

IN THE MATTER OF  
ANDREA D. CORBIN, P.T.  
License No.: 14690

\* BEFORE THE MARYLAND STATE  
\* BOARD OF PHYSICAL THERAPY  
\* EXAMINERS

Respondent

\* Case No.: PT 12-28

\* \* \*

\* \* \* \* \*

**CONSENT ORDER**

On September 21, 2012, the Maryland State Board of Physical Therapy Examiners (the "Board") charged Andrea D. Corbin, P.T. (the "Respondent"), License Number 14690, with violations of the Maryland Physical Therapy Act (the "Act"), Md. Health Occupations ("H.O.") Code Ann. §§ 13-101 *et seq.* (2009 Repl.Vol., 2011 Supp.).

The pertinent provisions of the Act under H.O. § 13-316 provide as follows:

**13-316. Denials, reprimands, probations, suspensions and revocations – Grounds**

Subject to the hearing provisions of § 13-317 of this subtitle, the Board may deny a license, temporary license, or restricted license to any applicant, reprimand any licensee or holder of a temporary license or restricted license, place any licensee or holder of a temporary license or restricted license on probation, or suspend or revoke a license, temporary license, or restricted license if the applicant, licensee or holder:

- ...
- (4) In the case of an individual who is authorized to practice physical therapy is grossly negligent:
    - (i) In the practice of physical therapy[;]
  - (15) Violates any provision of this title or rule or regulation adopted by the Board;
  - (19) Commits an act of unprofessional conduct in the practice of physical therapy or limited physical therapy[.]

### **FINDINGS OF FACT**

1. At all times relevant to the charges herein, the Respondent was licensed to practice physical therapy in the State of Maryland. The Respondent was originally licensed on April 18, 1978. The Respondent's license is currently active and will expire on May 31, 2014.
2. On or about May 12, 2012, the Board received a written complaint regarding the Respondent from an Administrator of a county department of social services. The complaint alleged that the Respondent had been unable to get a patient off the floor after an unsuccessful attempt to transfer the patient from his bed to a chair. It was further alleged that the Respondent screamed because she could not get the patient off the floor and told the patient that she had to leave. The Respondent handed the patient a telephone to call 911 for assistance and left his residence, leaving the patient on the floor. The telephone did not work and the patient had to crawl to get another telephone.
3. In furtherance of its investigation of the complaint, Board staff obtained records from various sources pertaining to the incident and interviewed the Respondent, her supervisor and the patient.
4. The Respondent has been employed since 1988 by a private health care agency ("Agency") that provides services, including physical therapy, to homebound patients.
5. The Agency's Physical Therapist job description includes, *inter alia*, the physical requirement of transferring and positioning patients.



6. On the afternoon of May 3, 2012, the Respondent visited the home of "Patient A," a male born in 1941, to provide physical therapy services. Patient A is confined to a motorized wheelchair and requires assistance to perform most activities of daily living.
7. The Respondent had visited Patient A on at least two previous occasions. The purpose of her visit on May 3, 2012 was to teach Patient A how to transfer safely between his bed his wheelchair.
8. The Respondent assisted Patient A transfer from his wheelchair to his bed. Patient A then told the Respondent that he wanted to return to his wheelchair because it was too early to remain in bed for the rest of the day.
9. When interviewed by Board staff regarding this incident, the Respondent stated that she was concerned about Patient A's safety because he had told her that he been in his chair for the last five days and had complained that he was exhausted.
10. The Respondent telephoned her supervisor at the Agency to discuss the matter and it was determined that she should transfer Patient A to his chair.
11. According to Patient A, during the transfer, the transfer board slipped and he could not hold himself on the bed so he let himself slide to a sitting position on the floor. The Respondent started screaming. Patient A told the Respondent that he was not injured and asked her to hand him the telephone so he could call the fire department for assistance. The Respondent handed him the telephone and before he could make a call, ran out the front door. Patient A discovered that telephone, which was a mobile telephone, was dead. Patient A yelled for the

Respondent to return, but she did not. Patient A then crawled across the floor to reach a cell phone. It took him approximately one-half hour to reach the phone. The fire department arrived about ten minutes later. At no time did the Respondent return to check on him.

12. When interviewed by Board staff, the Respondent stated that as Patient A began sliding off the bed, she assisted him to ensure that he did not fall. The Respondent acknowledged that she was "very emotional...because it took a lot for [her] to get him down."
13. The Respondent stated that at this point, she had a personal emergency. The Respondent described herself as having been "emotionally exhausted" and decided that she "could not stay because she was embarrassed."
14. The Respondent acknowledged that she did not know whether Patient A had called for assistance after she handed him the telephone, but assumed he would because she had told him to do so.
15. The Respondent further acknowledged that she did not call the fire department for him because she was aware he had done so himself on other occasions.
16. After the Respondent left Patient's A home, she drove away. She did not return to the Patient A's home to check on him nor did she wait in her vehicle for assistance to arrive.
17. The Respondent acknowledged that she did not wait for the fire department to arrive because she wanted to go home and change her clothes. She stated that she was not thinking clearly and failed to use good judgment.



18. The Respondent did not make it clear to her supervisor that she had left Patient A's home before the fire department rescue squad arrived.
19. In the Respondent's report of the incident she noted: "Therapist eased [Patient A] down to the floor to avert fall. Patient called fire department to lift him into the chair." During her interview with Board staff, the Respondent acknowledged that she had not documented that she had left Patient A "[b]ecause I didn't think it was professional to put it there."

### **CONCLUSIONS OF LAW**

The Respondent abandoned Patient A. Abandonment of a patient is an egregious and fundamental violation of the Act. The Respondent failed to report her conduct accurately. Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent was grossly negligent in the practice of physical therapy, committed an act of unprofessional conduct in the practice of physical therapy and violated the Act, in violation of H.O. § 13-316 (4), (15) and (19), respectively.

### **ORDER**

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 61<sup>st</sup> day of March, 2013, by a majority of the quorum of the Board:

**ORDERED** that the Respondent shall be suspended for one (1) month from the effective date of this Consent Order, which suspension is immediately stayed. The Board has carefully considered the Respondent's specific circumstances and concludes that they mitigate the severity of the sanction that the Board would otherwise have imposed. These factors include: the Respondent's prior unblemished 30 year history of practicing physical therapy; the absence of complaints regarding her practice

subsequent to the incident at issue; the Respondent's sincere acknowledgement of and remorse for her conduct; the lack of physical harm to the patient and the Respondent's concern regarding the possible harm she might have caused the patient. It is further

**ORDERED** that the Respondent shall be placed on **PROBATION** for a minimum of one (1) year, and it is further

**ORDERED** that within three (3) months of the effective date of the Consent Order, the Respondent shall successfully complete at he own expense a Board-approved ethics course; and it is further

**ORDERED** that after completing the Board-approved ethics course, the Respondent shall successfully complete at her won expense the next available law and ethics examination administered by the Board; and it is further

**ORDERED** that, should the Board receive information that the Respondent has violated the Act or if the Respondent violates any conditions of this Order, after providing the Respondent with notice and an opportunity for a hearing, the Board may take further disciplinary action against the Respondent, including suspension or revocation. The burden of proof for any action brought against the Respondent as a result of a breach of the conditions of the Order shall be on the Respondent to demonstrate compliance with the Order or conditions; and it is further

**ORDERED** that the Respondent shall practice in accordance with the laws and regulations governing the practice of physical therapy in Maryland; and it is further

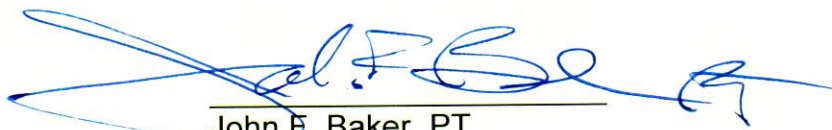
**ORDERED** that no sooner than one (1) year from the effective date of the Order, the Respondent may submit to the Board a written petition requesting termination of probation, provided that the Respondent can demonstrate compliance with the



conditions of this Order. Should the Respondent fail to demonstrate compliance, the Board may impose additional terms and conditions, as it deems necessary; and it is further

**ORDERED** that for purposes of public disclosure, as permitted by Md. State Gov't Code Ann. §10-617(h)(2009 Rep. Vol., 2011 Supp.), this document consists of the contents of the foregoing Findings of Fact, Conclusions of Law and Order and that the Board may also disclose same to any national reporting data bank to which it is mandated to report.

03/01/13  
Date

  
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John F. Baker, PT  
Chairperson

### **CONSENT**

I, Andrea D. Corbin, PT, acknowledge that I am represented by counsel and have consulted with counsel before entering this Consent Order. By this Consent and for the purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by the law. I agree to forego my opportunity to challenge these allegations. I acknowledge the legal authority and jurisdiction of the Board to initiate these proceedings and to issue and enforce this

Consent Order. I affirm that I am waiving my right to appeal any adverse ruling of the Board that I might have filed after any such hearing.

I sign this Consent Order after having an opportunity to consult with counsel, voluntarily and without reservation, and I fully understand and comprehend the language, meaning and terms of the Consent Order.

2-16-13  
Date

Andrea D. Corbin, PT  
Andrea D. Corbin, PT  
Respondent

STATE OF MARYLAND  
CITY/COUNTY OF Prince Georges

I HEREBY CERTIFY that on this 16<sup>th</sup> day of February 2013, before me, a Notary Public of the foregoing State and City/County personally appeared Andrea D. Corbin, PT, and made oath in due form of law that signing the foregoing Consent Order was her voluntary act and deed.

AS WITNESSETH my hand and notarial seal.

L. Barnes  
Notary Public

