

IN THE MATTER OF	*	BEFORE THE STATE
DAVID INSEL, N.H.A.	*	BOARD OF EXAMINERS OF
Respondent	*	NURSING HOME ADMINISTRATORS
License Number: R1955	*	Case Number: 2020-008

* * * * *

FINAL DECISION AND ORDER

On October 1, 2020, the Maryland State Board of Examiners of Nursing Home Administrators (the “Board”) charged David Insel (“Respondent”), a licensed nursing home administrator, under the Maryland Nursing Home Administrators Licensing Act, Md. Code Ann., Health Occ. §§ 9-101—9-501; and under COMAR 10.33.01 *et seq.*; COMAR 10.07 *et seq.*; and 42 C.F.R. § 483.12.

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

• • • • •

- (b) 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) 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 Respondent was charged with violating the following COMAR provisions:

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^[1];
 - (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:

....

- (b) Verbal abuse;
- (c) Sexual abuse[.]

¹ The term "patient" in the context of a nursing home is the same as "resident," and thus the terms are used interchangeably.

COMAR 10.07.09.15. Abuse of Residents.

C. Reports of Abuse.

- (1) A person who believes that a resident has been abused shall promptly report the alleged abuse to the:

- (b) Licensing and Certification Administration within the Department^[2];

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 Respondent was also charged under the following federal regulations:

42 C.F.R. § 483.12

- (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:
 - (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the

² The Office of Health Care Quality ("OHCQ") was formerly named the Licensing and Certification Administration.

allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

- (2) Have evidence that all alleged violations are thoroughly investigated.

....

- (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

An evidentiary hearing was held before the Board *via* video-conference on May 13 and 27, 2021. The Respondent was represented by counsel. The State was represented by an administrative prosecutor from the Health Occupations Prosecution and Litigation Unit of the Office of the Attorney General. At the hearing, the State presented the testimony of the Board investigator. The Respondent testified on his own behalf and also presented testimony from:

- Vice President of Operations for the Nursing Home Corporation
- Unit Nurse at Nursing Home (“Unit Director 10”)
- Director of Nursing for the Nursing Home (“DON”), and
- Mother of Resident 41 (“FM 2”)

During the hearing, the following documents (Joint Exhibits, State’s Exhibits, and Respondent’s Exhibits) were admitted into evidence:

Joint Exhibits:

1. January 18, 2019 Nursing Home Response to Notice of Immediate Jeopardy
2. March 13, 2019 Request for Informal Dispute Resolution with Attachments
3. Rosters of Nursing Home Staff and Residents
4. October 24, 2019, Request for Independent Informal Dispute Resolution
5. Resident 41's Admission Record Excerpt
6. December 23, 2018 to December 29 Staffing Sheets
7. Nursing Home's Investigation – before OHCQ Survey – Incidents involving Resident 41
 - A. Nursing Home's Incident Investigation Form
 - B. Notes by DON of Telephone Conversation with Resident 41's Mother, December 28, 2018
 - C. Written Statement of GNA 4, dated December 31, 2018
 - D. Investigation Interview Form for GNA 3, dated January 2, 2019
 - E. Electronic Incident Form, revised January 3, 2019
 - F. Investigation Interview Form for Nurse Supervisor 7, dated January 7, 2019
 - G. Investigation Interview Form for Social Worker, dated January 7, 2019
8. Nursing Home's Investigation – after OHCQ Survey Began – Involving Resident 41
 - A. Written Statement of Nurse Supervisor 14, dated January 19, 2019
 - B. Written Statement of Nurse 18, dated January 19, 2019
 - C. Notes of Interview of Nurse Supervisor 14, dated January 27, 2019
 - D. Notes of Interview of GNA 4, dated January 27, 2019
 - E. Notes of Interview of Nurse Supervisor 7, dated January 27, 2019
 - F. Notes of Interview of Nurse 18, dated January 27, 2019
9. Nursing Home Health and Management Corporation Improvement Plan
10. Nursing Home In-Service Attendance Sheets for Abuse. Incident Management, and Security Access from January-March 2019
11. Attendance Sheets for Abuse In-Service Training conducted on January 4, 2019 and January 10, 2019
12. Respondent's Certificates of Completion of Trainings
13. Police Department Incident Report
14. Police Department Supplemental Incident Report
15. Transcript of Board Investigator's Interview of Respondent, dated June 24, 2020
16. Letter from Respondent to Board's Investigator, dated January 25, 2020
17. Letter from Respondent to the Board's Investigator, dated July 9, 2020
18. Respondent's Licensing Information
19. Respondent's Nursing Home Awards and Recognitions
20. Board's Investigation Report, dated July 20, 2020
21. Board's Charges Against the Respondent, dated October 1, 2020

State's Exhibits

1. Notice of Immediate Jeopardy, Substandard Quality of Care and Possible Imposition of Other Remedies, dated March 1, 2019
2. (not offered)

3. Respondent's Cover Letter to OHCQ, for Plan of Correction, dated April 2, 2019 (State's Exhibit "S." page 10)
OHCQ letter to Respondent regarding Results of IDR, dated March 26, 2019 (S. pages 11-12)
Form CMS 2567 Statement of Deficiencies and Plan of Correction for Survey Completed January 28, 2019 (S. pages admitted 13, 25-43, 101-11, 127-28) (excluded pages 14-24, 44-100, 112-126)
4. Independent Informal Dispute Resolution Findings, December 3, 2019
5. Board Subpoena to OHCQ, dated January 12, 2021
6. Resident 41's Medical Records (excerpts)
7. Resident 41's Visitor Sign-In Logs (excerpts)
8. Employee Timecards
GNA 3 (S. 188-89)
GNA 4 (S. 190-91)
Nurse Supervisor 14 (S. 192-93)
Nurse Supervisor 7 (S. 194-99)
Nurse 18 (S. 200-01)
9. Staffing and Assignment Form for December 24, 2018
10. Nursing Home's Self-Report Forms to OHCQ (handwritten note on 206 not admitted)
11. A. Nursing Home's Investigation – after OHCQ's Survey regarding Resident 41³
B. Typed Statement from GNA 4, with two post-it notes
12. OHCQ Self-Report Form regarding Resident 6
13. Transcript for Training of Nurse 18
14. List of Nursing Home's GNAs, RNs, LPNs as of date of OHCQ Survey

Respondent's Exhibits

1. Investigation Report of Board's Investigator with attachments:
 1. CMS 2567 – OHCQ Survey of Nursing Home
 2. (not offered)
 3. Self-Report of Nursing Home to OHCQ
Nursing Home – Incident Investigation Form
Witness Statements
Abuse & Neglect – PowerPoint Training
 4. Letter, June 25, 2020, from Respondent to Board Investigator
Chronology of Events and
Police Report
Nurse 18 Statement
 5. (not offered)
 6. Circuit Court entries for FM 1
2. List of Nursing Home Employees who Did Not Witness Abuse

³ The document has copies of two Post-it notes on the bottom containing handwritten notes. (S.E. 207.) The Post-it notes were entered into evidence through the testimony of the Board's investigator during direct examination, but, on cross-examination, the investigator testified that he did not know who wrote the notes, and thus the Board has given the notes no weight.

3. Relias Abuse Training Materials

FINDINGS OF FACT

The Board finds that the following facts were proven by the preponderance of the evidence:

1. At all times relevant, the Respondent was licensed to practice nursing home administration in Maryland. The Respondent was initially licensed to practice as a nursing home administrator in Maryland on March 7, 2016, under license number R1955. The Respondent has maintained his license and is currently licensed.
2. At all times relevant, the Respondent was employed as the administrator of a nursing home (“Nursing Home”).⁴ The Nursing Home is located in Maryland. The Respondent has been the administrator at the Nursing Home for over four years.
3. The Board received as a complaint a Form CMS 2567 – Statement of Deficiencies and Plan of Correction from OHCQ after OHCQ conducted a survey of the Nursing Home.⁵ Based upon the Nursing Home’s self-report, OHCQ conducted the survey at the Nursing Home from January 17, 2019, through January 28, 2019. Based upon the complaint, the Board initiated an investigation.

RESIDENT 41

4. Resident 41 became a resident at the Nursing Home in May 2018. Resident 41 is a female, who was 28 years old in December 2018. As a result of cardiac arrest, Resident 41 suffers from anoxic encephalopathy and is in a persistent vegetative state. *[Resident 41]’s medical records revealed that the resident has a history of brain injury, is not able to verbalize whether [she] is in pain or frustrated, had a court-appointed guardian of their person due to lacking sufficient*

⁴ For purposes of ensuring privacy where possible, specific names have generally been omitted.

⁵ CMS is the Centers for Medicare & Medicaid Services of the U.S. Department of Health and Human Services.

*understanding or capacity to make or communicate responsible decisions and was completely dependent on staff for all activities of daily living, ADL.*⁶ Resident 41 is unable to meaningfully communicate and uses a “feeding tube.” Resident 41 does not have the capacity to consent to sexual activity. Prior to Resident 41’s brain injury, she had worked as a nursing assistant at hospitals.

Family Member 1 (FM 1)

5. Family Member 1 is the biological father or the stepfather or the former stepfather of Resident 41.⁷ He visited Resident 41 almost daily, sometimes with FM 2 (Resident 41’s mother) and sometimes by himself. He also spent the entire evening at the Nursing Home with Resident 41 on at least three occasions. On a few occasions, FM 1 was in the room while the Nursing Home staff was changing Resident 41’s gown, and the staff had to ask FM 1 to leave. FM 1 was unemployed during the relevant timeframe.

SEXUAL ABUSE WITNESSED

6. During the November and December 2018 period, FM 1 sexually abused Resident 41 on, at least, three occasions at the Nursing Home. Each of the three incidents of the sexual abuse were witnessed by a different Nursing Home employee: Nurse 18, Geriatric Nursing Assistant (“GNA”) 3, and GNA 4.

NURSE 18

7. On an unknown date in November 2018, at approximately 11:30 p.m., a nurse at the Nursing home, Nurse 18, lightly knocked on Resident 41’s room’s door at the Nursing Home. Nurse 18 did not expect anyone other than Resident 41 to be in the room. Nurse 18 walked into

⁶ This italicized sentence was stipulated to by the parties.

⁷ There was conflicting evidence on FM 1’s relation to Resident 41 and to FM 2. For purposes of this decision, FM 1’s familial status with respect to Resident 41 has little relevance.

Resident 41's room and saw FM 1 standing next to Resident 41 with his hand through the arm hole of Resident 41's shirt, rubbing the left side of Resident 41's bare breast. When Nurse 18 entered, FM 1 seemed startled, and FM 1 rapidly removed his hand from under Resident 41's breast. Resident 41's mother (FM 2) was also in the room, but FM 2 was asleep in a chair. Nurse 18 said excuse me and fed Resident 41.

8. Immediately thereafter, Nurse 18 reported this incident to her supervisor, Nurse Supervisor 14. Nurse Supervisor 14 responded to Nurse 18, "No, that can't happen. That's the father." Nurse Supervisor 14 did not report this incident, at this time, to the Respondent or to any other person in the Nursing Home's management.

GNA 3

9. On the evening of December 19, 2018, near midnight, GNA 3 knocked on Resident 41's door at the Nursing Home, and, when GNA 3 walked in the room, GNA 3 saw FM 1 sitting in a chair close to Resident 41, and FM 1's hands were on top of Resident 41's breasts on the outside of Resident 41's gown. FM 1's back was to the door. When FM 1 saw GNA 3 enter the room, FM 1 was startled and quickly removed his hands from Resident 41's breasts. FM 1 then stood up and sat on another chair. After observing the individual with his hands on Resident 41's breasts, GNA 3 took the resident's vital signs and then left FM 1 in the room with Resident 41.

10. GNA 3 did not immediately report the incident to another Nursing Home employee.

11. Nurse 18 documented in a nursing note, dated December 20, 2018 at 4:22 a.m., that FM 1 "spent the night in the room with" Resident 41.

12. Nurse Supervisor 14 also spoke with GNA 3, and GNA 3 told her about concerns she had with FM 1 and Resident 41. It is unclear when this conversation took place, but it was before Unit Director 10 was notified, on December 28, 2018, about Resident 41 being abused by FM 1.

GNA 4

13. In December 2018, on one evening, in the period from December 24 through December 27, GNA 4 was conducting a routine checkup of Resident 41. Upon opening the door, GNA 4 noticed that FM 1's hands were up the sleeve of Resident 41 and he was touching one of Resident 41's breasts. (J. 193.) GNA 4 was in shock. GNA 4 told FM 1, "OK sir, I'll be back" and closed the door.

14. GNA 4 told her supervisor what she witnessed with respect to FM 1 and Resident 41.

15. Nurse Supervisor 14 went to Resident 41's room to assess Resident 41 for physical signs of trauma. Nursing Supervisor 14 did not observe signs of a traumatic injury on Resident 41. Nursing Supervisor 14 did not record this assessment in Resident 41's medical records.

Respondent Notified of Incidents and Nursing Home Investigates

16. In the morning, on December 28, 2018, Nurse Supervisor 14 reported to Unit Director 10 the allegations of FM 1's abuse of Resident 41. After being notified, Unit Director 10, a registered nurse, also assessed Resident 41 and did not observe signs of trauma. At 7:00 a.m., on the same day, Unit Director 10 notified the DON of the allegations.

17. At about 8:00 am, on December 28, 2018, the DON and Unit Director 10 notified the Respondent of the allegations.

18. On December 28, 2018, the DON called FM 2 (Resident 41's mother) to inform her of allegations against FM 1. FM 2 told the DON that FM 1 would never do anything like that to Resident 41, that there had to be a misunderstanding, and that she was agreeable to telling FM 1 not to visit the facility. Later, the Respondent spoke with FM 2, and FM 2 asked the Respondent to allow FM 1 to visit Resident 41 with supervision. The Respondent denied the request.

19. On December 28, 2018, the Respondent researched the internet to obtain any relevant information pertaining to FM 1.

20. On December 28, 2018, the Nursing Home contacted the police to report the allegations.

21. On December 28, 2018, the police arrived at the Nursing Home to initiate its investigation. Nurse 18 was interviewed by the police about this incident and she told the police that the incident she witnessed occurred on an unknown date in November 2018. Nurse 18 told the police that she walked in the room and saw FM 1's "hand under the victim's shirt touching her breasts. [Nurse 18] advised that the suspect appeared startled when she entered the room and rapidly moved his hand from her breasts." The police report states that Nurse 18 wrote a statement "which was packed as evidence." The DON and Unit Director 10 also told the police that GNA 4 also "witnessed a similar chain of events on 12/24/18 and reported it to them." The police did not interview GNA 4 on that date because GNA 4 was not working when the police were at the Nursing Home. The police advised the Nursing Home that they would follow-up on December 31, 2018. The police also told the Nursing Home that FM 1 would not be able to enter the Nursing Home, and the Respondent immediately prohibited FM 1 from visiting the facility while the investigation was pending.

22. The Nursing Home sent a Self-Report to OHCQ on December 28, 2018, at approximately 5:00 p.m. The report states, "GNA reported that when entering [Resident 41's] room [] she observed [FM 1] touching [Resident 41] inappropriately to the breast area." The Self-Report did not identify the GNA, nor did the Self-Report provide the date of the incident.

23. On December 31, 2018, GNA 4 wrote a statement for the Nursing Home. The written statement said that the incident occurred on the evening of December 24, 2018, and that she reported what she saw to her supervisor on duty that evening.

24. Also, on December 31, 2018, the police returned to the Nursing Home. The Respondent told the police that Nurse 18 and GNA 4 witnessed Resident 41 being assaulted. The Respondent also told the police that GNA 3 thought she witnessed abuse. Nurse 18 was interviewed by the police again on December 31, 2018. Nurse 18 told the police that FM 1 spent the night visiting Resident 41 on two or three occasions by himself. Nurse 18 said that she saw FM 1 “rubbing the left side of [Resident 41’s] bare breast.” Nurse 18 also said that “there was no reason for anyone to place their hands on her chest.” On December 31, 2018, GNA 4 was also interviewed by the police. She told the police that, on December 24, 2018, she saw FM 1’s “hand was up the sleeve of [Resident 41’s] gown as he was touching her breast.” GNA 4 said she was in “shock.”

25. On January 2, 2019, GNA 3 was interviewed by Assistant Director of Nursing (“ADON”) 13 of the Nursing Home. The interview form states that GNA 3 saw a man’s hands on Resident 41’s chest and that the man removed his hands when he saw GNA 3 enter the room. GNA 3 said in the interview that she told “a co-worker” about this incident. The interview notes do not indicate who the co-worker was nor when she reported it to the “co-worker.” The interview form also does not address when the incident took place. Under “Date of Incident,” the form has “12/28/2018,” which is the date the Respondent was notified of allegations of abuse.

26. On January 4, 2019, the police spoke with GNA 3. GNA 3 told the police that the incident she witnessed took place around December 20, 2018, near midnight. GNA 3 told the police that she “was certain that [FM 1]’s hands were on top of [Resident 41’s] breasts, and on the outside of her gown.” To be clear, GNA 3 said, “both of his hands were on her breasts.” GNA 3 also told the police that she did not immediately report the incident because she thought FM 1 was Resident 1’s boyfriend.

27. On January 4, 2019, the Respondent signed the Nursing Home's Incident Investigation Form.

28. On January 4, 2019, the Nursing Home conducted in-service training for its nursing assistants on abuse, abuse recognition, and reporting abuse.

29. On January 7, 2019, FM 1 was arrested at the probation office. The police told the Respondent that FM 1 "was sentenced without bail because of his probation." After his arrest, FM 1 was interviewed by the police. FM 1 denied the allegations. He said he might rub Ben-Gay on Resident 41's joints and muscles to help her range of motion. FM 1 also said that, if Resident 41 is uncomfortable when she is fed through a feeding tube, he would place his hand on the upper part of her chest to calm her down. FM 1 also said that he does not stop what he is doing if a Nursing Home employee enters the room while he is with Resident 41. FM 1 also said that he does not go underneath the gown, unless he was rubbing a muscle relaxer on her shoulders.

OHCQ Begins Survey of Nursing Home

30. On January 17, 2019, OHCQ began its survey of the Nursing Home. OHCQ is the state survey agency for inspections of nursing homes in Maryland.

31. In an interview with OHCQ on January 18, 2019, Nursing Supervisor 14 reported that GNA 4 had notified her of abuse concerns towards the end of the evening shift on December 27, 2018. Nursing Supervisor 14 confirmed that she did not contact the DON or the Administrator about the abuse allegation on December 27, 2018, but instead, she waited until the morning of the following day, December 28, 2018, to inform Unit Director 10.

32. On January 18, 2019, GNA 4 was interviewed by OHCQ. GNA 4 said that the incident she witnessed involving FM 1 and Resident 41 took place on Christmas Eve and confirmed her written statement that the incident she witnessed occurred on December 24, 2018.

33. On January 18, 2019, in an interview with OHCQ, Nurse 18 reported that “before Christmas” “she personally . . . had seen [FM 1] in a compromised position rubbing the left chest and arm” of Resident 41.
34. On January 18, 2019, ADON 13 (who interviewed GNA 3) reported to OHCQ that GNA 3 shared her observations of the incident to GNA 4.
35. On January 19, 2019, Nurse 18 was interviewed by the Nursing Home’s DON. Nurse 18 wrote the statement on the interview form. The statement did not state when the incident occurred or when it was reported.
36. GNA 3 was interviewed by OHCQ on January 22, 2019. GNA 3 explained that the co-worker that she told about the incident was GNA 4.
37. On January 23, 2019, OHCQ interviewed Nurse 18.
38. On January 25, 2019, OHCQ again interviewed the Respondent. The Respondent said that he did not know what Nurse 18 told the police.
39. On January 27, 2019, Nurse 18 was interviewed by the Respondent and Nurse Unit Manager 10. This interview did not address when the incident occurred.
40. Also on January 27, 2019, GNA 4 was interviewed by the Respondent and Unit Director 10. The interview notes say that GNA 4 observed the conduct at issue *after Christmas*, and that GNA 4 was mistaken when she first gave the statement (four weeks earlier). Her earlier statements said the abuse occurred on December 24, 2018, Christmas Eve. The interview notes state that GNA 4 changed the date of her observations when she was interviewed by OHCQ since Nurse Supervisor 14 was not working on Christmas Eve. The notes also indicate that FM 1’s hand was on Resident 41’s breast. GNA 4 also gave another written statement in which she stated that the incident

occurred on December 27, 2018, stating, “The supervisor I directly reported the incident to was not working on December 24, 2018.”

FM 1 – Criminal Proceedings

41. FM 1 was criminally indicted, in the Circuit Court for Baltimore County, on nine counts, including abuse of a vulnerable adult, assault, and sex offenses, concerning the incidents at issue involving Resident 41. There was either a not guilty finding or a judgment of acquittal for each of the charges.

RESIDENT 6

42. On January 18, 2019, during OHCQ’s survey of the Nursing Home, a photograph of a person was noticed at the nurse’s station by an OHCQ surveyor. At that time, OHCQ interviewed Nursing Home Unit Manager 24, requesting information on the photograph. Unit Manager 24 “explained that it was a picture of a family member of Resident 6 who was no longer allowed to enter the facility due to verbal abuse directed at the Resident and a staff member a month ago.”

43. The incident, in which a family member of Resident 6 was allegedly heard by Nursing Home staff verbally abusing Resident 6, occurred on December 28, 2018, and the Nursing Home did not report the incident of alleged abuse to OHCQ at that time.

44. On March 1, 2019, the Nursing Home was cited by OHCQ for a deficiency for its failure to send a report of the alleged verbal abuse to OHCQ.

45. On March 11, 2019, the Nursing Home sent to OHCQ its self-report and its follow-up report concerning the alleged verbal abuse of Resident 6.

DISCUSSION

RESIDENT 41

I. FAILURE TO PROTECT RESIDENT 41 FROM SEXUAL ABUSE

Under the Patient's Bill of Rights, a resident has the right to be free from sexual abuse. COMAR 10.07.09.08C(5)(c). And, under COMAR 10.07.02.09A(1), the nursing home administrator is responsible for the implementation and enforcement of the Patient's Bill of Rights.

The evidence overwhelmingly shows that FM 1 sexually abused Resident 41. On the day this was reported to the police, December 28, 2018, Nurse 18, according to the police report, said that, on an unknown date in November 2018, she walked into Resident 41's room and "observed [FM 1's] hand under [Resident 41's] shirt touching her breasts. [Nurse 18] advised [FM 1] appeared startled when she entered the room and rapidly moved his hand from her breasts." On December 31, 2018, the police again interviewed Nurse 18, who, according to the police report, stated, on December 24, 2018, FM 1's "hand was through the arm hole and underneath [Resident 41's] gown. He was rubbing the left side of [Resident 41's] bare breast." Also, on December 31, 2018, the police interviewed GNA 4, who, according to the police report, observed that "[FM 1's] hand was up the sleeve of [Resident 41's] gown as he was touching her breast. [GNA 4] stated, 'He was definitely in her shirt.' When she observed what was occurring, [GNA 4] stated that she was in 'shock.'" On January 4, 2019, the police interviewed GNA 3, who, observed, "around December 20, 2018, near midnight," that "[FM 1] had both hands on top of [Resident 41's] breasts. [FM 1] was startled by [GNA 3], so he quickly pulled his hands off [Resident 41]." According to the police report, "[GNA 3] was certain that [FM 1's] hands were on top of her breasts." There are, thus, three independent eyewitnesses, who each, on separate occasions, observed remarkably similar conduct by FM 1. And there was no medical, or other, justification for FM 1 to be touching Resident 41's breasts. Clearly, due to her medical condition, Resident 41 could not consent to the touching FM 1 engaged in.

The Respondent claims that, based on the judgment of acquittal/not guilty disposition in FM 1's criminal proceedings, there is insufficient evidence to find that sexual abuse occurred. The Board, however, has given the disposition of the criminal proceeding little weight. First, the beyond a reasonable doubt standard of proof in criminal proceedings is a higher burden for the prosecution than the preponderance of evidence standard in administrative proceedings. Also, the rules governing the admission of evidence are more relaxed in administrative proceedings. The Respondent also presented evidence (the testimony of FM 2) to indicate that there was an innocent explanation for what the witnesses observed. FM 2 stated that she (FM 2) and FM 1 massaged Resident 41 and they performed range of motion exercises for Resident 41. FM 2 described the massages: "You just massage her back, her arms, her legs and do her range of motion. Put muscle cream all over her body and keep massaging it." FM 2 did not mention that the massages or range of motion exercises included touching Resident 41's breasts. The Board finds that FM 1's touching of Resident 41's breasts were not part of a massage or a range of motion exercise. The evidence in this case proved convincingly that Resident 41 was sexually abused by FM 1 on, at least, three occasions at the Nursing Home.

The Respondent next contends that he was unaware of FM 1's alleged abuse of Resident 41 until December 28, 2018, and, once he became aware of the suspected abuse, he immediately called the police and prohibited FM 1 from the Nursing Home. Although the Respondent was unaware of the conduct at issue until December 28, 2018, the Respondent failed to ensure that, before then, the Nursing Home had sufficient safeguards to protect Resident 41. Those safeguards should have been the Nursing Home staff members, who should have known how to respond when they came upon compelling evidence of abuse. The staff did not respond appropriately. While certain staff members did tell other staff of the abuse they witnessed, ultimately, the staff did not

notify the upper management of the Nursing Home in a timely manner, leaving Resident 41 wholly unprotected for at least a month in 2018. Even without the direct observations of sexual abuse, FM 1 displayed disturbing behavior that should have been communicated to the Respondent, or, at least, to the Director of Nursing. The Respondent was not notified until December 28, 2018, of the allegations of abuse because his staff was not sufficiently prepared to react appropriately to the abuse they witnessed. It was the Respondent's responsibility to ensure that his staff knew to immediately report suspicions of abuse. Here, that did not occur.

Resident 41 was a victim of sexual abuse on at least three occasions, during the November and December 2018 period, at the Nursing Home, despite there being several Nursing Home employees who witnessed or had knowledge of these incidents. The Respondent did not substantially enforce and implement the Patient's Bill of Rights requirements, pertaining to protecting Resident 41 from sexual, thus the Respondent violated Md. Code Ann., Health Occ. § 9-314(b)(3), COMAR 10.07.02.09A(2), and COMAR 10.07.09.08C(5)(c) pursuant to COMAR 10.33.01.15A(2).

II. REPORTING OF ALLEGED ABUSE

Alleged violations of abuse shall be reported to the nursing home administrator and State Survey Agency within two hours. 42 CFR § 483.12(c)(1). Also, allegations of abuse must be promptly reported to the appropriate law enforcement agency, state survey agency, or Office on Aging. COMAR 10.07.09.15C(1). Nursing staff observed Resident 41 being sexual abused, once in November 2018 and once on December 19, 2018, but the incidents were not timely reported to the appropriate law enforcement agency, OHCQ, or the Office on Aging. *See* COMAR 10.07.09.15C(2). And all three incidents that were witnessed were not reported as required by 42 CFR § 483.12(c)(1). The Respondent was responsible for the Nursing Home's compliance with

the reporting requirements. COMAR 10.07.02.09A(1) and (2). The reporting requirements, set forth in 42 CFR § 483.12(c)(1) and COMAR 10.07.09.15C, were not substantially met, in violation of H.O. § 9-314(b)(3).

III. REPORTING RESULTS OF NURSING HOME INVESTIGATION TO STATE SURVEY AGENCY WITHIN FIVE DAYS

The Respondent was also charged with violating 42 CFR § 483.12(c)(4), which requires that the results of the Nursing Home's investigation be reported to the State Survey Agency within 5 working days of the incident. The Respondent was notified of the incident on December 28, 2018, and the follow-up report was submitted to OHCQ on January 3, 2019. While the incidents took place well before January 3, 2019, the Respondent did submit a timely follow-up report. The five-day follow-up report did not contain the results of the investigation. It instead said the investigation was ongoing. Considering the particular complexity of this case, and the fact that the five-day period occurred over the New Year holiday when key employees were on vacation, the Board does not take issue with the "ongoing" investigation notification to OHCQ. In sum, the Board does not find that Respondent failed to meet substantially the requirements of 42 CFR § 483.12(c)(4).

IV. FAILURE TO FACILITATE AND OVERSEE FACILITY'S QUALITY IMPROVEMENT PROCESS

The inadequate responses by the Nursing Home staff demonstrate that the quality improvement processes were not substantially complied with. Based upon the evidence in this case, the Board finds that the Nursing Home staff was not adequately trained in recognizing, preventing, or reporting abuse. While the staff may have undergone training addressing abuse of residents, the staff failed to protect Resident 41 to such an extent that it is clear that any training the staff received was ineffective.

Unit Director 10 explained what the staff members who observed the abuse should have done: “Ask them to excuse themselves from the room and call the nursing supervisor and report the incident immediately, but to ultimately keep the resident safe and not to leave the room.” Then the nursing supervisor should have immediately reported the witnesses’ observations to the Respondent, or the witnesses could have reported the abuse directly to the Respondent.

For, at least, four weeks, Resident 41 was left unprotected against FM 1 at the Nursing Home, despite a Nursing Home staff member having observed Resident 41 being sexually abused by FM 1. In addition to the incident in November, there were two other instances in which staff observed sexual abuse of Resident 41 but did not take action in a timely manner to protect her. Although the staff reported it to a supervisor or co-worker, the incidents were not timely communicated to the administrator. There were at least four Nursing Home staff members who were aware of the sexual abuse or were aware of compelling evidence of sexual abuse (Nurse 18, Nurse Supervisor 14, GNA 3 and GNA 4), but none of these four acted appropriately to protect Resident 41. This course of events evinces systemic deficiencies in the Nursing Home concerning an extraordinarily serious area, the protection of residents from abuse, demonstrating a failure by the Respondent to substantially enforce and facilitate the Nursing Home’s quality improvement process to such an extent as to endanger the residents and, in Resident 41’s case, resulting in her suffering actual sexual abuse. Based on these circumstances, the Respondent failed to meet substantially the requirements of COMAR 10.33.01.15A(10), in violation of Health Occ. § 9-314(b)(3).

Based on the fact that the Respondent was not notified of the abuse of Resident 41 until December 28, 2018, the Board has determined that COMAR 10.33.01.15A(10) (quality improvement/endangerment) directly captures the circumstances of this case, and therefore the

more general resident endangerment ground, COMAR 10.33.01.15A(9), applies more to circumstances in which the administrator had a more direct connection to the endangerment, for instance, in cases in which an administrator had knowledge and failed to act or acted with that knowledge in a manner that endangered the resident(s), thus the Board has decided to dismiss the COMAR 10.33.01.15A(9) ground.

V. THE ALLEGATIONS WERE NOT THOROUGHLY INVESTIGATED

The Respondent put forth several arguments, in his defense, concerning the charge that the Nursing Home did not thoroughly investigate the incidents. The Respondent's main contention is that the Nursing Home interviewed numerous employees, amassed numerous witness statements from the key witnesses and reviewed other relevant documentation. The Respondent also contends that the circumstances were made difficult for an investigation due to conflicting statements of witnesses, most notably, the date GNA 4 witnessed the incident, thus there was much work performed by the Respondent in trying to figure out the discrepancies in the evidence. In sum, the Respondent posits that, while the investigation did have some shortcomings, the evidence demonstrates that the Nursing Home put forward an investigation that substantially complied with the regulatory requirements.

While this case presented complicating factors, the investigation overall missed significant pieces that are crucial to any investigation. The three main missing pieces concern when the incidents took place, who the eyewitnesses first spoke to about their observations, and essential details of what the witnesses observed.

Determining when an incident takes place should have been a priority. But on Nurse 18's interview form sheet, which is dated January 19, 2019, the date of the incident is not mentioned or addressed. When the police interviewed Nurse 18, on December 28, 2018, Nurse 18 told them

that the incident occurred sometime in November 2018. The Respondent testified that the first time he heard that the incident witnessed by Nurse 18 occurred in November was from OHCQ during the survey. The Respondent testified that he told OHCQ that he had “spoken with every single possible person that could have been there or wasn’t there and I’ve never heard November before.” The Respondent also testified that Nurse 18 “swears that never [sic] said anything and never saw anything in November.” Nonetheless, on the interview form describing the Respondent’s interview with Nurse 18 (this interview took place on January 27, 2019), there is no mention of the date of the incident and it is not addressed on the form.

On GNA 3’s interview form, the date of the incident is listed as “12/28/2018,” which was when the Respondent first heard of the allegations, not when the abuse observed by GNA 4 occurred. Likewise, on the Nursing Home’s internal Incident Investigation Form incorrectly lists “12/28/18 7AM” as the date of the incidents.

GNA 4 wrote a statement for the Nursing Home stating that “December 24th” was when she observed the incident, and this statement was attached to the internal investigation form. But four weeks later, the Respondent and Unit Director 10 interviewed GNA 4, and GNA 4 said that she was mistaken about the date and indicated that the abuse she witnessed occurred on December 27, not December 24.

Also important to an investigation is identifying the person to whom an eyewitness first spoke to about what they observed. At the very least, this could aid in determining when an incident occurred. It would also provide, to an extent, corroboration of the witness’s account of events. Here, GNA 4’s 12/31/18 written statement says that she “reported what I had seen to my supervisor on duty that evening.” The name of the person to whom it was reported is crucial, but it was not mentioned in GNA 4’s written statement. Four weeks later, the documentation of the

Respondent's interview with GNA 4 says that GNA 4 reported it to Nurse Supervisor 14, but, by that point, GNA 4 had changed the date in which she said she witnessed the incident based upon Nurse Supervisor 14's work schedule in December 2018. Nurse Supervisor 14's written statement, dated January 18, 2019, states that, on December 27, 2018, GNA 4 reported the incident to her and that she (Nurse Supervisor 14) assessed Resident 41, but the assessment is not recorded in the medical records.

Also, in the January 27, 2019, interview, GNA 4 mentions that she also spoke to Nurse 18 about FM 1 conduct with Resident 41 at the time she reported it to Nurse Supervisor 14. But, by that time, GNA 4 could not "recall what [Nurse 18] might have seen or said." What Nurse 18 said to GNA 4 at that time in December was lost because the statement the Nursing Home obtained from GNA 4 in December was lacking in thoroughness.

For GNA 3's interview on January 2, 2019, the Nursing Home interviewer wrote that GNA 3 said that "I shared it with a co-worker." That was not adequate. The identity of the co-worker should have been reported at that point.

In terms of documenting the details of the witnesses' observations, the Nursing Home's investigation documentation was far too vague. The Nursing Home's interview form for Nurse 18, dated January 19, 2019, says that FM 1 was rubbing the "left side of chest area." GNA 3's interview form states that FM 1 had his hands "on her chest." GNA 4's written statement (12/31/18) states, "I noticed the Patient's Father's Hands in her shirt around her breast area." None of these statements says that FM 1's hands were on Resident 41's breast or breasts. On January 27, 2019, when the Respondent interviewed GNA 4, GNA 4 was asked, "When you say you saw the hand on the breast which hand was it and what did it look like." But there is no indication in the interview form stating when or where GNA 4 said the hand was "on the breast."

Comparing these statements to those documented by the police demonstrates how inadequate the Nursing Home's investigation was. On December 31, 2018, Nurse 18 told the police that FM 1 was "rubbing the left side of [Resident 41's] bare breast." Also, on December 31, 2018, GNA 4 told the police that FM 1 was "touching her breast." On January 4, 2019, GNA 3 told the police that FM 1 "had both hands on top of [Resident 41's] breasts." In a sexual abuse investigation, if a witness sees a person's hands on a resident's breast, the documentation needs to be more specific than stating that the suspect's hand was on a resident's chest area.

Thus, while the Nursing Home did amass a lot of statements from the key witnesses, the statements were not thorough. And while an investigation is meant to find the facts, and despite three separate employees each stating that they each observed extraordinarily similar, disturbing conduct by FM 1, the Respondent testified, "And this case, as cloudy as it might have been or as questionable as it might have been, the first day that it was reported to me, it only became cloudier and cloudier and cloudier as time went on."

The Respondent failed to substantially meet the thoroughness requirements for the Nursing Home's investigation concerning the sexual abuse of Resident 41, in violation of COMAR 10.07.09.15D(1) and 42 CFR § 483.12(c)(2); Health Occ. § 9-314(b)(3); COMAR 10.33.01.15A(2); COMAR 10.07.02.09A(1) and (2).

VI. ACTIONS TO PROTECT RESIDENTS DURING AND AFTER INVESTIGATION

On December 28, 2018, the day the Respondent was notified that the Nursing Home staff observed FM 1 sexually abusing Resident 41, the Nursing Home contacted the police. The Respondent also instituted an order prohibiting FM 1 from entering the Nursing Home. Based on the information on the Nursing Home's visitor sign-in log, there was some debate as to whether FM 1 appeared at the Nursing Home on December 28, 2018, to visit Resident 41, but the Board

finds that the date initially written (December 28, 2018 – 4:50 to 6:00) was changed to December 27, 2018, and the Board finds that the change to December 27, 2018, was correct. Thus, the Board finds that FM 1 did not visit Resident 41 at the Nursing Home once the Respondent was notified of the incidents. FM 2 also requested that FM 1 be allowed to visit with supervision. This request was denied.

The Respondent also immediately began extensive trainings for the Nursing Home staff on sexual abuse prevention and reporting. The Respondent also testified as to the impact that this case had on the facility's reporting of suspected misconduct. According to the Respondent, the reports for possible abuse and possible malfeasance has increased dramatically. The Board has determined that the regulation requiring the Nursing Home take appropriate action to prevent further incident during and after the investigation, COMAR 10.07.09.15D(2), was not violated.

RESIDENT 6

VII. FAILURE TO REPORT ALLEGATIONS REGARDING RESIDENT 6 TO STATE AGENCY

The Nursing Home failed to timely report to OHCQ the allegation that Resident 6 was verbally abused. On January 18, 2019, during OHCQ's survey of the Nursing Home, a photograph of a person was noticed at the nurse's station by an OHCQ surveyor, and OHCQ inquired about the photograph. The photograph was of a family member of Resident 6 who was no longer allowed to enter the facility due to alleged verbal abuse directed at the Resident and a staff member on December 28, 2018. The Nursing Home did not report the incident of alleged abuse to OHCQ at that time. On March 1, 2019, the Nursing Home was cited by OHCQ for a deficiency, because it did not send a report of the alleged verbal abuse to OHCQ. On March 11, 2019, the Nursing Home sent to OHCQ its self-report and its follow-up report concerning the alleged verbal abuse of Resident 6. There was a failure to substantially meet the requirements for timely reporting this

allegation of verbal abuse toward Resident 6 to OHCQ, in violation of COMAR 10.07.09.15 and 42 CFR § 483.12(c), and thus, the Respondent was in violation of Health Occ. § 9-314(b)(3), pursuant to COMAR 10.33.01.15A(1) and (2); COMAR 10.07.02.09A(1) and (2). The Board dismisses the COMAR 10.07.09.08C(5)(b) ground.

CONCLUSIONS OF LAW

Based on the Findings of Fact and Discussion, the Board concludes that the Respondent violated the following statutory and regulatory provisions:

Health Occ. § 9-314(b)(3)

(b) Subject to the hearing provisions of § 9-315 of this subtitle, the Board may . . . reprimand any licensee . . . , place any license . . . on probation, suspend or revoke a licensee . . . , or impose a civil fine if the . . . licensee:

....
(3) Otherwise fails to meet substantially the standards of practice adopted by the Board under § 9-205 of this title[.]⁸

COMAR 10.33.01.15A(1), (2), (10)

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

....

⁸ Under Health Occ. § 9-205(a), “. . . the Board may: (1) Adopt rules and regulations to carry out the provisions of this title.”

(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 10.07.02.09A(1), (2)

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.

COMAR 10.07.09.08C(5)(c)

.....

C. A resident has the right to:

.....

(5) Be free from:

.....

(c) Sexual abuse[.]

COMAR 10.07.09.15C(1), D(1)

.....

C. Reports of Abuse.

(1) A person who believes that a resident has been abused shall promptly report the alleged abuse to the:

(a) Appropriate law enforcement agency,

(b) Licensing and Certification Administration within the Department,^[9] or

(c) The Office on Aging.

.....

D. Investigations. A nursing facility shall:

⁹ The Office of Health Care Quality ("OHCQ") was formerly named the Licensing and Certification Administration.

- (1) Thoroughly investigate all allegations of abuse[.]

42 C.F.R. § 483.12(c)(1), (2)

- (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:
 - (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.
 - (2) Have evidence that all alleged violations are thoroughly investigated.

The charges under COMAR 10.33.01.15A(9), COMAR 10.07.09.15D(2), COMAR 10.07.09.08C(5)(b), and 42 CFR 483.12(c)(4) are dismissed.

SANCTION

The Board finds the evidence to be overwhelming that Resident 41 suffered sexual abuse at the Nursing Home. There are three eyewitnesses who each saw FM 1 touching Resident 41's breasts. In the days immediately after the abuse was reported to the police, each eyewitness told the police that FM 1 touched a breast or both breasts of the resident. It was not until December 28, 2018, that the Nursing Home finally took effective measures to protect Resident 41 from FM 1. This is of significant consequence, because Nurse 18 saw Resident 41 being abused sometime in November 2018.

There is no evidence that the Respondent intentionally put Resident 41 in harm's way, but the nursing home administrator is responsible for ensuring that the residents in the facility are not sexually abused. This was not a situation in which an administrator was powerless to prevent such abuse. As the person ultimately responsible for protecting the residents from abuse, a nursing home administrator must ensure that he or she is immediately notified if an employee comes across significant evidence of abuse. To Resident 41's detriment, the requirement to communicate to the Respondent evidence of abuse was not instilled into the employees. It took over four weeks and three separate incidents of sexual abuse before the Respondent was notified.

There is no question that the Respondent genuinely wants to protect the residents, and the Respondent made sure that the police and OHCQ were notified on the same day that he was made aware of the abuse suffered by Resident 41 (although this was not the case with Resident 6). But it is of paramount importance that the administrator emphasizes and reinforces with his or her staff the absolute importance in protecting residents from abuse and ensures that nursing home employees know how to do so. The Respondent did not do this in time to protect Resident 41. As a result, Resident 41 was left unprotected for a substantial period after an employee witnesses Resident 41 being abused.

The Board is very aware of the enormous challenges an administrator faces in managing a nursing home. There are extremely vulnerable and frail residents, many staff members, visitors, and unpredictable and complex issues that arise on a daily basis. But the law places an extraordinarily high priority on protecting these particularly vulnerable residents from abuse. And there are occasions in which abuse occurs even with staff properly trained and prepared in which the administrator could not be faulted. But this is not one of those occasions. The extent of the

employees' failures in protecting Resident 41 indicates a systemic breakdown. And the failures in this case were consequential.

The Respondent's record, however, indicates that he is capable of making the necessary corrections, he has no previous disciplinary history, he did provide training to his employees soon after the incidents at issue were reported to him, and he was cooperative with the Board's investigation.

The Board finds that the appropriate sanction is a reprimand, a \$1000 civil fine, and probation until the Respondent completes courses in resident rights (which shall include protecting nursing home residents from abuse) and the quality improvement process.

ORDER

It is, thus, by the Board, hereby:

ORDERED that the Respondent, David Insel, LNHA, is **REPRIMANDED**; and it is further

ORDERED that, within **SIX MONTHS**, the Respondent shall pay a civil fine of **\$1000**.¹⁰ The Payment shall be by money order or bank certified check made payable to BENHA, and mailed to the Maryland Board of Nursing Home Administrators, 4201 Patterson Avenue, Room 305, Baltimore, Maryland 21215; and it is further

ORDERED that the Respondent is placed on **PROBATION** until the Respondent has complied with the following terms and conditions of probation:

WITHIN ONE YEAR, the Respondent is required to take and successfully complete **courses** in (1) resident rights, which shall include but need not be limited to, protecting nursing

¹⁰ See Health Occ. § 9-314.1.

home residents from sexual abuse, and (2) quality assurance processes for nursing homes. The following terms 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 may 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) once the Board receives documentation that the Respondent successfully completed the courses, the Board will terminate the probation; and
- (g) the Respondent shall provide the Board with documentation that he successfully completed the courses no later than one year after the Final Decision and Order goes into effect; and it is further

ORDERED that, if the Respondent allegedly fails to comply with any term or condition imposed by probation, the Respondent shall be given notice and an opportunity for a hearing. After the hearing, if the Board determines that the Respondent has failed to comply with any term or condition imposed by probation, the Board may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, or suspend the Respondent's license, 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 on the Respondent; and it is further

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

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

ORDERED that the Final Decision and Order is a **PUBLIC DOCUMENT**. *See* Health Occ. § 1-607; Md. Code Ann., Gen. Prov. § 4-333(b)(6).

1/31/2022
Date

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

NOTICE OF RIGHT TO APPEAL

Pursuant to § 9-316(b) of the Health Occupations Article, the Respondent has the right to seek judicial review of this Final Decision and Order. Any petition for judicial review must be filed in court within 30 days from the date this Final Decision and Order was sent to the Respondent. The Final Decision and Order was sent on the date that it was issued. The petition for judicial review must be made as directed in the Maryland Administrative Procedure Act, Md. Code Ann., State Gov't § 10-222, and Maryland Rules 7-201 *et seq.*

If the Respondent petitions for judicial review of this Final Decision and Order, the Board is a party and should be served with the court's process. Also, a copy of the petition for judicial review should be sent to the Board of Examiners of Nursing Home Administrators, 4201 Patterson Avenue, Room 305, Baltimore, Maryland 21215. In addition, the Respondent should send a copy of the petition for judicial review to the Board's counsel, David Wagner, Assistant Attorney General, Office of the Attorney General, 300 W. Preston Street, Suite 302, Baltimore, Maryland

21201 and by email at david.wagner@maryland.gov The administrative prosecutor is not involved in the circuit court process and does not need to be served or copied on pleadings filed in circuit court.