

IN THE MATTER OF	*	BEFORE THE STATE BOARD
BRENDA RICE, N.H.A.	*	OF EXAMINERS OF
Respondent	*	NURSING HOME ADMINISTRATORS
License Number: R1572	*	Case Number: 2019-003
* * * * *		

FINAL DECISION AND ORDER

This case concerns events occurring, in 2018, at a nursing home (the “Nursing Home”) in Maryland, while the Respondent Brenda Rice (the “Respondent”), a licensed nursing home administrator, was the Nursing Home’s administrator.¹ The Maryland State Board of Examiners of Nursing Home Administrators (the “Board”) received a complaint from the Office of Health Care Quality (“OHCQ”), which provided the Board with the survey report it issued pursuant to the investigation OHCQ conducted concerning the 2018 events at the Nursing Home. After its own investigation, the Board, on February 4, 2020, issued Charges Under the Maryland Nursing Home Administrators Licensing Act (the “Charges”) against the Respondent. The Charges were based under the Maryland Nursing Home Administrators Licensing Act, Md. Code Ann., Health Occ. §§ 9-101—9-501, and corresponding regulations. Specifically, the Board charged the Respondent with violating the following statutes and regulations:

Health Occ. § 9-314

(b) Subject to the hearing provisions of § 9-315 of this subtitle, the Board may . . . reprimand any licensee . . . , place any license . . . on probation, suspend or revoke a licensee . . . , or impose a civil fine if the . . . 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[.]²

¹ To the extent possible, this document has used generic names and titles to protect privacy and confidentiality.

² Under Health Occ. § 9-205(a), “. . . the Board may: (1) Adopt rules and regulations to carry out the provisions of this title.”

COMAR 10.33.01.15

A. Pursuant to Health Occupations Article, §9-314(b)(3), Annotated Code of Maryland, the Board may . . . suspend or revoke a license of a nursing home administrator, or reprimand or otherwise discipline . . . a licensee after due notice and an opportunity to be heard at a formal hearing, upon evidence that the 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 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 patient³;

(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 10.07.02.09

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

....

C. A resident has the right to:

....

(5) Be free from:

....

³ Although the Board prefers the word "residents" to refer to the individuals residing at a nursing home, the words residents and patients are often used interchangeably, as it the case here.

(c) Sexual abuse[.]

COMAR 10.07.09.15

.....

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 November 18, 2020, an evidentiary hearing on the Charges was held before the Board by video-conference. At the hearing, the State was represented by an Administrative Prosecutor from the Office of the Attorney General, and the Respondent was present and was represented by legal counsel. The State presented the testimony of one witness, an Investigator for the Board. The Respondent testified on her own behalf and presented the testimony of six additional witnesses⁴:

- (1) Director of Nursing (“DON”) of the Nursing Home;
- (2) Administrator-In-Training (“AIT”) at the Nursing Home;
- (3) Staff 3, Director of Social Services (“SW”);
- (4) Nursing Home Unit Manager 1;
- (5) Staff 1, RN, Unit Manager at the Nursing Home; and
- (6) a licensed nursing home administrator, who was qualified for the Respondent as an expert in nursing home administration (the “Expert”).

The State offered the following 22 exhibits, which were all admitted into evidence:

1. OHCQ Form 2567 Statement of Deficiencies and Plan of Correction and OHCQ Complaint Survey Resident and Staff Rosters for survey of the Nursing Home, completed on September 27, 2018;
2. Transcript of Board Investigators Interview of DON, dated July 12, 2019;

⁴ The titles of the Nursing Home employees reflect their titles at the Nursing Home during the relevant period.

3. Baltimore County Police Department Incident Report;
4. OHCQ's Surveyor's Investigative Notes for survey of the Nursing Home completed on September 27, 2018;
5. Transcript of Board Investigator's Interview of Staff 4, dated July 30, 2019;
6. Staff 4 written statement to the Nursing Home, dated September 13, 2018;
7. Transcript of Board Investigator's Interview of Staff 2, dated September 10, 2019;
8. Staff 2's written statement to the Respondent;
9. Resident 1's Medical Records (excerpt);
10. Social Service Progress Note and Admission Record for Resident 3's;
11. Resident 2's Medical Records (excerpt)
 - Admission Record
 - Progress Notes
 - Physician Certifications Related to Medical Condition, Decision-Making, and Treatment Limitations
 - Behavioral Health Progress Note, dated September 16, 2018
 - Genesis Physician Services Progress Note, dated September 18, 2018
 - Physician's Interim/Telephone Orders
 - Care Plan, printed October 9, 2018;
12. Nursing Home's Investigation Documents;
13. Nursing Home's OPS #300 Abuse Prohibition
 - Revision date July 1, 2019
 - Revision date July 1, 2018;
14. Plan of Correction OPS #300;
15. Transcript of Board Investigator's Interview of Unit Manager 1, dated September 24, 2019;
16. Transcript of Board Investigator's Interview of the Respondent, dated September 30, 2019;
17. Post-Survey Documents received from the Nursing Home's Executive Director — dated October 8, 2019
 - Resident Council Minutes
 - Census List
 - Invoices for Resident 2
 - Sign-in Sheets for Staff Education
 - Resident 2's Care Plan, printed October 8, 2019;
18. Email correspondence from the Respondent's attorney to the Board's Investigator with addendums to the Respondent's interview;
19. Letter from AIT, dated October 24, 2019;
20. Licensing Information;
21. Maryland Board of Examiners of Nursing Home Administrators Report of Investigation, dated October 29, 2019;
22. Charges Under the Maryland Nursing Home Administrators Licensing Act, dated February 4, 2020.

The following exhibits of the Respondent were admitted into evidence:

1. Self-Report to OHCQ September 14, 2018 [in State's Exhibit 12];

2. Follow-up Self Report September 20, 2018 [in State's Exhibit 12];
4. Action Plan Tool [in State's Exhibit 12];
6. OPS #300 (Genesis Amended Policy) [in State's Exhibit 13 and 14];
8. Nine Letters of Support
9. CV of Respondent's Expert
10. Respondent's Expert Report

Prior to the evidentiary hearing, the Respondent, through her counsel, asked the Board to issue subpoenas to be served on OHCQ and the Nursing Home for the production of documents to be sent directly to the Respondent's counsel. The subpoena request asked for all documents related to the OHCQ survey as well as psychiatric assessments, progress notes, change in condition reports, etc., for three current or former Nursing Home residents. The Board responded that the request was inconsistent with the notice and time requirements of laws governing the confidentiality of medical and mental health records. Thus, the Board explained that, before it issued the subpoenas, the Board would need to be assured that the subpoenas would comply with the applicable laws. The Respondent amended the subpoena request to not include the specific requests for the residents' health care related assessments and notes, but the Respondent maintained the general requests for all documents related to the survey conducted by OHCQ, which would still include medical and mental health records of the residents at issue. The Board responded, reiterating that it needed to be assured that the subpoenas were not illegal, and again asked for the applicable laws pertaining to the disclosure of the documents requested. No further substantive amendments to the request were made.⁵ The Board was not assured that the process for subpoenaing the documents at issue would comply with Maryland law. This was based on the Board's assessment that the requested subpoenas, which did not comply with the notice and time requirements of the subpoena process, would violate Maryland law, most

⁵ The Respondent did ask to change the person being served for one of the requested subpoenas.

specifically with the laws governing the disclosure of medical and mental health records.⁶ Health-Gen. I §§ 4-301—4-309. The Respondent also had not responded to the Board’s inquires pertaining to the pertinent legal authorities. The Board denied the amended subpoena request.

On October 19, 2020, the State filed a Motion to Exclude Documentary and Testimonial Evidence, and the Respondent filed an opposition. The State requested that the expert report of the Expert, mentioned in, and attached to, the Respondent’s pre-hearing statement be excluded from evidence and that the testimony of the Expert be excluded.

The State’s main argument was that the expert report was deficient because, according to the State, it did not address the material issues in the case and it failed to provide a sufficient factual basis or sufficient reasoning. COMAR 10.33.01.17J(1)(b) states that a party shall provide the other party with a “detailed written report summarizing the expert’s testimony, which includes the opinion offered and the factual basis and reasons underlying the opinion.” The Board found that the Expert’s report was sufficient to meet the requirements of COMAR 10.33.01.17J(1)(b). The report provided a sufficiently detailed account of the Expert’s opinions, the factual bases for the opinions, and the expert’s reasoning. The Board explained that the State could challenge the quality and accuracy of the facts, opinions, and reasoning contained in the report through cross examination and the presentation of evidence at the hearing. The motion to exclude was therefore denied.

FINDINGS OF FACT⁷

The Board finds that the following facts were proven by the preponderance of evidence:

⁶ There are criminal penalties for knowingly and willfully violating the subtitle for any person, “including an officer or employee of a government unit.” Health-Gen. § 4-309(d).

⁷ The Findings of Fact include facts stipulated to by the parties which are integrated into the Findings of Fact.

1. The Respondent was initially issued a license to practice as a nursing home administrator in Maryland on May 2, 2002, under license number R1572. The Respondent has an active license through May 1, 2022. The Respondent was licensed to practice as a nursing home administrator in Maryland at all times relevant to this case.

2. The Respondent has had no disciplinary action taken against her by the Board prior to the Charges at issue here.

3. At all relevant times at issue in this matter, the Respondent was employed as the administrator at the Nursing Home, located in Baltimore County, Maryland. The Respondent was employed as the administrator of the Nursing Home from May 2018 to February 2019.

4. Resident 2, a female, was a resident of the Nursing Home. In September 2018, she was 50 years old. She was diagnosed with Cerebrovascular Accident (CVA), severe expressive aphasia, and Vascular Dementia. On December 4, 2015, and, on January 20, 2016, a physician certified Resident 2 as lacking decision making capacity pertaining to medical condition, decision making, and treatment limitations. On August 22, 2018, Resident 2 was assessed as having a Brief Interview for Mental Status (“BIMS”) score of 3/15, which indicates severe cognitive impairment. In a progress note, dated July 21, 2018, concerning a Care Plan Evaluation, the goal for Resident 2 was that she “will be able to make simple decisions by responding yes or no for the next 90 days.”

5. During the relevant period, Resident 1 was a 59-year-old male resident of the Nursing Home. His diagnoses included multiple sclerosis, paraplegia, major depressive disorder, hypertension and GERD. He was “alert and oriented x3 and able to communicate his needs.” Resident 1 had a BIMS score of 15/15 entered on the MDS assessment dated July 20, 2018, indicating he was cognitively intact.

6. During the relevant period, Resident 3, a 51-year-old male, was a resident of the Nursing Home. Resident 3 had a BIMS score of 14/15 on July 30, 2018, indicating he was cognitively intact. His diagnoses included Cerebrovascular Accident and Aphasia.

7. On September 3, 2018, Staff 4, a licensed practical nurse, went to Resident 1's room to inform him that a scheduled medical scan had been rescheduled. Staff 4 knocked three times on the door. Staff 4 thought Resident 1 was sleeping. Staff 4 entered the room and saw Resident 2 performing oral sex on Resident 1. Staff 4 did not intervene. She excused herself, left the room, closed the door, thus allowing Resident 1 and Resident 2 to continue. Staff 4 did not review Resident's medical records to inquire into the level of Resident 2's decision-making capacity.

8. On September 11, 2018, while Staff 2, a Geriatric Nursing Assistant ("GNA"), was changing the adult briefs of Resident 1, Staff 2 observed that Resident 1 became sexually aroused as evinced by his erection. Resident 1 asked Staff 2 how the erection would be taken care of. Staff 2 said she did not know. Resident 1 then asked Staff 2 to call Resident 2 to his room. Staff 2 went to Resident 2 and told her that Resident 1 wanted Resident 2 to visit him in his room.

9. Staff 2 later spoke to Staff 4 about the incident.

10. On September 14, 2018, the Respondent was involved in the daily rounds at a nursing station on the Second Floor. During the rounds, Staff 4 mentioned that she was upset with Staff 2 concerning how Staff 2 interacted with Resident 1. The Respondent told Staff 4 to follow-up with Unit Manager 1.

11. Staff 4 spoke to Unit Manager 1 about the sexual activity between Resident 2 and Resident 1.

12. The Unit Manager 1 and Staff 4 went into the Director of Nursing's (DON's) office and reported the incident to her.

13. The Respondent was called into the DON's office and spoke to the Unit Manager 1 and Staff 4 about the sexual activity between Resident 1 and Resident 2. Staff 4 said the incident took place on September 3, 2018.

14. On September 14, the Nursing Home notified the medical director and Resident 2's physician. The Nursing Home also notified the ombudsman, who was familiar with Residents 1 and 2.

15. The Respondent called Resident 2's sister to inform her of the situation. The sister came to the Nursing Home. The Respondent asked the sister whether the Nursing Home should call the police, and the sister said, "yes." The sister also said that, "If that happened, she is being taken advantage of."

16. Resident 1 was interviewed by the Respondent, DON, SW and AIT. Resident 1. Resident 1 stated that he had engaged in sexual activity with Resident 2 on three occasions. Resident 1 also mentioned that Resident 3 was also involved in sexual activity with Resident 2.

17. Resident 3 was interviewed by the Respondent, and Resident 3 stated that he fondled Resident 2's breast. Resident 3 also said that he gave Resident 2 cigarettes in return.

18. The Respondent, DON, AIT, and SW met with Resident 2 and interviewed her. Resident 2 denied that she had engaged in sexual activity with any other residents. She repeatedly said, "No, it's in there and God Damn." According the Nursing Home's Investigation, "As such, it was impossible to obtain any information from her."

19. On September 14, 2018, at 3:53 p.m., SW documented an incident involving Resident 3. The note, dated September 14, 2018, at 3:53 pm., states, "[Resident 3] has been

reportedly fondling/groping a female LTC patient's breast on his unit. DON, CED & AIT met with patient to initiate investigation. CP will be initiated pending completion of investigation."

20. A social service progress note for Resident 2 was written on September 14, 2018, at 3:57 pm, stating "This SW was informed that patient has been having sexual interaction with two LTC male patients —[Resident 3] & [Resident 1]. It is suspected that patient is doing the acts for the purpose of money and/or cigarettes." The social service progress note further stated that the SW contacted the psychiatrist to see Resident 2 as soon as possible to determine whether she is capable for consenting to sexual interaction. The note also discussed a meeting between the Respondent, DON, AIT, and the SW and Resident 2. The note stated that Resident 2 was asked whether she had engaged in sexual acts with other residents and specifically with Residents 1 and 3. Resident 2 repeatedly said "no" to the extent that the Respondent "had to ensure that patient was capable of saying the word 'yes'." Ultimately Resident 2 demonstrated that she could say "yes." The Respondent told Resident 2 that she cannot enter either of the rooms of Residents 1 and 3, as well as no other men's rooms and cannot be outside with them when they smoke. According to the note, the Respondent "told the patient that she cannot engage in any sexual activity while in the facility." Resident 2 left the meeting "clearly upset."

21. Resident 2 engaged in sexual activity with another resident between September 3, 2018, when Staff 4 observed sexual activity with Resident 2 and Resident 1, and September 14, 2018, when the Resident 2's sexual activity was reported to the Respondent.

22. The Nursing Home notified the police, on September 14, 2018, at 6:51 pm. A Police Officer spoke with the Respondent, who said that, on September 13, two residents were caught engaging in oral sex. According to the police report, Resident 2 had "limited mental capacity due to early onset dementia." The Respondent also offered that she could not determine

whether Resident 2 could give consent to oral sex. Resident 2 was interviewed by an Officer and refused to acknowledge that she had done anything sexual with Resident 1. According to the police report, Resident 1 told the Officer that Resident 2 “had encouraged that she perform oral sex on him, and that he did not force himself or coerce her into doing anything sexual with her. According to the report, “when asked Complainant Rice [the Respondent] advised that she had also heard that [Resident 2] had done sexual things with other members of the nursing home.” The Respondent also said that Resident 2 was going to be evaluated to determine mental capacity.

23. On September 14, 2018, Resident 2 was transferred from the second floor to a room on the ground floor of the Nursing Home, according to Resident 2’s progress notes, “[d]ue to circumstances involving 2 pts on the 2nd floor.” The order to transition Resident 2 to the ground floor was made over the telephone, on September 14, 2018, by a nurse practitioner, and the written order was signed on October 4, 2018.

24. The AIT at the Nursing Home was assigned to acclimate Resident 2 to her new environment. The AIT arranged to move Resident 2’s personal items to her new room. Resident 2 was gesturing that something was wrong which the AIT initially could not determine. Later the AIT discovered that Resident 2 associated a lot with a doll baby, which was missing from her personal items. The AIT was later able to reunite Resident 2 with the doll and to make Resident 2 comfortable in her new environment.

25. On September 14, 2018, the care plan of Resident 1 was updated to state, “[Resident 1] has a tendency to exhibit sexual acts towards other female patients who may not be able to fully consent to their sexual actions.” In pertinent part, under “Goal,” “Patient will not engage[] in any sexual act with another patient unless they give[] their consent until next review.” Also, under “Goal,” “Patient is not to enter any female’s room unless accompanied by a

staff member until the next review period.” There were interventions listed, but there was not an increase in supervision. For instance, under “Interventions, ”When sexually inappropriate behaviors occur, approach the resident/patient in a calm, unhurried manner; reassure as necessary.”

26. Resident 3’s care plan had an initiation date of September 14, 2018, addressing his tendency to exhibit sexual acts towards other females who may not be able to fully consent to their sexual advances. It does not appear his supervision level was increased.

27. Resident 2’s care plan was not updated on September 14, 2018, to address the potential for sexual exploitation by other residents with interventions to ensure her safety. On September 25, 2018, the DON and Administrator confirmed with OHCQ that the level of supervision had not been increased for Resident 2.

28. The Nursing Home submitted a Self-Report Form to OHCQ on September 14, 2018. The Self-Report stated, “On 9/13/18 it was reported that [Resident 1] and [Resident 2] were engaged in sexual activity. The physician, responsible parties and law enforcement were notified. An investigation was initiated to determine [Resident 2]’s ability to consent to sexual relations.”

29. On or about September 15, 2018, Staff 4 provided a written statement about the incident to the Nursing Home. Staff 4’s written statement was addressed to the attention of the “DON/Administrator.” The written statement is dated incorrectly as September 13, 2018. Staff 4 wrote that on September 3rd she went to Resident 1’s room to tell him that a scheduled medical scan was canceled. She knocked on the door but there was no answer, so she thought he was sleeping. She went in the room and saw Resident 2 performing oral sex on Resident 1. Staff 4 said that she was sorry and excused herself out of the room. She thought they were adults,

because this was their home. Staff 4's letter said, "Later that day, which was on the 4th, I knew [Resident 1] asked for [Viagra]." Staff 4's letter said, "I was still trying to finish my documentation when [Staff 2] came up to the nurses station, and asked if it was right to call a resident for another resident." Staff 2 stated that she was cleaning Resident 1 and he had an erection, and Resident 1 asked Staff 2, "Who is going to help him ease it out?" Staff 2 said she did not know. Resident 1 then asked her to get Resident 2 "and she went." Staff 4 told Staff 2, "next time don't do it. Let him get off the bed and go get her himself because I feel it's - - it was abuse and vulnerable." "[H]e should not be allow[ed] of getting away with it." Staff 4 wrote that she "mentioned it to the unit manager, both; they adult and its consented, until[] you stated its not consented. I have cleared my conscience."

30. A Behavioral Health Services note dated September 16, 2018, signed by the psychiatrist who evaluated Resident 2 states that "[Resident 2] has impairment of recall, reasoning and orientation. Her dementia is moderate. She is not competent to make personal decisions including sexual relations. Agree to move to more secure floor."

31. On September 17, Staff 2 was interviewed by the Respondent. Staff 2 wrote the following written statement:

To
Brenda L. Rice
Center Senior Executive Director

On Tuesday 9/11th/18, while I was changing [Resident 1]'s diaper his pennis (*sic*) erect and he said I should leave him and helped him to call [Resident 2], [which] I did and spoke with [Staff 4] the nurse on duty about it.

Yours,
[Staff 2]

32. On September 18, 2018, the medical director of the Nursing Home evaluated Resident 2 and determined that Resident 2's

capacity to engage in sexual relations is profoundly complicated by her expressive aphasia. She cannot verbalize consent. The staff report a very purposeful behavior of seeking sexual intimacy. That being said, it is impossible to be comfortable that the patient understands the possible ramifications and dangers of being sexually active. Therefore, I believe she is not capable to making a decision to enter into a sexual relationship.

33. The Nursing Home submitted a follow-up Self-Report to OHCQ on September 20, 2018, which set forth the Nursing Home's report on its investigation. It states the following:

a. On September 13, 2018, "it was reported" that Resident 1 and Resident 2 "were engaged in sexual activity"; that "the physician, responsible parties and law enforcement were notified"; and an "investigation was initiated to determine [Resident 2]'s ability to consent to sexual relations";

b. Resident 1 is a 59 year old, male, who "is alert and oriented x 3 and able to communicate his needs. His diagnoses include multiple sclerosis, paraplegia, contractures, major depressive disorder, HTN, and GERD. He was interviewed on September 14, 2018, and "admitted to receiving oral sex from [Resident 2] on three separate occasions." Resident 1 further said that Resident 2 came into his room and "it was her idea to give him oral sex";

c. Resident 2, a 50-year-old female, "is alert and oriented x 1 and is unable to communicate her needs." Resident 2 was interviewed on September 14, 2018, and that she denied performing oral sex on Resident 1 "by repeatedly saying, 'No, [i]t's in there and God Damn.' As such, it was impossible to obtain

any information from her.” Resident 2 was “moved to the lower level of the building to separate her from [Resident 1].”

d. In the Nursing Home’s interview with Staff 4, LPN, Staff 4 “revealed that on the evening of 9-3-18 she went into [Resident 1]’s room after knocking on his door. . . . When she entered the room, she saw [Resident 2] performing oral sex on [Resident 1]. Believing it was consensual, she excused herself, left the room and closed the door.”

e. On September 16, 2018, Resident 2 was evaluated by a psychiatrist, and “it was determined that [Resident 2] was unable to provide consent for engaging in sexual activity”; and that, on September 18, 2018, Resident 2 was seen by the Nursing Home’s medical director, who “concluded that [Resident 2] was unable to consent to sexual activity”;

f. After the completion of the investigation, it was “determined that [Resident 2] provided oral sex to [Resident 1] in his room. Due to [Resident 2]’s lack of capacity to provide consent for such activity, she will not be allowed to engage in sexual activity and will be closely monitored for further contact with male residents in their room.”⁸

34. On September 25, 2018, during the OHCQ survey, the Respondent confirmed that the level of supervision had not been increased for Resident 2 but all staff “look out for her.” The Administrator and DON were asked if Residents 1 & 2 were supervised during smoke breaks. The response was that they keep their distance from one another.

⁸ The follow-up report to OHCQ said, the Nursing Home “staff will be educated on resident rights to engage in sexual activity and the process to report such information to Administration, so consent and privacy of the involved parties is ensured.”

35. Neither during nor after the Nursing Home's investigation was the level of supervision for Resident 2 increased.

36. On October 1, 2018, after OHCQ had conducted its survey, Resident 2's care plan was updated to address Resident 2's "demonstrated desire/tendency to engage in intimate relationships with male residents but unable to make an informed decision related to: CVA with severe expressive/receptive aphasia and impaired judgment." The interventions included that Resident 2 was aware that she was not to visit the second floor, the resident was not to "visit known actively sexual male residents," and staff were to monitor conditions that may contribute to inappropriate sexual behavior, including psychiatric disorder(s), cognitive loss/dementia, CVA, delirium, delusions, hallucinations, head injury, etc."

37. On October 11, 2018, Resident 2 was discharged from the Nursing Home.

38. After the sexual incidents at issue were reported, the Nursing Home, in September and October 2018, provided training to its staff, including training on sexual abuse in general, including sexual contact between residents; sexual abuse reporting; and resident rights pertaining to intimate relationships.

39. The Board received a Statement of Deficiencies and Plan of Correction from the OHCQ after OHCQ conducted a complaint survey of the Nursing Home from September 25, 2018, through September 27, 2018.

DISCUSSION⁹

I. SEXUAL ABUSE

⁹ In evaluating the evidence, the Board used its experience, technical competence, and specialized knowledge. *See* Md. Code Ann., State Gov't § 10-213(i).

In this case, Resident 2 suffered from sexual abuse because she engaged in sexual activity in the Nursing Home with another resident, or with two residents, despite not having the capacity to consent to the sexual activity. While there is a dispute as to the number of times Resident 2 engaged in sexual activity, there is no dispute that she engaged in sexual activity in the nursing home in September 2018.

Sexual Abuse Occurred

Resident 2 was Cognitively Impaired without Capacity to Consent to Sexual Activity

At the time that Resident 2 engaged in sexual activity at the Nursing Home, in 2018, she was severely cognitively impaired. Resident 2's diagnoses included severe expressive aphasia, CVA, and vascular dementia. Documented in her Minimum Data Set (MDS) assessment,¹⁰ dated August 21, 2018, Resident 2 had a BIMS Score of 3, indicating severe cognitive impairment. On January 20, 2016, a physician certified that Resident 2 lacked decision making capacity related to medical condition, decision making, and treatment limitations. Soon after the sexual conduct was reported, in September 2018, two physicians performed evaluations of Resident 2. On September 16, 2018, a psychiatrist found that Resident 2 is "not competent" to make decisions concerning sexual relations. On September 18, 2018, the Nursing Home's medical director found that Resident 2 "clearly cannot verbalize consent," and wrote that he believes "she is not capable to making a decision to enter into a sexual relationship." There is no indication Resident 2's cognitive functioning changed from on or around September 3, 2018, to when these two evaluations were conducted.

One staff member, Unit Manager 1, articulated what the physicians found:

Q. And did you believe that [Resident 2] had the ability to consent to sexual interactions?

¹⁰ The MDS is a comprehensive assessment of the resident conducted by the nursing home's staff.

A. No.

Q. Why?

A. Because she wasn't completely with it. Like, she had a stroke so, like, she could – I don't know how to, like explain it, but she wasn't – she wasn't like, able to consent as far as I mean you would be able to consent.

Likewise, when one of Resident 2's sisters was told that Resident 2 was witnessed performing oral sex on another resident, the sister's response was, "If that happened, she is being taken advantage of."

Resident 2 Engaged in Sexual Activity.

There is no question that Resident 2 engaged in sexual activity while a resident at the Nursing Home in September 2018. While it is difficult to discern the exact number of occasions in which Resident 2 engaged in sexual activity with another resident, it is clear to the Board, and the Board finds, that Resident 2 had engaged in sexual activity with another resident on more than one occasion. The Board further finds that Resident 2 engaged in sexual activity with another resident between September 3, 2018, when Staff 4 observed Resident 2 performing oral sex upon Resident 1, and September 14, 2018, when the Respondent became aware of sexual activity involving Resident 2.

In addition to the September 3, 2018, observation by Staff 4, Staff 2 described an incident occurring on September 11, 2018, when Resident 1 was sexually aroused and asked for Staff 2 to call Resident 2 to his room, and Staff 2 complied with Resident 1's request. Also, SW wrote, that she was "informed that [Resident 2] has been having sexual interaction with 2 LTC male patients – [Resident 3] & [Resident 1]." Additionally, SW documented that Resident 3 engaged in sexual activity with Resident 2. Resident 3 was interviewed by the Respondent and he said that he fondled Resident 2's breast and that it was in exchange for cigarettes. The Respondent also told the police that she had heard that Resident 2 "had done sexual things with other

members at the nursing home.” Moreover, the Nursing Home’s investigation found that Resident 3 “admitted to receiving oral sex from [Resident 2] on three separate occasions.” In a progress note, dated September 18, 2018, for Resident 2, the physician wrote “The staff report that she has been actively seeking out men and has been engaging in oral sex.” The physician further wrote, “The staff report a very purposeful behavior of seeking physical intimacy.”

Between the September 3, 2018, sexual activity observed by Staff 4, and September 14, 2018, when Resident 2’s sexual activity was reported to the Respondent, there was an 11-day window within which the Board finds that Resident 2 engaged in further sexual activity. Resident 2 was sexually active; Resident 1 stated he engaged in sexual activity with Resident 2 on three occasions; and Resident 1 clearly was focused on sexual activity with her during this period. There also was no effort by the Nursing Home during this period to prevent Resident 2 from engaging in sexual activity, and Resident 1 and Resident 2 had easy access to each other’s room.

Sexual Abuse Occurred due to a Systemic Breakdown

The actions of two Nursing Home staff members, Staff 4, an LPN, and Staff 2, a GNA, demonstrate a systemic breakdown in the Nursing Home with respect to protecting a resident from sexual abuse. These staff members were not prepared to handle how to appropriately react to sexual abuse of a resident who lacked the capacity to consent to sexual activity with another person. This breakdown shows a substantial failure in the oversight of the Nursing Home to ensure that the staff was prepared to prevent sexual abuse, resulting in the Nursing Home not having sufficient safeguards to protect a severely cognitively impaired resident from suffering sexual abuse.

First, when sexual activity was observed by Staff 4, on September 3, 2018, Staff 4 allowed it to continue. Staff 4 did not intervene, nor did she call for assistance to determine a response. She simply left the room. Staff 4 indicated that she considered them adults who were allowed to make their own decisions with respect to sexual activity. Staff 4, however, did not inquire of the patient's decision-making capacity by, at least, reviewing the resident's patient chart. Then, Staff 4 waited 10-11 days to report the sexual activity involving Residents 1 and 2 that she had witnessed.

With Staff 2, she was asked by Resident 1 to tell Resident 2 to go to his room. It was clear that it was for sexual purposes. Staff 2, nonetheless, complied with Resident 1's request. Although Staff 2 did informally mention this incident to Staff 4, the information travelled no further for several days, and did not reach the DON or the Respondent until September 14, 2018. Because the information did not reach the DON or Respondent level, between September 3 and September 14, Residents 1 and 2 were allowed unfettered access to each other to engage in sexual activity.

II. INVESTIGATION BY NURSING HOME

1. The Nursing Home Investigation was Insufficient because it Assumed there was only One Instance of Sexual Abuse despite Indicators there was More than One Instance.

Almost the entire direction of the Nursing Home's investigation consisted of scrutinizing one incident, the September 3, 2018 incident in which Staff 4 walked in on Residents 1 and 2 engaging in sexual activity. There were, however, other avenues that should have been thoroughly pursued: (1) Resident 3's fondling of Resident 2's breasts, (2) Staff 2's relaying Resident 1's message for Resident 2 to go to his room for obvious sexual purposes, and (3) indications Resident 1 had more than one sexual episode with Resident 2. By not pursuing these

avenues, there was a substantial failure on the part of the Nursing Home to thoroughly investigate the allegations of abuse.

A. Resident 3

Concerning Resident 3, despite the evidence that Resident 3 engaged in sexual activity with Resident 2, this suspected activity was not thoroughly investigated and it was not reported to OHCQ. OHCQ found a social services note in Resident 3's file, stating, "This SW was informed that patient is doing the acts for the purpose of money and/or cigarettes." Both Resident 1 and Resident 3 indicated that Resident 3 had been involved in sexual activity with Resident 2. With respect to information that Resident 3 may have had sexual activity with Resident 2, the Respondent testified:

The next question you asked is why wasn't there a self-report. So part of the investigation we couldn't substantiate. I had a resident – [Resident 1] saying [Resident 3] fondled her and [Resident 3] saying I fondled her breast – you know, but there's no evidence that – when we talked with [Resident 2] she adamantly denied having any contact with either of these gentlemen even though we did know because we had a witness to the interaction between her and [Resident 1].

The Respondent indicated that the Nursing Home was not able to substantiate Resident 3's sexual conduct with Resident 2 because the alleged victim denied the conduct. Therefore, this allegation was not part of a self-report. The Nursing Home did not thoroughly investigate, or report to OHCQ, the likelihood that Resident 2 had engaged in sexual activity with Resident 3. It seemingly based its determination on its interviews of Residents 1, 2, and 3. While Residents 1 and 3 readily acknowledged that Resident 3 fondled Resident 2, and both of these residents were cognitively intact, the Respondent seemed to give weight to Resident 2 who, according to the Respondent, "adamantly denied" having "contact" with both Resident 1 and Resident 3. But, at the same time, the Respondent knew that Resident 2 was observed by Staff 4 engaging in

sexual activity with Resident 1. The Respondent was also aware of Resident 2's significant cognitive limitations. Even further, Resident 2 may just not have felt comfortable discussing intimate sexual activity with nursing home staff. The Respondent further expressed her view that Resident 1 mentioned Resident 3's sexual activity with Resident 2 because Resident 1 was now being investigated by the police and was "trying to throw everybody under the bus." This, however, would not explain why Resident 3 acknowledged that he fondled Resident 2's breast, which he acknowledged when he was interviewed by the Respondent. And none of this information would lead one to determine when or where the incident occurred, if it did. The Respondent represented that she believed Resident 3's purported sexual activity with Resident 2 was in the 5 day follow-up report. It was not. The Nursing Home did not make a sufficient effort to determine whether Resident 3 engaged in sexual abuse upon a severely cognitively impaired resident.

B. Staff 2

During its investigation, the Nursing Home had Staff 2 describe in writing her interaction with Resident 1 when Resident 1 asked Staff 2 to call Resident 2 to his room. The letter Staff 2 wrote was addressed to the Respondent, stating, "On Tuesday 9/11th/18, while I was changing [Resident 1]'s diaper his penis (*sic*) erect and he said I should leave him and helped him to call [Resident 2], [which] I did and spoke with [Staff 4] the nurse on duty about it." This information was not included in the Nursing Home's investigation report nor in its follow-up self-report to OHCQ. Instead, OHCQ found this written statement in the Nursing Home's investigative file.

Further, the Nursing Home's investigation did not pursue Staff 2's interaction with Resident 1 as a possible sexual episode separate from Staff 4's. In other words, they viewed this as one, not two, incidents, despite the indicators that Staff 2's actions were not what led to the

sexual activity witnessed by Staff 4, such as the date given on Staff 2's written statement, Tuesday, September 11, 2018, which is eight days after the date given on Staff 4's written statement, September 3, 2018.

C. Extent of Residents 1 and 2's Sexual Relationship

The Nursing Home's Investigative Report provided to OHCQ stated, "[Resident 1] was interviewed on 9-14-18 and admitted to receiving oral sex from [Resident 2] on three separate occasions. He stated that she came into his room and it was her idea to give him oral sex." This is consistent with a progress note, dated September 18, 2018, for Resident 2, in which the physician wrote, "The staff report that she has been actively seeking out men and has been engaging in oral sex." The physician further wrote, "The staff report a very purposeful behavior of seeking physical intimacy." The Nursing Home did not give Resident 1's version credence or pursue this avenue.

III. DURING INVESTIGATION, AND AFTERWARD, WHETHER APPROPRIATE ACTION TO PREVENT FURTHER INCIDENTS OF ABUSE WAS TAKEN

The Nursing Home's failure to pursue appropriate avenues of investigation, as described above, limited the information the facility had to formulate and implement specific measures to protect vulnerable residents from sexual abuse during the investigation and afterward. Although the Nursing Home provided training to its staff on sexual abuse and there is no evidence that incidents of abuse occurred during the Nursing Home's investigation (or afterward), the evidence indicates that the Nursing Home did not take appropriate action to ensure that further abuse incidents would not occur during these periods.

On September 14, 2018, Resident 2 was transferred from the Second Floor to the Ground Floor to distance herself from Residents 1 and 2. Two weeks later, on October 1, 2018, after OHCQ surveyed the Nursing Home, Resident 2's care plan was updated to say, "Resident will be

monitored by staff for potential relationships with male residents.” The care plan did not include a provision for staff to accompany Resident 2 when she leaves the unit. Supervision levels were not increased and there was no plan when Resident 2 went into the smoking area or simply left the ground level at which she was now residing.

Further, the Nursing Home did not impose appropriate measures to ensure that Resident 1 and 3 did not act upon other residents who lacked the capacity to consent to sexual activity. The Respondent mentioned measures such as informing Resident 1 and Resident 3 to use a certain elevator, one that Resident 2 would not be using. And, on September 14, 2018, Resident 1’s care plan had as a “Goal,” that “Patient is not to enter any female patient’s room unless accompanied by a staff member until the next review date.” But the supervision levels of for Residents 1 and 3 were not clearly increased. There were no strict protocols placed sufficient to prevent Residents 1 and 3 from manipulating other vulnerable residents into sexual activity with them.

Respondent’s Expert Witness

The Respondent’s expert witness (“Expert”) was qualified as an expert in nursing home administration. The Expert has been licensed by the Board since 2014. Prior being a licensed nursing home administrator, the Expert worked as the director of social services at various nursing homes throughout the State. The Expert worked as an administrator at three nursing homes, prior to 2019, at which time she became an administrator at her current (at the time of the hearing) nursing home facility.

The Expert testified, prior to the Respondent finding out about the sexual activity Resident 2 had been engaged in, that she (the Expert) found no indication in the record that indicated that Resident 2 would be sexually assaulted by anyone. This was primarily based upon

Resident 2 being an independent smoker and independent with her mobility: “She knew where her room was.” The Expert said that “although deemed incompetent with a BIMS score that was low due to her expressive aphasia[,] I could not find anything regarding that sexual exploitation which was investigated and then turned in according to OHCQ.” The Expert was focused on “why would this person be considered a target for sexual exploitation.” The Expert also found that Resident 2 “was expressive with her roommate over temperature” and gave an “apology hug,” demonstrating to the Expert that “there is some type of receptive competence there that may not be necessarily indicated on that BIMS score that we saw or those incompetent certs in the chart.”

The Expert found that after the Respondent first learned of the sexual abuse on September 14, 2018, she recalled “there was an immediate investigation launched. I was able to see her internal investigation, *any witness statements that were taken, . . .*” The Expert determined that when the Respondent was first made aware of the situation, the Expert “found absolutely no deviation in the process.”

The Board does not adopt the Expert’s opinions. It does not appear that the Expert was aware of some of the most crucial circumstances of the incidents. For instance, the Expert testified that she was not sure where the September 3 date even came from (although it was in the Nursing Home’s investigation reports and in Staff 4’s written statement), and that “I found zero documentation or any indication anywhere that this occurred prior to the 13th or 14th.”

On cross examination the Expert testified that she did not find any potential for exploitation against Resident 2 despite a BIMS score of 3, a care plan that focused on Resident 2 making simple decisions, that she was twice certified as lacking adequate decision-making capacity, and that due to severe aphasia “she can’t express” which “doesn’t mean she doesn’t

understand.” Despite having testified that there was nothing in Resident 2’s chart indicating that she was at risk for any type of sexual exploitation or harm, when asked that under her care plan, which focused on Resident 2 making simple decisions and whether consenting to sexual acts is deemed a simple decision, the Expert said, “I’m not really qualified to answer that.” When asked about the written statement from Staff 2 about her involvement with Residents 1 and 2 on September 11, 2018, the Expert initially testified, “I couldn’t find in any of the documents that it happened at all,” but when shown the statement, said she did remember seeing it. The Expert then acknowledged that Staff 2’s involvement in the September 11 incident was not reported to OHCQ, despite Staff 2’s letter being addressed to the Respondent. The Expert maintained that the Staff 2 incident was not investigated by the Nursing Home because the facility was unaware of it. The Expert also said that the reports of Resident 3 engaging in a sexual act with Resident 2 were not reported to OHCQ and were not adequately investigated. Ultimately, the Expert testified that she was “not sure” whether there was evidence that possible sexual conduct between Residents 2 and 3 was investigated.

In sum, the Expert was not aware of crucial facts, downplayed Resident 2’s severe limitations, and did not adequately support her opinions of the Nursing Home’s investigation. The Board does not find the Expert’s testimony helpful and does not rely on it.

CONCLUSIONS OF LAW

Based on the Findings of Fact and Discussion, the Board concludes that the Respondent violated the following statutory and regulatory provisions:

Health Occ. § 9-314

(b) Subject to the hearing provisions of § 9-315 of this subtitle, the Board may . . . reprimand any licensee . . . , place any license . . . on probation, suspend or revoke a licensee . . . , or impose a civil fine if the . . . licensee:

.....

(3) Otherwise fails to meet substantially the standards of practice adopted by the Board under § 9-205 of this title[.]¹¹

COMAR 10.33.01.15

A. Pursuant to Health Occupations Article, §9-314(b)(3), Annotated Code of Maryland, the Board may . . . suspend or revoke a license of a nursing home administrator, or reprimand or otherwise discipline . . . a licensee after due notice and an opportunity to be heard at a formal hearing, upon evidence that the 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 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 10.07.02.09

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

.....

C. A resident has the right to:

.....

(5) Be free from:

¹¹ Under Health Occ. § 9-205(a), “. . . the Board may: (1) Adopt rules and regulations to carry out the provisions of this title.”

....
(c) Sexual abuse[.]

COMAR 10.07.09.15
....

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.

SANCTION

This case involves a nursing home administrator with a long and distinguished career who has demonstrated a deep interest and effectiveness in taking care of the residents of the nursing homes in which she has managed. The Board is fully aware of the enormous challenges administrators face in managing nursing homes, but the laws and regulations governing nursing homes place exceedingly paramount importance in protecting residents from abuse, whether it is verbal, physical, or sexual.

Specifically, COMAR 10.07.02.09A(2) holds the administrator responsible for implementation and enforcement of the Patient's Bill of Rights, which states that a resident right is to be free from sexual abuse. The responsibility of the administrator in this area is so encompassing and imperative that there is very minimal space for lapses in ensuring the protection of the residents in this area. Certainly there could be instances in which there is abuse of a resident despite staff being fully and properly educated and trained in which there is little, if anything, the administrator could have done to prevent it. This, however, is not one of those instances.

Here, there were at least two staff members who were wholly ill-prepared to react appropriately to what should have been obvious was a resident who did not have the capacity to consent to sexual activity with other residents. Yet, when sexual activity was observed by Staff 4, Staff 4 did not intervene, allowing the sexual activity to continue. Then Staff 4 did not report it to appropriate management until 11 days later, which continued opportunities for Resident 2 to be sexually exploited for this period. Staff 2 was willing, and did, call Resident 2 to Resident 1's room, despite obvious indicators that Resident 2 was called to engage in sexual activity. It is unlikely that these inappropriate responses by staff would have taken place had the Respondent had concrete forewarning. But the actions of the staff were so outside the bounds of acceptable care and oversight of residents that the administrator, who is responsible for ensuring that sexual abuse does not occur, oversaw a system of protection that was extensively flawed. The staff were not safeguards for Resident 2 and the required protective breakdowns were so severe that the Board finds that administrator should be held accountable.

While the resident was a victim of actual harm in this matter, and the Board considers the harm serious, and the victim was especially vulnerable, the Board has considered the absence of a disciplinary history and that the Respondent cooperated with the proceedings. The Respondent also did report the incident to the appropriate authorities, although its investigation was incomplete; did ensure training for the staff after the abuse was reported to her; and there was clear intention for remedial measures, although specific protective measures were generally vague and unfocussed. And there was certainly no intentional conduct on the part of the Respondent that led to the harm suffered by Resident 2.

ORDER

It is, thus, 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**.¹² The Payment shall be by money order or bank certified check made payable to BENHA, and mailed to the Maryland Board of Nursing Home Administrators, 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, (2) quality assurance processes for nursing homes, and (3) sex and sexuality in 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 she 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

¹² See Health Occ. § 14-314.1.

(g) the Respondent shall provide the Board with documentation that she successfully completed the courses no later than one year after the Final Decision and 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 Final Decision and Order; and it is further

ORDERED that any time period prescribed in this order begins when the Final Decision and Order goes into effect. The Final Decision and 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 Final Decision and Order is a **PUBLIC DOCUMENT**. *See* Health Occ. § 1-607; Md. Code Ann., Gen. Prov. § 4-333(b)(6).

April 6, 2021
Date

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

NOTICE OF RIGHT TO APPEAL

Pursuant to § 9-316(b) of the Health Occupations Article, the Respondent has the right to seek judicial review of this Final Decision and Order. Any petition for judicial review must be filed in court within 30 days from the date this Final Decision and Order was sent to the Respondent. The Final Decision and Order was sent on the date that it was issued. The petition for judicial review must be made as directed in the Maryland Administrative Procedure Act, Md. Code Ann., State Gov't § 10-222, and Maryland Rules 7-201 *et seq.*

If the Respondent petitions for judicial review of this Final Decision and Order, the Board is a party and should be served with the court's process. Also, a copy of the petition for judicial review should be sent to the Board of Examiners of Nursing Home Administrators, 4201 Patterson Avenue, Room 305, Baltimore, Maryland 21215. In addition, the Respondent should send a copy of the petition for judicial review to the Board's counsel, David Wagner, Assistant Attorney General, Office of the Attorney General, 300 W. Preston Street, Suite 302, Baltimore, Maryland 21201 and by email at david.wagner@maryland.gov. The administrative prosecutor is not involved in the circuit court process and does not need to be served or copied on pleadings filed in circuit court.