ORDER BOOK

IN THE MATTER OF	*	**BEFORE THE MARYLAND STATE**
MARY E. NAYLOR, P.T.	*	**BOARDOF PHYSICIAL THERAPY**
License No.: 20708	*	**EXAMINERS**
Respondent	*	**Case No.: PT 10-36**

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

CONSENT ORDER

On August 22, 2011, the Maryland State Board of Physical Therapy Examiners (the "Board") charged Mary E. Naylor, P.T. (the "Respondent") with violations of certain provisions of the Maryland Physical Therapy Act (the "Act"), Md. Health Occupations ("H.O.") Code Ann. §§ 13-101 *et seq.* (2009 Repl.Vol.).

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

> 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:
>
> ...
>
> (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;
>
> ...
>
> (25) Fails to meet accepted standards in delivering physical therapy...care.

The Board further charged the Respondent with the following violations of the Code of Maryland Regulations (Code Md. Regs.) tit. 10, § 38.02.01 – **Code of Ethics**:

...

B. The physical therapist...shall respect the dignity of the patient;

...

F. The physical therapist...shall report to the Board of Physical Therapy Examiners all information that indicates a person is allegedly performing, or aiding and abetting, the illegal or unsafe practice of physical therapy[.]

The Board further charges the Respondent with the following violations of Code Md. Regs. tit. 10, § 38.02.02 – **Sexual Misconduct**:

A. A physical therapist ...may not engage in sexual misconduct.

B. Sexual misconduct includes, but is not limited to:

(1) Sexual behavior with a client or patient in the context of professional evaluation, treatment, procedure or service to the client or patient, regardless of the setting in which the professional service is rendered;

...

(7) Physical contact of a sexual nature with a patient[.]

The Board further charged the Respondent with violations of Code Md. Regs. tit. 10, § 38.03.02-1 – **Requirements for Documentation:**

A. The physical therapist shall document legibly the patient's chart each time the patient is seen for:

(1) The initial visit, by including the following information:

...

(e) Evaluation and results of tests (measurable and objective data);
(f) Interpretation;
(g) Goals;
(h) Modalities, or procedures, or both, used during the initial visit and the parameters involved including the areas of the body treated;
(i) Plan of care including suggested modalities, or procedures, or both, number of visits per week, and number of weeks[.]

(2) Subsequent visits, by including the following information (progress notes):

...

(c) Modalities, or procedures, or both, with any changes in the parameters involved and areas of body treated;
(d) Objective status;
(e) Response to current treatment, if any;
(f) Changes in plan of care[.]

(3) Reevaluation, by including the following information in the report, which may be in combination with visit note, if treated during the same visit:

...

(b) Number of treatments, since the initial evaluation or last reevaluation;
(c) Reevaluation, tests, and measurements of areas of body treated;
(d) Changes from previous objective findings;
(e) Interpretation of results;
(f) Goals met or not met and reasons;
(g) Updated goals;
(h) Updated plan of care including recommendations for follow-up[.]

(4) Discharge, by including the following information in the discharge summary, which may be combined with the final visit note, if seen by the physical therapist on the final visit and written by the physical therapist:

...

(b) Reason for discharge;
(c) Objective status;
(d) Recommendations for follow-up[.]

On October 13, 2011, a conference with regard to this matter was held before the Board's Case Resolution Conference ("CRC") Panel. As a result of the CRC, the Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law and Order.

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 September 4, 2002. The Respondent's license is currently active and will expire on May 31, 2012.

2. At all times relevant hereto, the Respondent was employed as the Clinical Director of a physical therapy facility in Bowie, Maryland ("Facility A").[1]

3. On March 9, 2010, the Board received a written complaint from a physical therapy assistant ("PTA") who worked at Facility A ("Complainant 1") stating that in October 2009, the Respondent had confided to the Complainant that she had had an inappropriate sexual relationship with a patient ("Complaint 1").

4. Complainant 1 stated that when the Respondent told her of the inappropriate relationship, Complainant 1 advised her to immediately stop the relationship and to discharge Patient A from her care. Thereafter, the Respondent continued to treat Patient A. In or around October 2009, Complainant 1, who noted that working conditions were becoming uncomfortable, reported the Respondent's conduct to one of the owners of Facility A ("Owner A").

5. According to Complainant 1, Owner A advised the Respondent to stop treating Patient A and to refer him to one Facility A's other offices. Instead, the Respondent placed Patient A on the schedule of another PT at Facility A.

6. On March 15, 2010, the Board received a written complaint regarding the Respondent from four of the Respondent's co-workers at Facility A, ("Complaint 2").

[1] Facility A is one of several branch offices of Company A. Names of individuals and facilities will not be used in this document in order to preserve confidentiality.

7. In Complaint 2, the complainants described various work disruptions at Facility A from June to November 2009 which they attributed to the Respondent's relationship with Patient A. The Respondent was seen crying while she treated patients and on one occasion was observed crying in a private treatment room while treating Patient A. The complainants reported that the Respondent would leave Facility A suddenly for last-minute appointments which would require the rescheduling or reassigning of her patients.

8. Upon receipt of Complaints 1 and 2, the Board initiated an investigation of the allegations, which investigation included interviews of employees, the co-owners of Facility A and the Respondent as well as a review of the Respondent's treatment records of Patient A.

Findings of Fact Pertaining to the Respondent's Violation of the Code of Ethics. §10.38.02.01B

9. In furtherance of its investigation, the Board subpoenaed from Facility A the Respondent's personnel file. The following concerns were noted:

   a. On October 7, 2009, Owner A met with the Respondent to discuss concerns he had received from a PT at Facility A[2] regarding the Respondent and Patient A. The PT had told Owner A that the Respondent spent an excessive amount of time when treating Patient A, often behind closed doors. The Respondent denied that she had an inappropriate relationship with Patient A, stating that his case was complicated. Owner A advised the Respondent that the

[2] The PT was one of the employees who filed a written complaint with the Board.

discomfort of the staff and their allegations were sufficient for him to conclude that the Respondent should no longer treat Patient A, or at the very least, treat him in the open gym area.

b. On October 30, 2009, both owners of Facility A, Owner A and Owner B, met with the Respondent to discuss concerns regarding her relationship with Patient A. The Respondent continued to deny that she had engaged in inappropriate conduct with Patient A. The owners instructed the Respondent to remove Patient A from her schedule and the Respondent stated she would do so.

c. On November 3, 2009, the owners determined that the Respondent had not removed Patient A from her schedule and instructed her once again to do so.

d. On November 17, 2009, Owner A once again discussed with the Respondent concerns that had been raised by several additional employees of Facility A regarding her relationship with Patient A. The Respondent once again denied having an inappropriate relationship with Patient A.[3]

10. On September 14, 2010, Board staff interviewed the Respondent under oath. The Respondent stated that she had resigned from Facility A in April 2010 and was employed at a different PT facility.

11. During the interview, the Respondent admitted that she had had an inappropriate sexual relationship with Patient A from the fall of 2009 until

[3] Owners A and B failed to report to the Board the concerns regarding the Respondent and Patient A. The Board charged both with violating the Code of Ethics. The Board also charged Owner B with violating the standard of documentation.

February 2010. The Respondent stated that she fully understands that she violated the Code of Ethics and is attempting to make amends.

Findings of Fact Pertaining to the Respondent's Violation of the Code of Ethics. §10.38.02.01B

12. The Board's investigation of the complaints regarding the Respondent revealed that Owner B had an inappropriate sexual relationship with a patient, Patient B, whom he later employed at Facility A.

13. When interviewed by Board staff, the Respondent acknowledged that she was aware that Owner B was having a sexual relationship with Patient B while Patient B was a patient.

14. The Respondent stated that she did not report the inappropriate relationship to the Board because she had no physical evidence and because she believed that other employees, at least one of whom refused to work for the company because of the relationship, had already made a report to the Board.

Findings of fact regarding Violations of Standards of Practice

a. General Deficiencies

15. From February 12, 2009 through December 3, 2009, the Respondent and on occasion, other therapists at Faculty A, provided physical therapy treatment to Patient A for three separate injuries. Review of the Respondent's treatment records for Patient A revealed multiple deficiencies, including, but not limited to:

a. Inadequate assessments;

b. Failure to conduct re-evaluations consistently;

c. Inadequate documentation to show progress towards goals;

d. Lack of communication with other therapists resulting in inconsistent treatments; and

e. Failure to address primary treatment goals.

b. Findings of fact Pertaining to Treatment of Lumbar and Thoracic Areas – February 12, 2009 through June 29, 2009

16. On February 12, 2009, Patient A presented to Facility A after injuring his lower back in a motor vehicle accident. Patient A was treated for this complaint through June 29, 2009, a total of 48 visits. The Respondent was Patient A's primary PT. Review of the Respondent's records revealed violations of the standards for documentation including, but not limited to, those set forth below.

17. In Patient A's initial assessment, the Respondent failed to assess Patient A's thoracic spine.

18. The Respondent failed to conduct 30, 60 or 90 day re-evaluations.

19. On February 12 and 17, 2009, the Respondent billed for neuromuscular re-education ("NMR") for exercises that qualify as therapeutic exercises.

20. On several occasions, the Respondent billed for units of NMR in the absence of supporting documentation.

21. In March 2009, Patient A reported that he was having pain in his mid-back area; the Respondent failed to treat this area.

22. On March 27, 2009, a PT other than the Respondent documented her recommendation that Patient A commence core strength and stability

exercises. The Respondent failed to provide those exercises to Patient A, nor did she document her rationale for not doing so.

23. The Respondent failed to document her assessment of Patient A in several notes in April and May 2009.

24. On April 9, 2009, Patient A was billed for two units of manual therapy and one unit each of ultrasound, hot/cold packs and electrical stimulation (unattended) in the absence of a treatment note. The Respondent had treated Patient A on visits before and after this date.

25. The Respondent failed to conduct a discharge assessment or document a discharge summary.

26. The Respondent performed the same treatment at most of Patient A's visits with minimal results; she failed to document Patient A's status nor did she consider the possibility that he was malingering.

27. The Respondent's treatment of Patient A for this injury subsequent to March 12, 2009 is difficult to justify, particularly in the absence of re-evaluations, assessments and documentation of his progress towards treatment goals.

c. Findings of fact pertaining to Treatment to Cervical Spine and Right Shoulder – February 13, 2009 through June 10, 2009

28. On February 13, 2009, Patient A presented to Facility A after slipping on ice and injuring his cervical spine and right shoulder. He was treated by the Respondent and several other PTs through June 10, 2009, a total of 30 visits. A review of the Respondent's treatment records revealed

violations of the standards of documentation including but not limited to those set forth below.

29. The Respondent conducted Patient A's initial assessment on February 13, 2009. On that date, she inappropriately billed one unit of NMR when conducting therapeutic exercises.

30. Throughout Patient A's treatment for this injury, the Respondent failed to communicate adequately with other therapists. She changed treatments and modalities that had been provided by other PTs on previous visits without documenting her treatment rationale.

31. The Respondent consistently failed to document Patient A's progress towards his treatment goals.

32. The Respondent failed to educate Patient A to refrain from some of his activities such as golfing, hunting and performing a strenuous exercise program when it appeared these activities aggravated his injury.

33. On several occasions, the Respondent charged for units of therapeutic exercise in the absence of documentation that the exercise(s) had been performed for the necessary period of time.

34. On two occasions in March 2009, the Respondent billed for units of NMR in the absence of documentation that she performed that procedure.

35. The Respondent treated Patient A's thoracic spine and TMJ without adequately evaluating those areas; she failed to document thorough objective findings, goals or prognosis.

d. Findings of fact pertaining to Treatment of Lumbar and Thoracic Areas – October 6, 2009 through November 20, 2009

36. On October 6, 2009, Patient A presented to Facility A after injuring his back. The Respondent treated Patient A for all 13 visits, November 20, 2009. A review of the Respondent's treatment records revealed violations of the standards of documentation including but not limited to those set forth below.

37. The Respondent failed to document adequate assessments, including functional measurements, goals and progression towards goals.

38. The Respondent failed to document a 30-day re-evaluation.

39. The Respondent performed the same treatment over the entire treatment period with minimal changes in Patient A's subjective pain level.

40. The Respondent documented that one of primary treatment goals was to increase core stability and range of motion; however, she failed to direct Patient A to perform core stabilization exercises or stretches.

41. Patient A had scheduled an appointment for December 3, 2009. He cancelled that appointment and did not return to Facility A for treatment after that date. The Respondent failed to document a discharge summary.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent's conduct constitutes violations of the Act, specifically, H.O. § 13-316 (15), (19) and/or (25), the Board's Code of Ethics and Standards of Practice – Requirements for Documentation as charged.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 20th day of December, 2011, by a majority of the quorum of the Board:

ORDERED that the Respondent shall be suspended for one (1) year from the effective date of this Consent Order, with all but one (1) month stayed. The Board has considered the Respondent's circumstances, including her recent health condition and that of her spouse, and considers them to mitigate the severity of the sanction in this case. The Board will permit the Respondent to choose the starting date of her one (1) month active suspension, provided the active suspension occurs within the one (1) year suspension period. The Respondent shall notify the Board in writing of the beginning date of the active portion of her suspension; and it is further

ORDERED that the Respondent shall be placed on **PROBATION** for a minimum of **TWO (2) YEARS**, which probationary period shall run concurrently with the period of suspension; and it is further

ORDERED that as a condition of probation, the Respondent shall successfully complete within six (6) months of the effective date of the Consent Order a Board-approved course in documentation and coding; and it is further

ORDERED that the Respondent shall be responsible for all costs under this Consent Order; 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 two (2) years 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.), 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.

12/20/11
Date

John F. Baker, PT
Chairperson

CONSENT

I, Mary E. Naylor, 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.

11/29/11
Date

MEN PT
Mary E. Naylor, PT
Respondent

STATE OF MARYLAND
CITY/COUNTY OF Howard

I HEREBY CERTIFY that on this 29th day of November 2011, before me, a Notary Public of the foregoing State and City/County personally appeared Mary E. Naylor, 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.

Notary Public

TAIINA EASON
MY COMMISSION EXPIRES
JAN. 27 2015
HOWARD COUNTY, MD
NOTARY PUBLIC