IN THE MATTER OF	*	**BEFORE THE**
CHERYLE A. MINES, N.H.A.	*	**MARYLAND STATE**
License No. R1217	*	**BOARD OF EXAMINERS OF**
Respondent	*	**NURSING HOME ADMINISTRATORS**
	*	**Case Number: 2007-1217**

* *

CONSENT ORDER

PROCEDURAL BACKGROUND

On December 17, 2008, the State Board of Examiners of Nursing Home Administrators (the "Board") charged **CHERYLE A. MINES, N.H.A.** (the "Respondent"), License No. R1217, with violating certain provisions of the Maryland Nursing Home Administrators Licensing Act ("the Act"), codified at Md. Health Occ. ("H.O.") Code Ann. §§ 9-101 *et seq.* (2005 Repl. Vol.) and related regulations.

Specifically, the Board charged the Respondent with violating the following provisions of § 9-314(b) of the Act:

> 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 Board also charged the Respondent with violating the following regulations: Code Md. Regs. ("COMAR") tit. 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 homes; [and]

* * * *

(9) Has endangered or sanctioned the endangerment of the safety, health, and life of any patient.

On February 11, 2009, 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. The Respondent is licensed to practice as a nursing home administrator in the State of Maryland, currently possessing License Number R1217. The Respondent was originally licensed by the Board on September 10, 1993.

2. At all times relevant herein, the Respondent was employed as the administrator for the Bethesda Health and Rehabilitation Center ("Bethesda Health"), a 200 bed nursing home located at 5721 Grosvenor Lane, Bethesda, Maryland.

3. On or about March 27, 2007, to March 30, 2007, and April 2, April 3, April 5,

April 12, and April 17, 2007, the Office of Health Care Quality ("OHCQ") carried out an annual survey at Bethesda Health. OHCQ issued a Statement of Deficiencies and Plan of Correction to the facility on April 17, 2007, in which it cited numerous deficiencies and concluded that the facility was providing substandard quality of care to its residents.

4. OHCQ's survey consisted of the review of the medical records of thirty-three (33) residents of Bethesda Health, observation of resident care and staff practices, and interviews with residents, resident family members, the ombudsman, and facility staff. The survey found multiple examples where staff provided deficient care to residents, including: failing to evaluate and/or document clinical changes in residents' medical conditions; failing to notify physicians in a timely manner of changes in residents' medical conditions; failing to assure the safety of residents; failing to administer medical treatments; failing to assure that physician orders were followed, including failing to provide medication management or medical treatments according to physicians' orders; failing to provide appropriate palliative care; failing to coordinate care with hospice services; failing to coordinate medical care; failing to appropriately assess residents; failing to provide podiatry care; failing to perform range of motion exercises; failing to ensure that immunizations were provided; failing to maintain appropriate staffing levels; failing to update residents' "DNR" (do not resuscitate) orders; failing to ensure that residents' injuries were promptly reported and investigated; and failing to review drug regimens.

5. Examples of the survey findings include but are not limited to the following:

RESIDENT #25[1]

6. According to the OHCQ survey report, Resident #25 was a resident at Bethesda Health from February 2006 until January 2007. Her medical history included chronic diagnoses of hypertension, hypothyroidism, and advanced dementia with significant history of dysphagia and pneumonia. Resident #25 was dependent on Bethesda Health for all activities of daily living.

7. On January 27, 2007, the nurse supervisor at Bethesda Health received a telephone call from Resident #25's primary care physician requesting the nurse supervisor to assess Resident #25.

8. The nurse supervisor documented that Resident #25 was "semi-conscious, very warm to the touch, sweating, congested (and) labored breathing." Resident #25's temperature was 102 degrees. The Emergency medical services records reveal that 911 personnel arrived to find Resident #25 in respiratory distress and non-responsive.

9. The OHCQ survey further revealed that hospital emergency room records documented that Resident #25 was unresponsive, cyanotic and severely hypoxic with a pulse oximetry of 60% oxygen. Resident #25's breathing improved with suctioning and nebulizer treatments but due to hypoxic respiratory failure, Resident #25 did not regain her level of consciousness. She was referred to hospice where she died the next day.

10. Resident #25's attending physician was interviewed by OHCQ surveyors. The physician stated that she was contacted by the charge nurse in the afternoon of January 27, 2007. The physician issued an order for a chest x-ray and nebulizer

[1] The names of the individuals identified herein are confidential. The Respondent is aware of the identity of all individuals referenced herein.

treatments. The physician stated that the charge nurse was not clear in reporting Resident #25's condition during the telephone call. The physician questioned whether the nurse had even completed an evaluation of Resident #25. As a result of these concerns, the physician contacted the nurse supervisor to request the supervisor to assess Resident #25.

11. The nurse supervisor informed OHCQ surveyors that she only became aware of Resident #25's condition upon receiving the telephone call from the physician on January 27, 2007. The nurse supervisor stated that when she went to assist Resident #25 after receiving the telephone call from the physician, she immediately recognized that Resident #25 was acutely ill and in distress. According to the nurse supervisor, "anyone could tell (the resident) needed to go to the hospital."

12. The OHCQ survey revealed that Resident #25's family had hired a private duty assistant who was with the resident on January 27, 2007. The private duty assistant arrived at Bethesda Health at approximately 3:30 – 3:45 p.m. and was concerned about Resident #25's condition.

13. According to the OHCQ survey, the private duty assistant was unable to get the nursing staff to respond after three or four requests so she contacted Resident #25's daughter. Resident #25's daughter arrived at Bethesda Health at 5:20 p.m. to find Resident #25 "unresponsive, cyanotic, blue, with trouble breathing."

14. According to Resident #25's daughter, staff at Bethesda Health could not locate the equipment for the nebulizer treatment ordered by the treating physician.

15. The OHCQ survey report concluded that the 7:00 a.m. to 3:00 p.m. (7-3) daytime nurse and the 3:00 p.m. to 11:00 p.m. (3-11) evening charge nurse failed to

clinically evaluate the change in Resident #25's respiratory condition for a total of five hours or more. OHCQ also concluded that the 3-11 evening charge nurse failed to administer the nebulizer treatment and neglected to provide an appropriate emergency response when Resident #25 was in acute respiratory distress.

RESIDENT #13

16. At the time of the OHCQ survey report, Resident #13 was a ninety-one (91) year old woman with multiple diagnoses including end stage dementia, altered mental status, diverticulosis, and hypertension.

17. Pursuant to a supplemental report regarding Bethesda Health issued by OHCQ, Resident #13 choked to death on May 29, 2007, because the nursing staff at Bethesda Health failed to clear her tracheotomy tube of mucus. Despite Resident #13's death as a result of a blocked tracheotomy tube, the OHCQ survey revealed discrepancies in Resident #13's treatment records at Bethesda Health, which indicate that the nursing staff regularly cleaned Resident #13's breathing tube.

INEFFECTIVE AND INEFFICIENT ADMINISTRATION

18. The April 17, 2007, OHCQ survey report cited Bethesda Health for failing to comply with 42 C.F.R. § 483.75, which provides that "[a] facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." This was based in part on the fact that OHCQ concluded that Bethesda Health had a common practice of transporting its residents to the emergency room via a taxi cab.

19. OHCQ found that Bethesda Health did not have a contract with the taxi cab

driver and/or verification of any CPR or first aid training with the taxi cab driver. In fact, it was discovered that the taxi cab driver was not certified in CPR or first aid. OHCQ found that Bethesda Health sent residents to the hospital via taxi cab that were in acute distress and unaccompanied by any facility staff.

20. On one occasion, a resident (identified as Resident #36 in the survey report) was admitted to Bethesda Health following a left hip fracture and surgical repair. Resident #36's medical diagnosis included coronary artery disease, chronic obstructive pulmonary disease, hypothyroidism, atrial fibrillation and a history of congestive heart failure.

21. Seven days after his admission, Resident #36 was transferred to the emergency room from Bethesda Health via taxi cab after a physician's order stated that he should be transferred to the hospital emergency room "for paracentesis (secondary to) (increased) abdominal girth and abdominal sonogram."

22. OHCQ surveyors reviewed hospital emergency room records revealing that the emergency room triage assessment documented Resident #36 as a "walk in." The resident's own source of information was used by emergency room personnel to evaluate that he was at risk when the resident stated "my stomach is as hard as a rock and I have fluid build-up in my legs."

23. OHCQ also concluded that Bethesda Health engaged in a pattern of failure to either report internally and/or to the State agency injuries of unknown origin and allegations of staff to resident or resident to resident abuse as well as a pattern of failing to conduct comprehensive investigations when the injuries or allegations were unknown.

24. OHCQ found that the Bethesda Health staff member responsible for

investigating resident to resident abuse – the Assistant Director of Nurses – did not have any prior experience in this area and had not been provided with the necessary training and oversight to conduct investigations. The Assistant Director of Nurses was also unaware of Bethesda Health's procedures for conducting investigations.

25. After receiving the annual survey report from OHCQ, the Board opened an investigation into the Respondent's conduct. As part of its investigation, the Board's investigator interviewed the Respondent, who was duly sworn, on January 26, 2008. The Respondent informed the Board's investigator that she was the administrator at Bethesda Health from August 1 or 2, 2005, until August 20, 2007. She further informed the Board's Investigator that her duties were to oversee the overall operations of the facility.

26. During the investigative interview, the Respondent told the Board's investigator that she faced difficulties upon starting at Bethesda Health. She explained that she inherited several staff vacancies including the assistant director of nursing and registered nurses throughout the facility. She further stated that there was turnover of management and staff during the first six months of her tenure including the food services manager position. She also explained that there were financial difficulties facing the facility.

27. The Respondent informed the Board's investigator that she regularly attended QI and QA meetings at Bethesda Health. She also stated that she performed drug regimen reviews through the quality assurance committee at Bethesda Health.

28. The Respondent admitted to the Board's investigator that she did not have any direct involvement with obtaining wheelchair services for residents, but that the unit

secretary or nurses would obtain wheelchair mobile van services for residents. She further admitted that she was final signatory on all incident reports involving an injury to a resident and that she would complete follow-up to ensure that the situation had been resolved.

29. Pursuant to a Board issued subpoena, the Board obtained the resident council minutes from Bethesda Health from September 2006 through February 2007. During the meetings, residents voiced concerns such as pain medicine not being given in a timely manner, fear of retaliation for reporting a nurse not giving medication, lack of shower chairs, and cleanliness of rooms. Despite an invitation to attend, the minutes revealed that the Respondent attended only one of the nine meetings.

30. As a result of the Board's investigation and the survey reports issued by OHCQ, the records obtained by the Board during its investigation were referred to an expert in nursing home administration for an opinion on the Respondent's compliance with the standards of practice.

31. On or about October 16, 2008, the Board's expert issued a report of his findings. The conclusions of the Board's expert are detailed below.

32. The Board's expert stated that the records revealed a pattern of deficient practices without any proof of administrative follow through on behalf of the Respondent, among others. The Board's expert specifically concluded that the Respondent failed to take an active role in follow through of resident concerns at Bethesda Health and in resolving on-going issues at Bethesda Health.

33. The Board's expert supported his opinion by pointing to the Respondent's lack of attendance at Resident and Family Council Quality Assessment meetings as well as

the lack of any evidence of disciplinary action against staff members responsible for the deficient practices at Bethesda Health.

34. The Board's expert further stated that the transport of residents via taxi cab was not an acceptable standard within the practice of nursing home administration. According to the Board's expert, it is the normal practice for a nursing home administrator to review facility invoices and to question any inappropriate invoices such as an invoice for a taxi cab.

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 tile, 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: Has violated any of the provisions of the law pertaining to the licensing of nursing home administrators or the regulations of the Board pertaining to it, in violation of COMAR 10.33.01.15A(1); Has violated any of the provisions of the law or 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, in violation of 10.33.01.15A(2); and Has endangered or sanctioned the endangerment of the safety, health, and life of any patient, in violation of COMAR 10.33.01.15A(9).

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, it is this 8th day of April, 2009, by a quorum of the Board considering this case:

ORDERED that the Respondent shall be placed on **PROBATION** for a minimum of **EIGHTEEN (18) MONTHS,** beginning on the date the Board executes this Consent Order, 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 expense, Board-approved courses in: (a) quality assurance process/procedures; (b) resident rights; (c) ethics; and (d) leadership/hiring practices. The Respondent shall submit the course descriptions and course curriculums to the Board for its approval prior to enrolling in these courses. The Board reserves the right to reject any of the course(s) that the Respondent proposes and may, in its discretion, require additional information about any course(s) the Respondent proposes. The Respondent shall be responsible for providing the Board with adequate written verification that she has successfully completed each course. 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 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) staffing issues, including staffing ratios and shortages; (ii) quality assurance programs and

procedures; (iii) resident care; and (iv) complaints of family members and residents.

(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 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.

4. 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 no earlier than **eighteen (18) months** from the effective date of this Consent Order, and only if 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 be it 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 reprimand, additional probation, suspension, revocation and/or monetary fine; and be it further

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

ORDERED that this Consent Order shall be a public document pursuant to Md. State Gov't Code Ann. § 10-611 *et seq.* (2004 Repl. Vol.).

4-8-09
Date

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

CONSENT

I, Cheryle A. Mines, 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 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.

March 27, 2009
Date

Cheryle A. Mines
Cheryle A. Mines, N.H.A.
Respondent

Read and approved:

3/24/09
Date

Laurence B. Russell, Esquire
Counsel for Cheryle A. Mines

NOTARY PUBLIC

STATE OF MARYLAND
CITY/COUNTY OF:

I HEREBY CERTIFY that on this 27 day of March, 2009, before me, a Notary Public of the State and County aforesaid, personally appeared Cheryle A. Mines, 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.

Notary Public

6/28/12
My commission expires: