

SUMMARY SHEET
SOUTH CAROLINA BOARD OF HEALTH AND ENVIRONMENTAL CONTROL

May 12, 2016

() ACTION/DECISION

(X) INFORMATION

I. TITLE: Health Regulation Administrative Orders, Consent Orders, and Sanctions.

II. SUBJECT: Health Regulation Administrative Orders, Consent Orders, and Sanctions executed during the period of January 1, 2016, through March 31, 2016.

III. FACTS: Between January 1, 2016 and March 31, 2016, Health Regulation issued one (1) Administrative Order and thirteen (13) Consent Orders with a total of \$74,850 in assessed monetary penalties.

Health Regulation Bureau	Health Care Facility, Provider or Equipment	Administrative Orders	Consent Orders	Assessed Penalties
Radiological Health	Radioactive Material	0	1	\$12,000
Health Facilities Licensing	Community Residential Care Facility	0	3	\$51,000
	Adult Day Care Facility	1	0	\$5,000
EMS & Trauma	Ambulance Services Provider	0	2	\$2,100
	First Responder Services Provider	0	1	\$1,000
	EMT, Intermediate EMT, Advanced EMT, or Paramedic	0	6	\$3,750
TOTAL		1	13	\$74,850

Approved By:

Shelly Bezanson Kelly
Director of Health Regulation

HEALTH REGULATION ENFORCEMENT REPORT
SOUTH CAROLINA BOARD OF HEALTH AND ENVIRONMENTAL CONTROL

May 12, 2016

Bureau of Health Facilities Licensing

Facility Type	Total # of Beds or Participants	Total # of Licensed Facilities in South Carolina
Community Residential Care Facilities	17,409 Beds	470
Adult Day Care Facilities	3,997 Participants	91

1. Gene’s Residential Care #1 (CRCF) – Elgin, SC

Investigation: The Department visited Gene’s Residential Care (“Gene’s”), a licensed community residential care facility (“CRCF”), numerous times to conduct general inspections, resident care focused inspections, kitchen and sanitation inspections, fire and life safety inspections, and follow-up inspections. After the Department conducted a follow-up inspection in September 2015, the Department determined to impose a monetary penalty on the facility based on the violations cited, the history of compliance, and severity of the violations.

Violations: Between July 2013 and September 2015, the Department cited Gene’s for 33 violations of Regulation 61-84, *Standards for Licensing Community Residential Care Facilities*. Specifically, Gene’s was issued 24 citations for violating various provisions of Regulation 61-84, Section 504.A. Gene’s twice failed to document its CLIA waiver authorizing staff members to monitor resident blood sugar levels. Gene’s received two citations for not keeping equipment and building fixtures in good condition and failing to keep the facility free from offensive odors. Finally, Gene’s twice failed to document a current annual tuberculosis risk assessment.

Enforcement Action: The parties met on December 17, 2015, and were able to reach an agreement for resolving this matter. Pursuant to the Consent Order executed on February 1, 2016, the Department imposed a \$16,500 monetary penalty against Gene’s requiring a payment of \$5,500 with the remaining \$11,000 held in abeyance pending 6 months of substantial compliance.

Prior Sanctions: None.

2. Bloom at Hilton Head (CRCF) – Hilton Head Island, SC

Investigation: Between March 2014 and August 2015, the Department visited Bloom three times to conduct a complaint investigation, general inspections, and a follow-up inspection. As a result of these visits, the Department decided to pursue enforcement action against Bloom.

Violations: Between March 2014 and August 2015, Bloom was cited for numerous violations of Regulation 61-84. Specifically, Bloom twice failed to document the tuberculosis status of private sitters. Bloom twice failed to document, sign, and revise the residents’ individual care plans. Bloom improperly retained a bed and wheelchair bound resident that required two-person assistance at all times and required assistance with all activities of daily living. Bloom twice failed to perform resident physical examinations as required by regulation. Bloom failed to have prescription medication available for administration to patients on three different occasions. Bloom twice failed to ensure onsite reviews of the medication

program by a pharmacist on a quarterly basis. Bloom failed on three occasions to ensure medications were labeled for administration pursuant to physician's orders. Bloom failed to ensure expired medications were not stored with current medications on three occasions. Bloom twice failed to document the results of residents' purified protein derivative ("PPD") test and failed to document the second step of the resident's two-step PPD test. Finally, Bloom failed to have "no smoking" signs in resident rooms with oxygen tanks and failed to ensure bar soap was available for residents.

Enforcement Action: The parties met on January 7, 2016, and were able to reach an agreement for resolving this matter. By Consent Order executed on February 12, 2016, the Department imposed a \$14,000 monetary penalty against Bloom requiring payment of \$7,500 and the remaining \$6,500 held in abeyance pending 6 months of substantial compliance.

Prior Sanctions: None.

3. M & M Residential Care Home (CRCF) – Marion, SC

Investigation: As a result of general inspections and follow-up inspections between August 2013 and September 2015, the Department decided to pursue enforcement action against M & M.

Violations: M & M was cited for many violations of Regulation 61-84. Specifically, M & M did not have a copy of the regulation on file on three different occasions. M & M twice failed to timely submit plans of correction to the Department for inspection and investigation reports. M & M failed on three different occasions to document staff training for first aid, communicable diseases, OSHA/bloodborne pathogens, confidential patient information, Bill of Rights for Residents, fire response, medication management, specific person care, restraint techniques, and emergency procedures. Finally, M & M twice failed to document the second step of the two-step tuberculin skin test for residents.

Enforcement Action: The parties met on December 7, 2015, and were able to reach an agreement for resolving this matter. By Consent Order executed February 23, 2016, the Department imposed a \$20,500 monetary penalty against M & M requiring payment of \$7,000 with the remaining \$13,500 held in abeyance pending 6 months of substantial compliance.

Prior Sanctions: None.

4. Denise P. Washington & Marlboro Adult Care, Inc. (Adult Day Care Facility) – Bennettsville, SC

Investigation: Marlboro Adult Care, Inc. ("Marlboro") is the owner and former licensee of Marlboro Adult Day Health Care, a facility previously licensed by the Department. Denise P. Washington was the registered agent of Marlboro Adult Care, Inc. and the administrator of Marlboro Adult Day Health Care. The facility failed to submit to the Department completed license applications and fees for 2014-2015 and 2015-2016. In December 2015, the Department visited the facility at the last know address and discovered that it had a census of 13 participants, the participants were being transported to the facility, the participant records contained physical examinations, and a monthly activity schedule for participants was posted. Furthermore, Ms. Washington confirmed the facility had been in continuous operation as an adult day care facility since 2002. After the site visit, the Department sent an investigation report to the facility describing violations, and to date, the Department has not received the facility's plan of correction for the cited violations.

Violations: The Department found that Ms. Washington and Marlboro were operating an unlicensed day care facility for adults in violation in Regulation 61-75, *Standards for Licensing Day Care Facilities for Adults*. After Marlboro's license had expired, Ms. Washington and Marlboro continued to provide a

program of individual and group activities and therapies for adults with community-based care and hours of operation consistent with an adult day care facility.

Enforcement Action: By Administrative Order executed February 12, 2016, the Department imposed a \$5,000 monetary penalty against Ms. Washington and Marlboro.

Prior Sanctions: None.

Bureau of EMS & Trauma

EMS Provider Type	Total # of Providers in South Carolina
EMT	5,509
EMT – Intermediate	517
Advanced EMT	310
Paramedic	3,658
Ambulance Services Provider	261
First Responder Services Provider	2

5. Jeffery Eugene DeYoung (EMT – Intermediate)

Investigation: On December 9, 2015, the Reidville Fire Department contacted the Department in reference to the status of Mr. DeYoung’s EMT certificate. At that time, the Department determined that Mr. DeYoung’s Intermediate EMT certificate had expired on March 15, 2015. Following an investigation, the Department found that Mr. DeYoung had continued to perform as the primary patient care EMT for 14 calls between March 2015 and December 2015, a time period in which he was uncertified as an Intermediate EMT.

Violations: The Department found that Mr. DeYoung violated S.C. Code Section 44-61-80(A) by providing patient care that is within the scope of an EMT without obtaining proper certification.

Enforcement Action: The parties agreed to resolve this matter by consent order. Pursuant to the Consent Order executed on January 13, 2016, Mr. DeYoung agreed to pay a \$500 monetary penalty.

Prior Sanctions: None.

6. Reidville Fire Department (Licensed Provider of First Responder Services)

Investigation: On December 9, 2015, the Reidville Fire Department contacted the Department in reference to the status of one of their employee’s EMT certificate. At that time, the Department determined that this employee’s Intermediate EMT certificate had expired on March 15, 2015. Following an investigation, the Department found that Reidville Fire Department had continued to allow this employee to perform as the primary patient care EMT for 14 calls between March 16, 2015 and December 9, 2015, a time period in which he was uncertified as an Intermediate EMT.

Violations: The Department found that Reidville Fire Department violated S.C. Code Section 44-61-70(B)(1) by allowing an uncertified person to provide patient care that is within the scope of an EMT without proper certification.

Enforcement Action: The parties agreed to resolve this matter by consent order. Pursuant to the Consent Order executed on January 13, 2016, Reidville Fire Department agreed to pay \$1,000.

Prior Sanctions: None.

7. John D. Perdue (Advanced EMT)

Investigation: On December 4, 2015, the Department received a copy of an internal investigation completed by Aiken County EMS regarding an advanced emergency medical technician (“AEMT”) performing an unnecessary skill on a coworker. According to Aiken County’s internal investigation, Mr. Perdue, while on duty for Aiken County EMS performed an external jugular vein intravenous catheterization (“EJ”) on a coworker and her friend. An EJ is an IV, which is placed in the external jugular vein located in the neck. A possible side effect of this procedure is the increased risk of causing an air embolus, which may travel to the brain causing permanent disability or death. Due to this risk, Aiken County EMS’s medical control physician lists, in the official signed protocols of Aiken County EMS, performing an EJ as next to last resort procedure. The last resort procedure is an interosseous line, which is an IV that is started directly into a patient’s bone. The two victims, the coworker and her friend, were not suffering from any form of illness or injury that would have necessitated an EJ.

Violations: The Department found that Mr. Perdue committed misconduct by violating the S.C. Code Section 44-61-80(F)(6) by disregarding an appropriate order by a physician concerning emergency treatment or transportation, by performing an EJ on a person which did not require such an intervention. The Department further found that Mr. Perdue violated S.C. Code Section 44-61-80(F)(14) by acting in a manner that created a substantial possibility that death or serious physical harm could result. Specifically, when Mr. Perdue started an EJ on a person that did not require such an intervention, his intervention could have caused an air embolus to form and travel to the person’s brain causing permanent disability or death.

Enforcement Action: The parties agreed to resolve this matter by consent order. Pursuant to the Consent Order executed on February 9, 2016, Mr. Perdue agreed to an 18-month suspension of his AEMT certificate to be held in abeyance for 18 months pending substantial compliance. Mr. Perdue also agreed to a \$1,250 monetary penalty requiring payment of \$250 and the rest to be held in abeyance. Mr. Perdue also agreed to not enroll in Paramedic school for 18 months. Mr. Perdue also agreed to attend and successfully complete a NAEMT Principles of Ethics and Personal Leadership class within 12 months.

Prior Sanctions: None

8. Kimberly Weaver (Paramedic)

Investigation: On September 11, 2015, while working with Darlington County EMS (“Darlington”), Ms. Weaver responded to a report of a patient having difficulty breathing. According to Ms. Weaver’s patient care report, the total time from the receipt of the 911 call to the time that the ambulance departed from the scene was 15 minutes. The actual time from initial patient contact until the departure of the ambulance was 8 minutes. Ms. Weaver’s patient care report stated that the patient signed a transport refusal waiver. Per Darlington’s Universal Patient Care Protocol, every patient contacted is to have at least one full set of vital signs, including the patient’s blood pressure, pulse, respirations, and pain/severity. Per Ms.

Weaver's patient care report, the only vital signs she obtained were listening to the patient's lung sounds and obtaining the patient's oxygen saturation level.

Violations: The Department found that Ms. Weaver violated the S.C. Code Section 44-61-80(F)(6) by disregarding an appropriate order by a physician concerning emergency treatment or transportation. The appropriate order involved in this matter was the Universal Patient Care Protocol of Darlington County EMS Standing Orders, signed by their Medical Control Physician, Dr. Alexander H. Cohen.

Enforcement Action: The parties agreed to resolve this matter by consent order. Pursuant to the Consent Order executed on February 12, 2016, Ms. Weaver agreed to successfully complete a protocol review and exam regarding the emergency medical protocols for Darlington County EMS. Ms. Weaver also agreed to perform at least two hours of training on EMS Documentation. Both items are to be proctored by the Training Officer of Darlington County EMS and completed within 90 days.

Prior Sanctions: None

9. Christian Scott McAlister (Advanced EMT)

Investigation: On December 4, 2015, the Department received a copy of an internal investigation completed by Aiken County EMS regarding an AEMT performing an unnecessary skill on a coworker. According to Aiken County's internal investigation, Mr. McAlister, while on duty for Aiken County EMS performed an external jugular vein intravenous catheterization ("EJ") on an off duty coworker. An EJ is an IV, which is placed in the external jugular vein located in the neck. A possible side effect of this procedure is the increased risk of causing an air embolus which may travel to the brain causing permanent disability or death. Due to this risk, Aiken County EMS's medical control physician lists, in the official signed protocols of Aiken County EMS, performing an EJ as next to last resort procedure. The last resort procedure is the interosseous line, which is an IV that is started directly into a patient's bone. The coworker was not suffering from any form of illness or injury that would have necessitated an EJ.

Violations: The Department found that Mr. McAlister committed misconduct by violating the S.C. Code Section 44-61-80(F)(6) by disregarding an appropriate order by a physician concerning emergency treatment or transportation, by performing an EJ on a person which did not require such an intervention. The Department further found that Mr. McAlister violated S.C. Code Section 44-61-80(F)(14) by acting in a manner that created a substantial possibility that death or serious physical harm could result. Specifically, when Mr. McAlister started an EJ on a person that did not require such an intervention, the intervention could have caused an air embolus to form that could travel to the person's brain causing permanent disability or death.

Enforcement Action: The parties agreed to resolve this matter by consent order. Pursuant to the Consent Order executed on February 19, 2016, Mr. McAlister agreed to an 18-month suspension of his AEMT certificate held in abeyance for 18 months pending substantial compliance. Mr. McAlister also agreed to a \$1,500 monetary penalty, requiring payment of \$500 with the rest held in abeyance for 18 months pending substantial compliance. Mr. McAlister also agreed to not enroll in Paramedic school for 18 months. Mr. McAlister also agreed to attend and successfully complete a NAEMT Principles of Ethics and Personal Leadership class within 12 months.

Prior Sanctions: None

10. American Pride Medical Transport, LLC (Ambulance Service Provider)

Investigation: On October 27, 2015, the Department received a complaint that American Pride Medical Transport, LLC (“American Pride”) was operating two ambulances without required equipment. During 2014 and 2015, the Department conducted 16 separate inspections of American Pride ambulances, which resulted in cited violations that had to be corrected prior to the ambulances passing the inspections. Several of the 16 inspections were re-inspections of ambulances that had previously failed initial inspections. One of the ambulances mentioned in the October complaint was inspected by the Department and was found to not have an oxygen regulator for the main oxygen tank, thus making it impossible to administer oxygen to any patient that would have required oxygen. During the compliance inspection of this ambulance, it was also found that the ambulance did not have a functioning siren. This unit was placed out of service by the Department until these deficiencies were corrected and re-inspected by the Department. The second ambulance mentioned in the October complaint was not inspected by the Department due to it being on a call. Upon discussions with American Pride’s Management, that ambulance was allowed to complete their current call and then place the unit out of service until it could be inspected by the Department the following day. During a compliance meeting with the owners of American Pride, the owners admitted to the Department that the second ambulance also failed to have a functioning siren. Both ambulances were re-inspected by the Department prior to being placed back in service.

Violations: The Department found that American Pride violated S.C. Code Section 44-61-70(B)(5) by operating two of its ambulances without a working siren and one of those ambulances without working permanent on-board oxygen.

Enforcement Action: The parties agreed to resolve this matter by consent order. Pursuant to the Consent Order executed on March 1, 2016, American Pride agreed to pay \$600.

Prior Sanctions: None.

11. Allendale County Rescue Squad (Ambulance Service Provider)

Investigation: On January 26, 2016, while the Department was preparing for an onsite inspection of Allendale, the Department found that one of the employees of Allendale had a valid National Registry of Emergency Medical Technicians certification, but did not have a South Carolina EMT certificate. As a result, the Department determined the employee performed patient care within the scope of an EMT on at least three ambulance runs from October 2015 to January 2016, a time period in which she was uncertified as a South Carolina EMT.

Violations: The Department found that Allendale County Rescue Squad violated S.C. Code Section 44-61-70(B)(1) by allowing an uncertified person to provide patient care that is within the scope of an EMT without proper certification.

Enforcement Action: The parties agreed to resolve this matter by consent order. Pursuant to the Consent Order executed on March 15, 2016, Allendale County Rescue Squad agreed to a \$1,500 monetary penalty, requiring payment of \$500 with the rest held in abeyance for 12 months pending substantial compliance.

Prior Sanctions: None.

12. Lauren Riddle (EMT)

Investigation: On January 26, 2016, while the Department was preparing for an onsite inspection of Allendale County Rescue Squad, the Department found that one of the employees of Allendale had a

valid National Registry of Emergency Medical Technicians certification, but did not have a South Carolina EMT certificate. As a result, the Department determined Ms. Riddle performed patient care within the scope of an EMT on at least three ambulance runs from October 2015 to January 2016, a time period in which she was uncertified as a South Carolina EMT.

Violations: The Department found that Ms. Riddle violated S.C. Code Section 44-61-80(A) by providing patient care that is within the scope of an EMT without obtaining proper certification.

Enforcement Action: The parties agreed to resolve this matter by consent order. Pursuant to the Consent Order executed on March 15, 2016, Ms. Riddle agreed to a \$500 monetary penalty to be held in abeyance for 12 months pending substantial compliance.

Prior Sanctions: None.

13. Lawrence James Huffman (Paramedic)

Investigation: On January 1, 2015, while working for Shoreline Medical Transport (“Shoreline”), Mr. Huffman responded to Hampton Regional Medical Center (“HRMC”) to transfer a patient to the Medical University of South Carolina (“MUSC”). Mr. Huffman was accompanied on the transport by a HRMC registered nurse. Shoreline’s Director notified the Department that Mr. Huffman’s patient care report contained statements of treatment and interventions that the patient received during the transport from Mr. Huffman that, in fact, did not take place. Mr. Huffman was terminated from his employment with Shoreline as a result of his actions. When interviewed by the Department, Mr. Huffman openly admitted that the documentation on his patient care report was not accurate. Mr. Huffman stated that he had written a “rough draft” of his report prior to the transport in the narrative section of Shoreline’s mobile tablet due to the fact that he knew that the route he would be taking did not have reliable internet capabilities. He further stated that he did go back into the reporting software once back at his station to revise his report and to delete the actions that did not take place. However, Mr. Huffman stated that somehow his original “rough draft” was uploaded instead of the actual corrected patient care report.

Violations: The Department found that Mr. Huffman violated the S.C. Code Section 44-61-80(F)(16) by submitting falsified documentation, i.e., the patient care report, required by the Department.

Enforcement Action: The parties agreed to resolve this matter by consent order. Pursuant to the Consent Order executed on March 29, 2016, Mr. Huffman agreed to successfully complete a NAEMT Principle of Ethics and Personal Leadership course within 6 months.

Prior Sanctions: None

Bureau of Radiological Health

Radioactive Material Licensees	Total # of Licensees in South Carolina
Specific Radioactive Material Licensees	370
General Radioactive Material Licensees	300
General Radioactive Material Licensee Registrants	75

14. GS2 Engineering & Environmental Consultants, Inc. (Radioactive Material) – Columbia, SC

Investigation: The Department conducted an inspection of GS2 on June 17, 2015. After finding violations during the inspection, the Department decided to pursue enforcement action against GS2.

Violations: The Department cited GS2 for three violations of Regulation 61-63, *Radioactive Materials (Title A)*. First, GS2 failed to secure portable gauges utilizing a minimum of two independent physical controls when not under control and constant surveillance. Second, GS2 failed to supply and require the use of individual monitoring devices by an adult likely to receive, in one year, a dose in excess of regulatory limits for operating a moisture density gauge. Lastly, GS2 failed to secure from unauthorized removal or access licensed materials stored in controlled or unrestricted areas.

Enforcement Action: The parties held an enforcement conference in August 2015 and following that meeting, the Department sent a consent order to GS2 in September 2015. GS2 failed to execute the consent order, so the Department issued an administrative order in December 2015. Subsequent to issuance of the administrative order, the parties had a discussion and agreed to the terms of a consent order. Pursuant to the Consent Order executed on January 25, 2016, GS2 agreed to a \$12,000 monetary penalty. Execution of the Consent Order rendered the previously issued administrative order null and void.

Prior Sanctions: None.