

IN THE MATTER OF	*	BEFORE THE STATE
Tara M. Hoffman, N.H.A.	*	BOARD OF EXAMINERS OF
Respondent	*	NURSING HOME ADMINISTRATORS
License Number: R1762	*	Case Number: 2020-005

* * * * *

CONSENT ORDER

On August 6, 2020, the State Board of Examiners of Nursing Home Administrators (the “Board”) charged **Tara M. Hoffman, N.H.A.** (the “Respondent”) under the Maryland Nursing Home Administrators Licensing Act (the “Act”) codified at Md. Code Ann., Health Occ. §§ 9-101 *et seq.* (2014 Repl. Vol. and 2019 Supp.); and under Code Md. Regs. (“COMAR”) 10.33.01 *et seq.* and 10.07.01 *et seq.*

Specifically, the Board charged the Respondent under the following provisions of Health Occ. § 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:

....

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

The pertinent provisions of Health Occ. § 9-205 provide as follows:

- (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[.]

The Respondent was also charged under the following COMAR provisions:

COMAR 10.33.01.15. 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:
 - (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 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 10.07.09.08. Resident's Rights and Services.

.....

C. A resident has the right to:

.....

(5) Be free from:

(a) Physical abuse;

.....

(c) Sexual abuse[.]

COMAR 10.07.09.15. Abuse of Residents.

.....

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.

COMAR 10.07.02.09. Administration and Resident Care.

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.

FINDINGS OF FACT

The Board makes the following findings of fact:

1. At all times relevant hereto, the Respondent was a licensed nursing home administrator ("N.H.A."). The Respondent was initially issued a license to practice as an

N.H.A. on March 14, 2008 under license number R1762. The Respondent's license is scheduled to expire on March 13, 2022.

2. From approximately mid-April 2019 to on or about June 5, 2019, the Respondent was employed as the administrator of a nursing home ("Nursing Home"),¹ located in Montgomery County, Maryland.

Complaint

3. The Board received a Statement of Deficiencies and Plan of Correction from the Office of Health Care Quality ("OHCQ") after OHCQ conducted a survey of the Nursing Home.

4. OHCQ conducted the survey at the Nursing Home from May 7, 2019 to May 10, 2019. On May 9, 2019, "an immediate jeopardy to resident's safety in the smoking area was determined." On May 9, 2019, at 9:00 p.m. the Nursing Home provided a plan of correction. The immediate jeopardy was abated on May 10, 2019 at 3:00 p.m. following the Nursing Home's implementation of corrective actions to ensure all unsafe smokers receive direct supervision in the smoking area. On May 10, 2019, an extended survey was conducted based on the determination of the immediate jeopardy to residents' safety in the smoking area.

¹ For purposes of ensuring confidentiality, proper names have been omitted and replaced with generic placeholders..

5. The OHCQ Statement of Deficiencies and Plan of Correction revealed the following:

- i. There were a total of 23 smokers in the Nursing Home, 12 of which were unsafe smokers who required direct supervision. Of the 12 unsafe smokers who required direct supervision, 4 needed to wear a protective apron while smoking.
- ii. OHCQ's interview with the DON on May 8, 2019 "revealed that different department staff members were assigned to provide monitoring in the smoking area during smoking times."
- iii. Facility staff who were assigned to monitor smoking had different methods to monitor smokers, some of which monitored the smoking area either via the window on the door of the Nursing Home, or via video camera footage located at the nursing station 122 feet from the smoking area.
- iv. There were blind spots of the smoking area that could not be seen through the 11 in x 11 in window on the door.
- v. OHCQ's review of the video camera footage located at the nursing station revealed that only the legs of the residents in the smoking area were visible on the video camera.
- vi. There were three incidents in the Nursing Homes' smoking area – April 28, 2019; April 30, 2019; and May 1, 2019.

April 28, 2019:

- i. On April 28, 2019 at 1:45 p.m. there was a resident to resident altercation between Resident #4 and Resident #5 in the smoking area.
- ii. Staff #3 was the designated personnel to monitor the smoking area between 7:00 a.m. and 6:30 p.m. on the weekends and holidays.
- iii. At approximately 1:00 p.m., Staff #3 was busy in the dining area with other residents. Therefore, Staff #3 asked Staff #2 to open the door to the smoking area for smokers.
- iv. Staff #1 observed Staff #2 open the door for all smokers at 1:00 p.m., then Staff #2 walked back to the nursing station which was 122 feet away from the smoking area. When Staff #1 walked towards the breakroom, Staff #1 heard a commotion coming from the smoking area. Therefore, Staff #1 walked towards the door and watched through an 11 in x 11 in window on the door. Staff #1 observed Resident #4 and Resident #5 fighting. Staff #1 called other staff who were in the breakroom to help.
- v. No staff were present in the smoking area on April 28, 2019 at 1:45 p.m. when Staff #1 went to the smoking area to separate Resident #4 and Resident #5.
- vi. There were two unsafe smokers that required direct supervision (Resident #5 and Resident #6) in the smoking area on April 28, 2019

between 1:00 p.m. and 1:45 p.m. without direct supervision by the Nursing Home staff.

- vii. The Nursing Home's investigation report and interviews of Staff #2 and Staff #3 revealed they were not aware of a smoker list and did not know where the protective aprons were located for unsafe smokers.
- viii. There was no documented evidence that Staff #2 and Staff #3 received in-services related to safe smoking/tobacco use when offered by the staff development nurse on March 19, 2019.

April 30, 2019:

- i. On April 30, 2019 at around 1:40 p.m., Resident #1² had an altercation in the smoking area with Resident #4. As a result of the altercation, Resident #1 had a laceration on the lower lip.
- ii. Staff #4 was the assigned personnel to monitor the smoking area on April 30, 2019 between 1:00 p.m. and 1:45 p.m.
- iii. Staff #4 documented that they "watched resident #1 and resident #4 fighting in the smoking area through a video camera, which was located at the . . . nursing station (122 feet away from the smoking area)."
- iv. OHCQ's interview of Staff #4 revealed Staff #4 "could not tolerate cigarette smoke due to health issues. Therefore, staff #4 was allowed to open the door for smokers at 1 PM Mondays through Fridays, walk back to the . . . nursing station and monitor through the video camera."

² Resident #1 was a safe smoker but still required direct supervision while smoking in the smoking area.

- v. Only one of the residents present in the smoking area during the time of the incident was interviewed as part of the Nursing Home's investigation.
- vi. The psychiatrist documented on May 3, 2019, that Resident #4 had "2 resident-resident altercations and 1 inappropriate touching" between April 28, 2019 and May 1, 2019.

May 1, 2019:

- i. On May 1, 2019, Resident #3 reported to the Nursing Home that Resident #4 touched Resident #3 inappropriately in the smoking area.
- ii. The Nursing Home initiated an investigation and contacted the police regarding Resident #3's report on May 1, 2019.
- iii. Resident #1 provided a statement on May 1, 2019, that Resident #1 observed Resident #4 touch Resident #3 in the smoking area. Resident #4 denied the allegation.
- iv. According to the psychiatrist's progress note dated May 3, 2019, Resident #3 also reported to the psychiatrist that "'another resident reached over and touched [R]esident #3.' Then, [R]esident #3 'slapped that resident and left the smoking area and informed staff of the incident.'"
- v. The Nursing Home's investigation did not include interviews of the staff members who were assigned to monitor the smoking area on May 1, 2019.

- vi. The Nursing Home’s final investigative report dated May 5, 2019, “revealed that the facility was unable to substantiate [R]esident #3’s allegation because [R]esident #3 told the police on 05-01-19 that [R]esident #4 never touched him/her.”
6. OHCQ made the following findings as a result of its investigation:
 - i. The Nursing Home “failed to provide direct supervision in the smoking area for unsafe smokers.”
 - ii. There was no evidence that the facility staff addressed the issue of no direct supervision in the smoking area for unsafe smokers after the incident on April 28, 2019 or after the incident on April 30, 2019.
 - iii. After the incident on April 28, 2019 and after the incident on April 30, 2019, there was no evidence that Staff #3 received in-services/training to understand their role while in the smoking area. And there was no evidence that Staff #3, Staff #4, and Staff #6 knew how to identify unsafe smokers and what level assistance each unsafe smoker might need.
 - iv. After the incidents, the Nursing Home “failed to conduct a thorough investigation and to determine whether the current smoking monitoring system in the smoking area was effective or not.”
 - v. The Nursing Home “failed to define the expectation of direct supervision in the smoking area and to offer training to the designated personnel who monitored the smoking area.”

- vi. The Nursing Home staff failed to “thoroughly” investigate the incidents on April 30, 2019 and May 1, 2019.

Board Investigation

7. Based upon the OHCQ survey, the Board initiated an investigation.
8. On May 19, 2020, in an interview with the Board’s investigator, the

Respondent stated the following under oath:

- i. She was employed in “an interim position through a[n] agency that placed” her at the Nursing Home as the administrator.
- ii. Her job duties included “my daily rounds. I reported to make sure people were under their budgets. I was the go-to person if they needed extra staff, extra, you know, supplies and materials. I was responsible for just overseeing how the building was going while I was there. . . . the majority of my day got [*sic*] spent working with the residents because they were very unhappy with a bunch of things.”
- iii. She stated that she did not draft the plan of correction, but admitted that the plan of correction did “go through [her] to see.” She further stated that she did not “think, you know, that I offered too terribly much to them at that time, other than to help once it was sent in, help them implement the policies that were . . . written and changed” because she “wasn’t going to be there to be part of the solution.”
- iv. She admitted that she read and signed the plan of correction.

- v. She further admitted that she was aware that being the administrator required her to be fully engaged in the whole process of running the facility.

9. Based on the foregoing, the Board finds that the Respondent's violations falls within category (1), tier (2) of the Board's sanctioning guidelines. *See* COMAR 10.33.01.22B (committed a violation which resulted in moderate potential for resident harm). The range of potential sanctions under (1), tier (2) is a minimum sanction of a \$500 civil fine and probation for 1 year, to a maximum sanction of maximum civil fine allowable, suspension for 2 years, and probation for three years. The Board's decision to depart from the sanctioning guidelines and impose a lesser sanction is based upon the mitigating factors in this case, including the Respondent's lack of a prior disciplinary record, the Respondent provided full disclosure to the Board and cooperated during the Board proceedings, the absence of premeditation to commit the violation, the fact that the Respondent worked at the nursing facility for a limited period, and the violation was present before she began work at the facility. The Board also considered the courses the Respondent completed after this incident to educate herself, including, but not limited to courses on Ethical Principles of Administering Health Care to the Elderly, Ethics for Healthcare Professionals, Healthcare preparedness, HIPAA protecting patients' rights, Implementing change in long term care, improving nursing home quality, Protecting yourself from malpractice claims, Federal regulations of long term care facilities, the science and practice of improving health care, and residents' rights.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board finds as a matter of law that the Respondent violated the following provisions: Health Occ. § 9-314(b)(3); COMAR 10.33.01.15A(1), (2), (9), (10); COMAR 10.07.09.08C(5)(a), (c); COMAR 10.07.09.15D(1), (2); and COMAR 10.07.02.09A(2).

ORDER

It is, thus, by the Board, hereby:

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

ORDERED that the Respondent shall not use any of the courses named in paragraph 9 of the Findings of Fact to fulfill any continuing education credits required for license renewal; and it is further

ORDERED that, within **ONE YEAR**, the Respondent shall pay a civil fine of **\$1000**. The Payment shall be by money order or bank certified check made payable to BENHA, and mailed to 4201 Patterson Avenue, Room 305, Baltimore, Maryland 21215; and it is further

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

ORDERED that 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 Consent Order is a **PUBLIC DOCUMENT**, and the Board may disclose same to any national reporting bank to which it is mandated to report.

November 18, 2020

Date

Ronda B. Bell

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

CONSENT

I, Tara M. Hoffman 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 any right to appeal this Consent Order.

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.

10/31/20
Date

Tara M. Hoffman
Tara M. Hoffman, N.H.A.
Respondent

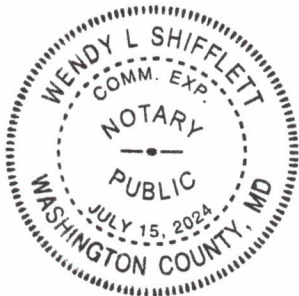
NOTARY

STATE OF Maryland

CITY/COUNTY OF Frederick

I HEREBY CERTIFY that on this 31 day of October,
2020, before me, a Notary Public of the foregoing State and City/County, did personally
appear Tara Hoffman N.H.A., 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.



Wendy L. Shifflett
Notary Public

My commission expires: July 15, 2024