IN THE MATTER OF	*	BEFORE THE
	*	
SUSAN L. STONE, NHA	*	MARYLAND STATE BOARD OF
	*	
Respondent	*	EXAMINERS OF NURSING HOME
	*	
	*	ADMINISTRATORS
	*	
License Number R1509	*	Case No. 2015-001
	*	

* * * * * * * * * * * * *

CONSENT ORDER

PROCEDURAL BACKGROUND

On June 8, 2015, the State Board of Examiners of Nursing Home Administrators (the "Board") charged Susan L. Stone, N.H.A. (the "Respondent"), License Number R1509, with violating provisions of the Maryland Nursing Home Administrators Licensing Act (the "Act") codified at Md. Code Ann., Health Occ. ("H.O.") § 9-101 *et seq* (2014 Repl. Vol.) and Code Md. Regs. ("COMAR") 10.33.01.15 *et seq*.

Specifically, the Board charged Respondent with, among other things, violating the following provisions of H.O. § 9-314:

> (b) Grounds for reprimands, suspensions, revocations, and fines. – Subject to the hearing provisions of § 9-315 of this subtitle, the Board may 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 of COMAR 10.33.01.15:

> 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; [and/or]
>
> (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;

In addition, the Board also charged Respondent with violating the following provisions of H.G. § 19-345.2 pertaining to the rights of individuals in health care facilities provide the following (referenced in COMAR 10.33.01.15A(1):

> **§ 19.345.2. Involuntary discharge.**
>
> (a) *Requirements.* – In addition to the provisions of §§ 19-345 and 19-345.1 of this subtitle, a facility may not involuntary discharge or transfer a resident unless, within 48 hours before the discharge or transfer, the facility has:
>
> (1) Provided or obtained:
>
> (i) A comprehensive medical assessment and evaluation of the resident, including a physical examination, that is documented in the resident's medical record;
>
> (ii) A post discharge plan of care for the resident that is developed, if possible, with the participation of the resident's next of kin, guardian, or legal representative; and
>
> (iii) Written documentation from the resident's attending physician indicating that the transfer or discharge is in accordance with the post discharge plan of care and is not contraindicated by the resident's medical condition; and
>
> (2) Provided information to the resident concerning the resident's rights to make decisions concerning health care, including:
>
> (i) The right to accept or refuse medical treatment;

(ii) The right to make an advance directive, including the right to make a living will and the right to appoint an agent to make health care decisions; and

(iii) The right to revoke an advance directive.

(b) *Written consent to discharge.* –

(1) Except as provided in paragraphs (2) and (3) of this subsection, a facility may not discharge or transfer a resident unless the resident is capable of and has consented in writing to the discharge or transfer.

(2) A facility may discharge or transfer a resident without obtaining the written consent of the resident if the discharge or transfer:

(i) Is in accordance with a post discharge plan of care developed under subsection (a) of this section; and

(ii) Is to a safe and secure environment where the resident will be under the care of

1. Another licensed, certified, or registered care provider;

or

2. Another person who has agreed in writing to provide a safe and secure environment.

(3) A Facility that is certified as a continuing care provider under Title 10, Subtitle 4 of the Human Services Article is not subject to the provisions of subsection (b) of this section if:

(i) The facility transfers a resident to a lesser level of care within the same facility in accordance with a contractual agreement between the facility and the resident; and

(ii) The transfer is approved by the attending physician.

(d) *Discharge planning process.* – If the requirements of §§ 19-345 and 19-345.1 of this subtitle and subsections (a) and (b) of this section have been met, the resident's next of kin or legal representative shall cooperate and assist in the discharge planning process, including:

(1) Contacting, cooperating with, and assisting other facilities considering admitting the resident; and

(2) Cooperating with governmental agencies, including applying for medical assistance for the resident.

On November 18, 2015, 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 Findings of Fact, Conclusions of Law, Order, and Consent.

FINDINGS OF FACT

BACKGROUND FINDINGS

1. Respondent was originally licensed as a Nursing Home Administrator (NHA) on December 18, 2000, under license number R1509.

2. Respondent's current license will expire on December 17, 2016.

3. At all times relevant hereto, Respondent was the NHA of a nursing home located in Baltimore, Maryland ("Facility A"). As NHA, Respondent was responsible for ensuring, among other things, that patients at Facility A were discharged properly and that their rights were respected.

4. On or about February 6, 2014, the Board received a report of a complaint survey of Facility A conducted by the Office of Health Care Quality ("OHCQ").

5. The OHCQ survey report revealed the following:

   a. Resident A was admitted to Facility A on November 6, 2012;

   b. On October 23, 2013, Resident A was admitted to a local hospital;

   c. On November 6, 2013, Resident A was ready for discharge from the hospital to Facility A; however, Facility A staff refused to accept Resident

A;

d. Review of Resident A's medical record failed to reveal any physician documentation as to why Facility A did not permit Resident A to return to Facility A after her brief hospitalization;

e. Facility A staff failed to provide, as soon as practical, a written involuntary discharge notice to Resident A or Resident A's guardian;

f. Facility A staff discharged Resident A without the benefit of sufficient preparation, including obtaining a facility that would accept Resident A.

6. During an interview with OHCQ's surveyor, the Respondent stated that:

a. She was waiting for a State evaluation to be completed before she would allow Resident A to return to Facility A;

b. Facility A staff did not attempt to try to find another facility for Resident A during Resident A's hospitalization.

7. OHCQ made the following findings as a result of its investigation:

a. Facility A staff failed to permit Resident A to return to Facility A after a brief hospital admission;

b. An attending physician failed to document in Resident A's medical file the supporting reasons for the involuntary discharge;

c. Facility A staff failed to provide, as soon as was practical, a written notice of Resident A's involuntary discharge notice to Resident A or Resident A's guardian; and

d. Facility A abruptly discharged Resident A without benefit of sufficient

preparation, including obtaining an accepting facility for Resident A.[1]

BOARD INVESTIGATIVE FINDINGS

8. Based upon the survey complaint, the Board initiated an investigation.

9. The Board's investigation revealed that, on October 23, 2013, Resident A was admitted to a psychiatric hospital located in Baltimore, Maryland ("Hospital A") because she was acting out sexually, and was delusional and non-directable.

10. On November 1, 2013, Resident A's social worker at Hospital A ("Social Worker") left a telephonic message with the Director of Nursing ("DON") at Facility A to advise that Resident A's projected discharge date was November 5 or 6, 2013.

11. On November 5, 2013, the Social Worker was advised by the Respondent that a bed was not available at Facility A and that it was the consensus of Facility A staff that Resident A would be "more suited for another type of environment." The Social Worker was further advised that Facility A did not accept patients who would require long-term care to Facility A's rehabilitation unit.

12. Later on November 5, 2013, the Respondent notified the Social Worker that a Facility "nurse case manager" would assess Resident A at Hospital A that day.

13. The individual who reported to Hospital A to assess Resident A was not a nurse case manager, but rather was Facility A's "community ambassador."

14. After having seen Resident A on November 5, 2013, the community ambassador initially advised the Social Worker that Facility A would readmit Resident A to Facility A on

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[1] As a result of the OHCQ investigation with regard to Resident A, OHCQ concluded that Facility A was not in substantial compliance with state requirements for nursing homes. OHCQ imposed a civil monetary penalty on Facility A and required Facility A to submit a Plan of Correction.

November 6, 2014. When the Social Worker requested a written commitment from Facility A that Resident A would be readmitted, he was advised by the community ambassador that Facility A required that Hospital A first complete various forms, including a clearance performed by a separate agency that would take several days to complete.

15. On or about November 21, 2013, Resident A was discharged from Hospital A and was admitted by Hospital B, a general hospital, because she was experiencing chest pains.

16. On or about November 26, 2013, Resident A was discharged from Hospital B and admitted to a nursing facility other than Facility A.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent failed to substantially meet the standards of practice adopted by the Board under H.O. § 9-205, in violation of H.O. § 9-314(b)(3). The Board had charged the Respondent with committing an act of unprofessional conduct in the licensee's practice as a nursing home administrator, in violation of H.O. §9-314(b)(11); upon its Investigative Findings, the Board dismisses this charge.

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); and 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 COMAR 10.33.01.15(A)(2). As referenced in COMAR 10.33.01.15A(1), Resident A's rights were violated under Md. Code Ann, Health Gen. § 19.345.2 – Involuntary Discharge. The Board

had charged the Respondent with endangering or sanctioning the endangerment of the safety, health and life of any patient pursuant to COMAR 10.33.01.15A(9); upon its Investigative Findings, the Board dismisses this charge.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is, by a majority vote of the Board members present, hereby:

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

ORDERED that the Respondent shall within one (1) year of the date the Board executes this Consent Order complete a course in residents' rights. With respect to the course, the Respondent shall submit the course description and course curriculum to the Board for its approval prior to enrolling in the course. The Board reserves the right to reject the course the Respondent proposes, and may, in its discretion, require additional information about any course the Respondent offers to fulfill this condition. The Respondent shall be solely responsible for furnishing the Board with adequate verification that she has successfully completed the course according to the terms set forth herein. The Respondent may not use any continuing education requirements that are mandated for licensure renewal in this State. If the Respondent fails to successfully complete the course according to the terms set forth herein, such failure shall constitute a violation of this Consent Order; and it is further

ORDERED that if the Respondent violates any of the terms and conditions of this Consent Order, the Board, in its discretion, after notice and opportunity for a hearing, may impose any sections 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, probation, suspension, revocation and/or monetary fine; and it is further

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

ORDERED that this Consent Order shall be a public document.

12/9/2015
Date

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

CONSENT

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

12/7/15
Date

Susan L. Stone, N.H.A.
Respondent

12/7/15
Date

James C. Buck, Esq.
Counsel for Ms. Stone

NOTARY PUBLIC

STATE OF MARYLAND
CITY/COUNTY OF:

I HEREBY CERTIFY that on this 7th day of December, 2015, before me, a Notary Public of the State and County aforesaid, personally appeared Susan L. Stone, 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.

Karla D. Smoot
Notary Public

My Commission Expires April 11, 2017
My commission expires