Team Advocacy Inspection for March 16, 2017
Twilite Manor Adult Residential Care
Inspection conducted by Nicole Davis, P&A Team Advocate, Emily Caldwell, Volunteer, and Kristen Kinney, Volunteer

Facility Information

Twilite Manor Adult Residential Care is located in Lexington County at 2306 Forrest Street, Cayce, SC 29033-2124. Team arrived at the facility at 12:47 PM and exited the facility at 4:36 PM. The administrator, Jenny Weatherford, was present for the inspection. The facility is operated by Seashar LLC. There were five staff members and two volunteers present when Team arrived. The facility is licensed for 28 beds. The census was 27 on the day of Team's inspection. The DHEC license had an expiration date of May 31, 2017. An administrator's license was current and posted. The facility had a written emergency plan to evacuate to Rapha Residential Care, 3959 Fish Hatchery Road, Gaston, SC 29053.

Overview of Visit

During Team's visit we interviewed four residents; talked to residents and staff; reviewed six residents' records, medications and medication administration records; and toured the facility. Team did not observe lunch; lunch was completed by the time Team arrived. Team conducted an exit interview with the administrator.

Report Summary

A TB risk assessment was not available for review. Residents would like more activities to do at the facility. Two residents reported needing podiatrist appointments. Resident A's MAR had not been signed for administration on any 8PM medications on 3/4/17. Resident B's MAR had not been signed for administration on any 8PM medications on 3/4/17. Resident C had a prescription for Glycolax Powder, use one capful nightly, mix with 8 ounces of water, juice or soda. The MAR had not been signed for administration at 8PM on 3/11/17. Resident C had a prescription for Bupropion SR 150, take one tablet by mouth twice day and Topiramate 50 m, take one tablet by mouth twice a day. The MAR had not been signed for administration at 8PM on 3/4/17. Resident F's MAR had not been signed for any 8PM medications on 3/4/17. With the exception of one medication, Resident E's MAR had not been signed for administration for 8PM medications on 3/4/17 and 3/16/17. Resident E had a prescription for Arthritis Pain Relief ER 650, take one tablet by mouth twice a day. The MAR had not been signed for administration at 8AM on 3/9/17. Resident A's most recent physical examination did not address the resident's dietary needs or whether the resident could be cared for in this type of facility. Resident A's most recent individual care plan was dated 9/1/16. The care plan did not address whether the resident had an advanced directive. Resident A's most recent monthly observation note was dated 1/20/17. Resident B's most recent individual care plan was dated 4/16/16. Resident B's admission packet did not include a rate. Resident B's most recent monthly observation note was dated 1/23/17. Resident B did not have documentation of a TB test available for review. Resident C's most recent individual care plan

did not address the resident's toileting, grooming, medication or nutrition; the entire page was left blank. Resident C's most recent monthly observation note was dated 1/15/17. Resident D did not have a signed written agreement available. Resident D's most recent monthly observation note was dated 12/25/16. Resident D did not have a photograph available. Resident E's most recent physical examination was dated 2/23/16. Resident E's most recent individual care plan was dated 7/13/16. Resident E's most recent monthly observation note was dated 1/20/17; a December 2016 note was not available for review. Resident F's most recent physical examination did not address the resident's dietary needs. Resident F's most recent monthly observation note was dated 1/23/17. Resident F did not have documentation of a TB test available for review. One staff member did not have a TB test available for review. Items in the refrigerator were not properly labeled. The cleaning closet was unsecured and contained chemicals. The railing on the front porch was loose. The ramp on the front porch was not secured; it was not connected to the building. One bathroom closet contained Lysol and Clorox; residents' personal hygiene items were also stored in the closet. Residents reported not being treated with respect by some staff members. One resident (not in Team's sample) was seen with bruising on his hands/arms. Staff reported the resident is a high fall risk, always falling. Staff members were unsure how the bruising occurred (different stories with overnight or after breakfast). The resident uses a walker. The administrator reported the resident is on weekly hospice care; has been at the facility approximately 7-8 months. Team spoke with the resident, he reported he fell. Team is concerned about the supervision. The administrator reported night checks are held at one hour intervals. Team suggested increasing the frequency of the checks since incidents appear to happen at night with the resident.

Areas of Commendation

- The facility was clean and free of any odors. Resident rooms were organized. It was very homelike with wall hangings, a piano, plants and season appropriate decorations. There were several sitting areas inside and outside of the facility for residents to use. Resident rooms were personalized.
- A current activity calendar was posted throughout the facility. Activities included Church, bingo, bean toss and card games.
- A Church activity occurred during Team's inspection.
- Staff was very helpful during the inspection.
- Residents appeared to have a good rapport with the administrator.
- The facility was kept at a comfortable temperature.
- Water temperatures were in the appropriate range.
- There was an adequate supply of food present.
- DHEC inspections were available for review.
- Annual HVAC, electrical and fire alarm inspections were current.
- Current First Aid/CPR training documentation was present. SLED checks were completed.
- All prescribed medications were present. The controlled substance log coincided with the amount of medication present.
- Emergency evacuation routes were posted throughout the facility. Fire drills were completed monthly.

Areas Needing Improvement

Health/Safety

- A TB risk assessment was not available for review. [Note: The administrator reported she would locate the document and fax to Team. As of 3/23/17, Team has not received anything.]
- One resident (not in Team's sample) was seen with bruising on his hands/arms. Staff reported the resident is a high fall risk, always falling. Staff members were unsure how the bruising occurred (different stories with overnight or after breakfast). The resident uses a walker. The administrator reported the resident is on weekly hospice care; has been at the facility approximately 7-8 months. Team spoke with the resident, he reported he fell. Team is concerned about the supervision. The administrator reported night checks are held at one hour intervals. Team suggested increasing the frequency of the checks since incidents appear to happen at night with the resident.
- The cleaning closet was unsecured and contained chemicals. [Note: Staff secured the door immediately.]
- One bathroom closet contained Lysol and Clorox; residents' personal hygiene items were also stored in the closet.
- The ramp on the front porch was not secured; it was not connected to the building.

Supervision & Administrator

- No concerns noted.

Residents' Rights

- Residents reported not being treated with respect by some staff members. Team observed one staff member yelling at a resident, stating she was "acting very ugly today."

Recreation

- Residents would like more activities to do at the facility. One resident reported "I wish they'd do more here, we rarely do what's on the calendar".

Residents' Activities of Daily Living (ADLs)

- Two residents reported needing podiatrist appointments.

Medication Storage and Administration

- Resident A's MAR had not been signed for administration on any 8PM medications on 3/4/17.
- Resident B's MAR had not been signed for administration on any 8PM medications on 3/4/17.
- Resident C had a prescription for Glycolax Powder, use one capful nightly, mix with 8 ounces of water, juice or soda. The MAR had not been signed for administration at 8PM on 3/11/17.

- Resident C had a prescription for Bupropion SR 150, take one tablet by mouth twice day and Topiramate 50 m, take one tablet by mouth twice a day. The MAR had not been signed for administration at 8PM on 3/4/17.
- Resident F's MAR had not been signed for any 8PM medications on 3/4/17.
- With the exception of one medication, Resident E's MAR had not been signed for administration for 8PM medications on 3/4/17 and 3/16/17.
- Resident E had a prescription for Arthritis Pain Relief ER 650, take one tablet by mouth twice a day. The MAR had not been signed for administration at 8AM on 3/9/17.

Meals & Food Storage

- Items in the refrigerator were not properly labeled. [Note: Staff immediately corrected.]

Resident Records

- Resident A's most recent physical examination did not address the resident's dietary needs or whether the resident could be cared for in this type of facility.
- Resident A's most recent individual care plan was dated 9/1/16. The care plan did not address whether the resident had an advanced directive.
- Resident A's most recent monthly observation note was dated 1/20/17.
- Resident B's most recent individual care plan was dated 4/16/16.
- Resident B's admission packet did not include a rate.
- Resident B's most recent monthly observation note was dated 1/23/17.
- Resident B did not have documentation of a TB test available for review. [Note: The administrator reported she would locate the document and fax to Team. As of 3/23/17, Team has not received anything.]
- Resident C's most recent individual care plan did not address the resident's toileting, grooming, medication or nutrition; the entire page was left blank.
- Resident C's most recent monthly observation note was dated 1/15/17.
- Resident D did not have a signed written agreement available.
- Resident D's most recent monthly observation note was dated 12/25/16.
- Resident D did not have a photograph available.
- Resident E's most recent physical examination was dated 2/23/16.
- Resident E's most recent individual care plan was dated 7/13/16.
- Resident E's most recent monthly observation note was dated 1/20/17; a December 2016 note was not available for review.
- Resident F's most recent physical examination did not address the resident's dietary needs.
- Resident F's most recent monthly observation note was dated 1/23/17.
- Resident F did not have documentation of a TB test available for review. [Note: The administrator reported she would locate the document and fax to Team. As of 3/23/17, Team has not received anything.]

Resident Personal Needs Allowances

- No concerns noted.

Appropriateness of Placement

- No concerns noted.

Personnel Records

- One staff member did not have a TB test available for review.

Housekeeping, Maintenance, Furnishings

- The railing on the front porch was loose.
- One bathroom did not have a hand drying device available.

Additional Recommendations

- Two residents would like to work.
- 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.