

IN THE MATTER OF * **BEFORE THE**
MARK M. MCELWEE, N.H.A. * **MARYLAND STATE BOARD OF**
RESPONDENT * **EXAMINERS OF NURSING HOME**
* **ADMINISTRATORS**
License Number: R1444 * **Case Number: 2020-004**

* * * * *

CONSENT ORDER

On October 15, 2021, the Maryland State Board of Examiners of Nursing Home Administrators (the “Board”) charged Mark McElwee, LNHA, (the “Respondent”), License Number R1444, under the Maryland Nursing Home Administrators Licensing Act (the “Act”), codified at Md. Code Ann., Health Occ. §§ 9-101 *et seq.* (2014 Repl. Vol. and 2019 Supp.); and under Code Md. Regs (“COMAR”) 10.33;01 *et seq.* and 10.07.01 *et seq.*

Specifically, the Board charged the Respondent under the following provisions of Health Occ. § 9-314:

....

(b) Grounds for reprimands, suspensions, revocations, and fines: -- Subject to the hearing provisions of § 9-315 of this subtitle, the Board may deny a license or limited license to any applicant, reprimand any licensee or holder of a limited license, place any licensee or holder of a limited license on probation, suspend or revoke a license or limited license, or impose a civil fine if the applicant, holder, or licensee:

....

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

....

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

- (a) Powers: -- In addition to the powers set forth elsewhere in this title, the Board may:
 - (1) Adopt rules and regulations to carry out the provisions of this title[.]

The pertinent provisions of COMAR provide as follows:

COMAR 10.33.01.15. Suspension and Revocation of Licenses.

- A. Pursuant to Health Occupations Article, §9-314(b)(3), Annotated Code of Maryland, the Board may deny a license or limited license to any applicant, suspend or revoke a license of a nursing home administrator, or reprimand or otherwise discipline an applicant or a licensee after due notice and an opportunity to be heard at a formal hearing, upon evidence that the applicant or licensee:
 - (1) Has violated any of the provisions of the law pertaining to the licensing of nursing home administrators or the regulations of the Board pertaining to it;
 - (2) Has violated any of the provisions of the law or regulations of the licensing or supervising authority or agency of the State or political subdivision of it having jurisdiction of the operation and licensing of nursing facilities;
 -
 - (9) Has endangered or sanctioned the endangerment of the safety, health, and life of any patient;
 - (10) Has failed to oversee and facilitate the nursing facility's quality improvement processes to the extent that the safety, health, or life of any patient has been endangered[.]

COMAR 10.07.09.08. Resident's Rights and Services.

.....

C. A resident has the right to:

.....

(5) Be free from:

(a) Physical abuse;

.....

(c) Sexual abuse[.]

COMAR 10.07.09.15. Abuse of Residents.

....

D. Investigations. A nursing facility shall:

- (1) Thoroughly investigate all allegations of abuse; and
- (2) Take appropriate action to prevent further incidents of abuse while the investigation is in progress, and after that.

COMAR 10.07.02.09. Administration and Resident Care.

A. Responsibility.

- (1) The licensee shall be responsible for the overall conduct of the comprehensive care facility or extended care facility and for compliance with applicable laws and regulations.
- (2) The administrator shall be responsible for the implementation and enforcement of all provisions of the Patient's Bill of Rights Regulations under COMAR 10.07.09.

The pertinent provisions of the Federal Regulations provide as follows:

42 C.F.R. § 483.12 Freedom from abuse, neglect, and exploitation.

The resident has the right to be free from abuse, neglect, and misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the patient's medical symptoms.

- (a) The facility must-
- (1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;
 -
- (b) The facility must develop and implement written policies that:
- (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,
 - (2) Establish policies and procedures to investigate any such allegations, and
 - (3) Include training as required at paragraph § 483.95
 - (4) Establish coordination with the QAPI program required under § 483.75
 -
- (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:
-
 - (2) Have evidence that all alleged violations are thoroughly investigated.
 - (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

On December 22, 2021, the Respondent and his attorney appeared at a Case

Resolution Conference (“CRC”) before the CRC Panel of the Board. As a result of the negotiations before and during the CRC, the Respondent agreed to enter into the following Consent Order consisting of Findings of Fact, Conclusions of Law, Order, and Consent.

FINDINGS OF FACT

The Board makes the following Findings of Fact:

1. At all times relevant hereto, the Respondent was a licensed nursing home administrator in Maryland. The Respondent was initially issued a license to practice as a nursing home administrator on August 18, 2000, under license number R1444. The Respondent’s license is scheduled to expire on August 14, 2023.
2. At all times relevant hereto, the Respondent was employed as the administrator of a nursing home (“Nursing Home”),¹ located in Baltimore, Maryland.

July 2, 2019 Office of Health Care Quality Annual Survey

3. The Office of Health Care Quality (“OHCQ”) conducted an annual survey (“July 2019 OHCQ Survey”) of the Nursing Home on June 26-28, 2019 and July 1-2, 2019. On June 28, 2019 at 1:49 p.m., an “immediate jeopardy situation” was identified based on the Nursing Home’s failure to provide adequate supervision for Resident #5; and, failure to promptly investigate and initiate corrective actions for repeated expressions of sexually inappropriate behavior by Resident #5 which posed an immediate threat to the health and safety of other vulnerable residents.

¹ For privacy purposes, where possible, proper names have been omitted and replaced with generic placeholders.

4. The Nursing Home initially submitted three (3) plans of action which were rejected by OHCQ. A fourth plan of removal was submitted and approved at 7:06 p.m. on June 28, 2019. However, the immediate jeopardy was not removed until July 1, 2019 at 5:30 p.m. After the removal of the immediate jeopardy, the deficient practice remained with potential for more than minimal harm at a scope and severity of D.

5. The July 2019 OHCQ Survey Report revealed the following:²

- a. The Nursing Home failed to provide ongoing supervision of Resident #5³ who had a history of making sexual comments to female/male residents and staff and engaged in inappropriate touching of a resident.
- b. Resident #5's medical records revealed that the male patient had diagnoses that included dementia, schizoaffective disorder and unspecified psychosis. A Substitute Decision Making form dated July 31, 2018 indicated that Resident #5 was unable to make medical and financial decisions due to schizoaffective disorder; and, Decision Making Capacity and Treatment Limitation forms dated June 21, 2011 and June 20, 2018 indicated Resident #5 was not capable of making and communicating decisions regarding medical care.
- c. The facility failed to conduct thorough investigations of incidents and inappropriate sexual expressions by Resident #5 towards Residents #1 and #6.

December 6, 2018 Incident

- d. The Nursing Home failed to ensure a cognitively impaired resident ("Resident #6") was free from abuse by Resident #5 who was found fondling Resident #6 in his/her room.

² The deficiencies cited to in paragraph 5 of this document only constitute a portion of the deficiencies found at the Nursing Home and do not constitute all of the deficiencies cited by the OHCQ Surveyor in Form CMS-2567, dated July 2, 2019. For the complete list of deficiencies cited in the July 2, 2019 report, please see the Summary of Statement of Deficiencies on pp. 1-53 on Form CMS-2567 for the OHCQ Survey conducted at the Nursing Home on June 26 through June 28, 2019 and July 1, 2019 through July 2, 2019.

³ As a matter of convenience, the resident and staff identifiers used in this charging document are consistent with the placeholders used in OHCQ's Survey Report.

- e. Resident #6's diagnoses included dementia and behavioral disturbances.⁴ Resident #6's BIMS score was 5 out of 15, indicating severe cognitive impairment.
- f. An incident report revealed that on December 6, 2018, staff found Resident #6 in Resident #5's room with the door closed. Staff observed Resident #5 rubbing Resident #6's buttocks and Resident #6 was "hugging and feeling on" Resident #5.
- g. In a progress note dated December 6, 2018 at 4:46 p.m., LPN #2 documented that Resident #6 wandered to another unit and was found in Resident #5's room hugging and "feeling on him." Resident #5 was rubbing Resident #6's buttocks. The residents were separated.
- h. The December 31, 2018 initial Care Plan for Resident #5, which was updated on April 25, 2019, indicated that Resident #5 had a "fondness for females/males." The interventions cited required staff to "maintain a calm approach" and redirect Resident #5 if the resident is found in a female/male's room and obtain a psychiatric evaluation. If Resident #5 became physically aggressive, staff were to move Resident #5 to a calm environment.

June 7, 2019 Incident

- i. The Nursing Home failed to thoroughly investigate incidents of sexually inappropriate behavior.
- j. A Progress Note dated June 7, 2019 and written by RN #1 stated that Resident #5 had a fondness for male/female residents, and approaches them with impulsiveness and aggressiveness. RN #1 documented that Resident #5 had an episode of holding a male/female resident from behind and the residents were separated. RN #1 documented that Resident #5 said, "I like [him/her]."
- k. In an interview, the DON told the OHCQ Surveyor that this incident involved Resident #5 inappropriately touching a staff member and not another resident and she discussed the incident with the psychiatric Nurse Practitioner. The DON was unable to identify the staff member

⁴ According to Assessment of Resident #6 on December 20, 2018, Resident #6 was confused and continued to engage in "caretaking for other residents" due to her strong identity and history as a caregiver.

involved.

- l. During an interview with the OHCQ Surveyor, RN #2 said that Resident #1 was the resident referenced in the incident that occurred on June 7, 2019. RN #2 said that while Resident #5 touched other residents inappropriately, he was fixated on Resident #1. RN #2 said that Resident #5 told her he could not control his impulses towards Resident #1.

June 13, 2019 Transfer to Hospital for Evaluation

- m. A physician's note dated June 11, 2019 documented that Resident #5 had behavior issues with inappropriate behavior towards females/males and was referred for psychiatric evaluation.
- n. On June 13, 2019, the physician wrote an order to transfer Resident #5 to the hospital ("Hospital") for evaluation due to change in mental status.
- o. The Hospital's Physician Progress Note dated June 13, 2019, at 6:16 p.m. reported that Resident #5 was sent to the emergency room because he/she was acting out sexually towards resident and staff and that nursing home staff were requesting new placement for Resident #5.
- p. The Nursing Home failed to document the details of Resident #5's change in condition in his medical records which resulted in Resident #5's transfer to a hospital on June 13, 2019. The physician's order dated June 13, 2019 ordering Resident #5 to be transferred merely stated that Resident #5 was being transferred to the emergency department for evaluation of a "change in mental status."
- q. In the interview with the OHCQ Surveyor, the DON stated that Resident #5 was pacing more as though he was looking for something and making sexual comments to female staff and residents. These behaviors were not documented in Resident #5's medical record.

June 18, 2019 Incident

- r. The Nursing Home failed to ensure a cognitively impaired resident, Resident #1, was free from abuse by Resident #5 who engaged in inappropriate touching of Resident #1.

- s. According to the incident report, a kitchen staff member (“Dietary Aide #1”) reported that on June 18, 2019, Resident #5 had inappropriate contact with Resident #1 in the dining room at approximately 9:00 a.m. Resident #5 was seen on top of Resident #1 and attempting to remove Resident #1’s pants.
- t. In Dietary Aide #1’s written statement dated June 18, 2019, the Dietary Aide wrote that she went into the dining room to clean up and found Resident #1 on the floor with Resident #5 on top of her. Resident #1 was crying and Resident #5 was trying to remove Resident #1’s pants.
- u. The DON documented in a Progress Note dated June 18, 2019 at 1:14 p.m. that Resident #5 was fully clothed when found with Resident #1. The residents were separated and Resident #5 was placed on one-to-one observation.
- v. The Social Services designee documented on June 19, 2019 at 9:02 a.m. that the kitchen staff member notified her that Resident #5 had been lying on top of Resident #1 and trying to pull Resident #1’s pants down. Resident #5 verbalized that he had raped Resident #1 and did not know why he/she did it.
- w. In an interview with the OHCQ Surveyor on June 27, 2019, the DON stated that after they separated Resident #5 and Resident #1 on June 18, 2019, that Resident #1 was “shaky” and appeared to be hugging herself. The DON said she took Resident #1 back to her room and to assess Resident #1 to make sure she had no injuries. The DON said that the facility concluded that there was no actual sexual contact and therefore no need to send Resident #1 to the hospital for evaluation. The DON also told the OHCQ Surveyor that Resident #5 had a history of verbalizing that he wanted to marry or rape someone.
- x. In her interview with the OHCQ Surveyor on June 27, 2019, LPN #1 said she was called from another unit to go to the cafeteria and that she found Resident #1 with her pants partially down. When LPN #1 redirected Resident #5 back to his room, Resident #5 stated, “I was trying to rape her.”
- y. In an interview with the OHCQ Surveyor on June 27, 2019, GNA #2 reported that approximately one month earlier (in May 2019) she

heard commotion in the hallway and found Resident #5 on the floor attempting to hold Resident #1 down. When Resident #1 tried to get up, Resident #5 tried to pull her back down and stated that he “loved her.” GNA #2 told the OHCQ Surveyor that she reported this incident to the DON and provided the DON a written statement regarding the incident.⁵

- z. GNA #5 reported to the OHCQ Surveyor, that it wasn’t until after the incident that occurred on June 18, 2019 that she was told to stay with Resident #5 at all times and provide 1:1 supervision.⁶
- aa. Upon review of the Nursing Home’s investigation packet⁷ of the June 18, 2019 incident, the OHCQ Surveyor found that the Nursing Home had failed to thoroughly investigate the incident and the possible contributing factors, failed to provide adequate education following the incident, and failed to implement sufficient interventions to maintain the safety of the residents from future harm. These deficiencies are what prompted the declaration of the immediate jeopardy situation on June 28, 2019.

June 24, 2019 Transfer to Hospital for Evaluation

- bb. Patient #5’s medical records contained a telephone order dated June 24, 2019 at 3:30 p.m. that directed staff to send Resident #5 to the hospital for evaluation for inappropriate sexual behavior and endangering self and others.
- cc. During an interview with the OHCQ Surveyor, the Respondent stated he had no knowledge of the inappropriate touching incident involving Resident #5 that occurred on June 7, 2019. The Respondent stated that Resident #5 remained on one-to-one observation after the incident that occurred on June 18, 2019 until his transfer to the hospital on June 24, 2019. The Respondent stated that he had not received reports of any other incidents.

6. As a result of its investigation in July 2019, OHCQ made the following findings:

⁵ The OHCQ Surveyor was not provided a copy of GNA #2’s written statement about this incident.

⁶ A review of Resident #5’s medical records revealed no physician’s order or plan in Resident #5’s Plan of Care that indicated staff were to provide 1:1 supervision to Resident #5.

⁷ The Nursing Home’s investigation packet only contained Dietary Aide #1’s statement, a blank incident form, contact information for a police officer and the self-report. No other staff statements were obtained.

- a. The Nursing Home failed to post a sign that directs residents and visitors to the location of the survey results in violation of C.F.R. § 483.10(g)(10)(11).
- b. The Nursing Home violated C.F.R. 483.12 in that it:
 - i. Failed to provide ongoing supervision of Resident #5 who had a history of making sexual comments to female/male residents and staff and engaged in inappropriate touching of a female resident;
 - ii. Failed to ensure a cognitively impaired resident (Resident #1) was free of abuse by Resident #5 who engaged in inappropriate touching of Resident #1;
 - iii. Failed to ensure a cognitively impaired resident (Resident #6) was free of abuse by Resident #5 who was found fondling Resident #6 in his room;
 - iv. Failed to thoroughly investigate incidents of sexually inappropriate behavior by Resident #5 to prevent future occurrences of the behavior;
 - v. Failed to protect a cognitively impaired resident (Resident #3) from abuse by GNA #4[.]
- c. The Nursing Home's failure to provide adequate supervision for Resident #5 and promptly investigate and initiate corrective actions for repeated expressions of sexually inappropriate behavior by Resident #5, posed an immediate threat to the health and safety of other vulnerable residents resulting in an immediate jeopardy situation.

7. By letter dated July 18, 2019, OHCQ issued a Notice of Immediate Jeopardy, Substandard Quality of Care and Possible Imposition of Other Remedies to the Respondent based upon the findings of the Health Survey conducted on June 25-June 28, 2019 and July 1-2, 2019.

8. By letter dated July 29, 2019, OHCQ Health Facilities Survey Coordinator issued a

Notice of Current Deficiencies and Possible Imposition of Remedies to the Respondent
reissuing a corrected form CMS-2567 to the Respondent.

9. On or about August 21, 2019, OHCQ received a *Revised Plan of Correction*⁸ from the Nursing Home's new administrator ("Administrator 2") in which she indicated that: 1) Notice of availability of the results of the most recent survey was posted in a case near the desk at the main entrance; 2) Resident #5 was transferred and admitted to a hospital on June 24, 2019; 3) Resident #1 was transferred and admitted to a hospital on June 30, 2019; 4) Resident #6 remained at the facility; 5) the Administrator, social worker, and DON re-educated facility staff on identifying behaviors that could lead to incidents of inappropriate touching of cognitively impaired residents; 6) the components of the investigation process of these types of incidents would include, but not be limited to, collecting resident and employee statements, communications with responsible parties, reviewing of staffing assignments, review of resident care plans, physician orders, staff education, etc.; 7) immediate actions would be taken when a resident exhibits sexually inappropriate /aggressive behavior to include a review of staffing patterns and education regarding accurate documentation and reporting of incidents, along with prevention of abuse and neglect.; 8) facility staff were re-educated on June 30, 2019 regarding the levels of supervision provided by nursing staff so that all facility staff understands what one-to-one

⁸ The description of the Nursing Home's August 21, 2019 Revised Plan of Correction in paragraph 9 of this document serves as only a brief summary of the Revised Plan of Correction and does not constitute the entire detailed Revised Plan of Correction submitted to OHCQ by the Nursing Home. See pages 1-53 of the Revised Plan of Correction Form CMS-2567, signed by Administrator 2 on August 21, 2019, for a complete list of all the corrections made by the Nursing Home.

supervision entails.

Board Investigation

10. Based upon the July 2019 OHCQ survey, the Board initiated an investigation and obtained the following documents: the OHCQ Surveyor's investigative notes, staffing sheets, relevant resident medical records, correspondence between OHCQ and the Respondent.

11. In his March 20, 2020 written statement to the Board, the Respondent wrote the following:

- a. Regulations indicate that his role as an NHA "amounts to almost nothing, or at least nothing directly" related to "molding clinical judgement."
- b. He is responsible for the "overall conduct" of the facility, as well as the implementation and enforcement of the resident's bill of rights. But that "overall conduct" of the facilities only includes tasks such as "maintenance of employment records", "development and maintenance of policies regarding admission, clinical records, and infection control."
- c. An NHA is "limited to dealing with employment issues."
- d. The alleged failures cited in the survey documents were entirely dependent on the nursing staff's clinical judgment.
- e. There was nothing he could have done about any of the clinical matters regarding Resident #5.
- f. He could make sure that all facility and staff knew and enforced the facility's policy regarding investigation and reporting of incidents of abuse.
- g. The alleged incident on June 7, 2019 involved a staff member and was not reportable.

- h. He took all the steps within his power to prevent and remedy the alleged abuse and “the fact that Resident #5 acted out sexually is a failure attributable to lack of nursing judgment.”

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent violated:

Health Occ. § 9-314

- (b) Grounds for reprimands, suspensions, revocations, and fines: -- Subject to the hearing provisions of § 9-315 of this subtitle, the Board may deny a license or limited license to any applicant, reprimand any licensee or holder of a limited license, place any licensee or holder of a limited license on probation, suspend or revoke a license or limited license, or impose a civil fine if the applicant, holder, or licensee:

....

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

....

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

- (a) Powers: -- In addition to the powers set forth elsewhere in this title, the Board may:
 - (1) Adopt rules and regulations to carry out the provisions of this title[.]

COMAR 10.33.01.15. Suspension and Revocation of Licenses.

- A. Pursuant to Health Occupations Article, §9-314(b)(3), Annotated Code of Maryland, the Board may deny a license or limited license to any applicant, suspend or revoke a license of a nursing home administrator, or reprimand or otherwise discipline an applicant or a licensee after due notice and an opportunity to be heard at a formal hearing, upon evidence that the applicant or licensee:

- (1) Has violated any of the provisions of the law pertaining to the licensing of nursing home administrators or the regulations of the Board pertaining to it;
- (2) Has violated any of the provisions of the law or regulations of the licensing or supervising authority or agency of the State or political subdivision of it having jurisdiction of the operation and licensing of nursing facilities;

....

- (9) Has endangered or sanctioned the endangerment of the safety, health, and life of any patient;
- (10) Has failed to oversee and facilitate the nursing facility's quality improvement processes to the extent that the safety, health, or life of any patient has been endangered[.]

COMAR 10.07.09.08. Resident's Rights and Services.

....

C. A resident has the right to:

....

- (5) Be free from:
 - (a) Physical abuse;
-
- (c) Sexual abuse[.]

COMAR 10.07.09.15. Abuse of Residents.

....

D. Investigations. A nursing facility shall:

- (1) Thoroughly investigate all allegations of abuse; and

- (2) Take appropriate action to prevent further incidents of abuse while the investigation is in progress, and after that.

COMAR 10.07.02.09. Administration and Resident Care.

A. Responsibility.

- (1) The licensee shall be responsible for the overall conduct of the comprehensive care facility or extended care facility and for compliance with applicable laws and regulations.
- (2) The administrator shall be responsible for the implementation and enforcement of all provisions of the Patient's Bill of Rights Regulations under COMAR 10.07.09.

42 C.F.R § 483.10 Resident rights.

....

- (e) Respect and dignity. The resident has a right to be treated with respect and dignity, including:
 - (3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health and safety of other residents.

42 C.F.R. § 483.12 Freedom from abuse, neglect, and exploitation.

The resident has the right to be free from abuse, neglect, and misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the patient's medical symptoms.

- (a) The facility must –
 - (1) Not use verbal, mental, sexual, or physical abuse, corporal

punishment, or involuntary seclusion;

-
- (b) The facility must develop and implement written policies and procedures that:
- (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,
 - (2) Establish policies and procedures to investigate any such allegations, and
 - (3) Include training as required at paragraph § 483.95
 - (4) Establish coordination with the QAPI program required under § 483.75

-
- (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

-
- (2) Have evidence that all alleged violations are thoroughly investigated.
 - (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.
-

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is, by the Board,
hereby:

ORDERED that the Respondent Mark M. McElwee, LNHA, is **REPRIMANDED**;

and it is further

ORDERED that the Respondent is placed on **PROBATION** for a **MINIMUM** of

ONE YEAR. During the probationary period, the Respondent shall comply with the following probationary terms and conditions:

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

2. Within **ONE YEAR**, the Respondent shall enroll in and successfully complete, at his expense, Board-approved courses in: **(a) quality assurance process/procedures; (b) resident rights (which shall include the prevention of sexual abuse); (c) ethics; and (d) responsibilities and role of the nursing home administrator.** The following terms and conditions apply:

- (a) It is the Respondent's responsibility to locate, enroll in and obtain the Board's Credentials Committee's approval of the courses before the courses are begun
- (b) The Respondent shall provide the Board with the appropriate course information for the courses he intends to take, which will be presented to the Board's Credentials Committee;
- (c) After completion of the approved courses, the Respondent must provide documentation to the Board that the Respondent has successfully completed the courses;
- (d) The courses shall not be used to fulfill the continuing education credits required for license renewal;
- (e) The Respondent is responsible for the cost of the courses;
- (f) The Respondent shall provide the Board with documentation that he successfully completed the courses no later than **ONE (1) YEAR** after the Consent Order goes into effect.

3. The Respondent shall not petition the Board for early termination of probation or any of the terms and conditions of the Consent Order.

AND IT IS FUTHER ORDERED that **no earlier than ONE YEAR** 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 the probationary status be terminated. The probation will be terminated if the Respondent has complied with all probationary terms and conditions; and it is further

ORDERED that, if the Respondent allegedly fails to comply with any of the terms or conditions of this Consent Order, the Respondent shall be given notice and an opportunity for a hearing. After the hearing, if the Board determines that the Respondent failed to comply with the any term or condition of the Consent Order, the Board may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, or suspend the Respondent's license with appropriate terms and conditions, or revoke the Respondent's license. The Board may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine in an amount allowed under Health Occ. § 9-314.1; and it is further

ORDERED that a violation of probation constitutes a violation of this Consent Order; and it is further

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

ORDERED that if the Respondent's license expires or becomes inactive during the period of probation, the probation and any conditions will be tolled; and it is further

ORDERED that during the period of probation, the Respondent's status as a

Mark McElwee, NHA
License Number R1444
Consent Order

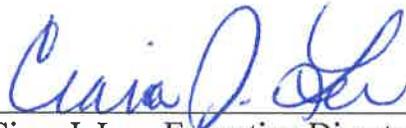
licensed nursing home administrator shall be listed in the Board's database and on its website as being on probation; and it is further

ORDERED that any time prescribed in this Order begins when the Consent Order goes into effect. The Consent Order goes into effect upon the signature of the Board's Executive Director, who is designated to sign on behalf of the Board; and it is further

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

See also Health Occ. § 1-607; Gen. Prov. § 4-333(b)(6).

1/19/2022
Date 



Ciara J. Lee, Executive Director
Maryland State Board of Examiners of Nursing
Home Administrators

CONSENT

I, Mark M. McElwee, LNHA, License No. R1444, acknowledge that I have had the opportunity to consult with counsel before signing this Consent. By this Consent, I agree and accept to be bound by this Consent Order and its conditions and restrictions. I waive my rights to a full evidentiary hearing and I waive any rights I may have had to contest the Findings of Fact, Conclusions of Law and Order.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel,

Mark McElwee, NHA
License Number R1444
Consent Order

to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections as provided by law. I acknowledge the legal authority and the jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I also affirm that I am waiving any right to appeal this Consent Order.

I acknowledge that by failing to abide by the conditions set forth in this Consent Order, I may be subject to disciplinary actions, which may include revocation of my license to practice as a nursing home administrator.

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.

1/14/2022
Date

Mark M. McElwee
Mark M. McElwee, LNHA

Mark McElwee, NHA
License Number R1444
Consent Order

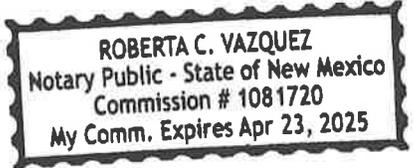
NOTARIZATION

STATE OF New Mexico

CITY/COUNTY OF Steubenville

I HEREBY CERTIFY that on this 14 day of Jan, 2022,
before me, a Notary Public of the State and City/County aforesaid, personally appeared
Mark M. McElwee, and gave oath in due form of law that signing the foregoing Consent
Order was his voluntary act and deed.

AS WITNESSETH, my hand and Notary Seal.



Roberta C. Vazquez
Notary Public

My commission Expires: April 23, 2025