IN THE MATTER OF	*	**BEFORE THE MARYLAND**
	*	
KHALILAH Q. JEFFERSON	*	**BOARD OF NURSING**
	*	
License Number: R147535	*	
CRNP-Family	*	

* *

ORDER FOR SUMMARY SUSPENSION OF REGISTERED NURSE LICENSE AND CERTIFIED REGISTERED NURSE PRACTITIONER CERTIFICATE PURSUANT TO SECTION 10-226(c)(2) OF THE ADMINISTRATIVE PROCEDURE ACT

The Maryland Board of Nursing (the "Board") hereby orders the **SUMMARY SUSPENSION** of the Registered Nurse license and Certified Registered Nurse Practitioner ("CRNP") Certificate, license number **R147535**, of **KHALILAH Q. JEFFERSON** (the "Respondent"), in the State of Maryland. The Board takes this action pursuant to the authority of Maryland Code Ann., State Government Article ("SG") § 10-226 (c) (2) (2021 Repl. Vol.), which provides:

> A unit may order summarily the suspension of a license if the unit:
> (i) finds that the public health, safety, or welfare imperatively requires emergency action; and
> (ii) promptly gives the licensee:
> 1. Written notice of the suspension, the finding and the reasons that support the finding; and
> 2. An opportunity to be heard.

The Board has reason, as set forth below, to find that the public health, safety, or welfare imperatively requires emergency action under SG § 10-226 (c) (2).

INVESTIGATIVE FINDINGS AND REASONS IN SUPPORT OF SUMMARY SUSPENSION

Based on investigatory information obtained by, received by, made known to and available to the Board, the Board has reason to believe that the following facts are true:[1]

1. On February 16, 2000, the Respondent was issued a Registered Nurse (RN) license in the State of Maryland. The Respondent's RN license has an "active-compact" status and is due to expire on January 28, 2023.

2. On November 13, 2013, the Respondent was issued a Certified Registered Nurse Practitioner-Family certificate in the State of Maryland. The Respondent's CRNP-Family certificate is active and due to expire on January 28, 2023.

DISTRICT OF COLUMBIA – BOARD OF NURSING ("DC BOARD")

3. On July 7, 2022, the DC Board issued a Decision and Order, which ordered the Respondent's Nurse Practitioner License, RN961391, "be and is hereby Revoked" and provided that "the Order does not affect the Registered Nursing License of the same number, RN961391".

4. The Decision and Order includes the following:

> **Background**
> ....
> On January 13, 2022, the Board issued a Notice of Intent to Take Disciplinary Action (NOI) against her APRN authorization, issued in the category of nurse practitioner....
> The NOI was sent to Respondent at her address of record by certified mail on February 16, 2022 and delivered on February 19, 2022. Thereafter, the notice was also sent to Respondent's counsel, who represented her during the investigative process. Counsel attempted to contact her but was unsuccessful in getting a response and therefore concluded that he was no longer her attorney of choice and unable to accept service.
> ....

[1]The statements regarding the Respondent's conduct identified herein are intended to provide the Respondent with reasonable notice of the asserted facts. They are not intended as, and do not necessarily represent, a complete description of the evidence, either documentary or testimonial, to be offered against the Respondent.

Findings of Fact

Based on the evidence in its record,[2] the Board enters the following findings of fact:

i. Respondent was initially licensed as a registered nurse in the District on August 29, 2000. She was granted the advanced practice registered nurse (APRN) authorization as a Nurse Practitioner (NP) on October 6, 2017. She held RN and NP licenses during all times relevant.

ii. On July 26, 2018, JW went to CWS to have an abortion. Her appointment was for 9:30 AM. JW was 32 years old at the time and weighed 278 pounds. She had previously been pregnant three times and had had caesarian sections due to complications.

iii. Prior to the start of the procedure, an ultrasound was performed to determine the fetus age and condition. Respondent and the ultrasound technician determined JW's pregnancy to be at 16 weeks and 5 days.

iv. The procedure began with the administration of 400 mcg of misoprostol at 10:32 AM, with instruction for the dosage to be repeated every four hours. It is unclear what time the actual abortion procedure was initiated but likely around approximately 11 AM.[3] The procedure was terminated without being completed because JW experienced pain and could not tolerate its continuance. The decision was made to administer twilight sedation.

v. The procedure was resumed at 1:30 PM. At 1:40 PM, 1 mg of midazolam and 3 ml of ketamine was administered intravenously. The procedure was terminated again at approximately 2 PM because JW was again experiencing pain. In response to the pain, JW began to resist and move around – possibly due to the dissociative effect of the medications.

vi. The procedure was halted at 2 PM. JW was prescribed 800 mcg of misoprostol to be repeated every three hours. She was placed in the recovery room at about 2:10 PM and was kept on the recovery room with periodic blood pressure monitoring at 2:30 PM, 2:55 PM, 3:30 PM, 6:30 PM, and 9:30 PM.

vii. It is likely that another attempt was made at approximately 3:30 PM but was again unsuccessful due to JW's experiencing pain. She was given 800 mcg of misoprostol at 5:45 PM and again at 8:48 PM.

viii. Another attempt was made at approximately 10:45 PM. At approximately midnight, Respondent was able to remove the placenta, one arm, and one lower leg of the fetus. But the procedure was halted once again due to JW's pain. At approximately 12:37 AM (July 27, 2018), JW refused further procedures and called 911 to take her to a hospital. Respondent filled out the Against Medical Advice form seeking to indicate that JW was leaving without proper discharge. JW refused to sign the form.

---

[2] In addition to the professional expertise of its members, the Board also benefitted from an evaluation and opinion of an external objective peer reviewer.

[3] The Abortion Procedure Record showed the 10:32 AM administration of misoprostol and then the evacuation procedure starting at 1:30 PM. It is unclear what occurred during the three hours in between but it is unlikely that nothing had been done during that time. The patient recalled that the procedure was started at around 11 AM. A note entered by a clinic personnel stated that after she performed the pre-procedure ultrasound, "I next saw the patient in the recovery room …The next time I came in contact with the patient, I escorted her to the procedure room 2 to have her prepare for the procedure. This was at approximately 1:30 PM." The fact that the patient was placed in the recovery room supports the patient's recollection that an effort had been made prior to 1:30 PM.

ix. To the emergency medical personnel, who documented arriving to provide assistance at 12:47 AM, JW indicated extreme pain in all quadrants of her abdomen. The ambulance took her to Washington Hospital Center (WHC), arriving there at 1:06 AM.

x. At WHC, JW's pregnancy was assessed to be 20 weeks and 3 days. She was found to have lacerations in the vagina and uterus due [to] the abortion attempts. WHC physicians performed repair and completed the evacuation of the fetus.

xi. Respondent's records are of note in many areas as indicated below.

xii. The Abortion Procedure Record noted only one procedure at 1:30 PM and the discontinuation of it at 2:30 PM. There was no mention of the earlier or later attempts.

xiii. The recovery room record was not noted to indicate that JW was placed there not for postoperative monitoring but rather for monitoring continued cervical preparation.

xiv. Respondent composed a progress note at 12:42 AM but began it with the administration of 800 mcg of misoprostol at 5:45 PM and 8:48 PM. She also noted the procedure time of 10:45 PM but failed to account for any development between the cessation of the procedure at 2:00 PM (as noted on Abortion Procedure Record) and the administration of misoprostol at 5:45 PM. In this note, Respondent recorded that the placenta, one arm and one leg were removed but this fact was not recorded in the Abortion Procedure Record. There was no notation of the weight, identification, or assessment of the tissue.

xv. Respondent's record did not indicate that JW's condition was monitored during the attempted procedures. There was no indication of whether JW received any sustenance either orally or intravenously during the 15 hours she remained at CWS.

xvi. There was indication that Respondent had used forceps but this was not recorded.

xvii. Respondent ordered several administration [sic] of misoprostol, starting with 400 mcg to be administered every four hours at 10:32 AM. There was no record whether and when the prescribed dosage was repeated. At approximately 2 PM, Respondent ordered administration of 800 mcg to be given every three hours. At 5:45 PM, JW was given 800 mcg of misoprostol and again at 8:48 PM. The instruction was for the dosage to be repeated every three hours. However, there was no further record of the administration of misoprostol after 8:48 PM.

xviii. The recommended safe dosage of misoprostol is 2,000 mcg during a 12-hour period and 200-400 mcg for each dosage in 13-20 weeks' pregnancy. While it is unclear how much had been administered, the records show at least 2800 [mcg] had been administered to JW.

xix. While Respondent made the decision to perform the procedure with twilight sedation, she only documented one occasion of twilight sedation administration – at 1:40 PM. Respondent admitted that she continued the attempts over the progress of that day - until the final attempt which started at 10:45 PM and may have continued until midnight – there were no other records of twilight sedation being administered after 1:40 PM. Respondent confirmed that when she resumed the procedure later in the day, it was based on twilight sedation. She had no explanation as to why the medication was not documented.

Analysis and Conclusions of Law

....

The care provided by Respondent to JW on July 26, 2018 was egregiously deficient. As an overweight patient with history of caesarian sections, JW should have been assessed as a high-risk patient. Yet only the routine ultrasound was performed, which failed to accurately assess the fetal age or location of the placenta. Respondent did not monitor JW's condition during the several attempts at the procedure. There was no recording of JW's heart rate or oxygen levels during the procedure. Under these conditions, it is unconscionable to keep the patient in the facility for 15 hours as Respondent had done here. Respondent should have reached a determination long before midnight of that day that JW's case was complicated than her skills or facility to provide adequate care. Yet, Respondent sought to prevent JW from seeking the care that she knew she needed when she called 911 to pick her up. Respondent tried to get JW to sign the Against Medical Advice form. In this regard, Respondent's action pointed to a serious lack of concern – thus constituting a willful disregard - for the client's welfare and safety.

Respondent's administration and prescription of medications are also below standards. When the procedure started – at approximately 10:32 AM - JW was administered 400 mcg of misoprostol to be repeated every four hours. But there was no subsequent notation of the repeated dosage(s) until the next indication that 800 mcg was given at 2PM to be repeated every three hours. Respondent next administered another 800 mcg of misoprostol at 5:45 PM and again at 8:48 PM. At this point, the patient had received at least 2800 mcg of misoprostol – perhaps more if the repeated dosage was given at any point in time without being recorded. This is well beyond the recommended safe dosage. Respondent's practice in this case both failed to conform to the prevailing standards as well as indicated a careless disregard for JW's health and safety.

....

In this case, Respondent failed to accurately record the exact number and timing of her attempts to complete the abortion. The patient remained at the facility from about 9:30 AM until after midnight. Respondent's record showed only an attempt at 1:30 PM and another at 10:45 PM. In her statement to DC Health Investigator, Respondent admitted to making more than the recorded two attempts. Further, the lack of documentation with regard to the patient's welfare during these 15 hours, for example, sustenance and vital signs, shows a lack of concern for and attention to the patient's health and safety. It is notable that when asked about the missing vital sign documentation, Respondent responded that she did not document vital signs during the procedure. However, it is indisputable that the procedure did not take place continuously between 9:30 AM and midnight. Additionally, Respondent failed to document every instance of the administration of controlled substance to the patient. As described, there was only one record of ketamine and midazolam being administered at 1:40 PM. However, by Respondent's own admission, she made subsequent efforts to complete the evacuation of the fetus with the patient under twilight sedation.

DISCUSSION

5. The DC Board revoked the Respondent's Nurse Practitioner license based on the "egregiously deficient" care provided to the patient on July 26 and 27, 2018.

6. Patient JW was under the Respondent's care for fifteen (15) hours and during that period, the Respondent: (1) failed to appropriately assess the patient's risks for the procedure (2) made several failed attempts to complete the procedure and failed to monitor the patient's response and tolerance, including vital signs, during the attempts (3) failed to accurately document the amount and time of the administration of controlled substances (ketamine and midazolam) during twilight sedation (4) prescribed and administered misoprostol in amounts that were above the recommended dosage (5) failed to accurately and completely document the care provided to the patient (6) failed to refer the patient to another facility, resulting in the patient recognizing that the Respondent and the facility could not provide the appropriate care and calling 911 on her own, to which the Respondent responded by requesting that the patient sign a AMA form.

7. At the hospital, the patient was treated for multiple lacerations to the uterus and vagina and the evacuation of the fetus was completed.

8. The DC Board concluded that the Respondent's actions constituted a willful and careless disregard for the patient's health and safety.

9. The Respondent holds an active, multi-state Maryland RN license and CRNP certificate. The Respondent's continued practice as a RN and CRNP poses a serious risk and danger to the public health, safety, and welfare.

CONCLUSION OF LAW

Based on the foregoing investigative findings and reasons, the Board finds that the public health, safety or welfare imperatively requires emergency action in this case pursuant to Md. Code Ann., State Govt. § 10-226 (c)(2) (2021 Repl. Vol.).

ORDER

It is hereby:

ORDERED that pursuant to the authority vested in the Board of Nursing by Maryland Code Ann., State Govt. § 10-226 (c)(2) (2021 Repl. Vol.), the Registered Nurse license and CRNP certificate, license number **R147535**, of **KHALILAH Q. JEFFERSON**, in the State of Maryland are hereby **SUMMARILY SUSPENDED**; and be it further

ORDERED that there will be a Show Cause Hearing on **August 24, 2022, at 11:00 AM** before the Board at the Maryland Board of Nursing offices, 4140 Patterson Avenue, Baltimore, Maryland 21215: and be it further

ORDERED that if, the suspension of the Respondent's RN license and CRNP certificate is continued following a Show Cause Hearing, the Respondent has the right to a full evidentiary hearing before the Board and a hearing will be scheduled before the Board if the Respondent submits a written request for an evidentiary hearing to the Board **no later than thirty (30) days from the date of the Board's written decision issued after the Show Cause Hearing;** and be it further

ORDERED that if the Respondent does not submit a timely written request to the Board for an evidentiary hearing within 30 days from the date of the Board's written decision issued after the Show Cause Hearing, the Respondent shall have waived all rights now and in the future to any hearing on the merits of the summary suspension of the Respondent's RN license and CRNP certificate and the factual allegations contained in this Order for Summary Suspension; and it is further

ORDERED that this Order for Summary Suspension shall remain in effect and the summary suspension of the Respondent's RN license and CRNP certificate shall continue until further Order of the Board; and it is further

ORDERED that this, "Order for Summary Suspension of Registered Nurse License and Certified Registered Nurse Practitioner Certificate" is a **PUBLIC RECORD** pursuant to Md. Code Ann., General Provisions § 4-101 *et seq.*& § 4-333 (2019 Repl. Vol.).

August 1, 2022
Date

Karen E.B. Evans, MSN, RN-BC
The Executive Director's Signature
Appears on the Original Document

K
E
Maryland Board of Nursing