SUMMARY SHEET
SOUTH CAROLINA BOARD OF HEALTH AND ENVIRONMENTAL CONTROL

January 5, 2017

( ) ACTION/DECISION

(X) INFORMATION

I. **TITLE:** Health Regulation Administrative and Consent Orders.

II. **SUBJECT:** Health Regulation Administrative Orders, Consent Orders, and Emergency Suspension Orders for the period of November 1, 2016, through November 30, 2016.

III. **FACTS:** For the period of November 1, 2016, through November 30, 2016, Health Regulation reports one (1) Emergency Suspension Order, two (2) Administrative Orders, and five (5) Consent Orders with a total of five thousand dollars ($5,000) in assessed monetary penalties.

Health Regulation Bureau	Health Care Facility, Provider or Equipment	Administrative Orders	Consent Orders	Emergency Suspension Orders	Assessed Penalties
Health Facilities Licensing	Unlicensed Home Health Agency	0	1	0	$5,000
EMS & Trauma	Paramedics	1	3	0	$0
	EMTs	1	1	1	$0
TOTAL		**2**	**5**	**1**	**$5,000**

Approved By:

_____
Shelly Bezanson Kelly
Director of Health Regulation

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

January 5, 2017

Bureau of Health Facilities Licensing

Facility Type	Total # of Beds or Participants	Total # of Licensed Facilities in South Carolina
Unlicensed Home Health Agency	N/A	82

1. Open Hands Nursing Agency, LLC (Unlicensed Home Health Agency) – Florence, SC

Investigation: Department representatives visited Open Hands Nursing Agency, LLC ("Open Hands") on July 12, 2016, to conduct a complaint investigation.

Violations: Based upon the investigation, the Department found Open Hands in violation of Regulation 61-77, Standards for Licensing Home Health Agencies, and the South Carolina Code of Laws. Specifically, Open Hands was cited for violating Section 102.A of R.61-77 and S.C. Code Sections 44-7-260(A)(10) and 44-69-30 for providing home health services in the state and representing itself as a provider of home health services in the state without first obtaining a license from the Department

Enforcement Action: By Consent Order executed November 30, 2016, the Department imposed a five thousand dollar ($5,000) monetary penalty against Open Hands for violating the Certificate of Need and Licensing Act, the Home Health Agencies Act, and Regulation 61-77. Open Hands is required to make payment of the assessed monetary penalty in five (5) consecutive monthly installments of one thousand dollars ($1,000) each.

Prior Sanctions: None.

Bureau of EMS & Trauma

EMS Provider Type	Total # of Providers in South Carolina
EMT	5,164
EMT – Intermediate	442
Advanced EMT	305
Paramedic	3,641
Athletic Trainers	875
Ambulance Services Provider	256
First Responder Services Provider	2

2. Clayton L. Coker (Paramedic)

Investigation: On May 23, 2016, the Department received notification regarding an incident alleging inappropriate actions by a Richland County EMS crew. On May 6, 2016, Mr. Coker and his partner responded to a call concerning a patient who suffered a seizure and a fall at the Richland County Alvin S. Glenn Detention Facility. Mr. Coker and his partner's assessment of the patient was incomplete and led to inappropriate patient care by the crew. Mr. Coker also witnessed his partner providing the abovementioned substandard care and failed to document such care and report it to a supervisor. Mr. Coker also completed and signed the patient care report for this call. Due to the abovementioned observations, Mr. Coker falsified the patient care report for this call by stating that the patient had normal findings during the crew's assessment when in fact the patient did not have normal findings.

Violations: As a result of its investigation, the Department found Mr. Coker committed "misconduct," as defined by S.C. Code Section 44-61-80(F)(6) and Section 1100(B)(6) of Regulation 61-7, by disregarding an appropriate order by a physician concerning emergency treatment. Specifically, Mr. Coker failed to follow the RCEMS Spinal Immobilization Clearance Protocol. First, Mr. Coker failed to perform a full and thorough assessment of the patient. Secondly, Mr. Coker did not place the patient, who exhibited focal deficits, in full spinal immobilization. Mr. Coker further committed "misconduct," as defined by S.C. Code Section 44-61-80(F)(13) and Section 1100(B)(14) of Regulation 61-7, by observing another EMT fail to conduct a full assessment and fail to place a patient in full spinal immobilization despite the patient exhibiting focal deficits. Mr. Coker did not document the substandard care in the patient care report that he completed and submitted. Mr. Coker also committed "misconduct," as defined by S.C. Code Section 44-61-80(F)(14) and Section 1100(B)(15) of Regulation 61-7, by failing to place a patient exhibiting focal deficits in full spinal immobilization. By failing to immobilize, the patient was exposed to unnecessary and unsafe movement, thereby creating a substantial possibility of severe damage to the patient's spine. Finally, Mr. Coker committed "misconduct," as defined by S.C. Code Section 44-61-80(F)(16) and Section 1100(B)(17) of Regulation 61-7, by falsifying documentation required by the Department. Specifically, Mr. Coker falsely reported on the patient care report that the patient had normal findings in regards to the patient assessment when, in fact, the patient did not have normal findings.

Enforcement Action: The parties met and were able to resolve this matter pursuant to a Consent Order executed October 24, 2016. Pursuant to the terms of the Consent Order, Mr. Coker agreed to a one (1) year restriction of his Paramedic certificate. The Department agreed to issue Mr. Coker an EMT certification card valid for six (6) months from the execution of the Consent Order. During these six (6) months, if Mr. Coker complies with the EMS Act and Regulation 61-7, the remaining six (6) months of the restriction will be held in abeyance and the Department will reissue Mr. Coker's Paramedic card. Should Mr. Coker fail to comply with the abovementioned requirements, the Department may call in all or a portion of the remaining six (6) months of the agreed upon restriction and/or take other enforcement action in accordance with the EMS Act and Regulation 61-7. Mr. Coker further agreed to successfully complete a National Association of Emergency Medical Technicians Principles of Ethics and Personal Leadership course within six (6) months of execution of the Consent Order and provide proof of completion to the Department. Finally, Mr. Coker agreed to successfully complete a recognized continuing education class on trauma within six (6) months of execution of the Consent Order, consisting of a minimum of sixteen (16) hours and be appropriate for his certification level and contain both didactic and skills assessments. Mr. Coker is required to submit proof of completion to the Department.

Prior Sanctions: None.

3. Michael Todd Adams (EMT)

Investigation: On May 23, 2016, the Department received notification regarding an incident alleging inappropriate actions by a Richland County EMS crew. On May 6, 2016, Mr. Adams and his partner responded to a call concerning a patient who suffered a seizure and a fall at the Richland County Alvin S. Glenn Detention Facility. Mr. Adams and his partner's assessment of the patient was incomplete and led to inappropriate patient care by the crew. Mr. Adams also witnessed his partner providing the abovementioned substandard care and failed to document such care and report it to a supervisor.

Violations: As a result of its investigation, the Department found Mr. Adams committed "misconduct," as defined by S.C. Code Section 44-61-80(F)(6) and Section 1100(B)(6) of Regulation 61-7, by disregarding an appropriate order by a physician concerning emergency treatment. Specifically, Mr. Adams failed to follow the RCEMS Spinal Immobilization Clearance Protocol. First, Mr. Adams failed to perform a full and thorough assessment of the patient. Secondly, Mr. Adams did not place the patient, who exhibited focal deficits, in full spinal immobilization. Mr. Adams further committed "misconduct," as defined by S.C. Code Section 44-61-80(F)(13) and Section 1100(B)(14) of Regulation 61-7, by observing another EMT fail to conduct a full assessment and fail to place a patient in full spinal immobilization despite the patient exhibiting focal deficits. Mr. Adams also committed "misconduct," as defined by S.C. Code Section 44-61-80(F)(14) and Section 1100(B)(15) of Regulation 61-7, by failing to place a patient exhibiting focal deficits in full spinal immobilization. By failing to immobilize, the patient was exposed to unnecessary and unsafe movement, thereby creating a substantial possibility of severe damage to the patient's spine.

Enforcement Action: By Consent Order executed November 2, 2016, Mr. Adams agreed to: successfully complete a National Association of Emergency Medical Technicians Principles of Ethics and Personal Leadership course within six (6) months of execution of the Consent Order and provide proof of completion to the Department; successfully complete a recognized continuing education class on trauma within six (6) months of execution of the Consent Order, consisting of a minimum of sixteen (16) hours and be appropriate for his certification level and contain both didactic and skills assessments, and submit proof of completion to the Department; and successfully complete a state-approved EMT refresher class within six (6) months of execution of the Consent Order and submit proof of completion to the Department. Pursuant to the terms of the Consent Order, Mr. Adams agreed that should he fail to comply with the EMS Act, Regulation 61-7, or the terms of the Consent Order during the six (6) months following execution of the Consent Order, the Department may suspend his EMT certificate for one (1) year. In addition to the agreed upon suspension, the Department may impose additional sanctions, including revocation of Mr. Adams's EMT certificate, in accordance with the EMS Act, Regulation 61-7, and any other applicable law.

Prior Sanctions: None.

4. Tory J. Maszk (Paramedic)

Investigation: On March 21, 2016, the Department received notification of alleged regulatory violations by Tory Maszk, a Paramedic with Vital Care EMS ("VCEMS"). The Department initiated an investigation into the allegations and found that Ms. Maszk was involved in a motor vehicle accident while driving a VCEMS ambulance. In accordance with VCEMS protocol, Ms. Maszk submitted to a post-accident drug screening and tested positive for multiple drugs. Following the results of the drug screening, Ms. Maszk's employment with VCEMS was terminated. Ms. Maszk's drug use rendered her unable to perform as an EMT, as evidenced by her motor vehicle accident while driving a VCEMS ambulance.

Violations: Ms. Maszk admitted to having a history of drug addiction and therefore committed "misconduct," as defined by S.C. Code Section 44-61-80(F)(3) and Section 1100(B)(3) of Regulation 61-

7, by being addicted to drugs to such a degree as to render her unfit to perform as an EMT. Ms. Maszk committed further "misconduct," as defined by S.C. Code Section 44-61-80(F)(11) and Section 1100(B)(11) of Regulation 61-7, by being irresponsible in the operation of an emergency vehicle.

Enforcement Action: By Consent Order executed November 1, 2016, Ms. Maszk agreed to a suspension of her EMT-Paramedic certificate until March 29, 2018. The suspension is effective upon execution of the Consent Order and includes all levels of certification. On or after March 29 2017, Ms. Maszk may apply to the Department to lift the suspension and reinstate her EMT-Paramedic certificate. In order for the Department to list the suspension and reinstate her certificate, Ms. Maszk must provide the Department with proof of successful completion of an outpatient treatment program for drug addiction.

Prior Sanctions: None.

5. Phillip Thomas Gregory (Paramedic)

Investigation: On March 11, 2016, the Department received notification regarding alleged actions of Mr. Gregory that occurred on February 20, 2016. Mr. Gregory and his EMT partner received a call from dispatch requesting an interfacility transfer of a stroke patient from Springs Memorial Hospital to Carolina Medical Center. The patient was being transferred due to having received tissue plasminogen activator (TPA) for their stroke. Therefore, the patient was being transferred to a facility that could provide a higher level of care than the initial facility. Mr. Gregory made multiple attempts to avoid having to provide the transfer. By delaying the transfer, Mr. Gregory increased the time that the patient was not in the care of a facility that was most appropriate to treat the patient's conditions and increased the possibility that the patient could have had a serious bleeding issue as a result of the TPA.

Violations: As a result of its investigation, the Department found Mr. Gregory committed "misconduct," as defined by S.C. Code Section 44-61-80(F)(14) and Section 1100(B)(15) of Regulation 61-7, by creating a substantial possibility that death or serious physical harm could result from his actions. The delayed transfer created a substantial possibility that the patient could suffer a brain bleed which could result in permanent disability or death. Mr. Gregory committed further "misconduct," as defined by S.C. Code Section 44-61-80(F)(16) and Section 1100(B)(17) of Regulation 61-7, by failing to complete and submit a patient care report, as required by the Department, for the patient transfer from Springs Memorial Hospital to the American Transmed base.

Enforcement Action: The parties met and were able to resolve this matter pursuant to a Consent Order executed November 8, 2016. Pursuant to the terms of the Consent Order, Mr. Gregory agrees to a one (1) year restriction of his Paramedic certificate. The Department agrees to issue Mr. Gregory an EMT certification card valid for six (6) months from the execution of the Consent Order. During these six (6) months, if Mr. Gregory complies with the EMS Act and Regulation 61-7, the remaining six (6) months of the restriction will be held in abeyance and the Department will reissue Mr. Gregory's Paramedic card. Should Mr. Gregory fail to comply with the abovementioned requirements during the six (6) months following reissuance of his Paramedic card, the Department may call in all or a portion of the remaining six (6) months of the agreed upon restriction and/or take other enforcement action in accordance with the EMS Act and Regulation 61-7. Mr. Gregory further agreed to successfully complete a National Association of Emergency Medical Technicians Principles of Ethics and Personal Leadership course within six (6) months of execution of the Consent Order and provide proof of completion to the Department.

Prior Sanctions: None.

6. Benjamin Blake Pope (EMT)

Investigation: On October 26, 2016, the Department was notified of Mr. Pope's arrest in Spartanburg County. Upon notification, the Department initiated an investigation into the matter. The Department discovered that Mr. Pope was arrested on October 26, 2016, and charged with two (2) counts of indecent exposure.

Violations: The charges against Mr. Pope, specifically two (2) counts of indecent exposure, are crimes involving moral turpitude and gross immorality. The Department found that Mr. Pope's arrest demonstrated a capacity for inappropriate and criminal behavior towards individuals placed within his trust. The Department determined that a clear and present danger would exist to the public health, safety, and welfare if Mr. Pope's EMT certificate was not immediately suspended pending further investigation.

Enforcement Action: Mr. Pope's EMT certificate was immediately suspended on an emergency basis pursuant to the Emergency Suspension Order executed November 3, 2016. The Department will continue to monitor Mr. Pope's criminal matters.

Prior Sanctions: None.

7. Jake H. Walker (EMT)

Investigation: On July 25, 2016, the Department was notified of alleged misconduct by Mr. Walker involving his failure to complete electronic patient care reports ("ePCRs"). The Department initiated an investigation into the matter and found that while employed as an EMT by American Transmed, from June 24, 2016, to July 27, 2016, Mr. Walker performed an additional fifty-one (51) runs as the primary care attendant where he failed to complete ePCRs. The Department contacted Mr. Walker and requested an interview. After scheduling the interview, Mr. Walker requested another date. The Department was amenable to rescheduling and requested Mr. Walker's availability. Mr. Walker has since not responded to the Department.

Violations: Mr. Walker committed "misconduct," as defined by S.C. Code Section 44-61-80(F)(17) and Section 1100(B)(17) of Regulation 61-7, by violating Section 1301(B) of Regulation 61-7. Section 1301(B) requires the primary care attendant to document all patient contact, care, and transport decisions within the ePCR and to complete such documentation within twenty-four (24) hours of the conclusion of the call.

Enforcement Action: Pursuant to the Administrative Order executed November 3, 2016, Mr. Walker's EMT certificate is suspended for one (1) year. The suspension of Mr. Walker's EMT certificate includes all levels of certification. Mr. Walker shall return his certification card to the Department.

Prior Sanctions: None.

8. James W. Davenport (Paramedic)

Investigation: On April 13, 2016, the Department received a complaint involving alleged conduct by Mr. Davenport. The Department initiated an investigation into the allegations of the complaint. As a result of the investigation, the Department found that on March 19, 2016, while working for the Iva Rescue Squad, Mr. Davenport and his EMT partner responded to a patient with a stab wound and an approximately seven (7) inch knife embedded in the upper left quadrant of his abdomen. Upon arrival to the scene, Mr. Davenport was unprofessional and verbally abusive to the patient. Additionally, Mr. Davenport provided a deficient and incomplete initial assessment of the patient by not obtaining the patient's blood pressure, pulse, or Glasgow Coma Scale. Throughout the treatment of the patient, Mr. Davenport violated multiple

Anderson County EMS protocols, including, but not limited to, failing to evaluate the patient's weakness, mechanism of injury, DCAPBTLS (deformities, contusions, abrasions, punctures, bruises, tenderness, laceration, and swelling), and rigid guarded abdomen; and failing to initiate the airway management protocol, a cardiac monitor-lead II, and intravenous access protocol. Moreover, after providing incomplete and deficient assessment and treatment, Mr. Davenport stood up the patient, who still had a knife embedded in his abdomen, and walked him out of his residence to the stretcher at the rear of the ambulance. Additionally, while Mr. Davenport bandaged the patient's wound and stabilized the knife, the additional and unnecessary movements facilitated by Mr. Davenport created a substantial possibility of death or serious physical injury. Finally, after ambulating the patient to the ambulance, Mr. Davenport discontinued care and transferred care to a lower level of provider, his EMT partner, for care during the transport to the emergency room.

Violations: As a result of its investigation, the Department found Mr. Davenport committed "misconduct," as defined by S.C. Code Section 44-61-80(F)(6) and Section 1100(B)(6) of Regulation 61-7, by disregarding appropriate patient assessment and treatment protocols that were signed and approved by Iva Rescue Squad's medical control physician. Additionally, Mr. Davenport committed "misconduct," as defined by S.C. Code Section 44-61-80(F)(8) and Section 1100(B)(8) of Regulation 61-7, by discontinuing care of a patient without providing for the further administration of care by an equal or higher medical authority. Finally, Mr. Davenport committed "misconduct," as defined by S.C. Code Section 44-61-80(F)(14) and Section 1100(B)(15) of Regulation 61-7, by creating a substantial possibility that death or serious physical harm could result from his actions or inactions.

Enforcement Action: On June 23, 2016, the Department convened the Investigative Review Committee ("IRC") to review the investigation of Mr. Davenport. Mr. Davenport and his counsel attended the IRC meeting. Department representatives and Mr. Davenport attempted to resolve this matter by way of a consent order, but were unsuccessful. Therefore, pursuant to the Administrative Order executed October 21, 2016, Mr. Davenport's Paramedic certification is revoked. The Department will not reissue the certificate for a period of four (4) years. Following expiration of the four (4) year period, Mr. Davenport may petition for reinstatement. Mr. Davenport shall return his certification card to the Department.

Prior Sanctions: None.