

IN THE MATTER OF * **BEFORE THE**
VINITTA L. RUSSELL, N.H.A. * **MARYLAND STATE**
License No. R1117 * **BOARD OF EXAMINERS OF**
Respondent * **NURSING HOME ADMINISTRATORS**
* **Case Number: 2010-003**

* * * * *

CONSENT ORDER

PROCEDURAL BACKGROUND

On June 15, 2011, the Maryland State Board of Examiners of Nursing Home Administrators (the "Board") charged **VINITTA L. RUSSELL, N.H.A.** (the "Respondent"), License Number R1117, with violating certain provisions of the Maryland Nursing Home Administrators Licensing Act ("the Act"), Md. Health Occ. Code Ann. §§ 9-101 *et seq.* (2009 Repl. Vol. and 2010 Supp.) and Code of Maryland Regulations ("COMAR") tit. 10, § 33.01.15 and COMAR 10.07.09.08.

Specifically, the Board charged the Respondent with violating the following provisions of the Act:

H.O. § 9-314

(b) *Grounds for reprimands, suspensions, revocations, and fines.* -- Subject to the hearing provisions of § 9-315 of this subtitle, the Board may . . . reprimand any licensee . . . place any licensee . . . on probation, suspend or revoke a license . . . 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;

H.O. § 9-205

(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;
(b) *Duties.* -- In addition to the duties set forth elsewhere in this title, the Board shall:

- (2) Adopt standards for:
 - (ii) Practice of licensees.

The Board also charged the Respondent with violating the following COMAR provisions:

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 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 homes;
- (9) Has endangered or sanctioned the endangerment of the safety, health, and life of any patient; [and]
- (10) Has failed to oversee and facilitate the nursing facilities quality improvement processes to the extent that the safety, health, or life of any patient has been endangered[.]

COMAR 10.07.09.08

C. A resident has the right to:

- (2) Receive treatment, care, and services that are in an environment that promotes maintenance or enhancement of each resident's quality of life.

On August 4, 2011, a Case Resolution Conference was convened in this matter. Based on negotiations occurring as a result of this Case Resolution Conference, the Respondent agreed to enter into this Consent Order, consisting of Procedural Background, Findings of Fact, Conclusions of Law, Order, Consent, and Notary.

FINDINGS OF FACT

The Board finds the following:

1. At all times relevant hereto, the Respondent was and is licensed to practice as a nursing home administrator (“NHA”) in the State of Maryland. The Respondent was originally licensed by the Board on September 22, 1993, under License Number R1117.

2. At all times relevant hereto, the Respondent was employed as the NHA at the Ravenwood Nursing and Rehabilitation Center (“Ravenwood”), a nursing home and rehabilitation center located at 501 West Franklin Street, Baltimore, Maryland 21201. The Respondent reportedly became the NHA at Ravenwood in or around December 2009.

3. The Board initiated an investigation of the Respondent after reviewing a complaint about an incident that occurred over the July 4, 2010, weekend at Ravenwood, when the building’s air conditioning system failed, causing high temperatures within the building and the evacuation of its residents.

4. Prior to the weekend of July 4, 2010, staff persons at Ravenwood, including the director of maintenance, notified the Respondent that the building’s air conditioning system had been in need of repair for some time. Two of the four air conditioning compressors at Ravenwood had been inoperable since September 2009; as of June 2009, the cooling tower had only one functional pump instead of two; and one of two pumps from the water circulating system was inoperable and in need of replacement.

5. Weather forecasts for the Baltimore metropolitan area for the July 4, 2010, weekend predicted temperatures reaching into the upper 90s to low 100s Fahrenheit.

6. The Respondent completed her workday at Ravenwood on Friday, July 2, 2010, at approximately 6:00 p.m. The Respondent was not scheduled to work during the weekend (Saturday, July 3, 2010, and Sunday, July 4, 2010) or Monday, July 5, 2010, a federal holiday.

6. Sometime during the July 4, 2010, weekend, the building's air conditioning system began to fail, resulting in high temperatures in the building. Staff persons at Ravenwood noticed the elevation in the building's temperature and attempted to notify the Respondent of this situation. Beginning on July 4, 2010, several staff persons at Ravenwood attempted to contact the Respondent through telephone calls, electronic mail or text messages to inform her that the building was getting hot, or that the air conditioning system was either not functioning or not cooling the building sufficiently.

7. On Sunday, July 4, 2010, at approximately 10:30 a.m., the corporate director of operations sent the Respondent an electronic mail message, informing her that the air conditioning system at Ravenwood was not operating. The Respondent did not retrieve this electronic mail message during this weekend, however.

9. On July 4, 2010, in the early afternoon, the Director of Nursing ("DON") at Ravenwood contacted the Respondent by text message and informed her that the building administrator had warned her that the building was hot. The DON ordered the placement of fans and additional hydration for the residents. The DON also attempted to contact the Respondent by cellular telephone to inform her of the increasing temperature in the building at approximately 2:59 p.m., without success.

10. On July 4, 2010, during the afternoon, the director of maintenance informed the Respondent by telephone that the building was “too hot” and that he had concerns about the functioning of the air conditioning system. The director of maintenance requested that the Respondent authorize him to call in a contractor to address the situation. The Respondent authorized the director of maintenance to contact an air conditioning contractor to repair the system.

11. The Respondent did not appropriately follow up on this information at that time.

12. On July 5, 2010, during the late evening hours, a resident of Ravenwood telephoned 911 and reported that the building was too hot and that as a result, the resident was having breathing difficulties. Baltimore City Fire Department and emergency medical services (“EMS”) personnel responded to the call at approximately 11:30 p.m., and treated the resident. Fire department personnel notified the Maryland State Office of Health Care Quality (“OHCCQ”) about the conditions at Ravenwood.

13. Ravenwood staff persons contacted the Respondent and notified her that a resident had called 911 and that fire department and EMS personnel were at the facility to investigate the high temperatures in the building.

14. The Respondent arrived at Ravenwood at approximately 1:30 a.m. on Tuesday, July 6, 2010, and acknowledged that the air conditioning system was “completely down” and that the building’s temperature was “excessive.” The Respondent met with the responding fire department and EMS personnel and at about 4:30 a.m. to 5:00 a.m., placed portable air conditioners on the third and fourth floors of the building. The Respondent ordered the transfer of the residents to the first floor of the building, which had

a functioning air conditioning system that was separate and apart from the system that controlled the rest of the building.

15. OHCQ surveyors arrived at Ravenwood on the morning of July 6, 2010, for purposes of conducting an on-site investigation of the facility. At about 9:30 a.m., the surveyors measured the temperature in the residents' areas on the third and fourth floors as being between 90 and 94 degrees Fahrenheit, even after the portable air conditioning units had been installed and were running for approximately four hours.

16. OHCQ surveyors inspected other areas of the building, including the kitchen areas. At about 10:00 a.m., they inspected the refrigeration units in the kitchen and found that the door to the walk-in refrigerator was propped open with a food cart. The thermometer for the unit registered 60 degrees Fahrenheit. Refrigeration units typically must be maintained at 41 degrees Fahrenheit to reduce the risk of food borne illness. See COMAR 10.15.03.06B(7). At that time, the dietary manager checked the temperatures of various prepared foods in the refrigerator. A container of macaroni salad was 46 degrees Fahrenheit and one containing chicken salad was 48 degrees Fahrenheit. The dietary manager voluntarily discarded these foods.

16. OHCQ surveyors interviewed various staff persons at Ravenwood, who stated that "no air temperature readings from the weekend through July 6, 2010, were known by the nursing Supervisors, DON (director of nursing), ADON (assistant director of nursing), or NHA and that with the exception of the refrigerator monitors, no other thermometers were present in the resident areas." Ravenwood staff persons further stated that as of July 4, 2010, the Respondent had been informed by telephone that the building was hot and that a building maintenance employee was not able to fix the air conditioning

system, which required contacting an outside contractor to address the problem. A licensed practical nurse at Ravenwood stated that during the morning of July 5, 2010, it got “really hot,” and a nursing Supervisor stated that when she entered the building at 3:00 p.m., it was hot.

17. OHCQ coordinated an evacuation plan with the Respondent and other staff persons at Ravenwood beginning on the afternoon of July 6, 2010. The evacuation was completed by the late evening of July 7, 2010. Approximately 150 residents were transferred in the evacuation.

18. During the July 4, 2010, weekend, at a time when temperatures were predicted to reach the high 90s to low 100s Fahrenheit, the air conditioning system at Ravenwood failed, resulting in extremely high temperatures and unhealthy living conditions, which required the forced evacuation and relocation of the residents of Ravenwood.

19. Well before the July 4, 2010, the Respondent was aware that the air conditioning system at Ravenwood was in a state of disrepair. The Respondent was also aware that the temperature forecast for the July 4, 2010, weekend called for temperatures in the upper 90s to low 100s Fahrenheit. The Respondent failed to assure that the building’s air conditioning system was in full working order prior to the summer season of 2010. The Respondent failed to develop a plan with the nursing and plant maintenance personnel to monitor and assess the building temperatures and conditions during the July 4, 2010, weekend. The Respondent failed to provide for early implementation of an alternative cooling system, if needed. The Respondent failed to prepare and plan for resident comfort and safety in the event of increasing air temperatures in the resident care

areas. The Respondent failed to respond in a timely and appropriate manner when placed on notice that the building temperatures were escalating to high levels. The OHCQ surveyors found that “failure to plan for the probability of high temperatures in the resident care areas due to the faulty cooling system and area temperatures lead to an urgent and unplanned evacuation of 150 residents on July 6, 2010”

20. The OHCQ survey determined that the facility administration, which the Respondent headed, failed to comply with governing regulations for maintaining equipment in a manner that protected the health and safety of the residents; and failed to adequately assess and monitor the environmental conditions inside Ravenwood on July 4 and 5, 2010, until a resident contacted emergency services. The Respondent’s failure to appropriately respond to the loss of air conditioning at Ravenwood endangered the nursing home’s residents.

21. The OHCQ survey stated that the Respondent violated the following COMAR health regulations: COMAR 10.07.02.07A(1) and (2); COMAR 10.07.02.26R; COMAR 10.07.02.34B(1); COMAR 10.07.09.08A; COMAR 10.07.09.08C(1) and (2); and/or COMAR 10.15.03.06B(7).

ALLEGATIONS REGARDING VIOLATIONS OF THE TITLE AND RELATED REGULATIONS

22. The Respondent’s actions, as described above, constitute a violation of H.O. § 9-314(3): Otherwise failing to meet substantially the standards of practice adopted by the Board under § 9-205 of this title.

23. The Respondent’s actions, as described above, constitute violations the following provisions of COMAR: COMAR 10.33.01.15A(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; COMAR 10.33.01.15A(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; COMAR 10.33.01.15A(9), Has endangered or sanctioned the endangerment of the safety, health, and life of any patient; COMAR 10.33.01.15A(10), Has failed to oversee and facilitate the nursing facilities quality improvement processes to the extent that the safety, health, or life of any patient has been endangered; COMAR 10.07.09.08C, A resident has the right to: (2) Receive treatment, care, and services that are in an environment that promotes maintenance or enhancement of each resident's quality of life.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent failed to meet substantially the standards of practice adopted by the Board under § 9-205 of this title, in violation of H.O. § 9-314(b)(3).

In addition, the Board concludes as a matter of law that the Respondent violated the following COMAR regulations: COMAR 10.33.01.15A(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; COMAR 10.33.01.15A(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; COMAR 10.33.01.15A(9), Has endangered or sanctioned the endangerment of the safety, health, and life of any patient; COMAR 10.33.01.15A(10), Has

failed to oversee and facilitate the nursing facilities quality improvement processes to the extent that the safety, health, or life of any patient has been endangered; COMAR 10.07.09.08C, A resident has the right to: (2) Receive treatment, care, and services that are in an environment that promotes maintenance or enhancement of each resident's quality of life.

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, it is this 14th day of September, 2011, by a quorum of the Board considering this case:

ORDERED that the Respondent's license to practice as a nursing home administrator shall be **SUSPENDED** for a period of **THREE (3) MONTHS**, to commence on the date the Board executes this Consent Order; and it is further

ORDERED that after the conclusion of the entire **THREE (3) MONTH** period of **SUSPENSION**, the Board will issue an order lifting the suspension of the Respondent's license; and it is further

ORDERED that the Respondent shall be placed on **PROBATION** for a minimum of **THREE (3) YEARS**, to commence on the date the Board lifts the suspension of the Respondent's license, and continuing until she satisfactorily complies with the following terms and conditions:

1. Within **one (1) year** of the date of the Consent Order, the Respondent shall enroll in and successfully complete, at her own expense, comprehensive, Board-approved classroom courses in: (a) resident rights/advocacy; (b) quality assurance/management involving nursing homes; and (c) emergency preparedness. The Respondent shall submit the course descriptions and course curricula to the Board for its approval prior to enrolling

in these courses. The Board reserves the right to reject any of the course(s) the Respondent proposes and may, in its discretion, require additional information about any course(s) the Respondent proposes. The Respondent shall be solely responsible for furnishing the Board with adequate written verification that she has successfully completed each course according to the terms set forth herein. The Respondent may not apply any continuing education credits earned through taking any of these courses to satisfy any continuing education requirements that are mandated for licensure renewal in this State.

2. In the event the Respondent is employed as a nursing home administrator at any time during the probationary period, her practice shall be supervised, at her own expense, by a Board-approved supervisor who is licensed to practice as a nursing home administrator in the State of Maryland, subject to the following terms and conditions:

- (a) The Respondent shall submit in writing the name of a proposed supervisor to the Board for the Board's approval prior to beginning the supervisory arrangement. The proposed supervisor shall have no prior personal, professional, or financial relationship with the Respondent. The Board reserves the right to reject the supervisor the Respondent proposes and may, in its discretion, require additional information about any supervisor the Respondent proposes as fulfillment of this condition.
- (b) The Respondent shall provide the supervisor with copies of this Consent Order and shall authorize the Board to provide any other documents to the supervisor that it deems relevant for purposes of supervision. The Respondent shall be responsible for assuring that the supervisor notifies the Board in writing of his/her acceptance of the supervisory role of the

Respondent.

- (c) While the Respondent is employed as a nursing home administrator during the probationary period, the supervisor shall meet with the Respondent at the facility where she is employed at least once per month for the duration of her probation. During these meetings, the supervisor shall review and discuss with the Respondent, subject matter including but not limited to: (i) the operations of all departments, including any staffing issues and shortages; (ii) quality assurance programs and procedures; (iii) resident care; and (iv) complaints of residents and family members.
 - (d) The Respondent shall be responsible for assuring that the supervisor submits written quarterly reports to the Board. These quarterly reports shall include, but are not limited to, a discussion of: (i) facility maintenance issues; (ii) quality assurance programs and procedures; (iii) resident care; and (iv) any other issues the supervisor determines is significant to report to the Board.
 - (e) The Respondent shall make no changes to the terms and conditions of the supervisory requirements set forth in subparagraphs (a)-(d) above without prior Board approval. The Board has sole authority to approve a change of the supervisor or a change in the terms and conditions of the supervisory arrangement.
3. The Respondent shall not serve as a preceptor in the administrator-in-training program.
 4. The Respondent shall practice according to the Maryland Nursing Home

Administrators Licensing Act and in accordance with all applicable laws, statutes, and regulations pertaining to the practice of nursing home administration.

5. The Respondent shall not petition the Board for early termination of probation or any of the terms and conditions of the Consent Order.

AND BE IT FURTHER ORDERED that after the conclusion of the entire **THREE (3) YEAR** period of **PROBATION**, and provided the Respondent has satisfactorily complied with all of the terms and conditions of probation and the Consent Order, the Respondent may submit to the Board a written petition requesting that her probationary status be terminated. Before making a decision on the Respondent's petition for termination of probation, the Board may, in its discretion, require that the Respondent personally appear before the full Board, or a panel of the Board, for the purpose of determining whether she has satisfactorily complied with all of the terms and conditions of the Consent Order and whether her probation should be terminated; and it is further

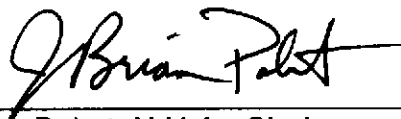
ORDERED that if the Respondent violates any of the terms and conditions of probation and/or of this Consent Order, the Board, in its discretion, after notice and opportunity for a hearing, may impose any sanctions the Board may impose under Md. Health Occ. Code Ann. §§ 9-314 and 9-314.5 of the Maryland Nursing Home Administrators Licensing Act, including but not limited to, reprimand, additional probation, suspension, revocation and/or monetary fine; and it is further

ORDERED that the Respondent shall be responsible for all costs incurred to comply with this Consent Order; and it is further

ORDERED that this Consent Order shall be a public document pursuant to Md. State Gov't Code Ann. § 10-611 *et seq.* (2009 Rep. Vol. and 2010 Supp.).

Date

9/14/2011



J. Brian Pabst, N.H.A., Chair
State Board of Examiners of
Nursing Home Administrators

CONSENT

I, Vinitta L. Russell, N.H.A., acknowledge that I have had the opportunity to consult with counsel before signing this document. I have reviewed the Findings of Fact and Conclusions of Law, and 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 and Conclusions of Law.

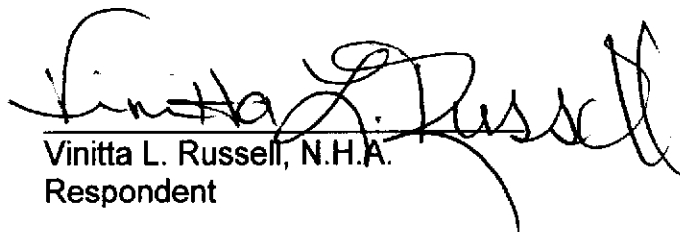
I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections 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.

Date

8/8/11



Vinitta L. Russell, N.H.A.
Respondent

NOTARY PUBLIC

STATE OF Maryland

CITY/COUNTY OF: Baltimore

I HEREBY CERTIFY that on this 8th day of August, 2011, before me, a Notary Public of the State and County aforesaid, personally appeared Vinita L. Russell, N.H.A., and gave oath in due form of law that the foregoing Consent Order was her voluntary act and deed.

AS WITNESS, my hand and Notary Seal.

Aldella Juanita Prince-Mwamba
Notary Public
(Aldella Juanita Prince-Mwamba)

06/24/2013

My commission expires: _____

