IN THE MATTER OF	*	**BEFORE THE**
JANICE EDWARDS	*	**BOARD OF MORTICIANS**
LICENSE NUMBER: M00685	*	**AND FUNERAL DIRECTORS**
Respondent	*	**CASE NUMBER: 13-135**

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ORDER FOR SUMMARY SUSPENSION

The Maryland Board of Morticians and Funeral Directors (the "Board") hereby **SUMMARILY SUSPENDS** the license of **JANICE EDWARDS (the "Respondent"), License Number M00685 (D.O.B. 07/14/1947)**, to practice mortuary science in the State of Maryland. The Board takes such action pursuant to its authority under Md. State Gov't Code Ann. ("S.G.") § 10-226(c) (2009 Repl. Vol.) concluding that the public health, safety or welfare imperatively requires emergency action.

INVESTIGATIVE FINDINGS

Based on the 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. The Respondent was initially licensed to practice mortuary science in the State of Maryland under license number M00685 on May 1, 1985. The Respondent's license is current and will expire on April 30, 2014.

2. At all times relevant to the statements herein, the Respondent was the co-owner and supervising mortician at Establishment A, a funeral establishment located at

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

3910 Silver Hill Road, Suitland, Maryland 20746. The Respondent co-owns Establishment A with Leroy Hodges (M00247).

3. By a Final Order dated November 19, 1998, the Respondent was disciplined by the Board for violating H.O. §§ 7-316(a)(18), (25), (26), (27) and H.O. § 7-406. The Respondent's license was suspended for 10 days and she was ordered to complete a course on HIV and AIDS awareness and a course on universal precautions.

4. On or about July 23, 2010, the Board conducted an inspection of Establishment A. Mr. Hodges was present.

5. The inspection revealed the following deficiencies:

a. The ownership sign was not posted in a public area;

b. The preparation room was unsanitary;

c. The eye wash station was empty;

d. The inspector observed dirty instruments;

e. Biohazard waste was found in regular trash containers;

f. The service hearse did not contain a universal kit;

g. The carpet in the chapel area was temporarily secured;

h. There were two caskets without prices in the display area;

i. Establishment A was using an outdated form for disposition of cremated remains;

j. There was no hand wash sink;

k. Body fluid biohazard waste was present in the storage cabinet;

l. Chemicals were not marked;

m. The biohazard waste container did not have a bottom or a cover; and

n. There were many rust-covered and non-impervious areas.

6. According to the inspection form, Establishment A was given 30 days to correct the deficiencies identified during the inspection.

7. On or about July 27, 2010, the Board's inspector returned to Establishment A for a follow-up inspection. Mr. Hodges refused to allow the Board's inspector access for a full inspection and refused to provide additional paperwork as requested by the Board's inspector.

8. On or about July 2, 2012, the Board conducted an annual inspection of Establishment A. The inspection revealed the following deficiencies:

a. The ownership sign did not reflect the name of the establishment, and the lettering was not a minimum of one inch;

b. The preparation room walls were not impervious (i.e. holes in the walls);

c. The preparation room walls were unsanitary with bodily fluids;

d. There was a large gap at the cabinet base;

e. The body supports were unsanitary, and were not smooth and impervious;

f. The preparation room floor was unsanitary and non-impervious (i.e. holes in the vinyl flooring);

g. The preparation room floor was littered with mop strings;

h. The wallpaper in the preparation room was not smooth and impervious;

i. The drain pipe for bodily fluids was rusted and eroded where it met the floor, and was not painted, smooth or impervious;

j. The biohazard waste was placed in a regular trash can;

k. The preparation tables were rusty and unsanitary and were not impervious;

l. There was exposed wood that was unsealed and unsanitary; and

m. The floor moulding was loose, causing unsanitary conditions.

9. The deficiencies identified at the July 2, 2012 inspection were discussed with the Respondent, who also signed the inspection report. A copy of the inspection report was left with the Respondent, and she was given 30 days to make all corrections.

10. On or about September 5, 2012, the Board's inspector returned to Establishment A for a follow-up inspection. Upon the inspector's arrival, neither the Respondent nor Mr. Hodges was on the premises and the preparation room was locked.

11. While waiting for the Respondent to arrive, the Board's inspector inspected other areas of Establishment A besides the preparation room. The Board's inspector found that there were ceiling tiles in the chapel area that were loose and in danger of falling. The Board's inspector also observed that the Respondent did not correct the ownership sign.

12. Upon the arrival of the Respondent, the Board's inspector inspected the preparation room and identified the following deficiencies:

a. The preparation room walls had not been repaired;

b. The preparation table drain pipe had not been repaired;

c. The preparation tables were still rusted;

d. The floor moulding had not been repaired;

e. A mop bucket filled with dirty water was observed in the preparation room;

f. The preparation room floor was littered with mop strings;

g. There was exposed wood that was unsealed and unsanitary; and

h. The wallpaper had not been repaired.

13. The Board's inspector also observed two bodies on a Formica countertop with visible body fluids on the countertop, and one body on a padded stretcher with corrosion on the stretcher carriage and wheels.[2]

14. On or about April 23, 2013, the Board's inspector conducted a second follow-up inspection of Establishment A and identified the following deficiencies:

a. The wallpaper had not been repaired;

b. The preparation room walls had not been repaired;

c. The floors were unsanitary (i.e. holes in vinyl flooring, dirty mop strings in the floor, and dirt on the floor);

d. The walls were unsanitary (i.e. body fluid and filth);

e. Three embalmed bodies were observed on top of a countertop. One male body was clothed and lying in what appeared to be dried

[2] The September 5, 2012 inspection was terminated prematurely because Mr. Hodges was hostile toward the Board's inspector.

body fluids and two additional bodies (one male and one female) were unclothed. All three bodies were under one plastic sheet;

f. A mop bucket filled with dirty water was observed in the preparation room;

g. Broken cabinet doors where chemicals are stored; and

h. Loose ceiling tiles in the chapel area.

15. Further investigation revealed that the two unclothed human remains were Decedent A (male, date of death: April 17, 2013) and Decedent B (female, date of death: January 4, 2013).[3]

16. A form titled, "Identification of Body to be Cremated," which was witnessed by the Respondent, indicated that Establishment A took possession of Decedent B on or about January 8, 2013. Documents observed during the inspection indicate that Decedent B was to be embalmed and that a viewing and a service with a rental casket had been purchased. Decedent B's remains were not encased in a casket or a container.

17. In furtherance of the Board's investigation, the Board's inspector contacted Decedent B's next of kin, who indicated that they owed a balance of approximately $2200 on Decedent B's funeral bill. According to Decedent B's next of kin, the Respondent-Establishment would not release Decedent B's remains until the balance was paid.

18. Decedent B's remains are still in the Respondent-Establishment's custody.

[3] In order to maintain confidentiality, decedent's names will not be used in this document, but will be provided to the Respondent upon request to the administrative prosecutor.

19. The deficiencies observed at the inspection on April 23, 2013 were discussed with the Respondent, who signed the inspection form. A copy of the inspection form, along with copies of the inspection forms from the previous two inspections, were left with the Respondent.

CONCLUSIONS OF LAW

Based on the foregoing investigative findings, the Board concludes that the public health, safety, and welfare imperatively requires emergency action in this case, pursuant to Md. State Gov't Code Ann. § 10-226(c)(2).

ORDER

Based on the foregoing Investigative Findings and Conclusions of Law, it is this 12th day of June 2013, by a majority of the Board:

ORDERED that the license issued to the Respondent to practice mortuary science in the State of Maryland under license number M00685 is hereby **SUMMARILY SUSPENDED**; and it is further

ORDERED that the Respondent is prohibited from practicing mortuary science the State of Maryland; and it is further

ORDERED that a post-deprivation hearing on the Summary Suspension has been scheduled for **Wednesday, July 10, 2013 at 10:15 a.m.** at the State Board of Morticians and Funeral Directors, 4201 Patterson Avenue, Baltimore, Maryland 21215; and be it further

ORDERED that the Respondent shall immediately return all licenses to the Board; and it is further

ORDERED that this **ORDER FOR SUMMARY SUSPENSION** is a **PUBLIC DOCUMENT** as defined in Md. State Gov't Code Ann. §§ 10-611 *et seq.* (2009 Repl. Vol. and 2010 Supp.).

6/18/13
Date

Dr. Hari P. Close, President
Maryland Board of Morticians and Funeral Directors