SUMMARY SHEET
SOUTH CAROLINA BOARD OF HEALTH AND ENVIRONMENTAL CONTROL

March 7, 2019

( ) ACTION/DECISION

(X) INFORMATION

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

II. **SUBJECT:** Health Regulation Administrative Orders and Consent Orders for the period of November 1, 2018, through January 31, 2019.

III. **FACTS:** For the period of November 1, 2018, through January 31, 2019, Health Regulation reports 1 Administrative Order, 20 Consent Orders, and 1 Emergency Suspension Order totaling $63,710 in assessed monetary penalties.

Health Regulation Bureau	Facility, Service, Provider, or Equipment Type	Administrative Orders	Consent Orders	Emergency Suspension Orders	Assessed Penalties
Health Facilities Licensing	In-Home Care Provider	0	4	0	14,000
	Community Residential Care Facility	1	0	0	2,600
	Midwife Apprentice	0	1	0	0
	Hospital	0	2	0	5,500
EMS & Trauma	Ambulance Services Provider	0	1	0	300
	Paramedic	0	4	0	300
	Advanced Emergency Medical Technician	0	1	0	0
	Emergency Medical Technician	0	3	1	500
Radiological Health	Dental X-Ray Facility	0	1	0	2,250
	Mammography Facility	0	1	0	30,000
	Chiropractic X-Ray Facility	0	1	0	260
	Radioactive Material	0	1	0	8,000
TOTAL		**1**	**20**	**1**	**$63,710**

Approved By:

Shelly Bezanson Kelly
Director of Health Regulation

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

March 7, 2019

Bureau of Health Facilities Licensing

Facility Type	Total # of Licensed Providers
In-Home Care Providers	610

1. Tasha Savage and Archangel Home Care, LLC – Cherry Grove, SC

Inspections and Investigations: On July 19, 2018, the Department conducted a complaint investigation of this provider to determine whether they established, operated, maintained, and/or represented themselves as an in-home care provider.

Violations: The Department determined that based on the July 2018 investigation, the provider was operating as an unlicensed in-home care provider.

Enforcement Action: By Consent Order, the provider agreed to pay a $4,000 monetary penalty and to not establish, operate, maintain, or represent themselves as in-home care provider without first obtaining a license from the Department. Archangel Home Care paid the $4,000 penalty and has become a licensed in-home care provider.

Prior Actions: None.

2. Eric Crawford – Rock Hill, SC

Inspections and Investigations: On September 26, 2018, the Department conducted a complaint investigation of Mr. Crawford to determine whether he established, operated, maintained, and/or represented himself as an in-home care provider.

Violations: The Department determined that based on the September 2018 investigation, Mr. Crawford was operating as an unlicensed in-home care provider.

Enforcement Action: By Consent Order, Mr. Crawford agreed to pay a $4,000 monetary penalty and to not establish, operate, maintain, or represent himself as an in-home care provider without first obtaining a license from the Department. Mr. Crawford paid the $4,000 penalty and has submitted a pending application to become a licensed in-home care provider.

Prior Actions: None.

3. Lisa Emerson and Emerson Family Care, LLC – Beaufort, SC

Inspections and Investigations: On June 12, 2018, the Department conducted a complaint investigation of this provider to determine whether they established, operated, maintained, and/or represented themselves as an in-home care provider.

Violations: The Department determined that based on the June 2018 investigation, the provider was operating as an unlicensed in-home care provider.

Enforcement Action: By Consent Order, the provider agreed to pay a $4,000 monetary penalty and to not establish, operate, maintain, or represent themselves as in-home care provider without first obtaining a license from the Department. The provider paid the $4,000 penalty and has become a licensed in-home care provider.

Prior Actions: None.

4. Sarah R. Cooper – West Columbia, SC

Inspections and Investigations: On August 28, 2018, the Department conducted a complaint investigation of Ms. Cooper to determine whether she established, operated, maintained, and/or represented herself as an in-home care provider.

Violations: The Department determined that based on the August 2018 investigation, Ms. Cooper was operating as an unlicensed in-home care provider. Though Ms. Cooper was not providing in-home care services to any clients, she was representing herself as an in-home care provider through advertisements and marketing.

Enforcement Action: By Consent Order, Ms. Cooper agreed to pay a $2,000 monetary penalty, and to not establish, operate, maintain, or represent herself as in-home care provider without first obtaining a license from the Department. Ms. Cooper paid the $2,000 penalty and has not applied to become a licensed in-home care provider.

Prior Actions: None.

Facility Type	Total # of Licensed Facilities	Total # of Beds
Community Residential Care Facility	494	20,598

5. Midland Park Residential Home Care – North Charleston, SC

Inspections and Investigations: On September 10, 2018, in anticipation of Hurricane Florence, the Governor issued Executive Order No. 2018-28, Mandatory Medical Evacuation of Healthcare Facilities, which ordered a mandatory medical evacuation of all healthcare facilities licensed by the Department located in specific evacuation zones. Midland Park is a facility located in one of the zones subject to the Order. On September 13, 2018, after the Department did not receive notification from Midland Park of its evacuation, Department staff visited Midland Park and cited the facility for regulatory violations.

Violations: The Department cited Midland Park for two regulatory violations. First, Midland Park failed to implement its written plan for actions at a time of need following the Governor's Order on September 10, 2018. When Department staff visited, there were 41 residents and four staff members present, and the administrator indicated the facility was not evacuating. Second, Midland Park had four separate means of egress from the building blocked by furniture. The facility was required to submit an acceptable plan of

correction for the cited violations, but the Department issued a citation-by-mail for failing to submit a plan.

Enforcement Action: By Administrative Order, the Department ordered Midland Park to pay a $2,600 monetary penalty. Midland Park paid the $2,600 penalty.

Prior Actions: None.

Facility Type	Total # of Licensed Facilities	Total # of Beds
Hospitals and Institutional General Infirmaries	103	14,951

6. Rebound Behavioral Health – Lancaster, SC

Inspections and Investigations: The Department visited Rebound numerous times to conduct routine inspections and on July 6, 2018 to conduct a complaint investigation.

Violations: As a result of the July 2018 investigation, the Department cited the facility for having set up more beds than the number of beds stated on the facility's license. The facility was licensed for 24 psychiatric beds and 18 substance abuse beds for a total of 42 licensed beds. The facility had 29 beds set up in the Alpha unit and 32 beds set up in the Beta for a total of 61 beds.

Enforcement Action: By Consent Order, Rebound agreed to a $500 monetary penalty and has paid the full amount. Rebound also agreed to initiate action to correct the violation that initiated this enforcement action. Rebound has since been issued Certificate of Need (CON), construction, and licensing approvals for the addition of 21 psychiatric beds. Rebound is now licensed for 45 psychiatric beds and 18 substance abuse beds for a total of 63 licensed beds on the facility's license.

Prior Actions: None.

7. Rebound Behavioral Health – Lancaster, SC

Inspections and Investigations: During the July 6, 2018 complaint investigation, the Department also found that Rebound was operating an unlicensed facility type at the hospital.

Violations: The Department cited Rebound for operating, maintaining, and representing itself as a residential treatment program facility without first obtaining a license. A residential treatment program facility, one of five modalities of a "facility for chemically dependent or addicted persons," requires a license from the Department.

Enforcement Action: By Consent Order, Rebound agreed to pay a $5,000 monetary penalty, which has been paid in the full amount, and to not operate as a residential treatment program facility without first obtaining a license. Rebound further agreed that its apartment lodge housing would not operate as a facility for chemically dependent or addicted persons unless and until it obtains a license.

Prior Actions: None.

Provider Type	Total # of Licensed Providers
Midwife	34
Midwife Apprentice	7

8. Jennifer Kitchton – Midwife Apprentice

Inspections and Investigations: In March 2018, the Department conducted a complaint investigation and found that Ms. Kitchton attended the labor process in the role of assistant and student. However, the actions of Ms. Kitchton are reserved for licensed midwife apprentices and midwives. Documentation shows that Ms. Kitchton confirmed a client was in active labor and monitored the client until the licensed midwife arrived.

Violations: The Department determined that Ms. Kitchton performed acts reserved for midwife apprentices and midwives without first obtaining a license from the Department. Specifically, Ms. Kitchton ascertained that labor was in progress and contact the midwife with that confirmation. According to the Licensed Midwives Regulations, both "ascertaining labor is in progress" as well as "providing care and supervision during labor" are midwife duties.

Enforcement Action: By Consent Order, Ms. Kitchton agreed to remain in substantial compliance and not practice or perform duties as a midwife or midwife apprentice without first obtaining a license. Ms. Kitchton also agreed to implement action to correct the violation that initiated this enforcement action. Ms. Kitchton has since become a licensed midwife apprentice.

Prior Actions: None.

Bureau of Emergency Medical Services and Trauma

Provider Type	Total # of Licensed Providers
Ambulance Services Provider	274

9. Marlboro County Rescue Squad, Inc. – Ambulance Services Provider

Inspections and Investigations: On February 13, 2018, Marlboro County Rescue Squad, Inc. (MCRS) self-reported to the Department its use of a non-permitted ambulance to conduct one patient transport. The Department investigated and substantiated this self-reported violation.

Violations: The Department determined that MCRS violated the state EMS Act by utilizing a non-permitted vehicle as an ambulance on one patient transport. MCRS furnished, operated, conducted, maintained, and engaged in the business or service of providing ambulance service without obtaining a permit for a vehicle that was operated as an ambulance.

Enforcement Action: By Consent Order, MCRS agreed to a $300 monetary penalty with $200 of the penalty to be held in abeyance for 12 months. MCRS paid the required amount of $100.

Prior Actions: None.

Provider Type	Total # of Certified Providers
Paramedic	3,841

10. Vernon Morano Wells Jr. – Paramedic

Inspections and Investigations: In June 2018, the Department received a complaint and a notification regarding patient care allegedly provided by Mr. Wells. The Department initiated an investigation and found that Mr. Wells did not follow EMS protocols on two patient calls. On the first call, Mr. Wells did not apply a 12/15-lead ECG on a patient suffering from hypotension, weakness and dizziness, bilateral rales, and low blood pressure. The EMS protocol states that ECG monitoring and 12/15-lead evaluations should occur within 5 minutes of the initial assessment of all patients with complaints, signs or symptoms that could potentially impact the cardio pulmonary system. On the second call, Mr. Wells applied an ECG monitor to a patient but there was no record of asystole recorded in two leads on the ECG monitor nor was an ECG strip provided in the documentation that would reflect asystolic rhythm in two leads prior to determining death. The EMS protocol requires asystole to be present in two leads with a prolonged downtime before determining death and withholding resuscitation.

Violations: The Department determined that Mr. Wells committed misconduct by disregarding appropriate orders of a physician concerning emergency treatment. The ECG & 12/15-Lead Monitoring protocol and Field Determination of Death Protocol are both approved by the Medical Control Physician.

Enforcement Action: By Consent Order, Mr. Wells agreed to immediately surrender his paramedic certificate and be issued an EMT certificate. Mr. Wells agreed to complete a 48-hour paramedic refresher course, advanced cardiac life support course, prehospital trauma life support course, and National Association of Emergency Medical Technicians Principles of Ethics and Personal Leadership course. Upon submission of proof of successful completion of these courses, but no earlier than six months, the Department will reissue the paramedic certificate to Mr. Wells.

Prior Actions: None.

11. James Santanto Miller – Paramedic

Inspections and Investigations: On November 28, 2018, the Department received information regarding Mr. Miller's alleged conduct while working for Greenwood County EMS. The Department initiated an investigation and found that Mr. Miller and his advanced EMT partner were dispatched to a nursing home for a patient complaining of breathing problems. Mr. Miller and his partner acknowledged the call to the supervisor, over the radio, and electronically, and then drove to the ambulance station to have the oncoming crew run the call. This created almost a 40-minute delay in response time to the patient.

Violations: The Department determined that Mr. Miller committed misconduct by actions and inactions that created a substantial possibility that death or serious physical harm could result. Mr. Miller and his partner created a substantial possibility of death or serious physical harm to the patient by intentionally

driving to the ambulance station to switch out crews and creating an almost 40-minute delay in patient treatment.

Enforcement Actions: By Consent Order, Mr. Miller agreed to a $300 monetary penalty with $150 of the penalty to be held in abeyance for 12 months. Mr. Miller also agreed to a 6-month suspension of his paramedic certificate to be held in abeyance for 12 months. Mr. Miller also agreed to complete a National Association of Emergency Medical Technicians Principles in Ethics and Personal Leadership course within 12 months.

Prior Actions: None.

12. Margaret S. Hickman – Paramedic

Inspections and Investigations: In October 2017, the Department was notified of care provided by Ms. Hickman while working for McLeod Health d/b/a Cypress Transport Service. The Department initiated an investigation and found that while transporting a patient, Ms. Hickman administered 10 mg of morphine in one dose but the patient care report indicated the patient was given "5 mg of morphine at beginning of transport and again one hour later."

Violations: The Department determined Ms. Hickman committed misconduct by falsifying information in the patient care report, a document required by the Department.

Enforcement Action: By Consent Order, Ms. Hickman agreed to immediately surrender her paramedic certificate and be issued an EMT certificate. Ms. Hickman also agreed to complete a 48-hour paramedic refresher course and a National Association of Emergency Medical Technicians Principles of Ethics and Personal Leadership course. Upon submission of proof of the completed courses, the Department will reissue the paramedic certificate to Ms. Hickman.

Prior Actions: None.

13. Alison K. B. Harmon – Paramedic

Inspections and Investigations: On October 16, 2018, the Department initiated an investigation after receiving an anonymous complaint and video recording regarding Ms. Harmon's care of a patient while working for Orangeburg County EMS. The Orangeburg County Sheriff's Office (OCSO) had requested that an EMS crew consisting of Ms. Harmon, her EMT partner, and an EMT trainee evaluate an adult male in their custody on September 10, 2018. The three EMS crew members, including Ms. Harmon, assessed the patient and then Ms. Harmon's EMT partner documented that the patient was conscious and alert in the patient care report. The patient was released to OCSO without being transported to the hospital for medical evaluation. However, according to the video recording, the patient was nonverbal and unable to communicate, indicating he may have an altered mental status. Later that day, the same EMS crew was dispatched to a pedestrian struck by an automobile, which turned out to be the same patient from their earlier call. After the patient was assessed and treated with traumatic cardiac arrest protocols, Ms. Harmon pronounced the patient dead on arrival.

Violations: The Department determined Ms. Harmon committed four misconduct violations. First, Ms. Givens committed misconduct by disregarding an appropriate order by a physician concerning emergency treatment and transportation. Specifically, Ms. Harmon did not follow Orangeburg County EMS standing orders and protocols by failing to properly assess the patient and by failing to transport the patient to the hospital. Second, Ms. Harmon committed misconduct by discontinuing care and abandoning the patient without the patient's consent and without providing further administration of care by an equal or higher

medical authority. After performing assessments on the patient, Ms. Harmon discontinued care and abandoned the patient by transferring custody of the patient to the sheriff, not an equal or higher medical authority. Third, Ms. Harmon committed misconduct because her actions and inactions created a substantial possibility that death or serious physical harm could result. Ms. Harmon's discontinuation of care and abandonment created the substantial possibility that death or serious physical harm could result to the patient.

Enforcement Action: By Consent Order, Ms. Harmon agreed to an immediate suspension of her paramedic certificate and will be issued an EMT certificate. Ms. Harmon also agreed to complete the National Association of Emergency Medical Technicians Principles of Ethics and Personal Leadership course within six months. Upon submission of proof of the completed course, but no earlier than 16 months, the Department will reissue the paramedic certificate to Ms. Harmon.

Prior Actions: None.

Provider Type	Total # of Certified Providers
Advanced EMT	418

14. Chastin Danielle Frazier – Advanced EMT

Inspections and Investigations: On September 21, 2018, the Department received notification concerning Ms. Frazier while she was working for Southern Ambulance a/b/a Southstar Ambulance Service. The Department initiated an investigation and found that, while on duty on September 20, 2018, Ms. Frazier admitted to purchasing illegal substances and alleges that her EMT partner smoked the illegal substances. Ms. Frazier did not document nor report this event to her supervisor.

Violations: The Department determined Ms. Frazier committed misconduct by creating a substantial possibility that death or serious physical harm could result from her actions and inactions. Specifically, obtaining and smoking illegal substances created a substantial possibility of death or serious physical harm to the EMTs as well as any patients receiving care.

Enforcement Action: By Consent Order, Ms. Frazier agreed to a six-month suspension of her advanced EMT certificate and Ms. Frazier agreed to not perform any functions associated with this certificate. Ms. Frazier also agreed to not be a driver for a licensed ambulance or emergency medical responder agency for six months.

Prior Actions: None.

Provider Type	Total # of Certified Providers
EMT	6,185

15. Robert E. Valbert III – EMT

Inspections and Investigations: On December 11, 2018, the Department was notified of Mr. Valbert being arrested and charged with two counts of criminal sexual conduct with a minor. The Department continues to actively monitor Mr. Valbert's criminal matters.

Violations: The Department is authorized to take enforcement action against an EMT any time the EMT is guilty of misconduct. The Department determined that the alleged conduct of Mr. Valbert may arise to misconduct as defined by the state EMS Act. Misconduct constitutes in part an EMT who is convicted of or currently under indictment for a felony or another crime involving moral turpitude, drugs, or gross immorality. Specifically, Mr. Valbert's arrest for two counts of criminal sexual conduct with a minor is a felony that involves moral turpitude and gross immorality. The Department is further authorized to suspend a certificate pending the investigation of a complaint or allegation regarding the commission of an offense including crime of moral turpitude. The Department believes that the arrest of Mr. Valbert, an EMT placed in a position of public trust, demonstrates a capacity for inappropriate and criminal behavior towards individual placed within his trust.

Enforcement Action: Based on Mr. Valbert's arrest for a felony involving moral turpitude and gross immorality, the Department determined to immediately suspend Mr. Valbert's EMT certificate pending further investigation of Mr. Valbert's criminal matters.

Prior Actions: None.

16. Jamie Dubois Givens – EMT

Inspections and Investigations: On October 16, 2018, the Department initiated an investigation after receiving an anonymous complaint and video recording regarding Ms. Givens' care of a patient while working for Orangeburg County EMS. According to the video recording and a later interview with Ms. Givens', the Orangeburg County Sheriff's Office (OCSO) had requested that an EMS crew consisting of Ms. Givens, her paramedic partner, and an EMT trainee evaluate an adult male in their custody on September 10, 2018. The three EMS crew members, including Ms. Givens, assessed the patient and then Ms. Givens documented that the patient was conscious and alert in the patient care report. The patient was released to OCSO without being transported to the hospital for medical evaluation. However, according to the video recording, the patient was nonverbal and unable to communicate, indicating he may have an altered mental status. Later that day, the same EMS crew was dispatched to a pedestrian struck by an automobile, which turned out to be the same patient from their earlier call. After the patient was assessed and treated with traumatic cardiac arrest protocols, the paramedic partner pronounced the patient dead on arrival.

Violations: The Department determined Ms. Givens committed four misconduct violations. First, Ms. Givens committed misconduct by disregarding an appropriate order by a physician concerning emergency treatment and transportation. Specifically, Ms. Givens did not follow Orangeburg County EMS standing orders and protocols by failing to properly assess the patient and by failing to transport the patient to the hospital. Second, Ms. Givens committed misconduct by discontinuing care and abandoning the patient without the patient's consent and without providing further administration of care by an equal or higher medical authority. Third, Ms. Givens committed misconduct by observing substandard care by other EMTs without documenting the event or notifying a supervisor. Ms. Givens observed the substandard care being provided by her EMS crew and did not document this in any incident report. Ms. Givens observed the release of the patient who was in an altered mental state and incapable of making a rational, informed decision about care and unable to give consent or refuse treatment. Lastly, Ms. Givens committed misconduct by falsifying the patient care record to read that the patient was alert and oriented, when the video and interviews show the patient was not alert and oriented.

Enforcement Action: By Consent Order, Ms. Givens agreed to a six-month suspension of her EMT certificate to be held in abeyance for 12 months. Ms. Givens also agreed to complete the National Association of Emergency Medical Technicians Principles of Ethics and Personal Leadership course within 12 months.

Prior Actions: None.

17. Haleigh Elise Morris – EMT

Inspections and Investigations: On September 21, 2018, the Department received notification of allegations concerning Ms. Morris while she was working for Southern Ambulance a/b/a Southstar Ambulance Service. The Department initiated an investigation and found that, while on duty on September 20, 2018, Ms. Morris had knowledge that her advanced EMT partner purchased illegal substances and alleges that her advanced EMT partner smoked the illegal substances. Ms. Morris did not document nor report this event to her supervisor.

Violations: The Department determined Ms. Morris committed misconduct by creating a substantial possibility that death or serious physical harm could result from her actions and inactions. Specifically, obtaining and smoking illegal substances created a substantial possibility of death or serious physical harm to the EMT as well as any patients being cared for.

Enforcement Action: By Consent Order, Ms. Morris agreed to a six-month suspension of her EMT certificate and Ms. Morris agreed to not perform any functions associated with this certificate. Ms. Morris also agreed to not be a driver for a licensed ambulance or emergency medical responder agency for six months.

Prior Actions: None.

18. Trevor G. Sizemore – EMT

Inspections and Investigations: On March 29, 2018, the Department received information regarding an incident involving Mr. Sizemore while working for Greenwood County EMS. The Department initiated an investigation and found that Mr. Sizemore and his partner were dispatched to a residence for a patient with a self-inflicted gunshot wound to the head. The patient was pronounced dead on arrival. Mr. Sizemore took a picture of the deceased patient on his personal cell phone and uploaded it onto his Facebook page.

Violations: The Department determined that Mr. Sizemore committed two misconduct violations. First, Mr. Sizemore committed misconduct by revealing confidences entrusted to him in the course of medical attendance. Second, Mr. Sizemore committed misconduct by failing to comply with the confidentiality provisions of the state EMS Act, which state that the identity of a patient must be treated as confidential.

Enforcement Action: By Consent Order, Mr. Sizemore agreed to a $500 monetary penalty with $250 of the penalty being held in abeyance for 12 months. Mr. Sizemore also agreed to a three-month suspension of his EMT certificate to be held in abeyance for 12 months. Mr. Sizemore also agreed to complete a National Association of Emergency Medical Technicians Principles of Ethics and Personal Leadership course within 12 months.

Prior Actions: None.

Bureau of Radiological Health

Radioactive Material License Type	Total # of Radioactive Material Licenses	Total # of Medical/Academic Broad Licenses
Medical/Academic Broad License	337	3

19. Medical University of South Carolina – Radioactive Material License

Inspections and Investigations: On April 3, 2018, the Department received a report of a medical event from MUSC involving an Elekta Flexitron high dose rate brachtherapy unit. Licensees are required to report to the Department any event in which the administration of radioactive material or radiation from radioactive material results in actions such as a dose differing from the prescribed dose or an administration of a dose being delivered by the wrong mode of treatment. After the Department was notified of a medical event by MUSC, the Department conducted an investigation of the medical event.

Violations: The Department determined that MUSC committed two regulatory violations. First, MUSC failed to develop, implement and maintain procedures for the Elekta Flexitron that provide high confidence each administration is directed to the treatment site specified in the written directive. Second, at the time of the medical event, MUSC had failed to designate in writing the individual using the Elekta Flexitron as an "authorized user" of that device. A condition of MUSC's license requires "authorized users" be "designated in writing, by the licensee's Radiation Safety Committee."

Enforcement Action: By Consent Order, MUSC agreed to a $8,000 monetary penalty and paid the full amount of the penalty. MUSC also agreed to submit acceptable written procedures for the Elekta Flexitron providing high confidence each administration will be in accordance with the written directive.

Prior Actions: None.

Radiological Health Facility Type	Total # of Registered Facilities
Dental X-Ray	1,725

20. Dennis A. Martin, DMD – Dental X-Ray Facility

Inspections and Investigations: The Department conducted inspections in April 1999, January 2004, April 2008, August 2013, and February 2018, and found that Dr. Martin repeatedly violated the same regulatory requirements.

Violations: As result of the February 2018 inspection, the Department cited Dr. Martin for failing to show current records of equipment performance testing and failed to ensure minimum patient exposure. Dr. Martin had been cited for the same equipment performance testing violation as a result of four previous inspections. Dr. Martin had also previously been cited for the minimum patient exposure violation at the

August 2013 inspection. Dr. Martin repeatedly violated the X-Rays Regulation by failing to complete equipment performance testing and failing to ensure minimum patient exposure.

Enforcement Action: By Consent Order, Dr. Martin agreed to a $2,250 monetary penalty with $1,687.50 to be held in abeyance for 36 months. Dr. Martin paid the $562.50 that was due within 30 days of the Order.

Prior Actions: None.

Radiological Health Facility Type	Total # of Registered Facilities
Mammography	105

21. Little River Medical Center – Mammography Facility

Inspections and Investigations: The Department conducted inspections in July 2014, July 2015, July 2016, July 2017, and July 2018 and found that Little River repeatedly violated the same regulatory requirements.

Violations: As a result of the July 2018 inspection, the Department cited Little River for failing to maintain documentation of physician continuing experience, continuing education, technologist initial qualifications, quality control tests, and personnel records. The Department cited many of the same violations during the previous four inspections.

Enforcement Action: By Consent Order, Little River agreed to a $30,000 monetary penalty with $22,500 to be held in abeyance for 24 months. Little River paid the $7,500 due within 30 days of the Order. Little River also agreed to provide documentation of quality control testing on a monthly basis.

Prior Actions: None.

Radiological Health Facility Type	Total # of Registered Facilities
Chiropractic X-Ray	475

22. St. Andrews Chiropractic – Chiropractic X-Ray Facility

Inspections and Investigations: The Department conducted inspections in August 2012, September 2015, and February 2018, and found that St. Andrews repeatedly violated the same regulatory requirement.

Violations: As a result of the February 2018 inspection, the Department cited St. Andrews for failing to ensure minimum patient exposure and had repeatedly violated the X-Rays Regulation.

Enforcement Action: By Consent Order, St. Andrews agreed to a $260 monetary penalty and paid the full amount within 30 days of the Order.

Prior Actions: None.