IN THE MATTER OF	*	**BEFORE THE MARYLAND**
	*	
MYCHAL LYNN PILIA	*	**BOARD OF NURSING**
	*	
LICENSE No.: R213201	*	
CERTIFIED REGISTERED NURSE	*	
MIDWIFE	*	

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CONSENT ORDER OF PROBATION
OF
REGISTERED NURSE LICENSE
AND
CERTIFIED NURSE MIDWIFE CERTIFICATE

In 2019, the Maryland Board of Nursing (the "Board") received several complaints regarding the nursing/nurse midwifery practice of **MYCHAL LYNN PILIA** (the "Respondent"). The Board investigated the allegations in the complaints and on July 12, 2021, the Board issued a "Notice of Agency Action: Charges under the Maryland Nurse Practice Act" ("Charges"), against the Respondent's Registered Nurse license and Certified Registered Nurse Midwife certification, in the State of Maryland. The Charges alleged that the Respondent violated the Maryland Nurse Practice Act ("the Act"), Md. Code Ann., Health Occupations Article ("Health Occ.") § 8- 316 (a) (8), (25) and (30).

The Respondent and the State agrees to, and the Board hereby accepts, the following Findings of Fact, Conclusions of Law, and Order.

I. FINDINGS OF FACT

The Board finds that:

1. On September 9, 2014, the Respondent was issued a Registered Nurse ("RN") license in the State of Maryland. The Respondent's RN license has a status of "active" and is due to expire on July 28, 2023.

2. On March 26, 2015, the Respondent was issued certification as Registered Nurse Midwife ("CRNM"), in the State of Maryland. The Respondent's CRNM certification is "active" and is due to expire on July 28, 2023.

3. The Respondent is the owner of Birth Center ("BC"), which is licensed by the Office of Health Care Quality ("OHCQ") to operate as a freestanding birth center in Maryland.[1] On or about October 8, 2021, the Respondent notified the OHCQ that BC was closed on September 30, 2021.

PATIENT A:

4. On or about February 4, 2019, the Board received a complaint from MD, an OB/GYN Hospitalist at Hospital A. regarding the Respondent's CRNM practice.

5. The complaint alleged that on September 14, 2018, a newborn was transferred from BC to Hospital A, with a history of a six-minute shoulder dystocia that resulted in a humerus fracture; the newborn required CPR and was transferred to another hospital for head cooling; and the midwife did not bring any prenatal records, written documentation of maneuvers to treat shoulder dystocia or written documentation of resuscitation efforts to the Hospital A.

[1] On or about June 1, 2020, BC entered into a Settlement Agreement ("Agreement") with OHCQ and agreed that BC's license would be placed on a probationary status for the duration of the Agreement and the expiration of the Agreement "shall occur one year from the date of reopening" providing certain conditions are met.

BC Medical Records:

6. The patient's first BC visit was on June 26, 2018 and the visit notes completed by the Respondent include the following:

Chief Complaint: Desires birth center care.
Antepartum Problem/Risk List: VBAC[2] 1
Summary: G4[3]P2[4] @ 30 weeks presents for new OB visit. First birth was home birth to hospital transfer which resulted in a cesarean for FTP,[5] second birth was a hospital VBAC.
Diagnostics: Fasting glucose 77; 1hr 50 gm glucose tolerance = 102

7. The patient was seen by the Respondent for a 2nd OB visit on July 12, 2018.

8. On July 12, 2018, the patient signed a Gestational Diabetes Information and Consent Form ("GDM[6] Consent")[7] but did not indicate if she consented to gestational diabetes screening.

The GDM Consent includes the following information:

Are there other alternative methods for screening GDM?
Other methods of screening have less evidence supporting them and include a meal-based carbohydrate challenge test, random blood sugar spot checks, and the hemoglobin-A1C blood test (assesses blood sugar control over 2-3 months).
These factors are associated with INCREASED risk for developing GDM:

- BMI over 30
- Increased Maternal Age
- History of GDM
- Family History of diabetes
- Hispanic, Native American, South or East Asian, African American, or Pacific Island descent

9. On July 12, 2018, the patient signed an Informed Consent for a Vaginal Birth After Cesarean (VBAC) at [Birth Center] ("VBAC Consent"). The VBAC Consent provides, in part:

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[2] Vaginal Birth After Cesarean section.
[3] Gravida = number of pregnancies
[4] Para = number of births of viable gestational age.
[5] Failure to Progress.
[6] Gestational Diabetes Mellitus.
[7] The GDM Consent included an article titled Gestational Diabetes and the Glucola Test, dated June 14, 2012.

The American Association of Birth Centers has further stated that VBAC should be treated as normal birth if there is a low transverse uterine scar and adequate physician/institutional backup is available in the unlikely event of an obstetric emergency.
The documented risk of low transverse uterine scar rupture (tear) is the same as the risk of uterine rupture in a non-scarred uterus as long as there has been no postpartum infection.

10. The New Patient Health History Form, dated July 12, 2018, provides the following regarding Obstetrical History:

Year/Type of pregnancy/delivery/Weeks/Sex/Weight
2014: C section/42 weeks/male/10.1
2016: VBAC/38 weeks/male/7.14

11. The patient had additional OB visits with the Respondent on July 26, 2018, August 7, 2018, August 14, 2018, August 21, 2018, August 28, 2018, September 4, 2018, September 11, 2018 at 1236 [sic] and September 11, 2018 at 1248.

12. The Labor Intake documented Admission Date/Time as 9/12/2018 12:15 pm and Labor Start Date/Time as 9/12/2018 10:00 am.

13. The first documentation in the Labor and Delivery Flow Notes was dated/timed 9/12/2018 12:31 pm. Additional entries indicated, in some instances, the same date with two different times:

9/12/2018 3:25 pm 9/12/2018 2:12 pm
9/12/2018 3:35 pm 9/12/2018 2:12 pm
9/12/2018 4:28 pm 9/12/2018 2:12 pm
9/12/2018 7:38 pm 9/12/2018 2:12 pm[8]
9/12/2018 4:40 pm 9/12/2018 2:12 pm
9/12/2018 4:45 pm 9/12/2018 2:12 pm
9/12/2018 5:00 pm 9/12/2018 2:12 pm
9/12/2018 5:30 pm 9/12/2018 2:12 pm
9/12/2018 6:00 pm 9/12/2018 2:12 pm[9]
9/12/2018 6:10 pm 6/12/2018 2:12 pm
9/12/2018 6:20 pm 6/12/2018 2:12 pm

[8] The Respondent documented an Addendum Sub-note on 9/12/2018 8:21 pm "738 pm note was incorrect. The correct time for that note was 1625 pm."
[9] The Respondent documented - Notes: All previous notes has [sic] 2 second of duration and 45 between ctx, was actually 2 minutes between ctx and lasting 45 seconds.

9/12/2018 0700 pm 6/12/2018 6:41 pm

14. The Labor and Delivery Flow Notes, starting with dated/timed **9/12/2018 6:41pm**, document the following:

Maternal Position: Hands & Knees 9-12-2018 2:12 pm
Fetal Presentation: OA (by visualized)
Assessment:
1828 fetus crowning
1833 attempted to doppler FHTs[10] but unable to d/t maternal position and strong contraction/pushing efforts, prepared for imminent delivery
1835 head delivered
1836 fetus rotated from OA to ROA and turtle sign noted, Mychal began shoulder dystocia maneuvers – McRoberts first
1837 attempted to corkscrew counter clockwise
1838 CNM then stepped in and assisted mother into [sic] hands and knees, gentle traction applied, no change, lifted right leg into lunge position
1839 CNM attempted to deliver posterior shoulder, attempted corkscrew maneuver, unable and assisted mother back into McRoberts position. Suprapubic pressure applied. No change in position of posterior shoulder. Communicated findings to mother. Notified father to call EMS.
1840 Mychal attempted to corkscrew infant counter clockwise, unable. Immediately attempted posterior shoulder again. Was able grasp under fetus' right arm to up in front of infant's chest. Palpable pop felt in upper arm.
1841 Arm was delivered and infant delivered and placed on mother's abdomen, now reclining in bed. Dried and stimulated – gasping only. BVM attempted while on abdomen without chest rise. No HR noted – infant placed next to mother on Resus-A-Cradle and positioned in sniffing position for open airway.
1842 Mychal initiated CPR. [CNM] attempted BVM[11] with no chest rise seen after adjusting mask and pressure. [RN] attempting to place infant on SaO2 monitor without success.
1843 Mychal placed LMA,[12] while [CNM] continued chest compressions, and attached BVM to O2 and respirations successfully given, chest rise noted. CPR continued 3:1 ratio with midwives. Infant increasingly turning pink.
1848 CPR discontinued when FHT were noted at 100 and spontaneous breathing began.
1849 HR >100 infant with some tone, body and extremities pink, head purple.
1850 Blowby O2 given, good respiratory effort and cry. Body pink, head purple.
1852 EMS arrived
1854 …Infant supported in resus-a-cradle and was handed to EMS provider and placed on their stretcher. Warming pads and warmed blankets placed, right arm secured next to infant in the resus-a-cradle.

[10] Fetal Heart Tones (Fetal Heart Rate FHR).
[11] Bag valve mask ventilation.
[12] Laryngeal mask airway ventilation.

1902 Enroute to [Hospital A] – Mychal and [Father] accompanying infant in ambulance.

15. Baby A's APGAR[13] scores were recorded as: 0 (1 minute); 2 (5 minutes) and 8 (10 minutes).

Hospital A: Baby A Medical Records

16. Baby A arrived at Hospital A's ED on 9/12/2018 at 1911 and "did not need any ongoing resuscitation, ha[d] good tone, good cry, and was not bradycardic." The baby was admitted to the NICU and approximately four hours later, was transferred to Hospital B for therapeutic hypothermia and orthopedic evaluation.

17. The Discharge Summary provides the final diagnoses as Perinatal Depression and Right Humerus Midshaft Displaced Fracture.

THE RESPONDENT'S WRITTEN RESPONSE TO THE COMPLAINT

18. In a written response, dated September 6, 2019, the Respondent reported:

> Records were not transcribed at the time of transfer, Mychal transferred in ambulance with infant. She brought her computer and paper charting and sat down with the physician and gave a detailed report of reason for transfer, dystocia and resuscitative measures verbally reported. She stayed at the hospital until infant was transferred to [Hospital B]. A hard copy of the chart was given to NICU at [Hospital B] at day 2 visit.
> No epinephrine was administered to neonate during resuscitation. We did not have IV access to give this medication.
> Templates were brand new and not functioning appropriately. Since this incident we have updated all of our charting and formulated printing a function for fast print/fax procedure at time of transfers. The chart was not provided to [Hospital A], that was a mistake/oversight.

19. The Respondent did not meet the CRNM standards of practice for the following reasons including, but not limited to:

I. Failed to provide adequate, science-based patient education about GDM and glucose challenging testing to allow for fully informed decision making.

[13] Test used to assess the newborn (Appearance, Pulse, Grimace, Activity and Respiration)

II. Failed to provide the patient with complete and accurate education/information to ensure an informed decision/consent regarding VBAC and TOLAC. The maternal history should have prompted evaluation of fetal growth during pregnancy and counseling about the patient's risk for macrosomia should have been documented as part of TOLAC counseling.

III. Failed to document patient care in a coherent and sequential order to ensure continuity of care.

IV. Failed to follow the standard of care for neonatal resuscitation – failed to use SpO2 monitoring to monitor progress during resuscitation (only the baby's skin color was assessed and documented); failure to administer epinephrine and inability to fully care for a depressed newborn.

V. Failed to transfer medical records with the patient to Hospital A.

PATIENT B

20. On or about February 4, 2019, the Board received a complaint from MD, regarding the Respondent's CRNM practice. The complaint alleged that on December 28, 2018, the Respondent transferred a patient with fetal heart rate decelerations to Hospital A; a transfer form was not completed; there was an inappropriate evaluation of thyroid dysfunction; the Respondent failed to identify and mange uterine size-to-date discrepancy and patient records were received several hours after the patient transfer.

BC Medical Records:

21. Visit Notes for the patient's first BC visit was completed by the Respondent but a date was not identified.[14] The Visit Notes include the following information:

Antepartum Problem/Risk List
1. hx infertility
2. hx left ovarian tumor
3. Hashimotos Plan: Obtain prior lab work, monitor TSH & Thyroid antibodies, consult endocrinology prn

Summary:
G5P0 @ 9 weeks for NOB.
Hx Hashimotos thyroiditis. Improved on gluten and dairy free diet. Had lab work last week – will provide for us. Discussed TSH Q trimester and monitor thyroid antibodies. Endocrinology consult, as needed.

[14] A New Patient Health History Form was completed on May 17, 2018.

22. The patient had additional OB visits with the Respondent on June 13, 2018, July 11, 2018, August 7, 2018, September 4, 2018, October 2, 2018, October 16, 2018, October 30, 2018, November 15, 2018[15], November 29, 2018[16], December 5, 2018,[17] December 11, 2018,[18] December 19, 2018[19] and December 26, 2018.[20]

23. Thyroid Function test results were as follows:

Date Collected: 1/9/2018 – TSH 0.442 Flag Low.
Date Collected: 7/6/2018 – TSH (Final) Thyrotropin 0.033 Flag Low.
Date Collected: 7/11/2018 – Thyroxine (T4) Free 1.12; Triiodothyronine (T3) free 2.5; Thyroid Peroxidase (TPO) 63 Flag High.
Date Collected: 10/2/2018 – TSH – Thyrotropin 0.338 Flag Low; TPO 50 Flag High.
Date Collected: 12/5/2018 – TSH - Thyrotropin 0.344 Flag Low; TPO 37 Flag High.

24. The Labor and Delivery Notes provide the following:

Admission: 12/28/2018 at 4:10 am
Labor Start: 12/28/2018 12:00 am
No ROM Recorded
Discharged to Hospital
Mode of Transport: Car
Emergency Transfer during 1st Stage
Reason: Non-Reassuring Fetal Heart Tones
Hospital Called: 12/28/2018 7:21 am [Hospital A]
BC Departure: 12/28/2018 7:20 am
Hospital Arrival: 12/28/2018 7:25 am
Labor Flow:
12/28/2018 04:15 am – No FHT or B/P recorded.
12/28/2018 4:45 am – No FHT or B/P recorded.
12/28/2018 5:00 am – FHT 130; no B/P recorded.
12/28/2018 6:00 am – FHT 135; no B/P recorded.
12/28/2018 7:15 am – FHT 30, decrease on doppler; no B/P recorded. Attended by Mychal Pilia. Assessed FHT in the 70s. Changed positions to left side lying no increases noted, changed to right side lying FHT tones lower in 50s, attempted left side lying again with

[15] Documented Fundal Height (FH) as 37, Estimated Gestational Age (EGA) as 35/1. FH measurement used to assess fetal growth and development.
[16] A fundal height was not documented during this visit. Documented 3EGA 37/1
[17] Documented FH 38, EGA 38/0.
[18] Documented FH 36, EGA 38/6.
[19] Documented FH 35, EGA 40/0.
[20] Documented FH 37, EGA 41/0.

> FHT continuing to decrease. Discussed with [Patient B] to start an IV for hydration and start oxygen, but decided to go directly to the hospital for non-reassure FHT.
> Walking from birth room to the front room. FHT assessed again and they were 30s. States she could feel baby moving. Enroute [Patient B] and [Individual] in their car. Myself and doula in my car by 0720.

Hospital A: Medical Records

25. The **Admit Note and History** includes the following information:

> 12/28/18 09:35:
> G5P0040 at 41w2d. sent from [Birth Center] with decelerations. VS moderate hypertension Cat I to II- occasional variables. Awaiting prenatal records from Mykal. Prenatal records reviewed – had low TSH but no reflex free T4 was drawn to unsure if she has subclinical or overt hyperthyroidism. She was not referred for f/u despite low TSH in Oct. & Dec.
> 14:42: Prenatal records reviewed and office called to confirm GBS+ and clarify TSH levels. No free T4 was drawn so unsure [sic]
> if she is subclinical vs overt hyperthyroidism. Will draw TSH & free T4 with next blood draw.

THE RESPONDENT'S WRITTEN RESPONSE TO THE COMPLAINT

26. In a written response dated September 6, 2019, the Respondent reported:

> This client was admitted into labor for approximately 4 hours, upon which time a fetal deceleration was noted and was not improving, decision was made to transfer immediately. Call was placed enroute to [Hospital A], and records were immediately faxed while Mychal was in the waiting room at the hospital prior to clients getting admitted. [21]
> See chart for fundal height measurements. 13 weeks gest/13 measurement, 17/17, 21/21, 29/29, 31/30, 33/31, (different CNM measurement), 35/37, 37/no fundal height, 38/38, 39/36, 40/35, 41/37.
> Subclinical hypothyroidism – managed with diet changes and no medication. TSH and T4 I ordered on 7/12/2018, other CNM ordered TSH and antibodies on 10/3/2018 and 12/6/2018 – with improvement noted to TSH levels and antibodies.

27. The Respondent did not meet the CRNM standards of practice for the following reasons including, but not limited to:

I. Failed to transfer medical records with the patient to Hospital A. Records were faxed to the hospital almost three hours after the patient's arrival.

[21] The complainant (MD) submitted a copy of the BC records faxed to Hospital A. The fax cover sheet indicates fax date/time as "2018-12-28 14:10:26 GMT [Greenwich Mean Time]." Converted to EST 1410 = 10:10 am. The Respondent documented the patient arrived at Hospital A at 7:25 am.

II. Failed to document any follow up of abnormal thyroid test results during prenatal care; no documentation of evaluation of the thyroid test results or discussion with the patient or referral to an endocrinologist.
III. Failed to document the patient's blood pressure during labor at the birth center.
IV. Failed to order a growth ultrasound or document any evaluation of the reason(s) the fundal height was lagging behind the EGA by over 2 weeks, after normal growth through 38 weeks.

PATIENT C

28. On May 20, 2019, the Board received a complaint from MD regarding the Respondent's CRNM practice. The complaint alleged that on March 5, 2019, the patient presented to Hospital A and it was noted that syphilis screening was not done with prenatal labs and the diabetes screening done at 28 weeks was not the standard screening for GDM.

BC: Medical Records

29. On August 7, 2018, the patient presented at 8 weeks for her first OB visit. The patient had subsequent visits on September 6, 2018, October 3, 2018, November 7, 2018, December 12, 2018,[22] January 2, 2019, January 18, 2019, January 31, 2019, February 7, 2019, February 13, 2019, February 19, 2019, February 22, 2019, February 28, 2019.

30. On the March 5, 2019 visit, the patient presented with "swelling around the knees," B/P 146/100 and reported she "is ready to be transferred to [Hospital A]."

Hospital A: Medical Records

31. The Admit Note/History dated/timed March 5, 2019 at 1727, indicate: Pre-admission diagnosis: Hypertensive Disorder Pregnancy [HDP]; Chief Complaint: Scheduled Induction of Labor; Comment: Patient received care at [Birth Center]. Patient's BP

[22] The patient presented at 27 weeks and 4 days. Documented "Passed GDM screening – Fasting Blood sugar 104; 1-hour postprandial blood sugar 115."

elevated at prenatal appointment at 146/100 and sent to [Hospital A] for induction due to HDP.

THE RESPONDENT'S WRITTEN RESPONSE TO THE COMPLAINT

32. In a written response dated September 6, 2019, the Respondent reported:

> CDC recommends Syphilis screening in the 1st trimester for all women and repeated tested as needed. Hx of 1 sexual partner in 8 years.
> 12/12/18 "desired to wait until birth, understands s/s of concern to notify midwife.
> GDM screening was done fasting was 105 and 1 hour postprandial was 112. f/u GDM GTT was not done. Low glycemic index diet and increase in exercise was discussed. Random glucose was 91 on 2/22/19.

33. The Respondent did not meet the CRNM standards of practice for the following reasons including, but not limited to:

I. Failed to order the standard screening test for GDM. The screening test is a 50 G glucose challenge test not fasting and postprandial blood sugars.
II. Failed to order a prenatal syphilis screening test.

PATIENT D

34. On or about May 20, 2019, the Board received a complaint from MD, regarding the Respondent's CRNM practice.

35. According to the complaint, on May 4, 2019, the patient presented to Hospital A and reported her midwife told her she had preeclampsia; the patient presented to the midwife on May 1st and was noted to have severe hypertension and proteinuria; prenatal records did not show that the blood pressure was repeated; outpatient labs were ordered, including a 24 hour urine, which significantly delayed treatment for eclampsia; the patient was diagnosed with preeclampsia and required treatment with antihypertensives.

36. The complaint further alleged that there was no prenatal syphilis screening and there was inappropriate GDM screening.

BC: Medical Records

37. On September 26, 2018, the patient presented at 7 weeks for her first OB visit. The patient had subsequent OB visits on October 18, 2018, November 14, 2018, December 12, 2018, January 9, 2019 and January 31, 2019.

38. The patient presented at 29 weeks for an appointment on February 26, 2019 and the visit notes include the following:

> Here today for GDM screening.
> Fasting Blood Sugar 102; 1-hr postprandial blood sugar 103, 2-hr postprandial blood sugar 95, 3-hr postprandial blood sugar 87.
> Passed 3-hour GGT.

39. The patient had additional OB visits on March 12, 2019, March 26, 2019, April 11, 2019, April 17, 2019 and April 24, 2019.

40. At a May 1, 2019 visit, visit notes include the following:

> B/P 160/86; UA Protein Trace; PIH[23] labs sent; trace protein in urinalysis.

41. The result of a 24-hour Total Protein Urine, collected on May 2, 2019, was reported as High at 330 (range 30-150).

Hospital A: Medical Records

42. The Admit Note/History dated and timed for May 4, 2019 at 1411, provides the following:

> 30 yo G2P1001 at 38w4d. Patient known to [Birth Center]. She had a w/u for preeclampsia on 5/1/19 when she was noted to have severe HTN and proteinuria. VS – mild to severe HTN, mild tachycardia. Pt appears very anxious, she is tearful.
> No RPR. No glucola noted.
> Preeclampsia – recommend induction – is having severe HTN – will treat severe HTN prn.
> **1327**: BP 174/92 on L&D, was 150s-160s in triage.

[23] Pregnancy Induced Hypertension.

THE RESPONDENT'S WRITTEN RESPONSE TO THE COMPLAINT

43. In a written response dated September 6, 2019, the Respondent reported:

> This client was told at her final prenatal visit that she had risked out of the birth center with pre-eclampsia. We had a discussion on how to move forward with the process. That I would need to call the hospital to transfer care over, give report and send her records. Before leaving the office that day the client stated that she needed time to think about it. She was very upset. It was expected of her to contact me with her decision.
> I messaged the client asking her what her plan was for going to the hospital, and there was no concrete reply. She said she was discussing the decision with her spouse. I then received a text message from the client several days after her last prenatal visit stating that she was at the hospital and to send her records. She had been at the hospital approximately 4 hours when the message was received. I called the hospital and told them the situation and that I did not know when she was planning to go into the hospital until I received that text message. I called report to the nurse and faxed over the records. I told the nurse that the client had severe anxiety and had not communicated with me for a few days since she was told she risked out of the birth center....[24]
> I discuss with my clients the plan of care and transfer, and once they leave my office, I have no control of the choices they make for themselves. She was told she had preeclampsia and needed to go to the hospital same day. She was told to go home and pack her bags and go to the hospital. She did not go to the hospital for four days. Yes, there was delay in her care, that was the client's decision.

44. The Respondent did not meet the CRNM standards of practice for the following reasons including, but not limited to:

I. Failed to: (1) urgently refer the patient to the hospital for follow up of hypertension (2) document such a referral and contact the hospital to inform them that the patient had been referred (3) document providing report to the providers at the hospital and forwarding the patient's records in anticipation of the patient's arrival (4) repeat the blood pressure on 5-1-19 (5) counsel and/or document counseling the patient about the "risk out" from the birth center and on danger signs of pre-eclampsia.

II. Failed to order the standard screening test for GDM. The standard screening test is a 50 G glucose challenge test not fasting and postprandial blood sugars.

III. Failed to order prenatal syphilis screening test.

[24] None of the Respondent's purported communication with the patient and the hospital are documented in the medical records.

PATIENT E

45. On or about December 20, 2019, the Board received a complaint from Doula, regarding the Respondent's CRNM practice. The complaint alleged, among other things, that a patient gave birth at BC in July, and the baby sustained a "birth injury."

BC: Medical Records

46. On December 14, 2018, the patient presented at 7 weeks 6 days for the first OB visit. The patient had subsequent visits on January 15, 2019, January 24, 2019, February 13, 2019, March 14, 2019, April 10, 2019, May 7, 2019, May 30, 2019, June 13, 2019, June 27, 2019, July 3, 2019, July 11, 2019, July 18, 2019 and July 23, 2019.

47. On July 25, 2019, the patient presented at 39 weeks 5 days in early labor. The documented Care Plan was "return to care with active labor signs, 9 pm, or as needed."

48. The Labor and Delivery Notes provide the following:

Admission: 7/25/2019 2:10 pm
Labor Start: 7/25/2019 02:00 am
Rupture of Membranes: SROM, 7/25/2019 02:00 AM
Notes: 2004 no fetal heart tones able to be obtained by doppler. 2008 episiotomy cut and fetus crowned at 2009. 2010 head delivered and double nuchal cord reduced on perineum, then body delivered.
2008: EMS called
2010; Infant born, no respirations or heart tones auscultated or palpated. Multiple breaths given to infant via mouth to mouth/nose as BVM attached to O2.
2011: No heart tones or pulse, baby placed on resus-a-cradle with dry towel, chest compressions started and BVM in place, poor chest rise observed, resumed mouth to mouth/nose respirations at a rate of 3 chest compressions to 1 breath. Heat pad placed on infant's lower body.
2012: no respirations or heart tones/pulse continued CPR.
2013: LMA placed good chest rise observed and bilateral breath sounds auscultated during BVM respiration. Infant continues with no respiration or heart tones/pulse. CPR continued.
2014: IO catheter attempted in right tibia, flushed with saline and felt fluid posterior leg. IO removed.
2015: 2nd attempt. IO catheter placed in left tibia. CPR continued.
2016: 0.4 ml 1:10000 epinephrine administered with flush, no response. CPR continued.

2017: EMS arrived
2018: Infant remains without spontaneous respirations and pulse. CPR continued. O2 monitor placed on toe by EMS.
2019: 2nd dose of 0.4 ml epinephrine administered by EMS with flush and pads placed on chest and back to check heart rhythm. HR on monitor in 120s, auscultated heart rate correlated with monitor, but no pulse felt, instructed by EMS to continue CPR. CPR continued.
2023: Cord clamped and cut, CPR still in progress.
2024: Resus-a-cradle and infant placed on stretcher with CPR in progress by BC staff. Once infant secured on stretcher EMS took over CPR.
2025: Departed Birth Center
APGAR Scores: 0 (1 min); 1 (5 mins); 1 (10 mins).
Labor Flow Sheet:
7/25/2019
2:10 pm – FHT 133 on doppler; Pulse 90
03:04 pm – FHT 130 on doppler; no pulse documented
3:15 pm – No FHT or pulse documented
3:35 pm – FHT 133 on doppler; no pulse documented
04:05 pm – FHT 142 on doppler; no pulse documented
4:28 pm – FHT 125 on doppler; no pulse documented
4:45 pm – No FHT or Pulse documented
5:00 pm – FHT 128 on doppler; no pulse documented
5:30 pm – FHT 132 on doppler; no pulse documented
6:00 pm – FHT 130 on doppler; P 84
6:20 pm – FHT 125 on doppler; no pulse documented
6:35 pm – FHT 130 on doppler; no pulse documented; BP 132/74
6:50 pm – FHT 135 on doppler; no pulse
7:05 pm – FHT 128 on doppler; no pulse documented
7:20 pm – no FHT or pulse documented
7:30 pm - FHT 117 on doppler; no pulse documented
7:34 pm – FHT 80 on doppler; no pulse documented
7:36 pm – FHT 120 on doppler; no pulse documented
7:40 pm – FHT 125 on doppler; no pulse documented
7:45 pm – FHT 113 on doppler; no pulse documented

49. The Labor Flow Additional Details include the following entry:

7/25/2019 7:55 pm: Assessment; Right side lying FHT of 77, changed position to left side lying FHT remained decreased to 82. Changed position to hands and knees and FHTs improved to 130s.

Hospital A: Medical Records

50. According to Baby E's Discharge Summary, the baby was admitted on July 25, 2019, "… the ambulance team intubated infant and continued chest compressions. On arrival to the ER at 20:43, infant was being ventilated via an ET, bagged with room air, mottle purple generalized color… Infant transported to NICU."

51. Baby E was transferred to Hospital B on July 25, 2019 for therapeutic hypothermia, with diagnoses Perinatal Asphyxia, Metabolic acidosis and need for sepsis evaluation.[25]

52. The Respondent did not meet the CRNM standards of practice for the following reasons including, but not limited to:

    I. Failed to monitor and document patient's pulse along with FHT, especially when FHT decelerations occurred. This would have differentiated if heart tones auscultated/documented were those of the baby or the mother. Maternal pulse was last documented at 7/25/2019 at 6:00 pm, almost two hours before the last documented FHT, at 7/25/2019 7:55 pm.

DISCUSSION

In 2019, the Board received multiple complaints regarding the Respondent's nursing/nurse midwifery practice.

Based on the above Findings of Fact in Paragraphs 19, 27, 33, 44 and 52, the Board finds that the Respondent violated Health Occ. § 8-316 (a) (8), (25) with underlying grounds COMAR 10.27.19.02 A. (5) and COMAR 10.27.19.02 C. (12); and (30) with underlying grounds COMAR 10.27.09.03. B (2) b (i) and (ii), COMAR 10.27.05.04 A (1) and (2), COMAR 10.27.05.06 A (1), (2) and (3) and COMAR 10.27.05.09.

[25] Baby E was discharged from Hospital B on August 30, 2019 with diagnoses including Neonatal Encephalopathy, Severe Hypoxic Ischemic Encephalopathy and Seizures.

The Board concludes that the Respondent's violations of the Act fall within F. (2) of the Board's sanctioning guidelines – "Practice Inconsistent with Generally Accepted Standards of Care." *See* COMAR 10.27.26.07 F. (2). The range of potential sanctions under category F. (2) is reprimand to revocation and the range of potential monetary penalties is $1000 to $5000.

II. CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent violated the Act as follows:

§8-316 (a):

(8) Does an act that is inconsistent with generally accepted professional standards in the practice of registered nursing or licensed practical nursing;

(25) Engages in conduct that violates the professional code of ethics; *to wit*,
Code of Maryland Regulations ("COMAR") 10.27.19.02 A. A nurse shall:
(5) Assume responsibility and accountability for individual nursing judgments and actions;
COMAR 10.27.19.02 C. A nurse may not engage in behavior that dishonors the profession whether or not acting in the capacity or identity of a licensed nurse, including, but not limited to:
(12) Engaging in unprofessional or immoral conduct;

(30) Violates regulations adopted by the Board or an order from the Board; *to wit*;
COMAR 10.27.09.03 B. (2) (b)
The RN shall demonstrate knowledge of and comply with:
(i) Relevant professional practice standards;
(ii) Statutes and regulations governing nursing;
COMAR 10.27.05.04 **Required Documentation**
A. A certified nurse midwife who provides clinical midwifery services across the reproductive lifespan shall:
(1) Maintain a medical record for each client; and
(2) In the case of a transfer of care to another provider or a facility, transfer the client's medical records with the client;
COMAR 10.27.05.06 **Scope of Practice**
A. A certified nurse midwife who meets the requirements of Regulation .02 of this chapter may perform the following functions:

(1) Independent management of clients appropriate to the skill and educational preparation of the certified nurse midwife and the nurse midwife's clinical practice guidelines;
(2) Consult or collaborate with a physician or other health care provider as needed; and
(3) Refer clients with complications beyond the scope of practice of the certified nurse midwife to a licensed physician;

COMAR 10.27.05.09 **Compliance**
The certified nurse midwife shall develop and comply with clinical practice guidelines as defined in Regulation .01B of this chapter.[26]

III. ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is hereby:

ORDERED, that beginning on the effective date of this Consent Order, the Registered Nurse license, license number **R213201**, and **Certified Nurse Midwife Certificate**, of **MYCHAL LYNN PILIA,** to practice in the State of Maryland, shall be placed on **PROBATION FOR A MINIMUM OF THREE (3) YEARS,** subject to the following terms and conditions:

1. The status of the Respondent's Registered Nurse license and CRNP certificate will be listed in the Board's records and on the Board's website with the status of "**PROBATION**";

2. The Respondent may seek employment as a RN or RN/CRNM but shall obtain Board approval before accepting any new position as a RN or RN/CRNM;

3. The Respondent shall immediately notify all employers of the probationary status of the Respondent's RN license and CRNM certificate and arrange for all employers to submit, in writing, confirmation that they have reviewed this Consent Order;

[26] COMAR 10.27.05.01 B. (8) provides: "Clinical practice guidelines" means written standards using guidelines established by:
(a) The ACNM Standards for the Practice of Midwifery.
(b) Any other national certifying body recognized by the Board.

4. If the Respondent is engaged in practice as a CRNM at any time during the probationary period, the Respondent's practice shall be subject to peer review and supervision by a Board-approved CRNM-Supervisor (the "Nurse Supervisor"), subject to the following terms and conditions:

a. Within **SIXTY (60) DAYS** of the effective date of this Order, or the date by which the Respondent begins practice as a CRNM, if the Respondent is not engaged in CRNM practice on the effective date of this Order, the Respondent shall obtain a Board-approved Nurse Supervisor to peer review her CRNM practice. The Nurse Supervisor shall not share a current business, or have a personal or financial relationship with the Respondent. The Respondent shall obtain prior approval from the Board before entering into a peer supervisory arrangement with a Nurse Supervisor. As part of the approval process, the Respondent shall provide the Board with the curriculum vitae and any other information requested by the Board regarding the qualifications of the proposed Nurse Supervisor;

b. The Respondent shall be responsible for ensuring that the Nurse Supervisor submits to the Board written confirmation of acceptance of the peer review supervisory role and written confirmation that the Respondent has provided the Nurse Supervisor with a copy of this Order;

c. The Respondent shall meet with the Nurse Supervisor once per month for a minimum of **THREE (3) YEARS**. Each month, the Nurse Supervisor shall randomly select **FIVE (5)** of the Respondent's cases, review all relevant patient records, and discuss the **FIVE** cases with the Respondent, with a particular focus on compliance with the standards of practice and provide feedback regarding the Respondent's practice and any recommended improvement and corrective action.

d. If the Respondent engages in CRNM practice while subject to this Order, the Respondent shall be responsible for ensuring that the Board-approved Nurse Supervisor submits **quarterly written reports** to the Board, on the schedule provided by the Board's Compliance and Monitoring Dept. Each quarterly report must include: a summary all **FIFTEEN** cases peer reviewed during the prior 90-day period, the Nurse Supervisor's assessment of the Respondent's practice, performance and compliance with the appropriate standards of practice and any identified areas for improvement and corrective action. Failure to ensure that the Nurse Supervisor submits written quarterly reports to the Board as scheduled is a violation of probation and this Order;

e. If the peer-supervisor arrangement with the Nurse Supervisor is terminated for any reason, the Respondent and the Nurse Supervisor shall notify the Board in writing within **THREE (3) DAYS** of the termination of the arrangement. The written notifications submitted by the Respondent and Nurse Supervisor shall include the reasons for termination of the arrangement.

f. An unsatisfactory report will be considered a violation of probation and this Consent Order;

5. If the Respondent at any time, while subject to this Order, is employed as a RN, and not as a CRNM, the Respondent shall arrange for the Respondent's supervisor at her place of employment to submit **written quarterly work-site reports** to the Board, evaluating the Respondent's work performance and nursing practice. If the Respondent's employment terminates at any of the Respondent's place(s) of employment before the due date of a quarterly work-site report, a final work-site report is due on the last day of employment. It is the Respondent's responsibility to ensure that work-site reports are submitted to the Board and to notify the Respondent's supervisor when the reports are due. An unsatisfactory report will be considered a violation of probation and this Consent Order;

6. The Respondent shall submit to the Board **written monthly self-reports**, even if the Respondent is not employed as a RN or CRNM. If the Respondent is practicing as a CRNM, the Respondent shall submit **written monthly self-reports**, which include a description of her experience with the peer review arrangement with the Nurse Supervisor and any changes, improvements or corrective actions implemented in her CRNM practice. Failure to submit monthly self-reports or failure to provide monthly self-reports on time shall constitute a violation of probation and this Order;

7. The Respondent shall notify the Board in writing of any RN or CRNM position from which the Respondent is terminated by the employer and/or any RN or CRNM position from which the Respondent voluntarily resigns within **THREE (3) DAYS** of the date of termination or resignation. The Respondent shall include the reasons for the termination or resignation in the written notification; and it is further

8. At any time during the probationary period, the Board may, in its discretion, order

the Respondent to submit to an examination by a healthcare provider designated by the Board. If so ordered, the Board shall pay for the cost of the examination. The Respondent shall sign all necessary consent forms required to authorize disclosure of the healthcare provider's written report to the Board. Furthermore, the Respondent consents to the use and disclosure of the healthcare provider's report, as well as any other medical, mental health, or substance use disorder treatment records, in any subsequent Board proceeding, including, but not limited to, any final, public order issued by the Board.

ORDERED that, pursuant to the Nurse Licensure Compact, the multistate status of the Respondent's RN license, shall be **deactivated** during the pendency of this Consent Order. Accordingly, the Respondent's RN license shall be designated as **single-state only**, and the Respondent shall not have a multistate licensure privilege to practice as an RN in any party state to the Nurse Licensure Compact. The multistate status of the Respondent's RN license shall not be reactivated unless and until the probation imposed by this Consent Order is terminated; the Respondent's RN license is restored to full unencumbered and active status; and the Respondent is not otherwise disqualified from holding a multistate license at that time; and it is further

ORDERED that, if the Respondent moves permanently or temporarily, either within or outside the State of Maryland, the Respondent shall notify the Board of the new address and phone number within **THREE (3) DAYS** of the move; and it is further

ORDERED that, the Respondent shall disclose a copy of this Consent Order to the nursing board of another state where employed and submit to this Board written acknowledgement that the nursing board(s) have reviewed this Consent Order; and it is further

ORDERED that, in the event that the Board issues to the Respondent any other type of license and/or certificate that the Board is authorized to grant, that license and/or certificate shall also be subject to the terms of this Consent Order; and it is further

ORDERED that, the Respondent shall obey all state and federal laws. If the Respondent is convicted of, or pleads guilty to, any crime(s), whether or not any appeal or other proceeding is pending to have the conviction or plea set aside, the Respondent shall notify the Board, in writing, of any conviction(s) or guilty plea(s) within **TEN (10) DAYS** of the conviction or guilty plea. Failure to report a conviction or guilty plea to the Board in writing within **TEN (10) DAYS** is a violation of probation and this Consent Order; and it is further

ORDERED that, **the Respondent shall contact and schedule an appointment with the Board of Nursing's Discipline/Compliance Unit, no later than TEN (10) DAYS from the effective date of this Consent Order**, for the purpose of beginning compliance with its terms and conditions; be it further

ORDERED that, the Respondent shall submit to an in-person, face-to-face annual meeting with Board staff throughout the entire duration of the probationary period **if** requested to do so;

ORDERED that, the Respondent shall be responsible for paying all costs required to comply with all of the terms and conditions of the probation and this Consent Order; and it is further

ORDERED that, the Respondent shall successfully complete Board-approved Continuing Education Units (CEUs) for CRNMs, in the following topics: **ANTEPARTUM AND INTRAPARTUM MANAGEMENT; DOCUMENTATION; ETHICS; INTERMITTENT AUSCULTATION**, and submit documentary proof of successful completion of the CEUs to the Board within **NINETY (90) DAYS** of the effective date of this Consent Order; and it is further

ORDERED that, there shall be no early termination of probation. After **THREE (3) YEARS** from the effective date of this Consent Order, the Board will consider a petition for termination of the Respondent's probationary status, provided that the Respondent has been compliant with all of the probationary terms of this Consent Order and safely employed as an RN/CRNM for at least **TWELVE (12) MONTHS** immediately preceding the petition for termination of probationary status; and it is further

ORDERED that, failure to comply with any of the terms and conditions in this Consent Order shall constitute a violation of the Order; and it is further

ORDERED that, if the Respondent violates any of the terms and conditions of this Consent Order, the Board, in its discretion, after notice and an opportunity for an evidentiary hearing, may impose, by further public Order of the Board, any sanction(s) authorized by Health Occ. § 8-316 and COMAR 10.27.26, including reprimand, additional probation, suspension, revocation, and/or a monetary penalty;

ORDERED that this Consent Order is a **PUBLIC RECORD** pursuant to Md. Code Ann., Gen. Prov. §§ 4-101 *et seq.* (2019 Repl. Vol.).

1/26/2022
Date

Gary Hicks
The Board President's Signature
Appears on the Original Document

President
Maryland Board of Nursing

CONSENT

By this Consent, I acknowledge that I have read this Consent Order in its entirety and I hereby admit the truth of the Findings of Fact and accept and submit to 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 legal counsel authorized to practice law in Maryland, to confront witnesses, to give testimony, to request subpoenas for witnesses, to call witnesses on my own behalf, to introduce testimony and evidence on my own behalf, and to all other substantive and procedural protections provided by law. I waive these rights, as well as any appeal rights under Maryland Code Annotated, State Government Article § 10-222.

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

MYCHAL LYNN PILIA
R213201/CRNM

NOTARIZATION

CITY: —

COUNTY: Frederick County, Maryland

I HEREBY CERTIFY that on this 3rd day of January, 2022, before me, Notary Public of the State and City/County aforesaid, **MYCHAL LYNN PILIA,** personally appeared, and declared and affirmed under penalties of perjury that signing the foregoing Consent Order was her voluntary act and deed.

AS WITNESSETH my hand and notarial seal.

SEAL

CARRIE SHIFLETT
Notary Public - State of Maryland
Frederick County
My Commission Expires Mar 1, 2023

Notary Public

My Commission Expires: 03/01/2023