

SUMMARY SHEET
BOARD OF HEALTH AND ENVIRONMENTAL CONTROL

January 8, 2015

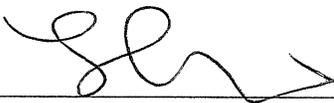
_____ ACTION/DECISION

 X INFORMATION

- I. TITLE: Administrative and Consent Orders issued by Health Regulation.
- II. SUBJECT: Administrative and Consent Orders issued by Health Regulation for the period of November 1, 2014, through November 30, 2014.
- III. FACTS: For the period of November 1, 2014, through November 30, 2014, Health Regulation issued four (4) Consent Orders and one (1) Administrative Order with total assessed civil penalties in the amount of \$11,500.00.

Program Area	Consent Orders	Administrative Orders	Assessed Penalties
Emergency Medical Services and Trauma	2	0	0
Health Facilities Licensing	2	1	\$11,500.00
TOTAL	4	1	\$11,500.00

Approved By:



Jamie Shuster
Director of Public Health

HEALTH REGULATION ENFORCEMENT REPORT
BOARD OF HEALTH AND ENVIRONMENTAL CONTROL

January 8, 2015

DIVISION OF EMS & TRAUMA

1. Mark Fowke (EMT – Basic No. SC007285)

Investigation: In October 2014, Mr. Fowke transported a patient with end-stage renal disease (“ESRD”) to and from the dialysis center for Metro One Ambulance Service, Inc. Mr. Fowke was the only licensed EMT crew member aboard the ambulance and failed to attend to the ESRD patient during transport. Specifically, Mr. Fowke and the ambulance driver were seen exiting the doors of the driver’s compartment and proceeding to the rear of the ambulance to remove the patient. Mr. Fowke and the ambulance driver opened the rear doors, removed a stretcher, and loaded the patient onto the stretcher. The ESRD patient had been riding in the rear of the ambulance without a licensed EMT crew member present. Mr. Fowke admitted to performing these actions on at least four (4) different occasions.

Code Violations: Pursuant to S.C. Code Ann. § 44-61-80(F) and S.C. Code Ann. Regs. 61-7.1100.B.8, the Department found Mr. Fowke committed misconduct in initiating care of a ESRD patient at the scene, discontinuing such care, abandoning the patient without the patient’s consent, and without providing for the further administration of care by an equal or higher medical authority. Specifically, on at least four (4) separate transports, Mr. Fowke discontinued care of the patient by leaving the patient unattended in the patient compartment of the ambulance and remaining in the driver’s compartment of the ambulance. No licensed EMT crew member remained in the patient compartment during the transport of the patient, and the patient did not consent to such discontinuation of care. Pursuant to S.C. Code Ann. Regs. 61-7.1000.A, during the transportation of patients, there shall be an EMT-Basic, Intermediate, or Paramedic in the patient compartment of the ambulance at all times.

Enforcement Action: On October 14, 2014, the Department informed Mr. Fowke it was considering an enforcement action and requested Mr. Fowke attend an enforcement conference to discuss the above-referenced violations. The parties met on November 7, 2014, and agreed to the terms of the Consent Order. Pursuant to the Consent Order executed on November 18, 2014, Mr. Fowke surrendered his South Carolina EMT – Basic certification card (No. SC007285) to the Department for two (2) years.

2. Michael Lowder (EMT – Intermediate No. SC017997)

Investigation: While Mr. Lowder was working for Piedmont Medical Center EMS, he responded to a call from a sick, diabetic patient. Mr. Lowder took two (2) photographs of the patient’s legs with his personal cell phone and told the patient he was sending the photographs to the on-line medical control physician (“OLMC”). Mr. Lowder did not send the photographs to the OLMC and did not delete the photographs at the patient’s home. The Department obtained a “screenshot” with the two (2) photographs in a cell phone text message conversation between two (2) individuals, one (1) of whom was Mr. Lowder. Mr. Lowder later verified he took those two (2) photographs of the patient’s legs.

Code Violations: The Department found Mr. Lowder committed misconduct as defined by S.C. Code Ann. § 44-61-80(F)(9) and S.C. Code Ann. Regs. 61-7.1100.B.9. Mr. Lowder revealed confidences entrusted to him in the course of medical attendance by taking two (2) photographs of a patient’s legs and sending them to persons not involved in the continuity of this patient’s care. Further, the revelation of such confidences was neither required by law nor necessary to protect the welfare of the individual or the community.

Enforcement Action: On October 10, 2014, the Department informed Mr. Lowder it was considering enforcement action and requested Mr. Lowder attend an enforcement conference. On November 7, 2014, the parties met and agreed to the terms of the Consent Order. Pursuant to the Consent Order executed on

November 18, 2014, Mr. Lowder surrendered his South Carolina EMT – Intermediate certification card (No. SC017997) to the Department for a period of four (4) years.

BUREAU OF HEALTH FACILITIES LICENSING

3. Windsor House West (Community Residential Care Facility)

Location: 850 John B. White, Sr. Blvd., Spartanburg, SC 29306

Investigation: The Department visited Windsor House West (“WHW”) to conduct general inspections and complaint investigations on February 27, 2013, November 19, 2013 (general inspection visit only), and April 22, 2014.

Code Violations: The Department found Windsor House West in violation of and repeated violation of S.C. Code Ann. Regs. 61-84, *Standards for Licensing Community Residential Care Facilities*. The Department considered the history of noncompliance and severity level of violations to conclude the imposition of a civil monetary penalty was warranted as set forth in Section 302.F of Regulation 61-84 for the following violations:

- **Resident physical examination.** Section 1101.A by failing to ensure residents’ physical examinations were dated when signed by physician, failing to have current physical examinations for residents, failing to ensure residents’ physical examinations addressed the appropriateness of placement in a community residential care facility and the need or lack thereof for the continuous daily attention of a licensed nurse; (Class I violation carries penalty range of \$2,000-5,000 for a third occurrence.)
- **Medication management.** Section 1201.A by failing to ensure residents’ prescribed medications and dietary supplements were available for administration and failing to ensure residents’ medications were stored, secured, and inaccessible to residents; (Class I violation carries penalty range of \$2,000-5,000 for a third occurrence.)
- **Housekeeping.** Section 1703.A.1 by failing to ensure the facility and its grounds were maintained in a clean condition; and (Class II violation carries penalty range of \$500-1,500 for a second occurrence.)
- **Temperature control.** Section 2403.A by failing to ensure hot water plumbing fixtures accessible to residents were maintained between one hundred (100) degrees and one hundred and twenty (120) degrees Fahrenheit. (Class I violation carries penalty range of \$2,000-5,000 for a third occurrence.)

Enforcement Action: On July 24, 2014, the Department notified WHW it was considering an enforcement action and requested WHW attend an enforcement conference to discuss the above-referenced violations. The parties met on October 2, 2014, and agreed to settle the matter by Consent Order. On October 21, 2014, the Department mailed the proposed Consent Order to WHW to be reviewed, signed, and returned by November 5, 2014. On November 12, 2014, the parties executed the Consent Order, which imposed a monetary penalty of \$11,500 on WHW. Pursuant to the Consent Order agreement, WHW made a payment of \$2,500 of the monetary penalty within thirty (30) days of execution of the Consent Order with the remainder of the monetary penalty stayed upon a twelve (12) month period of substantial compliance of with Regulation 61-84 and the Consent Order. Additionally, under the Consent Order, WHW was required to initiate action to correct the above-referenced violations and attend a compliance assistance meeting with the Department within forty-five (45) days of execution of the Consent Order.

4. Brandy Brandfass (Licensed Midwife No. LMW-0037)

Location: 2412 Yellow Jacket Rd., Huger, SC 29450

Investigation: From October 2013 to March 2014, the Department received alleged complaints about Ms. Brandfass’s performance as a licensed midwife. The Department requested Ms. Brandfass provide copies of appropriate patient medical records in order to investigate the thirteen (13) complaints and three (3) citations-by-mail.

Code Violations: The Department found Ms. Brandfass in violation of the following sections of S.C. Code Ann. Regs. 61-24, *Licensed Midwives*:

- Inspection. Section B.6 on one (1) occasion by failing to timely provide the Department with records of mothers and newborns that she cared for;
- Prenatal care. Section F.1 on two (2) occasions by failing to have documentation of two (2) required prenatal visits with a physician, community health center, or health department; Section F.2 on five (5) occasions by failing to ensure she or another appropriate health care provider saw her patients at least once every four (4) weeks until thirty-two (32) weeks gestation, once every two (2) weeks from thirty-two (32) until thirty-six (36) weeks gestation, and weekly after thirty-six (36) weeks; Section F.3 on three (3) occasions by failing to conduct at least one (1) prenatal visit to each patient's home during the last six (6) weeks of pregnancy; Section F.5 on five (5) occasions by failing to obtain signed informed consent forms from each patient;
- Intrapartum care. Section G.5 on one (1) occasion by administering drugs or medications without a consultation with and prescription by a physician;
- Postpartum care. Section H.2 on three (3) occasions by failing to conduct a subsequent checkup visit with a mother and neonate within twenty-four (24) to thirty-six (36) hours after delivery;
- Newborn care. Section I.3 on four (4) occasions by failing to notify the county health department in the county where the infant resides within three (3) days of delivery in order for a metabolic screening specimen to be obtained; Section I.4 on one (1) occasion by failing to provide subsequent care of a newborn in the days and weeks following birth;
- Physician referral. Section J.1 on one (1) occasion by failing to consult with a physician after noticing a mother having a vaginal prolapse, which is a significant deviation from the normal;
- Physician referral or consultation required. Section K.15 on one (1) occasion by failing to obtain medical consultation or refer for medical care a patient who was anemic, i.e., Hematocrit under 32 or Hemoglobin under 11.5 (patient had Hemoglobin under 11.5); Section K.34 on one (1) occasion by failing to obtain medical consultation or refer for medical care a patient who had meconium-stained amniotic fluid; Section K.40 on one (1) occasion by failing to obtain medical consultation or refer for medical care a patient who did not progress in dilation, effacement or station within a two (2) hour period while in active labor; Section K.41 on one (1) occasion by failing to obtain medical consultation or refer for medical care a patient who did not show continued progress to delivery after two (2) hours in second stage (primigravida) or after one (1) hour for multigravida; Section K.46 on one (1) occasion by failing to obtain medical consultation or refer for medical care a patient who retained membrane fragments; and
- Record keeping and reporting. Section O.1.c on three (3) occasions by failing to ensure the records of mothers and neonates were available to the Department for review; Section O.2 on four (4) occasions by failing to assure the registration of the babies' births with the county health department were made within five (5) days of birth; and Section O.3.a on one (1) occasion by failing to file a quarterly report with the Department for the third (3rd) quarter of 2013.

Enforcement Action: On March 28, 2014, the Department notified Ms. Brandfass it was considering an enforcement action and requested Ms. Brandfass attend an enforcement conference to discuss the above-referenced violations. The parties met on April 10, 2014, and agreed to settle the matter by Consent Order. On June 13, 2014, the Department mailed Ms. Brandfass the proposed Consent Order to sign and return within fifteen (15) days. On August 8, 2014, the Department again mailed Ms. Brandfass the proposed Consent Order to sign and return by August 15, 2014. Ms. Brandfass twice failed to sign and return the agreed upon Consent Order. The Department subsequently issued an Administrative Order revoking Ms. Brandfass's license to practice as a licensed midwife.

5. Lisa Marie Johnson (Licensed Midwife No. LMW-0043)

Location: 323 Lorraine Rd., Fort Mill, SC 29708

Investigation: The Department conducted complaint investigations on July 31, 2013, and September 16, 2014, and a routine inspection on September 23, 2013.

Code Violations: The Department found Ms. Johnson in violation of the following sections of S.C. Code Ann. Regs. 61-24, *Licensed Midwives*:

- **Intrapartum care medications.** Section G.5 on three (3) occasions by administering drugs and/or medications without a consultation with and/or prescription by a physician; and
- **Problems necessitating physician referral.** Section J.1 on two (2) occasions by failing to consult with a physician after providing positive pressure ventilation and artificial ventilation by mouth-to-mouth to a newborn, which are both significant deviations from the normal pregnancy.

Enforcement Action: On September 19, 2014, the Department notified Ms. Johnson about the enforcement action under consideration and invited Ms. Johnson to an enforcement conference to discuss the matter before the Department made its final decision. The parties met on September 25, 2014, and agreed to settle the matter by Consent Order. On October 20, 2014, the Department mailed Ms. Johnson the proposed Consent Order to review, sign, and return by November 4, 2014. The parties executed the Consent Order on November 18, 2014. Pursuant to the Consent Order, Ms. Johnson agreed to a ninety (90) day suspension of her license to practice as a midwife in South Carolina. Ms. Johnson's suspension will be stayed upon substantial compliance with Regulation 61-24 for the twelve (12) month period following execution of the Consent Order. In addition, Ms. Johnson shall submit to the Department for review all completed medical records of mothers and newborns on a monthly basis for a twelve (12) month substantial compliance period following execution of the Consent Order. If the Department finds Ms. Johnson in substantial noncompliance with Regulation 61-24 or the Consent Order, the Department may impose all or a part of the ninety (90) day suspension which is held in abeyance.