ORDER BOOK

IN THE MATTER OF	*	**BEFORE THE MARYLAND**
TRACEY VAUGHT	*	**STATE BOARD OF**
Respondent	*	**PHYSICAL THERAPY**
License Number: 17970	*	**Case Number: 09-56**

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CONSENT ORDER

PROCEDURAL BACKGROUND

On or about July 13, 2011, the Maryland Board of Physical Therapy (the "Board"), charged Tracey Vaught, P.T. (the "Respondent") (D.O.B.04/27/1963), License Number 17970, with violations of the Maryland Physical Therapy Practice Act (the "Act"), Md. Health Occ. Code Ann. ("H.O.") § 13-101 *et seq.* (2009 Repl. Vol. and 2010 Supp.).

Specifically the Board charged the Respondent with the following provisions under § 13-316 of the Act:

> Subject to the hearing provisions of § 13-317 of this subtitle, the Board may deny a license or restricted license to any applicant, reprimand any licensee or holder of a restricted license, place any licensee or holder of a restricted license on probation, or suspend or revoke a 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 provisions of this title or rule or regulation Adopted by the Board;
>
> (25) Fails to meet accepted standards in delivering physical therapy or limited physical therapy[.]

The pertinent provisions of the title, rule or regulation referred to, *infra,* in §13-316(15) provide the following:

COMAR 10.38.03.02 **Standards of Practice.**

§ A(2) The physical therapist shall:

(a) Exercise sound professional judgment in the use of evaluation and treatment procedures;

(e) Evaluate the patient and develop a plan of care before the patient is treated; and

(g) Reevaluate the patient as the patient's condition requires, but at least every 30 days, unless the physical therapist, consistent with accepted standards of physical therapy care, documents in the treatment record an appropriate rationale for not reevaluating the patient[.]

COMAR 10.38.03.02-1 **Requirements for Documentation.**

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

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

(f) Changes in plan of care[.]

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

(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; and

(h) Updated plan of care including recommendations for follow up[.]

On or about September 20, 2011, the Respondent appeared before the Case Resolution Conference Committee (the "CRC") of the Board in order to explore a mutually agreeable resolution of the Charges.

FINDINGS OF FACT

The Board finds the following:

I. BACKGROUND

1. At all times relevant hereto, the Respondent was and is a physical therapist, licensed to practice in the State of Maryland. The Respondent was initially licensed in Maryland on January 17, 1995. The Respondent's license expires on May 31, 2012.

2. At all times relevant hereto, the Respondent was engaged in the practice of physical therapy and employed by a physical therapy and sports medicine treatment facility ("Facility A")[1] in Chevy Chase, MD.

II. THE COMPLAINT

3. On or about December 15, 2008, the Board received information from the Health Care Alternative Dispute Resolution Office regarding a civil claim against the Respondent. The claim, filed by a former patient of the Respondent alleged, among other things, that the Respondent was negligent in her treatment and care of an eighty-six (86) year old male patient ("Patient A") and that her negligence caused or contributed to Patient A suffering a cervical dislocation and fracture.

4. The civil claim also alleged[2] that the Respondent[3] breached the appropriate standard of care of a reasonably competent physical therapist by:

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[1] Facility names are not used in this document order to preserve confidentiality.
[2] The allegations set forth in the civil claim have been abridged and/or paraphrased and do not purport to be direct quotes.

(a) failing to timely and properly assess Patient A's overall physical condition at the beginning of each of the physical therapy sessions;

(b) failing to develop an appropriate management plan for the proper treatment of Patient A during his physical therapy sessions;

(c) failing to consult with Patient A's physicians with regards to Patient A's cardiac history and history of hypotension;

(d) failing to verify that Patient A had received appropriate authorization from his cardiologist, to engage in physical therapy treatments;

(e) failing to implement strategies to prevent patient injury during physical therapy sessions; and

(f) failing to properly monitor and/or supervise Patient A during the physical therapy sessions.

5. On or about June 10, 2009, the Board initiated an investigation of the allegations set forth in the complaint. In furtherance of its investigation, the Board referred the matter to a consultant physical therapist ("the Expert") regarding the Respondent's care and treatment of Patient A. The Board also obtained relevant medical records and interviewed several witnesses, including the Respondent.

III. BOARD INVESTIGATION

6. The Board's investigation revealed that Patient A presented to Facility A on August 20, 2005 following a right total knee replacement and degenerative joint disease of the left knee. It was noted in his medical records that Patient A suffered from "posterior displacement of the body weight during gait and poor balance."

7. Patient A's medical records document that at the time that he began treatment at Facility A, Patient A was neurologically sound and was independently

[3] The Respondent was not the only named defendant in the civil claim.

performing activities of daily living, but sought to increase his rehabilitative efforts following surgery.

8. Beginning in August 2005 through November 2007, Patient A received physical therapy at Facility A several times per week. The physical therapy included Measurement and fitting of orthotics, manual therapy, and therapeutic exercises. The Respondent was one of several physical therapists employed by Facility A, who provided treatment and care to Patient A. The progress notes suggest that the Respondent treated Patient A on at least six (6) occasions.

9. On or about May 10, 2007, Patient A alerted the Respondent that he was scheduled to receive an artificial cardiac pacemaker.[4] The Respondent noted in Patient A's chart that before resuming treatment, Patient A would need clearance from his cardiologist prior to returning to his physical therapy regimen.

10. On or about June 21, 2007, the Respondent permitted Patient A to resume therapy without medical clearance she previously documented in her therapy notes.

11. The Expert retained by the Board, opined that the standard of practice requires that a patient be reevaluated if his medical status changes or at least every thirty (30) days. Although in Patient A's case, there had been both a lapse of thirty (30) days and a change in his medical status, the Respondent failed to reevaluate Patient A prior to his return to physical therapy and/or modify his treatment plan in any way. She further failed to document or alert other physical therapists as to Patient A's change in medical status.

[4] An artificial cardiac pacemaker is a medical device that uses electrical impulses to maintain an adequate heart beat.

12. The Expert also noted that... "[the Respondent] treated [Patient A] 4 times after placement of his pacemaker, without medical clearance and monitoring [his] blood pressure and pulse. According to the Standards of Practice Requirements for Documentation, a blood pressure is necessary to be taken secondary to its potential effect on the course of treatment received and goals established at the evaluation/reevaluation".

13. On or about August 28, 2007, Patient A reported to Therapist 2 that his physician had informed him that he was "overmedicated" regarding the management of his hypotension[5].

14. On or about October 2, 2007 Patient A reported to Therapist 2 that he had experienced "dizzy spells" that he believed were the result of his hypotension treatment.

15. Despite Patient A's repeated communications regarding placement of a pacemaker, ongoing cardiac treatment, medication and side effects, including but not limited to "dizzy spells" and hypotension, neither the Respondent, nor anyone on her behalf reevaluated Patient A or consulted with his treating cardiologist regarding his ability to safely resume physical therapy.

16. The Respondent failed to perform and/or document Patient A's changes in his plan of care, his treatment goals, or any changes in medical status.

17. On November 1, 2007, Patient A arrived at Facility A for a physical therapy session with Therapist 2. The Board's investigation revealed that Patient A was

[5] Hypotension is commonly referred to as low blood pressure.

directed to..."start on the Shuttle[6] machine while Therapist 2 completed paperwork for another patient in the staff office. Therapist 2 stated that she..."would be just a few more minutes". Patient A was not supervised or assisted in any way.

18. The Board's investigation revealed that Patient A attempted to secure himself on the Shuttle equipment but discovered that the Shuttle bands were not properly adjusted. Patient A attempted to get off the machine, unassisted, to adjust the bands. While he was doing so, he fell, striking the ground.

19. During her interview with Board staff on July 22, 2009, the Respondent stated that at the time of the Respondent's fall, she was treating Patient A's wife. She heard a loud noise, ran towards the direction of the noise and discovered Patient A lying on the floor.

20. Patient A was transported by ambulance to the emergency room of the nearest hospital ("Hospital A") where he was diagnosed with a cervical fracture and dislocation. He remained a patient at Hospital A for thirteen (13) days during which time he underwent surgery to repair his cervical fracture.

21. Following his discharge from Hospital A, Patient A received rehabilitative and sub-acute nursing care. He subsequently developed neck pain and left side weakness. He sought a consultation from health care providers at another local hospital ("Hospital B"). In order to alleviate his pain, it was recommended that Patient A undergo another surgical procedure ("Surgery 2") on his cervical spine.

[6] During the July 22, 2009 interview with the Board Therapist 2 described the Shuttle machine as a type of a leg press with bands that provide variable amounts of resistance.

22. On or about February 5, 2008, Patient A was admitted to Hospital B to undergo Surgery 2. He remained at Hospital 2 until February 25, 2008. At that time, he was discharged and once again received rehabilitative and sub-acute nursing care.

23. Following Surgery 2, Patient A experienced numerous complications, resulting in a myriad of medical procedures, including but not limited to, the placement of a gastronomy tube for nutrition, an indwelling urinary catheter, and treatment for the development of bedsores.

24. Since his discharge from Hospital B, Patient A has required home nursing care and assistance with daily living due to his neurological and physical deficits. Prior to the unsupervised fall at Facility A, Patient A was neurologically sound, and independent in his daily activities of living.

25. The Expert concluded, among other things, that the Respondent violated the Act, through her failure to meet the acceptable standard of care in the delivery of physical therapy, in the following ways:

a. failed to document a treatment plan, including objective findings justifying continued physical therapy treatment;

b. failed to properly assess and/or document Patient A's clinical progress, increase in mobility or potential to benefit from continued physical therapy treatment;

c. failed to maintain adequate progress notes, including treatment modalities, date and signature;

d. failed to obtain medical clearance following placement of the pacemaker;

e. failed to communicate and/or document communication between she and other treating health care providers;

f. failed to reevaluate the patient; and

g. consistently failed to properly monitor vital signs.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent violated H.O. §13-316 (15) and (25) and COMAR 10.38.03.02 (A) (2)(a), (e), and (g) and/or 10.38.03.02-1(A) (2) (f), and/or (3) (c), (d), (e), (f), (g), and (h). The Board dismisses the charges under H.O. § 13-316 (4)(i).

ORDER

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

ORDERED that the Respondent's license to practice physical therapy shall be placed on **PROBATION** for a period of **ONE (1) YEAR,** to commence from the date that this Consent Order is executed, and it is further

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

ORDERED that within six (6) months of the date of this Consent Order, the Respondent shall enroll in and successfully complete the Maryland Physical Therapy Law and Ethics Course; and it is further

ORDERED that the Continuing Education requirements required by this Consent Order shall not count toward fulfilling other continuing education requirements that the

Respondent must fulfill in order to renew her license to practice physical therapy; and it is further

ORDERED that Respondent shall comply with the Maryland Physical Therapy Act and all laws, statutes and regulations pertaining to the practice of physical therapy; and it is further

ORDERED that if Respondent violates any of the terms and conditions of this probation and/or this Consent Order, the Board, in its discretion, after notice and an opportunity for an evidentiary hearing before an Administrative Law Judge at the Office of Administrative Hearings if there is a genuine dispute as to the underlying material facts, or after an opportunity for a show cause hearing before the Board, may impose any sanction which the Board may have imposed in this case under the Maryland Physical Therapy Act, including a reprimand, probation, suspension, revocation and/or a monetary fine, said violation being proved by a preponderance of the evidence; and it is further

ORDERED that at the conclusion of the one (1) year probationary period and the Board's receipt of documentation confirming successful completion of the probationary conditions, the Respondent may petition the Board for termination of probation; and it is further

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

ORDERED that this Consent Order is considered a **PUBLIC DOCUMENT** pursuant to Md. State Gov't. Code Ann. § 10-611 et seq. (2009 Repl. Vol. and 2011 Supp.).

12/20/11
Date

John Baker, P.T., D.P.T.
Chair, Board of Physical Therapy Examiners

CONSENT OF TRACY VAUGHT, P.T.

I, TRACY VAUGHT, P.T., acknowledge that I have had the opportunity to consult with counsel before signing this document. By this Consent, I agree and accept to be bound by the foregoing Consent Order and its conditions and restrictions. I waive any rights I may have had to contest the Findings of Fact and Conclusions of Law.

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, confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections as provided by law. I acknowledge the legal authority and jurisdiction of the Board to initiate these proceedings and to issue and enforce the 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 had an opportunity to consult with counsel, without reservation, and I fully understand and comprehend the language, meaning and terms of this Consent Order. I voluntarily sign this Order, and understand its meaning and effect.

11-14-11
Date

Tracy Vaught, P.T.
Respondent

Read and approved by:

Michael Flynn, Esq., Attorney for the Respondent

NOTARY

STATE OF MARYLAND

CITY/COUNTY OF Charles :

I HEREBY CERTIFY that on this 14th day of November, 2011, before me, a Notary Public of the foregoing State personally appeared Tracy Vaught, P.T. License Number PT17970, and made oath in due form of law that signing the foregoing Consent Order was her voluntary act and deed, and the statements made herein are true and correct.

AS WITNESSETH my hand and notarial seal.

Heather Conrad
Notary Public

My Commission Expires: 7/20/2013