IN THE MATTER OF	*	**BEFORE THE STATE**
REILLY SMITH, N.H.A.	*	**BOARD OF EXAMINERS OF**
RESPONDENT	*	**NURSING HOME ADMINISTRATORS**
License Number: R1703	*	**Case Number: 2020-001**

* * * * * * * * * * * * *

CONSENT ORDER

On October 29, 2020, the Maryland State Board of Examiners of Nursing Home Administrators (the "Board") charged **REILLY SMITH, Nursing Home Administrator** ("N.H.A."), (the "Respondent"), License Number R1703, 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:
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> . . . .
>
> (3) Otherwise fails to meet substantially the standards of practice adopted by the Board under § 9-205 of this title;
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> . . . .

(11) Commits an act of unprofessional conduct in the licensee's practice as a nursing home administrator[.][1]

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

[1] Any charged ground that is dismissed is noted in the Conclusions of Law and is not included in this section.

> extent that the safety, health, or life of any patient has been endangered[.]

COMAR 10.07.09.08. Resident's Rights and Services.

. . . .

C. A resident has the right to:

. . . .

(5) Be free from:

(a) Physical abuse;
(b) Verbal abuse;
(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:

(a) Appropriate law enforcement agency;
(b) Licensing and Certification Administration within the Department; or
(c) The Office on Aging.

(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;

(b) May be subject to a penalty imposed by the Secretary of up to $1,000 for failing to report an alleged abuse 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.

COMAR 10.07.02.09. Administration and Resident Care.

A. Responsibility.

(1) The licensee shall be responsible for the overall conduct of the comprehensive care facility or extended care facility and for compliance with applicable laws and regulations.

(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.

The pertinent provisions of the Federal Regulations provide as follows:

42 C.F.R § 483.10 Resident rights.

....

(e) Respect and dignity. The resident has a right to be treated with respect and dignity, including:

(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health and safety of other residents.

42 C.F.R. § 483.12 Freedom from abuse, neglect, and exploitation.

The resident has the right to be free from abuse, neglect, and misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the patient's medical symptoms.

....

(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

(2) Have evidence that all alleged violations are thoroughly investigated.

(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken[.]

On December 22, 2020, the Respondent and his attorney appeared at a Case Resolution Conference ("CRC") before a committee of the Board. As a result of the negotiations 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 February 10, 2006, under license number R1703. The Respondent's license is scheduled to expire on February 10, 2022.

2. At all times relevant hereto, the Respondent was employed as the administrator of a nursing home ("Nursing Home"),[2] located in Baltimore, Maryland.

March 2, 2017 Office of Health Care Quality Annual Survey

3. The Office of Health Care Quality ("OHCQ") conducted an annual survey ("March 2017 OHCQ Survey") of the Nursing Home on February 7, 8, 9, 10 and 14, 2017; and March 1 and 2, 2017. On March 2, 2017 at 2:38 p.m., an "immediate jeopardy situation" was identified related to the Nursing Home's failure to take timely and appropriate action to keep Patient B and other residents in the Nursing Home safe and free from harm. The Nursing Home initially submitted two (2) plans of removal which were rejected by OHCQ. A third plan of removal was submitted and approved at 7:34 p.m. on March 2, 2017. Subsequently, the immediate jeopardy was abated, however, the deficient practice remained with potential for more than minimal harm at a scope and severity of E.

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

4. The March 2017 OHCQ Survey Report revealed the following:

a. On March 2, 2017 at 2:28 p.m., an immediate jeopardy situation was identified related to the Nursing Home's failure to take timely and appropriate action to keep a patient and other resident of the facility safe and free from harm.

b. Patient A's medical record revealed that the 96-year-old female had diagnoses that included coronary artery disease, hypertension (HTN), dementia, anxiety disorder, and depression. Patient A's Minimum Data Set revealed that the resident was dependent on staff for all personal care needs and required 1 person assist to transfer to a chair and for ambulation to the bathroom.

c. Patient B's medical record revealed that the 79-year-old female had diagnoses including dementia, HTN, and depression. Patient B's MDS indicated that the resident was able to ambulate independently but was at risk for falls. Patient B's medical record further revealed that Patient B was transferred from a secure dementia unit to a less secure dementia unit on June 11, 2016.

d. During interviews with the OHCQ Director on March 1, 2017, the Respondent, Director of Nursing ("DON 1"), and psychiatric nurse practitioner ("Nurse Practitioner") failed to provide a rationale for the transfer.[3]

e. A nursing progress note documented that on June 23, 2016, Patient B defecated in her bed, on the floor, and in the hallway and "was found wandering half naked in the hallway."

f. Patient B became Patient A's roommate on or about June 11, 2016.

g. Within thirteen days of being transferred to the less secure unit, it was documented on June 24, 2016, that Patient B was getting out of bed at night and was found wandering in other residents' rooms and getting into their beds.

h. According to the psychiatric Nurse Practitioner's Progress Notes, on or about September 14, 2016, Patient B "became delusional,"

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[3] According to the Social Worker's Progress Notes, based on Patient B's family's request, Patient B was transferred to a room in the long-term care unit on or about June 11, 2016.

went out on the balcony, and was aggressive and screaming. The Nurse Practitioner documented that Patient A was "quite frightened" of Patient B.

i. A registered nurse ("RN 1") documented in an incident report that on October 13, 2016 at approximately 12:54 a.m., Patient A's alarm went off and she was crying. Patient A reported that Patient B came over and told her to get out of bed. When Patient A told Patient B "no," Patient B hit Patient A in the stomach. When the staff entered the room, and told Patient B to get back into bed, Patient B used foul language towards the staff and Patient A. RN 1 documented that she made the medical director aware of the incident.

j. The psychiatric Nurse Practitioner was also notified of the incident on October 13, 2016. The Nurse Practitioner reviewed Patient B's medications and ordered that Patient B continue to go to the secure dementia unit during the day. However, Patient B remained in the room with Patient A during the evening and night.

k. On October 19, 2016, the Nurse Practitioner met with both Patient A and Patient B. The Nurse Practitioner documented in her notes for Patient A, that Patient A's chief complaint was "anxiety from roommate" and that Patient A had recently been struck by her roommate, Patient B.

l. In her October 19, 2016 note for Patient B, the Nurse Practitioner documented that Patient B was being sent to a locked unit during the day but was returning to her room (on the unsecured unit) at night to sleep while waiting for an available bed to transfer to on the secured unit. The Nurse Practitioner documented that Patient B continued to be "restless at night, wandering throughout the unit at night."

m. On October 20, 2016, the Nurse Practitioner documented in a follow-up assessment note that on October 19, 2016, Patient B "was propelling through the unit, yelling, angry…went to bed but did not remain there, up again, required 1:1 all night."

n. During an interview on February 9, 2017, the licensed practical nurse clinical manager ("Clinical Manager") stated that Patient B and Patient A remained roommates until on or about October 25,

2016 when Patient B was transferred to a geriatric psychiatric facility.

o. On or about November 30, 2016, Patient B returned to the Nursing Home and was admitted to the secure dementia unit.

p. On January 6, 2017, Patient B was transferred back to the same unit as Patient A.

q. In a February 8, 2017 interview, Patient A said she was fearful of Patient B who had previously hit her and she had seen Patient B in the hallway recently. Patient A said she was fearful when she would go out of her room for activities and felt that the staff did not care.

r. When asked if there was any discussion or plan to move Patient B to another room after the hitting incident on 10/13/16, the Administrator (Respondent) denied that Patient B and Patient A were roommates, even after documentation showed that they were roommates. Later, the Respondent indicated that Patient B was not moved because they didn't have an available bed in the secure dementia unit and they "didn't have a safe person downstairs to switch [Patient B[with" and that they "would take [Patient B] back up at night when [Patient B] was good and tired." The Respondent said that, "Patient A consented to this agreement." There was no documentation in the medical records to indicate that Patient A agreed to this plan.

s. The Nursing Home had documentation that they investigated and terminated an employee for an incident in which the employee physically and verbally abused Patient C when the employee pulled on the arm of Patient C causing bruising. However, the Nursing Home failed to report the results of their investigation to OHCQ. On February 8, 2017, the Respondent confirmed with the OHCQ Surveyor that an investigation occurred but stated that the incident was not reported to OHCQ because "the Ombudsman came to see Patient D [*sic*] so we didn't report it to your office."

t. Staff interviews and medical records indicated that on August 26, 2016 at 6:00 p.m., Patient E was seen choking Patient F. A licensed practical nurse ("LPN 2") had to remove Patient E's hands from around Patient F's neck. During an interview with the OHCQ Surveyor, the Administrator (Respondent) confirmed that this

incident was not reported to OHCQ within 24 hours of the incident.

5. As a result of its investigation in February 2017 and March 2017, OHCQ made the following findings:[4]

a. The Nursing Home failed to have a system in place to keep a resident (Patient B) with cognitive deficits, wandering and unsafe behaviors from harming herself and from harming others.

b. The Nursing Home failed to adequately address Patient B's unsafe, unpredictable and threatening behaviors towards her roommate (Patient A), other residents, and staff in a timely manner.

c. The Nursing Home failed to initiate timely and appropriate responses to Patient B's behaviors which in turn left Patient B and the additional residents of the facility at risk for harm.

d. An immediate jeopardy situation was identified on March 2, 2017 by the OHCQ Survey Team due to the systematic failure of the Nursing Home to take timely and appropriate action to keep Patient B and the other residents of the facility safe and free from harm.

e. The Facility failed to have a system in place to keep Patient A safe from actual and potential psychosocial harm from another resident who was identified as a wanderer with unpredictable behaviors (Patient B). The failure resulted in physical and psychosocial harm of Patient A when she was left for an extended period of time in

[4] The findings listed in paragraph 5 of this document do not constitute all of the deficiencies found and cited in the March 2, 2017 OHCQ Survey Report. For the complete Summary Statement of Deficiencies, see pages 1-79 of the Department of Health and Human Services Centers for Medicare and Medicaid Services OHCQ Survey Report dated March 2, 2017.

the same environment with Patient B, after being hit and expressing fear and anxiety.

f. The Facility failed to report allegations of abuse to the State survey and certification agency regarding 4 of the 29 residents (Patient A, Patient C, Patient D, and Patient E).

6. On or about May 31, 2017, OHCQ received a Statement of Deficiencies and Plan of Correction from the Respondent in which he indicated that all personnel would receive in-service training on the Nursing Home's process regarding reporting and responding to allegations of abuse, including "resident to resident" altercations. In addition, a quality assurance and performance improvement team ("QAPI Team") would be responsible for monitoring the OHCQ self-report process which included daily reviews of shift communication, internal tracking documentation of resident progress notes, confirming the absence of resident to resident altercations and reported abuse. The focus of the monitoring was to ensure timely and responsive actions to abuse findings.

January 25, 2018 OHCQ Complaint Survey

7. OHCQ conducted a complaint survey ("January 2018 OHCQ Survey") of the Nursing Home on January 11, 12, 17-19, 2018. The Respondent left employment at the nursing home in mid-January 2018.

8. Based on the findings of the OHCQ Survey Team, on January 19, 2018, an immediate jeopardy was called by OHCQ related to the Nursing Home's failure to have a system in place to thoroughly investigate allegations of abuse, protect residents after an allegation was made, and to provide education to staff after an allegation of abuse was made.

9. After the Nursing Home's initial plan of action was rejected, the OHCQ Survey Team accepted the second plan submitted on January 19, 2018 in which the Nursing Home indicated that social workers and unit managers would be directly involved in the investigation process and that the Guides would no longer be included in the investigation process regarding abuse allegations. Furthermore, all staff would be re-educated on events that require contact with the Respondent or the DON, and the DON would complete initial reports and final reports involving allegations of abuse.

10. The January 2018 OHCQ Survey Report revealed the following:

a. The Nursing Home failed to thoroughly investigate injuries of unknown origin and allegations of abuse involving five (5) patients.

b. The Respondent told OHCQ Surveyors that certain designated staff members ("Guides") are responsible for investigating patient injuries of unknown origin. The Guides are also geriatric nursing assistants (GNAs). The investigations were conducted in conjunction with the unit (nurse) manager.

c. On or about August 24, 2017, Patient G was observed with large dark bruises on the right flank, inner aspect of right upper arm, and outer aspect of right lower extremity. bruised to her/his body during morning care and the patient was unable to explain how the bruises occurred. Patient G also had several small bilateral bruises on both lower extremities. No statements were obtained from the three nurses who had worked with the patient during the 48 hours prior to the discovery of the bruises.

d. A sexual abuse allegation was reported by Patient H on October 9, 2017 in which she stated someone had touched her private area in the middle of the night. The Nursing Home failed to interview the GNA that was assigned to Patient H on that night.

e. On or about June 16, 2017, the family of Patient I reported to a GNA that Patient I reported he was yelled at and told to go back to his room. Patient I then reported to the GNA that it happened

the same day Patient I fell out of bed. There was no investigation conducted regarding the Patient's fall out of bed.

f. Patient J reported on September 17, 2017 that the GNA that had taken care of him on the prior evening had thrown Patient J on the bed causing pain to the patient's arm. The Surveyors found no Resident Abuse Investigation Report Form. There was no documentation regarding the investigation conducted. Only four witness statements were obtained and most were incomplete and failed to have required information on them including dates, time, and the patient's name.

g. On or about July 12, 2017, one patient ("Patient K") complained that a registered nurse ("RN 2") inappropriately touched him/her on the lips to force Patient K to take her/his morning medications. The Nursing Home did not substantiate the allegation but said that it provided re-education to RN 2. No documentation for re-education could be found.

h. Between May 1, 2017 and January 18, 2018, there were five (5) incidents in which three patients (Patient L, Patient M, and Patient N) used the call bell requesting assistance and GNAs either failed to respond or responded and failed to provide care to the patients for more than 2 hours, leaving the patients to sit in their own incontinent or soiled diapers.

i. There were two incidents (May 2, 2017 and November 25, 2017) in which patients (Patient O and Patient P) reported thefts and misappropriation of money. The Guides failed to investigate the incidents thoroughly, failed to interview relevant staff, failed to report the incident to local law enforcement, and failed to report the incident to the State agency.

j. One patient ("Patient Q") reported that an employee ("Employee") had dragged her across the floor to the bathroom. The Nursing Home could not substantiate the allegation, but ordered that the Employee be re-educated and no longer provide care to the patient. However, documentation indicates that the employee continued to be assigned to Patient Q and no documentation of re-education could be found.

k. There were three incidents in which patients (Patient R, Patient S and Patient J) requested that the GNAs ("GNA 1 and GNA 2") no

longer be assigned to care for them due to verbal abuse. Patient J also stated that GNA 1 frightened him/her and was rough when providing care on or about November 21, 2017. After the Guides conducted incomplete investigations, the Nursing Home failed to substantiate the abuse and said the GNAs would be re-educated. There was evidence that the GNAs had continued to be assigned to care for the patients and no documentation that the GNAs received re-education or training.

l. In July 2017, Patient T went missing on the Nursing Home's property and on or about August 24, 2017, Patient T eloped from the Nursing Home. The QA Nurse stated that since they knew how Patient T was able to leave, they did not do a formal investigation.

m. The Director of Nursing and QA Nurse stated that mock survey results were reported to the Nursing Home on December 20, 2017 that identified issues with the facility's abuse investigations process. DON 2 confirmed that no quality assurance plan has been put in place to address the facility's abuse investigation process.

11. As a result of its investigation in January 2018, OHCQ made the following findings:[5]

a. The Nursing Home failed to protect residents against incidents of neglect and abuse.

b. The Nursing Home failed to ensure that allegations of misappropriation were investigated and reported to the State agency.

c. The Nursing Home failed to ensure measures were in place to prevent further incidents of abuse.

d. The Nursing Home failed to ensure allegations of abuse were thoroughly investigated.

[5] The findings listed in paragraph 9 of this document do not constitute all of the deficiencies found and cited in the January 25, 2018 OHCQ Survey Report.

Board Investigation

12. Based upon the March 2017 and January 2018 OHCQ surveys, the Board initiated an investigation.

13. On September 20, 2019, the Board's investigator interviewed the Clinical Manager who stated the following:

a. She was employed as a manager at the Nursing Home for eleven years.[6] She left the Nursing Home in August 2017.

b. Patient A and Patient B were in the same room and both had dementia. Patient B got out of her bed and into bed with Patient A. Patient A told Patient B it was not her bed. Patient B struck Patient A's stomach.

c. The next day, the incident was discussed at the morning meeting. The Respondent, DON, assistant director of nursing ("ADON") and social work were in the meeting.

d. When the incident was discussed, the Respondent said that, because the incident was resident on resident, they didn't have to report it.

e. They had meetings every morning, and "every day we would discuss the behaviors of [Patient B]." She thought Patient B should be transferred to another facility.

f. During the March 2017 OHCQ Survey, the Respondent would have a meeting with them at the end of the day to discuss what the State had said. The Respondent said he still would not have reported the incident between Patient B and Patient A.

g. After the OHCQ Surveyors left, the Respondent suspended her and DON 1 for a day because he said they did not inform him that Patient A and Patient B were in a room together. The Respondent said he had to suspend them because the State was asking

[6] According to the Maryland Board of Nursing's website, the Clinical Manager was issued a license to practice as a Licensed Practical Nurse in January 2000 which is active and due to expire in February 2021.

questions about the situation and that the suspension was only a "formality."

h. There were other incidents that occurred in the past in which patients had fallen or eloped from the facilities in which the Respondent did not report the incidents to the State.

14. The Board Investigator interviewed the assistant director of nursing ("ADON 1") on August 28, 2019 who stated the following:

a. She worked at the Nursing Home from August 2016 until July 2017 as the ADON. Her job duties included reporting incidents to the Respondent and to facilitate education.

b. She was not aware of the incident between Patient A and Patient B until the March 2017 OHCQ Survey and was not aware of any incident reports being filed.

c. She forwarded investigative information to the Respondent but was not sure what happened after that.

d. She resigned in July 2017 because the Respondent had hired someone he knew from another long-term care facility ("Facility A") to be the ADON and she was demoted to a unit manager.

15. During an interview with the Board Investigator on September 13, 2019, the current Assistant Director of Nursing ("ADON 2") stated the following:

a. She is a registered nurse.

b. She began working at the Nursing Home on May 22, 2017, two months after the March 2017 OHCQ Survey. She was hired to be a staff educator.

c. She previously worked with the Respondent at Facility A.

d. The Respondent told her that an informal dispute resolution ("IDR") process took place regarding the March 2017 OHCQ Survey and the Nursing Home was "absolved" of any wrong doing.

e. She was responsible for making sure all the staff received abuse training.

f. By the time she was hired, corrective action had already been taken regarding the incident with Patient A.

g. During the January 2018 OHCQ Survey, she provided documentation to the OHCQ Surveyors for training she did for the GNAs.

h. She did not conduct investigations. When she was hired, the system was already in place in which the Guides, who were GNAs, conducted the investigations. She assumed the investigations were done correctly.

i. The Guides did not do hands-on care of the patients. They could, but they had their own office and they did other administrative things.

j. The Guides reported their investigative findings to the Respondent.

k. The new administrator who replaced the Respondent took the responsibility of investigations away from the Guides. The investigation process is now the responsibility of the nursing management, the DON, and social worker.

16. On September 13, 2019, the Board Investigator interviewed the current Director of Nursing ("DON 2") who stated the following:

a. She is a registered nurse and previously worked at Facility A with the Respondent.

b. She began working at the Nursing Home on May 1, 2017, two months after the March 2017 OHCQ Survey. She was at the Nursing Home during the IDR process.

c. There was a second visit in June or July 2017 by a surveyor to review self-reports and the Respondent told her that everything was fine.

d. The Guides worked with the unit managers to make sure the unit ran smoothly. She didn't know what kind of training the Guides had. The Guides did not report to her. The Guides reported their investigative findings to the Respondent.

e. She had a conversation with the Respondent once in which she suggested, that as the DON, she should do one of the investigations, and she said she would start the interviews and the process, but the Respondent told her that they had a process in place and that the Guides would do the investigation.

f. She saw some of the statements that the Guides would collect, but did not see the whole (abuse) reports put together.

g. The Respondent oversaw the self-report process and was responsible for ensuring the reports were filed with the State.

h. During the January 2018 OHCQ Survey She believed there were 19 issues with self-reports.

17. The Board Investigator interviewed the current Administrator of the Nursing Home on August 2, 2019. The current Administrator stated the following:

a. He began working as the Administrator for the Nursing Home on March 18, 2018.

b. He was involved in the IDR for the January 2018 OHCQ Survey.

c. As a result of the appeal process, the actual harm cited in the January 2018 OHCQ Survey was at an L level and stayed at an L level even after the appeal. The March 2017 OHCQ Survey was reduced to a G level, which still indicated actual harm.

d. He could not find copies of any of prior incident reports or documentation of any of the filings of incident reports done by the Respondent.

18. The Board received a letter dated September 17, 2018 from the Respondent in which the Respondent stated the following:

a. The majority of the deficiencies in the March 2017 OHCQ Survey "were those that posed minimal potential harm and affected only a few residents."

b. As a result of the IDR process, one deficiency from the March 2017 OHCQ Survey characterized as posing immediate jeopardy was reduced to a deficiency of no actual harm.

c. "The handling of one situation involving [Patient A and Patient B] did present some concerns."

d. The deficiency report makes numerous references which are inaccurate and do not accurately represent the interdisciplinary efforts put forth involving Patient B.

CONCLUSIONS OF LAW

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

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;

. . . .

(11) Commits an act of unprofessional conduct in the licensee's practice as a nursing home administrator[.][7]

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

[7] The Charge of Health Occ. § 9-314(b)(9) is dismissed.

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:

(3) 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;

(4) 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 10.07.09.08.

. . . .

C. A resident has the right to:

. . . .

(5) Be free from:

(a) Physical abuse;
(b) Verbal abuse;
(c) Sexual abuse[.]

COMAR 10.07.09.15.

. . . .

C. Reports of Abuse.

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

(a) Appropriate law enforcement agency;
(b) Licensing and Certification Administration within the Department; or
(c) The Office on Aging.

(2) An employee of a nursing facility who believes that a resident has been abused:

(c) Shall report the alleged abuse as set forth in §C(1) of this regulation within 3 days after learning of the alleged abuse;

(d) May be subject to a penalty imposed by the Secretary of up to $1,000 for failing to report an alleged abuse 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.

COMAR 10.07.02.09. Administration and Resident Care.

B. Responsibility.

(2) The licensee shall be responsible for the overall conduct of the comprehensive care facility or extended care facility and for compliance with applicable laws and regulations.

(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.

42 C.F.R § 483.10

....

(e) Respect and dignity. The resident has a right to be treated with respect and dignity, including:

(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health and safety of other residents.

42 C.F.R. § 483.12

The resident has the right to be free from abuse, neglect, and misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the patient's medical symptoms.

....

(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(5) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

(6) Have evidence that all alleged violations are thoroughly investigated.

(7) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

(8) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken[.]

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, 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 the Board of Examiners of Nursing Home Administrators, 4201 Patterson Avenue, Room 305, Baltimore, Maryland 21215; and it is further

ORDERED that the Respondent is placed on **PROBATION** for a minimum of **ONE YEAR**. During probation, the Respondent shall comply with the following probationary terms and conditions:

1. Within **ONE YEAR**, the Respondent shall enroll in and successfully complete courses in: **(a) quality assurance process/procedures; (b) resident rights; (c) ethics; (d) leadership/hiring practices**. The following terms and conditions 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) 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;

2. If the Respondent practices as a nursing home administrator in Maryland during the probationary period, the Respondent's practice as a nursing home administrator in Maryland shall be supervised during probation for a period of **10 MONTHS**. The Board-approved supervisor shall be licensed to practice as a nursing home administrator in the State of Maryland. The following terms and conditions apply:

a) The Respondent shall submit in writing the name of the proposed supervisor to the Board for the Board's approval prior to beginning the supervisory arrangement. The proposed supervisor shall have no prior personal, professional, or financial relationship with the Respondent. The Board reserves the right to reject the supervisor the Respondent proposes and

may, in its discretion, require additional information about any supervisor the Respondent proposes as fulfillment of this condition. The Respondent is responsible for the cost of the supervision.

b) The Respondent shall provide the supervisor copies of this Consent Order and shall authorize the Board to provide any other documents to the supervisor that it deems relevant for purposes of supervision. The Respondent shall be responsible for assuring that the supervisor notifies the Board in writing of his/her acceptance of the supervisory role of the Respondent.

c) While the Respondent is employed as a nursing home administrator during the probationary period, the supervisor shall meet with the Respondent at the facility where he is employed at least once per month for **ten months**. The meetings may be conducted remotely if, due to the COVID-19 pandemic, in-person meetings are not feasible. During these meetings, the supervisor shall review and discuss with the Respondent, subject matter including but not limited to: (i) the operations of all departments, including any staffing issues and shortages; (ii) quality assurance programs and procedures; (iii) resident care; and (iv) complaints of residents and family members.

d) The Respondent shall be responsible for assuring that the supervisor submits written reports, **every three months**, to the Board. These quarterly reports shall include, but are not limited to, a discussion of: (i) staffing issues, including staffing ratios and shortages; (ii) quality assurance programs and procedures; (iii) resident care; and (iv) complaints of family members and residents.

e) The Respondent shall make no changes to the terms and conditions of the supervisory requirements set forth in subparagraphs (a)-(d) above without prior board approval. The Board has sole authority to approve a change of the supervisor or a change in the terms and conditions of the supervisory arrangement.

f) In the event that the supervisor discontinues supervising the Respondent for any reason, the Respondent shall immediately

notify the Board and submit a replacement candidate to serve as his supervisor under the terms specified above;

3. The Respondent shall practice according to the Maryland Nursing Home Administrators Licensing Act and in accordance with all applicable laws, statutes, and regulations pertaining to the practice of nursing home administration;

4. The Respondent shall not petition the Board for early termination of probation or any of the terms and conditions of the Consent Order; and it is further

ORDERED that no earlier than **ONE YEAR** from the date this Consent Order goes into effect, and only if the Respondent has satisfactorily complied with all of the terms and conditions of probation and the Consent Order, the Respondent may submit to the Board a written petition requesting that the probation be terminated. The probation will be terminated if the Respondent has complied with all probationary terms and conditions; and it is further

ORDERED that, if the Respondent allegedly fails to comply with any term or condition of this Consent Order, 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 of the Consent Order, 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 in an amount allowed under Health Occ. § 9-314.1; and it is further

ORDERED that a violation of probation constitutes a violation of this Consent Order; and it is further

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

ORDERED that if the Respondent's license expires or becomes inactive during the period of probation, the probation and any conditions will be tolled;

ORDERED that, during the period of probation, the Respondent's status as a licensed nursing home administrator shall be listed in the Board's database and on its website as being on probation; 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 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 Interim Executive Director, who signs on behalf of the Board; and it is further

ORDERED that the Consent Order is considered a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., Gen. Prov. § 4-333(b)(6); Health Occ. § 1-607, and is reportable to any entity to whom the Board is obligated to report.

February 10, 2021
Date

Andrea L. Hill
Andrea L. Hill, Interim Executive Director
Maryland State Board of Examiners of Nursing
Home Administrators

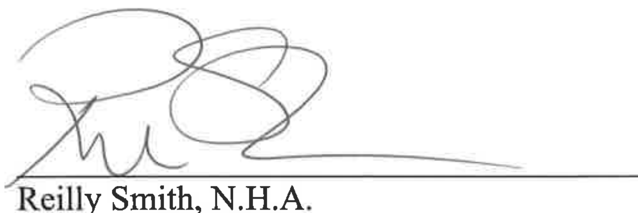
CONSENT

I, Reilly Smith, 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.

1/22/2021
Date


Reilly Smith, N.H.A.

NOTARY

STATE OF Maryland

COUNTY OF Baltimore

I HEREBY CERTIFY that on this 22nd day of January, 2020, before me, a Notary Public of the State and City/County aforesaid, personally appeared **Reilly Smith, NHA**, and gave 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.

Darlene M. Behner
Notary Public

My commission Expires: January 14, 2025