

IN THE MATTER OF
EUGENE AMANAHU, N.H.A.

Respondent

License Number: R1860

*** BEFORE THE STATE BOARD**
*** OF EXAMINERS OF NURSING**
*** HOME ADMINISTRATORS**
*** Case Number: 2020-003**

* * * * *

CONSENT ORDER

On September 24, 2020, the State Board of Examiners of Nursing Home Administrators (the “Board”) charged Eugene Amanahu, N.H.A. (the “Respondent”) 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:

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 the Code of Maryland Regulations (“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.

42 CFR § 483.25 Quality of care.

Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices, including but not limited to the following:

....

- (d) *Accidents.* The facility must ensure that -
- (1) The resident environment remains as free of accident hazards as is possible; and
 - (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

To resolve the charges, the Board and the Respondent have agreed to enter into the Consent Order, which includes Findings of Fact, Conclusions of Law, Order, and Consent.

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 2, 2012, under license number R1860. The Respondent's license is currently active and scheduled to expire on May 1, 2022.

2. The Respondent was employed as the administrator of a nursing home ("Nursing Home"),¹ located in Montgomery County, Maryland from September 2, 2014 until February 22, 2019.

Complaint

3. On August 8, 2018, the Nursing Home submitted an ASE Complaint/Incident Investigation Report ("Report") to the Office of Health Care Quality ("OHCQ") regarding a July 29, 2018 incident involving the elopement of Resident #33. The Report stated in part:

[Resident #33] found outside of the facility and was redirected back to facility. Investigation initiated . . . This investigation involved record review, interview of staff and Resident, environmental observations as well as Resident assessment. It was noted that Resident left [Nursing Home] through side door behind a family member. Staff identified that resident was missing and started a resident search. Resident was located at the bus stop and brought back to facility. This investigation was unable to definitively identify how the Resident made it to the bus stop. No injuries or complaints of pain noted. No injury or Abuse noted. Resident was transferred to our Life Engagement Unit which is a secured unit. Care Plan updated, physician and patient representative were informed.

4. On or about August 28 through 31, 2018, OHCQ conducted a survey at the Nursing Home in response to the incident report. The Board was copied on a Statement of Deficiencies and Plan of Correction ("Survey Report") that was sent to the Respondent, as the administrator of the Nursing Home, from OHCQ.

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

5. The OHCQ Survey Report revealed the following:
- a. On 08-29-18, surveyor reviewed [the written investigation/Report submitted by the Nursing Home on 8-8-2018].
 - b. On 08-29-18 at 10:45 AM, surveyor interview of the Director of Nursing revealed that Resident #33 had walked to a bus stop and boarded a bus. Someone at the Metro transit station called the [Nursing Home] after seeing the resident's name band. Then the weekend supervisor went to the station and picked up the resident.
 - c. Surveyor review of bus routes from the bus stop closest to the [Nursing Home] revealed that the route Resident #33 likely traveled was approximately 16 minutes long with 19 stops.
 - d. Further review of the [Nursing Home's] written investigation revealed no detailed information of how [R]esident #33 was located. In addition, it was unclear of the exact location where the resident was found.
 - e. On 08-29-18 at 9:50AM, the Administrator demonstrated for the surveyor that the wander guard transmitter worked when passed by the front door sensor. Next, the Administrator tested the breezeway door to the courtyard and the alarm did not sound when the transmitter was passed in front of the door sensor. The Administrator then went to the patio door to the courtyard, again the alarm did not sound. The maintenance director came with the machine used to test the transmitters and the door sensors. The machine indicated that both the transmitter and the door sensors were functional. The Administrator, Maintenance Director, and the surveyor returned to the breezeway door when the corporate consultant walked over and demonstrated that the alarm was functional, but it only sounds when the door is opened.
 - f. On 08-29-18 at 10 AM, surveyor observation of the alarm panels for the wander guard system located on the wall at the first-floor nursing station revealed three panels with speakers that were labeled with the door ways. The speaker on the first panel that sounds for the breezeway door alarm was covered with bandage tape. The alarm could still be heard but at a lower volume. On interview, the Administrator could not say why the bandage was on the speaker or indicate how long it was on the speaker. Despite reported checks of the wander guard system, neither the Administrator nor Maintenance Director knew how the system worked on the doors leading to the

courtyard and were unaware of the tape that covered the speaker of the alarm panel box.

- g. Surveyor review of statements that the [Nursing Home] gathered for the investigation revealed that the investigation did not include statements from the receptionist who worked at the time of the event, other residents who might have witnessed the incident, family members who may have been visiting that day, or of the person at the bus station who identified Resident #33 by the name band and called to notify the [Nursing Home] of the resident's location. In addition, interviews of staff only included the supervisor, the nurse who heard the alarm, the nurse who was assigned to the resident, and the nursing assistant who was assigned to the resident. There were no interviews of other staff who may have had information to add to the investigation.
- h. On 08-29-18, surveyor review of the clinical record revealed a nurses' note, written on 07-26-18 at 7:23 PM, that documented ["Wander guard in place for safety awareness check for placement and battery function with electronic device every shift (Resident #33) currently is wandering around the floor with his/her things trying to leave the building saying he/she has worked his/her shift and is ready to leave to take care of his/her son."] Resident #33 was put on the (locked) unit until later this evening.² There were no additional details of how Resident #33 would be monitored when not on the locked unit.
- i. In addition, review of a nurse's note written on 07-29-18 at 12:10 PM revealed that the resident had eloped. Surveyor review of the care plan for Resident #33 revealed no evidence that it was revised after the elopement attempt to reflect any plan for increased monitoring or other interventions to prevent elopement.
- j. On 08-29-18 at 1:15 PM, surveyor interview with the Director of Nursing revealed that the interdisciplinary team had discussed Resident #33's attempted elopement at grand rounds on 07-26-18. The plan was to take the resident to the locked unit for activities if the resident was noted to be out of his/her room in the hallway. This was the plan until a room became available on the locked unit. The Director of Nursing stated that there was a

² According to the Respondent, the plan was to move Resident #33 to the locked unit when a bed opened up. Until then, whenever Resident #33 was found wandering, staff would redirect Resident #33 to the locked unit.

care plan update note written on 07-26-18. However, surveyor review of the nursing note revealed that the note was written on 07-29-18 at 4:54 PM after the actual elopement, as a late entry for 07-26-18.

- k. Further review of the clinical record revealed no documented evidence of any increase or change in monitoring of Resident #33 after the attempted elopement on 07-26-18. In addition, there was no revision of the care plan on 07-26-18 after the attempted elopement.
- l. Surveyor review of the nurse's notes written on 07-29-18 revealed that Resident #33 was observed on the unit refusing medications at 9:50 AM. At 10:50 AM, the resident was observed in the hallway of the unit. There was no evidence that Resident #33 was redirected or taken to the locked unit for activities as the Director of Nursing had stated was the plan.
- m. On 07-29-18 at 12:10 PM, the nurse's note revealed that Resident #33 was not observed in own room. Dining room, basement and other units checked, and resident not observed. Elopement protocol activated.
- n. On 07-29-18 at 1:50 PM, a nurse's note was written that documented Resident #33 was found outside of the [Nursing Home] and was returned back inside the [Nursing Home].
- o. Further review of the [Nursing Home] investigation of the elopement revealed evidence that, after the elopement of Resident #33, the wander guard system and doors were checked, an audit was completed on all residents who were wanderers, signs were posted on the doors to let family members know not to allow residents to go out the door with them and written notifications stating the same, were sent to family members.
- p. In addition, the [Nursing Home] stated they would educate all staff on the importance of supervision of vulnerable residents and include the need for staff to look beyond the area of any beeping alarm.
- q. However, surveyor review of staff training revealed that, since 07-29-18, only 63 of 154 [Nursing Home] staff were trained on elopement protocol and adequate supervision and only 27 of 154 [Nursing Home] staff were trained on prompt response to all beeps and alarms.

6. OHCQ made the following findings as a result of its investigation:
- a. The [Nursing Home] failed to thoroughly investigate the elopement of Resident #33 as an incident of possible neglect.
 - b. The [Nursing Home] investigation failed to include all necessary interviews and details to determine the potential of neglect.
 - a. The [Nursing Home] failed to revise the residents care plans in a timely and accurate manner to reflect the resident's current clinical status.
 - b. The [Nursing Home] failed to maintain a safe environment for a cognitively impaired resident with a history of exit seeking behavior, and the [Nursing Home] failed to review and revise the plan of care and adequately supervise a resident with exit seeking behavior. This deficient practice placed the resident at risk for elopement and serious harm.
 - c. The [Nursing Home] administration failed to thoroughly investigate a case of possible neglect, which compromised the health and safety of [R]esident #33, when the resident eloped. In addition, after the elopement the [Nursing Home] administration failed to ensure that all staff were trained regarding inadequate supervision that could lead to elopement, their elopement protocol, and neglect and abuse which compromised the safety of all the residents at risk for elopement.

Board Investigation

7. On August 23, 2019, in an interview with the Board's investigator, the Respondent stated that:
- a. He was employed as the administrator at the Nursing Home from September 2014 until February 2019.
 - b. Resident #33 was a former employee of the Nursing Home and was noted by the Respondent to have a BIM score of 5.³

³ BIMS stands for Brief Interview for Mental Status. The BIMS test is used to get a quick snapshot of how well a resident is functioning cognitively at the moment. It is a required screening tool used in nursing homes to assess cognition. Because the BIMS is given every quarter, the scores can help measure if a resident is improving, remaining the same, or declining in cognitive ability. Once added

- c. Resident #33 was listed as an elopement risk at, or shortly after, their admission to the Nursing Home.
- d. On July 26, 2018, Resident #33 was observed exhibiting signs of confusion and verbalizing that they wanted to go home to take care of their child.
- e. In response to these observations, a psychological evaluation was ordered.
- f. The Respondent stated that after the July 26, 2018 near-elopement incident, the interdisciplinary team met to discuss revisions to Resident #33's plan of care, however, the Respondent admits that the discussed revisions to the plan of care never made it from the meeting minutes to the resident's chart.
- g. On July 29, 2018, a member of the Nursing Home staff heard the door alarm and looked around but found nothing. After noting that Resident #33 was not around, staff then implemented the elopement process. Just as staff were searching the property, someone called the Nursing Home and alerted staff that the resident was at a transit station.
- h. Neither the Respondent nor his staff were able to identify exactly how the resident left the building and made it to the transit station.
- i. The Respondent admitted that at the time of the survey, there was a percentage of the Nursing Home staff that had not attended the staff education regarding elopement, neglect and abuse that was ordered after the July 29, 2018 incident.
- j. In response to a question regarding what he could have done to prevent this elopement incident, the Respondent stated:

I am going to be honest with you. As the administrator, there is really nothing I could have done as the administrator to prevent this elopement... to tell you the lesson I learned ... I should have asked to actually see the [training] signature sheet.... But if it is – what would I have done differently intervention? We did everything for this patient, there is really nothing we

up, the scores provide information on the resident's level of cognition: 13 to 15 points: intact cognition; 8 to 12 points: moderately impaired cognition; 0-7 points: severely impaired cognition.

could have done differently leading to this elopement[.]

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent violated the following: Health Occ. § 9-314(b)(3); COMAR 10.33.01.15A(1), (2), (9), (10); and 42 CFR § 483.25(d)(1) and (2).

ORDER

It is, thus, by the Board, hereby

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

ORDERED that, within **ONE YEAR**, the Respondent shall pay a civil fine of **\$500**. The Payment shall be by money order or bank certified check made payable to BENHA, and mailed to Maryland State Board of Examiners of Nursing Home Administrators, 4201 Patterson Avenue, Room 305, Baltimore, Maryland 21215; and it is further

ORDERED that, if the Board determines, after notice and an opportunity for a hearing before the Board, that the Respondent has failed to comply with any of the terms or conditions of this Consent Order, the Board, in its discretion, may impose a reprimand, probation with appropriate terms and conditions, the suspension or revocation of the Respondent's license to practice as a nursing home administrator in Maryland, and/or a civil fine; 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 or Acting 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. See Health Occ. § 1-607; Md. Code Ann., Gen. Prov. § 4-333(b)(6).

January 12, 2021
Date

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

CONSENT

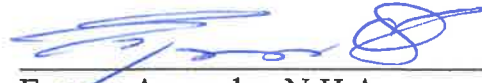
I, Eugene Amanahu, N.H.A., acknowledge that I have had the opportunity to consult with counsel before signing this document. By this Consent, I agree and accept to be bound by this Consent Order and its conditions and restrictions. I waive any rights I may have had to contest the Findings of Fact, Conclusions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

12/18/20
Date


Eugene Amanahu, N.H.A.
Respondent

NOTARY

STATE OF MD

CITY/COUNTY OF Howard

I HEREBY CERTIFY that on this 18th day of Dec, 2020, before me, a Notary Public of the foregoing State and City/County, did personally appear Eugene Amanahu, 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: 2/8/2023

