training in emergency procedures. Of the five employees’ records reviewed, one employee’s record did not contain evidence of training in confidentiality of resident records, one did not contain a job description, and one did not contain evidence of orientation to the facility. One contained an employment health assessment dated August 10, 2006, almost two months after the June 25, 2006, hire date, well after initial contact with residents. One employee’s record contained an employment health assessment that was not signed by a physician or other authorized healthcare provider. One employee’s record had TB skin tests dated August 10, 2006, and October 6, 2006, after resident contact; similarly, the record of one employee hired November 11, 2006, contained “documentation” of a TB skin test placed on April 25, 2006, but purportedly read three days earlier, April 22, 2006;<sup>83</sup> the record also lacked documentation in that case of a second-step TB test. For two employees who were present at the time of the inspection, there were no employee records available for review at all.

None of the staff members had CPR (cardiopulmonary resuscitation) certification documentation from the facility. One employee’s record did include CPR certification as part of orientation for another facility. There was no documentation of training in the use of restraints for a designated staff member or members. No one at the facility had been designated or trained in recreational activities; it was stated that one person coordinated activities, but there was no record on-site for that employee. Also, the licensee had not

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<sup>83</sup> Pursuant to federal Center for Disease Control, TB testing involves an under skin injection and then a reading of any reaction 2-3 days later. [http://www.cdc.gov/tb/faqs/qa\\_latentbinf.htm#latent2](http://www.cdc.gov/tb/faqs/qa_latentbinf.htm#latent2)

notified the Department of Health Licensing in writing within ten days of a change in the facility's administrator as required by regulation. (The staff person who stated that she was the administrator was different from the individual listed in the Department records.) The posted grievance and complaint procedure contained an incorrect and out-of-date telephone number for the DHEC Division of Health Licensing. There was a written quality improvement program, but there was no indication it had been implemented. Finally, several residents expressed fear of retaliation by staff members for being interviewed by or speaking to inspectors.

On December 12, 2006, while DMH was conducting a site visit, two residents outside began to argue and yell and threaten each other. No staff went outside to address the matter, although a volunteer did go outside after a few minutes to watch. The other residents worked to calm the situation. Even when the angry resident came inside in a rage, staff still did nothing.

On November 28, 2007, there was a complaint filed with DHEC that Peachtree did not have enough staff for the residents. On November 29, the staffing was reviewed and no documentation could be provided showing the proper staff to resident ratio.

On December 19, 2007, the local Emergency Medical Service (EMS) sent a letter reporting problems that EMS paramedics had noted at Peachtree over the prior year, along with EMS complaints and visit logs detailing some of the problems EMS responders encountered. From January 25 to December 13, 2007, EMS responded to a total of 154 calls to Peachtree, with the highest number of monthly calls totaling 21 in June 2007. One complaint notes that when they came to pick up a resident, the owner would not stop arguing with the resident, who was on a stretcher, about his radio. As a result, the patient became enraged and began to hit the wall, and the EMS responder was forced to inform the owner that he was interfering with the crew's safety by continuing to argue with the resident. On other occasions, responders could not locate staff or staff was unaware that EMS had been dispatched. EMS crews received complaints from residents about poor care, including lack of staff availability to administer prescribed medications and meals. Also, they reported that they responded to a resident who complained of arm pain. A staff member told the responder that the resident was not really hurting, that he should not have called 911, and tried to convince the resident to return to his room.



## **Sanitation, Health, and Safety**

From 2006 to 2008, Peachtree had problems with sanitation. For instance, dishes in need of washing were placed on shelves and the overhead lights were full of dead insects; at other times, dirty dishes from breakfast were piled in the dining area well after breakfast had ended. A DHEC inspection conducted on October 30, 2006, found the outdoor area in front of the facility unsafe due to the lack of protection from the physical hazards presented by the road.

The November 14, 2006, DHEC inspection found the following maintenance problems: water damage to the wall and ceiling in the lobby; inoperable emergency light in the hall on Wing B; inoperable or damaged air conditioning unit in two rooms; exit light on Wing A inoperable; ceiling damage around the vent in a bedroom; drawers off track in bathrooms throughout the facility; closet doors missing in residents' rooms throughout the facility; torn screen on porch at the end of Wing A; an inoperable toilet on Wing A; scarred and marred walls throughout facility; fascia board on outside of the facility was peeling and rotting; cool air was inoperable on one air conditioning unit; a stain on the ceiling; no cover on an oscillating fan; an unsecured bed headboard; a wobbly and unsecured toilet rail; and a broken storage door in Wing B. There were no provisions observed in residents' rooms for storing soiled linen. No paper towels or hand drying methods or liquid soap were observed in several common restrooms throughout the facility.

Unsecured oxygen cylinders were observed in a bedroom on Wing B, and twelve unsecured oxygen cylinders were observed in the medication room.<sup>84</sup> Unsecured medications were observed in several residents' rooms.

No rooms had bureaus for storing clothing. Dust was observed throughout the facility. A strong urine odor was noted in one room. Bed linens in several rooms needed replacement. Floors were dirty and stained throughout the facility. Splatter was observed on a bedroom door. Cobwebs were observed throughout. There was a smell of

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<sup>84</sup> Oxygen bottles present a hazard unless properly secured.

smoke on Wing B and throughout facility. Heavy dust was observed in the laundry room and on top of the water heater. Clothing was all over the floor in one bedroom. Chemicals and caustic cleaning agents were stored unsafely in the Wing B storage room, as the door lock was broken. There was no hot water in the men's and women's restrooms. Fire extinguishers throughout the facility had not been initialed monthly to show their inspection by staff. Supplies and equipment were stored on the floor in the storage and medication rooms. First aid kits were not adequate.

At the same time (November 14, 2006), a DHEC Food and Sanitation inspection of Peachtree's kitchen was conducted. That inspection also found many problems: the cook was not wearing a hair restraint while cooking; the dishwasher was inoperable; sanitizing test strips were not available at the three-compartment sink; dishes had been piled in all three compartments of the sink making the standard three-step washing procedure impossible; there were no vacuum breakers observed on two hot-water faucets at the rear wash area; there was no liquid hand soap at the kitchen hand wash sink, and both soap dispensers were empty; numerous live flies were observed in the main kitchen; the kitchen floor and walls were soiled and splattered; walls in the dining room were marred and scarred; untreated and unpainted plywood was being used as a barrier in the dining area; the doorknob was missing from the dining room door; a light over the dishwasher had a loosely hanging cover; light covers were missing on four lights in the dining room and one light under the stove hood; and a staff drink was stored uncovered with residents' foods. The storage room behind the facility, where the floor freezer was stored, was extremely cluttered and soiled, and several broken refrigerators and a broken-down and abandoned van were stored behind the kitchen. The final sanitation grade given was a "C," with a score of 70, the lowest possible passing score.<sup>85</sup>

A year later, conditions had not improved. In November 2007, a complaint was received alleging "filthy" and "unsanitary" conditions, including "roaches in the dining room and food" and "flies all over." A site visit by DMH on November 9, 2007, found cigarette butts on the floor of a resident's room, a half-filled urinal on the floor by a resident's bed, and two dirty residents' bathrooms. The front window of the facility was

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<sup>85</sup> In February 2007, the kitchen received another "C" sanitation rating.

broken, and the glass had been “replaced” with thin cardboard; a window in one activity room had been broken the prior June and replaced with plywood.

An inspection on November 29, 2007, found that while interior areas did not appear unsanitary, there was an unsanitary area behind the facility where garbage had been piled for burning and partially burned. The inspectors did find an “excessive number” of flies in the kitchen and dining room. A visit by DMH four days later, on December 3, 2007, found the large pile of trash still present and large numbers of flies still present in the burned area behind the facility, the kitchen, the dining area, and on residents’ food.

On December 18, 2007, DHEC investigators found upwards of thirty partially closed bags of trash and other debris piled at the rear of the facility. The trash was not properly stored in closed containers and many of the bags had been torn open by animals. The garbage had attracted vermin, rodents, flies, and other animals, violating DHEC regulations R. 61-25 and 61-84.1703 (requiring facility and grounds be neat, uncluttered, clean, and free of vermin and offensive odors). The DHEC inspector’s report noted that “the trash and debris varied considerably – from cans, bottles, and papers to diapers and clothing.”

Several additional violations of health, safety, and fire regulations were found during the December 18 inspection, among them violations of several sections of DHEC Regulation R. 61-84.1502.B (lack of protective light covers and broken electrical receptacle cover for heating unit); two outside bedroom windows, required as emergency exits, were respectively screwed and painted shut, in violation of §2703.B; staff did not have access to the rooms containing the boilers and furnaces, in violation of §2101; one resident’s room lacked a heating unit, in violation of §2601.A; panic hardware on the rear exit doors had been torn and dismantled in violation of §2301.A; there was a buildup of lint around dryers in the laundry room, in violation §1601; the fire alarm system could not be tested, as staff had no knowledge how to operate it, in violation of §1503.A.3; there was a lack of documentation to show that fire drills had been performed at least quarterly, in violation of §1504; there was no access to records to determine if periodic inspections and tests of fire protection systems had occurred, in violation of §1502; and a

lack of a cover was missing on the junction box in the ceiling of the dining room, in violation of §1502.B.

DMH and P&A inspections in January 2008 found the mechanisms to open and close the front door and an emergency door had been broken off so that the doors could not be locked; similarly, the windows found broken in earlier inspections had still not been repaired: one was covered in plywood and the other in cardboard; the water fountain was non-functional; a window beside the front door still replaced only with cardboard and duct tape; the floor and couch were dirty; the alarm system was disconnected with visible wires; there was a strong smell of smoke near the kitchen; broken glass, cigarette butts, a discarded walker frame and an old toothbrush were outside one of the backyard exits; the sliding glass doors from the day room were covered with particle board; there was a puddle of water in front of the ice machine, and the drain from the back of the machine was leaking; the kitchen ceiling had water spots and it was falling; bed linens were dirty, stained, and worn; the trash pile was still present in the backyard; there was a covered shed nearby where bags of trash were sitting on top of a table; there were exposed pipes on the exterior porch; the cover for a heating unit in one resident's room was not secure; residents and staff reported seeing mice on the premises; residents' bedrooms lacked sheets entirely; and the toilets and floors were very dirty.

A P&A inspection on February 28, 2006, found several windows had been replaced with plywood or cardboard. One resident room did not have a doorknob. Fire exit doors were not securely locked, so that anyone could enter at any time. A sliding glass door had been replaced by plastic. Roaches were crawling on the kitchen floor. Mouse feces were seen on the floor of the pantry.

During a P&A inspection January 28, 2008, a resident stated she had been hit on the head by another resident. Another resident stated that staff would not let him call P&A if he tried.

## **Food**

There were also consistent problems with the residents' food supply from 2006 through 2008. As early as May 31, 2006, DHEC staff cited Peachtree because the menus provided for review did not reflect special diets or indicate that they were signed by a dietitian or reviewed by a health care authority. DHEC thus could not determine if

appropriate diets were being served for those who had specific medical dietary needs. (The Administrative Law Court later found insufficient evidence to show that Peachtree had not provided planned menus approved by a dietician or physician.) A subsequent inspection on June 21, 2006 again found no diabetic menus available for review, and Peachtree was again cited for this violation.

Throughout this time period, there were repeated incidents of little to no food or drink for residents; meals served were different from the posted menus; the ingredients for the rest of the day's posted meals and snacks were not in stock; staff in the kitchen did not know what would be served for lunch nor about residents' special diets; residents with food allergies were forced to eat those foods since there was nothing else offered; one of the kitchen refrigerators was not operating; unidentifiable objects were in both of the other operating refrigerators; tacked on a wall in the kitchen was a packet of papers labeled "Renal Diabetic Diet": this packet had phone numbers written on it and pieces of paper torn off the bottom of the sheets; cooks could not explain what was done for residents on special diets.

DHEC conducted a food, safety, and general inspection on November 14, 2006. At the time of that inspection, records of food and supplies purchased during the previous six months were not available for review. There was no documentation that menus for medically-prescribed diets were planned by a professionally qualified dietician or reviewed and approved by a healthcare provider. A current, complete diet manual was not available. There were no special diets listed for diabetic residents or residents in need of any other type of special diet. The cook did not demonstrate sufficient knowledge of food values in order to make appropriate substitutions for residents who needed a special diet. The posted menu was not placed in a conspicuous and resident-accessible location and was several weeks out of date (dated 10/30-11/05). At the time of the inspection, there was less than 1/3 gallon of milk in the facility for 23 residents.

A DHEC visit on November 29, 2007, found there was not a one-week supply of staple foods. The posted menu was not followed, and substitutions were not listed or recorded. There was also no gas for cooking the food that was available (as detailed below). A follow-up visit the next day, November 30, did find that an adequate amount of food had been purchased and was being kept on hand. However, subsequent visits on

December 3 and December 18, 2007, found the kitchen pantry and freezer locked and staff unable to access those areas. Investigators were therefore not able to verify if there was a sufficient supply of staple foods, but on December 18, the food that was verifiably on-hand was not sufficient to meet, and did not agree with, the posted menu.

A resident interviewed by P&A staff on December 3, 2007, stated that the night before, the meal served had been chicken and noodles, but the chicken was spoiled so everyone quit eating; residents ate only green beans.

On December 31, 2007, the LTC Ombudsman's office again noted a "very limited" supply of food, and no snack items were seen. When the administrator called and said she was bringing food, staff members said in the past the administrator promised to bring food, but then did not or brought only small amounts.

During an inspection by P&A staff on January 18, 2008, one resident stated that "nine times out of ten you do not get enough [food]."

Although it was not the reason for the facility's closure, the final inspection on March 28, 2008, found insufficient food on hand to feed the residents, in addition to the other issues that led to closure.

### **Financial Management & Utility Maintenance**

As early as June 21, 2006, DHEC cited Peachtree for failure to maintain phone service, as an inspection on that date found the phones disconnected and residents dependent on personal cell phones. This also led to a general safety violation, as the fire alarm system was rendered inoperable by the lack of phone service, forcing residents to report emergencies using their personal cell phones.

At about the same time, on June 22, 2006, Peachtree admitted to having problems meeting payroll obligations.<sup>86</sup>

A DHEC inspection on November 14, 2006, also noted several problems with residents' financial records. In four of four resident's records reviewed, no date was listed on which residents were to receive their personal needs allowances and no refund policy was documented. There was no documentation or accounting of the resident's financial records for two residents whose funds were managed by the facility. There was

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<sup>86</sup> While this arguably violated R. 61-84.103(K) requiring CRCFs to be financially able to meet all obligations necessary to proper operation of the facility, the Administrative Law Judge waived this sanction, holding that the regulation applied only to the initial request for licensure.

no documentation of quarterly financial reports to residents whose funds were managed by the facility. Inspectors also noted that, according to several residents interviewed, no telephone was available for residents' use, and residents were only allowed to use the office telephone after office hours.

New problems with the utilities were discovered on November 28, 2007. Following a complaint, a DHEC staff member telephoned Peachtree and spoke with individuals present there. The individuals verified there was no gas for cooking at the facility. Later that same day, Mr. Donnelly the owner informed DHEC that he probably would not be able to obtain gas until the following Monday, five days later.

A November 29, 2007, inspection verified that no cooking gas was available. In addition to the problems noted elsewhere in this report, inspectors noted that the cooking stove in the kitchen was not operable as there was no gas supply on hand. At that time, at least one staff member also reported to the DHEC inspector that staff had not received a paycheck since October 24, 2007. When DMH inspected several days later, on Monday, December 3, 2007, the situation with the lack of gas had apparently still not been resolved, and staff was observed cooking meals on an electric skillet.

On December 18, 2007, a DHEC inspector's report noted that the kitchen was non-functional, lunch was being prepared on a small electric plate, the facility lacked heat, with residents wearing coats inside, and that most of the electric lights were turned off or inoperable. It was also reported that Peachtree was in the early stages of foreclosure on a \$900,000 mortgage and was subject to an outstanding \$56,000 mechanic's lien. An inspection that same day confirmed (among other violations) that the ambient temperature at Peachtree was between 60 and 64 degrees, which violates §2601.C of Regulation 61-84 (requiring facilities to maintain a temperature between 72 and 78 degrees Fahrenheit in resident areas). This was because "the heating unit for [the hallways, corridors, sitting rooms and dining room] operates on natural gas and currently there is no supply of gas to operate the system." (DHEC Inspector's Report 12/18/2007.) Resident rooms did each have individual electrical heating units.

On December 20, 2007, DHEC had received information indicating Peachtree was \$1,867 in arrears on its electric bill and was facing cancellation of basic heat.<sup>87</sup> A visit by the LTC Ombudsman's Office on December 31 confirmed that at least one resident's bedroom did not have heat.

An inspection by DMH and P&A staff on January 2, 2008, found these issues continuing. According to the report that day, there was "no heat in the common living areas including all resident lounges, the dining room, the hallways, the laundry room, the medication room and offices. Reportedly the gas was turned off due to non-payment more than a month ago." Similarly, meals for all 26 residents were still being prepared "using a family-sized electric skillet and a small fryer" as the gas supply to the stove was still cancelled.

An inspection by P&A staff on January 18, 2008, found that interior rooms had temperatures ranging between 65 and 68 degrees. Hot water temperatures were measured as low as 65 degrees and no higher than 101 degrees.

On February 19, 2008, DHEC confirmed reports that the phone service at Peachtree had again been discontinued for nonpayment and that as a result the fire alarm system no longer met regulatory requirements. The fire marshal gave Peachtree 48 hours to restore phone service, but as of February 27, 2008, phone service had not been restored and the local Winnsboro fire marshal had not taken further action.

On February 22, 2008, the LTC Ombudsman visited Peachtree and again found the gas was turned off, the stove and oven did not work, the residents lacked heat, and meals were being cooked over hot plates.

A P&A inspection on February 28, 2008, found the indoor temperature was 56 degrees Fahrenheit in the front common room. The facility's telephones were not functional, and staff and residents were relying on staff's personal cell phones for all calls outside the facility. There was no gas to cook with; the cook stated she prepared meals using a hot plate and skillet as the gas had been out for over two weeks.

*Finally*, on February 29, 2008, Peachtree reached its last crisis point when Peachtree's pharmaceutical provider, Palmetto Long Term Care Pharmacy, sent a letter

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<sup>87</sup> Affidavit by Dennis Gibbs, DHEC staff member, based on communications from the SC Longterm Care Ombudsman



stating it would terminate its contract with Peachtree on April 1st if the entire past due balance was not paid. Peachtree attempted to negotiate partial payment, but the pharmacy would not accept it and demanded full payment, refusing to provide any further medications to the facility. The medications already provided by Palmetto were sufficient for the residents' needs until the evening of March 27, 2008. Peachtree did not satisfy the account, and Palmetto did not provide further medications. Therefore, on the morning of March 28, Palmetto notified DHEC that it believed several residents were without crucial medications, and an emergency situation was likely to exist. DHEC inspectors visited the facility and confirmed that many prescription drugs were not available for inspection; these drugs were necessary to manage a wide range of residents' conditions, from heart conditions to AIDS to potential seizures to mental illness, and sudden cessation of many of them was potentially fatal.<sup>88</sup>

DHEC suspended Peachtree's license to operate based on the "imminent threat" provision, S.C. Code § 44-7-320(A)(3), and closed the facility; five days later, on April 2, 2008, an emergency hearing was held, at which the Administrative Law Judge confirmed both the license suspension and the license revocation.<sup>89</sup> This final and permanent closing of the facility took well over two years from when DHEC first noted deficiencies in 2006 and involved more than 40 inspections by DHEC and other agencies.

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<sup>88</sup> The list of missing drugs included Keppa, Nexium, Abilify, Cerefolin, Risperdal, Phenytoin, Dilatin, Depakote, Topamax, Amlodipine, Zyprexa, Benztropine, Cogentin, Lisenopril, Lotrel, Terazosin, Amiodarone, Furosemide, Diovan, Metoprolol, Orphenadrine, Hydrochlorothiazide, Invega, Seroquel, Lexapro, Lipitor, Gabapentin, Ryataz, Trovada, Benazepril, Naproxen, Crestor, Amlodipine, Simvastatin, and Trazodone.

<sup>89</sup> The written order of the Administrative Law Court was issued April 7, 2008.