

BOARD OF HEALTH AND ENVIRONMENTAL CONTROL

SUMMARY SHEET

January 14, 2010

ACTION/DECISION

___ INFORMATION

- I. TITLE: Final Consideration for Final Approval - Proposed Revision of Regulation 61-84, Standards For Licensing Community Residential Care Facilities. State Register Document No. 4108
Legislative Review is Required
- II. SUBJECT: Request for Finding of Need and Reasonableness Pursuant to S.C. Code Section 1-23-111
- III. FACTS:

1. Pursuant to Section to S.C. Code Ann. Section 44-7-250, *et seq.*, Regulation 61-84, Standards for Licensing Community Residential Care Facilities, was published in the *State Register* on May 23, 1986, May 24, 1991, and was subsequently revised and published in the *State Register* on July 27, 2001. Since that time there have been changes in applicable laws, *e.g.*, criminal record checks of direct care staff, and there have been certain guidelines, directives, interpretations, and changes in Division policy that have led to the necessity to amend these regulations in order to make them more up-to-date.

2. S.C. Code Ann. Section 1-23-120 of the Administrative Procedures Act requires state agencies to perform a review of their regulations every five years and update them, if necessary.

3. As a result of the review of this regulation, certain sections of the regulation were identified as needing revision including: definitions, *i.e.*, proposed new definitions on airborne infection isolation, blood assay for Mycobacterium tuberculosis (BAMT), contact investigation, incident, latent TB infection (LTBI), private sitter, quarterly and risk assessment; revision of definitions: annual, local transportation, and peak hours; Non-Departmental publications referenced in this regulation; compliance with structural standards; the living quarters in the facility for individuals other than residents; application completion ; the fiscal responsibilities of the proposed facility licensee and facility licensee; license fees; Department reports availability; conditions affecting the determination of enforcement action; determination of monetary penalty amounts; appeal procedure for enforcement actions; facility responsibilities for written policies and procedures; a criminal background check for direct care staff; administrator licensing law; facility staff provision of care; staff training documentation and verification; staff provision of resident recreational activities; private sitters for residents (proposed new Section at 506); facility compliance with reporting of incidents; change of administrator reporting responsibilities; time period for notes of observation; age of resident photograph; resident assessment documentation requirements; criteria for resident admission and retention; documentation requirements for statement of resident rights and grievance procedures; resident finances fiscal management documentation; resident use of telephone; content of resident physical examination; medication and first aid items availability; medication and treatment orders; time period for physician signing verbal orders; documentation of treatments; clarification of unit dose system; refrigeration of medications; documentation of controlled substances; menu approvals for medically prescribed diets; facility staff use of alcohol-based hand sanitizers; counties affected by letter of agreement for sheltering facilities; documentation of continuity of

essential services; resident fire response training; tuberculin skin testing for residents and staff; health screening for facility pets; kitchen firefighting equipment; non-combustible or flame retardant materials; facility 'no smoking' areas; mirrors in resident rooms; use of bar soap in shared bathrooms; facility telephones for resident use; and barriers to natural or manmade bodies of water on or adjacent to the facility property. Additionally, there may be changes to improve its overall quality, *i.e.*, stylistic changes and language clarifications. The table of contents will be updated, and other minor corrections may be proposed as needed.

4. A Summary of the Revised Regulation and Text of the Proposed Amendment are submitted as Attachments B and C.

5. Department staff initiated the statutory process for revision of R.61-84 by publication of a Notice of Drafting in the *State Register* on May 22, 2009. Copies of a preliminary draft were provided to current community residential care facility administrators, providers, agencies, provider organizations, and other interested parties on May 22, 2009, for their review and the Department responded to their written questions and concerns. DHEC staff originally initiated the statutory process for revision of R.61-84 by publication of a Notice of Drafting in the *State Register* on May 23, 2008. Subsequently, DHEC staff determined that an expanded scope of revision was needed, and another Notice of Drafting was published in the *State Register* for revision on May 22, 2009. DHEC has received comments from members of the regulated community subsequent to May 22, 2009, as well as from other related sources, making written recommendations. DHEC staff consulted with and met formally with members of the Residential Care Advisory Committee, as well as with other members of the regulated community, on October 22, 2008, June 3, 2009, and November 17, 2009, and the proposed revision was discussed. Suggestions/comments from these sources were considered in the draft. A copy of the Notice of Drafting is submitted as Attachment F.

6. All comments received during the drafting public comment period were considered in formulating the proposed revision of R.61-84. The proposed revision was reviewed internally prior to seeking Board initial approval to provide notice of opportunity for public comment.

7. On October 8, 2009, the Board approved the publication of a Notice of Proposed Regulation that was published in the *State Register* on October 23, 2009, and for a Staff Informational Forum to be conducted on November 30, 2009. Also, a public hearing to be conducted by the Board was scheduled for January 14, 2010. The notice of proposed regulation, the Staff Informational Forum, and the public hearing for the proposed revision were also published on the Department's website in the Regulation Development Update. An excerpt of the Notice is submitted as Attachment E.

8. The Department received comments from the SC Association of Residential Care Homes (SCARCH), representing one hundred eighty-nine (189) members of the regulated community, the Sincere Homeowners United Together (SHOUT), representing twenty-nine (29) members of the regulated community, Aging Services of South Carolina, representing thirty-six (36) members of the regulated community, the South Carolina Assisted Living Federation of America (SCALFA), and five (5) other members of the regulated community. Six (6) other comments were received from interested parties including certain state agencies, and additional comments were received from Department staff during the forum comment period. All comments received during this period were considered in formulating the proposed revision before the Board.

9. Copies of the proposed revision were mailed to all commenters on January 3, 2010.

10. The final proposed regulation was approved by appropriate Department staff. A Summary and text of the Proposed Regulation are submitted as Attachments B and C. A Summary of Public Comments and Department Responses is submitted as Attachment D.

11. Department staff is requesting final approval of the proposed revision of R.61-84. If approved by the Board, the proposed revision will be filed with the Legislative Council for submission to the General Assembly for its review.

IV. ANALYSIS:

1. The proposed amendment is needed and reasonable because it will update and enhance the following areas: definitions, *i.e.*, proposed new definitions on airborne infection isolation, blood assay for *Mycobacterium tuberculosis* (BAMT), contact investigation, incident, latent TB infection (LTBI), private sitter, quarterly and risk assessment; revision of definitions: annual, local transportation, and peak hours; Non-Departmental publications referenced in this regulation; compliance with structural standards; the living quarters in the facility for individuals other than residents; application completion; the fiscal responsibilities of the proposed facility licensee and facility licensee; license fees; Department reports availability; conditions affecting the determination of enforcement action; determination of monetary penalty amounts; appeal procedure for enforcement actions; facility responsibilities for written policies and procedures; a criminal background check for direct care staff; administrator licensing law; facility staff provision of care; staff training documentation and verification; staff provision of resident recreational activities; private sitters for residents (proposed new Section at 506); facility compliance with reporting of incidents; change of administrator reporting responsibilities; time period for notes of observation; age of resident photograph; resident assessment documentation requirements; criteria for resident admission and retention; documentation requirements for statement of resident rights and grievance procedures; resident finances fiscal management documentation; resident use of telephone; content of resident physical examination; medication and first aid items availability; medication and treatment orders; time period for physician signing verbal orders; documentation of treatments; clarification of unit dose system; refrigeration of medications; documentation of controlled substances; menu approvals for medically prescribed diets; facility staff use of alcohol-based hand sanitizers; counties affected by letter of agreement for sheltering facilities; documentation of continuity of essential services; resident fire response training; tuberculin skin testing for residents and staff; health screening for facility pets; kitchen firefighting equipment; non-combustible or flame retardant materials; facility 'no smoking' areas; mirrors in resident rooms; use of bar soap in shared bathrooms; facility telephones for resident use; and barriers to natural or manmade bodies of water on or adjacent to the facility property.

Additionally, changes are proposed throughout the regulation to improve its overall quality, *i.e.*, stylistic changes and language clarifications. The table of contents will be updated and other minor corrections may be proposed as needed.

2. The proposed amendment is needed and reasonable because it will clarify/add to the current regulation in a manner that will improve individual agency methods to provide quality care/service to residents.

3. The proposed amendment is needed and reasonable because it will update the current regulation by incorporating certain exceptions/guidances that DHEC has implemented since the last revision.

4. A detailed Statement of Need and Reasonableness is submitted as Attachment A.

V. RECOMMENDATION: The Department's Bureau of Health Facilities Regulation recommends that the Board consider the attached information, find for the need and reasonableness of the proposed regulation, and approve it for submission to the legislature.

Dennis L. Gibbs
Director
Bureau of Health Facilities Regulation

Pamela M. Dukes
Deputy Commissioner
Health Regulation

Attachments:

- A. Statement of Need and Reasonableness and Statement of Rationale
- B. Summary of Proposed Revision
- C. Strikethrough/Underlined Version of Proposed Revision
- D. Summary of Public Comments and Department Response
- E. Excerpt of Notice of Proposed Regulation as Published in the *State Register*
- F. Notice of Drafting as Published in the *State Register*

ATTACHMENT A
STATEMENT OF NEED AND REASONABLENESS
OF PROPOSED AMENDMENT OF
R.61-84, STANDARDS FOR LICENSING COMMUNITY RESIDENTIAL CARE FACILITIES
January 14, 2010

This statement of need and reasonableness was determined by staff analysis pursuant to the SC Code, Sections 1-23-115(C)(1)-(3) and (9)-(11).

DESCRIPTION OF REGULATION: R.61-84, Standards For Licensing Community Residential Care Facilities.

Purpose of Regulation Amendment: This amendment will update certain sections of the regulation that need to be addressed as determined by staff review. The Department has conducted its five-year review of its regulations pursuant to S.C. Code, Section 1-23-120. R.61-84 has not been amended since July 27, 2001; it is necessary to amend the regulation to bring it current.

The Department proposes to amend Regulation 61-84 to update and enhance the following areas: definitions, *i.e.*, proposed new definitions on airborne infection isolation, blood assay for Mycobacterium tuberculosis (BAMT), contact investigation, incident, latent TB infection (LTBI), private sitter, quarterly and risk assessment; revision of definitions: annual, local transportation, and peak hours; Non-Departmental publications referenced in this regulation; compliance with structural standards; the living quarters in the facility for individuals other than residents; application completion ; the fiscal responsibilities of the proposed facility licensee and facility licensee; license fees; Department reports availability; conditions affecting the determination of enforcement action; determination of monetary penalty amounts; appeal procedure for enforcement actions; facility responsibilities for written policies and procedures; a criminal background check for direct care staff ; administrator licensing law; facility staff provision of care; staff training documentation and verification; staff provision of resident recreational activities; private sitters for residents (proposed new Section at 506); facility compliance with reporting of incidents; change of administrator reporting responsibilities; time period for notes of observation; age of resident photograph; resident assessment documentation requirements; criteria for resident admission and retention; documentation requirements for statement of resident rights and grievance procedures; resident finances fiscal management documentation; resident use of telephone; content of resident physical examination; medication and first aid items availability; medication and treatment orders; time period for physician signing verbal orders; documentation of treatments; clarification of unit dose system; refrigeration of medications; documentation of controlled substances; menu approvals for medically prescribed diets; facility staff use of alcohol-based hand sanitizers; counties affected by letter of agreement for sheltering facilities; documentation of continuity of essential services; resident fire response training; tuberculin skin testing for residents and staff; health screening for facility pets; kitchen firefighting equipment; non-combustible or flame retardant materials; facility 'no smoking' areas; mirrors in resident rooms; use of bar soap in shared bathrooms; facility telephones for resident use; and barriers to natural or manmade bodies of water on or adjacent to the facility property.

Additionally, changes will be proposed throughout the regulation to improve its overall quality, *i.e.*, stylistic changes and language clarifications. The table of contents will be updated, and other minor corrections may be proposed as needed. See Determination of Need and Reasonableness below.

Legal Authority. Section 44-7-250, S.C. Code of Laws (1976, as amended)

Plan for Implementation: The proposed amendment will take effect upon publication in the *State Register*

following approval by the Board and the General Assembly. The proposed amendment will be implemented by providing the regulated community with copies of the regulation, and enforced through inspections by DHEC.

This regulation revision is needed and reasonable because its development will satisfy a legislative mandate pursuant to S.C. Code Ann. Section 1-23-120.

The regulation was last amended July 27, 2001. Since that time there have been changes in applicable laws, *e.g.*, criminal record checks of direct care staff, Bill of Rights for Residents of Long-Term Care Facilities, and there have been certain guidelines, directives, interpretations, and changes in Division policy that have led to the necessity to amend these regulations in order to make them more up-to-date.

The proposed amendment is needed and reasonable in order to update and improve the overall quality of the regulation.

The proposed amendment is needed and reasonable because it will clarify/add to the current regulation in a manner that will improve individual agency methods to provide quality care/service to residents.

The proposed amendment is needed and reasonable because it will update the current regulation by incorporating certain exceptions/guidances that the Department has implemented since the last revision.

DETERMINATION OF COSTS AND BENEFITS: There will be no cost to political subdivisions of the state. There will be minimal costs to the regulated community. The revision includes an incremental fee increase beginning the January subsequent to the effective date of the regulation from \$10 per licensed bed to \$15 per licensed bed to \$20 per licensed bed over a three-year period. Such increase in fees is not excessive on a per license basis.

Processing applications for the community residential care facility licensing program requires considerable commitment of the Department's fiscal resources. Inflation has increased the costs associated with inspections, investigations, processing licenses, and travel. Program costs have been incurred for increased confidentiality requirements of Department records, contributing to an overall increase in costs to run an effective program. The anticipated growth of elderly citizens needing community residential care in South Carolina will increase the demands on Department staff and resources. In addition, in expanding its enforcement of the regulation, the Department has increased its onsite consultation efforts to foster regulatory compliance, and such activity is an added cost.

The program will be able to continue service to the state's community residential care providers and residents in a timely, effective and efficient manner. The public's health and environment will be protected by the continued vigilance of regulatory oversight of this program.

Community residential care facility fees have not increased since 2001. Even though there was a fee increase in 2001, since the 2001 fiscal year, the fees have still generated less money than is needed to operate the program. The program remains underfunded until such time as a fee increase is authorized.

Monies generated over and above the costs of the current program go into the general fund to cover the costs of inflation and increased costs incurred over the years. According to the U.S. Department of Labor, Bureau of Labor Statistics, costs have increased on average approximately 3% per year since 2001, including a Consumer Price Index average for 2008 that reflected a 3.8% increase. With the probable continued increases in costs, the proposed fee increase is both reasonable and necessary.

UNCERTAINTIES OF ESTIMATES: None

EFFECT ON ENVIRONMENT AND PUBLIC HEALTH: There will be no effect on the environment. The regulation revision will promote public health by updating standards for regulating community residential care facilities.

DETRIMENTAL EFFECT ON THE ENVIRONMENT AND PUBLIC HEALTH IF THE REGULATION AMENDMENT IS NOT IMPLEMENTED: There will be an adverse effect on the public health if the regulation revision is not implemented since it is likely that continuing to utilize an outdated regulation for regulatory purposes would not advance the promotion of preventing negative health outcomes. There will be possible detrimental effect on public health in general and vulnerable adults specifically because the program will not have the resources to continue vigilant regulatory oversight of community residential care facilities in a timely, effective, and efficient manner.

ATTACHMENT B
SUMMARY OF PROPOSED REVISION OF
R.61-84, STANDARDS FOR LICENSING COMMUNITY RESIDENTIAL CARE FACILITIES
January 14, 2010

Table of Contents:

The table has been updated and is being replaced in its entirety with classifications and punctuation added for consistency with the text of the regulation.

Body of Document:

Section 100 includes definitions and references.

- 101.F. - This proposed subsection adds and defines “Airborne Infection Isolation”.
- 101.H. - This subsection defines “Annual” and is revised from “once every 365 days” to “at least every twelve to thirteen (12 to 13) months.”
- 101.L. - This proposed subsection adds and defines “Blood Assay for *Mycobacterium tuberculosis* (BAMT)”.
- 101.O. - This proposed subsection adds and defines “Contact Investigation”.
- 101.BB. - This proposed subsection adds and defines “Incident”.
- 101.GG. - This proposed subsection adds and defines “Latent TB Infection (LTBI)”.
- 101.HH. – This subsection defines “Legend Drug” and is revised for wording clarity.
- 101.LL. – This subsection defines “Local Transportation” and is revised to include “as addressed by the resident written agreement” and deletes the term “and needs.”
- 101.PP. – This subsection defines “Peak Hours” and is revised to include a requirement for reporting facility peak hours to the Department.
- 101.WW. - This proposed subsection adds and defines “Private Sitter”.
- 101.YY. - This proposed subsection adds and defines “Quarterly”.
- 101.III. - This proposed subsection adds and defines “Risk Assessment”.

Section 102. References

- 102.B.18. - This proposed subsection adds a reference for “Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health Care Settings” (2005).

Section 103. License Requirements

103.B. - This subsection is revised for wording clarity.

103.D. - This subsection is deleted.

103.F – This subsection is revised to clarify who may or may not occupy resident rooms, other bedrooms within the facility or resident recreational or dining areas.

103.I – This subsection is revised to clarify the requirements for submitting an application for license.

103.J – This subsection is revised to address a criminal background check for proposed licensees and deletes the requirement for letters of reference.

103.K – This subsection is revised to address a licensing fee increase from \$10 per licensed bed to an incremental change from \$15 to \$20 per licensed bed over a three year period. In addition, the subsection is revised to address an initial license fee of \$500 for proposed facilities with sixteen (16) or more proposed licensed beds and \$250 for less than sixteen (16) proposed licensed beds. In those instances where there is a proposed licensed bed increase through application with the Department, in addition to the annual license fee, there shall be an initial proposed license bed increase fee of \$500 with sixteen (16) or more proposed licensed beds and \$250 for less than sixteen (16) proposed licensed beds.

Section 200. Enforcing Regulations

202.E. – This subsection is revised to address the posting of inspection reports.

Section 302. Violation Classifications

302.E. – This subsection is revised to address factors that may result in enforcement actions.

302.F. – This subsection is revised and adjusted for consistency with S.C. state statute.

302.G. – This subsection addresses Departmental decisions regarding enforcement actions and the appeals process available to affected parties. Also clarification for code of applicable laws.

Section 400. Policies and Procedures

401.A. – This subsection requires facility policies and procedures to be written.

Section 500. Staff/Training

501.B. – This subsection addresses the employment requirement for direct care staff/direct care volunteers to include a criminal record check in accordance with applicable law, as amended. This also addresses criminal background checks for contracted private sitters.

502.A. – This subsection addresses the applicable code of laws requiring an administrator to be licensed.

503.B. – This subsection is revised to clarify that direct care duties include “supervision” of residents.

504.A. – This introductory only subsection is revised to update staff and private sitter training requirements and requires documentation of the training.

504.B. – This subsection addresses the designation and training of staff responsible for resident recreational activities and requires documentation of the training.

506. - This proposed section is added to address contractual requirements for private sitters, including, but not limited to, policy and procedure requirements; the requirement to check for prior convictions pursuant to Section 501.B.; orientation to the facility; health assessment and determination of TB status; and exclusion from minimum staffing requirements of Section 503.A.

Section 601. Incidents/Accidents – Subsection title revised.

601.A-I. – This subsection is revised and addresses changes in incident reporting to the Department and updates examples of incidents to be included in a report as well as the statutory requirement to report resident abuse to the South Carolina Long Term Care Ombudsman Program.

Section 604. Administrator Change

604. – This subsection addresses reporting requirements for a change of administrator and the hours the new appointee will be working. In addition, there is a stylistic change for clarity.

Section 700. Resident Records

701.B.6. - This subsection is revised to require daily and/or monthly notes of observation according to resident's condition.

701.B.10. – This subsection is revised to address the conditions under which a resident photograph is updated, including photograph size.

702. – This subsection addresses documentation requirements for resident assessments.

Section 800. Admission/Retention

801.B-C. – This subsection is revised to clarify the conditions under which individuals are not eligible for admission or retention in a community residential care facility and to clarify levels of violation classifications.

Section 900. Resident Care/Services

901.A.8. – This subsection is revised to address the requirement for Resident's Bill of Rights and grievance procedures to be documented.

902.H. – This subsection addresses the availability of resident funds quarterly reports.

Section 1000. Rights and Assurances

1001.L. – This subsection clarifies resident freedom to use the telephone.

Section 1100. Resident Physical Examination and TB

1101.A. – This subsection is revised to include permitting physicians licensed in states other than South Carolina to perform the admission physical examination and to rearrange numerically the required components of the physical examination.

1101.F. – This subsection is revised for consistency and clarity with revised Section 1702.

1101.G. – This subsection is revised for consistency and clarity with revised Section 1702. In addition, there are stylistic changes for clarity.

Section 1200. Medication Management

1201.A. – This subsection addresses the availability of medications and supplies.

1202. – This subsection title is revised to include treatment orders.

1202.A. – This subsection addresses physician orders for medications and treatments.

1202.B. – This subsection addresses the signing and dating of physician orders.

1203. – This subsection title is renamed to include treatment administration.

1203.A. – This subsection addresses the administration and documentation of treatments.

1205.B. – This subsection addresses medication containers, *i.e.*, the multi-dose system.

1206.A. – This subsection addresses the storage of refrigerated medications and adds the requirement for thermometers in medication storage refrigerators.

1206.C. – This subsection addresses control and accountability of controlled medications.

Section 1300. Meal Service

1306.A. – This subsection addresses menu planning and documentation requirements. It adds the requirement that all special diet menus be signed and dated by a dietitian, physician or other authorized healthcare provider.

1309.A. – This subsection addresses the use of alcohol-based waterless hand sanitizers.

Section 1400. Emergency Procedures/Disaster Preparedness

1401.B.1.c. – This subsection revises the sheltering plan requirement for Berkeley and Dorchester counties.

1403. – This subsection is revised to require that the continuity of essential services plan be written.

Section 1500. Fire Prevention

1503.C. – This subsection revises the fire response training requirement for residents to assist other residents in case of fire.

Section 1700. Infection Control and Environment

1702.A-D. - This subsection is revised to address the requirement for a facility to conduct an annual tuberculosis risk assessment to determine the facility's risk classification. It updates the requirement for staff/volunteer/private sitter and resident tuberculosis screening in accordance with the 2005 CDC guidelines.

Proposed items added include the use of alternative tuberculosis screening elements, the BAMT. This subsection also addresses resident isolation requirements that include reference to an Airborne Infection Isolation room as required by the CDC if the resident with contagious pulmonary tuberculosis remains in the facility.

1705.A. – This subsection addresses health screening requirements for pets prior to resident contact. The change was proposed in error to occur at 1705.B in the *State Register* Notice of Drafting, but will occur at 1705.A. The change, as proposed, was not altered; only the section where placed.

Section 2200. Fire Protection Equipment and Systems

2201.D. – This subsection addresses fire extinguishers located in the kitchen.

2207.D. – This subsection deletes portable partitions from the furnishings/equipment that must be in accordance with NFPA 701, Standard Methods of Fire Tests for Flame-Resistant Textiles and Films. In addition, there is a stylistic change for clarity.

2207.E. – This proposed subsection item is added to address designated smoking/non-smoking areas of the facility.

2207.F. – The change was proposed in error and is not included in the text as the fire code addresses areas where signage is required.

Section 2700. Physical Plant

2702.J. – This subsection revises the requirement for mirrors in resident rooms. In addition, there is a stylistic change for clarity.

2704.D. – This subsection addresses the communal use of bar soap in resident bathing areas. In addition, there is a stylistic change for clarity.

2715.A. – This subsection addresses fixed line telephone service. In addition, there is a stylistic change for clarity.

2717.A. – This subsection is revised to delete examples of outdoor areas routinely used by residents where unsafe physical hazards exist.

ATTACHMENT C

Strikethrough/Underlined Version of Proposed Revision
DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL
CHAPTER 61

Statutory Authority: S.C. Code Ann. Section 44-7-250, *et seq*

TEXT OF PROPOSED REVISION
R.61-84, STANDARDS FOR LICENSING COMMUNITY RESIDENTIAL CARE FACILITIES
January 14, 2010

~~Indicates Matter Stricken~~

Indicates New Matter

Text:

61-84. Standards for Licensing Community Residential Care Facilities.

Replace Table of Contents to read:

Table of Contents

SECTION 100 - DEFINITIONS AND LICENSE REQUIREMENTS

101. Definitions.

102. References.

103. License Requirements (II).

SECTION 200 - ENFORCING REGULATIONS

201. General.

202. Inspections/Investigations.

203. Consultations.

SECTION 300 - ENFORCEMENT ACTIONS

301. General.

302. Violation Classifications.

SECTION 400 - POLICIES AND PROCEDURES

401. General (II).

SECTION 500 - STAFF/TRAINING

- 501. General (II).
- 502. Administrator (II).
- 503. Staffing (I).
- 504. Inservice Training (II).
- 505. Health Status (I).
- 506. Private Sitters (II).
- SECTION 600 - REPORTING
- 601. Incidents/~~Accidents~~.
- 602. Fire/Disasters (II).
- 603. Communicable Diseases and Animal Bites (I).
- 604. Administrator Change.
- 605. Accounting of Controlled Substances (II).
- 606. Emergency Placements.
- 607. Facility Closure.
- 608. Zero Census.
- SECTION 700 - RESIDENT RECORDS
- 701. Content (II).
- 702. Assessment (II).
- 703. Individual Care Plan (II).
- 704. Record Maintenance.
- SECTION 800 - ADMISSION/RETENTION
- 801. General (I).
- SECTION 900 - RESIDENT CARE/SERVICES
- 901. General.
- 902. Fiscal Management (II).
- 903. Recreation.
- 904. Transportation (I).
- 905. Safety Precautions/Restraints (I).
- 906. Discharge/Transfer.
- SECTION 1000 - RIGHTS AND ASSURANCES
- 1001. General (I).
- SECTION 1100- RESIDENT PHYSICAL EXAMINATION AND TB SCREENING
- 1101. General (II).
- SECTION 1200 - MEDICATION MANAGEMENT
- 1201. General (I).
- 1202. Medication and Treatment Orders (I).
- 1203. Administering Medication/Treatments (I).
- 1204. Pharmacy Services (I).
- 1205. Medication Containers (I).
- 1206. Medication Storage (I).
- 1207. Disposition of Medications (I).
- SECTION 1300 - MEAL SERVICE
- 1301. General (II).
- 1302. Food and Food Storage.
- 1303. Food Equipment and Utensils (II).
- 1304. Meals and Services.
- 1305. Meal Service Personnel (II).
- 1306. Diets.
- 1307. Menus.

1308. Ice and Drinking Water (II).
1309. Equipment (II).
1310. Refuse Storage and Disposal (II).
SECTION 1400 - EMERGENCY PROCEDURES/DISASTER PREPAREDNESS
1401. Disaster Preparedness (II).
1402. Emergency Call Numbers.
1403. Continuity of Essential Services (II).
SECTION 1500 - FIRE PREVENTION
1501. Arrangements for Fire Department Response/Protection (I).
1502. Tests and Inspections (I).
1503. Fire Response Training (I).
1504. Fire Drills (I).
SECTION 1600 - MAINTENANCE
1601. General (II).
SECTION 1700 - INFECTION CONTROL AND ENVIRONMENT
1701. Staff Practices (I).
1702. Tuberculin Skin Testing (I).
1703. Housekeeping (II).
1704. Infectious Waste (I).
1705. Pets (II).
1706. Clean/Soiled Linen and Clothing (II).
SECTION 1800 - QUALITY IMPROVEMENT PROGRAM
1801. General (II).
SECTION 1900 - DESIGN AND CONSTRUCTION
1901. General (II).
1902. Local and State Codes and Standards (II).
1903. Construction/Systems (II).
1904. Submission of Plans and Specifications.
SECTION 2000 - GENERAL CONSTRUCTION REQUIREMENTS
2001. Height and Area Limitations (II).
2002. Fire-Resistive Rating (I).
2003. Vertical Openings (I).
2004. Wall and Partition Openings (I).
2005. Ceiling Openings (I).
2006. Firewalls (I).
2007. Floor Finishes (II).
2008. Wall Finishes (I).
2009. Curtains and Draperies (II).
SECTION 2100 - HAZARDOUS ELEMENTS OF CONSTRUCTION
2101. Furnaces and Boilers (I).
2102. Dampers (I).
SECTION 2200 - FIRE PROTECTION EQUIPMENT AND SYSTEMS
2201. Firefighting Equipment (I).
2202. Automatic Sprinkler System (I).
2203. Fire Alarms (I).
2204. Smoke Detectors (I).
2205. Flammable Liquids (I).
2206. Gases (I).
2207. Furnishings/Equipment (I).

SECTION 2300 - EXITS

2301. Number and Locations of Exits (I).

SECTION 2400 - WATER SUPPLY/HYGIENE

2401. Design and Construction (II).

2402. Disinfection of Water Lines (I).

2403. Temperature Control (I).

2404. Stop Valves.

2405. Cross-connections (I).

2406. Design and Construction of Wastewater Systems (I).

SECTION 2500 - ELECTRICAL

2501. General (I).

2502. Panelboards (II).

2503. Lighting.

2504. Receptacles (II).

2505. Ground Fault Protection (I).

2506. Exit Signs (I).

2507. Emergency Electric Service (I).

SECTION 2600 - HEATING, VENTILATION, AND AIR CONDITIONING

2601. General (II).

SECTION 2700 - PHYSICAL PLANT

2701. Facility Accommodations/Floor Area (II).

2702. Resident Rooms.

2703. Resident Room Floor Area.

2704. Bathrooms/Restrooms (II).

2705. Doors (II).

2706. Elevators (II).

2707. Corridors (II).

2708. Ramps (II).

2709. Landings (II).

2710. Handrails/Guardrails (II).

2711. Screens (II).

2712. Windows/Mirrors.

2713. Janitor's Closet (II).

2714. Storage Areas.

2715. Telephone Service.

2716. Location.

2717. Outdoor Area.

SECTION 2800 - SEVERABILITY

2801. General.

SECTION 2900 - GENERAL

2901. General.

SECTION 100 - DEFINITIONS AND LICENSE REQUIREMENTS

Add eight new definitions to Section 101 in alphabetical order and adjust outline; revise three existing definitions, to read:

101. Definitions

F. Airborne Infection Isolation (AII). A room designed to maintain Airborne Infection Isolation, formerly called a negative pressure isolation room. An Airborne Infection Isolation room is a single-occupancy resident care room used to isolate persons with suspected or confirmed infectious tuberculosis (TB) disease. Environmental factors are controlled in Airborne Infection Isolation rooms to minimize the transmission of infectious agents that are usually spread from person-to-person by droplet nuclei associated with coughing or aerosolization of contaminated fluids. Airborne Infection Isolation rooms may provide negative pressure in the room (so that air flows under the door gap into the room), an air flow rate of six to twelve (6 to 12) air changes per hour (ACH), and direct exhaust of air from the room to the outside of the building or recirculation of air through a high efficiency particulate air (HEPA) filter.

~~F.G.~~ Alzheimer's Special Care Unit or Program. A facility or area within a facility providing a secure, segregated special program or unit for residents with a diagnosis of probable Alzheimer's disease and/or related dementia to prevent or limit access by a resident outside the designated or separated areas, and that advertises, markets, or otherwise promotes the facility as providing specialized care/services for persons with Alzheimer's disease and/or related dementia or both.

~~G.H.~~ Annual. ~~Once each 365 days.~~ A time period that requires an activity to be performed at least every twelve to thirteen (12 to 13) months.

~~H.I.~~ Architect. An individual currently registered as such by the S.C. State Board of Architectural Examiners.

~~H.J.~~ Assessment. A procedure for determining the nature and extent of the problem(s) and needs of a resident/potential resident to ascertain if the facility can adequately address those problems, meet those needs, and to secure information for use in the development of the individual care plan. Included in the process are an evaluation of the physical, emotional, behavioral, social, spiritual, nutritional, recreational, and, when appropriate, vocational, educational, legal status/needs of a resident/potential resident. Consideration of each resident's needs, strengths, and weaknesses shall be included in the assessment.

~~H.K.~~ Authorized Healthcare Provider. An individual authorized by law and currently licensed in S.C. to provide specific treatments, care, or services to residents. Examples of individuals who may be authorized by law to provide the aforementioned treatment/care/services may include, but are not limited to, advanced practice registered nurses, physician's assistants.

L. Blood Assay for *Mycobacterium tuberculosis* (BAMT). A general term to refer to *in vitro* diagnostic tests that assess for the presence of tuberculosis (TB) infection with *M. tuberculosis*. This term includes, but is not limited to, IFN- γ release assays (IGRA).

~~K.M.~~ Boarding House. A business/entity which provides room and board to an individual(s) and which does not provide a degree of personal care to more than one individual.

~~L.N.~~ Community Residential Care Facility (CRCF). 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.

M-O. Contact Investigation. Procedures that occur when a case of infectious TB is identified, including finding persons (contacts) exposed to the case, testing and evaluation of contacts to identify Latent TB Infection (LTBI) or TB disease, and treatment of these persons, as indicated.

P. Controlled Substance. A medication or other substance included in Schedule I, II, II, IV, and V of the Federal Controlled Substances Act and the South Carolina Controlled Substances Act.

N-Q. Consultation. A visit to a licensed facility by individuals authorized by the Department to provide information to facilities to enable/encourage facilities to better comply with the regulations.

O-R. Dentist. An individual currently licensed to practice dentistry by the S.C. Board of Dentistry.

P-S. Dietitian. A person who is registered by the Commission on Dietetic Registration.

Q-T. Department. The S.C. Department of Health and Environmental Control (DHEC).

R-U. Designee. A staff member designated by the administrator to act on his/her behalf.

S-V. Direct Care Staff Member/Direct Care Volunteer. Those individuals who provide assistance with activities of daily living to residents.

T-W. Discharge. The point at which residence in a facility is terminated and the facility no longer maintains active responsibility for the care of the resident.

U-X. Dispensing Medication. The transfer of possession of one or more doses of a drug or device by a licensed pharmacist or person as permitted by law, to the ultimate consumer or his/her agent pursuant to a lawful order of a practitioner in a suitable container appropriately labeled for subsequent administration to, or use by a resident.

Y-Y. Existing Facility. A facility which was in operation and/or one which, as approved by the Department, began the construction or renovation of a building, for the purpose of operating the facility, prior to the promulgation of this regulation. The licensing standards governing new facilities apply if and when an existing facility is not continuously operated and licensed under this regulation.

WZ. Facility. A community residential care facility licensed by the Department.

X-AA. 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.

BB. Incident. An unusual unexpected adverse event resulting in harm, injury, or death of staff or residents, accidents, e.g., medication errors, adverse medication reactions, elopement of a resident.

Y-CC. Individual Care Plan (ICP). A documented regimen of appropriate care/services or written action plan prepared by the facility for each resident based on assessment data and which is to be implemented for the benefit of the resident.

~~Z-DD~~. Initial License. A license granted to a new facility.

~~AA-EE~~. Inspection. A visit by authorized individuals to a facility or to a proposed facility for the purpose of determining compliance with this regulation.

~~BB-FF~~. Investigation. A visit by authorized individuals to a licensed or unlicensed entity for the purpose of determining the validity of allegations received by the Department relating to this regulation.

GG. Latent TB Infection (LTBI). Infection with *M. tuberculosis*. Persons with Latent TB Infection carry the organism that causes TB but do not have TB disease, are asymptomatic, and are noninfectious. Such persons usually have a positive reaction to the tuberculin skin test and/or positive BAMT.

~~CC-HH~~ Legend Drug.

1. A drug when, under federal law, is required, prior to being dispensed or delivered, to be labeled with any of the following statements:

- a. "Caution: Federal law prohibits dispensing without prescription";
- b. "Rx only" or;

2. A drug which is required by any applicable federal or state law to be dispensed pursuant only to a prescription drug order or is restricted to use by practitioners only;

3. Any drug products considered to be a public health threat, after notice and public hearing as designated by the S.C. Board of Pharmacy; or

4. Any prescribed compounded prescription ~~is a legend~~ drug within the meaning of the Pharmacy Act.

~~DD-II~~. License. The authorization to operate a facility as defined in this regulation and as evidenced by a current certificate issued by the Department to a facility.

~~EE-JJ~~. Licensed Nurse. A person to whom the S.C. Board of Nursing has issued a license as a registered nurse or licensed practical nurse.

~~FF-KK~~. Licensee. The individual, corporation, organization, or public entity that has received a license to provide care/services at a facility and with whom rests the ultimate responsibility for compliance with this regulation.

~~GG-LL~~. Local Transportation. The maximum travel distance the facility shall undertake, at no cost to the resident, as addressed by the resident written agreement, to secure/provide health care for residents. Local transportation shall be based on a reasonable assessment of the proximity of customary health care resources in the region, *e.g.*, nearest hospitals, physicians and other health care providers, and appropriate consideration of resident preferences. ~~and needs~~

~~HH-MM~~. Medication. A substance that has therapeutic effects, including, but not limited to, legend, nonlegend, herbal products, over-the counter, nonprescription, vitamins, and nutritional supplements, etc.

~~II.NN.~~ II.NN. New Facility. All buildings or portions of buildings, new and existing building(s), that are:

1. Being licensed for the first time;
2. Providing a different service that requires a change in the type of license;
3. Being licensed after the previous licensee's license has been revoked, suspended, or after the previous licensee has voluntarily surrendered the license and the facility has not continuously operated.

~~II.OO.~~ II.OO. Nonlegend Drug. A drug which may be sold without a prescription and which is labeled for use by the consumer in accordance with the requirements of the laws of this State and the federal government.

~~KK.PP.~~ KK.PP. Peak Hours. Those hours from 7 a.m. to 7 p.m., or as otherwise ~~determined by the facility, which shall be justifiable and reasonable, and in consideration of residents' presence in the facility, and acuity of their needs~~ approved in writing by the Department.

~~LL.QQ.~~ LL.QQ. Personal Care. The provision by the staff members/direct care volunteers of the facility of one or more of the following services, as required by the individual care plan or orders by the physician or other authorized healthcare provider or as reasonably requested by the resident, including:

1. Assisting and/or directing the resident with activities of daily living;
2. Being aware of the resident's general whereabouts, although the resident may travel independently in the community;
3. Monitoring of the activities of the resident while on the premises of the residence to ensure his/her health, safety, and well-being.

~~MM.RR.~~ MM.RR. Personal Monies. All monies which are available to the resident for his/her personal use, including family donations.

~~NN.SS.~~ NN.SS. Pharmacist. An individual currently registered as such by the S.C. Board of Pharmacy.

~~OO.TT.~~ OO.TT. Physical Examination. An examination of a resident by a physician or other authorized healthcare provider which addresses those issues identified in Section 1101 of this regulation.

~~PP.UU.~~ PP.UU. Physician. An individual currently licensed to practice medicine by the S.C. Board of Medical Examiners.

~~QQ.VV.~~ QQ.VV. Physician's Assistant. An individual currently licensed as such by the S.C. Board of Medical Examiners.

~~WW.~~ WW. Private Sitter. A private contractor not associated with or employed by the facility with whom the resident or the resident's responsible party contracts to provide sitter or companion services.

~~RR.XX.~~ RR.XX. Quality Improvement Program. The process used by a facility to examine its methods and practices of providing care/services, identify the ways to improve its performance, and take actions that result in higher quality of care/services for the facility's residents.

YY. Quarterly. A time period that requires an activity to be performed at least four (4) times a year within intervals ranging from eighty-one to ninety-nine (81 to 99) days.

~~SS-ZZ.~~ Ramp. An inclined accessible route that facilitates entrance to or egress from or within a facility.

~~TT-AAA.~~ Related/Relative. This degree of kinship is considered “within the third degree of consanguinity,” *e.g.*, a spouse, son, daughter, sister, brother, parent, aunt, uncle, niece, nephew, grandparent, great-grandparent, grandchild, or great-grandchild.

~~UU-BBB.~~ Repeat Violation. The recurrence of a violation cited under the same section of the regulation within a 36-month period. The time-period determinant of repeat violation status is applicable in instances when there are ownership changes.

~~VV-CCC.~~ Resident. Any individual, other than staff members/volunteers or owner and their family members, who resides in a facility.

~~WW-DDD.~~ Resident Room. An area enclosed by four ceiling high walls that can house one or more residents of the facility.

~~XX-EEE.~~ Respite Care. Short-term care (a period of six weeks or less) provided to an individual to relieve the family members or other persons caring for the individual.

~~YY-FFF.~~ Responsible Party. A person who is authorized by law to make decisions on behalf of a resident, to include, but not be limited to, a court-appointed guardian (or legal guardian as referred to in the Resident’s Bill of Rights) or conservator, or health care or other durable power of attorney.

~~ZZ-GGG.~~ Restraint. A device which inhibits the movement of a resident, *e.g.*, posey vest, geri-chair.

~~AAA.HHH.~~ Revocation of License. An action by the Department to cancel or annul a facility license by recalling, withdrawing, or rescinding its authority to operate.

III. Risk Assessment. An initial and ongoing evaluation of the risk for transmission of *M. tuberculosis* in a particular healthcare setting. To perform a risk assessment, the following factors shall be considered: the community rate of TB, number of TB patients encountered in the setting, and the speed with which patients with TB disease are suspected, isolated, and evaluated. The TB risk assessment determines the types of administrative and environmental controls and respiratory protection needed for a setting.

~~BBB-IJJ.~~ Sponsor. The public agency or individual involved in one or more of the following: protective custody authorized by law, placement, providing ongoing services, or assisting in providing services to a resident(s) consistent with the wishes of the resident or responsible party or specific administrative or court order.

~~CCC-LLL.~~ Staff Member. An adult, to include the administrator, who is a compensated employee of the facility on either a full or part-time basis.

~~DDD-LLL.~~ Suspend License. An action by the Department requiring a facility to cease operations for a period of time or to require a facility to cease admitting residents, until such time as the Department rescinds that restriction.

~~EEEE~~ MMM. Volunteer. An adult who performs tasks at the facility at the direction of the administrator without compensation.

102. References.

Revise Section 102.B.18 to read:

18. Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings, December 30, 2005;

103. License Requirements (II).

Revise five subsections in Section 103; delete one subsection; adjust outline in alphabetical order.

B. Compliance. An initial license shall not be issued to a proposed facility that has ~~been not~~ not been previously and continuously licensed under Department regulations until the licensee has demonstrated to the Department that the proposed facility is in substantial compliance with the licensing standards. In the event a licensee who already has a facility/activity licensed by the Department makes application for another facility or increase in licensed bed capacity, the currently licensed facility/activity shall be in substantial compliance with the applicable standards prior to the Department issuing a license to the proposed facility or amended license to the existing facility. A copy of the licensing standards shall be maintained at the facility and accessible to all staff members/volunteers. Facilities shall comply with applicable local, state, and federal laws, codes, and regulations.

~~D. Compliance with Structural Standards, upon Change of Ownership, No later than December 31, 2015. When changes in ownership occur, the new licensee shall, through coordination with the Department's Division of Health Facilities Construction, formulate a plan for the facility to shall be in compliance with current building and fire and life safety codes within 24 months of the date of the ownership change, unless specific standards are exempted by the Department. Facilities are not required to modify square footage of resident rooms and maximum number of beds in resident rooms, except that those facilities which that have resident rooms with five (5) or more licensed beds shall reduce the maximum number of beds per room to no more than four (4) within 12 months from the date of ownership change. no later than December 31, 2015.~~

~~ED~~. Licensed Bed Capacity. No facility that has been authorized to provide a set number of licensed beds, as identified on the face of the license, shall exceed the bed capacity. No facility shall establish new care/services or occupy additional beds or renovated space without first obtaining authorization from the Department. Beds for use of staff members/volunteers are not included in the licensed bed capacity number, provided such beds and locations are so identified and used exclusively by staff members/volunteers. (I)

~~FE~~. Persons Received in Excess of Licensed Bed Capacity. No facility shall receive for care or services persons in excess of the licensed bed capacity, except in cases of justified emergencies. (I)

EXCEPTION: In the event that the facility temporarily provides shelter for evacuees who have been displaced due to a disaster, then for the duration of that emergency, provided the health, safety, and well-being of all residents are not compromised, it is permissible to temporarily exceed the licensed capacity for the facility in order to accommodate these individuals (See Section 606).

~~GF~~. Living Quarters for Staff Members. In addition to residents, only staff members, volunteers, or

owners of the facility and members of the owner's immediate family may reside in facilities licensed under this regulation. Resident rooms shall not be utilized by ~~staff members/family/volunteers~~ any individuals other than facility residents, nor shall bedrooms of ~~staff members/family/volunteers~~ members of the owner or the licensee/volunteers be utilized by residents. Staff members/family members of the owner or licensee/volunteers shall not use resident living rooms, recreational areas or dining rooms unless they are on duty.

HG. Issuance and Terms of License.

1. A license is issued by the Department and shall be posted in a conspicuous place in a public area within the facility.

2. The issuance of a license does not guarantee adequacy of individual care, services, personal safety, fire safety, or the well-being of any resident or occupant of a facility.

3. A license is not assignable or transferable and is subject to revocation at any time by the Department for the licensee's failure to comply with the laws and regulations of this State.

4. A license shall be effective for a specified facility, at a specific location(s), for a specified period following the date of issue as determined by the Department. A license shall remain in effect until the Department notifies the licensee of a change in that status.

5. Facilities owned by the same entity but which are not located on the same adjoining or contiguous property shall be separately licensed. Roads or local streets, except limited access, *e.g.*, interstate highways, shall not be considered as dividing otherwise adjoining or contiguous property.

6. Separate licenses are not required, but may be issued, for separate buildings on the same or adjoining grounds where a single level or type of care is provided.

7. Multiple types of facilities on the same premises shall be licensed separately even though owned by the same entity.

8. Facilities may furnish respite care provided compliance with the standards of this regulation are met.

HI. Facility Name. No proposed facility shall be named nor shall any existing facility have its name changed to the same or similar name as any other facility licensed in S.C. The Department shall determine if names are similar. If the facility is part of a "chain operation" it shall then have the geographic area in which it is located as part of its name.

II. Application. Applicants for a license shall submit to the Department a completed and accurate application on a form prescribed and furnished by the Department prior to initial licensing and periodically thereafter at intervals determined by the Department. The application includes both the applicant's oath assuring that the contents of the application are accurate/true, and that the applicant will comply with this regulation. The application shall be signed by the owner(s) if an individual or partnership; in the case of a corporation, by two of its officers; or in the case of a governmental unit, by the head of the governmental department having jurisdiction. The application shall set forth the full name and address of the facility for which the license is sought and of the owner in the event his/her address is different from that of the facility, the names of the persons in control of the facility. The Department may require additional information,

including affirmative evidence of the applicant's ability to comply with these regulations. Corporations or limited partnerships, limited liability companies or any other organized business entity shall must be registered with the S. C. Office of the Secretary of State if required to do so by S. C. state law.

~~K~~J. Licensee. Prior to the Department issuing an initial license, the proposed A-licensee shall submit to the Department the result of a criminal background check (CBC). original letters of reference from three persons not related to, nor employed by the licensee, that attest to the licensee's reputable and responsible character, and the financial ability and competence to operate a community residential care facility (if owner is a corporation, then references for the chief executive officer of the corporation; if a partnership, then references for each partner owning five percent or more). One of the references shall be the result of a criminal background check with S.C. State Law Enforcement, or by letter from the local police department. The extent of the CBC shall, at a minimum, include a state background check conducted by the S. C. State Law Enforcement Division (SLED). If the licensee is a corporation, limited partnership, limited liability company or any other organized business entity, then the CBC shall be conducted on the chief executive officer or head of that entity; if a partnership, then the CBC shall be conducted on each partner owning five percent (5%) or more. For e Out-of-state licensees, references shall, at a minimum, include a state criminal background check CBC from that state where the licensee currently resides in addition to the S.C. CBC conducted by SLED. If the licensee has been a resident of South Carolina or any other state for less than twelve (12) months, or residency for twelve (12) months or more cannot be verified, a Federal CBC must be conducted. The proposed licensee shall be financially able to meet all obligations necessary to the proper operation of the facility. Prior to or subsequent to being licensed, the licensee shall not have a conviction or pled no contest (nolo contendere) for abuse, neglect, or exploitation of a child or vulnerable adult as defined per S.C. Code Ann., Section 43-35-10, et seq. (1976, as amended). Subsequent to the issuance of an initial license, the licensee shall maintain a reputable and responsible character and be financially able to operate the facility.

~~L~~K. Licensing Fees. The annual license fee as of the January following the effective date of this regulation shall be \$10.00 fifteen dollars (\$15) per licensed bed, or \$75.00 whichever is greater. The second January following the effective date of this regulation, the annual license fee shall be seventeen dollars and fifty cents (\$17.50) per licensed bed. The third January following the effective date of this regulation, the annual license fee shall be twenty dollars (\$20) per licensed bed. Such fee shall be made payable by check or money order credit card to the Department and is not refundable. Fees for additional beds shall be prorated based upon the remaining months of the licensure year. If the application is denied or withdrawn, a portion of the fee shall may be refunded based upon the remaining months of the licensure year, or \$75.00 whichever is lesser. For proposed facilities where applications for licensing have been submitted to the Department, in addition to the annual license fee, there shall be an initial license fee of five hundred dollars (\$500) for proposed facilities with sixteen (16) or more proposed licensed beds and two hundred and fifty dollars (\$250) for less than sixteen (16) proposed licensed beds. In those instances where there is a proposed licensed bed increase through application with the Department, in addition to the annual license fee, there shall be an initial proposed license bed increase fee of five hundred dollars (\$500) with sixteen (16) or more proposed licensed beds and two hundred and fifty dollars (\$250) for less than sixteen (16) proposed licensed beds.

~~M~~L. Late Fee. Failure to submit a renewal application or fee 30 days or more after the license expiration date may result in a late fee of \$75.00 or 25% of the licensing fee amount, whichever is greater, in addition to the licensing fee. Continual failure to submit completed and accurate renewal applications and/or fees by the time-period specified by the Department may result in an enforcement action.

~~N~~M. License Renewal. For a license to be renewed, applicants shall file an application with the Department, pay a license fee, and shall not be undergoing enforcement actions by the Department. If the

license renewal is delayed due to enforcement actions, the renewal license shall be issued only when the matter has been resolved satisfactorily by the Department, or when the adjudicatory process is completed, whichever is applicable.

ØN. Change of License.

1. A facility shall request issuance of an amended license by application to the Department prior to any of the following circumstances:

- a. Change of ownership;
- b. Change of licensed bed capacity;
- c. Change of facility location from one geographic site to another.

2. Changes in facility name or address (as notified by the post office) shall be accomplished by application or by letter from the licensee.

PQ. Exceptions to Licensing Standards. The Department has the authority to make exceptions to these standards where it is determined that the health, safety, and wellbeing of the residents are not compromised, and provided the standard is not specifically required by statute.

SECTION 200 – ENFORCING REGULATIONS

Section 202. Inspections/Investigations.

Revise Section 202.E to read:

E. ~~Reports of inspections~~ A copy of the most recent report of the resident care focused inspection and the most recent general inspection conducted by the Department, including the facility response, shall be ~~made~~ available ~~by the facility upon request~~ in a conspicuous place in a public area within the facility with the redaction of the names of those individuals in the report as provided by Sections 44-7-310 and 44-7-315 of the S.C. Code of Laws, 1976, as amended.

SECTION 300 – ENFORCEMENT ACTIONS

Section 302. Violation Classifications.

Revise Section 302.E to read:

E. ~~In arriving determining at a decision to take an~~ enforcement actions the Department shall consider the following factors:

1. Specific conditions and their impact or potential impact on health, safety or well-being of the residents including: deficiencies in medication management, such as evidence that residents are not routinely receiving their prescribed medications; serious waste water problems, such as toilets not operating or open sewage covering the grounds; housekeeping/maintenance/fire and life safety-related problems that pose a health threat to the residents; power/water/gas or other utility and/or service outages; residents exposed to air temperature extremes that jeopardize their health; unsafe condition of the building/structure such as a roof in

danger of collapse; indictment of an administrator for malfeasance or a felony, which by its nature, such as drug dealing, indicates a threat to the residents; direct evidence of abuse, neglect, or exploitation; lack of food or evidence that the residents are not being fed properly; no staff available at the facility with residents present; unsafe procedures/treatment being practiced by staff; (I)

2. Repeated failure of the licensee/facility to pay assessed charges for utilities and/or services resulting in repeated or ongoing threats to terminate the contracted utilities and/or services. (II)

3. Efforts by the facility to correct cited violations;

~~behavior of the licensee that would reflect negatively on the licensee's character such as illegal/illicit activities;~~

4. Overall conditions of the facility;

5. History of compliance; and

6. Any other pertinent conditions that may be applicable to current statutes and regulations.

Revise Section 302 F to read:

F. When a decision is made to impose imposing a monetary penalties penalty, the Department may invoke S.C. Code Ann. Section 44-7-320 (C) (1976, as amended) to determine the dollar amount or may utilize the following schedule shall be used as a guide to determine the dollar amount:

**Frequency of violation
of standard within a
36-month period:
MONETARY PENALTY RANGES**

FREQUENCY	CLASS I	CLASS II	CLASS III
1 st	\$500 – 1,500	\$300 - 800	\$100 - 300
2 nd	1000 – 3000	500 – 1500	300 - 800
3 rd	2000 – 5000	1000 – 3000	500 – 1500
4 th	5000	2000 – 5000	1000 – 3000
5 th	7500 <u>5000</u>	5000	2000 – 5000
6 th	10,000 <u>5000</u>	7500 <u>5000</u>	5000

Revise Section 302.G to read:

G. ~~Any enforcement action taken by the Department decision involving the issuance, denial, renewal, suspension, or revocation of a license and/or the imposition of monetary penalties where an enforcement action order has been issued may be appealed by an affected person with standing in a manner pursuant to applicable law, including S.C. Code Title 44, Chapter 1 and Title 1, Chapter 23, the Administrative Procedures Act Section 1-23-310, et seq., S.C. Code of Laws, 1976, as amended.~~

SECTION 400 – POLICIES AND PROCEDURES

Section 401. General (II).

Revise Section 401.A to read:

A. Written policies and procedures addressing each section of this regulation regarding resident care, rights, and the operation of the facility shall be developed and implemented, and revised as required in order to accurately reflect actual facility operation. The policies and procedures shall address the provision of any special care offered by the facility which would include how the facility shall meet the specialized needs of the affected residents such as Alzheimer’s disease and/or related dementia, physically/developmentally disabled, in accordance with any laws which pertain to that service offered, *e.g.*, Alzheimer’s Special Care Disclosure Act. Facilities shall establish a time-period for review of all policies and procedures. These policies and procedures shall be accessible at all times and a hard copy shall be available or be readily accessible.

SECTION 500 – STAFF/TRAINING

Section 501. General (II).

Revise Section 501.B to read:

B. Staff members/direct care volunteers/private sitters of the facility shall not have a prior conviction or pled no contest (*nolo contendere*) ~~for to child or adult abuse, neglect, or mistreatment, exploitation of a child or a vulnerable adult as defined in S. C. Code Ann. Section 43-35-10, et seq. (1976, as amended).~~ 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)

Section 502. Administrator.

Revise Section 502.A to read:

A. The facility administrator shall be licensed as a CRCF administrator in accordance with ~~Section 40-35-32 of the S.C. Code of Laws Ann. Section 40-35-30 (1976, as amended).~~ In addition, all other applicable provisions of Title 40, Chapter 35, S.C. Code of Laws, ~~1993,~~ 1976, as amended, shall be followed.

Section 503. Staffing (I).

Revise 503.B to read:

B. The number and qualifications of staff members/volunteers shall be determined by the number and condition of the residents. There shall be sufficient staff members/volunteers to provide supervision, direct

care and basic services for residents, e.g., those with Alzheimer's disease and/or related dementia or in an Alzheimer's special care unit or program. The minimum number of staff members/volunteers that shall be maintained in all facilities:

Section 504. Inservice Training ~~(I)~~(II).

Revise Section 504.A introductory only; subsection items 1-11 remain the same:

A. Documentation of all inservice training shall be signed and dated by both the individual providing the training and the individual receiving the training. 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 and private sitters in the context with of their job duties and responsibilities, prior to resident contact and at a frequency determined by the facility, but at least annually unless otherwise specified by certificate, e.g., cardiopulmonary resuscitation (CPR):

Revise Section 504.B to read:

B. ~~Those staff members/volunteers~~ At least one staff person shall be trained and responsible for providing/coordinating recreational activities for the residents and shall receive appropriate training prior to contact with residents and at least annually thereafter. Documentation of staff training for providing/coordinating recreational activities shall be maintained.

Add new Section 506 to read:

Section 506. Private Sitters (II).

A. Unless the written agreement (See Section 901.A) between a resident and the facility prohibits the use of private sitters, the facility shall establish a formalized private sitter program directed by a facility staff member so that residents or their responsible party may contract for sitter services.

1. The facility shall assure that private sitters have been chosen in accordance with the Residents Bill of Rights.

2. Facilities allowing the use of private sitters shall establish written policies and procedures for private sitters that include an orientation to the facility consisting, at least, of the following:

- a. Residents' rights;
- b. Confidentiality;
- c. Disaster preparedness;
- d. Emergency response procedures;
- e. Safety procedures and precautions; and
- f. Infection control.

3. There shall be accurate current information maintained regarding private sitters including:

a. Name, address and telephone number;

b. Documentation of orientation to the facility, including residents' rights, regulation compliance, policies and procedures, training, and duties;

c. Date of initial resident contact may be maintained by the facility, if applicable.

B. The facility shall maintain the following documentation regarding private sitters:

1. A health assessment (in accordance with Section 505.A) within three (3) months prior to initial resident contact or his or her first day working as a private sitter;

2. A criminal record check (See Section 501.B.) completed prior to working as a private sitter;

3. Determination of TB status (See Section 1702.D.) prior to initial resident contact or his or her first day working as a private sitter.

C. Private sitters shall not be included in the minimum staffing requirements of Section 503.A.

D. Private sitters shall sign in and sign out with facility staff upon entering or leaving the facility. Private sitters shall display identification in accordance with facility policies and procedures that is visible at all times while on duty.

SECTION 600 – REPORTING

Revise Section 601 to read:

Section 601. Incidents/Accidents.

~~A. A record of each incident and/or accident, including usage of mechanical/physical restraints, involving residents, staff members or volunteers, occurring in the facility or on the facility grounds, shall be documented, reviewed, investigated, and if necessary, evaluated in accordance with facility policies and procedures, and retained.~~

~~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.~~

~~2. Serious medical conditions shall be considered as, but not limited to: fractures of major limbs or joints, severe burns, severe lacerations, severe hematomas, and actual/suspected abuse/neglect/exploitation of residents.~~

~~B. Reports shall contain at a minimum: facility name, resident age and sex, date of incident/accident, location, witness names, extent/type of injury and how treated, (e.g., hospitalization), identified cause of~~

incident/accident, internal investigation results if cause unknown, identity of other agencies notified of incident/accident and the date of the report. Serious incidents and/or medical conditions as defined in Section 601.C and any sudden or unexpected illness or medication administration error resulting in death or inpatient hospitalization shall be reported immediately via telephone to the attending physician, the resident's next-of-kin or responsible party, and the sponsoring agency.

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 shall be notified not later than 10 days of the occurrence. A serious incident is one that results in death or a significant loss of function or damage to a body structure, not related to the natural course of a resident's illness or underlying condition or normal course of treatment, and resulting from an incident occurring within the facility or on the facility grounds. A serious incident shall be considered as, but is not limited to:

1. Falls or trauma resulting in fractures of major limbs or joints;
2. Resident suicides;
3. Medication errors;
4. Criminal events or assaults against residents;
5. Medical equipment errors; or,
6. Resident neglect or exploitation, suspected or confirmed resident abuse.

D. Medication errors and adverse medication reactions shall be reported immediately to the next of kin or responsible party, prescriber, supervising staff member, and administrator, and no later than 12 hours, as applicable to the sponsoring agency, and recorded in the resident record. The Department's Division of Health Licensing shall be notified in writing within ten (10) days of the occurrence of a serious incident.

E. Changes in the resident's condition, to the extent that serious health concerns, e.g., heart attack, are evident, shall be reported immediately to the attending physician and the next of kin/responsible party, and no later than 12 hours afterwards to the administrator and the sponsor. (1) Reports submitted to the Department shall contain at a minimum: facility name, resident age and sex, date of incident, location, witness names, extent and type of injury and how treated, e.g., hospitalization, identified cause of incident, internal investigation results if cause unknown, identity of other agencies notified of incident and the date of the report.

F. Incidents where residents have left the premises without notice to staff members of intent to leave and have not returned to the facility within twenty-four (24) hours shall be reported to the administrator or his or her designee, local law enforcement, and the resident's responsible party, when appropriate. The Division of Health Licensing shall be notified in writing not later than ten (10) days of the occurrence. When residents who are cognitively impaired leave the premises without notice to staff members, regardless of the time-period of departure, the administrator or his or her designee, local law enforcement, next-of-kin, and sponsoring agency shall be contacted immediately by telephone or facsimile. DHL shall be notified not later

than ten (10) days following the occurrence.

G. Medication errors and adverse medication reactions shall be reported immediately after discovery to the prescriber and other staff in accordance with facility policies and procedures.

H. Changes in a resident's condition, to the extent that serious health concerns, e.g., heart attack, are evident, shall be reported to the attending physician and the next-of-kin or responsible party in a timely manner, consistent with the severity or urgency of the condition in accordance with facility policies and procedures. (I)

I. Abuse and suspected abuse, neglect, or exploitation of residents shall be reported to the South Carolina Long-Term Care Ombudsman Program in accordance with S.C. Code of Law Section 43-35-25 (1976, as amended).

Revise Section 604 to read:

Section 604. Administrator Change.

DHL shall be notified in writing by the licensee within ten (10) days of any change in administrator. The notice shall include at a minimum the name of the newly-appointed individual, the effective date of the appointment, and a copy of the administrator's license and the hours each day that the newly-appointed individual will be working as the administrator of the facility.

SECTION 700 – RESIDENT RECORDS

Section 701. Content (II).

Revise Section 701.B(6) and (10) to read:

B. Specific entries/documentation shall include at a minimum:

6. Notes of observation. In instances that involve significant changes in a resident's medical condition and/or the occurrence of a serious incident, notes of observation shall be documented at least daily until the condition is stabilized and/or the incident is resolved. In all other instances, notes of observation for residents shall be documented at least monthly;

10. Photograph of resident. Resident photographs shall be at a minimum two and one half inches by three and one half inches (2 ½ by 3 ½ inches) in size, dated, and no more than twenty-four (24) months old unless significant changes in appearance have occurred necessitating a more recent photograph.

Revise Section 702 to read:

Section 702. Assessment (II).

A ~~complete~~ written assessment of the resident in accordance with Section 101.~~I~~.J shall be conducted by a direct care staff member as evidenced by his or her signature within a time-period determined by the facility,

but no later than 72 hours after admission.

SECTION 800 – ADMISSION/RETENTION

Section 801. General (I).

Revise Sections 801.B and C; Sections A, D and E remain the same:

B. The facility shall admit and retain only those persons ~~whose needs can be met by the accommodations and services provided.~~ appropriate for placement in a CRCF in compliance with the standards of this regulation. (†)

C. Persons not eligible for admission/retention are:

1. Any person who is likely to endanger him/herself or others as determined by a physician or other authorized healthcare provider; (†)

2. Any person other than an adult; (II)

3. Any person needing hospitalization or nursing home care; (†)

4. Anyone needing the continuous daily attention of a ~~facility staff~~ licensed nurse. Nursing care may be furnished to residents in need of short-term intermittent nursing care (no more than fourteen (14) consecutive days) while convalescing from illness or injury, provided the nursing services, e.g., the utilization of a home health nurse for sterile dressing changes or for observation related to a surgical site, are not furnished by a licensed nurse facility staff members or a home health nurse. e.g., the utilization of a home health nurse for sterile dressing changes or for observation related to a surgical site. (†)

5. Any person who requires one of the following nursing services determined by the South Carolina Board of Nursing to require the skills of a licensed nurse for no more than fourteen (14) consecutive days:

a. Daily skilled monitoring/observation (except as permitted for no more than fourteen (14) consecutive days) due to an unstable or complex medical condition, e.g., brittle diabetes, dialysis patients with complications such as infections in the blood;

b. Serious aggressive, violent or socially inappropriate behavioral symptoms which cannot be controlled or improved in the facility;

c. Medications that require frequent dosage adjustment, regulation and/or monitoring, e.g., diabetics receiving sliding scale insulin;

d. Intravenous medications or fluids, regular intra-muscular and subcutaneous injections by staff. This does not include injections administered on a part-time or intermittent basis by non-staff licensed nurses. Routine injection(s) of insulin scheduled daily or less frequently are permitted;

e. Care of urinary catheter that cannot be managed independently by the resident;

f. Treatment of stage 2, 3 or 4 decubitus ulcers, or multiple pressure sores or other widespread skin disorder (important considerations include: signs of infection, full thickness tissue loss, or requirement of sterile technique);

g. Nasogastric tube feeding or having to be fed by a syringe or straw due to difficulties in swallowing. Gastronomy tube feedings that cannot be managed independently by the resident;

h. Suctioning of the nose and/or mouth;

i. Tracheostomy or sterile care of the tracheostomy that cannot be managed independently by the resident;

j. Receiving oxygen for the first time, which requires adjustment and evaluation of oxygen concentration;

k. Dependency in all activities of daily living for more than fourteen (14) consecutive days, e.g., bedridden; incapable of locomotion; unable to transfer; totally incontinent of urinary and/or bowel function; must be totally bathed and dressed and toileted and needs extensive assistance to eat. The facility should develop a transfer plan by the tenth (10th) day of total dependency for transfer on the fifteenth (15th) day if the resident is not improving; or

l. Sterile dressing changes. Licensed staff nurses or home health nurses may perform these changes for no more than fourteen (14) consecutive days before discharge is appropriate.

§ 6. Anyone not meeting facility requirements for admission; the facility may determine who is eligible for admission and retention in its policies, provided compliance with local, state, and federal laws and regulations is accomplished.

SECTION 900 – RESIDENT CARE/SERVICES

Section 901. General.

Revise Section 901.A.8 to read:

A. There shall be a written agreement between the resident, and/or his/her responsible party, and the facility. The agreement shall include at least the following:

~~8. Statement of resident personal rights, and the grievance procedure.~~ Documentation of the explanation of the Resident's Bill of Rights and the grievance procedure. (II)

Section 902. Fiscal Management (II).

Revise Section 902.H to read:

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. Documentation of quarterly reports to residents shall be readily available for review.

SECTION 1000 – RIGHTS AND ASSURANCES

Section 1001. General (II).

Revise Section 1001.L to read:

L. Residents shall be permitted to use the telephone and shall be allowed privacy when ~~making~~ placing or receiving telephone calls. This access shall include business hours from 7 a.m. through 8 p.m., seven (7) days a week, and other times when appropriate. This telephone service shall be available for use by residents and/or visitors for their private, discretionary use; pay phones for this purpose are acceptable. Telephones capable of only local calls are acceptable for this purpose, provided other arrangements exist to provide resident/visitor discretionary access to a telephone capable of long distance service.

SECTION 1100 – RESIDENT PHYSICAL EXAMINATION AND TB SCREENING

Section 1101. General (I).

Revise Section 1101.A to read:

A. A physical examination shall be completed for residents within thirty (30) days prior to admission and at least annually thereafter. Physical examinations conducted within thirty (30) days prior to admission by physicians licensed in states other than South Carolina are permitted for new admissions under the condition that residents obtain an attending physician licensed in South Carolina within thirty (30) days of admission to the facility and undergo a second (2nd) physical examination by that physician within thirty (30) days of admission to the facility. The physical examination shall be updated to include new medical information if the resident's condition has changed since the last physical examination was completed. The physical examination shall address:

1. ~~†~~The appropriateness of placement in a CRCF;
2. ~~m~~Medications/~~treatments~~ ~~required~~ ~~ordered~~;
3. ~~and s~~Self-administration status;
4. ~~and i~~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.*; ~~and~~;
5. The need of (or lack thereof) for the continuous daily attention of a licensed nurse.

Revise Section 1101.F. to read:

F. Isolation Provisions. Residents with contagious pulmonary tuberculosis shall be separated (See Section 1702.E) from all other noninfected residents until declared noncontagious by a physician or other authorized healthcare provider. Should it be determined that the facility cannot care for the resident to the degree which assures the health and safety of the resident and the other residents of the facility, the resident shall be relocated to a facility that can meet his/her needs.

Revise Section 1101.G. to read:

G. In the event that a resident transfers from a facility licensed by the Department to a CRCF, an additional admission physical examination shall not be required, provided the sending facility has had a physical examination conducted on the resident not earlier than twelve (12) months prior to the admission of the resident to the CRCF, and the physical examination meets requirements specified in Sections 1101.A - C above unless the receiving facility has an indication that the health status of the resident has changed significantly. A tuberculin skin test and/or BAMT shall be required within one (1) month after admission to the CRCF to which the resident transfers, to document baseline status for that facility. The receiving facility shall acquire a copy of the admission physical examination/tuberculin skin test and/or BAMT from the facility transferring the resident. (See Section 1702.~~BE~~ regarding tuberculin skin testing and/or BAMT.)

SECTION 1200 – MEDICATION MANAGEMENT

Section 1201. General (I).

Revise Section 1201.A to read:

A. Medications, including controlled substances, medical supplies, and those items necessary for the rendering of first aid shall be available and properly managed in accordance with local, state, and federal laws and regulations. Such management shall address the securing, storing, and administering of medications, medical supplies, first aid supplies, and biologicals, their disposal when discontinued or outdated, and their disposition at discharge, death, or transfer of a resident.

Section 1202. Medication Orders (I).

Revise Section 1202 title to read:

Section 1202. Medication and Treatment Orders (I).

Revise Section 1202.A and B to read:

A. Medications and treatments, to include oxygen, shall be administered to residents only upon orders (to include standing orders) of a physician or other authorized healthcare provider. Medications accompanying residents at admission may be administered to residents provided the medication is in the original labeled container and the order is subsequently obtained as a part of the admission physical examination. Should there be concerns regarding the appropriateness of administering medications due to the condition/state of the medication, *e.g.*, expired, makeshift or illegible labels, or the condition/state of health of the newly-admitted resident, staff members shall consult with or make arrangements to have the resident examined by a physician or other authorized healthcare provider, or at the local hospital emergency room prior to administering any medications.

B. All orders (including verbal orders) shall be received only by staff members authorized by the facility, and shall be signed and dated by a physician or other authorized healthcare provider no later than ~~72 hours~~ three (3) business days after the order is given.

1203. Administering Medication (I).

Revise Section 1203 title to read:

1203. Administering Medication/Treatments (I).

Revise Section 1203.A to read:

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. Each physician ordered treatment or medication dose administered ~~or~~/supervised shall be properly recorded by initialing on the resident's medication administration record (MAR) as the medication is administered or treatment record as treatment is rendered. 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. The treatment record shall document the type of treatment, date and time of treatment and signature of the individual administering treatment. If the ordered dosage is to be given on a varying schedule, *e.g.*, "take two tablets the first day and one tablet every other day by mouth with noon meal," the number of tablets shall also be recorded.

Section 1205. Medication Containers (I).

Revise Section 1205.B to read:

B. Medications for each resident shall be kept in the original container(s) including unit dose systems; there shall be no transferring between containers (except in instances such as in Section 1203.E above), or opening blister packs to remove medications for destruction or adding new medications for administration, except under the direction of a pharmacist. In addition, for those facilities that utilize the unit dose system or multi-dose system, e.g., Medicine On Time, an on-site review of the medication program by a pharmacist shall be conducted on at least a quarterly basis to assure the program has been properly implemented and maintained. For changes in dosage, the new packaging shall be available in the facility no later than the next administration time subsequent to the order.

Section 1206. Medication Storage (I).

Revise Section 1206.A to read:

A. Medications shall be properly stored and safeguarded to prevent access by unauthorized persons. Expired or discontinued medications shall not be stored with current medications. Storage areas shall be locked, and of sufficient size for clean and orderly storage. Storage areas shall not be located near sources of heat, humidity, or other hazards that may negatively impact medication effectiveness or shelf life. Medications requiring refrigeration shall be stored in a refrigerator at the temperature established by the U.S. Pharmacopeia (36-46 degrees F.). If a multi-use refrigerator is used to store medications outside the secured medication storage area, a separate locked box shall be used to store medications, provided the refrigerator is near the medication storage area. Accurate thermometers (within \pm 3 degrees) shall be provided in all refrigerators storing medications.

Revise Section 1206.C to read:

C. ~~A record of the stock and distribution of all controlled substances shall be maintained in such a manner that the disposition of each dose of any particular item may be readily traced. Records of receipt, administration and disposition of all controlled substances shall be maintained in sufficient detail to enable an accurate reconciliation.~~

SECTION 1300 – MEAL SERVICE

Section 1306. Diets.

Revise Section 1306.A to read:

A. If the facility accepts or retains residents in need of medically-prescribed special diets, the menus for such diets shall be planned by a professionally-qualified dietitian or shall be reviewed and approved by a physician or other authorized healthcare provider. The facility shall maintain documentation that each of these menus has been planned by a dietitian, a physician or other authorized healthcare provider. At a minimum, documentation for each resident's special diet menu shall include the signature of the dietitian, the physician or other authorized healthcare provider, his/her title, and the date he/she signed the menu. The facility shall ~~provide supervision of the preparation and~~ maintain staff capable of the preparation/serving of any special diet, e.g., low-sodium, low-fat, 1200-calorie, diabetic diet. Facility staff preparing a resident's special diet shall be knowledgeable of the procedure to prepare each special diet. The preparation of any resident's special diet shall follow the written guidance provided by a registered dietitian, physician, or other authorized healthcare provider authorizing the resident's special diet. For each resident receiving a special diet, this written guidance shall be documented in the resident's record. (I)

Section 1309. Equipment (II).

Revise Section 1309.A to read:

A. Liquid or powder soap dispensers and sanitary paper towels shall be available at each food service handwash lavatory. Alcohol-based waterless hand sanitizers shall not be used in lieu of liquid or powder soap.

SECTION 1400 – EMERGENCY PROCESURES/DISASTER PREPAREDNESS

Section 1401. Disaster Preparedness (II)

Revise Section 1401.B.1.c to read:

B. The disaster plan shall include, but not be limited to:

1. A sheltering plan to include:

c. A letter of agreement signed by an authorized representative of each sheltering facility which shall include: the number of relocated residents that can be accommodated; sleeping, feeding, and medication plans for the relocated residents; and provisions for accommodating relocated staff members/ volunteers. The letter shall be updated annually with the sheltering facility and whenever significant changes occur. For those facilities located in Beaufort, ~~Berkeley~~, Charleston, Colleton, ~~Dorchester~~, Horry, Jasper, and Georgetown counties, at least one sheltering facility shall be located in a county other than these counties.

Section 1403. Continuity of Essential Services (II).

Revise Section 1403 to read:

There shall be a written plan to be implemented to assure the continuation of essential resident support services for such reasons as power outage, water shortage, or in the event of the absence from work of any portion of the workforce resulting from inclement weather or other causes.

SECTION 1500 –FIRE PREVENTION

Section 1503. Fire Response Training (I).

Revise Section 1503.C to read:

C. All residents capable of assisting in their evacuation shall be trained in the proper actions to take in the event of a fire, *e.g.*, actions to take if the primary escape route is blocked. ~~Residents shall be trained to assist each other in case of fire to the extent their physical and mental abilities permit them to do so without additional personal risk.~~

SECTION 1700 – INFECTION CONTROL AND ENVIRONMENT

Section 1702. Tuberculin Skin Testing (I).

Revise Section 1702 to read:

~~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. It is permissible for a licensed nurse to perform the tuberculin screening.~~

~~B. Testing Procedures.~~

~~1. Staff members/direct care volunteers of facilities shall be required to have evidence of a two-step tuberculin skin test within three months prior to resident contact. If there is a documented negative tuberculin skin test (at least single-step) within the previous 12 months, the person shall be required to have only one tuberculin skin test to establish a baseline status.~~

~~2. Staff members/direct care volunteers with negative test results from the initial two-step procedure shall be required to have an annual one-step skin test.~~

~~3. Residents shall have at least the first step within the period for completion of the admission physical examination as specified in Section 1101 (within 30 days prior to admission).~~

~~C. Positive Reactions/Exposure.~~

~~1. Individuals with tuberculin skin test reactions of 10mm or more of induration and known human immunodeficiency virus (HIV) positive individuals with tuberculin skin test reactions of 5mm or more of induration shall be referred to a physician or other authorized healthcare provider for appropriate evaluation.~~

~~2. All persons who are known or suspected to have tuberculosis (TB) shall be evaluated by a physician or other authorized healthcare provider.~~

~~3. Staff members/direct care volunteers will not be allowed to return to work until they have been declared noncontagious.~~

~~4. Residents with symptoms of TB shall be isolated and/or treated/referred as necessary until certified as noneontagious by a physician or other authorized healthcare provider.~~

~~5. Individuals who have had a prior history of TB shall be required to have a chest radiograph and certification within one month prior to employment/admission by a physician or other authorized healthcare provider that they are not contagious.~~

~~6. If an individual who was previously documented as skin test negative has an exposure to a documented case of TB, the facility shall immediately contact the local county health department or the Department's TB Control Division for consultation.~~

~~D. Treatment.~~

~~1. Preventive treatment of persons who are new positive reactors is recommended unless specifically contraindicated.~~

~~2. Individuals who complete treatment either for disease or infection are exempt from further treatment unless they develop symptoms of TB. An individual who remains asymptomatic shall not be required to have a chest radiograph, but shall have an annual documented assessment by a physician or other authorized healthcare provider for symptoms suggestive of TB, e.g., cough, weight loss, night sweats, fever, etc.~~

A. Tuberculin skin testing is a diagnostic tool for detecting *M. tuberculosis* infection. A small dose (0.1 mil) of purified protein derivative (PPD) tuberculin is injected just beneath the surface of the skin (by the intradermal Mantoux method), and the area is examined for induration (hard, dense, raised area at the site of the TST administration) forty-eight to seventy-two (48 to 72) hours after the injection (but positive reactions can still be measurable up to a week after administering the TST). The size of the indurated area is measured with a millimeter ruler and the reading is recorded in millimeters, including zero (0) mm to represent no induration. Redness/erythema is insignificant and is not measured or recorded. Authorized healthcare providers are permitted to perform tuberculin skin testing and symptom screening.

B. All facilities shall conduct an annual tuberculosis risk assessment (See Section 101.III) in accordance with CDC guidelines (See Section 102.B.18) to determine the appropriateness and frequency of tuberculosis screening and other tuberculosis related measures to be taken.

C. The risk classification, i.e., low risk, medium risk, shall be used as part of the risk assessment to

determine the need for an ongoing TB screening program for staff/direct care volunteers and residents and the frequency of screening. A risk classification shall be determined for the entire facility. In certain settings, e.g., healthcare organizations that encompass multiple sites or types of services, specific areas defined by geography, functional units, patient population, job type, or location within the setting may have separate risk classifications.

D. Staff/Direct Care Volunteers/Private Sitters Tuberculin Skin Testing

1. Tuberculosis Status. Prior to date of hire or initial resident contact, the tuberculosis status of staff/direct care volunteer/private sitters shall be determined in the following manner in accordance with the applicable risk classification:

2. Low Risk:

a. Baseline two-step Tuberculin Skin Test (TST) or a single Blood Assay for *Mycobacterium tuberculosis* (BAMT): All staff/direct care volunteers/private sitters (within three (3) months prior to contact with residents) unless there is a documented TST or a BAMT result during the previous twelve (12) months. If a newly employed staff/direct care volunteer or private sitter has had a documented negative TST or a BAMT result within the previous twelve (12) months, a single TST (or the single BAMT) can be administered and read to serve as the baseline prior to resident contact.

b. Periodic TST or BAMT is not required.

c. Post-exposure TST or a BAMT for staff/direct care volunteers upon unprotected exposure to *M. tuberculosis*: Perform a contact investigation when unprotected exposure is identified. Administer one (1) TST or a BAMT as soon as possible to all staff who have had unprotected exposure to an infectious TB case/suspect. If the TST or the BAMT result is negative, administer another TST or a BAMT eight to ten (8 to 10) weeks after that exposure to *M. tuberculosis* ended.

d. Post-exposure TST or a BAMT for private sitters upon unprotected exposure to *M. tuberculosis*: Written evidence of a contact investigation when unprotected exposure is identified shall be provided to the facility administrator. The private sitter shall provide documentation of a completed single TST or a BAMT prior to resident contact. If the TST or BAMT result is negative, the private sitter shall provide written evidence of an additional TST or BAMT eight to ten (8 to 10) weeks after that exposure to *M. tuberculosis* ended. (CDC: Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings, December 30, 2005).

e. Baseline positive with or without documentation of treatment for latent TB infection (LTBI) (See Section 101.GG) or TB disease shall have a symptoms screen prior to employment and annually thereafter.

f. Upon hire, staff/direct care volunteers/private sitters with a newly positive test result for *M. tuberculosis* infection (i.e., TST or BAMT) or signs or symptoms of tuberculosis, e.g., cough, weight loss, night sweats, fever, shall have a chest radiograph performed immediately to exclude TB disease (or evaluate an interpretable copy taken within the previous three (3) months). Repeat radiographs are not needed unless symptoms or signs of TB disease develop or unless recommended by a physician. These staff members/direct care volunteers/private sitters will be evaluated for the need for treatment of TB disease or latent TB infection (LTBI) and will be encouraged to follow the recommendations made by a physician with TB expertise (i.e., the Department's TB Control program).

3. Medium Risk:

a. Baseline two-step TST or a single BAMT: All staff/direct care volunteers/private sitters (within three (3) months prior to contact with residents) unless there is a documented TST or a BAMT result during the previous twelve (12) months. If a newly employed staff/direct care volunteer/private sitter has had a documented negative TST or a BAMT result within the previous twelve (12) months, a single TST (or the single BAMT) can be administered to serve as the baseline prior to resident contact.

b. Periodic testing (with TST or BAMT): Annually, of all staff/direct care volunteers who have risk of TB exposure and who have previous documented negative results. Instead of participating in periodic testing, staff/direct care volunteers with documented TB infection (positive TST or BAMT) shall receive a symptom screen annually. This screen shall be accomplished by educating the staff/direct care volunteers who have documented TB infection about symptoms of TB disease (including the staff's and/or direct care volunteers' responses concerning symptoms of TB disease), documenting the questioning of the staff/direct care volunteers about the presence of symptoms of TB disease, and instructing the staff/direct care volunteers to report any such symptoms immediately to the administrator. Treatment for latent TB infection (LTBI) shall be considered in accordance with CDC and Department guidelines and, if recommended, treatment completion shall be encouraged.

c. Periodic testing (with TST or BAMT): Annually, of all private sitters who have risk of TB exposure and who have previous documented negative results. Instead of participating in periodic testing, private sitters with documented TB infection (positive TST or BAMT) shall provide the facility with written evidence of a symptom screen annually. Documentation of education about symptoms of TB disease (including responses concerning symptoms of TB disease) and written evidence of the questioning about the presence of symptoms of TB disease, and the report of any such symptoms shall be provided immediately to the facility administrator.

d. Post-exposure TST or a BAMT for staff/direct care volunteers upon unprotected exposure to *M. tuberculosis*: Perform a contact investigation (See Section 101.O) when unprotected exposure is identified. Administer one (1) TST or a BAMT as soon as possible to all staff/direct care volunteers/private sitters who have had unprotected exposure to an infectious TB case/suspect. If the TST or the BAMT result is negative, administer another TST or BAMT eight to ten (8 to 10) weeks after that exposure to *M. tuberculosis* ended.

e. Post exposure TST or a BAMT for private sitters upon unprotected exposure to *M. tuberculosis*: Written evidence of a contact investigation when unprotected exposure is identified shall be provided to the facility administrator. The private sitter shall provide documentation of a completed single TST or a BAMT prior to resident contact. If the TST or BAMT result is negative, the private sitter shall provide written evidence of an additional TST or BAMT eight to ten (8 to 10) weeks after that exposure to *M. tuberculosis* ended.

4. Baseline Positive or Newly Positive Test Result:

a. Baseline positive with or without documentation of treatment for latent TB infection (LTBI) or TB disease shall have a symptoms screen prior to employment and annually thereafter.

b. Upon hire, staff/direct care volunteers/private sitters with a newly positive test result for *M. tuberculosis* infection (*i.e.*, TST or BAMT) or signs or symptoms of tuberculosis, *e.g.*, cough, weight loss, night sweats, fever, shall have a chest radiograph performed immediately to exclude TB disease (or evaluate an interpretable copy taken within the previous three (3) months). Repeat chest radiographs are not required

unless symptoms or signs of TB disease develop or unless recommended by a physician. These staff members/direct care volunteers/private sitters will be evaluated for the need for treatment of TB disease or latent TB infection (LTBI) and will be encouraged to follow the recommendations made by a physician with TB expertise (i.e., the Department's TB Control program).

c. Staff/direct care volunteers/private sitters who are known or suspected to have TB disease shall be excluded from work, required to undergo evaluation by a physician, and permitted to return to work only with written approval by the Department's TB Control program. Repeat chest radiographs are not required unless symptoms or signs of TB disease develop or unless recommended by a physician.

E. Resident Tuberculosis Screening (I)

1. Tuberculosis Status. Prior to admission, the tuberculosis status of a resident shall be determined in the following manner in accordance with the applicable risk classification:

a. For Low Risk and Medium Risk:

1. Admission/Baseline two-step TST or a single BAMT: All residents within thirty (30) days prior to admission shall have completed the first step of the two step tuberculin skin test followed seven to twenty one (7 to 21) days later by a second test unless there is a documented TST or a BAMT result during the previous twelve (12) months. If a newly-admitted resident has had a documented negative TST or a BAMT result within the previous twelve (12) months, a single TST (or the single BAMT) can be administered within one (1) month prior to admission to the facility to serve as the baseline. As an exception, a resident may be admitted with at least the first step of the TB screening process completed prior to admission and the second step within fourteen (14) days of admission.

2. Periodic TST or BAMT is not required.

3. Post-exposure TST or a BAMT for residents upon unprotected exposure to *M. tuberculosis*: Perform a contact investigation when unprotected exposure is identified. Administer one (1) TST or a BAMT as soon as possible to all residents who have had exposure to an infectious TB case/suspect. If the TST or the BAMT result is negative, administer another TST or a BAMT eight to ten (8 to 10) weeks after that exposure to *M. tuberculosis* ended.

b. Baseline Positive or Newly Positive Test Result:

1. Residents with a baseline positive or newly positive test result for *M. tuberculosis* infection (i.e., TST or BAMT) or documentation of treatment for latent TB infection (LTBI) or TB disease or signs or symptoms of tuberculosis, e.g., cough, weight loss, night sweats, fever, shall have a chest radiograph performed immediately to exclude TB disease (or evaluate an interpretable copy taken within the previous three (3) months). Routine repeat chest radiographs are not required unless symptoms or signs of TB disease develop or unless recommended by a physician. These residents shall be evaluated for the need for treatment. If diagnosed with latent TB infection (LTBI) the resident shall be encouraged to follow the recommendations made by a physician with TB expertise (i.e., the Department's TB Control program). For those residents diagnosed with TB disease, the facility shall assure that the affected residents follow the recommendations made by a physician with TB expertise (i.e., the Department's TB Control program).

2. Residents who are known or suspected to have TB disease shall be transferred from the

facility if the facility does not have an Airborne Infection Isolation room (See Section 101.F), required to undergo evaluation by a physician, and permitted to return to the facility only with written approval by the Department's TB Control program.

F. Individuals who have been declared in writing to be in an emergency crisis stabilization status may be admitted to the facility without the initial step of the two-step tuberculin skin test and/or while awaiting the result of a BAMT. These individuals shall be placed in an area separate from the general population. This admission to the facility may be made provided:

1. There is documentation at the facility of the declaration by Adult Protective Services of the South Carolina Department of Social Services or the South Carolina Department of Mental Health that the admission is, in fact, an emergency (NOTE: Only these agencies may declare these crisis stabilization admissions to be an emergency;

2. There is written evidence of a chest x-ray within one (1) month prior to admission and a written assessment by a physician or other authorized healthcare provider that there is no active TB and a negative assessment for signs and/or symptoms of tuberculosis; and,

3. The resident will receive the initial step of the two-step tuberculin test within twenty-four (24) hours of admission to the facility. The second step of the two-step tuberculin skin test must be administered within the next seven to fourteen (7 to 14) days.

Section 1705. Pets (II)

Revise Section 1705.A to read:

A. If the facility chooses to permit pets, healthy animals that are free of fleas, ticks, and intestinal parasites and have been screened by a veterinarian prior to ~~entering the facility~~ resident contact, have received required inoculations, if applicable, and that present no apparent threat to the health, safety, and well-being of the residents, may be permitted in the facility, provided they are sufficiently fed and cared for and that both the pets and their housing are kept clean.

SECTION 2200 – FIRE PROTECTION EQUIPMENT AND SYSTEMS

Section 2201. Firefighting Equipment (I).

Revise Section 2201.D to read:

D. The kitchen shall be equipped with a minimum of ~~one K-type and~~ one 20-BC-type fire extinguisher. Facilities with commercial fixed hood extinguishing systems shall be provided with an additional fire extinguisher of the K class type.

Section 2207. Furnishings/Equipment (I).

Revise Section 2207.D to read:

D. Wastebaskets, window dressings, ~~portable partitions~~, cubicle curtains, mattresses, and pillows shall be noncombustible, inherently flame-resistant, or treated or maintained flame-resistant in accordance with NFPA 701, Standard Methods of Fire Tests for Flame-Resistant Textiles and Films. As an exception, window blinds

require no flame treatments.

~~EXCEPTION: Window blinds require no flame treatments or documentation thereof.~~

Add Section 2207.E to read:

E. Smoking shall be allowed only in designated areas in accordance with the facility smoking policy. No smoking is permitted in resident rooms or staff bedrooms or bath/restrooms.

SECTION 2700 – PHYSICAL PLANT

Section 2702. Resident Rooms.

Revise Section 2702.J to read:

J. There shall be at least one (1) ~~full-length~~ mirror in each resident room or resident bathroom. As an exception, when a resident's condition is such that having a mirror may be detrimental to his/her well-being, e.g., agitation and confusion associated with Alzheimer's disease and/or related dementia, mirrors are not required.

~~EXCEPTION: When a resident's condition is such that having a mirror may be detrimental to his/her well-being, e.g., agitation and confusion associated with Alzheimer's disease and/or related dementia, full-length mirrors are not required.~~

Section 2704. Bathrooms/Restrooms (II).

Revise 2704 D to read:

D. There shall be at least one (1) handwash lavatory adjacent to each toilet. Liquid soap shall be provided in public restrooms and bathrooms used by more than one resident. Communal use of bar soap is prohibited. A sanitary individualized method of drying hands shall be available at each lavatory.

Section 2715. Telephone Service.

Revise Section 2715.A to read:

A. At least one (1) telephone shall be available on each floor of the facility with at least one (1) active main or fixed-line telephone service available. ~~for use by residents and/or visitors for their private, discretionary use; pay phones for this purpose are acceptable. Telephones capable of only local calls are acceptable for this purpose, provided other arrangements exist to provide resident/visitor discretionary access to a telephone capable of long distance service.~~

Section 2717. Outdoor Areas.

Revise Section 2717.A to read:

A. Outdoor areas where unsafe, unprotected physical hazards exist shall be enclosed by a fence or a natural barrier of a size, shape, and density that effectively impedes travel to the hazardous area. ~~Such areas~~

~~include but are not limited to steep grades, cliffs, open pits, high voltage electrical equipment, high speed or heavily traveled roads, and/or roads exceeding two lanes excluding turn lanes, ponds and swimming pools. (I)~~

ATTACHMENT D

**SUMMARY OF PUBLIC COMMENTS AND DEPARTMENT RESPONSE
FOR PROPOSED AMENDMENT OF
R.61-84, STANDARDS FOR LICENSING COMMUNITY RESIDENTIAL CARE FACILITIES
JANUARY 14, 2010**

SECTION/COMMENTOR	PUBLIC COMMENTS	STAFF RESPONSE
<p>Section 101.F 1) SC-ALFA & Capitol Consultants</p>	<p>1) Assisted living facilities would have difficulty providing an airborne infection bed.</p>	<p>Not Adopted.</p> <p>1) Only facilities that choose to keep a resident with suspected or confirmed infectious tuberculosis would be required to have an airborne infection isolation room.</p> <p><u>Text as proposed in State Register:</u></p> <p><u>F. Airborne Infection Isolation (AII). A room designed to maintain Airborne Infection Isolation, formerly called a negative pressure isolation room. An Airborne Infection Isolation room is a single-occupancy resident care room used to isolate persons with suspected or confirmed infectious tuberculosis (TB) disease. Environmental factors are controlled in Airborne Infection Isolation rooms to minimize the transmission of infectious agents that are usually spread from person-to-person by droplet nuclei associated with coughing or aerosolization of contaminated fluids. Airborne Infection Isolation rooms may provide negative pressure in the room (so that air flows under the door gap into the room), an air flow rate of six to twelve (6 to 12) air changes per hour (ACH), and direct exhaust of air from the room to the outside of the building or recirculation of air through a high efficiency particulate air (HEPA) filter.</u></p>
<p>Section 101.BB. 1) Protection and Advocacy for People with Disabilities, Inc.</p>	<p>1) As it relates to reporting restraint use, proposes defining incident as “any unusual OR adverse event which creates or implies an increased risk of harm, injury, or death of staff or residents. Examples include, but are not limited to,</p>	<p>Not Adopted.</p> <p>1) The resident record already requires documentation of</p>

SECTION/COMMENTOR	PUBLIC COMMENTS	STAFF RESPONSE
	<p>medication errors, falls resulting in a bruise, first degree burns, peer-on-peer violence, unexplained absence of residents for periods less than twenty-four hours, lack of necessary medical supplies, changes in a resident's condition to the extent that serious health concerns are evident, or any use of restraint.”</p>	<p>indications of sickness or injury, changes in physical condition, care/services provided and notes of observation that would include any unusual or adverse event or use of restraint.</p> <p><u>Text as proposed in State Register:</u></p> <p><u>BB. Incident. An unusual unexpected adverse event resulting in harm, injury, or death of staff or residents, accidents, e.g., medication errors, adverse medication reactions, elopement of a resident.</u></p>
<p>Section 103.D.</p> <p>1) Capitol Consultants</p> <p>2) SCDMH</p> <p>3) Tina Zaborowski, Country Christian Care, Inc.</p> <p>4) Candice Spencer, Village Community Care</p> <p>5) Sincere Home Owners United Together (SHOUT)</p> <p>6) Richie D. Barnes, Rockhaven Community Care Home</p> <p>7) Lisa Flaughner, April Valley</p>	<p>1) Grandfather in currently licensed facilities with building codes as to when they were originally licensed.</p> <p>2) The revised standard would force many CRCF's that cannot meet current building and fire life safety codes to close.</p> <p>3) This requirement will have significant financial impact on facilities if required to comply with current building and fire and life safety codes.</p> <p>4) Under this requirement, homes will not be able to change widths of hallways and cannot afford sprinkling and/or major construction.</p> <p>5) It is unclear what "exemptions" are referred to by the Department.</p> <p>6) Regulate smaller facilities separately from larger facilities by developing separate regulations.</p> <p>7) Basing structural standards on an international code is unfair to local businesses.</p>	<p>Adopted. Delete subsection 103.D</p> <p><u>Text as proposed in State Register:</u></p> <p>D. Compliance with Structural Standards, upon Change of Ownership. No later than December 31, 2015, When changes in ownership occur, the new licensee shall, through coordination with the Department's Division of Health Facilities Construction, formulate a plan for the facility to shall be in compliance with current building and fire and life safety codes within 24 months of the date of the ownership change, unless specific standards are exempted by the Department. Facilities are not required to modify square footage of resident rooms and maximum number of beds in resident rooms, except that those facilities which that have resident rooms with five (5) or more licensed beds shall reduce the maximum number of beds per room to no more than four (4) within 12 months from the date of ownership change, no later than December 31, 2015.</p> <p><u>Change per comment:</u></p> <p>D. Compliance with Structural Standards, upon Change of Ownership. No later than December 31, 2015, When changes in ownership occur, the new licensee shall, through coordination with the Department's Division of Health Facilities Construction, formulate a plan for the facility to shall be in</p>

SECTION/COMMENTOR	PUBLIC COMMENTS	STAFF RESPONSE
		<p>compliance with current building and fire and life safety codes within 24 months of the date of the ownership change, unless specific standards are exempted by the Department. Facilities are not required to modify square footage of resident rooms and maximum number of beds in resident rooms, except that those facilities which that have resident rooms with five (5) or more licensed beds shall reduce the maximum number of beds per room to no more than four (4) within 12 months from the date of ownership change, no later than December 31, 2015.</p>
<p>Section 103.G 1) SCDMH</p>	<p>1) It is recommended that the current standard remain, with adding “Staff members, family members of the owner/licensee, volunteers, and/or the administrator/operator shall not use resident living rooms, recreational areas or dining rooms unless they are on duty.”</p>	<p>Adopted partially.</p> <p>Modified as shown below:</p> <p><u>Text as proposed in State Register:</u></p> <p>G. Living Quarters for Staff Members. In addition to residents, only staff members, volunteers, or owners of the facility and members of the owner’s immediate family may reside in facilities licensed under this regulation. Resident rooms shall not be utilized by staff members/family/volunteers <u>any individuals other than facility residents or residents’ family members, nor shall bedrooms of staff members/family/volunteers members of the owner or the licensee/volunteers</u> be utilized by residents. <u>Staff members/family members of the owner or licensee/volunteers shall not use resident living rooms, recreational areas or dining rooms unless they are on duty.</u></p> <p><u>Change per comment:</u></p> <p>GE. Living Quarters for Staff Members. In addition to residents, only staff members, volunteers, or owners of the facility and members of the owner’s immediate family may reside in facilities licensed under this regulation. Resident rooms shall not be utilized by any individuals other than facility residents or residents’ family members, nor shall bedrooms of staff members/family members of the owner or the licensee be utilized by residents. Staff members/family members of the</p>

SECTION/COMMENTOR	PUBLIC COMMENTS	STAFF RESPONSE
		owner or licensee/volunteers shall not use resident living rooms, recreational areas or dining rooms unless they are on duty.
<p>Section 103.K</p> <p>1) Maxine Giles, South Island Assisted Living</p> <p>2) Protection and Advocacy for People with Disabilities, Inc.</p>	<p>1) Agree with background checks for direct care staff but do not agree with background checks for licensees.</p> <p>2) The regulation should require a check of the sex offender registry and the child abuse registry, if feasible.</p>	<p>Not Adopted.</p> <p>1) Requiring criminal background checks for both licensees and direct care staff is in the best interest of the residents.</p> <p>2) Checks of the sex offender registry and the child abuse registry, although not required, are certainly permissible should a facility determine that it is appropriate.</p> <p><u>Text as proposed in State Register:</u></p> <p>K. Licensee. <u>Prior to the Department issuing an initial license, the proposed A-licensee shall submit to the Department the result of a criminal background check (CBC), original letters of reference from three persons not related to, nor employed by the licensee, that attest to the licensee's reputable and responsible character, and the financial ability and competence to operate a community residential care facility (if owner is a corporation, then references for the chief executive officer of the corporation; if a partnership, then references for each partner owning five percent or more). One of the references shall be the result of a criminal background check with S.C. State Law Enforcement, or by letter from the local police department. The extent of the CBC shall, at a minimum, include a state background check conducted by the S. C. State Law Enforcement Division (SLED). If the licensee is a corporation, limited partnership, limited liability company or any other organized business entity, then the CBC shall be conducted on the chief executive officer or head of that entity; if a partnership, then the CBC shall be conducted on each partner owning five percent (5%) or more. For Out-of-state licensees, references shall, at a minimum, include a state criminal background check-CBC from that state where the licensee currently resides in addition to the S.C. CBC conducted by SLED. If the licensee has been a resident of South Carolina or any other state for less than twelve (12) months, or residency for twelve (12) months or more cannot be verified, a Federal CBC</u></p>

SECTION/COMMENTOR	PUBLIC COMMENTS	STAFF RESPONSE
		<p><u>must be conducted.</u> The <u>proposed</u> licensee shall be financially able to meet all obligations necessary to the proper operation of the facility. <u>Prior to or subsequent to being licensed, the licensee shall not have a conviction or pled no contest (nolo contendere) for abuse, neglect, or exploitation of a child or vulnerable adult as defined per S.C. Code Ann., Section 43-35-10, et seq. (1976, as amended).</u> <u>Subsequent to the issuance of an initial license, the licensee shall maintain a reputable and responsible character and be financially able to operate the facility.</u></p>
<p>Section 103.L 1) SC-ALFA 2) SCDMH 3) Tina Zaborowski, Country Christian Care 4) Sincere Home Owners United Together (SHOUT) 5) Lisa Flaughner, April Valley 6) DHEC Legal</p>	<ol style="list-style-type: none"> 1) To exceed \$15.00 per bed license fee is extreme. 2) The proposed revision would require 167% increase in licensing fees for a 16 bed facility. 3) This requirement will create a 100% increase in license fee charges. 4) Reduce the licensing fee from \$20 to \$13 or \$15 and gradually increase to \$20. 5) Do not impose higher fees that will put smaller facilities out of business. 6. Add “proposed” licensed beds for clarity. 	<p>Adopted partially. Modified as shown below:</p> <p><u>Text as proposed in State Register:</u></p> <p>L. Licensing Fees. The annual license fee shall be \$10.00 twenty dollars (\$20) per licensed bed or \$75.00 a minimum of two hundred dollars (\$200), whichever is greater. Such fee shall be made payable by check or money order <u>credit card</u> to the Department and is not refundable. Fees for additional beds shall be prorated based upon the remaining months of the licensure year. If the application is denied or withdrawn, a portion of the fee shall <u>may</u> be refunded based upon the remaining months of the licensure year, or \$75.00 two hundred dollars (\$200), whichever is lesser. <u>For proposed facilities where applications for licensing have been submitted to the Department, in addition to the annual license fee, there shall be an initial license fee of five hundred dollars (\$500) for proposed facilities with sixteen (16) or more proposed licensed beds and two hundred and fifty dollars (\$250) for less than sixteen (16) proposed licensed beds. In those instances where there is a proposed licensed bed increase through application with the Department, in addition to the annual license fee, there shall be an initial proposed license bed increase fee of five hundred dollars (\$500) with sixteen (16) or more proposed licensed beds and two hundred and fifty dollars (\$250) for less than sixteen</u></p>

SECTION/COMMENTOR	PUBLIC COMMENTS	STAFF RESPONSE
		<p><u>(16) licensed beds.</u></p> <p><u>Change per comment:</u></p> <p>L<u>K</u>. Licensing Fees. The annual license fee <u>as of the January following the effective date of this regulation shall be twenty fifteen dollars (\$20 15) per licensed bed, or a minimum of two hundred dollars (\$200), whichever is greater. The second January following the effective date of this regulation, the annual license fee shall be seventeen dollars and fifty cents (\$17.50) per licensed bed. The third January following the effective date of this regulation, the annual license fee shall be twenty dollars (\$20) per licensed bed.</u> Such fee shall be made payable by check or credit card to the Department and is not refundable. Fees for additional beds shall be prorated based upon the remaining months of the licensure year. If the application is denied or withdrawn, a portion of the fee may be refunded based upon the remaining months of the licensure year. or two hundred dollars (\$200), whichever is less. For proposed facilities where applications for licensing have been submitted to the Department, in addition to the annual license fee, there shall be an initial license fee of five hundred dollars (\$500) for proposed facilities with sixteen (16) or more proposed licensed beds and two hundred and fifty dollars (\$250) for less than sixteen (16) proposed licensed beds. In those instances where there is a proposed licensed bed increase through application with the Department, in addition to the annual license fee, there shall be an initial proposed license bed increase fee of five hundred dollars (\$500) with sixteen (16) or more proposed licensed beds and two hundred and fifty dollars (\$250) for less than sixteen (16) <u>proposed</u> licensed beds.</p>
<p>Section 202.E</p> <p>1) SC-ALFA</p> <p>2) Protection and Advocacy for People with Disabilities, Inc.</p> <p>3) Capitol Consultants</p>	<p>1) Add the statement “when it is apparent that the facility is not being proactive to correct the repeat violations.”</p> <p>2) Support posting information at the facility about DHEC inspection reports of the facility, including any corrective action and follow-ups.</p> <p>3) Results of a survey without a formal dispute resolution should not be required to be posted.</p>	<p>Not adopted.</p> <p>1) Facility Plans of Correction are reviewed for timeliness and appropriateness and follow up inspections may be conducted to assure compliance.</p> <p>2) Thank you for your comment.</p>

SECTION/COMMENTOR	PUBLIC COMMENTS	STAFF RESPONSE
		<p>3) The regulation does not prevent facilities from disputing citations nor from posting documentation reflecting that a report has been disputed.</p> <p><u>Text as proposed in State Register:</u></p> <p>E. Reports of inspections A copy of the most recent report of the resident care focused inspection and the most recent general inspection conducted by the Department, including the facility response, shall be made available by the facility upon request made available by the facility upon request in a conspicuous place in a public area within the facility with the redaction of the names of those individuals in the report as provided by Sections 44-7-310 and 44-7-315 of the S.C. Code of Laws, 1976, as amended.</p>
<p>Section 302.E 1) SCARCH</p>	<p>1) Define “extreme deficiencies”.</p>	<p>Adopted.</p> <p>1. Language modified as shown below:</p> <p><u>Text as proposed in State Register:</u></p> <p>E. In arriving <u>determining at a decision to take an</u> enforcement actionss the Department shall consider the following factors:</p> <p>1. Specific conditions and their impact or potential impact on health, safety or well-being of the residents <u>including: extreme deficiencies in medication management, such as evidence that residents are not routinely receiving their prescribed medications; serious waste water problems, such as toilets not operating or open sewage covering the grounds; extreme housekeeping/maintenance/fire and life safety-related problems that pose a health threat to the residents; power/water/gas or other utility and/or service outages; residents exposed to air temperature extremes that jeopardize their health; unsafe condition of the building/structure such as a roof in danger of collapse; indictment of an administrator for malfeasance or a felony, which by its nature, such as drug dealing, indicates a threat to the residents; direct evidence of</u></p>

SECTION/COMMENTOR	PUBLIC COMMENTS	STAFF RESPONSE
		<p><u>abuse, neglect, or exploitation; lack of food or evidence that the residents are not being fed properly; no staff available at the facility with residents present; unsafe procedures/treatment being practiced by staff; (1)</u></p> <p><u>Change per comment:</u></p> <p>E. In arriving <u>determining</u> at a decision to take an enforcement actions, the Department shall consider the following factors:</p> <p>1. Specific conditions and their impact or potential impact on health, safety or well-being of the residents including: extreme deficiencies in medication management, such as evidence that residents are not routinely receiving their prescribed medications; serious waste water problems, such as toilets not operating or open sewage covering the grounds; extreme housekeeping/maintenance/fire and life safety-related problems that pose a health threat to the residents; power/water/gas or other utility and/or service outages; residents exposed to air temperature extremes that jeopardize their health; unsafe condition of the building/structure such as a roof in danger of collapse; indictment of an administrator for malfeasance or a felony, which by its nature, such as drug dealing, indicates a threat to the residents; direct evidence of abuse, neglect, or exploitation; lack of food or evidence that the residents are not being fed properly; no staff available at the facility with residents present; unsafe procedures/treatment being practiced by staff; (1)</p>
<p>Section 503.B 1) Capitol Consultants</p>	<p>1) The word “supervision” is too vague to determine guidelines for a facility to determine staff ratios.</p>	<p>Not Adopted.</p> <p>1) The proposed revision does not change the current minimum staffing standards but addresses staffing above the minimum standard if required to meet resident care needs.</p> <p><u>Text as proposed in State Register:</u></p> <p>B. The number and qualifications of staff</p>

SECTION/COMMENTOR	PUBLIC COMMENTS	STAFF RESPONSE
		<p>members/volunteers shall be determined by the number and condition of the residents. There shall be sufficient staff members/volunteers to provide <u>supervision</u>, direct care and basic services <u>for residents, e.g., those with</u> Alzheimer’s disease and/or related dementia <u>or in an</u> Alzheimer’s special care unit or program. The minimum number of staff members/volunteers that shall be maintained in all facilities:</p>
<p>Section 601.A 1) Protection and Advocacy for People with Disabilities, Inc.</p>	<p>1) We oppose removing the requirement of documentation of the use of seclusion or restraint in Section 601.A.</p>	<p>Adopted.</p> <p>Modified as shown below:</p> <p><u>Text as proposed in State Register:</u></p> <p>A. A record of each incident and/or accident, including usage of mechanical/physical restraints, involving residents, staff members <u>or</u> volunteers, occurring in the facility or on the facility grounds, shall be <u>reviewed, investigated, if necessary,</u> <u>evaluated in accordance with facility policies and procedures,</u> <u>and retained.</u></p> <p><u>Change per comment:</u></p> <p>A. A record of each incident <u>including usage of mechanical/physical restraints,</u> involving residents, staff members or volunteers, occurring in the facility or on the facility grounds, shall be <u>documented,</u> reviewed, investigated, <u>and if necessary,</u> evaluated in accordance with facility policies and procedures, and retained.</p>
<p>Section 601.B 1) Protection and Advocacy for People with Disabilities, Inc.</p>	<p>1) Change to read “All ‘incidents’ as defined in §101.BB shall be documented in the resident’s file and reported to the resident’s responsible party, next of kin, or sponsor and to the facility administrator within twenty-four hours, as well as to the resident’s treating physician if appropriate, and to the prescriber in the case of medication errors.”</p>	<p>Not Adopted.</p> <p>1) The regulation currently requires documentation of injury, changes in physical/mental condition, physician orders, and recommendations for all medications, care and services in the resident record which would include incidents affecting residents’ health and welfare.</p> <p><u>Text as proposed in State Register:</u></p>

SECTION/COMMENTOR	PUBLIC COMMENTS	STAFF RESPONSE
		<p>B. Reports shall contain at a minimum: facility name, resident age and sex, date of incident/accident, location, witness names, extent/type of injury and how treated, (e.g., hospitalization), identified cause of incident/accident, internal investigation results if cause unknown, identity of other agencies notified of incident/accident and the date of the report. Serious incidents and/or medical conditions as defined in Section 601.C and any sudden or unexpected illness or medication administration error resulting in death or inpatient hospitalization shall be reported immediately via telephone to the attending physician, the resident's next-of-kin or responsible party, and the sponsoring agency.</p>
<p>Section 601.C. 1) Protection and Advocacy for People with Disabilities, Inc. 2) Aging Services of South Carolina 3) Central Midlands Council of Governments</p>	<p>1) Propose amending this language as follows: "A 'serious incident' is an 'incident', as defined in §101.BB, that:</p> <p style="padding-left: 40px;">a) Results in death or a significant loss of function or damage to a body structure, including, but not limited to: falls or trauma resulting in fractures of major limbs or joints; resident suicides; adverse medication reactions; criminal events or assaults against residents; any major burn; any wound requiring stitching; bone fractures, substantial hematoma, or injuries to internal organs, whether self-inflicted or inflicted by someone else; any resident death or injury while in restraints; any sudden or unexpected illness or medication administration error resulting in death or inpatient hospitalization; or</p> <p style="padding-left: 40px;">b) Any incident where a resident has left the premises without notice to staff members of intent to leave and has not returned to the facility within twenty-four (24) hours; or</p> <p style="padding-left: 40px;">c) Any incident which gives rise to the suspicion or allegation of resident abuse, neglect, or exploitation as defined in S.C. Code §43-35-10."</p> <p>2) Items 1, 2, 4, and 6 are serious in all instances but items 3 and 5 should be omitted.</p>	<p>Not Adopted.</p> <p>1 & 3) It would not be feasible to address every health and safety event individually. The proposed language reflects responsible reporting requirements to address significant changes in residents' condition.</p> <p>2) Medication errors and medical equipment errors can pose potentially serious health and safety consequences for physically fragile residents and therefore should remain a reportable occurrence.</p> <p><u>Text as proposed in State Register:</u></p> <p>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 shall be notified not later than 10 days of the occurrence. A serious incident is one that results in death or a significant loss of function or damage to a body structure, not related to the natural</p>

SECTION/COMMENTOR	PUBLIC COMMENTS	STAFF RESPONSE
	<p>3) Keeping the definition of serious injury to provide clarity as related to injuries would be beneficial.</p>	<p><u>course of a resident's illness or underlying condition or normal course of treatment, and resulting from an incident occurring within the facility or on the facility grounds. A serious incident shall be considered as, but is not limited to:</u></p> <ol style="list-style-type: none"> <u>1. Falls or trauma resulting in fractures of major limbs or joints;</u> <u>2. Resident suicides;</u> <u>3. Medication errors;</u> <u>4. Criminal events or assaults against residents;</u> <u>5. Medical equipment errors; or,</u> <u>6. Resident neglect or exploitation, suspected or confirmed resident abuse.</u>
<p>Section 601.F 1) SCARCH 2) DHEC Legal</p>	<ol style="list-style-type: none"> 1) Add notification by telephone or fascimilie. 2) Change "of" to "following" for clarity. 	<p>Adopted.</p> <p><u>Text as proposed in State Register:</u></p> <p><u>F. Incidents where residents have left the premises without notice to staff members of intent to leave and have not returned to the facility within twenty-four (24) hours shall be reported to the administrator or his or her designee, local law enforcement, and the resident's responsible party, when appropriate. The Division of Health Licensing shall be notified in writing not later than ten (10) days of the occurrence. When residents who are cognitively impaired leave the premises without notice to staff members, regardless of the time-period of departure, the administrator or his or her designee, local law enforcement, next-of-kin, and sponsoring agency shall be contacted immediately. DHL shall be notified not later than ten (10) days of the occurrence.</u></p> <p><u>Change per comment:</u></p>

SECTION/COMMENTOR	PUBLIC COMMENTS	STAFF RESPONSE
		<p>F. Incidents where residents have left the premises without notice to staff members of intent to leave and have not returned to the facility within twenty-four (24) hours shall be reported to the administrator or his or her designee, local law enforcement, and the resident's responsible party, when appropriate. The Division of Health Licensing shall be notified in writing not later than ten (10) days of the occurrence. When residents who are cognitively impaired leave the premises without notice to staff members, regardless of the time-period of departure, the administrator or his or her designee, local law enforcement, next-of-kin, and sponsoring agency shall be contacted immediately <u>by telephone or facsimile</u>. DHL shall be notified not later than ten (10) days of <u>following</u> the occurrence.</p>
<p>Section 701.B.6 1) Aging Services of South Carolina</p>	<p>1) Delete the last sentence as it is unclear what is meant by "all other instances."</p>	<p>Not Adopted.</p> <p>1) Requiring at least monthly documentation of observation is necessary to maintain an accurate and up to date reflection of a resident's condition.</p> <p><u>Text as proposed in State Register:</u></p> <p>B. Specific entries/documentation shall include at a minimum:</p> <p>6. <u>Notes of observation. In instances that involve significant changes in a resident's medical condition and/or the occurrence of a serious incident, notes of observation shall be documented at least daily until the condition is stabilized and/or the incident is resolved. In all other instances, notes of observation for residents shall be documented at least monthly;</u></p>
<p>Section 701.B.10 1) SC-ALFA</p>	<p>1) Agree with keeping pictures updated every 2 years or with significant change. 2) Requests a minimum size of 3" X 5" be included in the revised standard.</p>	<p>Adopted.</p> <p>Modified as shown below:</p>

SECTION/COMMENTOR	PUBLIC COMMENTS	STAFF RESPONSE
2) SCDMH		<p><u>Text as proposed in State Register:</u></p> <p>10. Photograph of resident. <u>Resident photographs shall be dated and no more than twenty-four (24) months old unless significant changes in appearance have occurred necessitating a more recent photograph.</u></p> <p><u>Change per comment:</u></p> <p>10. Photograph of resident. Resident photographs shall be <u>at a minimum two and one half inches by three and one half inches (2 ½ by 3 ½ inches) in size, dated, and no more than twenty-four (24) months old unless significant changes in appearance have occurred necessitating a more recent photograph.</u></p>
Section 801.C(5)(d) 1) SC-ALFA & Capitol Consultants	1) Licensed nurses should be allowed to administer subcutaneous injections of Forteo.	<p>Not adopted.</p> <p>1) Regular subcutaneous injections other than routine, scheduled injections of insulin for more than fourteen (14) consecutive days exceed short term intermittent nursing care guidelines.</p> <p><u>Text as proposed in State Register:</u></p> <p>C. Persons not eligible for admission/retention are:</p> <p>5. <u>Any person who requires one of the following nursing services determined by the South Carolina Board of Nursing to require the skills of a licensed nurse for no more than fourteen (14) consecutive days:</u></p> <p>d. <u>Intravenous medications or fluids, regular intra-muscular and subcutaneous injections by staff. This does not include injections administered on a part-time or intermittent basis by non-staff licensed nurses. Routine injection(s) of insulin scheduled daily or less frequently are permitted;</u></p>
Section 801.C(5)(h)	1) Add “unless managed independently by the resident.”	Not adopted.

SECTION/COMMENTOR	PUBLIC COMMENTS	STAFF RESPONSE
1) Capitol Consultants		<p>1) Suctioning of the nose and/or mouth is considered a skilled nursing function.</p> <p><u>Text as proposed in State Register:</u></p> <p>C. Persons not eligible for admission/retention are:</p> <p>5. <u>Any person who requires one of the following nursing services determined by the South Carolina Board of Nursing to require the skills of a licensed nurse for no more than fourteen (14) consecutive days:</u></p> <p><u>h. Suctioning of the nose and/or mouth;</u></p>
<p>Section 1001.L</p> <p>1) Protection and Advocacy for People with Disabilities, Inc.</p>	<p>1) Add language “including the ability to speak without being overheard” and the ability to make calls without “unreasonable delay or restriction.”</p>	<p>Adopted partially.</p> <p>1) Modified as shown below:</p> <p><u>Text as proposed in State Register:</u></p> <p>L. Residents shall be permitted to use the telephone and shall be allowed privacy when making <u>placing or receiving</u> telephone calls.</p> <p><u>Change per comment:</u></p> <p>L. Residents shall be permitted to use the telephone and shall be allowed privacy when placing or receiving telephone calls. <u>This access shall include business hours from 7 a.m. through 8 p.m., seven (7) days a week, and other times when appropriate. This telephone service shall be available for use by residents and/or visitors for their private, discretionary use; pay phones for this purpose are acceptable. Telephones capable of only local calls are acceptable for this purpose, provided other arrangements exist to provide resident/visitor discretionary access to a telephone capable of long distance service.</u></p>
Section 1101.A(2)	1) Change “required” to “prescribed”.	Adopted partially.

SECTION/COMMENTOR	PUBLIC COMMENTS	STAFF RESPONSE
1) SCARCH		<p><u>Text as proposed in State Register:</u></p> <p>A. A physical examination shall be completed for residents within <u>thirty (30) days</u> prior to admission and at least annually thereafter. <u>Physical examinations conducted within thirty (30) days prior to admission by physicians licensed in states other than South Carolina are permitted for new admissions under the condition that residents obtain an attending physician licensed in South Carolina within thirty (30) days of admission to the facility and undergo a second (2nd) physical examination by that physician within thirty (30) days of admission to the facility. The physical examination shall be updated to include new medical information if the resident's condition has changed since the last physical examination was completed.</u> The physical examination shall address:</p> <ol style="list-style-type: none"> <u>1. †The appropriateness of placement in a CRCF;</u> <u>2. ‡Medications/treatments required;</u> <p><u>Change per comment:</u></p> <p>A. A physical examination shall be completed for residents within thirty (30) days prior to admission and at least annually thereafter. Physical examinations conducted within thirty (30) days prior to admission by physicians licensed in states other than South Carolina are permitted for new admissions under the condition that residents obtain an attending physician licensed in South Carolina within thirty (30) days of admission to the facility and undergo a second (2nd) physical examination by that physician within thirty (30) days of admission to the facility. The physical examination shall be updated to include new medical information if the resident's condition has changed since the last physical examination was completed. The physical examination shall address:</p> <ol style="list-style-type: none"> 1. The appropriateness of placement in a CRCF; 2. Medications/treatments <u>ordered</u>;

SECTION/COMMENTOR	PUBLIC COMMENTS	STAFF RESPONSE
<p>Section 1702.E. 1) SC-ALFA & Capitol Consultants</p>	<p>1) Allow the second step of the resident two step PPD to be performed following admission.</p>	<p>Adopted.</p> <p>1) Modified as shown below:</p> <p><u>Text as proposed in State Register:</u></p> <p><u>E. Resident Tuberculosis Screening (I)</u></p> <p>1. <u>Tuberculosis Status. Prior to admission, the tuberculosis status of a resident shall be determined in the following manner in accordance with the applicable risk classification:</u></p> <p>a. <u>For Low Risk and Medium Risk:</u></p> <p>1. <u>Admission/Baseline two-step TST or a single BAMT: All residents within thirty (30) days prior to admission shall have completed the first step of the two step tuberculin skin test followed seven to twenty one (7 to 21) days later by a second test unless there is a documented TST or a BAMT result during the previous twelve (12) months. If a newly-admitted resident has had a documented negative TST or a BAMT result within the previous twelve (12) months, a single TST (or the single BAMT) can be administered within one (1) month prior to admission to the facility to serve as the baseline.</u></p> <p><u>Change per comment:</u></p> <p>E. Resident Tuberculosis Screening (I)</p> <p>1. Tuberculosis Status. Prior to admission, the tuberculosis status of a resident shall be determined in the following manner in accordance with the applicable risk classification:</p> <p>a. For Low Risk and Medium Risk:</p> <p>1. Admission/Baseline two-step TST or a</p>

SECTION/COMMENTOR	PUBLIC COMMENTS	STAFF RESPONSE
		<p>single BAMT: All residents within thirty (30) days prior to admission shall have completed the first step of the two step tuberculin skin test followed seven to twenty one (7 to 21) days later by a second test unless there is a documented TST or a BAMT result during the previous twelve (12) months. If a newly-admitted resident has had a documented negative TST or a BAMT result within the previous twelve (12) months, a single TST (or the single BAMT) can be administered within one (1) month prior to admission to the facility to serve as the baseline. <u>As an exception, a resident may be admitted with at least the first step of the TB screening process completed prior to admission and the second step with fourteen (14) days of admission.</u></p>
<p>Section 2207.D 1) SC-ALFA</p>	<p>1) Specify time frame between flame retardant treatments.</p>	<p>Not adopted.</p> <p>1) The Department defers to the NFPA 701, Standard Methods of Fire Tests for Flame-Resistant Textiles and Films for flame retardant treatment guidelines.</p> <p><u>Text as proposed in State Register:</u></p> <p>D. Wastebaskets, window dressings, portable partitions, cubicle curtains, mattresses, and pillows shall be noncombustible, inherently flame-resistant, or treated or maintained flame-resistant in accordance with NFPA 701, Standard Methods of Fire Tests for Flame-Resistant Textiles and Films. <u>As an exception, window blinds require no flame treatments.</u></p>
<p>Section 2715.A 1) Protection and Advocacy for People with Disabilities, Inc. 2) SCDMH</p>	<p>1) Require that residents have private access to the phone during normal business hours so they can make necessary calls without unreasonable delay or restriction. 2) Include language assuring residents can use the telephone during reasonable hours during the day such as 9 a.m. to 9 p.m.</p>	<p>Adopted partially.</p> <p>See modifications to Section 1001.L. regarding accessibility and privacy.</p> <p><u>Text as proposed in State Register:</u></p> <p>A. At least one (1) telephone shall be available on each floor of the facility <u>with at least one (1) active main or fixed-line telephone service available</u> for use by residents and/or</p>

SECTION/COMMENTOR	PUBLIC COMMENTS	STAFF RESPONSE
		<p>visitors for their private, discretionary use; pay phones for this purpose are acceptable. Telephones capable of only local calls are acceptable for this purpose, provided other arrangements exist to provide resident/visitor discretionary access to a telephone capable of long distance service.</p> <p><u>Change per comment:</u></p> <p>A. At least one (1) telephone shall be available on each floor of the facility with at least one (1) active main or fixed-line telephone service available for use by residents and/or visitors for their private, discretionary use; pay phones for this purpose are acceptable. Telephones capable of only local calls are acceptable for this purpose, provided other arrangements exist to provide resident/visitor discretionary access to a telephone</p>

ATTACHMENT E
Excerpt of Notice of Proposed Regulation as Published in the *State Register* October 23, 2009
44 PROPOSED REGULATIONS

Document No. 4108

DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

CHAPTER 61

Statutory Authority: 1976 Code Section 44-7-250

61-84. Standards for Licensing Community Residential Care Facilities

Preamble:

The Department proposes to amend Regulation 61-84 to update and enhance the following areas: definitions, *i.e.*, proposed new definitions on airborne infection isolation, blood assay for *Mycobacterium tuberculosis* (BAMT), contact investigation, incident, latent TB infection (LTBI), private sitter, quarterly and risk assessment; revision of definitions: annual, local transportation, and peak hours; Non-Departmental publications referenced in this regulation; compliance with structural and fire standards; the living quarters in the facility for individuals other than residents; application completion; the fiscal responsibilities of the proposed facility licensee and facility licensee; license fees; Department reports availability; conditions affecting the determination of enforcement action; determination of monetary penalty amounts; appeal procedure for enforcement actions; facility responsibilities for written policies and procedures; a criminal background check for direct care staff; administrator licensing law; facility staff provision of care; staff training documentation and verification; staff provision of resident recreational activities; private sitters for residents (proposed new Section at 506); facility compliance with reporting of incidents; change of administrator reporting responsibilities; time period for notes of observation; age of resident photograph; resident assessment documentation requirements; criteria for resident admission and retention; documentation requirements for statement of resident rights and grievance procedures; resident finances fiscal management documentation; resident use of telephone; content of resident physical examination; medication and first aid items availability; medication and treatment orders; time period for physician signing verbal orders; documentation of treatments; clarification of unit dose system; refrigeration of medications; documentation of controlled substances; menu approvals for medically prescribed diets; facility staff use of alcohol-based hand sanitizers; counties affected by letter of agreement for sheltering facilities; documentation of continuity of essential services; resident fire response training; tuberculin skin testing for residents and staff; health screening for facility pets; kitchen firefighting equipment; non-combustible or flame retardant materials; facility ‘no smoking’ areas; mirrors in resident rooms; use of bar soap in shared bathrooms; facility telephones for resident use; and barriers to natural or manmade bodies of water on or adjacent to the facility property.

Additionally, changes will be proposed throughout the regulation to improve its overall quality, *i.e.*, stylistic changes and language clarifications. The table of contents will be updated, and other minor corrections will be proposed as needed. See Determination of Need and Reasonableness below.

A Notice of Drafting for this proposed amendment was published in the *State Register* on May 22, 2009.

Section-by-Section Discussion of Proposed Revisions:

Table of Contents:

The table has been updated and is being replaced in its entirety with classifications and punctuation added for consistency with the text of the regulation.

ATTACHMENT F
DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL
CHAPTER 61

Statutory Authority: 1976 Code Sections 44-7-110 et seq.

Notice of Drafting:

The Department of Health and Environmental Control proposes to amend specific sections of Regulation 61-84, Standards For Licensing Community Residential Care Facilities. This current Notice of Drafting cancels, replaces and supercedes the proposed revisions noticed in a previous Notice of Drafting that was published in the State Register on May 23, 2008. Interested persons may submit written comments on the proposed revisions as listed below to Dennis L. Gibbs, Director, Division of Health Licensing, South Carolina Department of Health and Environmental Control, 2600 Bull Street, Columbia, South Carolina 29201. To be considered, all comments must be received no later than 5:00 p.m. on June 22, 2009, the close of the drafting comment period.

Synopsis:

The Department proposes to amend and is soliciting comments on specific sections of Regulation 61-84, to be limited to the revision/update of those sections relating to:

- (1) definitions, i.e., proposed new definitions on airborne infection isolation, blood assay for Mycobacterium tuberculosis (BAMT), contact investigation, incident, latent TB infection (LTBI), private sitter, quarterly and risk assessment; revision of definitions: annual, local transportation , and peak hours (Section 101);
- (2) Non-Departmental publications referenced in this regulation (Section 102.B);
- (3) compliance with structural standards (Section 103.D);
- (4) the living quarters in the facility for individuals other than residents (Section 103.G);
- (5) application completion (Section 103.J);
- (6) the fiscal responsibilities of the proposed facility licensee and facility licensee (Section 103.K);
- (7) license fees (Section 103.L);
- (8) Department reports availability (Section 202.E)
- (9) conditions affecting the determination of enforcement action (Section 302.E);
- (10) determination of monetary penalty amounts (Section 302.F);
- (11) appeal procedure for enforcement actions (Section 302.G);

- (12) facility responsibilities for written policies and procedures (Section 401.A);
- (13) a criminal background check for direct care staff (Section 501.B);
- (14) administrator licensing law (Section 502.A)
- (15) facility staff provision of care (Section 503.B);
- (16) staff training documentation and verification (Section 504.A);
- (17) staff provision of resident recreational activities (Section 504.B);
- (18) private sitters for residents (proposed new Section at 506);
- (19) facility compliance with reporting of incidents (Section 601);
- (20) change of administrator reporting responsibilities (Section 604);
- (21) time period for notes of observation (Section 701.B.6);
- (22) age of resident photograph (Section 701.B.10);
- (23) resident assessment documentation requirements (Section 702);
- (24) criteria for resident admission and retention (Section 801.B&C);
- (25) documentation requirements for statement of resident rights and grievance procedures (Section 901.A.8);
- (26) resident finances fiscal management documentation (Section 902.H);
- (27) resident use of telephone (Section 1001.L);
- (28) content of resident physical examination (Section 1101.A);
- (29) medication and first aid items availability (Section 1201.A);
- (30) medication and treatment orders (Section 1202);
- (31) time period for physician signing verbal orders (Section 1202.B)
- (32) documentation of treatments (Section 1203.A);
- (33) clarification of unit dose system (Section 1205.B);
- (34) refrigeration of medications (Section 1206.A.);

- (35) documentation of controlled substances (Section 1206.C);
- (36) menu approvals for medically prescribed diets (Section 1306.A);
- (37) facility staff use of alcohol-based hand sanitizers (Section 1309.A);
- (38) counties affected by letter of agreement for sheltering facilities (Section 1401.B.1.c);
- (39) documentation of continuity of essential services (Section 1403);
- (40) resident fire response training (Section 1503.C);
- (41) tuberculin skin testing for residents and staff (Section 1702);
- (42) health screening for facility pets (Section 1705. B);
- (43) kitchen firefighting equipment (Section 2201.D);
- (44) non-combustible or flame retardant materials (Section 2207.D);
- (45) facility ‘no smoking’ areas (Section 2207.E);
- (46) ‘smoking’ and ‘non-smoking’ areas signage (Section 2207.F);
- (47) mirrors in resident rooms (Section 2702.J);
- (48) use of bar soap in shared bathrooms (Section 2704.D);
- (49) facility telephones for resident use (Section 2715.A); and
- (50) barriers to natural or manmade bodies of water on or adjacent to the facility property (Section 2717.A).

Additionally, changes may be proposed throughout the regulation to improve its overall quality, i.e., stylistic changes and language clarifications. The table of contents will be updated, and other minor corrections may be proposed as needed.

Legislative review of this amendment is required.