Team Advocacy Inspection for July 6, 2015
Oasis Residential Home
Inspection conducted by Nicole Davis, P&A Team Advocate, and Kayla Sullivan, Volunteer

Facility Information

Oasis Residential Home is located in Georgetown County at 2317 Prince Street, Georgetown, SC 29440-2925. The facility also serves as an Adult Day Care. Team arrived at the facility at 11:56 AM and exited the facility at 3:33 PM. The administrator was present for the inspection. The facility is operated by Mazie Graham. There were four staff members present when Team arrived, the administrator arrived soon after. The facility is licensed for 22 beds. The census was 21 on the day of Team's inspection. The DHEC license had an expiration date of August 31, 2015. An administrator's license was current and posted. The facility had a written emergency plan to evacuate to Williamsburg Residential Care Facility, 14 WRCF Street, Kingstree, SC 29556.

Overview of Visit

During Team's visit we interviewed six residents; talked to residents and staff; reviewed six resident records, medications and medication administration records; and toured the facility. Lunch consisted of a substitution meal consisting of pasta salad, ribs, beans & rice, water or tea and a slice of pound cake. A substitution menu was not posted. Team conducted an exit interview with the administrator.

Report Summary

The most recent electrical inspection was conducted 3/28/14. The storage shed in the backyard was unsecured. One resident reported needing pants. Another resident reported needing t-shirts and socks. One resident reported needing undergarments. Resident A had a prescription for Ammonium Lactate 12% lotion, apply to feet every day and Timolol 0.5% eye drops, place one drop into affected eyes once daily. The MAR

had not been signed for administration on 7/2/15 and 7/6/15 for either medication. Resident A also had a prescription for Simvastatin 40 mg tablet, take one tablet by mouth once daily and Timolol 0.25% eye drops, instill one drop into both eyes two times daily. The MAR had not been signed for administration on 7/2/15 for either medication. Resident B had a prescription for Olanzapine 15 mg tablet, take one tablet by mouth at bedtime. The MAR had not been signed for administration on 7/1/15 and 7/2/15. Resident C had a prescription for Clozapine 100 mg tablet, take one tablet by mouth every morning and three tablets in the evening. The MAR had not been signed for administration in July. Resident C had a prescription for Ferrous Sulfate 325mg tablet, take one tablet by mouth twice a day and Vitamin C 500mg tablet, take one tablet by mouth daily. The medications were not available for administration and were last signed on 7/6/15. Resident C had a prescription for Proair hfa 90 mcg inhaler, inhale one to two puffs by inhalation route every six hours as needed. The medication was not present. Resident D had a prescription for Divalproex SOD ER 500mg tablet, take one tablet by mouth at bedtime. The medication was not present, was not signed for administration on 7/2/15 and was last signed for administration on 7/5/15. Resident D had a prescription for Donepezil HCL 10 mg tablet, take one tablet by mouth at bedtime. The MAR had not been signed for administration on 7/2/15. Resident D had a prescription for Glucerna Shake, drink one can twice a day between meals. The shakes were not present. The MAR was last signed for administration on 7/2/15. Resident F had a prescription for Hydrocodon-Apap-5-325, take one or two tablets by mouth as needed. The medication was not present. A substitution menu was not posted. In the refrigerator a bottle of juice was without a lid, relish had spilled onto several items, an egg was broken and several items were not dated. A opened can of Vienna sausage sat on the counter. Empty snack boxes were in the box where residents kept snacks. Resident A's most recent physical examination listed resident's diet as 1800 Cal ADA. In contrast, resident's individual care plan listed resident's diet as regular. Resident A's most recent individual care plan was dated 10/30/14. Resident B's most recent physical examination listed resident's diet as "< 2500mg sodium daily." In contrast, resident's individual care plan listed resident's diet as regular. Resident B's most recent individual care plan was dated 7/15/14. Resident C's most recent physical examination listed resident's diet as regular. In contrast, resident's individual care plan listed resident's diet as diabetic. Resident C's most recent individual care plan was dated 9/20/14. Resident D's most recent individual care plan did not address dietary needs. Resident E's most recent individual care plan was dated 6/30/14 and was signed only by the resident. Resident F's most recent individual care plan was dated 2/25/13 and was signed only by a staff member. Five of the records reviewed did not include admission Tb tests. Although the facility managed the funds of the residents, no documentation was present authorizing them to do so. Residents' allowances were not properly secured. The allowances were stored in an opened envelope, sitting in a personalized manila folder and were falling out onto the table. Resident A's most recent quarterly financial report was for Jan-Mar 2015 and was not signed. Resident B's personal funds ledger was not signed for each transaction. Resident B's recent quarterly report was for Jan-Mar 2015 and was not signed. Resident C's most recent quarterly financial report was for Jan-Mar 2015 and was not signed. Resident D's personal funds ledger was not signed for each transaction. Resident D's most recent quarterly report was for July-Sept 2014. Resident E had a quarterly report with the months Jan-Mar listed but no year was listed and the report was not signed by the resident. Resident F's most recent quarterly financial report was for Jan-Mar 2015 and was not signed. Annual training for one staff member was dated 2012. Staff records reviewed were not signed and dated by both the trainer

and trainee. Locks on the bathroom doors were missing. One bathroom needed to be cleaned and did not have toilet paper available. One bathroom contained bar soap. Full trash bags and paint cans were by a tree in the backyard.

Areas of Commendation

- The facility was well lit, contained a television, wall hangings, plants and board games. The facility did not have any unpleasant odors.
- A resident-led game of bingo occurred during Team's inspection.
- Team observed a good rapport between residents and staff.
- There was an adequate supply of food present.
- Lunch looked and smelled appetizing.
- The water temperatures were in the appropriate ranges.
- A current HVAC and fire alarm inspection was available for review.
- A current TB risk assessment was available for review.
- Necessary SLED checks were completed.
- Emergency evacuation routes were posted throughout the facility.
- Personal needs ledgers included the 2015 COLA increase.
- Fire drills were completed quarterly.
- Medications were properly stored and secured.

Areas Needing Improvement

Health/Safety

- The most recent electrical inspection was conducted 3/28/14.
- The storage shed in the backyard was unsecured.

Supervision & Administrator

- No concerns noted.

Residents' Rights

- No concerns noted.

Recreation

- No concerns noted.

Residents' Activities of Daily Living (ADLs)

- One resident reported needing pants.
- Another resident reported needing t-shirts and socks.

- One resident reported needing undergarments.

Medication Storage and Administration

- Resident A had a prescription for Ammonium Lactate 12% lotion, apply to feet every day and Timolol 0.5% eye drops, place one drop into affected eyes once daily. The MAR had not been signed for administration on 7/2/15 and 7/6/15 for either medication.
- Resident A also had a prescription for Simvastatin 40 mg tablet, take one tablet by mouth once daily and Timolol 0.25% eye drops, instill one drop into both eyes two times daily. The MAR had not been signed for administration on 7/2/15 for either medication.
- Resident B had a prescription for Olanzapine 15 mg tablet, take one tablet by mouth at bedtime. The MAR had not been signed for administration on 7/1/15 and 7/2/15.
- Resident C had a prescription for Clozapine 100 mg tablet, take one tablet by mouth every morning and three tablets in the evening. The MAR had not been signed for administration in July.
- Resident C had a prescription for Ferrous Sulfate 325mg tablet, take one tablet by mouth twice a day and Vitamin C 500mg tablet, take one tablet by mouth daily. The medications were not available for administration and were last signed on 7/6/15. [Note: The administrator reported they were scheduled to be delivered the evening of Team's inspection.]
- Resident C had a prescription for Proair hfa 90 mcg inhaler, inhale one to two puffs by inhalation route every six hours as needed. The medication was not present. [Note: The administrator reported the medication had been returned to the pharmacy due to the constant refusal by the resident.]
- Resident D had a prescription for Divalproex SOD ER 500mg tablet, take one tablet by mouth at bedtime. The medication was not present, was not signed for administration on 7/2/15 and was last signed for administration on 7/5/15.
- Resident D had a prescription for Donepezil HCL 10 mg tablet, take one tablet by mouth at bedtime. The MAR had not been signed for administration on 7/2/15.
- Resident D had a prescription for Glucerna Shake, drink one can twice a day between meals. The shakes were not present. The MAR was last signed for administration on 7/2/15. [Note: The administrator reported the case had not been received due to the holiday.]
- Resident F had a prescription for Hydrocodon-Apap-5-325, take one or two tablets by mouth as needed. The medication was not present. [Note: The administrator reported the medication had been discontinued but did not provide an order.]

Meals & Food Storage

- A substitution menu was not posted.
- In the refrigerator a bottle of juice was without a lid, relish had spilled onto several items, an egg was broken and several items were not dated.
- An opened can of Vienna sausage sat on the counter.
- Empty snack boxes were in the box where residents kept snacks.

Resident Records

- Resident A's most recent physical examination listed resident's diet as 1800 Cal ADA. In contrast, resident's individual care plan listed resident's diet as regular.
- Resident A's most recent individual care plan was dated 10/30/14.
- Resident B's most recent physical examination listed resident's diet as "<2500mg sodium daily." In contrast, resident's individual care plan listed resident's diet as regular.
- Resident B's most recent individual care plan was dated 7/15/14.
- Resident C's most recent physical examination listed resident's diet as regular. In contrast, resident's individual care plan listed resident's diet as diabetic.
- Resident C's most recent individual care plan was dated 9/20/14.
- Resident D's most recent individual care plan did not address dietary needs.
- Resident E's most recent individual care plan was dated 6/30/14 and was signed only by the resident.
- Resident F's most recent individual care plan was dated 2/25/13 and was signed only by a staff member.
- Five of the records reviewed did not include admission Tb tests. [Note: The administrator reported the charts had been thinned and that she would fax the documentation once located. As of 7/13/15 the documents have not been received.]

Resident Personal Needs Allowances

- Although the facility managed the funds of the residents, no documentation was present authorizing them to do so.
- Residents' allowances were not properly secured. The allowances were stored in an opened envelope, sitting in a personalized manila folder and falling out onto the table.
- Resident A's most recent quarterly financial report was for Jan-Mar 2015 and was not signed.
- Resident B's personal funds ledger was not signed for each transaction. The most recent quarterly report was for Jan-Mar 2015 and was not signed.
- Resident C's most recent quarterly financial report was for Jan-Mar 2015 and was not signed.
- Resident D's personal funds ledger was not signed for each transaction. The most recent quarterly report was for July-Sept 2014.
- Resident E had a quarterly report with the months Jan-Mar listed. A year was not listed and the report was not signed by the resident.
- Resident F's most recent quarterly financial report was for Jan-Mar 2015 and was not signed.

Appropriateness of Placement

- No concerns noted.

Personnel Records

- Annual training for one staff member was dated 2012.
- Staff records reviewed were not signed and dated by both the trainer and trainee.

Housekeeping, Maintenance, Furnishings

- Locks on the bathroom doors were missing.

- One bathroom needed to be cleaned and did not have toilet paper available. [Note: Staff began cleaning while Team was present.]
- One bathroom contained bar soap.
- Full trash bags and paint cans were by a tree in the backyard.

Additional Recommendations

- Four residents would like to move.
- One resident would like to work.

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.