

IN THE MATTER OF	*	BEFORE THE STATE BOARD
JOYCE DANIELS JONES, N.H.A.	*	OF EXAMINERS OF
Respondent	*	NURSING HOME
	*	ADMINISTRATORS
License Number: R1801	*	Case Number: 2016-001

* * * * *

CONSENT ORDER

PROCEDURAL BACKGROUND

On May 15, 2017, the State Board of Examiners of Nursing Home Administrators (the "Board") charged **JOYCE DANIELS JONES, N.H.A.** (the "Respondent"), License Number R1801, under the Maryland Nursing Home Administrators Licensing Act (the "Act") codified at Md. Code Ann., Health Occ. I ("Health Occ. I") §§ 9-101 *et seq.* (2014 Repl. Vol. and 2015 Supp.).

The Board charged the Respondent under the following provisions of Health Occ.

I § 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:

- (8) Willfully makes or files a false report or record in the practice of nursing home administration; [and]
- (11) Commits an act of unprofessional conduct in the licensee's practice as a nursing home administrator[.]

The pertinent provisions of Md. Code Regs. ("COMAR") 10.33.01 provide as follows:

.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: (4) Has practiced fraud, deceit, or misrepresentation in the licensee's capacity as a nursing home administrator[.]

On July 13, 2017, the Respondent appeared before a Case Resolution Conference (the "CRC") of the Board. As a result of negotiations occurring before 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 relevant times, the Respondent was and is a licensed nursing home administrator. The Respondent's license is active and scheduled to expire on November 17, 2017.
2. At all relevant times, the Respondent was employed as the administrator at Facility A, a nursing home in Maryland.¹
3. On or about November 6, 2015, the Office of Health Care Quality ("OHCQ") sent the Board a Statement of Deficiencies, issued in April 2015, against Facility A. The Statement of Deficiency was the result of an annual survey of Facility A to determine compliance with Medicare/Medicaid program requirements.

¹ For confidentiality purposes, names do not appear in this Consent Order. The Respondent is aware of the name of all nursing homes and individuals referenced herein.

4. Thereafter, the Board initiated an investigation.
5. On January 28, 29 and 30, 2015 and February 3 and 4, 2015, OHCQ conducted an annual survey of Facility A.
6. During the annual survey, staff and resident interviews revealed that Facility A failed to have a resident ("Resident A") re-evaluated after his custom wheelchair broke to determine how continuing to use the broken wheelchair would affect Resident A's functional abilities and well-being. Resident A's customized wheelchair had been broken for approximately eight months, preventing him from independently wheeling himself in his wheelchair.
7. According to OHCQ, Resident A stated that he is right-handed and trying to use his wheelchair with a broken right-side hand rim is difficult and caused him pain.
8. In the Plan of Correction, the Respondent stated that Resident A was re-evaluated and a new customized wheelchair was ordered for him.
9. On February 27, 2015, the Respondent requested an Informal Dispute Resolution ("IDR") to address certain deficiencies cited by OHCQ during the annual survey.
10. The Respondent disputed OHCQ's finding that Facility A failed to ensure that [Resident A] was provided with appropriate treatment and services to maintain or improve his abilities. Specifically, the Respondent stated that a review of Resident A's clinical records "reveals that he has had no decline in function or wheelchair mobility" because Resident A "has required extensive assistance in locomotion since at least" April 23, 2013.

11. However, the Respondent cited documentation, which contradicted her representation regarding Resident A's level of function. The Respondent provided a copy of section G of Resident A's Minimum Data Set ("MDS"), which indicates that Resident A required no set up or physical help from staff with regard to locomotion between April 23, 2013 and January 2014.

12. During the IDR, OHCQ questioned the Respondent about the discrepancy between her written submission and Resident A's MDS documentation. The Respondent and the Director of Nursing ("DON"), who also participated in the IDR meeting, stated that the written submission contained an error because Resident A was always independent with locomotion.

13. On April 6, 2015, OHCQ notified the Respondent of its decision following the IDR. OHCQ determined that the original determination of the scope and severity of the deficiency would remain unchanged because Facility A failed to provide any additional information and/or evidence that the citation was incorrect.

14. From February 27, 2015 through April 9, 2015, OCHQ conducted an offsite administrative review of Facility A and reviewed MDS data submitted to the Quality Improvement and Evaluation System, Assessment Submission and Processing System ("ASAP").

15. According to a Statement of Deficiencies dated April 9, 2015, Facility A failed to ensure accurate MDS documentation in the medical record for Resident A. Specifically, the Respondent and Facility A staff modified nine different assessments (36 entries under Section G of Resident A's MDS) from 3/2 (extensive assist self-performance -

with one person staff assistance required) to 1/0 (supervision self-performance with no staff assistance required) from January 2013 through January 2015.

16. During the administrative review process, OHCQ interviewed Facility A staff who reported that they did not have daily GNA coding documentation to support the record coding either before or after the modifications. Further, Facility A staff said that the modifications made to Resident A's MDS data were based solely on current observations and interviews with staff who remembered Resident A's status over the previous two years.

17. OHCQ determined that Facility A did not properly comply with the record modification procedures that are outlined in the Resident Assessment Instrument ("RAI") manual pertaining to resident clinical status.

18. On February 25, 2015 and February 27, 2015, Facility A staff modified a total of 36 MDS entries concerning Resident A's status regarding locomotion on and off the unit for both self-performance and staff assistance.

19. During the IDR meeting, OHCQ contacted Facility A's MDS Coordinator ("MDS Coordinator A"), whose electronic signature was in the modifications in the Federal database. MDS Coordinator A stated that based on information from Facility A staff members who were familiar with Resident A, the prior MDS coding entries for Resident A had been filed in error.

20. According to Facility A Regional Director of Operations, the original MDS coding entries for Resident A were reviewed as part of Facility A's response to the annual survey deficiency citation. Thereafter, the Respondent instructed MDS Coordinator A to modify the MDS coding for Resident A.

21. On or about August 31, 2016, a member of the Board's staff interviewed MDS Coordinator A under oath.
22. On or about September 9, 2016, a member of the Board's staff interviewed the Respondent under oath.
23. The Respondent stated that she did not have access to the Federal database for MDS coding; only MDS Coordinator A had access to the database.
24. The Respondent also stated that she met with Facility A management and the decision was made to change MDS coding entries.
25. The Respondent further acknowledged that she instructed the MDS Coordinator to modify the original MDS entries for Resident A.

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 of the Act and COMAR: Health Occ. I § 9-314(b)(8) Willfully makes or files a false report or record in the practice of nursing home administration; Health Occ. I § 9-314(b)(11) Commits an act of unprofessional conduct in the licensee's practice as a nursing home administrator; and COMAR 10.33.01.15A(4).

ORDER

It is, on the affirmative vote of a majority of the quorum of the Board, hereby:

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

ORDERED that the Respondent is placed on **PROBATION** for a minimum period of **EIGHTEEN MONTHS**.² During the probationary period, the Respondent shall comply with all of the following probationary terms and conditions:

1. Within **SIX (6) MONTHS**, the Respondent shall successfully complete a Board-approved course in professional ethics. The course may not be used to fulfill the continuing education credits required for license renewal. The Respondent must provide documentation to the Board that the Respondent has successfully completed the course; and

2. The Respondent shall comply with the Maryland Nursing Home Administrators Act, Health Occ. I §§ 9-101 *et seq.*, and all laws and regulations governing the practice of nursing home administration in Maryland.

AND IT IS FURTHER ORDERED that if the Board determines, after notice and an opportunity for a hearing before the Board, that Respondent has failed to comply with any term or condition of this Consent Order, the Board may reprimand Respondent, place Respondent on probation with appropriate terms and conditions, or suspend or revoke Respondent's license to practice nursing home administration in Maryland. The Board may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine upon Respondent; and it is further

ORDERED that after eighteen (18) months, the Respondent may submit a written petition to the Board requesting termination of probation. After consideration of the petition, the probation may be terminated by an order of the Board. The Respondent may be required to appear before the Board to discuss her petition for

² If Respondent's license expires while the Respondent is on probation the probationary period and any probationary conditions will be tolled.

termination. The Board will grant the petition to terminate the probation if the Respondent has complied with all of the probationary terms and conditions and there are no pending complaints related to the charges; and it is further

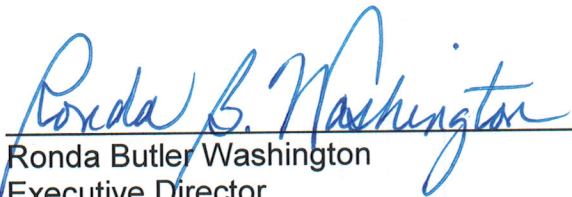
ORDERED that unless stated otherwise in the order, any time period prescribed in this order begins when the Consent Order goes into effect. The Consent Order goes into effect upon the signature of the Board's Executive Director, who signs on behalf of the Board; and it is further

ORDERED that the Respondent shall not apply for early termination of probation; and it is further

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

ORDERED that this Consent Order is a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., Gen. Prov. §§ 4-101 *et seq.* (2014).

9/13/2017
Date


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

CONSENT

I, Joyce Daniels Jones, 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 my right to appeal any adverse ruling of the Board that might have followed any such hearing.

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.

8/11/2017
Date

Joyce Daniels Jones
Joyce Daniels Jones, N.H.A.
Respondent

Read and approved:

Laurence B. Russell
Laurence B. Russell, Esquire
Counsel for Ms. Jones

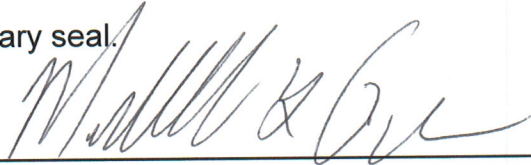
NOTARY

STATE OF Maryland

CITY/COUNTY OF Montgomery

I HEREBY CERTIFY that on this 11th day of August 2017,
2017, before me, a Notary Public of the foregoing State and City/County, did personally
appear Joyce Daniels Jones, and made oath in due form of law that signing the
foregoing Consent Order was her voluntary act and deed.

AS WITNESSETH my hand and notary seal.



Notary Public

My commission expires: June 26, 2020

