

SUMMARY SHEET  
SOUTH CAROLINA BOARD OF HEALTH AND ENVIRONMENTAL CONTROL

August 10, 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 May 1, 2017, through June 30, 2017.

**III. FACTS:** For the period of May 1, 2017, through June 30, 2017, Health Regulation reports thirteen (13) Consent Orders, two (2) Emergency Suspension Orders, and one (1) License Suspension with a total of fifteen thousand fifty dollars (\$15,050) in assessed monetary penalties.

Health Regulation Bureau	Health Care Facility, Provider or Equipment	Administrative Orders	Consent Orders	Emergency Suspension Orders	License Suspensions	Assessed Penalties
Radiological Health	Podiatric X-Ray Facility	0	4	0	0	\$12,000
EMS & Trauma	Paramedic	0	1	1	0	\$0
	Ambulance Services Provider	0	3	0	1	\$2,550
	EMT	0	5	1	0	\$500
<b>TOTAL</b>		<b>0</b>	<b>13</b>	<b>2</b>	<b>1</b>	<b>\$15,050</b>

Approved By:

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Shelly Bezanson Kelly  
Director of Health Regulation

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

August 10, 2017

**Bureau of Radiological Health**

Facility Type	Total # of Registered Providers in South Carolina
Podiatric X-Ray Facilities	64

- 1. Foot Institute St. Julian Place (Podiatric Facility) – Columbia, SC**
- Foot Institute West Columbia (Podiatric Facility) – West Columbia, SC**
- Foot Institute North Charleston (Podiatric Facility) – North Charleston, SC**
- Foot Institute Florence (Podiatric Facility) – Florence, SC**

Investigation: The Foot Institute applied to the Department for registration to provide x-ray services for four (4) separate facilities referenced above. During June and July 2015, the Department conducted initial inspections of the Foot Institute facilities and found multiple violations of Regulation 61-64, *X-Rays (Title B)*. The Department did not receive a final notice of corrective action for the alleged violations from the Foot Institute within the required sixty (60) days. Subsequently, representatives of the Department and the Foot Institute met on December 14, 2016, for an enforcement conference after several failed attempts to receive notice of corrective action from the Foot Institute.

Violations: Based upon the above-referenced inspections, the Department finds the Foot Institute in violation of R.61-64 for the following: failing to implement a sufficient radiation program and failing to use ALARA principles by not establishing a personnel monitoring program; failing to monitor individuals' occupational doses; failing to obtain employees' previous occupational dose records; failing to post recent measurements; failing to perform equipment performance tests on its x-ray units; failing to provide operating procedures; failing to conduct facility specific operator training for physicians; failing to provide patient shielding; failing to maintain an x-ray log; failing to post adequate signage; and failing to post pregnancy signage.

Enforcement Action: The Foot Institute agreed to the imposition of a three thousand dollar (\$3,000) civil penalty for each facility by four (4) separate Consent Orders. The Consent Orders required the Foot Institute to make payment of one thousand five hundred dollars (\$1,500) of each assessed monetary penalty within thirty (30) days of execution of the Consent Orders. The remaining one thousand five hundred dollars (\$1,500) of each assessed penalty will be stayed upon a twenty-four (24) month period of substantial compliance with R.61-64 and the terms of the Consent Orders. The Consent Orders further require the Foot Institute to submit copies of their personnel monitoring reports to the Department for the next twelve (12) months to ensure a sufficient radiation program is in place at each facility. Finally, the Consent Orders require the Foot Institute to submit a copy of their invoices for each facility documenting they are maintaining a 0.5 mm lead shield for the patient and 0.3 mm lead equivalent shield for the operator(s) to ensure that patients and operators are adequately shielded during x-ray procedures. The assessed monetary penalties for each facility have been received from the Foot Institute.

Prior Sanctions: None.

**Bureau of EMS & Trauma**

<b>EMS Provider Type</b>	<b>Total # of Providers in South Carolina</b>
EMT	5,882
Advanced EMT	382
Paramedic	3,666
Athletic Trainers	922
Ambulance Services Provider	258
First Responder Services Provider	2

**2. Steven J. Starr (Paramedic)**

Investigation: On January 23, 2017, the Department received notification regarding an incident involving alleged inappropriate actions by Mr. Starr. The Department initiated an investigation and made the following findings. On January 20, 2017, Mr. Starr and his EMT partner were dispatched by Dorchester County Dispatch to an emergency call for a patient who sustained a fall. Mr. Starr’s EMT partner notified dispatch that they were in route to the patient. After informing dispatch that they were responding to the call, Mr. Starr drove the ambulance to a restaurant, exited the ambulance and picked up food he ordered. Mr. Starr then returned to the ambulance and departed to the fall patient. A supervisor for Dorchester County EMS arrived on scene prior to Mr. Starr, cared for the patient, and cancelled Mr. Starr’s ambulance prior to its arrival.

Violations: As a result of its investigation, the Department found Mr. Starr committed “misconduct,” as defined by S.C. Code Section 44-61-80(F)(14) and Section 1100(B)(14) of Regulation 61-7, by creating a substantial possibility that serious physical harm or death could result from his actions or inactions. The hour following a traumatic injury is paramount for emergency medical treatment to prevent death or serious physical disability. Therefore, Mr. Starr’s unreasonable delay in responding to the patient created a substantial possibility of death or serious physical harm.

Enforcement Action: Pursuant to the terms of the Consent Order executed May 31, 2017, Mr. Starr agreed to a one (1) year suspension of his Paramedic certificate. Mr. Starr’s suspension shall be held in abeyance for one (1) year following execution of the Consent Order. Mr. Starr 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 submit proof of completion to the Department. Should Mr. Starr fail to comply with the abovementioned requirements, the Department may call in all or a portion of the agreed upon suspension and/or take other enforcement action in accordance with the EMS Act and Regulation 61-7.

Prior Sanctions: None.

**3. Brad Benjamin (EMT)**

Investigation: On May 4, 2017, the Department was notified of Mr. Benjamin’s arrest in Horry County. Upon notification, the Department initiated an investigation into the matter. The Department discovered

that Mr. Benjamin was arrested on April 24, 2017, and charged with assault and battery of a high and aggravated nature.

Violations: The charges against Mr. Benjamin, specifically, assault and battery of a high and aggravated nature, is a felony involving moral turpitude and gross immorality. The Department found that Mr. Benjamin's arrest demonstrated a capacity for inappropriate and criminal behavior towards individuals placed within his trust. The Department determines that a clear and present danger would exist to the public health, safety, and welfare if Mr. Benjamin's EMT certificate was not immediately suspended pending further investigation.

Enforcement Action: Mr. Benjamin's EMT certificate was immediately suspended on an emergency basis pursuant to the Emergency Suspension Order executed May 9, 2017. The Department will continue to monitor Mr. Benjamin's criminal matters.

Prior Sanctions: None.

#### **4. Springlake Medical Transport, LLC (Ambulance Services Provider)**

Investigation: On April 25, 2016, the Department and Springlake Medical Transport, LLC ("Springlake") met to discuss Springlake failing to timely submit electronic patient care reports ("ePCRs"). As a result of this meeting, Springlake provided the Department with a plan of action to correct this issue. Subsequently, the Department met with Springlake again on January 23, 2017, to discuss Springlake's failure to submit ePCRs within seventy-two (72) hours of completion of the call. Specifically, from June 30, 2016, to December 31, 2016, Springlake failed to submit one hundred fifty-nine (159) ePCRs into the Prehospital Medical Information System ("PreMIS") within seventy-two (72) hours of completion of the call.

Violations: As a result of its investigation, the Department found Springlake violated Section 1301.C of Regulation 61-7, by failing to submit one hundred fifty-nine (159) ePCRs into PreMIS within seventy-two (72) hours of completion of the various calls from June 30, 2016, to December 31, 2016.

Enforcement Action: Pursuant to the Consent Order executed May 5, 2017, Springlake agreed to a one thousand five hundred dollar (\$1,500) assessed monetary penalty, which shall be due within one hundred eighty (180) days of execution of the Consent Order. Springlake further agreed to a six (6) month suspension if the Department finds Springlake in violation of the EMS Act, Regulation 61-7, or the terms of the Consent Order within six (6) months following execution of the Consent Order.

Prior Sanctions: None.

#### **5. Stacy W. Widener (EMT)**

Investigation: On May 2, 2016, the Department received a complaint regarding alleged actions of Mr. Widener on April 23, 2016, while employed with Palmetto Ambulance. Based upon the investigation, the Department found that on April 23, 2016, Mr. Widener and his partner responded to a nursing home for a call regarding a patient suffering from decreased blood sugar. Upon arrival, after speaking with staff, Mr. Widener entered the patient's room and observed the nursing home staff administering a nebulized breathing treatment to the patient. Mr. Widener then left the patient's room without talking to the patient or the patient's responsible party and without knowing the certification or licensure level of the nursing home staff providing care to the patient. Mr. Widener then advised the nursing home staff that they needed to call 911 to get an advanced life support ambulance to continue treatment and transport the patient to the emergency room. Mr. Widener and his partner then departed the nursing home.

**Violations:** As a result of its investigation, the Department found Mr. Widener committed “misconduct,” as defined by S.C. Code Section 44-61-80(F)(8) and Section 1100(B)(8) of Regulation 61-7, by initiating care of a patient then discontinuing care and abandoning a patient without the consent of the patient or the patient’s responsible party and without providing for further administration of care by an equal or higher medical authority. Specifically, Mr. Widener responded to the call, consulted with nursing home staff, observed the patient, then discontinued care and abandoned the patient without consent and without arranging for the further administration of care by an EMT or higher medical authority.

**Enforcement Action:** Pursuant to the Consent Order executed May 4, 2017, Mr. Widener agreed to a six (6) month suspension of his EMT certificate. The suspension will be held in abeyance for six (6) months. Should Mr. Widener fail to comply with the EMS Act, Regulation 61-7, or the terms of the Consent Order, the Department may call in all or a portion of the agreed upon suspension. Additionally, Mr. Widener agreed to take a twenty-four (24) hour EMT refresher course within six (6) months following execution of the Consent Order and provide proof of successful completion to the Department.

**Prior Sanctions:** None.

## **6. William D. Rochester (EMT)**

**Investigation:** On September 7, 2016, the Department received notification that Mr. Rochester performed skills that were above the level for which he was certified. Mr. Rochester is employed by Greenville Health System d/b/a Oconee Memorial Hospital EMS (“Oconee”). At the time of the incident, Mr. Rochester was enrolled in a paramedic course. On August 27, 2016, Mr. Rochester was assigned by Oconee to work a medical standby at a scheduled special event with a registered nurse (“RN”). Near the end of the event, Oconee dispatch called for response for a patient suffering an allergic reaction. After realizing that the advanced life support (“ALS”) unit that was dispatched to the call was coming from a lengthy distance and that his basic life support (“BLS”) was closer to the call, Mr. Rochester contacted dispatch and advised that his unit would respond first to the scene. Upon arrival, Mr. Rochester determined the patient was suffering from a potential life threatening allergic reaction. Mr. Rochester administered epinephrine via an intramuscular (“IM”) injection. A certified EMT may only administer epinephrine by use of an auto-injector. The RN then initiated an intravenous (“IV”) line on the patient and Mr. Rochester utilized the IV line to administer Benadryl to the patient. A certified EMT cannot administer Benadryl. Thereafter, during the transfer, Mr. Rochester gave the transporting paramedic a verbal patient report on the care the patient received prior to arrival of the transporting ambulance. Information obtained during this verbal report was included in the transporting paramedic’s electronic patient care report (“ePCR”); however, Mr. Rochester failed to complete and submit the ePCR for his treatment of the patient prior to turning patient care over to the transporting ALS ambulance.

**Violations:** As a result of its investigation, the Department found Ms. Rochester committed “misconduct,” as defined by S.C. Code Section 44-61-80(F)(12) and Section 1100(B)(12) of Regulation 61-7, by performing skills above the level for which he was certified. Specifically, Mr. Rochester administered epinephrine via an IM injection and administered Benadryl via an IV injection. Mr. Rochester further 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) which requires the primary care attendant to document all patient contact, care, and transport within the ePCR and to complete such documentation within twenty-four (24) hours of the conclusion of the call. Specifically, Mr. Rochester failed to complete the required ePCR for a call in which he was the primary care attendant.

**Enforcement Action:** Pursuant to the terms of the Consent Order executed May 3, 2017, Mr. Rochester agreed to a one (1) year suspension of his EMT certificate. Mr. Rochester’s suspension shall be held in abeyance for one (1) year following execution of the Consent Order. Mr. Rochester 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 submit proof of completion to the Department. Should Mr. Rochester fail to comply with the abovementioned requirements, the Department may call in all or a portion of the agreed upon suspension and/or take other enforcement action in accordance with the EMS Act and Regulation 61-7.

Prior Sanctions: None.

#### **7. Zackery R. Stout (Paramedic)**

Investigation: On January 20, 2017, the Department was notified of Mr. Stout's arrest in Horry County. Upon notification, the Department initiated an investigation into the matter. The Department discovered that Mr. Stout was arrested on August 26, 2016, and charged with domestic violence in the second degree, and harassment in the first degree. Mr. Stout was also arrested on January 12, 2017, and charged with assault and battery in the second degree. Mr. Stout was arrested again on February 9, 2017, and charged with simple possession of marijuana. Mr. Stout subsequently pled guilty to the marijuana offense on February 23, 2017.

Violations: The charges against Mr. Stout, specifically, second degree domestic violence, first degree harassment, second degree assault and battery, and simple possession of marijuana, are criminal offenses involving moral turpitude, gross immorality, and drugs. The Department found that Mr. Stout's arrests demonstrated a capacity for inappropriate and criminal behavior towards individuals placed within his trust.

Enforcement Action: Mr. Stout's Paramedic certificate was immediately suspended on an emergency basis pursuant to the Emergency Suspension Order executed April 19, 2017.

Prior Sanctions: None.

#### **8. Pro Ambulance Service (Ambulance Services Provider)**

Investigation: On November 24, 2016, a Department inspector witnessed a Pro Ambulance Service ("Pro Ambulance") unit pulling into the parking lot of a medical facility. The ambulance appeared to only have one (1) person on board. Upon investigation, the Department determined the ambulance was being operated by an uncertified driver with no certified EMT on board. Moreover, the ambulance had no visible indication that it was "out of service."

Violations: As a result of its investigation, the Department found Pro Ambulance violated Section 406.A of Regulation 61-7 by failing to meet minimum ambulance staffing requirements. Specifically, the ambulance was being operated by an uncertified individual and no certified EMTs were aboard the on-duty ambulance.

Enforcement Action: Pursuant to the terms of the Consent Order executed June 23, 2017, Pro Ambulance agreed to a three hundred dollar (\$300) assessed monetary penalty, due within thirty (30) days of execution of the Consent Order.

Prior Sanctions: None.

#### **9. Mark W. Povelaitis (EMT)**

Investigation: On January 16, 2017, the Department received notification that Mr. Povelaitis allegedly performed skills that were above the level for which he was certified. Specifically, on January 15, 2017, while working for Mobile Care Ambulance Service ("Mobile Care"), Mr. Povelaitis and his EMT partner

were dispatched to transport a patient, how recently gave birth, from one hospital to another hospital that provides a higher level of care. At the time, the patient was being administered magnesium sulfate through an intravenous (“IV”) line. EMTs are not certified to transport a patient that is receiving medication through an IV line with the exception of normal saline. Mr. Povelaitis and his EMT partner transported the patient to the receiving hospital. Furthermore, according to Mobile Care’s protocols, which are signed and approved by its medical control physician, any patient receiving medication other than normal saline through an IV line must be placed on a cardiac monitor. Mr. Povelaitis and his EMT partner transported the patient without placing her on a cardiac monitor.

Violations: As a result of its investigation, the Department found Mr. Povelaitis committed “misconduct,” as defined by S.C. Code Section 44-61-80(F)(12) and Section 1100(B)(12) of Regulation 61-7, by performing skills above the level for which he was certified. Mr. Povelaitis further 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 and transportation.

Enforcement Action: Pursuant to the terms of the Consent Order executed June 2, 2017, Mr. Povelaitis agreed to a one (1) year suspension of his EMT certificate. Mr. Povelaitis’s suspension shall be held in abeyance for one (1) year following execution of the Consent Order. Mr. Povelaitis agreed to successfully complete a National Association of Emergency Medical Technicians Principles of Ethics and Personal Leadership course within one (1) year of execution of the Consent Order and submit proof of completion to the Department. Should Mr. Povelaitis fail to comply with the abovementioned requirements, the Department may call in all or a portion of the agreed upon suspension and/or take other enforcement action in accordance with the EMS Act and Regulation 61-7.

Prior Sanctions: None.

## **10. Guy S. Harris (EMT)**

Investigation: Mr. Harris was the EMT partner of Mr. Povelaitis on January 15, 2017. Therefore, the facts of this investigation are the same as those outlined above for Mr. Povelaitis.

Violations: As a result of its investigation, the Department found Mr. Harris committed “misconduct,” as defined by S.C. Code Section 44-61-80(F)(12) and Section 1100(B)(12) of Regulation 61-7, by performing skills above the level for which he was certified. Mr. Harris further 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 and transportation.

Enforcement Action: Pursuant to the terms of the Consent Order executed June 1, 2017, Mr. Harris agreed to a one (1) year suspension of his EMT certificate. Mr. Harris’s suspension shall be held in abeyance for one (1) year following execution of the Consent Order. Mr. Harris agreed to successfully complete a National Association of Emergency Medical Technicians Principles of Ethics and Personal Leadership course within one (1) year of execution of the Consent Order and submit proof of completion to the Department. Should Mr. Harris fail to comply with the abovementioned requirements, the Department may call in all or a portion of the agreed upon suspension and/or take other enforcement action in accordance with the EMS Act and Regulation 61-7.

Prior Sanctions: None.

## **11. Ontime Transport LLC (Ambulance Services Provider)**

Investigation: On January 9, 2017, Ontime Transport LLC (“Ontime”) notified the Department that one of its employees had worked as an EMT with an expired EMT certificate. As a result of its investigation, the Department determined the employee performed patient care within the scope of an EMT on eleven (11) ambulance runs while working for Ontime from December 16, 2016, to January 9, 2017, a time period in which he was uncertified as a South Carolina EMT. Further, on March 2, 2017, Ontime notified the Department that it had an employee who failed to enter electronic patient care reports (“ePCRs”) on thirty-eight (38) ambulance runs. As a result of its investigation, the Department determined that Ontime failed to create and submit ePCRs into PreMIS for thirty-eight (38) patient contacts from December 1, 2016, to February 21, 2017.

Violations: As a result of its investigation, the Department found Ontime violated S.C. Code Section 44-61-90 and Section 1301.A of Regulation 61-7, by failing to maintain ePCRs and by failing to create and submit ePCRs into PreMIS for thirty-eight (38) patient contacts from December 1, 2016, to February 21, 2017. Additionally, Ontime violated S.C Code Section 44-61-70(B)(1) by allowing an uncertified person to perform patient care within the scope of an EMT.

Enforcement Action: Pursuant to the Consent Order executed June 26, 2017, Ontime agreed to a seven hundred fifty dollar (\$750) assessed monetary penalty, which shall be due within one hundred twenty (120) days of execution of the Consent Order.

Prior Sanctions: None.

## **12. Fredrick M. Hilton, Jr. (EMT)**

Investigation: Mr. Hilton was the uncertified EMT employed by Ontime. Therefore, the facts of this investigation are the same as those outlined above for Ontime.

Violations: As a result of its investigation, the Department found Mr. Hilton 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 R.61-7, which 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 conclusion of the call. Specifically, from December 1, 2016, to February 21, 2017, Mr. Hilton failed to document and complete ePCRs for thirty-eight (38) calls that he was the primary care attendant.

Enforcement Action: Pursuant to the Consent Order executed June 24, 2017, Mr. Hilton agreed to a five hundred dollar (\$500) assessed monetary penalty. The assessed monetary penalty will be held in abeyance for twelve (12) months. Should Mr. Hilton fail to comply with the EMS Act, Regulation 61-7, or the terms of the Consent Order, the Department may call in all or a portion of the agreed upon monetary penalty.

Prior Sanctions: None.

## **13. American Pride Medical Transport, LLC (Ambulance Services Provider)**

Summary: On December 20, 2016, American Pride Medical Transport, LLC (“American Pride”) and the Department executed a Consent Order resulting from several regulatory violations involving American Pride’s ambulances. Pursuant to the Consent Order, American Pride agreed to the assessment of a five thousand dollar (\$5000) monetary penalty due to the Department within one hundred eighty (180) days of execution of the Consent Order. Additionally, pursuant to the Consent Order, American Pride agreed to a six (6) month suspension if it violated the Consent Order during the year following execution. On June 20, 2017, one hundred eighty-two (182) days after execution of the Consent Order, American Pride notified the Department that it would not be able to pay the agreed upon monetary penalty.

Violations: American Pride violated the Consent Order by failing to make payment of the agreed upon five thousand dollar (\$5000) monetary penalty.

Enforcement Action: American Pride's EMS provider license was suspended for six (6) months upon delivery of a certified letter on June 28, 2017. American Pride may not perform the functions associated with its provider license until it has complied with the statutory requirements and other conditions imposed by the Department

Prior Sanctions: In addition to the sanctions associated with the December 2016 Consent Order, on March 1, 2016, American Pride was assessed a six hundred dollar (\$600) monetary penalty via Consent Order for several regulatory violations involving American Pride's ambulances.