IN THE MATTER OF	*	BEFORE THE MARYLAND STATE
DOMENIC J. BORRO, LNHA	*	BOARD OF EXAMINERS OF
Respondent	*	NURSING HOME ADMINISTRATORS
License Number: R1890	*	Case Number: 2017-003

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ORDER FOR SUMMARY SUSPENSION OF LICENSE TO PRACTICE AS A NURSING HOME ADMINISTRATOR

The Maryland State Board of Examiners of Nursing Home Administrators (the "Board") hereby **SUMMARILY SUSPENDS** the license of **DOMENIC J. BORRO, LNHA** (the "Respondent"), License No. R1890, to practice as a nursing home administrator in the State of Maryland.

The Board takes such action pursuant to its authority under Md. Code Ann., State Gov't II ("State Gov't II") § 10-226(c)(2) (2014 Repl. Vol. and 2017 Supp.) and Md. Code Regs. ("COMAR") 10.33.01.20, finding that the public health, safety or welfare imperatively requires the immediate suspension of the Respondent's license.

INVESTIGATIVE FINDINGS

Based on information received by, and made known to the Board, and the investigatory information obtained by, received by and made known to and available to the Board, including the instances described below, the Board has reason to believe that the following facts are true:[1]

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

[1] The statements regarding the Respondent's conduct are intended to provide the Respondent with notice of the basis of the summary suspension. They are not intended as, and do not necessarily represent a complete description of the evidence, either documentary or testimonial, to be offered against the Respondent in connection with this matter.

LNHA on October 3, 2013, under license number R1890. The Respondent's latest LNHA license has written the expiration date of October 2, 2019.

2. At all times relevant hereto, a corporation ("Corporation")[2] operated a chain of five nursing home facilities in Anne Arundel County, Montgomery County, Prince George's County, and Washington County.

3. At all times relevant hereto, the Respondent was employed as the administrator of a nursing home ("Nursing Home"), one of the above-referenced facilities the Corporation operated in Washington County, Maryland.

4. By electronic mail to the Board dated December 27, 2016, the Maryland Office of Health Care Quality ("OHCQ") submitted a complaint with an attached lawsuit filed in Maryland by the Office of the Attorney General against the Corporation, alleging the Corporation and certain named individuals engaged in a scheme in which they "unsafely and unfairly evicted hundreds of frail, infirm, mentally ill, and physically and intellectually disabled people" from its five Maryland nursing homes. OHCQ requested that the Board investigate the allegations that were set forth in the lawsuit.

5. The lawsuit averred that in furtherance of this scheme, the Corporation "dumps" many of its evictees in homeless shelters, which lack the capacity to provide needed care, "trafficks" many others to predatory operators of "sham assisted living facilities," or "abandons its evictees far from their hometowns, in places where they have no family or connections to assist them." The lawsuit alleged that the Corporation pursued this scheme, which it referred to as "unlawful and at times inhumane," in order to maximize its profits, without regard to the health and safety of its residents. The

[2] For purposes of ensuring confidentiality, proper names have been omitted and replaced with generic placeholders. Upon written request, the Administrative Prosecutor will provide this information to the Respondent.

lawsuit further alleged that the Corporation engaged in this conduct on a "pervasive scale," where it "compromised the health and safety of hundreds of vulnerable people with whose care it has been entrusted, and that it has repeatedly and systematically violated" Maryland law and regulations. The lawsuit specifically referenced unlawful actions occurring at the Nursing Home and the Respondent's involvement in those actions as the nursing home administrator there.

6. Thereafter, the Board initiated an investigation in which it reviewed, *inter alia*, a series of resident discharges from the Nursing Home. The Board's investigation determined that the Respondent, in his capacity as the nursing home administrator at the Nursing Home, discharged, transferred, allowed or otherwise permitted the discharge or transfer of vulnerable and infirm residents, which compromised the health, safety or welfare of the residents. The Respondent's actions constitute a violation of State statutes and regulations governing the administration of nursing homes. As the administrator of the Nursing Home, the Respondent was responsible for final authority of any act or the making of any decision involved in the planning, organizing, directing, or controlling of the day-to-day operation of the Nursing Home. The Respondent's actions constitute, in whole or in part, a demonstration that his practices endanger the safety of nursing home residents. Examples of these inappropriate discharges are set forth *infra*.

<u>Resident # 13</u>

7. Resident # 13's family placed Resident # 13, a woman then in her 90s, at the Nursing Home in 2014 after she had been diagnosed with severe dementia with behavior disturbances, muscle weakness, and chronic pain syndrome.

8. On or about January 13, 2015, the Nursing Home issued a Notice of Proposed Involuntary Discharge or Transfer for failure to pay for a stay at the facility. The Nursing Home sent the notice to Resident # 13's home address and to her son. The Respondent signed the notice, which failed to identify the effective date of the transfer or discharge, or provide the facility location to which Resident # 13 would be moved. The Nursing Home did not discharge Resident # 13 at that time, however.

9. On or about January 30, 2015, the Nursing Home's Medical Director certified that Resident # 13 no longer had the mental capacity to make legal or financial decisions on her own behalf.

10. On or about July 23, 2015, Resident # 13 began receiving hospice services in the Nursing Home administered through the Hospice of Washington County after she had been diagnosed with arteriosclerotic cardiovascular disease.

11. On or about August 18, 2015, a court-appointed guardian was established for Resident # 13, to be her agent for various health care decisions, including arranging for her admission to and discharge from hospitals, nursing homes, and other places of treatment, as well as transfer from one medical facility to another.[3]

12. On or about October 15, 2015, the Nursing Home's Medical Director issued a Certification of End State, Terminal or Persistent Vegetative Condition, in which the Medical Director determined that Resident # 13 was in end-stage condition that was advanced, progressive and irreversible. The Nursing Home's Medical Director further certified that transfers to the hospital were to be withheld for Resident # 13.

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[3] The January 13, 2015, 30-day notice was not provided to Resident # 13's court-appointed attorney, Guardian of the Property, or Guardian of the Person.

13. On or about January 14, 2016, the Nursing Home issued a second Notice of Proposed Involuntary Discharge or Transfer for failure to pay. The Respondent signed the notice, which did not identify the effective date of the transfer or discharge, or provide the location to which Resident # 13 would be moved. The notice also informed Resident # 13 that "You have the right to request a hearing regarding this involuntary discharge. . . . If you or your representative elect to request a hearing . . . the request must be made within thirty (30) days of receipt of this notice . . . . You may continue to reside in this facility pending the outcome of the hearing."

14. According to social services notes for Resident # 13 dated January 22, 2016 and January 25, 2016, referrals were faxed to five different nursing homes. None of the identified nursing homes were the Corporation's nursing home located in Prince George's County, Maryland ("Nursing Home B").

15. On January 21, 2016, the Respondent sent an email to the Nursing Home's Discharge Planner, Social Services Assistant, a Social Worker, and a Nursing Home employee ("Employee") stating "I need . . . [Resident # 13] out ASAP! This is a priority and need updates daily."

16. On January 25, 2016, the Respondent notified a Senior Corporation Staff Member that the Nursing Home was waiting for a response to referrals sent to seven facilities in order to discharge Resident # 13. The Respondent subsequently notified the Senior Corporation Staff Member that the Nursing Home would make a decision about the fate of Resident # 13 by "wed[nesday] at the latest" and "[t]rust me I want this shit out too."

17. On January 27, 2016, approximately 16 days prior to the 30-day period from the second notice expired, the Respondent transferred or permitted the transfer of Resident # 13 from the Nursing Home to the Corporation's Prince George's County facility, Nursing Home B.[4]

18. According to the hospice registered nurse, in the Hospice Oncall/Unscheduled visit note dated January 27, 2016, Resident # 13 and her family were not in agreement with the discharge plan. Furthermore, according to the hospice registered nurse visit note, Nursing Home staff noted that the Nursing Home did not notify Resident # 13's son of the transfer, but Resident # 13's guardian was aware of the Nursing Home's plans to transfer Resident # 13.

19. The day after Resident # 13 was transferred to Nursing Home B, on January 28, 2016, a social service note from the Nursing Home was completed, stating "writer try to call RP [responsible party] to let her know of the discharge to [Nursing Home B] several times and there was no answer" and a voicemail message was not left.

20. In an email from the Nursing Home's Business Office Director dated February 4, 2016, the Respondent was provided with an attachment that stated:

> **<u>[Resident # 13] - $36,974.65</u>**
>
> 02/02/16 There will be a penalty on this case for $70,000 plus. Patient transferred to [Nursing Home B] where she is still a resident.

21. On February 11, 2016, the Nursing Home issued a statement to Resident # 13 which notified her that she had an outstanding balance of $122,190.00.

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[4] On or about January 29, 2016, Resident # 13's Guardian of the Property filed a timely appeal of the 30-day notice, requested mediation, and requested a Patient's Bill of Rights hearing.

22. On or about February 15, 2016, Resident # 13 was transferred from Nursing Home B to the hospital via private ambulance transport for a purported lung infection.[5]

23. From on or about February 16, 2016 to on or about March 9, 2016, the Office of Health Care Quality ("OHCQ") performed a complaint survey at the Nursing Home. OHCQ made the following investigative findings related to Resident # 13:

a. The Nursing Home "failed to provide a clear rationale for transferring a medically fragile resident (Resident #13) receiving hospice care, to a sister facility after issuing a Notice of Proposed Involuntary Discharge or Transfer . . . for failure to pay for a stay at the facility."

b. The Nursing Home records "do not indicate what interventions were implemented to preserve continuity of care in a stable environment for this medically fragile resident, or efforts to coordinate care and discharge planning with the responsible persons to ensure a safe and orderly discharge."

24. On or about March 1, 2016, Resident # 13, through her legal guardians, filed legal proceedings for a temporary restraining order against the Nursing Home in which it alleged that the Nursing Home "only moved [Resident # 13] to [Nursing Home B] so it could deny [Resident # 13] the rights to which she is entitled and circumvent the statutes and regulations which would have protected her had she been at the facility for 30 days. . . . leaving her bereft of the statutory protections provided by Maryland and Federal law . . . ."

25. On or about March 18, 2016, the Circuit Court for Frederick County, Maryland under Case Number C-16-000601, after considering Resident # 13's petition for relief, ordered the Nursing Home to readmit Resident # 13 to the Nursing Home and

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[5] Thereafter, according to the hospital records, Resident # 13 had been "deemed stable to be discharged back to her nursing facility with instructions for appropriate outpatient treatment and followup. [H]owever, her nursing home refused to accept her back. Administration, . . . and case management are working on solutions for [Resident # 13's] disposition and placement."

allow her to remain a resident there. The court found that Resident # 13 "will suffer immediate, substantial and irreparable harm in the form of extensive hospital bills and deteriorating physical health if she remains" at the hospital and that "such harm would be irreparable." Finally, the court found "that there is public interest in preventing nursing home facilities from circumventing federal regulations to discharge individuals from nursing home facilities."

26. On November 30, 2017, in an interview with the Board's investigator, the Respondent stated that:

a. Issuing two Notices of Proposed Involuntary Discharge or Transfer to a resident was not typical and may have been "a mishap on, on my business office who usually issues these and just gets my signature."

b. He never reviewed a resident's files or checked his employees' work to ensure accuracy for a Notice of Proposed Involuntary Discharge or Transfer because "it's a business office responsibility that, that I expect it to be done properly."

c. He believes a second Notice of Proposed Involuntary Discharge or Transfer was issued to Resident # 13 because "I think there was probably an issue with the first one and that we issued a second one to be safe."

d. He admitted that he "transferred the resident after two weeks, so, you know, in a survey process I probably theoretically should have been cited for this, this discharge."

e. Furthermore, he admitted that transferring Resident # 13 two weeks after the second Notice of Proposed Involuntary Discharge or Transfer was issued, was "certainly an error on my part" and "I, we shouldn't have discharged the resident two weeks after we issued a discharge. You know, we're supposed to give 30 days, but did not."

f. The Nursing Home social services department or discharge planning department "[u]sually" notified the responsible party of a resident's discharge, and he did not "verify that" or "oversee it."

g. Regarding the fact that Resident # 13's responsible party was called, but a voicemail message was not left, and the Nursing Home's staff did not talk to the responsible party prior to transferring Resident # 13, the Respondent stated "we failed to notify the responsible party in a meaning

way." The Respondent further admitted "[w]e shouldn't have discharged without having the responsible party at least being contacted and let know."

Resident # 15

27. In or around 2014, Resident # 15's family members noticed that Resident # 15, then a woman in her mid-70's, began exhibiting marked personality changes, memory loss and other aberrant behaviors that were inconsistent with her longstanding personality traits. This led her family to admit her to a series of various health care facilities.

28. On or about December 24, 2015, Resident # 15 executed a power of attorney ("POA") in which she appointed specific family members to be her agents for various health care decisions, including arranging for her admission to and discharge from hospitals and other places of treatment.

29. In an incident occurring on or about December 24, 2015, Resident # 15 became combative and irrationally violent toward her husband, culminating in her knocking him out of his wheelchair and beating him in the head with his cane, necessitating that his family call 911. Six emergency medical technicians were unable to get Resident # 15 to enter the ambulance voluntarily, requiring additional assistance from family members, who successfully placed her in the vehicle. Resident # 15 was admitted to a local hospital, which recommended that she be admitted to an in-patient facility for psychiatric care and behavioral management.

30. On or about December 30, 2015, Resident # 15 was transferred to an in-patient facility for psychiatric care. Staff mental health practitioners there assessed Resident # 15 and concluded that she was not capable of making and communicating decisions regarding medical care or code status due to dementia, and that her

incapacity was permanent. The health care facility placed Resident # 15 on various anti-psychotic and other psychoactive medications to manage her aberrant behaviors. Thereafter, staff mental health practitioners ordered neuropsychological and neurocognitive testing and concluded that her personality changes were all suggestive of a neuropsychiatric change associated with compromise to her frontal lobe functioning, and that she had frontotemporal dementia and depression.

31. On or about March 4, 2016, Resident # 15 was admitted to the Nursing Home with diagnoses of dementia, anxiety disorder, bipolar disorder, and major depressive disorder.[6]

32. Resident # 15's Care Plan was updated on August 3, 2016, in which it was noted that Resident # 15 "continues to be non compliant [*sic*] with meds [*sic*] . . . Resident continues to refuse to bathe at times, continue plan of care."

33. According to a progress note dated August 4, 2016, Resident # 15 "states she wants to be closer to her family. [A nursing home in Westernport, Maryland] willing to accept resident and resident ok with going to [the Westernport, Maryland nursing home]. [C]urrently waiting on confirmation on when [the Westernport, Maryland nursing home is] able to accept resident to their facility."

34. A progress note dated August 9, 2016, stated that Resident # 15 was

> agitated this shift due to floor change. Her room mate [*sic*] is complaining that she is not getting any rest due to residents constant pacing and grunting noises. She refused any care from this nurse and refused to take any of her medications . . . . I tried to convince her and show her that they truly are her meds and she still refuses. She is constantly asking questions and making non sense [*sic*] statements. I encouraged her to lay

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[6] Despite Resident # 15's lengthy medical history and prior assessments that determined that Resident # 15 was incapable of making and communicating decisions regarding medical care, when the resident was admitted to the Nursing Home, the Nursing Home's physician signed a certification dated March 7, 2016, stating that Resident # 15 was able to effectively make decisions regarding her medical care.

> down several times but she kept getting up and disturbing her room mate [*sic*] . . . . Will continue to monitor.

35. On or about August 12, 2016, the Maryland Department of Health Medical Care Programs issued a notice to Resident # 15 stating "the Utilization Control Agent for the Department of Health and Mental Hygiene has determined that your medical condition does not require that you receive care in a nursing facility. Therefore, Maryland Medicaid cannot pay for your care in a nursing facility." The notice gave Resident # 15 ninety (90) days to request a hearing on the matter.

36. On August 12, 2016, the Respondent discharged or permitted the discharge of Resident # 15 from the Nursing Home.

37. The Nursing Home's chart for Resident # 15 contains several contradictory discharge notes that were written on the day of discharge, August 12, 2016. According to a discharge progress note at 9:43 a.m., Resident # 15 "wishes to be discharged to home . . . and wishes to leave today." According to the discharge progress note, the responsible party notified was Resident # 15, not Resident # 15's family or POA. According to a second discharge progress note at 11:58 a.m., Resident # 15 was discharged at 11:56 a.m. "accompanied by husband." However, according to a third discharge progress note at 4:23 p.m., Resident # 15 "requested to go to her sons [*sic*] home a couple miles from her home"; therefore, a Nursing Home employee "[t]ook [R]esident [# 15] to her sons [*sic*] home as requested and resident safely took all of her belongings into home."

38. After the Respondent discharged Resident # 15, a licensed practical nurse from the Nursing Home drove Resident # 15 to her house, however, the door was locked and the resident could not get in the house. The licensed practical nurse then

drove Resident # 15 to her son's house. When they arrived at her son's house, Resident # 15 entered the house and the licensed practical nurse drove off. The licensed practical nurse left Resident # 15's son's property without going inside the house or speaking to anyone. Resident # 15's step-granddaughter was the only person in the house when Resident # 15 entered the house. Resident # 15's family was not informed that she would be taken to the house. When Resident # 15 entered the house, the step-granddaughter noticed she was "frantically pacing in and out of the house and repeating herself." Resident # 15 then left the house and ran down the driveway. The step-granddaughter was able to eventually get Resident # 15 to go back in the house. The step-granddaughter called her mother who contacted Resident # 15's son. Resident # 15's son returned to his house, and immediately drove Resident # 15 to a hospital for care. During the ride, Resident # 15 tried to jump out of the vehicle several times and Resident # 15 had to be physically restrained.

39. From on or about August 17, 2016 to on or about September 9, 2016, OHCQ performed a complaint survey at the Nursing Home. OHCQ made the following investigative findings related to Resident # 15:

a. "[T]he facility failed to allow a resident to remain in the facility until a safe discharge could be coordinated with family."

b. "[T]he facility failed to notify the family prior to discharge of a cognitively impaired resident."

c. "[T]he facility failed to discharge a cognitively impaired resident in a safe manner."

d. "[T]he facility failed to follow the plan of care for a safe discharge for a cognitively impaired resident."

e. "[T]he facility failed to have complete and accurate documentation in the medical record."

40. On or about September 26, 2016, OHCQ issued a notice to the Nursing Home, which advised the Nursing Home, *inter alia*, that OHCQ was imposing a $10,000 civil monetary penalty on it based on deficiencies at the facility. The Nursing Home filed an appeal on or about October 10, 2016.

41. On or about March 21, 2017, the Office of Administrative Hearings ("OAH") issued a Proposed Decision *In the Matter of NMS Healthcare of Hagerstown, LLC.*, OAH No.: DHMH-LCP-44-17-00683. The Proposed Decision included findings that the Nursing Home: 1) failed to properly discharge Resident # 15 by failing to provide written notice to the resident, representative, or interested family member, the State Long-Term Care Ombudsman, and the Maryland Department of Health, at least thirty (30) days prior to the proposed discharge; 2) failed to properly document the circumstances surrounding the discharge; 3) inaccurately documented in Resident # 15's medical record that Resident # 15 left the Nursing Home accompanied by her husband; and 4) Resident # 15 lacked capacity to consent to her discharge from the Nursing Home and 5) there was no urgency for Resident # 15 to be discharged that day without any discharge planning and without any notice to the family.

42. The Proposed Decision included the following Findings of Fact:

a. Resident # 15 never revoked the December 24, 2015, Power of Attorney.

b. On or about March 4, 2016, Resident # 15 was discharged from the local hospital and admitted to the Nursing Home. "Resident # 15's husband brought Resident # 15's POA [(Power of Attorney)] to [the Nursing Home] and waited while staff in the office made a copy of it for their records."

c. "On or about May 11, 2016, the facility sent Resident # 15's husband a notice that it intended to involuntarily discharge Resident # 15 because she had not paid, or made arrangements to pay, for her nursing home care. Resident # 15's husband filed an appeal with the OAH and also requested mediation. After Resident # 15's husband paid the bill, [the Nursing Home] rescinded the notice."

d. "On July 1, 2016, Resident # 15's family was advised that she was approved for Medicaid long term care benefits."

e. "On July 30, 2016, Resident # 15 was able to use short sentences to communicate but did not initiate communication. She was able to walk but was slightly unsteady and required supervision to ensure her safety."

f. "On August 6 or 7, 2016, Resident # 15 was moved to a different room on a different floor. No reason was documented in her medical record for the room change. Resident # 15's husband, daughter and son were not told the reason why Resident # 15 was moved and were not told that she was moved until after the move."

g. On August 11, 2016, a licensed practical nurse from the Nursing Home "contacted Resident # 15's husband at 5:55 p.m. and informed him that his wife had been denied Medicaid and she needed to be out of the facility because it was not getting paid for her care. [The licensed practical nurse] offered to take Resident # 15 to a nursing home in Baltimore, but her husband told [the licensed practical nurse] he did not want that to happen because then she would be farther away from him than she was at the facility."

h. On August 12, 2016, one of the individuals listed on Resident # 15's power of attorney "left several messages for [the licensed practical nurse] to contact her as soon as possible. [The licensed practical nurse] never returned her telephone call." The individual also "made telephone calls to other nursing homes to try and find one that was willing to admit her mother. She spoke to [a nursing home in Kensington, Maryland] who was willing to see Resident # 15's husband for a tour that morning."

i. The Washington County Commission on Aging ombudsman called the individual listed on the power of attorney "and told her that she went to the facility and staff there told her that Resident # 15 signed herself out of the facility and was being driven home."

j. The licensed practical nurse "arrived with Resident # 15 at her house before her son did. The door was locked and she could not get in." The licensed practical nurse then drove Resident # 15 to her son's house. "Resident # 15 got out of the car, went to the front door and found it open. She then went back and got her box of clothes out of [the licensed practical nurse's] car and went inside. [The licensed practical nurse] left without going inside the house or speaking with anyone."

k. "R.J., Resident # 15 's step-granddaughter, was the only person in the house when Resident # 15 entered the unlocked house. R.J. is a college student and was home for the weekend. She was doing laundry when she heard the sound of the sliding door opening and closing. She went to

investigate and found her step-grandmother frantically pacing in and out of the house and repeating herself. R.J. asked Resident # 15 how she got to the house and Resident # 15 said, 'they dropped me off.' R.J. immediately went to the window and looked outside but there were no vehicles there. Resident # 15 left the house and ran down the driveway. R.J. followed her and was able to get her to come back into the house and lay down. Resident # 15 needed continual encouragement to stay in the house and lie down."

l. "R.J. called her mother who in turn called her husband, D.J.R.; he left his parents' house and drove to his home. D.J.R. was able to get Resident # 15 to enter his vehicle. As he drove, he made a turn away from her house and towards the direction of the hospital. Resident # 15 tried to jump out of the vehicle and D.J.R. had to physically restrain his mother to prevent her from jumping out of the moving vehicle. Resident # 15 tried to jump out three more times on the ride to the hospital. When she arrived at the hospital, Resident # 15 would not leave D.J.R.'s vehicle. When she finally got out, she ran to her husband's van but could not get in because it was locked. She ran around the hospital and when 911 was called, she ran into the emergency room."

m. No one from the nursing staff at the Nursing Home completed the following tasks prior to discharging Resident # 15 from the facility:

   i. Discuss alternative options with resident and family;

   ii. Arrange trial pass;

   iii. Encourage caretaker to practice skills they will need after discharge;

   iv. Identify discharge plan upon admission;

   v. Collaborate with resident and family;

   vi. Identify safety hazards in the home prior to discharge;

   vii. Order appropriate supplies and equipment for home setting;

   viii. Modify environment as necessary;

   ix. Educate on medication regimen and diagnostic tests prior to discharge;

   x. Provide teaching on discharge medications;

   xi. Teach importance of follow up visits with community physician;

xii. Promote detailed plan of care at time of discharge;

xiii. Assess for support systems to cope with disability;

xiv. Ensure that home meets client's needs for ADLs and safety;

xv. Ensure that assistive adaptive devices are installed in home prior to discharge; and

xvi. Encourage resident and family to discuss their fears or concerns.

n. No one from the Nursing Home social services staff completed the following tasks prior to discharging Resident # 15 from the facility:

i. Explore if resident is positive towards discharge;

ii. Explore if family is positive towards discharge;

iii. Involve family; and

iv. 1:1 visits.

43. On or about May 18, 2017, after no exceptions to the Proposed Decision were filed, the Maryland Department of Health's Secretary adopted OAH's proposed decision as the final decision of the Maryland Department of Health.

44. On November 30, 2017, in an interview with the Board's investigator, the Respondent stated:

a. He "asked the discharge planner to find out where she would like to go and the resident said they [*sic*] would like to go there. So that was really all I needed to hear."

b. The discharge planner told the Respondent when the discharge planner returned to the facility that the discharge planner witnessed Resident # 15 go into the house "with her belongings and that's when my discharge planner pulled away."

<u>Resident # 16</u>

45. Resident # 16's family placed Resident # 16, a woman then in her 70s, at the Nursing Home in 2015 after she was involuntarily admitted to the hospital for

> exhibit[ing] behaviors that place her at significant risk of self harm such as wandering out into extremely cold weather and locking herself out of her home. Wandering down the road and being picked up by strangers and taken back to her home or to the neighbors homes. . . . when taken back to her home she sometimes insists that it is not her home, . . . [Resident # 16] has been known to open her windows in the house in the frigid weather for no apparent reason. She has been confused about where she lives as well as disoriented at times. . . . [Resident # 16] has been paranoid and has been experiencing hallucinations.

46. Resident # 16's admission diagnoses included psychotic disorder with hallucinations, Alzheimer's disease, type 2 diabetes mellititus, unspecified psychosis not due to a substance or known physiological condition, and hypertension.

47. On or about March 9, 2015, a Nursing Home physician certified that Resident # 16 was unable to: understand and sign admission documents and other information; understand the nature, extent, or probable consequences of the proposed treatment or course of treatment; make a rational evaluation of the burdens, risks, and benefits of the treatment; and effectively communicate a decision. Consequently, on or about December 11, 2015, a court-appointed guardian was established for Resident # 16, to be her agent for various health care decisions, including arranging for her admission to and discharge from hospitals, nursing homes, and other places of treatment, as well as transfer from one medical facility to another.

48. According to a Nursing Home social service note dated May 6, 2015, Resident # 16's responsible party attended a care plan meeting at the Nursing Home where the responsible party "was concerned about his mother wanting to leave, explained to son that she can not [*sic*] leave unless she has a safe place to go. Son seem [*sic*] ok after that. Reviewed plan of care and continue with plan of care."

49. On or about May 15, 2015, the Nursing Home issued a Notice of Proposed Involuntary Discharge or Transfer for failure to pay for a stay at the facility.

The Nursing Home sent the notice to Resident # 16's home address. The notice, which the Respondent signed, failed to identify the effective date of the transfer or discharge or provide the facility location to which Resident # 16 would be moved as required by.

50. According to a Nursing Home social service note, dated August 28, 2015, the responsible party for Resident # 16 requested that the Nursing Home fax referrals to two nursing homes. Neither of those nursing homes were the Assisted Living Facility in Baltimore, Maryland where Resident # 16 was subsequently discharged.

51. According to Nursing Home mental health progress notes dated December 10, 2015, and January 9, 2016, Resident # 16 was observed and it was determined that "if treatment is terminated now, continuation exacerbation or return of symptoms is likely. . . . informed staff-will f/u with monthly."

52. In a statement issued to Resident # 16 dated February 1, 2016, the Nursing Home notified Resident # 16 that she had an outstanding balance of $91,757.00; $12,035 of which was an advance billing for February 1, 2016 until February 29, 2016.[7]

53. On February 2, 2016, at approximately 2:07 p.m., the Respondent discharged or permitted the discharge of Resident # 16 to an unlicensed Assisted Living Facility in Baltimore, Maryland. According to a Nursing Home social service note dated February 2, 2016 at 3:07 p.m., Resident # 16's responsible party was notified of

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[7] In an email dated February 4, 2016, from the Nursing Home's Business Office Director the Respondent was provided with an attachment that stated:

[Resident # 16] - $38,648.47

02/02/16 This patient has been denied by medical assistance due to excess resources. Patient discharged to [Assisted Living Facility in Baltimore City]

Balances need to move to private and legal to sue.

Resident # 16's discharge to the Assisted Living Facility in Baltimore, Maryland. According to the Discharge Planning Checklist dated February 2, 2016, the Respondent reviewed and signed off on Resident # 16's discharge, including copies of communications with the responsible party regarding discharge were included in Resident # 16's record.

54. Resident # 16's responsible party was unable to locate Resident # 16 after he was given the wrong telephone number for the owner of the unlicensed Assisted Living Facility in Baltimore, Maryland. As a result, Resident # 16's responsible party then contacted the police department, which initially investigated the complaint as a kidnapping.

55. On February 4, 2016, Resident # 16 was located at a mall in Frederick, Maryland after the unlicensed Assisted Living Facility's owner dropped Resident # 16 there.

56. From on or about February 16, 2016 to March 9, 2016, OHCQ performed a complaint survey at the Nursing Home. OHCQ made the following investigative findings with respect to Resident # 16:

a. The Nursing Home "failed to notify the family of the location of Resident #16 at an assisted living unit following discharge, resulting in the need for police intervention in order to locate resident #16."

b. The Nursing Home "staff abruptly discharged a resident from the facility without the benefit of sufficient preparation that included participation of the resident and the resident's family in selecting the new residence."

c. The Nursing Home failed to "correctly document a correct phone number on 2 residents discharge instructions and social services notes."

57. On November 30, 2017, in an interview with the Board's investigator, the Respondent stated that:

a. The Nursing Home did not transfer residents to the unlicensed Assisted Living Facility in Baltimore, Maryland, often. "[W]e sent, you know, maybe one or two residents there, but then we found out the license was forged."

b. When a resident is transferred from the Nursing Home to a facility, the Respondent would verify that the facility was licensed by asking the facility for a copy of the license. The Respondent admitted that he did not check with the licensing agency to determine whether a facility is licensed prior to transferring a resident from the Nursing Home to a facility.[8]

c. He does not always verify that the items listed on the Nursing Home discharge planning checklist, including notification to the responsible party of the resident's discharge, are included in the resident's records.

d. He denied having any knowledge that the police conducted an investigation of an alleged kidnapping of Resident # 16 after Resident # 16 was discharged to the unlicensed Assisted Living Facility in Baltimore, Maryland. The Respondent further denied having any knowledge that Resident # 16's family contacted the Nursing Home regarding the missing resident.

e. He verified that on February 4, 2016 at 2:18 p.m., the Nursing Home's discharge planner forwarded an email to the Respondent attaching photographs of the unlicensed Assisted Living Facility in Baltimore, Maryland, acting as the facility's proof of their establishment. He further verified that on the same day Resident # 16's son allegedly contacted the police regarding the missing resident, the Respondent replied to the Discharge Planner's email stating "He needs to call the son. [T]he cops claim they cant [*sic*] get in touch with hiim [*sic*]."

f. The Respondent admitted "there's room for improvement for the processes, of course, . . . I definitely needed to be a little bit more involved in, in the situation, clearly."[9]

g. He admitted that after he received an email from a Nursing Home liaison on January 21, 2016 at 11:46 a.m. stating "I have a Mca dual skill [r]eady today but I may be able to hold it off until tomorrow if you can get a male mma discharged," he sent an email on January 21, 2016 at 11:50 a.m. to

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[8] In an interview with the Board's investigator on May 10, 2017, the Respondent stated that it was the discharge planner's responsibility to verify whether a facility was licensed or not.

[9] In an interview with the Board's investigator on May 10, 2017, however, the Respondent stated that he never had any concerns with the discharge process at the Nursing Home and that "we did everything by the book."

the Nursing Home staff stating "Anything that can go today? Like in 2 hrs? [*sic*] Im [*sic*] looking for a yes just in case you are wondering. $100 up for grabs." The Respondent claimed the email was a "performance bonus" which "incentifies [*sic*] . . . job performance."

h. He stated that he would have utilized a similar "performance bonus" at the nursing home where he was previously employed as an administrator in Delaware, but he did not have the opportunity to utilize incentives for discharges because the nursing home never had a full census.[10]

i. He further stated that he will use similar incentives at the nursing home where he is currently employed as the administrator in Montgomery County, Maryland, and that he did not "see why I couldn't."

<u>Summary</u>

58. As the administrator of the Nursing Home, the Respondent had a professional obligation to ensure that any vulnerable residents at the Nursing Home were discharged in a safe manner; the Respondent violated this professional obligation. A review of just three of the unsafe discharges revealed that the Respondent acknowledged permitting the transfer of a cognitively impaired resident (Resident # 13) prior to the 30-day notice requirement to a facility without verification that the facility was capable of providing the necessary care. This resulted in an order from the Circuit Court for Frederick County, Maryland that directed the Nursing Home to readmit the resident (Resident # 13) after the court found that the resident would suffer immediate, substantial and irreparable harm.

59. The Respondent also compromised the safety of a second cognitively impaired resident (Resident # 15), when the Respondent instructed the discharge planner to ask the resident where the resident would like to go because she would not be allowed to remain at the Nursing Home. The Respondent then permitted the

[10] According to the Respondent, after he left the Nursing Home in October 2016, he began working as the administrator at a nursing home in Wilmington, Delaware. The Respondent remained at the nursing home in Wilmington, Delaware until he began working as an administrator at a nursing home in Montgomery County, Maryland in August 2017.

discharge planner to drop off the resident in her family member's driveway without notifying the resident's family or power of attorney or even verifying anyone was at the house to aid the resident.

60. Finally, the Respondent permitted the discharge of a third cognitively impaired resident (Resident # 16) to an unlicensed Assisted Living Facility, which resulted in a police department investigation of the incident as a kidnapping when the responsible party and the police department were unable to contact the unlicensed ALF due to the incorrect contact information provided by the Nursing Home.

61. In addition to the reckless discharges of at least three vulnerable cognitively impaired residents, the Respondent has admitted that as the administrator of the Nursing Home, he did not verify the accuracy of any Notice of Proposed Involuntary Discharge or Transfer, did not verify with the licensing agency whether a facility is licensed prior to transferring vulnerable residents from the Nursing Home to a facility, or verify that a responsible party had been notified of a resident's discharge or transfer. The Respondent also admitted to enticing Nursing Home employees to discharge Nursing Home residents on short notice by offering monetary incentives, which he called "performance bonus[es]." He further stated that he did not see anything wrong with his "performance bonus[es]" and that he would continue to use monetary incentives for his employees to increase discharges at the nursing home where he is currently employed in Maryland.

62. Based on the above investigative facts, the Respondent presents a substantial likelihood of a risk of serious harm to the public health, safety, and welfare, and prior notice and opportunity to be heard are not feasible.

CONCLUSIONS OF LAW

Based upon the foregoing Investigative Findings, the Board concludes that the public health, safety, or welfare imperatively requires emergency action, and that pursuant to State Gov't II § 10-226(c)(2) and COMAR 10.33.01.20, the Respondent's license is immediately suspended.

ORDER

IT IS thus by the Board, hereby:

ORDERED that pursuant to the authority vested in the Board by State Govt. II § 10-226(c)(2)(2014 Repl. Vol. and 2017 Supp.) and COMAR 10.33.01.20(D), the Respondent's license to practice as a nursing home administrator in the State of Maryland (No. R1890) is hereby **SUMMARILY SUSPENDED;** and it is further

ORDERED that in accordance with COMAR 10.33.01.20(D)(2)(b), a post-deprivation hearing on the summary suspension of Respondent's license No. R1890 will be held on **Wednesday, February 14, 2018, at 1:00 p.m.** at the Board's offices, located at 4201 Patterson Avenue, Baltimore, Maryland, 21215-0095, at which the Respondent will be provided with an opportunity to show cause why the Board should lift the summary suspension and reinstate his license; and it is further

ORDERED that this is an Order of the Board, and as such, is a **PUBLIC DOCUMENT** pursuant to Md. Code Ann. Gen Prov. §§ 4-101 *et seq.* (2014), COMAR 10.33.01.20 (2017).

February 2, 2018
Date

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