DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Myers	2-27-09

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 090472	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR Cleared 3/5/09, letter attached.	[X] Prepare reply for appropriate signature DATE DUE 3-10-09 [ ] FOIA DATE DUE _____ [ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

From: Bryan Kost
To: Brenda James
Date: 2/27/2009 11:47 am
Subject: Log letter - Fw: Maxim Healthcare Survey request

Please log - thanks

From: Darius Nouri <danouri@maxhealth.com>
To: <kostbr@scdhhs.gov>
Date: 2/27/2009 10:40 am
Subject: Maxim Healthcare Survey request

CC: Darius Nouri <danouri@maxhealth.com>

Brian,

Thank you for getting back to me so quickly this morning. Per your request, here is a list of past surveys we need:

Greenville, SC (Provider # EX0579)

2003

2004

2006

Charleston, SC (Provider # EX0595)

2001

2002

2003

2004

2005

Columbia, SC (Provider # EX0664)

2002

2003

2004

Please let me know how long it may take to obtain all these. Should you have any questions, please feel free to call me at 864-242-1994.

Thank you in advance for your assistance.

Sincerely,

Darius Nouri
Accounts Manager
Maxim Healthcare Services
Greenville, SC
Ph: (864) 242-1994
Fax: (864) 241-9040

Sam - Bryan says this provider cannot find old surveys + would like us to send theirs to them. Hope this makes sense.
FCM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Myers / Waldrep	2-27-09

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 100472	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____	[X] Prepare reply for appropriate signature DATE DUE 3-10-09
	[ ] FOIA DATE DUE _____
	[ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1. Sam Waldrep	SW		
2. Roy Smith RS			
3. Debora Carter	DC 3/4/09		
4.			

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

March 5, 2009

Darius Nouri
Maxim Healthcare
555 N. Pleasantburg Drive, Suite 200
Greenville, SC 29607

Re: Maxim Healthcare Survey request

Dear Mr. Nouri:

This is in response to your recent request for the Maxim Healthcare reviews for Greenville (EX0579), Charleston (EX0595), and Columbia (EX0664). Enclosed are the reviews that you requested, with the exception of Greenville (EX0579) 2004 review, and Columbia (EX0664) 2003 review; there were no reviews for these locations during those years.

Sincerely,

Felicity Myers
Deputy Director

FM/wscd

Enclosures

Medical Services
P. O. Box 8206 Columbia South Carolina 29202-8206
(803) 898-2501 Fax (803) 255-8235

REPORT OF VISIT

SEND REPLY TO: **Community Long Term Care**
P.O. Box 8206
Columbia, SC 29202-8206

Administrator: Darius Nouri	Provider: (EX0579) Maxim Healthcare Ser.,Inc.	Address: 555 N. Pleasantburg Dr., Ste. 200

On Thursday, May 19, 2005 South Carolina Department of Health and Human Services representative(s) visited your facility/activity to conduct an Annual Survey. The areas observed are described below. If any violations were found, the class of violation and the applicable section of the Scope of Service for PCI and PCII are included. Please describe in the space provided the action you have planned or taken to correct these conditions and the completion date of those actions. You may attach additional sheets, if necessary. Please sign or initial in the appropriate space(s) and return this form to COMMUNITY LONG TERM CARE by June 12, 2005.

REVIEW RESULTS	CORRECTIVE ACTION / COMPLETION DATE
ADMINISTRATIVE REVIEW No deficiencies were noted. **SERVICE REVIEW** PCII Service (5 cases reviewed) 2 reviews (13%) Supervisory visit was not made within 30 days after PC II services started. ~~14 reviews (82%) Supervisory visits were not made according to scope of services~~. 6 reviews (38%) Services were not started on authorized start date. 5 reviews (33%) Provider did not notify CM/SC within 3 days of client changes. 8 reviews (47%) Services are not being delivered consistent with service plan. 14 cases (88%) Almost always notified CM/SC that services were not provided as authorized. 1 case (6%) Sometimes 1 review (33%) Backup plan was not used appropriately for this client.	Please see attached sheets.

REVIEW RESULTS	CORRECTIVE ACTION / COMPLETION DATE
1 review (6%) CLTC service plan is not in the client record. 5 reviews (100%) Record does not contain documentation that CM was notified that services were not started on authorized start date. **STAFF REVIEW** PCI Aide No deficiencies were noted. PCII Aide (8 cases reviewed) 3 reviews (38%) Aide has not received 12 hours in-service training per calendar year. PCII RN/LPN (8 cases reviewed) No deficiencies were noted.	
Signature of Reviewer: _____ Today's Date: May 22, 2005	Agency Administrator: [signature] Date: 6/6/05

Greenville, SC, Plan of Correction

Corrective Action/Completion Date

Effective May 19, 2005, all CLTC and HASCI clients will have the first Supervisory Visit completed within 30 days after PC II services are started. The Supervisory Visit will be done by the Director of Clinical Services, Clinical Supervisor or RN designee per CLTC standards. All nurses performing Supervisory Visits will be instructed by the Director of Clinical Services on CLTC standards for Supervisory Visits. The Director of Clinical Services will document in the RNs personnel file that this instruction has been completed. A Monthly Record Review of 5% of CLTC clients will be done by the Director of Clinical Services to ensure compliance with CLTC regulations until the Regional Director of Clinical Services is ensured that it is being done per CLTC regulations.

Effective May 19, 2005, all CLTC and HASCI clients will have services started on the authorized start date and the services will be consistent with the service plan per CLTC regulations. The Director of Clinical Services will instruct all internal staff on the need for compliance to this CLTC standard. A Monthly Record Review of 5% of CLTC clients will be done by the Director of Clinical Services to ensure compliance with CLTC regulations until the Regional Director of Clinical Services is ensured that it is being done per CLTC standards.

Effective May 19, 2005, the Director of Clinical Services, Clinical Supervisor or RN designee will notify CM/SC within 3 days of appropriate client changes and will continue to notify CM/SC when services are not provided as authorized, per CLTC standards. The Director of Clinical Services will instruct all nurses who do this notification per CLTC regulations and will document this instruction in their personnel file. A Monthly Record Review of 5% of CLTC clients will be done by the Director of Clinical Services to ensure compliance with CLTC standards until the Regional Director of Clinical Services is ensured that it is being done per CLTC regulations.

Effective May 19, 2005, the Director of Clinical Services will instruct the internal staff that a back up plan that is appropriate for a CLTC or HASCI client should be in place to be used appropriately. This will be audited by the Director of Clinical Services through the Monthly Record Review of 5% of CLTC clients to ensure compliance with CLTC regulations until the Regional Director of Clinical Services is ensured that it is being done per CLTC standards.

Effective May 19, 2005, the Director of Clinical Services will be auditing each CLTC and HASCI client record to ensure that the CLTC service plan is in the client record. A Monthly Record Review of 5% of CLTC clients will be done by the Director of Clinical Services to ensure compliance with CLTC standards until the Regional Director of Clinical Services is ensured that it is being done per CLTC regulations.

Effective May 19, 2005, all CLTC and HASCI clients will have the documentation of any notification of CM that services were not started on the authorized start date in their records. The Director of Clinical Services will instruct the Clinical Supervisor and RN designee regarding the documentation per the CLTC regulations. This will be documented in the appropriate personnel file for each of the Registered Nurses instructed. A Monthly Record Review of 5% of CLTC clients will be done by the Director of Clinical services to ensure compliance with CLTC standards until the Regional Director of Clinical Services is ensured that it is being done per CLTC regulations.

REPORT OF VISIT

SEND REPLY TO: **Community Long Term Care**
P.O. Box 8206
Columbia, SC 29202-8206

Administrator: Lorena Watson RN	Provider: (EX0595) Maxim Healthcare Services	Address: 3 S. Park Circle, Suite 105 Charleston, SC 29407

On Tuesday, January 18, 2005 South Carolina Department of Health and Human Services representative(s) visited your facility/activity to conduct an Annual Survey. The areas observed are described below. If any violations were found, the class of violation and the applicable section of the Scope of Service for PCI and PCII are included. Please describe in the space provided the action you have planned or taken to correct these conditions and the completion date of those actions. You may attach additional sheets, if necessary. Please sign or initial in the appropriate space(s) and return this form to COMMUNITY LONG TERM CARE by February 21, 2005.

REVIEW RESULTS	CORRECTIVE ACTION / COMPLETION DATE
ADMINISTRATIVE REVIEW No deficiencies were noted. **SERVICE REVIEW** PCII Service (4 cases reviewed) No deficiencies were noted. **STAFF REVIEW** PCI Aide No deficiencies were noted. PCII Aide (11 cases reviewed) 1 review (9%) Staff person does not have a current PPD tuberculin skin test. PCII RN/LPN (18 cases reviewed) No deficiencies were noted.	The employee no longer works for Maxim of Charleston. We have developed an intensive PPD program for new employees and current employees. It is being tracked by HR via the PC and all employee files have been updated. Thank you. 01/19/05

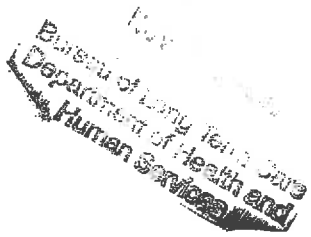
REVIEW RESULTS	CORRECTIVE ACTION / COMPLETION DATE
Signature of Reviewer: _____ Today's Date: January 31, 2005	Agency Administrator: [signature] for DOCS Date: 2/15/05

6/13/03

Addendum to Maxim Health Care
MNS

4 Clients
The records were reviewed.
The following deficiency was identified.
The authorization does not contain start date. (5722546301)

Nurse Surveyor: Carolyn Lockard



Corrective Action / Completion Date

The authorization was corrected by case manager on 6/13/03. The start date was 2/12/03. New authorizations will be reviewed for completeness by Director of Clinical Services, which will include start of care date, as of 6/14/03.

Thank You,
Sommer Chambers RN

REPORT OF VISIT

SEND REPLY TO: **Community Long Term Care**
P.O. Box 8206
Columbia, SC 29202-8206

Administrator: Jeremiah Davis	**Provider: (EX0595) Maxim Healthcare Services**	**Address: 3 S. Park Circle, Suite 105 Charleston, SC 29407**

On Friday, June 13, 2003 South Carolina Department of Health and Human Services representative(s) visited your facility/activity to conduct an Annual Survey. The areas observed are described below. If any violations were found, the class of violation and the applicable section of the Scope of Service for PCI and PCII are included. Please describe in the space provided the action you have planned or taken to correct these conditions and the completion date of those actions. You may attach additional sheets, if necessary. Please sign or initial in the appropriate space(s) and return this form to COMMUNITY LONG TERM CARE [redacted]

REVIEW RESULTS	CORRECTIVE ACTION / COMPLETION DATE
ADMINISTRATIVE REVIEW No deficiencies were noted. **SERVICE REVIEW** PCII Service (2 cases reviewed) No deficiencies were noted. **STAFF REVIEW** PCI Aide No deficiencies were noted. PCII Aide (1 case reviewed) No deficiencies were noted. PCII RN/LPN (6 cases reviewed) No deficiencies were noted.	

REVIEW RESULTS	CORRECTIVE ACTION / COMPLETION DATE
Signature of Reviewer: _____ Today's Date: June 16, 2003	Agency Administrator: _____ Date: _____

6/13/03

Addendum to Maxim Health Care
MNS

4 Clients
The records were reviewed.
The following deficiency was identified.
The authorization does not contain start date. (5722546301)

Nurse Surveyor: Carolyn Lockard

REPORT OF VISIT

SEND REPLY TO: Dayle Dayle
Community Long Term Care
P.O. Box 8206
Columbia, SC 29202-8206

Administrator: Jeremiah Davis	Provider: (EX0664) Maxim Healthcare Services	Address: 3321 Forest Drive Suite 9 Columbia, SC 29204

On Tuesday, January 13, 2004 South Carolina Department of Health and Human Services representative(s) visited your facility/activity to conduct an Annual Survey. The areas observed are described below. If any violations were found, the class of violation and the applicable section of the Scope of Service for PCI and PCII are included. Please describe in the space provided the action you have planned or taken to correct these conditions and the completion date of those actions. You may ~~attach additional~~ sheets, if necessary. Please sign or initial in the appropriate space(s) and return this form to COMMUNITY LONG TERM CARE by February 03, 2004. *

REVIEW RESULTS	CORRECTIVE ACTION / COMPLETION DATE
ADMINISTRATIVE REVIEW No deficiencies were noted. **SERVICE REVIEW** PCII Service 2 reviews (40%) Supervisory visit was not made within 30 days after PC II services started. 1 review (50%) Provider did not notify CM/SC within 3 days of client changes. 1 review (33%) Services are not being delivered consistent with service plan. **STAFF REVIEW** PCII Aide (3 cases reviewed) 1 review (33%) File does not contain documentation of competency evaluation. 1 review (33%) Aide was not evaluated by RN.	In the future supervisory visits will be done on time and providers will be notified immediately of changes in care. All attempts will be made to have consistent care provided. All charts & employees will be up to date on competencies. And nurse will do evals of all aides.

REVIEW RESULTS	CORRECTIVE ACTION / COMPLETION DATE
1 review (33%) Staff person did not have PPD tuberculin skin test 90 days prior to employment. 1 review (33%) Staff person does not have a current PPD tuberculin skin test. PCII RN/LPN (2 cases reviewed) No deficiencies were noted.	All PPD tests will be up to date
Signature of Reviewer: Carolyn Lockhart Today's Date: January 13, 2004	Agency Administrator: Shannon Neubauer RN BS Date: 2-2-04

REPORT OF VISIT

SEND REPLY TO: **Community Long Term Care**
P.O. Box 8206
Columbia, SC 29202-8206

Administrator: Greg Munzel	Facility: Maxim Healthcare Services, Inc	Address: 35 Park Circle, Suite 105 Charleston, SC 29407

On 03/14/01 South Carolina Department of Health and Environmental Control representative(s) visited your facility/activity to conduct an ___ **Initial Survey;** **__X__ Interim Survey;____ Annual Survey; _____ Special Survey; _____ Complaint Investigation.** The conditions observed are described below, including the class of violation and the applicable section of the Scope of Services for **__MNS-AC-PCII__** Please describe in the space provided the action you have planned or taken to correct these conditions and the completion da' `hose actions. You may attach additional sheets if necessary. Please sign or initial in the appropriate space(s) and return this form to COMMUNITY LONG TERM by _____.

DESCRIPTION/DATE TO BE CORRECTED	**CORRECTIVE ACTION/ COMPLETION DATE**
Services: See Above **Staffing:** Two (2) RNs, one (1) LPN, thirteen (13) PCAs All the personnel files were reviewed; no deficiencies were identified. **Conduct of Services:** **MNS:** One (1) client. One (1) record was reviewed; no deficiencies were identified. **AC:** One (1) client One (1) record was reviewed; no deficiencies were identified. **PCII:** Nine (9) clients All the records were reviewed; no deficiencies were identified. DHEC Signature: Florence Tumbokon Date: 3-21-01 TITLE: Florence E. Tumbokon, RN, M.S.N., Director Health Provider Section/Bureau of Certification PROGRAM: Compliance Review Program	_____ Signature of Agency Administrator Date: _____ Page _____ of _____

S. C. DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

INSPECTION REPORT SUPPLEMENT

DATE	NAME AND ADDRESS OF ESTABLISHMENT	PERMIT NO.
3/14/01	Magnum HCS - Chas	Interim MNS-PCII-AC

The item number noted below refers to defects marked on the Inspection Report

ITEM NO.	DEFECT OBSERVED AND CORRECTIVE ACTION NEEDED
	Staffing: FBU 1 RN - 13 PCA's All the personal files were reviewed No deficiencies were identified.
	Caseload of Service:
	MNS: 1 client 1 record was reviewed No deficiencies were identified.
	AC: 1 client 1 record was reviewed No deficiencies were identified.
	PCII: 4 clients All the records were reviewed. No deficiencies were identified.
	Recommended: Consist. PCA State Comp. civil laws.
	Nurse Supervisor Evaluation Reviewed

DHEC 1724 (REV.) (2M-5/87)

PLEASE CORRECT THE ABOVE DEFECTS

REPORT OF VISIT

SEND REPLY TO: **Community Long Term Care**
P.O. Box 8206
Columbia, SC 29202-8206

Administrator: Greg Munzel	Facility: Maxim Healthcare Services, Inc	Address: 35 Park Circle, Suite 105 Charleston, SC 29407

On 03/14/01 South Carolina Department of Health and Environmental Control representative(s) visited your facility/activity to conduct an ___ **Initial Survey;** **__X__ Interim Survey;____ Annual Survey; _____ Special Survey; _____ Complaint Investigation.** The conditions observed are described below, including the class of violation and the applicable section of the Scope of Services for **__MNS-AC-PCII__** Please describe in the space provided the action you have planned or taken to correct these conditions and the completion date of those actions. You may attach additional sheets if necessary. Please sign or initial in the appropriate space(s) and return this form to COMMUNITY LONG TERM CARE by _____ .

DESCRIPTION/DATE TO BE CORRECTED	**CORRECTIVE ACTION/ COMPLETION DATE**
Services: See Above **Staffing:** Two (2) RNs, one (1) LPN, thirteen (13) PCAs All the personnel files were reviewed; no deficiencies were identified. **Conduct of Services:** **MNS:** One (1) client. One (1) record was reviewed; no deficiencies were identified. **AC:** One (1) client One (1) record was reviewed; no deficiencies were identified. **PCII**: Nine (9) clients All the records were reviewed; no deficiencies were identified. DHEC Signature: Florence Tumbokon Date: 3-21-01 TITLE: Florence E. Tumbokon, RN, M.S.N., Director Health Provider Section/Bureau of Certification PROGRAM: Compliance Review Program	_____ Signature of Agency Administrator Date: _____ Page _____ of _____

S. C. DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

INSPECTION REPORT SUPPLEMENT

DATE	NAME AND ADDRESS OF ESTABLISHMENT	PERMIT NO.
3/14/01	Mary IM HCS - Chas	Inspect MNS - PCII - AC

The item number noted below refers to defects marked on the Inspection Report

ITEM NO.	DEFECT OBSERVED AND CORRECTIVE ACTION NEEDED
	Staffing: FBU 1 LPN - 17 PCA's
	All the personnel files were reviewed
	No deficiencies were identified.
	Conduct of Service:
	MNS - 1 client
	Records was reviewed
	No deficiencies were identified.
	AC: 1 client
	Records was reviewed
	No deficiencies were identified.
	PCII: 4 clients
	All the records were reviewed.
	No deficiencies were identified.
	Recommended:
	Comply w/ PCA
	State Comp. civil. Salem.
	Nurse - See report for complete Record

DHEC 1724 (REV.) (2M-5/87)

PLEASE CORRECT THE ABOVE DEFECTS

REPORT OF VISIT

SEND REPLY TO: **Community Long Term Care**
P.O. Box 8206
Columbia, SC 29202-8206

Administrator Peter Hall	Facility: Maxim Healthcare Services	Address: 3321 Forest Drive Suite 9 . Columbia, SC, 29204

South Carolina Department of Health and Human Service representative(s) visited your facility/activity to conduct an __X__ **Initial Survey;** _____ **Interim Survey Annual Survey;** _____ **Special Survey;** _____ **Complaint Investigation.** The conditions observed are described below, including the class of violation and the applicable section of the Scope of Services for **RRC**
_Please describe in the space provided the action you have planned or taken to correct these conditions and the completion date of those actions. You may attach additional sheets if necessary. Please sign or initial in the appropriate space(s) and return this form to COMMUNITY LONG TERM CARE by _____

DESCRIPTION/DATE TO BE CORRECTED	**CORRECTIVE ACTION/ COMPLETION DATE**
Services: See Above **Conduct of Services:** Policy – Procedure manual in good order-Includes Organizational chart Hours of operation Holiday Schedule ER/Disaster Plan Infection Control Program Back-Up Plan Nurse Locator Form In-service Program General liability insurance is current. Recommendations as discussed. Nurse Surveyor: Carolyn P Lockard	

Signature of Agency Administrator:

Date: page of

REPORT OF VISIT

SEND REPLY TO: **Community Long Term Care**
P.O. Box 8206
Columbia, SC 29202-8206

Administrator Peter Hall	Facility: Maxim Healthcare Services	Address: 3321 Forest Drive Suite 9 . Columbia, SC, 29204

South Carolina Department of Health and Human Service representative(s) visited your facility/activity to conduct an __X__ **Initial Survey;**
_____ **Interim Survey Annual Survey;** ____ **Special Survey;** _____ **Complaint Investigation.** The conditions observed are described below, including the class of violation and the applicable section of the Scope of Services for **RRC**
_ Please describe in the space provided the action you have planned or taken to correct these conditions and the completion date of those actions. You may attach additional sheets if necessary. Please sign or initial in the appropriate space(s) and return this form to COMMUNITY LONG TERM CARE by _____ .

DESCRIPTION/DATE TO BE CORRECTED	**CORRECTIVE ACTION/ COMPLETION DATE**
Services: See Above **Conduct of Services:** Policy – Procedure manual in good order-Includes Organizational chart Hours of operation Holiday Schedule ER/Disaster Plan Infection Control Program Back-Up Plan Nurse Locator Form In-service Program General liability insurance is current. Recommendations as discussed. Nurse Surveyor: Carolyn P Lockard	

Signature of Agency Administrator:

Date: page of

From: Bryan Kost
To: Brenda James
Date: 2/27/2009 11:47 am
Subject: Log letter - Fw: Maxim Healthcare Survey request

Please log - thanks

From: Darius Nouri <danouri@maxhealth.com>
To: <kostbr@scdhhs.gov>
Date: 2/27/2009 10:40 am
Subject: Maxim Healthcare Survey request

CC: Darius Nouri <danouri@maxhealth.com>

Brian,

Thank you for getting back to me so quickly this morning. Per your request, here is a list of past surveys we need:

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Charleston, SC (Provider # EX0595)

2001

2002

2003

2004

2005

Columbia, SC (Provider # EX0664)

2002

2003

2004

Please let me know how long it may take to obtain all these. Should you have any questions, please feel free to call me at 864-242-1994.

Thank you in advance for your assistance.

Sincerely,

Darius Nouri
Accounts Manager
Maxim Healthcare Services
Greenville, SC
Ph: (864) 242-1994
Fax: (864) 241-9040