Team Advocacy Inspection for October 27, 2016
L & M Residential Health Care Facility
Inspection conducted by Nicole Davis, P&A Team Advocate, Emily Caldwell, MSW Intern and Kristen Kinney, Volunteer

Facility Information

L & M Residential Health Care Facility is located in Berkeley County at 2504 Highway 311, Cross, SC 29436-3339. Team arrived at the facility at 10:15 AM and exited the facility at 12:25 PM. The administrator, Linda Taylor was present when Team arrived but left shortly after Team's arrival to attend a funeral. The facility is operated by L &M Residential Health Care Facility LLC. There was one staff member present when Team arrived. The facility is licensed for five beds. The census was four with two residents being present on the day of Team's inspection. The DHEC license had an expiration date of February 28, 2017. An administrator's license was current and posted. The facility had a written emergency plan to evacuate to the home of Geneva Gladden, 13th Blyth Court, Columbia, SC 29120.

Overview of Visit

During Team's visit we interviewed two residents; talked to residents and staff; reviewed three residents' records, medications and medication administration records; and toured the facility. Team did not observe a lunch. The posted menu was chilled burgers on a bun, fruit and a drink. Team conducted an exit interview with the staff.

Report Summary

A vast amount of bees were near the side of the house. An HVAC inspection was not available for review. Two emergency lights failed to illuminate when tested. An activity board was posted, however the day's activity was not occurring during the visit and the staff member was not aware of some of the activities listed. Resident reported a desire for more activities, specifically B.I.N.G.O. One resident reported needing eyeglasses. One resident reported a desire to get a flu shot. One resident would like to attend the workshop program with other residents. Resident A had a prescription for Lovastatin 40mg tablet, take one tablet by mouth once daily at bedtime. The medication was not available. Resident B had a prescription for Vitamin D 21.25mg 50,000, take one capsule by oral route once weekly for 30 days. The medication was not available. The MAR had not been signed for administration on 10/15/16. No explanation was given. Resident B had a prescription for Equate Stool Softener 100mg, take one tablet by mouth twice daily. The MAR had not been signed for the evening administration on 10/15/16 and 10/27/16. One resident had a prescription for Vitamin D3 1000 unit, take one capsule by mouth every day. The MAR had not been signed for administration on 10/11/16. No explanation was given. Meat in both the freezer and refrigerator was not properly labeled. There were several expired food products in the pantry. Resident A's most recent individual care plan only included the six month review form stating "still can bathe herself with some assistance. She has a very good appetite." The plan did not address dietary needs or any specific needs the resident may or may not have. A 72 hour assessment form from 10/8/14 was the only document addressing specific needs of the client. Resident B's most recent physical had the resident's diet as regular. In contrast, the diet in the individual care

plan was listed as low sugar. Resident C's most recent individual care plan only included the six month review form stating "needs have not changed, he still remains very independent." The plan did not address dietary needs or any specific needs the resident may or may not have. A 72 hour assessment form from 11/30/10 was the only document addressing specific needs of the client. Resident B's personal funds ledger was last signed August 2016. Also, the resident's most recent quarterly financial report was from June 2016. One resident reported a family member gives the administrator money for her, however no records were found regarding any transactions. Resident C's most recent signed quarterly financial report was dated March 2016. Staff medication training was not signed by the individual giving the training. Neither bathroom had toilet paper or a hand drying device. Several blinds were broken and appeared to need maintenance. A used, disposable absorbent under-pad was on a chair when Team arrived.

Areas of Commendation

- The facility was well-furnished in the common rooms with comfortable, upholstered furnishings and had a large front porch. There were a variety of plants, pictures and other objects to convey a home-like atmosphere. There were numerous sitting areas for residents.
- The facility had two types of fire extinguishers, up-to-date and throughout.
- Chemicals were locked up and stored appropriately.
- The water temperatures were within the correct range.
- Residents reported enjoying their experience at the facility. One resident reported "This is a great place to live. I've been in other places and ran away; I have no desire to leave here."
- Individual rooms were well maintained and had amenities like a large closet and TV.
- Residents reported that the people were nice and the food was great.
- The facility was kept at a comfortable temperature.
- Current First Aid/CPR training documentation was present. SLED checks were completed.
- Emergency evacuation routes were posted throughout the facility. Fire drills were completed monthly.
- Observation notes were current.

Areas Needing Improvement

Health/Safety

- A vast amount of bees were near the side of the house.
- An HVAC inspection was not available for review.

Supervision & Administrator

- No concerns noted.

Residents' Rights

- No concerns noted.

Recreation

- An activity board was posted, however the day's activity was not occurring during visit and staff member was not aware of some of the activities listed.

- Resident reported a desire for more activities, specifically B.I.N.G.O.
- One resident would like to attend the workshop program with other residents. [Note: The resident previously attended the workshop but had to stop due to an illness.]

Residents' Activities of Daily Living (ADLs)

- One resident reported needing eyeglasses.
- One resident reported a desire to get a flu shot.

Medication Storage and Administration

- Resident A had a prescription for Lovastatin 40mg tablet, take one tablet by mouth once daily at bedtime. The medication was not available. [Note: Staff reported this was scheduled to be picked up the evening of Team's inspection.]
- Resident B had a prescription for Vitamin D 21.25mg 50,000, take one capsule by oral route once weekly for 30 days. The medication was not available. The MAR had not been signed for administration on 10/15/16. No explanation was given.
- Resident B had a prescription for Equate Stool Softener 100mg, take one tablet by mouth twice daily. The MAR had not been signed for the evening administration on 10/15/16 and 10/27/16.
- One resident had a prescription for Vitamin D3 1000 unit, take one capsule by mouth every day. The MAR had not been signed for administration on 10/11/16. No explanation was given.

Meals & Food Storage

- Meat in both the freezer and refrigerator was not properly labeled.
- There were several expired food products in the pantry.

Resident Records

- Resident A's most recent individual care plan only included the six month review form stating "still can bathe herself with some assistance. She has a very good appetite." The plan did not address dietary needs or any specific needs the resident may or may not have. A 72 hour assessment form from 10/8/14 was the only document addressing specific needs of the client.
- Resident B's most recent physical had the resident's diet as regular. In contrast, the diet in the individual care plan was listed as low sugar.
- Resident C's most recent individual care plan only included the six month review form stating "needs have not changed, he still remains very independent." The plan did not address dietary needs or any specific needs the resident may or may not have. A 72 hour assessment form from 11/30/10 was the only document addressing specific needs of the client.

Resident Personal Needs Allowances

- Resident B's personal funds ledger was last signed August 2016. Also, the resident's most recent quarterly financial report was from June 2016.
- One resident reported family member gives the administrator money for her, however no records were found regarding any transactions.
- Resident C's most recent signed quarterly financial report was dated March 2016.

Appropriateness of Placement

- No concerns noted.

Personnel Records

- Staff medication training was not signed by the individual giving the training.

Housekeeping, Maintenance, Furnishings

- Neither bathroom had toilet paper or a hand drying device. [Note: The administrator and residents stated that residents are responsible for storing their own toilet paper.]
- Several blinds were broken and appeared to need maintenance.
- A used, disposable absorbent under-pad was on a chair when Team arrived, staff removed the pad during the exit interview. Team observed pads placed on several sitting areas in the living room area.
- Two emergency lights failed to illuminate when tested.

Additional Recommendations

- One resident would like to be taken to the polling place for election.

Please Note: Residents listed in the report are assigned random gender identification. This is for the purpose of making the report easier to read. However, the gender does not identify the individuals in the report.