IN THE MATTER OF	*	**BEFORE THE MARYLAND STATE**
JON S. PETERS, P.T.	*	**BOARD OF PHYSICIAL THERAPY**
License No.: 12627	*	**EXAMINERS**
Respondent		**Case No.: 01-6**

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

CONSENT ORDER

Based on information received and a subsequent investigation by the State Board of Physical Therapy Examiners (the "Board") and pursuant to Md. Health Occ. Code Ann., § 13-101 *et seq.* (the "Act"), the Board charged Jon S. Peters, P.T. (the "Respondent") with violations of the Act.

Specifically, the Board charged the Respondent with violating the following provisions of H.O. § 13-316:

> 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:
>
> (3) Practices physical therapy inconsistent with any written or oral order of:
>
> (i) a physician authorized to practice medicine in any state;
>
> (15) Submits a false statement to collect a fee;
>
> (16) Violates any provision of this title or rule or regulation adopted by the Board;
>
> (26) Fails to meet accepted standards in delivering physical therapy care.

The Board further charges the Respondent with the following violations of the Code of Maryland Regulations (Code Md. Regs.) tit. 10, § 38.03.02 Standards:

A. The physical therapist shall exercise sound professional judgment in the use of evaluation and treatment procedures.

The Board also charges the Respondent with violations of the Code Md. Regs. tit. 10, § 38.03.02-1 Requirements for Documentation:

A. As established by the American Physical Therapy Association of Maryland, and as approved by the Board, the physical therapist shall document the patient's chart as follows:

(1) For initial visit:

(a) Date,
(b) Condition/diagnosis for which physical therapy is being rendered,
(c) Onset,
(d) History, if not previously recorded,
(e) Evaluation and results of tests (measurable and objective data),
(f) Interpretation,
(g) Goals,
(h) Plan of care and
(i) Signature, title (PT) and license number;

(2) For subsequent visits:

(a) Date,
(b) Modalities, procedures, etc.,
(c) Cancellations, no-shows,
(d) Response to treatment,
(e) Signature and title (PT), with identifying signatures appearing on the patient's chart, although the flow chart may be initialed,
(f) Weekly progress or lack of it,
(g) Unusual incident/unusual response,
(h) Change in plan of care;
(i) Temporary discontinuation or interruption of services and reasons,
(j) Reevaluation, and
(k) If there is a physical therapist assistant, reevaluate and document as required by Regulation .02L of this chapter;

(3) For discharge or last visit:

(a) Date,
(b) Reason for discharge,
(c) Status at discharge,

(d) Recommendations for follow-up, and
(e) Signature and title.

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 17, 1969.

2. At all times relevant hereto, the Respondent practiced with the Potomac Valley Sports Medicine and Rehabilitation Center ("PVSM"), 3801 International Drive, Silver Spring, Maryland.

3. On or about September 29, 2000, the Board received a complaint from Patient A[1] alleging, *inter alia,* that the Respondent had provided to him physical therapy that was not consistent with the treatment order prescribed by Patient A's physician.

4. Thereafter, the Board initiated an investigation. The investigation revealed that on or about January 18, 2000, Patient A, then a seventy-eight (78) year old male, was referred by his orthopedic surgeon ("Dr. A.")[2] to PVSM for a short term of physical therapy to assist in determining the need for surgery to repair a torn rotator cuff in Patient A's right shoulder. Dr. A ordered that Patient A was to perform strengthening and range of motion ("ROM") exercises twice a week for three (3) weeks.

5. Thereafter, Patient A presented to the Respondent for physical therapy on January 24, 2000, February 2, 2000 and February 7, 2000. The Respondent

[1] To ensure confidentiality, the patient's name is not set forth in this document.
[2] At all times relevant to these charges, the orthopedic surgeon was a member of Potomac Valley Orthopedic Associates, whose Silver Spring office is located at the same address as PVSM.

documented or had caused to be documented on Patient A's "Training Diary"[3] that treatment on each of these dates consisted of six (6) minutes of exercise on the upper body ergometer ("UBE"), and theraband, finger ladder and wand exercises.

6. On February 8, 2000, Dr. A documented that Patient A required surgery to repair the rotator cuff tear. Dr. A performed the surgery on March 27, 2000.

7. On April 5, 2000, Dr. A noted in Patient A's record that the incision had "healed nicely," and he was referred to physical therapy "for passive range of motion only." Dr. A also completed a PVSM Physical Therapy Prescription Form upon which he indicated that Patient A was "status post open R.C. repair" and ordered "passive ROM [treatment modalities] only" two (2) to three (3) times a week for four (4) weeks.

8. Patient A presented to the Respondent for his first post-operative visit on April 10, 2000. The Respondent documented in the office note, "To P.T. for PROM only. Pt is extremely apprehensive re movement of the shoulder."

9. Patient A returned to the Respondent on April 12, 2000 at approximately 9:00 a.m. At the beginning of his physical therapy session on April 12, 2000, Patient A told the Respondent that on April 11, 2000 he had seen a pain specialist, Physician B, regarding his post-operative shoulder pain. Patient A reported that Physician B had administered trigger point injections and had advised Patient A to proceed carefully with physical therapy because he would not be able to feel pain as readily as a result of the injections. Patient A also told the Respondent that Physician B had recommended that heat should be applied to Patient A's shoulder prior to the physical therapy session. The Respondent told Patient A that there is no way to avoid pain during therapy.

[3] The "Training Diary" reflects number of repetitions or length of time that a patient performed an exercise or used a piece of equipment on a specific date.

10. The Respondent then instructed Patient A to perform exercises using the UBE, finger ladder and wand.

11. As he was performing these exercises, Patient A complained to the Respondent that he was in pain and was tired. The Respondent then raised and lowered Patient A's right arm in a windmill motion that caused Patient A additional discomfort.

12. The exercises that the Respondent instructed Patient A to perform on April 12, 2000 did not constitute the prescribed passive range of motion exercises; they were resistive, active and active assistive exercises.

13. The Respondent documented or caused to be documented entries in Patient A's Training Diary for April 12, 2000 that Patient A performed exercises on the UBE, finger ladder and wand exercises.

14. In the Respondent's office note of April 12, 2000, he documented the visit as follows:

> S: Shoulder quite sore. 1 staple still in situ. Draining less.
>
> O: Pt's shoulder is extremely tender/sensitive. Has trouble with any kind of motion. Will proceed very cautiously.
>
> A: Pt not tolerating PROM (gentle) well.
>
> P: Continue cautiously.

15. On April 14, 2000, Patient A returned to the Respondent. During the visit, the Respondent instructed a radiation technician (who is employed at Potomac Valley Orthopedic Associates as an orthopedic technician) to remove a suture from Patient A's shoulder wound. The Respondent then pressed on the wound to drain the area where the suture had been removed. The technician then placed a dressing on the wound

site. During the removal and drainage process, neither the Respondent nor the technician wore protective gloves. The technician wore protective gloves when she re-dressed the wound.

16. The Respondent's office note of the April 14, 2000 incident reads as follows:

> Pt came in & continues to c/o [complain of] shoulder discomfort with little let-up. Had tech remove remaining staple. There is a small drainage site, top of shoulder. It looked as if internal suture was working its way up. As the tech gently probed sersosanguineous fluid started flowing out. With gentle pressure considerably more fluid was expressed. There was no indication of infection and pt had no pain. Tech placed lg. gauze band aid on site which continued to ooze. There was no suture. Pt had no ill effects. He is scheduled to see M.D. 4/17/00.

17. When initially questioned about this incident by Board staff, the Respondent stated that the technician had removed the suture, drained the wound and re-dressed the wound.

18. Thereafter, the Respondent told Board staff that he had drained Patient A's wound rather than the technician, as he had originally claimed. The Respondent also reported to Board staff that on April 14, 2000, he applied moist heat and had Patient A perform therapeutic exercises. The Respondent failed to document these treatments in Patient A's record.

19. The Respondent's billing records reflect that he billed Patient A for one (1) unit of therapeutic exercise on April 14, 2000. As noted above, the Respondent failed to document in Patient A's treatment record that Patient A performed therapeutic exercises under the Respondent's direction on April 14, 2000.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes that the Respondent violated H.O. §§ 13-316 (3) (i), (15), (16) and (26) and Code Md. Regs. tit. 10 §§ 38.03.02(A) and 38.03.02-1.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law and agreement of the parties, it is this 11th day of December, 2001, by a majority of a quorum of the Board,

ORDERED that the Respondent shall be placed on **PROBATION** for **EIGHTEEN (18) MONTHS**, subject to the following conditions:

1. Within the first twelve (12) months of the probationary period, the Respondent shall attend and successfully complete a Board-approved documentation course; and

2. Within the first twelve (12) months of the probationary period, the Respondent shall attend and successfully complete a Board-approved interpersonal skills course; and

3. Within the first month of probation, the Respondent shall be subject to monitoring of all aspects of his practice, including but not limited to patient care and documentation, by a Board-approved monitor. The monitor shall observe the Respondent's practice at least once a week for a minimum of one (1) month. The Respondent shall ensure that the monitor submits a written report to the Board regarding his/her observations and evaluation of the Respondent's

practice at the end of one (1) month of monitoring. The report shall include the monitor's evaluation of the Respondent's physical therapy technique, the Respondent's conduct towards patients and the adequacy of the Respondent's documentation. The Board shall review the monitor's report and determine whether the Respondent requires continued monitoring. The Respondent will submit to continued monitoring if recommended by the Board.

ORDERED that the Respondent shall bear all costs associated with this Consent Order; and be it further

ORDERED that should the Board receive a report that the Respondent's practice is a threat to the public health, welfare and safety, the Board may take immediate action against the Respondent, providing notice and an opportunity to be heard are provided to the Respondent in a reasonable time thereafter. Should the Board receive in good faith information that the Respondent has substantially violated the Act, or if the Respondent violates any of the conditions of this Order or of Probation, the Board may take further disciplinary action against the Respondent, including suspension or revocation. The burden of proof for any action against the Respondent as a result of a breach of the conditions of the Order or of Probation shall be on the Respondent to demonstrate compliance with the Order or conditions; and be it further

ORDERED that the Respondent shall practice physical therapy competently and in accordance with all laws and regulations governing the practice; and be it further

ORDERED that this Consent Order is considered a PUBLIC DOCUMENT pursuant to Md. State Gov't Code Ann. § 10-611 *et seq.*

December 11, 2001
Date

Mindy Sacks, P.T.A.
Chair
State Board of Physical Therapy Examiners

CONSENT

I, Jon S. Peters, P.T., acknowledge that I am represented by legal counsel, and I have had the opportunity to consult with counsel before entering into signing this document. By this consent, I hereby admit the Findings of Fact and Conclusions of Law and submit to the foregoing Consent Order consisting of eleven (11) pages.

I acknowledge the validity of this Consent Order as if entered 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 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 my right to appeal any adverse ruling of the Board that might have followed any such hearing.

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

I acknowledge that if I fail to abide by the conditions set forth in this Order, the Board may impose disciplinary action against my license to practice physical therapy in the State of Maryland.

Date 1/26/01

Jon S. Peters, P.T.

STATE OF MARYLAND

~~CITY~~/COUNTY OF MONTGOMERY

I HEREBY CERTIFY that on this 3rd day of December, 2001, before me, a Notary Public in the State and City/County aforesaid, personally appeared Jon S. Peters, P.T., and made oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESSETH my hand and notarial seal.

Nancy E. Blank
Notary Public

My commission expires: 12-1-03