SUMMARY SHEET
SOUTH CAROLINA BOARD OF HEALTH AND ENVIRONMENTAL CONTROL

August 11, 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 May 1, 2022, through June 30, 2022.

**III.** **FACTS:** For the period of May 1, 2022, through June 30, 2022, Healthcare Quality reports 13 Consent Orders and 1 Emergency Suspension Order totaling $74,400 in assessed monetary penalties.

| Name of Bureau | Facility, Service, Provider, or Equipment Type | Administrative Orders | Consent Orders | Emergency Suspension Orders | Assessed Penalties | Required Payment |
|---|---|---|---|---|---|---|
| **Community Care** | Community Residential Care Facility (CRCF) | 0 | 5 | 0 | $28,000 | $20,000 |
| | Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID) | 0 | 2 | 0 | $8,000 | $8,000 |
| | Residential Treatment Facilities for Children and Adolescents (RTF) | 0 | 1 | 0 | $5,000 | $5,000 |
| **Healthcare Systems and Services** | Paramedic | 0 | 4 | 1 | $3,400 | $3,100 |
| **Radiological Health** | Radioactive Material | 0 | 1 | 0 | $30,000 | $10,000 |
| **TOTAL** | | **0** | **13** | **1** | **$74,400** | **$46,100** |

Submitted By:

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

August 11, 2022

## Bureau of Community Care

| Facility Type | Total Number of Licensed Facilities | Total Number of Licensed Beds |
|---|---|---|
| Community Residential Care Facility (CRCF) | 477 | 21,729 |

### 1. Southern Oaks Personal Care Home – Greenville, SC

**Investigation and Violations:** The Department conducted complaint investigations and routine follow-up inspections in March 2021, October 2021, and November 2021, and observed and cited Regulation 61-84, Section 1703, on four separate occurrences. The Department found that the facility repeatedly failed to ensure it was free of vermin.

**Enforcement Action:** The Department and the facility executed a consent order requiring the facility to pay a $3,000 civil monetary penalty within 30 days of executing the Consent Order.

**Remedial Action:** The facility has made the full required payment. The facility has also since voluntarily closed.

**Prior Orders:** None.

### 2. Oaks at Mt. Pleasant – Mount Pleasant, SC

**Investigation and Violations:** The Department investigated the facility in February 2022, and cited Regulation 61-84, Section 1001.A. The Department found that the facility violated R.61-84, Section 1001.A, by failing to ensure a resident was free from mental and physical abuse in accordance with S.C. Code Section 44-81-40(G) of the Bill of Rights for Residents of Long-Term Care Facilities.

**Enforcement Action:** The Department and the facility executed a consent order requiring the facility to pay a $3,000 monetary penalty within 30 days of the Consent Order.

**Remedial Action:** The facility has made the full required payment.

**Prior Orders:** None.

**3. Dalton's CMC Residential Care Facility – Orangeburg, SC**

**Investigation and Violations:** In January 2022, the Department conducted a routine general inspection at the facility, and cited Regulation 61-84, Section 202.C. Also, during January and February 2022, the Department issued five citations by mail to the facility for violating Regulation 61-84, Sections 202.D, 502.A, and 604. Specifically, the Department found:

- The facility violated Section 202.C on January 24, 2022, by failing to grant the Department access to the facility to perform an inspection.
- The facility violated Section 202.D on January 26, 2022, January 27, 2022, and February 2, 2022, by failing to submit to the Department written plans of correction for cited violations.
- The facility violated Section 502.A on January 13, 2022, January 19, 2022, and January 26, 2022, by failing to employ a licensed community residential care facility administrator.
- The facility violated Section 604 on January 13, 2022, by failing to notify the Department via telephone or email within 72 hours of the departure of its administrator.

**Enforcement Action:** The Department and the facility executed a consent order requiring the facility to pay a $5,000 monetary penalty in four payments of $1,250 each. The facility further agreed to schedule and attend a compliance assistance meeting with the Department within 45 days of the Consent Order.

**Remedial Action:** The Department has not received any payments from the facility. The Department conducted a compliance assistance meeting with the facility on July 26, 2022.

**Prior Orders:** The Department and the facility executed a consent order in May 2019, wherein the facility agreed to a $10,800 assessed monetary penalty. The facility was required to pay $6,000 in four consecutive monthly payments of $1,500, and the remaining $4,800 held in abeyance pending a six-month period of substantial compliance with Regulation 61-84 and the Consent Order. The May 2019 Consent Order resulted from 33 violations, some of which were repeat violations, related to, renewal applications, plans of correction, residents' finances, medications, sanitation, staff health assessments, and patient physical examinations.

**4. Beckman I CRCF – Columbia, SC**

**Investigation and Violations:** The Department investigated the facility in March 2022, and cited Regulation 61-84, Section 1001.A. Specifically, the Department found that the facility violation Regulation 61-84, Section 1001.A, by failing to ensure a resident was free from physical abuse in accordance with S.C. Code Section 44-81-40(G) of the Bill of Rights for Residents of Long-Term Care Facilities.

**Enforcement Action:** The Department and the facility executed a consent order requiring the facility to pay a $3,000 monetary penalty within 30 days of the Consent Order.

**Remedial Action:** The facility has made the full required payment.

**Prior Orders:** None.

**5. Dowdy's Community Care Home #2 – Columbia, SC**

**Investigation and Violations:** The Department conducted a food and sanitation inspection in May 2021, and routine follow-up inspections in August 2021 and February 2022, and cited the facility for repeatedly violating Regulation 61-84 as follows:

- Failing to conduct criminal background checks for all staff/direct care volunteers prior to employment.
- Failing to have documentation of staff in-service training in basic first-aid.
- Failing to have documentation of staff in-service training in management/care of persons with contagious and/or communicable disease.
- Failing to have documentation of staff in-service training in medication management.
- Failing to have documentation of staff in-service training in care of persons specific to the physical/mental condition(s) being care for in the Facility.
- Failing to have documentation of staff in-service training in use of restraint techniques.
- Failing to have documentation of staff in-service training in OSHA standards regarding blood-borne pathogens.
- Failing to have documentation of staff in-service training in confidentiality of resident information and records.
- Failing to have documentation of staff in-service training in the Bill of Rights for Residents of Long-Term Care Facilities, S.C. Code Sections 44-81-10, et. seq.
- Failing to have documentation of staff in-service training in fire response.
- Failing to have documentation of staff in-service training in emergency procedures/disaster preparedness.
- Failing to have documentation of residents' current annual physical examinations.
- Failing to ensure that the Facility's kitchen and the food prepared on-site was in compliance with Regulation 61-25.
- Failing to ensure resident rooms and bathrooms window treatments provided privacy.

**Enforcement Action:** The Department and the facility executed a consent order requiring the facility to pay $6,000 of the assessed $14,000 monetary penalty. The facility agreed to pay five monthly payments of $1,200 each. The remaining $8,000 of the assessed monetary penalty is stayed upon a six-month period of substantial compliance with Regulation 61-84 and the Consent Order. The facility further agrees to schedule and attend a compliance assistance meeting with the Department within 45 days of the Consent Order.

**Remedial Action:** The facility has made the first required payment of $1,200. The Department conducted a compliance assistance meeting with the facility on July 26, 2022.

**Prior Orders:** None.

| Facility Type | Total Number of Licensed Facilities | Total Number of Licensed Beds |
|---|---|---|
| Intermediate Care Facilities for Individuals with Intellectual Disabilities | 66 | 1,634 |

**6. Florence Gressette Residence – St. Matthews, SC**

**Investigation and Violations:** The Department investigated the facility in February 2022, and cited Regulation 61-13, Sections 500.A, 701.C, and 1100.A. Specifically, the Department found:

- The facility violated Regulation 61-13, Section 500.A, by failing to implement its policies and procedures regarding client care, rights, and operation of the facility.
- The facility violated Regulation 61-13, Section 701.C, by failing to notify the Department of a serious accident and/or incident within 24 hours of the serious accident and/or incident.
- The facility violated Regulation 61-13, Section 1100.A, by failing to ensure clients were protected from mental/psychological abuse in accordance with S.C. Code Section 44-81-40(G) of the Bill of Rights for Residents in Long-Term Care Facilities.

**Enforcement Action:** The Department and the facility executed a consent order requiring the facility to pay a $3,000 monetary penalty.

**Remedial Action:** The facility has made the full required payment.

**Prior Orders:** None.

**7. Fountain Inn Community Residence – Columbia, SC**

**Investigation and Violations:** The Department conducted an investigation in February 2022, and cited the facility for violating Regulation 61-13, Sections 500.A and 1100.A. Specifically, the Department found:

- The facility violated Regulation 61-13, Section 500.A, by failing to implement its policies and procedures regarding client care, rights, and operation of the facility.
- The facility violated Regulation 61-13, Section 1100.A, by failing to ensure clients were protected from physical abuse in accordance with S.C. Code Section 44-81-40(G) of the Bill of Rights for Residents in Long-Term Care Facilities.

**Enforcement Action:** The Department and the facility executed a consent order requiring the facility to pay a $5,000 monetary penalty.

**Remedial Action:** The facility has made the full required payment.

**Prior Orders:** None.

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

**8. Palmetto Pines Behavioral Health – Summerville, SC**

**Investigation and Violations:** The Department conducted an investigation in March 2022, and cited Regulation 61-103, Section 1002.A.6. Specifically, the facility violated R.61-103, Section 1002.A.6, by failing to ensure the residents were free from harm, abuse, or neglect, as outlined in the "Statement of Rights of Residents."

**Enforcement Action:** The Department and the facility executed a consent order requiring the facility to pay a $5,000 monetary penalty within 30 days of the Consent Order.

**Remedial Action:** The facility has made the full required payment.

**Prior Orders:** The Department and the facility previously executed a consent order in September 2021, which included four occurrences of violating R.61-103, Section 1002.A.6, among many other repeat violations. The facility agreed to a $12,100 assessed monetary penalty and made the required payment of $7,260 within 30 days of executing the Consent Order.

## Bureau of Healthcare Systems and Services

| Level of Certification | Total Number of Certified Paramedics |
|---|---|
| Paramedic | 4,198 |

**9. Stacey A. Winstead – Paramedic**

**Investigation and Violations:** In December 2021, the Department learned through an investigation that Ms. Winstead committed misconduct in May 2021. During a call, Ms. Winstead was observed on police body camera imagery leaving the immediate location of the patient and left the patient in the care of her partner, an EMT with basic level training. As a result, the Department found that Ms. Winstead committed misconduct as defined by S.C. Code Section 44-61-80(F)(8) and Regulation 61-7, Section 1100(B)(8) by discontinuing care of a patient at the scene of an accident or illness, discontinued care or abandoned the patient without the patient's consent or without providing for the further administration of care by an equal or higher medical authority.

The Department further found that Ms. Winstead committed misconduct as defined by S.C. Code Section 44-61-80(F)(14) and Regulation 61-7, Section 1100(B)(14) by her actions or inactions, created a substantial possibility that death or serious physical harm could result by leaving her patient, who was suspected of

ingesting drugs/medications to end their life, and abandon her patient who was experiencing a decreased level of consciousness and snoring respirations.

Lastly, the Department found Ms. Winstead committed misconduct as defined in S.C. Code Section 44-61-80(F) and Regulation 61-7, Section 1100(B)(18) by failing to provide a patient medical treatment of a quality deemed acceptable by the Department. The Department found that Ms. Winstead delayed starting patient care until after the patient was loaded into the ambulance for transport to the hospital. The patient care report indicated a 29-minute delay in placing the patient on a cardiac monitor could have identified cardiac rhythm abnormalities from ingested medications or drugs. The patient care report also indicated a 44-minute delay in starting an IV could have provided immediate access to the vascular system to deliver reversal agents for suspected overdose. The patient care report further indicated a 46-minute delay in obtaining blood samples before obtaining blood glucose measurement that demonstrates the failure to detect a simple cause of altered mental status, low blood glucose levels.

**Enforcement Action:** The Department and Ms. Winstead executed a consent order requiring Ms. Winstead to pay a $1,000 monetary penalty within 30 days of executing the Consent Order. In addition, Ms. Winstead's Paramedic certificate shall be restricted for two years, and during this time, Ms. Winstead will be limited to the authority of an EMT-Basic. Ms. Winstead is also required to complete an Advanced Medical Life Support (AMLS) Class.

**Remedial Action:** The Department has not received Ms. Winstead's required payment. The Department has not received proof of required class completion.

**Prior Orders:** The Department and Ms. Winstead previously executed a consent order in November 2019, after the Department determined Ms. Winstead committed misconduct by discontinuing care of patient at the scene of an illness without the patient's consent or without providing for the further administration of care by an equal or higher medical authority. The November 2019 Consent Order resulted in a six-month suspension held in abeyance for 12 months, and Ms. Winstead completed a Pre-Hospital Trauma and Life Support Class and a Professional Ethics and Personal Leadership (PEPL) Class.

**10. Patrick Morris – Paramedic**

**Investigation and Violations:** In March 2021, the Department learned through an investigation that Mr. Morris committed misconduct in February 2021. The Department found that Mr. Morris committed misconduct as defined by S.C. Code Section 44-61-80(F) and Regulation 61-7, Section 1100(B)(18), by failing to provide a patient emergency medical treatment of a quality deemed acceptable by the Department. The Department further found that Mr. Morris's failure resulted in delays and a subsequent transfer from a non-designated pediatric trauma center to a pediatric burn center.

**Enforcement Action:** In the interest of resolving this matter without delay and expense of litigation, Mr. Morris agreed to the entry of a consent order, but does not agree with the findings of fact and conclusions of law in the Consent Order. The Consent Order executed between the Department and Mr. Morris assessed a $300 monetary penalty against Mr. Morris to be held in abeyance subject to his completion of required education and job shadowing. Specifically, Mr. Morris is required to complete one hour of education on de-escalation techniques and 8 hours shadowing the Pediatric Trauma Program Manager at Grand Strand Medical Center. If Mr. Morris fails to complete the education and job shadowing requirements within 6 months, Mr. Morris will be required to pay $300 within 30 days.

**Remedial Action:** The Department has not received proof of completed education and job shadowing requirements.

**Prior Orders:** None.

**11. Thomas Szczepaniak – Paramedic**

**Investigation and Violations:** In December 2021, the Department learned through an investigation, that Mr. Szczepaniak committed misconduct in May 2021. The Department found Mr. Szczepaniak committed misconduct as follows:

- Mr. Szczepaniak committed misconducted, as defined in S.C. Code Section 44-61-80(F)(6) and Regulation 61-7, Section 1100(B)(6), by disregarding an appropriate order by a physician concerning emergency treatment and transportation.
- Mr. Szczepaniak committed misconduct, as defined by S.C. Code Section 44-61-80(F)(8) and Regulation 61-7, Section 1100(B)(8), after initiating patient care at the scene of a traumatic injury accident, discontinuing patient care and abandoning the patient, by failing to provide for the administration of care by an equal or higher medical authority.
- Mr. Szczepaniak committed misconduct, as defined by S.C. Code Section 44-61-80(F)(10) and Regulation 61-7, Section 1100(B)(10), by failing to follow the MANDATORY Adult Trauma Transport Protocol and failing to identify the need and provide for the appropriate transport to a Level 1 or 2 Trauma Center.
- Mr. Szczepaniak committed misconduct, as defined by S.C. Code Ann.§ 44-61-80(F)(14) and Regulation 61-7, Section 1100(B)(14), by failing to follow the 2019 version of Lexington County Protocol C-2 "Duty to Act" and by failing to perform a thorough head-to-toe assessment. A pelvic injury went unnoticed and untreated creating the substantial possibility that death or serious physical harm could result.
- Mr. Szczepaniak committed misconduct, as defined by S.C. Code Ann.§ 44-61-80(F) and Regulation 61-7, Section 1100(B)(18), by failing to provide a patient emergency medical treatment of a quality deemed acceptable by the Department.

**Enforcement Action:** The Department and Mr. Szczepaniak executed a consent order requiring Mr. Szczepaniak to pay a $1,500 monetary penalty within 30 days of the Consent Order. The other terms of the Consent Order require Mr. Szczepaniak to complete a Professional Ethics and Personal Leadership (PEPL) Class and complete a 30-hour Paramedic Refresher Course. In addition, the Department suspended Mr. Szczepaniak's Paramedic Certificate for two years to be held in abeyance for 12 months pending completion of the PEPL and paramedic refresher courses. Mr. Szczepaniak will be an EMT-Basic during the suspension period.

**Remedial Action:** Mr. Szczepaniak has made the full required payment. The Department has not received proof of required class and course completion.

**Prior Orders:** None.

**12. Gerald Ham – Paramedic**

**Investigation and Violations:** In January 2022, the Department learned through an investigation that Mr. Ham committed misconduct in June 2021. The Department found:

- Mr. Ham committed misconduct as defined in S.C. Code Section 44-61-80(F)(6) and Regulation 61-7, Section 1100(B)(10), by not recognizing a cardiac rhythm with electrical activity that should have been resuscitated.
- Mr. Ham committed misconduct as defined in S.C. Code Ann. § 44-61-80(F)(6) and Regulation 61-7, Section 1100(B)(14), by not following the American Heart Association (AHA) ACLS Guidelines and Timmonsville Rescue Squad EMS Protocols.

**Enforcement Action:** The Department and Mr. Ham executed a consent order requiring Mr. Ham to pay a $600 monetary penalty in three payments of $200 each. In addition, Mr. Ham is required to complete a Professional Ethics and Personal Leadership (PEPL) Class and an Advanced Medical Life Support (AMLS) Refresher Class within 12 months of the Consent Order. Finally, Mr. Ham agreed to a two-year suspension of his Paramedic Certificate held in abeyance for 12 months upon completion of the PEPL and AMLS Refresher Classes.

**Remedial Action:** Mr. Ham has made the full required payment of $600. The Department has not received proof of required class completion.

**Prior Orders:** None.

**13. Raymond Franklin Huffman – Paramedic**

**Investigation and Violations:** In October 2020, the Department was notified by South Carolina Law Enforcement Division (SLED) that Mr. Huffman was arrested. SLED's notification prompted the Department to open an investigation as it relates to any statutory or regulatory violations applicable to Mr. Huffman's Paramedic certificate issued by the Department. The Department found:

- Mr. Huffman had been arrested and charged with violating S.C. Code Section 16-13-230(A), breach of trust with fraudulent intent in the amount of more than $2,000 but less than $10,000, and with violating S.C. Code Section 16-16-20, computer crime in the second degree.
- Mr. Huffman was later federally indicted on 26 counts of theft of government property arising from the same events and in violation of 18 U.S.C. Section 641. Mr. Huffman signed a plea agreement in May 2022.

The Department continues to investigate Mr. Huffman's arrest and subsequent plea of guilt for felonies constituting gross immorality. Mr. Huffman's conduct arises to misconduct as defined by S.C. Code Section 44-61-80(F)(2) and Regulation 61-7, Section 302(B)(3). Specifically, Mr. Huffman's conduct arises to misconduct because he was convicted of or currently under indictment for a felony or another crime involving moral turpitude, drugs, or gross immorality.

**Enforcement Action:** As a Paramedic, Mr. Huffman is placed in a position of trust. The Department believes Mr. Huffman's indictment demonstrates a capacity for inappropriate and criminal behavior towards individuals placed within his trust. The Department has determined that a clear and present danger would exist to the public health, safety, and welfare if the Paramedic certificate issued to Mr. Huffman is

not immediately suspended pending further investigation. Therefore, the Department ordered that Mr. Huffman's Paramedic certificate be suspended immediately on an emergency basis.

**Remedial Action:** Not Applicable.

**Prior Orders:** None.

## Bureau of Radiological Health

| Radioactive Materials Licensee Type | Total Number of Licensees |
|---|---|
| Medical Private Practice | 62 |

### 14. Outpatient Diagnostic Center of Conway Medical Center – Conway, SC

**Investigation and Violations:** In December 2021, the Department conducted a routine inspection of the licensee, and cited the licensee for violating Regulation 61-63. Specifically, the Department found the licensee violated Regulation 61-63 as follows:

- Having an individual other than the radiation safety officer listed on the license perform the duties and responsibilities of the radiation safety officer.
- Having an individual other than the authorized user listed on the license supervise the medical use of radioactive material.
- Failing to conduct annual radiation safety training for employees on an annual basis as outlined in their policy.
- Failing to have a written directive for patients as outlined in their policy.
- Failing to establish the authority, duties, and responsibilities of the radiation safety officer in writing (delegation of authority).

**Enforcement Action:** After the Department and the licensee met for an enforcement conference on April 6, 2022, the licensee submitted a request to terminate their radioactive materials license on April 12. On June 6, the Department and licensee executed a consent order imposing a $30,000 monetary penalty against the licensee. The licensee agreed to pay $10,000 of the assessed penalty within 30 days of the Consent Order and the remaining $20,000 will be stayed. After the licensee's request to terminate is approved by the Department, the licensee shall not apply or reapply for a radioactive material license within 5 years of executing the Consent Order.

**Remedial Action:** The licensee made the full required payment. The licensee's license was terminated on June 7, 2022.

**Prior Orders:** None.