IN THE MATTER OF	*	**BEFORE THE STATE**
LINDA ASHDOWN, P.T.	*	**BOARD OF PHYSICAL**
LICENSE NO. 15450	*	**THERAPY EXAMINERS**
Respondent	*	**CASE NO.: 05-BP-458**

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FINAL CONSENT ORDER

Based on information received and a subsequent investigation by the State Board of Physical Therapy Examiners (the "Board"), and subject to Md. Health Occ. Code Ann. § 13-101, et seq., (2000 Repl. Vol.) (the "Act"), the Board charged Linda Ashdown, P.T., (the "Respondent"), with violations of the Act. Specifically, the Board charged the Respondent with violation of the following provisions of Md. Health Occ. Code Ann. § 13-316:

> Subject to the hearing provisions of § 13-317 of this subtitle, the Board may deny a license, temporary license, or restricted license to any applicant, reprimand any licensee or holder of a temporary license or restricted license, place any licensee or holder of a temporary license or restricted license on probation, or suspend or revoke a license, temporary license, or restricted license if the applicant, licensee, or holder:
>
> (15) Violates any provision of this title or rule or regulation adopted by the Board;
>
> (23) Provides professional services while:
> (i) Under the influence of alcohol;
>
> (25) Fails to meet accepted standards in delivering physical therapy or limited physical therapy care.

The Board also charged the Respondent with violating Code Md. Regs. tit. 10, § 38.03.02-1A (March 18, 2002):

.02-1 Requirements for Documentation.

A. The physical therapist shall document legibly the patient's chart each time the patient is seen for:

(1) The initial visit, by including the following information:

(a) Date;
(b) Condition, or diagnosis, or both, for which physical therapy is being rendered;
(c) Onset;
(d) History, if not previously recorded;
(e) Evaluation and results of tests (measurable and objective data);
(f) Interpretation;
(g) Goals;
(h) Modalities, or procedures, or both, used during the initial visit and the parameters involved including the areas of the body treated;
(i) Plan of care including suggested modalities, or procedures, or both, number of visits per week, and number of weeks; and
(j) Signature, title (PT), and license number.

(2) Subsequent visits, by including the following information (progress notes):

(a) Date;
(b) Cancellations, no-shows;
(c) Subjective response to previous treatment;
(d) Modalities, or procedures, or both, with any changes in the parameters involved and areas of body treated;
(e) Objective functional status;
(f) Response to current treatment;
(g) Continuation of or changes in plan of care; and
(h) Signature, title (PT), and license number, although the flow chart may be initialed.

(3) Reevaluation, by including the following information in the report, which may be in combination with visit note, if treated during the same visit:

(a) Date;

(b) Number of treatments;
(c) Reevaluation, tests, and measurements of areas of body treated;
(d) Changes from previous objective findings;
(e) Interpretation of results;
(f) Goals met or not met and reasons;
(g) Updated goals;
(h) Plan of care including recommendations for follow-up; and
(i) Signature, title (PT), and license number;

(4) Discharge, by including the following information in the discharge summary, which may be combined with the final visit note, if seen by the physical therapist on the final visit and written by the physical therapist:

(a) Date;
(b) Reason for discharge;
(c) Objective functional status;
(d) Recommendations for follow-up; and
(e) Signature, title (PT), and license number.

B. Notwithstanding §A (4) of this regulation, a physical therapist may direct a physical therapist assistant to treat a patient on a final visit.

C. The physical therapist assistant shall document the patient's chart each time the patient is seen by the physical therapist assistant following the physical therapist's initial evaluation or reevaluation by including the following:

(1) Date;

(2) Cancellations and no-shows;

(3) Subjective response to previous treatment;

(4) Modalities, procedures, or both, including parameters involved, and areas of body treated;

(5) Objective functional status;

(6) Response to treatment;

(7) Continuation of plan as established by the physical therapist or change of plan as authorized by the physical therapist; and

(8) Signature, title (PTA), and license number, although the flow chart may be initialed.

The Respondent was given notice of the issues underlying the Board's charges by a letter dated June 21, 2006. Accordingly, a Case Resolution Conference was held on July 20, 2006, and was attended by Jill Kuramoto, P.T. and Shirley Leeper, PTA, Board members, Ann Tyminski, Executive Director of the Board, and Linda Bethman, Counsel to the Board. Also in attendance were the Respondent and her attorney, Kevin M. Tracy, and the Administrative Prosecutor, Roberta Gill, Assistant Attorney General.

Following the Case Resolution Conference, the parties and the Board agreed to resolve the matter by way of settlement. The parties and the Board agreed to the following:

FINDINGS OF FACT

1. At all times relevant to the charges herein, the Respondent was licensed to practice physical therapy in the State of Maryland. The Respondent was originally licensed by the Board on August 31, 1983. The Respondent's license expires on May 31, 2008.

2. At all times relevant hereto, the Respondent worked as a physical therapist for Adventist Rehabilitation Center in Silver Spring, Montgomery County, Maryland, an *outpatient facility*. The Respondent was employed there from October 2004 through February 2005.

3. By a document dated March 24, 2005, one of the Respondent's former co-workers at the Center, an Occupational Therapist, filed a complaint with the Board. The complaint documented instances where the Respondent appeared to be working with a

mental/professional impairment. As a result, the Board conducted an investigation which disclosed the following:

A. When the Respondent was first hired, her supervisor, a Physical Therapist ("Supervising P.T.") who worked out of another Adventist location, gave the Respondent an orientation for an hour or two on the first day and then left it up to the Complainant to show her how to process the work;

B. While working at Adventist, the Respondent had difficulties in understanding the processing of forms, specifically, Medicare 700 forms, and her completed forms had to be reviewed and corrected nearly seven times a day prior to acceptance;

C. On many occasions, the Respondent failed to sign progress notes or forms;

D. During the Respondent's first week, the Complainant notified the Supervisor that the Respondent did not comprehend the day-to-day tasks of delivering skilled care and performing correct documentation after seeing a patient;[1]

E. The Respondent failed to meet the standards for generating documentation of an evaluation within 48 hours. In addition, the Respondent failed to use a goniometer in order to ensure that her measurements on range of motion (ROM) were accurate. In fact, the Respondent failed to take ROM measurements but would put "WNL" for "within normal limits" or "WFL" for "within functional limits;"

[1] The complainant likened the performance of the Respondent to someone with Alzheimer's or some similar disorder in that she could not remember things and was not upset about having to make a lot of corrections.

F. On several occasions, the Respondent's co-workers, including the Complainant and a Physical Therapist ("Training P.T.") who had been sent over to the Center to help train the Respondent, smelled alcohol on the Respondent's breath. In addition, some patients also reported that they smelled alcohol on the Respondent's breath. The Complainant mentioned this to the Supervising Physical Therapist on two-three occasions, but the Supervising Therapist did nothing about it;

G. With regard to Patient A, the Respondent had inconsistent documentation in that she recorded excessive time in the facility though the documentation did not support the treatment that the patient said she was there for; for example, the Respondent wrote that Patient A was there for two and a half hours but the documentation did not reflect same. The Respondent also failed to use objective measures or objective goals regarding Patient A. Furthermore, Patient A was one of the patients that indicated that the Respondent had the smell of alcohol on her breath;

H. The Respondent also left Patient C with moist heating pads on his knees, but failed to use a timer. Consequently, Patient C asked the Complainant to take them off because they had been on him for 40 minutes and had become cold. The Respondent also had Patient C ride the bicycle and do total gym activities, when his orders were specifically for "no resistive activities." Patient C cancelled his subsequent visits, stating that he was wasting his co-pays and that the Respondent made him hurt more;

I. Patient C was discharged and returned for service; however, the Respondent failed to record any objective measures on the re-evaluation. The Training PT

observed the Respondent while she conducted the re-evaluation and noted that the Respondent failed to use the goniometer, but did a manual muscle test. When the Training PT asked the Respondent to use the goniometer, the Respondent did so with the patient lying on the mat while and she lay on the mat in the opposite direction—head-to-toe and vice versa. After struggling with the goniometer for a while, the Respondent went to her desk, picked up a magnifying glass in order to get the readings, which she failed to document in Patient C's chart. Consequently, the following session, the Training PT conducted a complete re-evaluation of Patient C;

J. Patient E also made statements regarding the Respondent's impairment;

K. The Respondent had documentation issues, with inconsistent supporting data, for what was done to Patient G, who stated that she "did not think that the Respondent is in a position to be working with others;"

L. The Respondent did not follow treatments consistent with current practices with spinal-cord patients, and her objective data was either lacking or incomplete; in addition, there were goals listed that had no measurable outcomes or relevance to what was documented in the evaluations;

M. The Respondent recorded incomplete evaluations: of 34 patients evaluated during one week, the Respondent only fully documented in two charts, with the other 32 in various stages of incompleteness;

N. The P.T. who was sent to train the Respondent stated that she smelled alcohol on the Respondent's breath all day on February 11, 2005; consequently,

the Training P.T. sent to the Supervising PT an email, and subsequently discussed her findings with the Supervising PT in detail;

O. The Respondent was reminded that she needed to take objective measurements at least once a week and that her treatment plan had to match her goals;

P. As a result of these deficiencies, the Respondent's probationary period was extended, and, on February 16, 2005, the Respondent was terminated from Adventist;

Q. When interviewed by a Board investigator, the Respondent denied that she was impaired or drank while at work; rather, she claimed what was smelled was Listerine on her breath. The Respondent also claimed that she had mastered the forms, documented everything and always used a tape measure or goniometer. Furthermore, the Respondent claimed that the time when she left the patient she was treating, she had gone upstairs to talk to the patient's therapist and informed the patient to ring a bell or yell if it was too hot for him;

4. As a result of the above, the Board directed the Respondent to obtain a psychological evaluation from Ralph D. Raphael, Ph.D. The Respondent had two sessions with Dr. Raphael, and she submitted a witnessed urine sample, which was tested for the presence of alcohol or drugs, which test was negative. Dr. Raphael also interviewed the Respondent's current employer and a therapist at the Kolmac clinic, an outpatient drug and alcohol treatment program. He also received discharge summaries from both that program, as well as from Father Martin's Ashley, an inpatient drug and alcohol treatment center, which the Respondent entered on March 18, 2005 and was discharged from a month later. Dr. Raphael administered a brief screening of neuropsychological function.

5. Dr. Raphael reported, *inter alia*, that from 1997-2004, the Respondent worked at VNA as a Staff Physical Therapist, where she provided home care, which she initially liked but then found that she was having increasing difficulty with the paperwork. He further reported that she took a job with Adventist Rehab in September 2004 and worked there until February 2005, when she was fired. Thereafter she stopped working and devoted time to dealing with her problems with alcohol, including attending the above-mentioned programs. Dr. Raphael further reported that the Respondent attends two to three AA meetings per week and has two sponsors in AA. Furthermore, the Respondent attends monthly seminars held by Father Martin's Ashley and takes Antabuse occasionally. Dr. Raphael made several recommendations to ensure that the Respondent maintains sobriety.

6. In summary, the Respondent failed to: provide proper services to patients; perform evaluations with testing of strength, goniometric measurement, and assessments of function. In addition, at the above time period the Respondent was professionally, physically, or mentally incompetent to practice physical therapy.

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact, the Board finds that Respondent violated H.O. § 13-316 (15), (23), (25); Code Md. Regs. tit. 10 § 38.03.02-1 A (1), (2), (3) and (4), B, and C.

ORDER

Based on the foregoing Findings of Fact, Conclusions of Law and agreement of the parties, it is this 19th day of September, 2006, by a majority of a quorum of the Board,

ORDERED that the Respondent's license to practice physical therapy is hereby **SUSPENDED** for **six (6) months**, with that suspension is **STAYED**; and be it further

ORDERED that the Respondent shall be immediately placed on **PROBATION,** for **two (2) years**, during which time the Respondent shall be subject to the following conditions:

A. The Respondent shall successfully complete a Board-approved documentation course within the first six (6) months of Probation;

B. The Respondent shall successfully complete the Maryland Physical Therapy Law Course within the first year of Probation;

C. The Respondent shall practice with a Board-approved mentor during the first year of Probation, who shall report to the Board on the Respondent's compliance with the standards of practice of physical therapy, especially in regard to documentation, once a month for the first three months, and then quarterly thereafter;

D. The Respondent shall submit to random urine screenings at least every other month;

E. The Respondent shall remain abstinent from alcohol and all mood-

altering drugs;

F. The Respondent shall continue her weekly involvement in 12-step programs;

G. The Respondent shall participate in and comply with the requirements of a formal structured treatment program focusing on recovery from substance abuse and dependence. The program should include weekly meetings with a mental health professional who has expertise in substance abuse. The treatment can be either individual or group psychotherapy. The Respondent shall insure that the program submits to the Board quarterly progress reports; and be it further

ORDERED that the Respondent may petition the Board to modify the conditions of Probation after one (1) year, provided that the Respondent has fully complied with the above conditions and no complaints are pending regarding the Respondent before the Board; and be it further

ORDERED that the Respondent may petition the Board to terminate probation after two (2) years from the effective date of the probation provided that the Respondent has fully complied with the above conditions and no complaints are pending regarding the Respondent before the Board; and be it further

ORDERED that the Consent Order is effective as of the date of its signing by the Board; and be it further

ORDERED that should the Board receive a report that the Respondent has violated the Act or if the Respondent violates any conditions of this Order or of Probation, after providing the Respondent with notice and an opportunity for a hearing, the Board may take further disciplinary action against the Respondent, including lifting the suspension or revocation. The burden of proof for any action brought against the Respondent as a result of a breach of the conditions of the Order or of Probation shall be on the Respondent to demonstrate compliance with the Order or conditions; and be it further

ORDERED that the Respondent shall practice in accordance with the laws and regulations governing the practice of physical therapy in Maryland; and be it further

ORDERED that for purposes of public disclosure, as permitted by Md. State Govt. Code Ann. §10-617(h) (Repl. Vol. 1999), this document consists of the contents of the foregoing Findings of Fact, Conclusions of Law and Order and that the Board may also disclose same to any national reporting data bank that it is mandated to report to.

Margery F. Rodgers, P.T., Chair
State Board of Physical Therapy Examiners

CONSENT OF LINDA ASHDOWN, P.T.

I, Linda Ashdown, P.T., by affixing my signature hereto, acknowledge that:

1. I am represented by an attorney, Kevin Tracey, and have been advised by him of the legal implication of signing this Consent Order.

2. I am aware that without my consent, my license to practice physical therapy in this State cannot be limited except pursuant to the provisions of § 13-316 of the Act and the Administrative Procedure Act (APA), Md. State Govt. Code Ann. §10-201, et seq., (2004 Repl. Vol.).

3. I am aware that I am entitled to a formal evidentiary hearing before the Board.

By this Consent Order, I hereby consent and admit to the foregoing Findings of Fact, Conclusions of Law and Order, provided the Board adopts the foregoing Consent Order in its entirety. By doing so, I waive my right to a formal hearing as set forth in §13-317 of the Act and §10-201, et seq., of the APA, and any right to appeal as set forth in § 13-318 of the Act and §10-201, et seq., of the APA. I acknowledge that my failure to abide by the conditions set forth in this Order and following proper procedures, I may suffer disciplinary action, possibly including revocation, against my license to practice physical therapy in the State of Maryland.

9/18/06
Date

Linda Ashdown
Linda Ashdown, P.T.

STATE OF Maryland

CITY/COUNTY OF Prince George's :

I HEREBY CERTIFY that on this 18th day of September, 2006, before me, Karin M. Tracy (Print Name), a Notary Public of the foregoing State and (City/County), personally appeared Linda Ashdown, P.T., License No. 15450, 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 notarial seal.

Notary Public

My Commission Expires: 1·1·2007