

IN THE MATTER OF
BELEN C. POLICARPIO

Respondent,

License No.: R1035

* BEFORE THE MARYLAND
* STATE BOARD OF
* EXAMINERS
* OF NURSING HOME
* ADMINISTRATORS
* CASE NUMBER: 2018-002

* * * * *

PRE-CHARGE CONSENT ORDER

The Maryland State Board of Examiners of Nursing Home Administrators (the “Board”) voted to charge **BELEN C. POLICARPIO**, N.H.A., with violations under the Maryland Nursing Home Administrators Licensing Act (the “Act”), codified at Md. Code Ann., Health Occ. (“Health Occ.”) §§ 9-101 *et seq.* (2014 Repl. Vol. & 2018 Supp.).

The pertinent provisions of the Act are as follows:

§ 9-314. Investigations: grounds for reprimands, suspensions, revocation, and fines.

(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 Code of Maryland Regulations (“COMAR”) 10.33.01.15 provide as follows:

(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 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 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;

Pursuant to COMAR 10.33.01.15(A)(1) and (2), the pertinent provisions of 42 C.F.R. § 483.25, NFPA Title 99, and NFPC Title 101 provide as follows:

42 C.F.R. § 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--

....

- (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

NFPA Title 99. Health Care Facilities Code.

11.5.1.1.1 Smoking materials (e.g. matches, cigarettes, lighter, lighter fluid, tobacco in any form) shall be removed from patients receiving respiratory therapy.

11.5.1.1.2 When a nasal cannula and its associated supply tubing are delivering oxygen outside of a patient care space, no sources of open flame shall be permitted in the site of intentional expulsion.

NFPC Title 101 Life Safety Code.

19.7.4 Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions:

- (1) Smoking shall be prohibited in any room, ward or individual enclosed space where flammable liquid, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.
- (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.
- (3) Smoking by patients classified as not responsible shall be prohibited.
- (4) The requirement of 19.7.4.(3) shall not apply where the patient is under direct supervision.
- (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.

- (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.

FINDINGS OF FACT

The Board makes the following Findings of Fact:

1. On or about January 16, 1992, the Board issued the Respondent a license to practice as a Nursing Home Administrator (“NHA”), license number R1035. The Respondent’s NHA license is due to expire on January 15, 2020.
2. At all times relevant hereto, the Respondent was the NHA of a long-term care facility located in Montgomery County, Maryland (the “Facility”). As NHA, the Respondent was responsible for ensuring, among other things, that the patients remained safe.
3. On or about July 20, 2017, the Board received a report of a complaint survey of the Facility conducted by the Office of Health Care Quality (“OHCQ”). According to the complaint, OHCQ conducted a Quality Indicator Medicare/Medicare Recertification Survey (“Survey”) of the Facility in June 2017.
4. The OHCQ survey report revealed the following:

Resident A

- a. Resident A was admitted to the Facility in the beginning of June 2017, but was not on the Facility’s current list of smokers. On June 19, 2017, the OHCQ Surveyor observed, Resident A, an oxygen dependent resident, smoking in the outside designated smoking area with his/her portable oxygen tank next to him. Resident A did remove his/her nasal cannula when smoking. Resident A kept all his smoking materials, including lighter and cigarettes, at Resident A’s bedside. The Facility

had no documentation indicating that a safe smoking assessment or a care plan related to safety regarding oxygen and smoking was completed for Resident A.

Resident B

- b. Resident B had a smoking assessment which assessed the resident as high-risk and determined that the resident was a dependent smoker under the Facility's policy. Resident B was required to "utilize [a] smoking apron if indicated"; and was allowed to smoke "only in designated smoking areas." Resident B's care plan was not revised to include interventions after Resident B was found smoking in his room on or about January 5, 2017.
- c. On June 20, 2017, the Surveyor observed Resident B outside in the smoking area, unsupervised. Resident B discarded his lit cigarette by throwing it into a grassy area in the smoking area. Resident B's pants had burn holes in them and the resident was not wearing a smoking apron. Resident B said the burn holes in his clothing were from a time when he was taking a different medication and kept falling asleep while smoking. Resident B said he no longer takes that medication. Resident B returned to his room with his smoking materials.

Resident C

- d. Resident C's November 17, 2016 Plan of Care included the following safe smoking interventions: returning smoking materials to the nurses' station, accompanying Resident C, and remaining with the dependent smoker during smoking breaks.
- e. On March 18, 2017, Resident C observed outside in the smoking area with a burned spot on the out layer of his gown. On March 19, 2017, a safe smoking evaluation was completed for Resident C deeming Resident C a dependent smoker and requiring the resident be supervised, provided a smoking apron when he smoked, and kept all smoking materials at the nurse's station.
- f. Resident C's records indicate that on May 4, 2017, other residents notified a Facility licensed practical nurse ("LPN") that Resident C was in the smoking area and Resident C's clothes were on fire. Resident C refused to remove his clothes and the LPN and staff member had to forcefully remove Resident C's burning gown. The LPN documented that Resident C's mental state was "confused."

There was no documentation to indicate that any Facility staff were present at the time of the incident in the smoking area.

- g. After the second incident in which Resident C's clothes were on fire, there was no documentation to indicate that a reevaluation of Resident C's safe smoking plan was completed.

Resident D

- h. The Nursing Notes for Resident D indicate that Resident D was found smoking in his room on four separate occasions on May 28, 2017, May 29, 2017, June 2, 2017, and June 6, 2017. According to the Notes, Resident D was identified as a high-risk smoker and educated by staff regarding the hazards of having a lit cigarette in his room and endangering himself and other residents.

5. By letter dated July 20, 2017, OHCQ notified the Respondent that conditions at the Facility posed immediate jeopardy to the health and safety of the residents. According to the Survey, the Facility "failed to ensure that residents were free from accident hazards when residents who were assessed as high-risk for smoking hazards put residents at increased risk for serious harm from fire."

6. According to the Survey dated June 29, 2017, the "immediate jeopardy" was abated on June 20, 2017 at 9:00 p.m. following the Facility's implementation of corrective actions to ensure the health and safety of all residents who were at risk for serious harm from fire. According to the Facility's Plan of Correction, Residents A, B, and C had their care plans and assessments updated to address the dangers of unsafe smoking and the residents were counseled on the Facility's smoking policy and requirements for supervision.¹ In addition, the Facility instituted several interventions which included: creating a schedule to ensure proper supervision occurred in the smoking area for any resident requiring supervision;

¹ As of the date the Plan of Correction was completed, Resident D no longer resided at the Facility.

securing the smoking area door to ensure unsafe smokers would not be able to gain access to the area without supervision; having the Administrator physically assess the smoking area twice per shift to ensure unsafe smokers were supervised; and, having the Director of Nursing conduct weekly reviews of smoking patients' charts, monthly audits of safe smoking procedures, and forwarding results of the audits to the Quality Assurance Committee.

BOARD INVESTIGATION

7. Based upon the survey complaint, the Board initiated an investigation.
8. On June 20, 2018, the Board Investigator interviewed the Respondent. During the interview, the Respondent stated the following:
 - a. She worked at the Facility as the NHA from December 2016 to October 2017. She was terminated from the Facility due to budget cuts.
 - b. In February 2017, before the OHCQ Survey, she implemented environmental rounds in which department managers check each room daily for dirty clothes, cigarette lighters, knives, everything.
 - c. At the time of the June 2017 OHCQ Survey, the Facility did not have smoking aprons. She obtained the smoking aprons after the survey was done. Residents were required to go to the front desk and request an apron. The front desk receptionist had a book that had the list of residents required to wear the smoking apron.
 - d. Resident A was alert, oriented and on oxygen. At the time of the Survey, Resident A smoked with the oxygen, but the "nasal cord" [*sic*] was disconnected. One of the nurses advised Resident A that he should not be taking his oxygen tank with him when he smoked. They put signs in his room that said, "No smoking when oxygen is on." She doesn't know why Resident A had his smoking materials at his bedside because that was not the Facility policy. She doesn't know why Resident A was not on the Facility's list of resident smokers.

- e. Resident B would leave the Facility on his own. He refused to wear the apron and refused to change his clothes. He had the right to refuse. He was alert and oriented, so he didn't have to be supervised in the smoking area.
- f. Resident C was a dependent smoker and very combative. She was not at the Facility at the time Resident C caught his clothes on fire. She didn't know how Resident C obtained the cigarettes or lighter.
- g. Resident D was alert and oriented. Resident D's roommate reported to the nurses that Resident D was smoking in his room.² Resident D probably obtained the cigarettes and lighter from a family member. A social worker told Resident D's family that the resident could be discharged from the Facility for smoking in his room.
- h. The Facility's policy for a resident's first offense of smoking in his room was to give the resident notice of violation of the policy. On a second offense, a meeting with the resident's family was to be held to go over the resident's care plan. If a third incident occurred, a resident was to be given a 30-day notice that if the behavior continues the resident will be discharged. If a fourth incident occurred, the resident had a right to appeal the decision made to discharge.

CONCLUSIONS OF LAW

Based on the foregoing facts the Board concludes as a matter of law that the Respondent failed to substantially meet the standards of practice adopted by the Board under Health Occ. § 9-205, in violation of Health Occ. § 9-314(b)(3).

In addition, the Board concludes as a matter of law that the Respondent violated the following regulations: 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, in violation of COMAR 10.33.01.15A(1); Has violated any of the provisions of the law or

² Resident D was found to be smoking in his room on 4 separate dates between May 28, 2017 and June 6, 2017.

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, in violation of COMAR 10.33.01.15A(2), specifically 42 C.F.R. § 483.25(d)(2), NFPA 99 Health Care Facilities Code § 11.5.1.1.1 and § 11.5.1.1.2, and NFPC 101 Life Safety Code § 19.7.4; Has endangered or sanctioned the endangerment of the safety, health, and life of any patient, in violation of COMAR 10.33.01.15A(9); and, 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, in violation of COMAR 10.33.01.15A(10).

ORDER

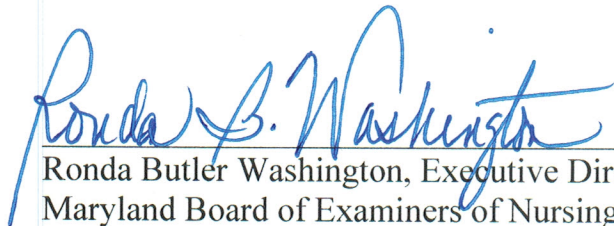
Based on the foregoing Findings of Fact and Conclusions of Law, it is, by the Board, hereby:

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

ORDERED that this Consent Order becomes effective upon the date of the signature of Ronda Butler Washington, Executive Director of the Board, who signs on behalf of the Board; and it is further

ORDERED that this Consent Order is a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., Gen. Prov. §§ 4-333 *et seq.* (2014).

9/18/2019
Date

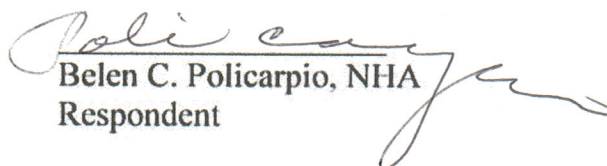

Ronda Butler Washington, Executive Director
Maryland Board of Examiners of Nursing Home
Administrators

CONSENT

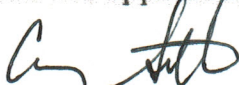
I, **BELEN C. POLICARPIO**, Respondent, by affixing my signature hereto, acknowledge that:

1. I am aware that I am entitled to be represented by counsel, and I have knowingly agreed to waive my right to counsel in this matter. I have knowingly and voluntarily agreed to enter into this Consent Order. By this Consent and for the purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.
2. I am aware that I am entitled to a formal evidentiary hearing pursuant to Md. Code Ann., Health Occ. § 9-315 (2014 Repl. Vol. & 2018 Supp.) and Md. Code Ann. State Gov't §§ 10-201 *et seq.* (2014 Rep. Vol.).
3. I acknowledge the validity and enforceability of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have 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.
4. I voluntarily enter into and agree by the terms and conditions set for the herein as a resolution of the case against me. I waive any right to contest the Findings of Fact and Conclusions of Law, and I waive my right to a full evidentiary hearing, as set forth above, and any right to appeal this Consent Order or any adverse ruling of the Board that might have followed any such hearing.
5. I sign this Consent Order voluntarily, without reservation, and fully understand and comprehend the language, meaning, and terms of this Consent Order.

9-11-2019
Date


Belen C. Policarpio, NHA
Respondent

Read and approved:


Cory Silkman, Esquire
Counsel for Ms. Policarpio

NOTARY

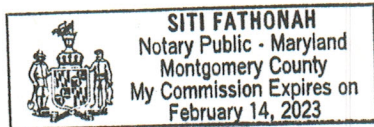
STATE OF: MARYLAND

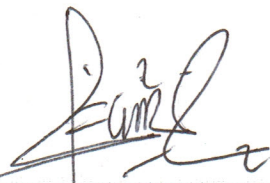
CITY/COUNTY: BETHESDA / MONTGOMERY

I HEREBY CERTIFY that on this 11th day of SEPTEMBER,
2019 before me, Notary Public of the State and City/County aforesaid, **BELEN C. POLICARPIO**, Respondent, personally appeared, and made oath in due form of law that signing the foregoing Pre-Charge Consent Order was the voluntary act and deed of **BELEN C. POLICARPIO**.

AS WITNESSETH, my hand and notarial seal.

SEAL





Notary Public

My Commission Expires: _____