STATE OF VERMONT
SECRETARY OF STATE
OFFICE OF PROFESSIONAL REGULATION
BOARD OF NURSING

IN RE:	)	
RIYA C. MATHEW	)	**Docket No. 2014-302**
License No. 026.0033517	)	

STIPULATION AND CONSENT ORDER

Now come the State of Vermont, by and through State Prosecuting Attorney Gabriel M. Gilman, and the respondent in this matter, Riya C. Mathew, represented by Attorney Matthew D. Gilmond, of Ryan Smith & Carbine, Ltd., Rutland, who stipulate and agree as follows:

Board Authority

1. The Vermont Board of Nursing ("Board") has jurisdiction to investigate and adjudicate allegations of unprofessional conduct committed by Nurses pursuant to 3 V.S.A. §§ 129, 129a; 26 V.S.A. Chapter 28; the Administrative Rules of the Board of Nursing ("ARBN"); and the Rules of the Office of Professional Regulation.

2. The Board may "[d]iscipline any licensee ... who has had ... a license ... disciplined by a licensing agency in another jurisdiction for conduct which would constitute unprofessional conduct in this state ..." 3 V.S.A. § 129(a)(5).

Statement of Facts

3. Riya C. Mathew ("Respondent") of Jersey City, New Jersey, is licensed by the Board as a registered nurse under license number 026.0033517. The license first issued on or about July 11, 2006. The license is active at this writing and is scheduled to expire in due course on March 31, 2015. There is no history of discipline in Vermont.

4. On or about January 10, 2014, the Maryland Board of Nursing reprimanded Respondent's Maryland nursing license pursuant to the *Final Decision and Order of Reprimand* attached hereto as Exhibit A.

5. Respondent complied with conditions imposed pursuant to the Maryland Order, including completion of a remedial course.

6. The parties agree that the Maryland discipline does not call for any restriction on Respondent's ability to practice in Vermont. The purpose of this Stipulation and Consent Order is to ensure, by reciprocal warning, that persons making licensing inquiries in Vermont may be fully informed of the Maryland Order of Reprimand.

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Prosecuting Attorney
Office of
Professional Regulation
89 Main Street
3rd Floor
Montpelier, VT
05620-3402

7. Respondent recognizes that collateral estoppel prevents re-litigation of the Maryland disciplinary matter in Vermont. Should the Maryland Order be vacated in the forum state, the parties agree that equity would dictate that this Stipulation and Consent Order, based as it is exclusively upon the Maryland Order, would be nullified as well.

Basis for Discipline

8. The conduct for which Respondent was disciplined in Maryland would constitute unprofessional conduct in Vermont pursuant, *inter alia*, to 3 V.S.A. § 129a(a)(6) (Delegating professional responsibilities to a person whom the licensed professional knows, or has reason to know, is not qualified by training, experience, education, or licensing credentials to perform them, or knowingly providing professional supervision or serving as a preceptor to a person who has not been licensed or registered as required by the laws of that person's profession).

Understandings

9. Respondent understands that the Nursing Board must review and accept the terms of the Consent Order. If the Board rejects any portion, the entire Stipulation and Consent Order shall be null and void.

10. Respondent specifically waives any claims that any disclosures made to the full Board during its review of this agreement prejudice her rights to a fair and impartial hearing if this agreement is not accepted by the Board and proceeds to a hearing on the merits.

11. Respondent has read and reviewed this entire document and agrees that it contains the entire agreement between the parties.

12. Respondent is not under the influence of any drugs or alcohol at the time she signs this Stipulation and Consent Order.

13. Respondent voluntarily enters into this agreement after the opportunity to consult with legal counsel and is not being coerced by anyone into signing this Stipulation and Consent Order.

14. Respondent voluntarily waives her right to a contested hearing before the Board of Nursing and waives any right to appeal from this Stipulation and Consent Order.

15. Respondent agrees that the Order set forth below may be entered by the Board.

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CONSENT ORDER

Based on the Stipulation above, it is **ORDERED AND ADJUDGED** as follows:

A. The Board of Nursing hereby **WARNS** the Respondent's license. Such warning is reciprocal to existing discipline in a foreign jurisdiction and does not arise from any misconduct in Vermont.

B. Should the underlying Maryland Order of Reprimand be vacated or expunged, it shall be Respondent's responsibility to notify the Board and provide satisfactory documentation of the same, whereupon this Consent Order may be vacated.

C. This Stipulation and Consent Order is a matter of public record and may be reported to other licensing authorities as provided in 3 V.S.A. §129(a).

D. This Stipulation and Consent Order will remain part of Respondent's licensing file and may be used for purposes of determining sanctions in any future disciplinary matter.

AGREED TO:

Dated: Dec 5, 2014

STATE OF VERMONT
SECRETARY OF STATE

By: _____
Gabriel Gilman
State Prosecuting Attorney

Dated: 12/8/14

RIYA C. MATHEW
RESPONDENT

By: _____
Riya C. Mathew

APPROVED AS TO FORM:

Dated: 12/10/14

MATTHEW D. GILMOND, ESQ.
ATTORNEY FOR RESPONDENT

By: _____
Matthew D. Gilmond

APPROVED AND SO ORDERED:

Dated: 1/12/15

VERMONT BOARD OF NURSING

By: _____
Chairperson

Date of Entry: 1/13/15

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
89 Main Street
3rd Floor
Montpelier, VT
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IN THE MATTER OF	*	**BEFORE THE**
	*	
RIYA MATHEW	*	**MARYLAND BOARD**
	*	
License Number R189157	*	**OF NURSING**

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FINAL DECISION AND ORDER OF REPRIMAND

I. PROCEDURAL BACKGROUND

On or about June 10, 2011, the Maryland Board of Nursing (the "Board") received a complaint regarding the nursing practice of Riya Mathew (the "Respondent"). As a result of that complaint, the Board conducted an investigation. Based on the information provided to the Board during the investigation, by letter to the Respondent dated July 22, 2013, the Board charged the Respondent with violations of the Nurse Practice Act, specifically Md. Code Ann., Health Occ. ("H.O.") § 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;

(10) Has violated any provision of this title;

(22) Delegates nursing acts or responsibilities to an individual that the licensee knows or has reason to know lacks the ability or knowledge to perform;

(24) Fails to properly supervise individuals to whom nursing acts or responsibilities have been delegated; and

(30) Violates regulations adopted by the Board or an order from the Board, specifically:

COMAR 10.27.09.02.I. Assignment, Delegation, and Supervision. (1) The RN may assign nursing acts or delegate nursing tasks to individuals who are competent to perform those act or tasks, when the assignment or delegation does not jeopardize the client's welfare.

COMAR 10.27.11.03.A. The nurse may delegate the responsibility to perform a nursing task to an unlicensed individual, a certified

nursing assistant, or a medication technician. The Delegating nurse retains the accountability for the nursing task.

COMAR 10.27.11.03.D. When delegating a nursing task to an unlicensed individual, certified nursing assistant, or medication technician the nurse shall:

(1) Make an assessment of the patient's nursing care needs before delegating the task;
(2) Either instruct the unlicensed individual, certified nursing assistant, or medication technician in the delegated task or verify the unlicensed individual's certified nursing assistant's, or medication technician's competency to perform the nursing task;
(3) Supervise the performance of the delegated nursing task in accordance with Regulation. 04 of this chapter;
(4) Be accountable and responsible for the delegated tasks;
(5) Evaluate the performance of the delegated nursing task; and
(6) Be responsible for assuring accurate documentation of outcomes on the nursing record.

COMAR 10.27.11.03.E. The nurse shall be the primary decision maker when delegating a nursing task to an unlicensed individual, certified nursing assistant, or medication technician. Nursing judgment shall be exercised within the context of the employing facility's model of nursing practice which includes a mechanism for:

(1) Identifying those individuals to whom nursing tasks may be delegated;
(2) Reevaluation of the competency of those to whom nursing tasks may be delegated;
(3) Recognizing that the final decision regarding delegation is within the scope of the nurse's professional judgment;

COMAR 10.27.11.03.F. The registered nurse shall assume the role of case manager in delegating nursing tasks,...in situations where the nurse had thoroughly assessed and documented that:

(1) The client's health care needs are chronic, stable, uncomplicated, routine, and predictable;
(2) The environment is conducive to the delegation of nursing tasks; and
(3) The client is unable to perform his or her own care.

COMAR 10.27.11.04.A. The nurse shall determine the required

degree of supervision after an evaluation of appropriate factors including, but not limited to the:

(1) Stability of the condition of the client;
(2) Training of the individual to whom the nursing task is being delegated;
(3) Nature of the nursing task being delegated;
(4) Orientation of the unlicensed individual, certified nursing assistant, or medication technician to the specific patient environment;
(5) Ability of the unlicensed individual, certified nursing assistant, or medication technician to perform the delegated nursing task in a safe and competent manner; and
(6) Reevaluation of the client's health status;

The Board's charging document also notified the Respondent of the Respondent's opportunity to request an evidentiary hearing before the Board regarding the Board's charges against her. The charging document further advised that if the Respondent failed to request a hearing within thirty (30) days from the issuance of the charging document, the Respondent would waive her right to a hearing. In the event of such a waiver, the charging document advised the Respondent that the Board would issue a default order pursuant to § 10-210(4) of the Administrative Procedure Act, Md. Code Ann., State Gov't §§ 10-201, *et seq.*, wherein the Board could, pursuant to H.O. § 8-316, sanction the Respondent's license. The Respondent failed to request a hearing. On December 17, 2013, a quorum of the Board was present and a default proceeding was held. Tracy Bull, administrative prosecutor, presented the case on behalf of the State of Maryland.

II. FINDINGS OF FACT

The Board makes the following findings of fact based upon the entirety of the record:

1. At all times relevant, the Respondent was licensed to practice as a registered nurse ("RN") in the State of Maryland, license number R189157.

2. On June 10, 2011, the Board received a complaint from the Department of Health and Human Services-Aging and Disability Services, Medicaid Waiver for Older Adults Program regarding the nursing and medication technician ("MT") practices at an Assisted Living Facility ("the ALF") in Rockville, Maryland.

3. The Assisted Living Manager (the "ALM") of the ALF is a certified MT in the State of Maryland.

4. The Owner (the "Owner") of the ALF is the mother of the ALM. The Owner is also the Alternate Assisted Living Manager and a certified MT in the State of Maryland.

5. The Respondent entered into a Delegating Nurse Consultation Agreement with the ALF on August 16, 2010. The Respondent was also the Delegating Nurse ("DN") for seven (7) other assisted living facilities operated by the Owner. Overall, the Respondent was the DN for a combined population of 67 residents.

6. According to Delegating Nurse Consultation Agreement, the DN was "responsible for the delegation of medication administration and supervision of medication to residents at [the ALF] in compliance with COMAR 10.07.14.20." Per the agreement, the DN was also responsible for teaching the medication administration training program, providing clinical updates to staff MTs, and assessing the competency of staff MTs during the 45-day visits. The agreement also stated that the DN "will only delegate medication administration to an individual who has completed a Board approved Medication Administration Training Program for Assisted Living and who is certified with the Board as a Medication Technician."

7. According to the complaint, on or about June 6, 2011, a Social Worker and Adult Evaluation and Review Services Nurse for Montgomery County ("AERS Nurse") were

conducting an on-site, joint re-assessment of services provided to a resident ("Resident-A") at the ALF.

8. During the on-site visit, the Social Worker and AERS Nurse observed a staff member ("Caregiver A") administer crushed-up medications in apple sauce to a resident. Caregiver A told the Social Worker and the AERS Nurse that she had to crush up the medications and put them into the applesauce of a resident because medications were found pocketed or spit out by the resident.

9. When questioned by the Social Worker as to her training and certification for medication administration, Caregiver A remained quiet and would not answer the Social Worker's question.

10. Caregiver A was not a certified MT. According to an Employee Schedule received from the ALF, Caregiver A worked seven days a week from 7:30 a.m. to 7:30 p.m. and is listed as a "housekeeper."

11. According to the Reportable Events Form dated June 6, 2011, when interviewed by the Social Worker, the ALM stated that he was the only MT in the ALF.

12. The ALM wrote in an April 11, 2011 care note, "Resident A remains mostly compliant with taking her medications from the medication technician."

13. On August 2, 2011, the Office of Health Care Quality ("OHCQ") conducted an unannounced visit based upon the complaints received from the Social Worker and AERS Nurse regarding medication management at the ALF.

14. According to the August 2, 2011 OHCQ survey report, when interviewed by the OHCQ surveyor, another caregiver ("Caregiver B") admitted to administering medications to Resident B. Caregiver B told the OHCQ surveyor that she mixed pre-crushed medications,

prepared by the ALM, in applesauce and fed it to Resident B. Caregiver B stated that she administered Seroquel[1] and Namenda[2] to Resident B. Caregiver B told the OHCQ surveyors that she had not received any medication administration training from the Respondent. Caregiver B was not a certified MT.

15. The June 2011 Medication Administration Record (MAR) for Resident B was initialed by the ALM, indicating that he administered the following medications to Resident B at the following times: 125 mcg Synthroid, 1 tablet by mouth each day (given at 7 a.m.); 10 mg Aricept, 1 tablet by mouth, twice daily (given at 8 a.m. and 8 p.m.); 10 mg Namenda, one tablet, twice daily (given at 8 a.m. and 8 p.m.); Toprol 25 mg, 1 tablet by mouth each day (given at 10 a.m.); Lexapro 10 mg, 1 tablet by mouth each day (given at 10 a.m.); 25 mg Seroquel, 1 tablet by mouth at noon for anxiety (given at 12 p.m.); Vytorin 10/20 mg, 1 tablet by mouth each day (given at 12 p.m.); and 25 mg Seroquel, take 1 tablet by mouth, at bedtime for anxiety (given at 8 p.m.).

16. According to the Summary Statement of Deficiencies in the OHCQ survey report, the ALF failed to comply with the Medication Management and Administration regulations under COMAR 10.07.14.29.A, which requires that "all staff who administer medications to resident shall have completed the medication administration course that is taught by a registered nurse who is approved by the Maryland Board of Nursing." The OHCQ surveyors also reported deficiencies for the ALF failing to comply with COMAR 10.07.14.29.B; COMAR 10.07.14.29.M; and COMAR 10.07.14.35.

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[1] Seroquel is the trade name for quetiapine, an antipsychotic. Some side effects include orthostatic hypotension, seizures, neuroleptic malignant, tachycardia, and tardive dyskinesia.

[2] Namenda is the trade name for memantine, an anti-Alzheimer agent.

17. When interviewed by the Board Investigator on November 10, 2011 about the OHCQ survey findings, Caregiver B initially stated that Resident B's medications were left out in a medication cup[3] by the ALM and she crushed them and mixed them with applesauce which she then fed to the resident. Later in the same interview, Caregiver B stated that Resident B's family had brought in the medications which she said she crushed up at the direction of the family. And then later in the same interview, Caregiver B stated that the family crushed Resident B's medication and fed it to the resident and she just made sure the resident swallowed it.

18. Upon review of the May 2011, June 2011, and July 2011 Medication Administration Records (MARs), the ALM's initials appear on every single day of the three month period for all medications administered to all of the residents.

19. When interviewed by the OHCQ surveyor, the ALM admitted to crushing medications and mixing them with applesauce to feed to the residents. At the time of the OHCQ survey in August 2011, neither Resident A nor Resident B had a physician's order for crushing their medications.

20. According to the Summary Statement of Deficiencies in the OHCQ survey report, the ALF failed to ensure that medications were administered consistent with current signed medical orders in violation of COMAR 10.07.14.29.M.

21. The OHCQ surveyors reviewed Resident A's records and found documentation that the pharmacist recommended on September 8, 2010 and April 9, 2011 that Resident A's

[3] In a September 28, 2006 OHCQ Survey Report of the ALF, the OHCQ Surveyors reported in the Summary Statement of Deficiencies that the Respondent, as the ALM, would leave medications in medication cups for uncertified/ untrained staff members to administer to residents. The Surveyors also found crushed medication in applesauce in a medication cup in the kitchen.

Sinemet blood level be checked. When questioned by the OHCQ surveyors, the ALM stated that Resident A's family did not want to pay $50 for a home care agency to draw the resident's blood or take the resident to an outside facility.

22. According to the Summary Statement of Deficiencies in the OHCQ survey report, the OHCQ surveyors found that the ALF failed to comply with COMAR 10.07.14.35 for failing to provide any documentation indicating that the ALF had made an attempt to follow the pharmacist's recommendation and failed to document any kind of communication with Resident A's family regarding the recommendation.

23. Upon further investigation, the Board Investigator obtained an OHCQ survey report for a survey conducted at the ALF on September 28, 2006. According to the Summary Statement of Deficiencies in the September 2006 survey report, the OHCQ surveyors observed uncertified and untrained staff members administering medications to residents seated at the dining room tables. The medications were in medication cups with each resident's name on it. According to the report, "additional observation revealed crushed up medication in apple sauce in a medication cup on the kitchen counter." The OHCQ surveyor found that the ALF violated regulations regarding Medication Management under COMAR 10.07.14.29.K because the staff member was not a certified MT and had received no training regarding medication administration.

24. According to the September 28, 2006 OHCQ survey report, when interviewed by the OHCQ surveyor, the ALM stated that he "pours the residents' medication in the medication cups for Staff #2 to administer to the residents while he went to another facility." The OHCQ surveyor wrote in the September 2006 survey report that the ALM "revealed his

acknowledgement that it is not acceptable practice to pour medicines and to allow someone else to administer them."

25. The OHCQ surveyor cited the following reference in her September 2006 OHCQ survey report:

> The Course Curriculum from the Maryland Board of Nursing for Medication Technician Training-Assisted Living, Chapter 2, Section 4, states in capital letters: 'You cannot have someone else chart medication that you have administered...only the person who has administered the medication may chart it.'

26. When interviewed by the Board's Investigator, the Respondent stated that she was not aware that Caregiver A and Caregiver B were administering medications to the residents. The Respondent also denied knowing that medications were being crushed and administered without a physician's order.

27. The Respondent told the Boards' Investigator that, after the OHCQ survey was completed, she reprimanded the ALM and required him to take an 8-hour renewal class.

28. The Respondent continues to be employed as the DN for the eight assisted living facilities operated by the Owner.

29. The Board finds that, based upon the OHCQ survey dated August 2, 2011, the Respondent, while acting as a delegating nurse, delegated nursing acts and responsibilities to individuals she knew or should have known did not have the knowledge or ability to perform them. Furthermore, once the Respondent delegated those acts, the Respondent failed to sufficiently supervise any of the nursing activity at the ALF. The Respondent's improper delegation and failure to properly supervise the staff at the ALF resulted in poor documentation and ignorance to physician orders on the medication administration. The Board finds that the Respondent's conduct violates H.O. § 8-316(a)(8), (22), and (24).

30. In its discretion, the Board declines to find that the Respondent violated H.O. § 8-316(a)(10) and (30). Accordingly, those charges will be dismissed.

31. The Board finds that the Respondent's violations of the Nurse Practice Act fall within category F.(1) of the Board's sanctioning guidelines. *See* COMAR 10.27.26.07.F.(1) The range of potential sanctions under category F.(1) includes reprimand to probation for five (5) years and/or a minimum fine of $1,000 to a maximum fine of $3,000. *Id.*

III. CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes that the Respondent violated H.O. § 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;

(22) Delegates nursing acts or responsibilities to an individual that the licensee knows or has reason to know lacks the ability or knowledge to perform; and

(24) Fails to properly supervise individuals to whom nursing acts or responsibilities have been delegated.

IV. ORDER

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

ORDERED that the July 22, 2013 charges issued by the Board in this case in its "Charges under the Maryland Nurse Practice Act" alleging violations of Md. Code Ann., Health Occ. § 8-316(a)(10) and (30) are hereby **DISMISSED**; and it is further

ORDERED that the license of the Respondent, license number R189157, to practice as a registered nurse in the State of Maryland is hereby **REPRIMANDED**; and it is further

ORDERED that the Respondent shall satisfactorily complete a course approved in

advance by the Board in **DELEGATION** and shall provide written proof of successful completion of this course to the Board within **SIX (6) MONTHS** of the effective date of this Order. Failure to provide written proof of successful completion of these courses shall constitute a violation of this Order; and it is further

ORDERED that the Respondent shall have contacted, and scheduled an appointment with, the Board of Nursing's Discipline/Compliance unit no later than **MONDAY FEBRUARY 10, 2014,** for the purpose of beginning compliance with the terms and conditions of this Order. Failure to do so will constitute a violation of this Order; and it is further

ORDERED that the Respondent is responsible for any costs associated with this Order; and be it further

ORDERED that if the Respondent violates any of the terms and conditions of this Order, the Board, in its discretion, after notice and an opportunity for an evidentiary hearing before the Board, if there is a genuine dispute as to the material fact(s), or an opportunity for a show cause hearing before the Board, may impose any other disciplinary sanction which the Board may have imposed in this case under H.O. § 8-316(a) including probation, suspension, revocation, and/or monetary fine, said violation being proven by a preponderance of the evidence; and it is further

ORDERED that this document is a **PUBLIC DOCUMENT** under Md. Code Ann., State Gov't §§ 10-611, *et seq.* (2009 Repl. Vol.).

Patricia A. Noble
The Executive Director's Signature
Appears on the Original Document

January 10, 2014
Date

NOTICE OF APPEAL RIGHTS

Any person aggrieved by a final decision of the Board under Md. Code Ann., Health Occ. § 8-316(a) may take a direct judicial appeal within thirty (30) days as provided by Md. Code Ann., Health Occ. § 8-318, Md. Code Ann., State Gov't § 10-222 and Title 7, Chapter 200 of the Maryland Rules, including Md. Rule 7-203 ("Time for Filing Action").