

IN THE MATTER OF	*	BEFORE THE
PAMELA YVETTE CALWELL, N.H.A.	*	MARYLAND STATE
License Number: R1376	*	BOARD OF EXAMINERS OF
Respondent	*	NURSING HOME ADMINISTRATORS
	*	Case Number: 2012-001

* * * * *

CONSENT ORDER

PROCEDURAL BACKGROUND

On January 10, 2013, the State Board of Examiners of Nursing Home Administrators (the "Board") charged PAMELA YVETTE CALWELL, N.H.A. (the "Respondent"), License Number R1376, with violating provisions of the Maryland Nursing Home Administrators Licensing Act ("the Act"), codified at Md. Health Occ. ("H.O.") Code Ann. §§ 9-101 et seq. (2009 Repl. Vol., 2012 Supp.) and Code Md. Regs ("COMAR") 10.33.01.15 et seq.

Specifically, the Board charged the Respondent with violating the following provisions of § 9-314(b) of the Act:

Subject to the hearing provisions of § 9-315 of this subtitle, the Board may deny a license or limited license to any applicant, reprimand any licensee or holder of a limited license, place any licensee or holder of a limited license on probation, suspend or revoke a license or limited license, or impose a civil fine if the applicant, holder, or licensee:

- (3) Otherwise fails to meet substantially the standards of practice adopted by the Board under § 9-205 of this title; [and/or]
- (11) Commits an act of unprofessional conduct in the licensee's practice as a nursing home administrator[.]

The Board also charged the Respondent with violating the following regulations:
Code of Maryland Regulations ("COMAR") tit. 10 § 33.01.15, "Suspension and Revocation of Licenses."

- A. Pursuant to Health Occupations Article, § 9-314(b)(3), Annotated Code of Maryland, the Board may ... suspend or revoke a license of a nursing home administrator, or reprimand or otherwise discipline ... a licensee after due notice and an opportunity to be heard at a formal hearing, upon evidence that the ... licensee:
- (1) Has violated any of the provisions of the law pertaining to the licensing of nursing home administrators or the regulations of the Board pertaining to it;
 - (2) Has violated any of the provisions of the law or regulations of the licensing or supervising authority or agency of the State or political subdivision of it having jurisdiction of the operation and licensing of nursing homes; [and/or]
* * * *
 - (9) Has endangered or sanctioned the endangerment of the safety, health, and life of any patient [.]

In addition, the Board also charged Respondent with violating the following provisions of H.G. § 19-345.2 pertaining to the rights of individuals in health care facilities (referenced in COMAR 10.33.01.15.A(1)):

(a) Requirements. -- In addition to the provisions of §§ 19-345 and 19-345.1 of this subtitle, a facility may not involuntarily discharge or transfer a resident unless, within 48 hours before the discharge or transfer, the facility has:

- (1) Provided or obtained:
 - (i) A comprehensive medical assessment and evaluation of the resident, including a physical examination, that is documented in the resident's medical record;
 - (ii) A post discharge plan of care for the resident that is developed, if possible, with the participation of the resident's next of kin, guardian, or legal representative; and
 - (iii) Written documentation from the resident's attending

physician indicating that the transfer or discharge is in accordance with the post discharge plan of care and is not contraindicated by the resident's medical condition; and

(2) Provided information to the resident concerning the resident's rights to make decisions concerning health care, including:

- (i) The right to accept or refuse medical treatment;
- (ii) The right to make an advance directive, including the right to make a living will and the right to appoint an agent to make health care decisions; and
- (iii) The right to revoke an advance directive.

(b) Resident's information. – Except as provided in subsection (c)(3) of this section, at the time of transfer or discharge, the facility shall provide the resident or the resident's next of kin, guardian, or legal representative with:

(1) A written statement of the medical assessment and evaluation and post discharge plan of care required under subsection (a) of this section;

(2) A written statement itemizing the medications currently being taken by the resident;

(3) To the extent permitted under State and federal law, at least a 3-day supply of the medications currently being taken by the resident;

(4) The information necessary to assist the resident, the resident's next of kin, or legal representative in obtaining additional prescriptions for necessary medication through consultation with the resident's treating physician; and

(5) A written statement containing the date, time, method, mode, and destination of discharge.

(c) Written consent to discharge. –

(1) Except as provided in paragraphs (2) and (3) of this subsection, a facility may not discharge or transfer a resident unless the resident is capable of and has consented in writing to the discharge or transfer.

(2) A facility may discharge or transfer a resident without obtaining the written consent of the resident if the discharge or transfer:

(i) Is in accordance with a post discharge plan of care developed under subsection (a) of this section; and

(ii) Is to a safe and secure environment where the resident will be under the care of:

1. Another licensed, certified, or registered care provider; or

2. Another person who has agreed in writing to provide a safe and secure environment.

(3) A facility that is certified as a continuing care provider under Title 10, Subtitle 4 of the Human Services Article is not subject to the provisions of subsection (b) of this section if:

(i) The facility transfers a resident to a lesser level of care within the same facility in accordance with a contractual agreement between the facility and the resident; and

(ii) The transfer is approved by the attending physician.

(d) Discharge planning process. -- If the requirements of §§ 19-345 and 19-345.1 of this subtitle and subsections (a) and (b) of this section have been met, the resident's next of kin or legal representative shall cooperate and assist in the discharge planning process, including:

(1) Contacting, cooperating with, and assisting other facilities considering admitting the resident; and

(2) Cooperating with governmental agencies, including applying for medical assistance for the resident.

On February 13, 2013, a Case Resolution Conference was convened in this matter. Based on negotiations occurring as a result of this Case Resolution Conference, the Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law, Order, and Consent.

FINDINGS OF FACT

BACKGROUND FINDINGS

1. At all times relevant to these charges, the Respondent was and is licensed to practice as a nursing home administrator in the State of Maryland. The Respondent was originally licensed by the Board on February 16, 1999, under License Number R1376.

2. At all times relevant to these charges, the Respondent was employed as the nursing home administrator ("NHA") for a nursing home located in Baltimore, Maryland ("Facility A"). As NHA, Respondent was responsible for ensuring, among other things, that patients at Facility A were discharged properly and that their rights were respected.

3. On October 14, 2011, the Board received a report of a complaint survey of Facility A conducted by the Office of Health Care Quality ("OHCQ").

4. The OHCQ survey report revealed the following:

- a. On September 15, 2011, a complaint was filed with OHCQ by a Baltimore County police officer ("Police Officer B") regarding Facility A's failure to accept a resident ("Resident A") back into Facility A after Resident A was arrested, processed through Central Booking and subsequently released on his own recognizance.
- b. Resident A's medical record reveals diagnoses including end-stage renal disease secondary to hypertension (for which he received dialysis three (3) days a week), gout, chronic anemia, hyperthyroidism and chronic pain.

- c. The Director of Nursing at Facility A stated that on September 13, 2011, Respondent received a call from a police officer ("Police Officer A") informing her that Resident A was under a warrant for his arrest due to a second degree assault charge that had occurred at another nursing facility.
- d. Police Officer A arranged to arrive at Facility A on September 14, 2011 to transport Resident A to Central Booking. Police Officer A received Resident A's list of medications and a wheelchair for transport. Police Officer A reported to an OHCQ surveyor that Respondent had instructed him not to return Resident A to Facility A after processing Resident A's arrest.

5. OHCQ's surveyor also interviewed Police Officer B and obtained a copy of his police report. Police Officer B reported the following:

- a. He was responsible for taking Resident A back to Facility A after Resident A's bail hearing. After numerous unsuccessful attempts to reach Facility A for transport of Resident A, Police Officer B ultimately arranged for Resident A's adult son to meet him at Facility A.
- b. When Police Officer B arrived at Facility A, he and Resident A were escorted out of the lobby to the outside parking lot and were told by Respondent that because of Resident A's criminal record, Facility A would not allow Resident A to return to the facility. Facility A staff

placed Resident A's belongings outside on the parking lot but failed to give Resident A his medications.

- c. Respondent instructed Police Officer B to transport Resident A to the emergency room ("ER"), but Police Officer B advised that he would not do so because Resident A had no injuries or medical conditions requiring immediate medical treatment. Respondent reiterated her request to transport Resident A to the ER and ordered both Resident A and Police Officer B off the grounds of Facility A.
 - d. While Police Officer B and Resident A awaited the arrival of Resident A's son on a public sidewalk near Facility A, a Baltimore City Fire Department Ambulance arrived in emergency response mode. The medic stated that he had received a report of an acutely sick man. Police Officer B relayed the recent events to the medic, and Resident A declined transport to the ER. Resident A's son arrived during the conversation and took Resident A to his home.
6. During an interview with OHCQ's surveyor, Respondent stated that:
- a. Upon his arrest, Resident A was not provided with a discharge notice or advised that his discharge was "Against Medical Advice."
 - b. Resident A did not want to return to Facility A and that she and her staff had tried to locate Resident A after his arrest in order to readmit him to Facility A per his physician's order.

- c. Resident A did not come back into Facility A, contrary to Police Officer B's statement.
 - d. She did not instruct Police Officer B to take Resident A to the ER upon his return to Facility A.
7. OHCQ made the following findings as a result of its investigation:
- a. Resident A was not safely discharged from Facility A. Upon discharge, Resident A should have received sufficient information regarding his dialysis appointments, arrangements to ensure he received his medications as prescribed and information to arrange for physician follow up.
 - b. Facility A's staff did not question the arrest process with Police Officer A; nor did staff accompany Resident A to the police station.
 - c. Only after Resident A had been taken to his son's home did Facility A staff attempt to schedule a dialysis appointment for him.
 - d. Respondent's statements to the police and to OHCQ staff were inconsistent.
8. Based upon the survey complaint, the Board initiated an investigation.

BOARD INVESTIGATIVE FINDINGS

9. The Board's investigation revealed that the notes of Facility A documenting that Resident A was not going to return and that he wanted to be "left alone" were inconsistent with the statements reflected in Police Officer B's report.

10. According to Facility A's nursing notes, staff did not attempt to contact Resident A until Resident A's doctor advised that Resident A needed to be seen in the office to arrange for medications.

11. During an interview under oath with the Board's investigator, Respondent provided the following information, some of which is inconsistent with OHCQ's reports and the police reports:

- a. Approximately six police officers arrived at Facility A to arrest Resident A.
- b. As Resident A was getting into a police officer's vehicle, he stated that he did not want to return to Facility A.
- c. Facility A provided the arresting officer with a "fact sheet" and a list of medications. No information was provided regarding Resident A's need for dialysis treatment at that time and was not provided until the next day when Resident A's son returned Facility A's telephone calls from the prior evening.
- d. When Police Officer B returned Resident A to Facility A, neither Police Officer B nor Resident A indicated that Resident A wished to return to the facility.
- e. Police Officer B called in advance of bringing Resident A to the facility and indicated that Resident A's son would be meeting them there. Resident A's son collected Resident A's belongings at that time and made no indication that Resident A would be returning to the facility. Respondent denied being present during this time.

f. On September 15, 2011, Resident A returned to Facility A after receiving dialysis.

12. Respondent's actions and/or inactions, as set forth herein, constitute failure to substantially meet the standards of practice pursuant to H.O. § 9-314(b)(3); unprofessional conduct pursuant to H.O. § 9-314(b)(11); and an illegal involuntary discharge of Resident A, in violation of COMAR 10.33.01.15A.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent: otherwise failed to meet substantially the standards of practice adopted by the Board under H.O. § 9-205, in violation of H.O. § 9-314(b)(3); committed an act of unprofessional conduct in the licensee's practice as a nursing home administrator, in violation of H.O. § 9-314(b)(11); and failed to follow discharge procedures, in violation of H.G. § 19-345.2.

In addition, the Board concludes as a matter of law that the Respondent violated the following COMAR regulations: Has violated any of the provisions of the law pertaining to the licensing of nursing home administrators or the regulations of the Board pertaining to it, in violation of COMAR 10.33.01.15A(1); has violated any of the provisions of the law or regulations of the licensing or supervising authority or agency of the State or political subdivision of it having jurisdiction of the operation and licensing of nursing homes, in violation of COMAR 10.33.01.15A(2); and has endangered or sanctioned the endangerment of the safety, health, and life of any patient, in violation of COMAR 10.33.01.15A(9).

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, it is this 13 day of March, 2013, by a quorum of the Board considering this case:

ORDERED that

1. The Respondent's license to practice as a nursing home administrator shall be **SUSPENDED** for a period of three (3) months, which suspension shall be immediately **STAYED**;

2. The Respondent shall be placed on probation for a minimum of one (1) year commencing on the date the Board executes this Consent Order and continuing until Respondent satisfactorily complies with the following terms and conditions:

a. Within thirty (30) days of the date the Board executes this Consent Order, the Respondent shall pay a civil fine to the Board by certified check or money order in the amount of two thousand (\$2000.00) dollars;

b. Within one (1) year of the date the Board executes this Consent Order, the Respondent shall successfully complete the following coursework: (1) an in-person course on patient discharge planning; (2) an in-person course on the needs of patients receiving regular dialysis treatment; and (3) a three-credit in-person college-level course on ethics. With respect to all three courses, the Respondent shall submit the course description and course curriculum to the Board for its approval prior to enrolling in the course. The Board reserves the right to reject the course(s) the Respondent proposes and may, in its discretion, require additional information about any course the Respondent offers to fulfill

this condition. The Respondent shall be solely responsible for furnishing the Board with adequate written verification that she has successfully completed the course according to the terms set forth herein. The Respondent may not use any continuing medical education credits earned through taking such coursework to fulfill any continuing medical education requirements that are mandated for licensure renewal in this State. If The Respondent fails to successfully complete the course according to the terms set forth herein, such failure shall constitute a violation of this Consent Order.

3. The Respondent shall practice according to the Maryland Nursing Home Administrators Licensing Act and in accordance with all applicable laws, statutes, and regulations pertaining to the practice of nursing home administration.

AND IT IS FURTHER ORDERED that after the conclusion of the one (1) year period of probation, the three-month suspension of Respondent's license shall be deemed complete and the Respondent may file a written petition for termination of her probationary status without further conditions or restrictions, but only if she has satisfactorily complied with all conditions of this Consent Order, including all terms and conditions of probation. Before making a decision on the Respondent's petition for termination of probation, the Board may, in its discretion, require that she personally appear before the full Board, or a panel of the Board, for the purpose of determining whether she has satisfactorily complied with all of the terms and conditions of the Consent Order and whether her probation should be terminated; and it is further

ORDERED that if the Respondent violates any of the terms and conditions of probation and/or of this Consent Order, the Board, in its discretion, after notice and

opportunity for a hearing, may impose any sanctions the Board may impose under Md. Health Occ. Code Ann. §§ 9-314 and 9-314.5 of the Maryland Nursing Home Administrators Licensing Act, including reprimand, additional probation, suspension, revocation and/or monetary fine; and it is further

ORDERED that the Respondent shall be responsible for all costs incurred to comply with this Consent Order; and it is further

ORDERED that this Consent Order shall be a public document pursuant to Md. State Gov't Code Ann. § 10-611 et seq. (2009 Repl. Vol.).

3/13/2013
Date

Patricia A. Hannigan
Patricia Hannigan, Executive Director
State Board of Examiners of
Nursing Home Administrators

CONSENT

I, Pamela Yvette Calwell, N.H.A., acknowledge that I have had the opportunity to consult with counsel before signing this document. I have reviewed the Findings of Fact and Conclusions of Law, and I agree and accept to be bound by this 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, to 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 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 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.

3/1/13
Date

Pamela Yvette Calwell
Pamela Yvette Calwell, N.H.A.
Respondent

Read and approved:
3/1/13
Date

Catherine A. Bledsoe
Catherine A. Bledsoe, Esquire
Counsel for Ms. Calwell

NOTARY PUBLIC

**STATE OF MARYLAND
CITY/COUNTY OF: .**

I HEREBY CERTIFY that on this 1 day of March, 2013,
before me, a Notary Public of the State and County aforesaid, personally appeared
Pamela Yvette Calwell, N.H.A., and gave oath in due form of law that the foregoing
Consent Order was her voluntary act and deed.

AS WITNESS, my hand and Notary Seal.

Yvonne Shary Probst
Notary Public

12-6-16
My commission expires:

