SUMMARY SHEET
SOUTH CAROLINA BOARD OF HEALTH AND ENVIRONMENTAL CONTROL

November 10, 2022

( ) ACTION/DECISION
(X) INFORMATION

I. **TITLE:** Healthcare Quality Administrative and Consent Orders.

II. **SUBJECT:** Healthcare Quality Administrative Orders and Consent Orders for the period of August 1, 2022, through September 30, 2022.

III. **FACTS:** For the period of August 1, 2022, through September 30, 2022, Healthcare Quality reports 1 Administrative Order and 8 Consent Orders totaling $77,195 in assessed monetary penalties.

Bureau	Facility, Service, Provider, or Equipment Type	Administrative Orders	Consent Orders	Assessed Penalties	Required Payment
Community Care	Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)	0	2	$25,000	$25,000
	Residential Treatment Facility for Children and Adolescents (RTF)	0	1	$40,900	$30,000
Healthcare Systems and Services	Emergency Medical Services (EMS) Agency	0	1	$6,000	$3,000
	Paramedic	0	3	$1,200	$1,200
	Emergency Medical Technician (EMT)	0	1	$300	$300
Radiological Health	Unregistered Vendor	1	0	$3,795	$3,795
TOTAL		**1**	**8**	**$77,195**	**$63,295**

Submitted By:

Gwendolyn C. Thompson

Gwen C. Thompson
Deputy Director
Healthcare Quality

HEALTHCARE QUALITY ENFORCEMENT REPORT
SOUTH CAROLINA BOARD OF HEALTH AND ENVIRONMENTAL CONTROL

November 10, 2022

Bureau of Community Care

Facility Type	Total Number of Licensed Facilities	Total Number of Licensed Beds
Residential Treatment Facility for Children and Adolescents	8	518

1. Three Rivers Residential Treatment – Midlands Campus – West Columbia (64 beds)

Investigation and Violations: Between May 2021 and March 2022, the Department conducted 7 investigations, a general inspection, and a follow-up general inspection. The Department cited the facility for the following violations of Regulation 61-103, *Residential Treatment Facilities for Children and Adolescents:*

- Failing to provide access to requested in-service training documentation for staff members;
- Repeatedly failing to implement its policies and procedures regarding "Resident Supervision and Round";
- Repeatedly failing to have documentation of initial and/or annual staff in-service training in the following:
    - Basic first aid;
    - Management and care of persons with contagious and/or communicable disease;
    - Medication management;
    - Care of persons specific to the physical or mental conditions being cared for in the facility;
    - Use of restraint techniques;
    - Crisis management;
    - OSHA standards regarding bloodborne pathogens;
    - Confidentiality of resident information and records;
    - Resident rights;
    - Fire response; and
    - Emergency procedures and disaster preparedness;
- Failing to notify the Department of the facility's internal investigation of a serious incident within five days;
- Failing to notify the Department within 24 hours of a serious incident;
- Repeatedly failing to ensure a resident was free from harm, including isolation, abuse, or neglect; and
- Failing to have resident's physician-ordered medications available for administration.

Enforcement Action: The Department and the facility executed a Consent Order, in which the facility agreed to an assessed $40,900 monetary penalty. The facility is required to pay $30,000 within 30 days of executing the Consent Order, and the $10,900 is held in abeyance upon a six-month period of substantial compliance with Regulation 61-103 and the Consent Order. The facility is required to initiate action to correct the violations that initiated this enforcement action and to ensure that all violations of Regulation

61-103 are not repeated. The facility is further required to schedule and attend a compliance assistance meeting with the Department within 45 days of executing the Consent Order.

Remedial Action: The facility has paid the required $30,000. The facility attended the compliance assistance meeting with the Department on September 21, 2022.

Prior Orders: None in the past five years.

Facility Type	Total Number of Licensed Facilities	Total Number of Licensed Beds
Intermediate Care Facility for Individuals with Intellectual Disabilities	66	1,629

2. Coastal Center Highlands 510 – Summerville (22 beds)

Investigation and Violations: The Department conducted an onsite investigation and found a staff member prevented a resident from leaving their room on five separate occasions. In addition, the staff member pushed the resident to the ground in a separate incident. As a result of these findings, the Department determined the facility failed to ensure clients were protected from mental and physical abuse and free from chemical and physical restraints as outlined in the *Bill of Rights for Residents in Long-Term Care Facilities*, which is a violation of Regulation 61-13, *Standards for Licensing Intermediate Care Facilities for Individuals with Intellectual Disabilities.*

Enforcement Action: The Department and the facility executed a Consent Order, in which the facility agreed to a $6,000 monetary penalty. The facility also agreed to initiate action to correct the violations that initiated the enforcement action and to ensure all violations of Regulation 61-13 are not repeated.

Remedial Action: The facility has paid the monetary penalty in full. The staff member involved in the incidents was terminated.

Prior Orders: None in the past five years.

3. Coastal Center Highlands Hillside – Summerville (188 beds)

Investigation and Violations: The Department conducted several onsite investigations and found in November 2021, January 2022, April 2022, and May 2022, the facility failed to ensure clients were protected from physical abuse as outlined in the *Bill of Rights for Residents in Long-Term Care Facilities*. The Department also found the facility failed to implement its policies and procedures regarding client care, rights, and operation of the facility in November 2021. As a result, the facility was cited for multiple violations of Regulation 61-13, *Standards for Licensing Intermediate Care Facilities for Individuals with Intellectual Disabilities.*

Enforcement Action: The Department and the facility executed a Consent Order, in which the facility agreed to a $19,000 monetary penalty. The facility also agreed to initiate action to correct the violations that initiated the enforcement action and to ensure all violations of Regulation 61-13 are not repeated.

Remedial Action: The facility has paid the monetary penalty in full. Staff members involved in the incidents were separated from employment.

Prior Orders: None in the past 5 years.

Bureau of Healthcare Systems and Services

EMS Provider Type	Total Number of Licensed EMS Agencies
EMS Agency	268

4. Dorchester County EMS – Advanced Life Support

Investigation and Violations: The Department found through investigation that the EMS agency allowed an EMT to provide patient care on 87 patient encounters with an expired certificate from August to October 2021. The Department found that the EMS agency violated the EMS Act and Regulation 61-7, *Emergency Medical Services,* by allowing an uncertified person to provide patient care.

Enforcement Action: The Department and the EMS agency executed a Consent Order, in which the EMS agency agreed to a $6,000 assessed monetary penalty. The EMS agency is required to pay $3,000 within 30 days of executing the Consent Order. The remaining $3,000 will be held in abeyance for 12 months pending substantial compliance with Regulation 61-7 and the Consent Order.

Remedial Action: The EMS agency has paid the required $3,000.

Prior Orders: None in the past five years.

Level of Certification	Total Number of Certified Paramedics
Paramedic	4,207

5. Andrew Heiney – Paramedic

Investigation and Violations: The Department was notified by Laurens County EMS that Mr. Heiney allowed an EMT to start an intravenous (IV) line and administer epinephrine (EPI) and 50% dextrose in water (D50W) to patient.

Mr. Heiney committed misconduct as defined by the EMS Act and Regulation 61-7, *Emergency Medical Services,* by allowing an EMT to knowingly start an IV line and administer EPI and D50W to a patient, which is outside of the EMT's scope of practice and also not authorized by the Medical Control Physician for Laurens County EMS.

Enforcement Action: The Department and Mr. Heiney executed a Consent Order in which Mr. Heiney agreed to pay a $300 monetary penalty.

Remedial Action: Mr. Heiney has made the required payment.

Prior Orders: None in the past five years.

6. Patricia Parker – Paramedic

Investigation and Violations: The Department was notified by Laurens County EMS that Ms. Parker allowed an EMT to start an intravenous (IV) line and administer epinephrine (EPI) and 50% dextrose in water (D50W) to a patient. In addition, it was reported that Ms. Parker reflected on a patient care report (PCR) that she personally started the IV line and administered EPI and D50W to a patient in cardiac arrest.

Ms. Parker committed misconduct as defined by the EMS Act and Regulation 61-7, *Emergency Medical Services*, by allowing an EMT to knowingly start an IV line and administer EPI and D50W to a patient, which is outside of the EMT's scope of practice and also not authorized by the Medical Control Physician for Laurens County EMS.

Ms. Parker further committed misconduct as defined by the EMS Act and Regulation 61-7 by falsifying a patient care report (PCR) to reflect she personally had started the IV line and administered EPI and D50W to a patient in cardiac arrest while knowing these skills were performed by her EMT partner, which were outside the scope of their practice.

Enforcement Action: The Department and Ms. Parker executed a Consent Order in which Ms. Parker agreed to pay a $600 monetary penalty in three monthly payments of $200 each.

Remedial Action: Ms. Parker has made the first two monthly payments of $200 each and has one monthly payment remaining as of October 31, 2022.

Prior Orders: None in the past five years.

7. Joseph George – Paramedic

Investigation and Violations: The Department conducted an investigation and found Mr. George failed to follow the appropriate protocol for field treatment of collapsed lungs. Mr. George failed to identify the proper location for plural decompression, failed to properly perform the plural decompression, and performed a procedure that caused a laceration of the patient's pulmonary artery requiring surgical repair.

The Department determined that Mr. George committed misconduct as defined by the EMS Act and Regulation 61-7, *Emergency Medical Services*, by disregarding an appropriate order by a physician concerning emergency treatment and transportation, by action or omission and without mitigating circumstance, contributed to or furthered the injury or illness of a patient under his care, and by his actions or inactions created a substantial possibility that death or serious physical harm could result.

Enforcement Action: The Department and Mr. George executed a Consent Order in which Mr. George agreed to pay a $300 monetary penalty within 30 days of executing the Consent Order. The Consent Order also included demoting Mr. George to an advanced emergency medical technician (AEMT) for the six-

month period following execution. Lastly, Mr. George agreed to complete a Pre-Hospital Trauma Life Support class within six months of executing the Consent Order.

Remedial Action: Mr. George has made the required payment. Mr. George has been demoted to an AEMT. Mr. George's completion of the Pre-Hospital Trauma Life Support class is still pending as of October 31, 2022.

Prior Actions: None in the past five years.

Level of Certification	Total Number of Certified EMTs
EMT	7,658

8. Rachelle Clark – EMT

Investigation and Violations: The Department was notified by Laurens County EMS that while operating as an EMT, Ms. Clark started an intravenous (IV) line and administered epinephrine (EPI) and 50% dextrose in water (D50W) to a patient in cardiac arrest.

Ms. Clark committed misconduct as defined by the EMS Act and Regulation 61-7, *Emergency Medical Services*, by performing advanced skills outside the scope of practice for an EMT. Specifically, Ms. Clark performed advanced, paramedic-level skills above the level for which she was certified or trained.

Enforcement Action: The Department and Ms. Clark executed a Consent Order in which Ms. Clark agreed to the assessment of a $300 monetary penalty.

Remedial Action: Ms. Parker has paid the required $300.

Prior Orders: None in the past five years.

Bureau of Radiological Health

9. American Dental Equipment, LLC d/b/a Lion's Dental Supply (LDS) (*Unregistered Vendor*)

Investigation and Violations: In May 2019, the Department received notification indicating Lion's Dental Supply (LDS) sold and shipped a MaxRay hand-held dental x-ray unit to a registered dental facility, Victory Dental Center. LDS is not registered as a vendor with the Department to engage in the business of selling, leasing or installing or offering to sell, lease or install x-ray machines or furnishing or offering to furnish any x-ray services in South Carolina pursuant to Regulation 61-64, *X-Rays (Title B)*. The Department mailed a notice of violation (NOV) and repeatedly attempted to make contact with individuals associated with LDS.

In May 2021, the Department conducted a routine inspection of Hollywood Animal Clinic (HAC), which is registered with the Department to possess and use x-ray equipment in South Carolina. During the inspection, HAC provided an invoice indicating LDS sold and shipped a MaxRay hand-held dental x-ray

unit to HAC. The Department mailed a Notice of Violation and Enforcement Conference (NOVEC) to the individuals associated with LDS and has not received a response.

Enforcement Action: As a result of the foregoing, the Department issued an Administrative Order against LDS assessing a monetary penalty of $3,795. LDS is required to pay the $3,795 within 30 days. In addition, LDS is required to refrain from engaging in the business of selling, leasing, or installing or offering to sell, lease or install x-ray machines or machine components for use in South Carolina unless and until LDS applies for registration and receives approval from the Department, complies with applicable statutory and regulatory requirements, and submits the $3,795 monetary penalty.

Remedial Action: As of October 31, 2022, the Department has not received a response from LDS.

Prior Actions: None in the past five years.