

IN THE MATTER OF

CHARLES R. WOODBERRY, JR., N.H.A.

Respondent

License Number: R1768

* BEFORE THE STATE BOARD
* OF EXAMINERS OF NURSING
* HOME ADMINISTRATORS
* Case Number: 2019-001

* * * * *

CONSENT ORDER

PROCEDURAL BACKGROUND

On February 19, 2020, the State Board of Examiners of Nursing Home Administrators (the “Board”) charged **CHARLES R. WOODBERRY, JR., N.H.A.** (the “Respondent”), License No. R1768, under the Maryland Nursing Home Administrators Licensing Act (the “Act”) codified at Md. Code Ann., Health Occ. §§ 9-101 *et seq.* (2014 Repl. Vol. and 2019 Supp.); and under Code Md. Regs. (“COMAR”) 10.33.01 *et seq.* and 10.07.01 *et seq.*

Specifically, the Board charged the Respondent under the following provisions of Health Occ. § 9-314:

.....

(b) *Grounds for reprimands, suspensions, revocations, and fines:* -- Subject to the hearing provisions of § 9-315 of this subtitle, the Board may deny a license or limited license to any applicant, reprimand any licensee or holder of a limited license, place any licensee or holder of a limited license on probation, suspend or revoke a license or limited license, or impose a civil fine if the applicant, holder, or licensee:

.....

(3) Otherwise fails to meet substantially the standards of practice adopted by the Board under § 9-205 of this title[.]

The pertinent provisions of Health Occ. § 9-205 provide as follows:

- (a) *Powers:* -- In addition to the powers set forth elsewhere in this title, the Board may:
 - (1) Adopt rules and regulations to carry out the provisions of this title[.]

The pertinent provisions of COMAR provide as follows:

COMAR 10.33.01.15. Suspension and Revocation of Licenses.

- A. Pursuant to Health Occupations Article, §9-314(b)(3), Annotated Code of Maryland, the Board may deny a license or limited license to any applicant, suspend or revoke a license of a nursing home administrator, or reprimand or otherwise discipline an applicant or a licensee after due notice and an opportunity to be heard at a formal hearing, upon evidence that the applicant or licensee:
 - (1) Has violated any of the provisions of the law pertaining to the licensing of nursing home administrators or the regulations of the Board pertaining to it;
 - (2) Has violated any of the provisions of the law or regulations of the licensing or supervising authority or agency of the State or political subdivision of it having jurisdiction of the operation and licensing of nursing facilities;
 -
 - (9) Has endangered or sanctioned the endangerment of the safety, health, and life of any patient;
 - (10) Has failed to oversee and facilitate the nursing facility's quality improvement processes to the extent that the safety, health, or life of any patient has been endangered[.]

COMAR 10.07.02.07. Inspection by Secretary.

....

B. Site Visits and Surveys.

- (1) The Department shall make a site visit and conduct a full survey of each licensed nursing home at least once per calendar year.
- (2) All surveys shall be unannounced.

COMAR 10.07.02.09. Administration and Resident Care.

A. Responsibility.

....

- (2) The administrator shall be responsible for the implementation and enforcement of all provisions of the Patient's Bill of Rights Regulations under COMAR 10.07.09.

COMAR 10.07.09.08. Resident's Rights and Services.

....

C. A resident has the right to:

....

- (5) Be free from:

....

- (c) Sexual abuse[.]

COMAR 10.07.09.15. Abuse of Residents.

....

C. Reports of Abuse.

- (1) A person who believes that a resident has been abused shall promptly report the alleged abuse to the:

....

- (b) Licensing and Certification Administration within the Department;
 - (2) An employee of a nursing facility who believes that a resident has been abused:
 - (a) Shall report the alleged abuse as set forth in §C(1) of this regulation within 3 days after learning of the alleged abuse;
- D. Investigations. A nursing facility shall:
- (1) Thoroughly investigate all allegations of abuse; and
 - (2) Take appropriate action to prevent further incidents of abuse while the investigation is in progress, and after that.

On August 27, 2020, the Respondent and his attorney appeared before a Case Resolution Conference (the "CRC") of the Board. As a result of negotiations occurring before and during the CRC, the Respondent agreed to enter into the following Consent Order, consisting of Procedural Background, Findings of Fact, Conclusions of Law, Order, Consent and Notary.

FINDINGS OF FACT

The Board makes the following Findings of Fact:

1. At all times relevant hereto, the Respondent was a licensed nursing home administrator ("N.H.A."). The Respondent was initially issued a license to practice as an N.H.A. on May 20, 2008, under license number R1768. The Respondent's license is currently active and scheduled to expire on May 19, 2022.

2. At all times relevant hereto, the Respondent was employed as the administrator of a nursing home (“Nursing Home”),¹ located in Montgomery County, Maryland.

Complaint

3. On or about May 4, 2017, the Board was copied on a Statement of Deficiencies and Plan of Correction (“Survey Report”) that was sent to the Respondent from the Office of Health Care Quality (“OHCQ”).
4. Following a review of the Survey Report, the Board requested additional documentation from OHCQ, the local police, and initiated an investigation.
5. According to an Application for Statement of Charges (“Application”), on April 2, 2017, local police responded to the Nursing Home after Resident #1 admitted to having sexual relations with Resident #2. The Application stated in part:

Upon arrival to the scene Officers made contact with the nursing staff who advised they observed the door to the victim’s, [Resident #2], room to be closed. Nursing staff informed Officers that due to [Resident #2]’s severe physical handicap her door is never to be closed. Upon opening the door, the nursing staff observed [Resident #1] seated on [Resident #2]’s bed. The nursing staff observed [Resident #2]’s diaper was removed. The nursing staff began to speak with [Resident #1] and he stated that he removed the diaper and had vaginal intercourse with [Resident #2] however, since he could not reach completion [Resident #1] then digitally penetrated [Resident #2][.]

6. On April 11, 2017, the Nursing Home submitted an ACTS Complaint/Incident Investigation Report to OHCQ regarding the April 2, 2017 incident between Resident #1 and Resident #2.

¹ For purposes of ensuring confidentiality, proper names have been omitted and replaced with generic placeholders..

7. On April 17, 2017 and April 18, 2017, OHCQ conducted the complaint survey at the Nursing Home.
8. The OHCQ Survey Report revealed the following:
 - a. Resident #1's medical record revealed "Resident #1 was residing in the facility since June 2015 for continuing care and services due to physical disability and chronic mental illness." It was also noted that Resident #1 was "alert, oriented, and capable of self-determination." The resident is "mobility impaired and wheelchair dependent, although able to move independently throughout the facility."
 - b. Resident #2's medical record revealed "Resident #2 was non-verbal, bedbound, unable to perform any self-care, and receiving hospice services due to advanced Huntington's Disease."
 - c. On June 26, 2016, a yearly comprehensive assessment was completed on Resident #1. The assessment identified that Resident #1 had behavioral symptoms that had an impact on others by significantly intruding on their privacy or activity, and by significantly disrupting care or the living environment of others. Record review revealed that the Nursing Home failed to develop a care plan to address the identified behavioral symptoms until December 5, 2016.
 - d. On October 25, 2016, a witness reported that Resident #1 approached a female resident and was asking "for sexual favor." Nursing staff contacted the attending physician who ordered a "Psych consult for inappropriate behavior in AM." The psych consult was not done until November 16, 2016. The Respondent and the DON revealed that no further action was taken by the facility since no sexual interaction occurred.
 - e. A Nursing Note dated November 29, 2016, stated that Resident #1 was "observed sitting at the edge of [Resident #2]'s bed. Resident redirected to his room. MD made aware with order for psych consult... Staff educated to monitor resident's behavior."
 - f. On December 2, 2016, a late entry was included in Resident #1's record: "Psych consult for resident entering female residents [*sic*] room."

- g. On December 5, 2016, a nursing progress note for Resident #1 stated: “Resident remains on 1:1 close monitoring. Assigned GNA educated to stay close to Resident and monitor his location on the Unit at all times. Resident makes inappropriate sexual advances to staff and residents... Resident also has history of offering money for sex or offering cigarettes for sex[.]”
- h. On December 5, 2016, an electronic order from Resident #1’s attending physician was entered requiring 1:1 monitoring for sexual advances every shift for safety.
- i. On December 7, 2016, Resident #1 was seen by the psychiatric nurse practitioner whose Consult Report stated the following: “...per staff [Resident #1] is continuing to make sexual advancements to female residents and entering their rooms without consent, and noncompliant with direction and care... Staff reports no improvement in symptoms.”
- j. Nursing Home staff continued 1:1 monitoring of Resident #1 from December 5, 2016 through February 10, 2017. Review of Daily Staffing Sheets, Clinical Progress Notes, and Treatment Administration Records (TARs) revealed infrequent, inconsistent, and missing documentation regarding monitoring of sexually inappropriate behavior.
- k. On February 10, 2017, Resident #1’s attending physician gave a new verbal order to monitor Resident #1 for sexual advances every shift for safety. Also, on February 10, 2017, the 1:1 supervision order for Resident #1 was discontinued.
- l. The Nursing Home did not revise Resident #1’s care plan to address the February 10, 2017 orders. At the time of the rape incident on April 2, 2017, “review of the care plan to address Resident #1’s sexual advances to other residents and staff revealed no revision of the care plan interventions when the 1:1 monitoring was stopped, and when the monitoring for sexual advances every shift was started. Without revision of the care plan regarding this change, it is unclear what the procedures were or how the monitoring was being provided by facility staff from 02-10-17 until 04-02-17 when Resident #1 committed a sexually abusive act against Resident #2.”
- m. On April 2, 2017, Resident #1 was observed seated on the bed of Resident #2 by Nursing Home staff at approximately 5:00 PM. Resident #2 was observed to be disrobed lying in her bed. Upon

questioning by nursing staff and local police, Resident #1 stated that he had committed a sexual act against Resident #2, who lacked the capacity to respond and consent to the sexual act. Resident #1 was taken into police custody² and removed from the Nursing Home. Resident #2 was transported to a local hospital for a forensic exam.

9. OHCQ made the following findings as a result of its investigation:
 - a. The Nursing Home failed to provide timely, appropriate, and effective interventions to prevent Resident #1 from committing a sexually abusive act against Resident #2.
 - b. The Nursing Home failed to promptly report and investigate earlier incidents of potential sexual abuse involving Resident #1 and Resident #2.
 - c. The Nursing Home failed to develop a care plan for behavioral symptoms identified in Resident #1's comprehensive assessment and for specific inappropriate behaviors displayed by Resident #1.
 - d. The Nursing Home failed to revise Resident #1's care plan to include changes in behavioral monitoring and treatment for Resident #1.
 - e. The Nursing Home failed to follow medical orders as given by Resident #1's attending physician.

Board Investigation

10. On September 18, 2018, in an interview with the Board's investigator, the Respondent stated that:
 - a. He was employed as the administrator at the Nursing Home from April 2016 to May 2017.

² On April 3, 2017, in the District Court for Montgomery County, Maryland, Resident #1 was charged with two (2) counts of Rape – Second Degree; one (1) count Sex Offense – Third Degree; and one (1) count Sex Offense 4th Degree – Sexual Contact. On or about May 25, 2017 the case was transferred to the Circuit Court for Montgomery County (Case # 131779C). On or about June 26, 2017 and again as recently as December 5, 2019, Resident #1 was “found to be incompetent to stand trial” and “by reason of a mental disorder, [Resident #1] is a danger to self or the person or property of another.”

- b. On April 2, 2017, he was out of town and received a call from the DON informing him that staff had found Resident #1 in another resident's room.
 - c. At the time of the incident, two (2) residents of the Nursing Home required 1:1 supervision, including Resident #1. Due to staffing callouts, only one staff member was assigned to monitor both 1:1 residents.
 - d. The Respondent knew Resident #1: "I knew he had prior history of being, you know, kind of touchy with the girls, like even the staff. I knew he had that behavior so that's how he got on one-on-one in the first place." The Respondent added: "I think [Resident #1] was smart enough to know, okay, if this person [Staff] goes to the bathroom this is my opportunity. And I think he pretty much preyed on this woman/[Resident #2], probably because he probably knew or was passing by and probably seen that she couldn't – maybe couldn't do nothing. Who knows?"
 - e. The Respondent claimed that he was not aware of the prior incidents occurring on October 25, 2016 or November 29, 2016.
 - f. After the survey, he implemented changes including increasing the frequency of the psych program³ to weekly, added a social worker position bringing the Nursing Home's total to two (2), and utilizing the Wanderguard system for residents who required additional monitoring.
11. On March 22, 2019, the Board's investigator interviewed the DON. The DON stated the following under oath:
- a. He was hired in March 2017 as an interim director of nursing. He was considered a "mobile DON" and worked out of the parent company's regional offices. He would travel to specific facilities depending on need.
 - b. On April 2, 2017, he received a call from staff at the Nursing Home informing him that an alleged sexual assault had taken place between Resident #1 and Resident #2. He reported to the Nursing Home.

³ The Respondent stated that when he arrived at the Nursing Home, he started a Psych Program that brought a psychiatric nurse practitioner ("NP") into the facility on a PRN basis. The NP would review a "psych book" to see who had orders for a "psych consult" or who the staff had concerns about.

- c. He was never informed by the Respondent that Resident #1 required 1:1 close monitoring. He also never met with the Respondent to discuss Resident #1's orders for 1:1 monitoring during his onboarding as DON.
12. On May 30, 2019, the Board's investigator interviewed the LPN on duty at the time of the April 2, 2017 incident. The LPN stated the following under oath:
- a. On April 2, 2017, she was passing her evening medications when a GNA alerted her to a potential incident. When she arrived at Resident #2's room, she observed Resident #1 sitting on the foot of Resident #2's bed, and Resident #2 was undressed and exposed. She immediately covered Resident #2 with a sheet and called the in-house supervisor.
 - b. She was only ever interviewed by the police – she was not interviewed as part of the Nursing Home's internal investigation

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board finds as a matter of law that the Respondent violated the following provisions:

Health Occ. § 9-314(b):

- (3) Otherwise fails to meet substantially the standards of practice adopted by the Board under § 9-205 of this title[.]

Health Occ. § 9-205:

- (a) *Powers:* -- In addition to the powers set forth elsewhere in this title, the Board may:
 - (1) Adopt rules and regulations to carry out the provisions of this title[.]

The pertinent provisions of COMAR provide as follows:

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- A. Pursuant to Health Occupations Article, §9-314(b)(3), Annotated Code of Maryland, the Board may deny a license

or limited license to any applicant, suspend or revoke a license of a nursing home administrator, or reprimand or otherwise discipline an applicant or a licensee after due notice and an opportunity to be heard at a formal hearing, upon evidence that the applicant or licensee:

- (1) Has violated any of the provisions of the law pertaining to the licensing of nursing home administrators or the regulations of the Board pertaining to it;
- (2) Has violated any of the provisions of the law or regulations of the licensing or supervising authority or agency of the State or political subdivision of it having jurisdiction of the operation and licensing of nursing facilities;

....

- (10) Has failed to oversee and facilitate the nursing facility's quality improvement processes to the extent that the safety, health, or life of any patient has been endangered[.]

COMAR 10.07.02.07. Inspection by Secretary.

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B. Site Visits and Surveys.

- (1) The Department shall make a site visit and conduct a full survey of each licensed nursing home at least once per calendar year.
- (2) All surveys shall be unannounced.

COMAR 10.07.02.09. Administration and Resident Care.

A. Responsibility.

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- (2) The administrator shall be responsible for the implementation and enforcement of all provisions of

the Patient's Bill of Rights Regulations under COMAR
10.07.09.

COMAR 10.07.09.08. Resident's Rights and Services.

.....

C. A resident has the right to:

.....

(5) Be free from:

.....

(c) Sexual abuse[.]

The Board declines to find that the Respondent violated COMAR
10.33.01.15(A)(9) and 10.07.09.15(D)(1)-(2).

ORDER

It is, by the Board, hereby:

ORDERED that the Respondent is **REPRIMANDED**; and it is further

ORDERED that, within **SIX MONTHS**, the Respondent shall pay a civil fine of
\$1000. The Payment shall be by money order or bank certified check made payable to
BENHA, and mailed to 4201 Patterson Avenue, Room 305, Baltimore, Maryland 21215;
and it is further

ORDERED that the Respondent is placed on **PROBATION** until the Respondent
has complied with the following terms and conditions of probation:

The Respondent is required to take and successfully complete courses in (1)
resident rights, which shall include but need not be limited to, preventing sexual abuse of

nursing home residents, and (2) quality assurance processes for nursing homes. The following terms apply:

- (a) it is the Respondent's responsibility to locate, enroll in and obtain the Board's Credentials Committee's approval of the courses before the courses are begun;
- (b) the Respondent shall provide the Board with the appropriate course information for the courses he intends to take, which will be presented to the Board's Credentials Committee;
- (c) after completion of the approved courses, the Respondent must provide documentation to the Board that the Respondent has successfully completed the courses;
- (d) the courses may not be used to fulfill the continuing education credits required for license renewal;
- (e) the Respondent is responsible for the cost of the courses;
- (f) once the Board receives documentation that the Respondent successfully completed the courses, the Board will terminate the probation; and
- (g) the Respondent shall provide the Board with documentation that he successfully completed the courses no later than one year after the Consent Order goes into effect; and it is further

ORDERED that, if the Respondent allegedly fails to comply with any term or condition imposed by probation, the Respondent shall be given notice and an opportunity for a hearing. After the hearing, if the Board determines that the Respondent has failed to comply with any term or condition imposed by probation, the Board may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, or suspend the Respondent's license with appropriate terms and conditions, or revoke the Respondent's license. The Board may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine on the Respondent; and it is further

ORDERED that the Respondent shall be responsible for all costs incurred in fulfilling the terms and conditions of this Consent Order; and it is further

ORDERED that any time period prescribed in this order begins when the Consent Order goes into effect. The Consent Order goes into effect upon the signature of the Board's Executive Director, who signs on behalf of the Board; and it is further

ORDERED that the Consent Order is a **PUBLIC DOCUMENT**, and the Board may disclose same to any national reporting bank to which it is mandated to report.

October 14, 2020

Date

Ronda B. Bell

Ronda Butler Bell, Executive Director
Maryland State Board of Examiners of Nursing
Home Administrators

CONSENT

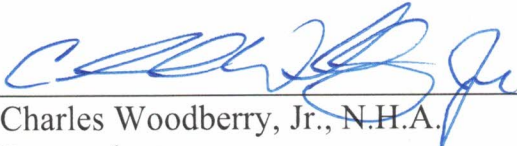
I, Charles Woodberry, Jr., N.H.A., acknowledge that I have had the opportunity to consult with counsel before signing this document. By this Consent, I agree and accept to be bound by this Consent Order and its conditions and restrictions. I waive any rights I may have had to contest the Findings of Fact, Conclusions of Law and Order.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections as provided by law. I acknowledge the legal authority and the jurisdiction of the Board to initiate these proceedings and to issue

and enforce this Consent Order. I also affirm that I am waiving any right to appeal this Consent Order.

I sign this Consent Order after having had an opportunity to consult with counsel, without reservation, and I fully understand and comprehend the language, meaning and terms of this Consent Order. I voluntarily sign this Order and understand its meaning and effect.

9/22/2020
Date


Charles Woodberry, Jr., N.H.A.
Respondent

NOTARY

STATE OF Maryland

CITY/COUNTY OF Montgomery

I HEREBY CERTIFY that on this 22ND day of September, 2020, before me, a Notary Public of the foregoing State and City/County, did personally appear Charles Woodberry, Jr., N.H.A., and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed.

AS WITNESSETH my hand and notary seal.


Notary Public

My commission expires: 3/26/2022

