

SUMMARY SHEET  
SOUTH CAROLINA BOARD OF HEALTH AND ENVIRONMENTAL CONTROL

November 9, 2023

- ( ) 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 September 1, 2023, through September 30, 2023.
- III. FACTS:** For the period of September 1, 2023, through September 30, 2023, Healthcare Quality reports 6 Consent Orders totaling \$9,600 in assessed monetary penalties.

<b>Bureau</b>	<b>Facility, Service, Provider, or Equipment Type</b>	<b>Administrative Orders</b>	<b>Consent Orders</b>	<b>Assessed Penalties</b>	<b>Required Payment</b>
<b>Community Care</b>	Residential Treatment Facility for Children and Adolescents		1	\$8,000	\$8,000
<b>Healthcare Systems and Services</b>	In-Home Care Provider		1	\$300	\$300
	Outpatient Facility for Chemically Dependent or Addicted Persons (CDAP)		1	\$300	\$300
	Adult Day Care		1	\$300	\$300
	Paramedic		2	\$700	\$700
<b>TOTAL</b>			<b>6</b>	<b>\$9,600</b>	<b>\$9,600</b>

Submitted By:

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Gwen C. Thompson  
Deputy Director  
Healthcare Quality

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

November 9, 2023

**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. Broadstep Academy – South Carolina – Hampton (Pickens, 55 beds)**

**Investigation and Violations:** On Jan. 5, 2023, Feb. 8, 2023, Jun. 13, 2023, staff visited the facility to conduct complaint investigations. Staff observed and cited the following violations:

- The Facility failed to implement its policies and procedures regarding resident care, rights and operations of the Facility.
- The Facility failed to immediately report to the Department a serious accident and/or incident.
- The Facility failed to submit a written report of its investigation of a serious accident and/or incident within 5 calendar days.
- The Facility failed to afford a resident the right to be treated with respect and dignity.
- The Facility failed to afford a resident the right to be care for in an atmosphere of sincere interest and concern in which needed support and services were provided.
- The Facility failed to afford residents their right to be free from harm, including abuse.
- The Facility failed maintain the Facility's building components.

**Enforcement:** The Department notified the Facility via certified mail on July 17, 2023, that an enforcement action was being considered. The Department and the Facility met and agreed to resolve this matter through a Consent Order. The Facility agreed to the assessment of a \$8,000 monetary penalty. The Facility has paid the penalty.

**Remedial Action:** The Facility also agrees to correct the violations that prompted this enforcement action, and to ensure that any other violations are not repeated.

**Prior Orders:** None in the past five years.

**Bureau of Healthcare Systems and Services**

Facility Type	Total Number of Licensed Facilities
In-Home Care Provider	952

**1. My Father's Touch**

**Investigation and Violations:** The Facility failed to submit a timely renewal application and licensing fees by the license expiration date.

**Enforcement:** The Department and the Facility decided to resolve the matter through a Consent Order. The Facility paid the \$300 monetary penalty.

**Remedial Action:** none

**Prior Orders:** None in the past 5 years.

Facility Type	Total Number of Licensed Facilities
Outpatient Facility for Chemically Dependent or Addicted Persons (CDAP)	88

**1. Solutions Recovery Counseling - Greenville**

**Investigation and Violations:** The Facility failed to submit a timely renewal application and licensing fees by the license expiration date.

**Enforcement:** The Department and the Facility decided to resolve the matter through a Consent Order. The Facility paid the \$300 monetary penalty.

**Remedial Action:** none

**Prior Orders:** None in the past 5 years.

Facility Type	Total Number of Licensed Facilities
Adult Day Care Facility	91

### 1. Triple E Adult Day Care #3

**Investigation and Violations:** The Facility failed to submit a timely renewal application and licensing fees by the license expiration date.

**Enforcement:** The Department and the Facility decided to resolve the matter through a Consent Order. The Facility paid the \$300 monetary penalty.

**Remedial Action:** none

**Prior Orders:** None in the past 5 years.

Facility Type	Total Number of Licensed Facilities
Paramedic	4,469

### 1. Josh Orlando

**Investigation and Violations:** The Department received and opened an investigation on Sept. 29, 2022. The complaint alleged Mr. Orlando assaulted a patient under his care. The Department determined that Mr. Orlando violated the regulation by committing misconduct and failing to provide a patient quality emergency medical treatment.

**Enforcement:** On Aug. 28, 2023, the Department notified Mr. Orlando that it was considering enforcement action. The parties met on Sept. 12, 2023, for an enforcement conference. Mr. Orlando agreed to the assessment of a \$500 monetary penalty and to complete certain classes/courses (see below). Mr. Orlando paid the monetary penalty.

**Remedial Action:** Mr. Orlando completed the required Professional Ethics and Personal Leadership (PEPL) course and online courses regarding first response, service to self, and creating safe scenes.

**Prior Orders:** None in the past 5 years.

### 2. Ander Pregartner

**Investigation and Violations:** The Department received and opened an investigation on Dec. 29, 2022. The complaint alleged Ms. Pregartner failed to meet patient care standards. The Department determined

that Ms. Pregartner failed to determine the blood glucose level of a patient with a suspected overdose. By failing to do so, the Department concluded Ms. Pregartner failed to provide a patient emergency medical treatment of a quality deemed acceptable by the Department and committed misconduct as defined by the EMS Act and Regulation. Specifically, regarding the misconduct, Department staff concluded Ms. Pregartner disregarded an appropriate order by a physician concerning emergency treatment and created a substantial possibility that death or serious physical harm could result from her actions/inactions.

**Enforcement:** On Jul. 19, 2023, the Department notified Ms. Pregartner that it was considering enforcement action. The parties met on Aug. 2, 2023, for an enforcement conference. Ms. Pregartner agreed to the assessment of a \$200 monetary penalty. Ms. Pregartner paid the monetary penalty.

**Remedial Action:** Ms. Pregartner completed a NAEMT course focused on Advanced Medical Life Support.

**Prior Orders:** None in the past 5 years.