IN THE MATTER OF	*	**BEFORE THE**
	*	
KRYSTAL GENEVA WILLIAMS	*	**MARYLAND BOARD**
	*	
Certificate No. MT0064096	*	**OF NURSING**
	*	

* * * * * * * * * * * * *

ORDER LIFTING AND TERMINATING SUMMARY SUSPENSION OF MEDICATION TECHNICIAN CERTIFICATE/ORDER DISMISSING CHARGES

On or about November 18, 2011, the Maryland Board of Nursing (the "Board") issued, via regular and certified mail, an "Order for Summary Suspension of Medication Technician Certificate and Notice of Charges" ("Summary Suspension Order and Charges") to Krystal Geneva Williams (the "Respondent"), a medication technician ("MT") in the State of Maryland, certificate number MT0064096.[1] The Summary Suspension Order and Charges notified the Respondent that the Board had summarily suspended her MT certificate pursuant to the Administrative Procedure Act, Md. Code Ann., State Gov't § 10-226(c)(2) (2009), and that the Board was charging her with violations of the Maryland Nurse Practice Act, Md. Code. Ann, Health Occ. §§ 8-101 *et seq.* (2009 Repl. Vol.), specifically § 8-6A-10(a) (7), (13), (14), (15), (19), (24), (29), and (30).

The Summary Suspension Order and Charges also notified the Respondent that a show cause hearing regarding the summary suspension was scheduled for December 13, 2011, to give the Respondent an opportunity to show cause as to why her certificate should not continue to be summarily suspended. The Summary Suspension Order and Charges further informed the Respondent that, if, following the show cause hearing, the Board voted to continue the summary suspension, she would have an opportunity to request an evidentiary hearing on the suspension within thirty days of the show cause hearing.

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[1] The November 18, 2011 Order for Summary Suspension and Charges is attached to this Order as Exhibit A.

On or about December 13, 2011, the Board held a show cause hearing, and the Respondent was not present. Following the show cause hearing, the Board voted to continue the summary suspension of the Respondent's MT certificate.

In November 2022, Board staff conducted an audit of old files. Upon review of the Respondent's file, the following was determined: (1) the Respondent timely requested an evidentiary hearing on the Summary Suspension and Charges; (2) no evidentiary hearing was held in this matter; (3) the Respondent's MT certificate remained summarily suspended; and (4) the charges remained pending and unresolved.

Upon consideration of the length of time that has passed since the issuance of the Summary Suspension Order and Charges (approximately 11 years), the Board concludes that the public health, safety, and welfare no longer imperatively requires the summary suspension of the Respondent's Maryland MT certificate. The Board also declines to pursue the pending charges issued on November 18, 2011, at this time. Accordingly, on its own initiative, the Board hereby issues this Order lifting and terminating the summary suspension of the Respondent's MT certificate and dismissing the charges.[2]

ORDER

Based upon the foregoing, it is hereby:

ORDERED that the summary suspension of the Respondent's certificate to practice as a medication technician in the State of Maryland (certificate number MT0064096), as ordered by the Board's November 18, 2011 Order for Summary Suspension and Charges, is hereby **LIFTED AND TERMINATED**; and it is further

[2] The Respondent's Maryland MT certificate otherwise expired on December 28, 2011.

ORDERED that the charges issued by the Board's November 18, 2011 Order for Summary Suspension and Charges are hereby **DISMISSED**; and it is further

ORDERED that this Order of the Maryland Board of Nursing is a **PUBLIC RECORD** pursuant to Md. Code Ann., General Provisions Article §§ 4-101, *et seq.* (2019).

February 9, 2023
Date

[redacted]
Karen E.B. Evans, MSN, RN-BC, SD-CLTC, CLC
Executive Director
Maryland Board of Nursing

IN THE MATTER OF	*	**BEFORE THE**
KRYSTAL WILLIAMS	*	**MARYLAND BOARD**
CERTIFICATE NO.: MT0064096	*	**OF NURSING**
	*	**OAG CASE NO.: 11-BP-408**

ORDER FOR SUMMARY SUSPENSION OF CERTIFIED MEDICATION TECHNICIAN CERTIFICATE AND NOTICE OF CHARGES

BACKGROUND

On or about May 18, 2011, the Maryland Board of Nursing ("the Board") received a complaint regarding the medication technician practice of Frances Matthews, ("Respondent"), MT0064096, from the Office of Health Care Quality ("OHCQ"), Maryland. The complaint alleges that the Respondent was the Medication Technician for an Assisted Living Facility ("ALF A") in Glenn Dale, Maryland. On March 8, 2011, Resident A,[1] who resided at ALF A in Glenn Dale, Maryland, was transferred to a hospital for multiple pressure ulcers and sepsis. Subsequently, OHCQ conducted a complaint survey of ALF A and cited multiple deficiencies for the facility.

Based upon further investigation and information received by the Board, the Board has reason, as set forth below, to find that the public health, safety or welfare imperatively requires emergency action under Md. Code Ann., State Gov't. § 10-226 (c) (2) (2009 Repl. Vol.).

[1] To ensure confidentiality, the name of Resident A is not set forth in this Order for Summary Suspension and Notice of Charges. The resident's name is available to the Respondent upon request to the Administrative Prosecutor.

Exhibit A

ALLEGATIONS OF FACT AND REASONS IN SUPPORT OF SUMMARY SUSPENSION AND CHARGES

The Board has received reliable information that the following facts are true:

1. At all times relevant to the statements herein, Respondent was and is certified to practice as a Medication Technician ("MT") in the State of Maryland. Respondent's MT certificate is active and expires on December 28, 2011.
2. In April 2011, the Office of Health Care Quality conducted complaint surveys of two Assisted Living Facilities ("ALF A" and "ALF B")[2] owned and operated by the same Assisted Living Manager ("the ALM")[3] and contracted with the same Delegating Nurse ("the DN").[4] ALF A is located in [redacted] Maryland. ALF B is located in Ft. Washington, Maryland.
3. Respondent was the Medication Technician for ALF A in [redacted] Maryland. The Respondent is also the daughter of the ALM.
4. On or about May 18, 2011, the Board received a complaint from the Office of Health Care Quality in Maryland regarding Respondent's practice as a Medication Technician.

ASSISTED LIVING FACILITY A ("ALF A")

5. Resident A was a 79-year-old male living at ALF A beginning in January 2011. Resident A had the following diagnoses: hypertension, Non-Insulin Dependent Diabetes

[2] To ensure confidentiality, the names of the Assisted Living Facilities, referred to as ALF A and ALF B, are not set forth in this Order for Summary Suspension and Notice of Charges. The names of the facilities are available to the Respondent upon request to the Administrative Prosecutor.
[3] To ensure confidentiality, the name of the Assisted Living Manager for ALF A and ALF B, referred to as "the ALM", is not set forth in this Order for Summary Suspension and Notice of Charges. The ALM's name is available to the Respondent upon request to the Administrative Prosecutor.
[4] To ensure confidentiality, the name of the Delegating Nurse, referred to as "the DN", is not set forth in this Order for Summary Suspension and Notice of Charges. The DN's name is available to the Respondent upon request to the Administrative Prosecutor.

Exhibit A

Mellitus, pacemaker, and dementia. ALF A had no documentation of any kind indicating that a physical examination or assessment was performed on Resident A upon his admission to ALF A.

6. On March 8, 2011, Resident A was taken by ambulance from ALF A to a hospital ("Hospital A")[5] in Cheverly, Maryland. According to the EMS records, Resident A's chief complaint was hypotension and "bursting bed sores", of which, the "onset of event occurred 30 days prior to calling EMS." In the ambulance report, the Emergency Medical Technician ("EMT") stated that when they arrived at ALF A, Resident A was not alert, and unable to answer any questions. The EMT wrote that the ALF caregiver told him that Resident A has "what they think are bed sores, but as time went on they have gotten worse." The caregiver told the EMT that the sores "have gotten bigger and a black liquid was coming out of them."
7. Medical records received from Hospital A describe the 7 pressure wounds found on Resident A's body as follows:

    a. Sacral Area, 20 cm x 20 cm, Unstageable

    b. Left Lower Back, 3 cm x 1 cm, Unstageable,

    c. Left Hip, 2 cm x 2 cm, Stage II[6]

    d. Left Shoulder, 1 cm x 1 cm, Stage II, with granulated tissue

    e. Left Upper Back, 3 cm x 3 cm, Stage I

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[5] To ensure confidentiality, the names of the hospitals, referred to as Hospital A and Hospital B, are not set forth in this Order for Summary Suspension and Notice of Charges. The hospitals' names are available to the Respondent upon request to the Administrative Prosecutor.

[6] The OHCQ Survey Report dated April 22, 2011, lists the stages of pressure ulcer areas as follows: Stage 1. A persistent area of skin redness without a break in the skin that does not disappear when pressure is relieved. Stage 2. A partial thickness is lost and may appear as an abrasion, blister , or shallow crater. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues –present as a deep crater with or without undermining adjacent tissue. Stage 4. A full thickness of skin and subcutaneous tissue are lost, exposing muscle or bone.

Exhibit A

f. Right Hip, 5 cm x 4 cm, Unstageable, black/brown eschar

g. Right Knee, 3 cm x 1 cm, Stage II, red, granulated tissue

8. Upon admission to Hospital A, Resident A was diagnosed with the following: sepsis[7] secondary to an infected sacral ulcer; leukocytosis secondary to sepsis; electrolyte imbalance; acute renal failure; hypotension; depression; and left lower leg pitting edema. Resident A also reported having coffee ground emesis earlier in the day.
9. On March 8, 2011, Resident A underwent surgical debridement of the right sacral decubitus[8] and the right hip decubitus. The operative report describes the sacral wound as grade 4 "malodourous, necrotic sacral decubitus ulcer over a span of approximately 20 cm in diameter" with "dark eschar." The hip wound was described as a grade 3 ulcer.
10. Upon discharge from Hospital A, Resident A was transferred to a long term acute care facility.
11. Resident A died on May 28, 2011.
12. Between April 14, 2011 and April 22, 2011, the Office of Health Care Quality ("OHCQ") conducted an unannounced complaint survey of ALF A for the purpose of determining the facilities compliance with COMAR 10.07.14, Assisted Living Regulations.
13. According to the matrix for OHCQ Survey Report dated April 22, 2011, the Respondent is listed as a Care Giver at ALF A.
14. According to the Summary Statement of Deficiencies, the OHCQ Surveyor reported that the Resident's rights to be free from abuse and neglect under COMAR10.07.14.35.(7) were not met as evidenced by the multiple pressure ulcers suffered by Resident A.

[7] Sepsis is the presence of bacteria or other pathogenic microorganisms or toxins in the blood or other tissue.
[8] Decubitus is another name for pressure ulcer or bed sore.

Exhibit A

15. According to the OHCQ Report for ALF A, the ALM told the Surveyor that Resident A arrived at ALF A free of pressure ulcers. The ALM stated that Resident A suffered from dementia, was unable to walk or feed himself and required total care.

16. In an interview with the Board's Investigator, Med Tech A said Resident A had no ulcers or skin breakdown when he first arrived at the facility and that Resident A was capable of limited bedside activity. Med Tech A stated that she (Med Tech A) provided very little care for Resident A and that the Respondent provided most of the care to Resident A.

17. By letter dated June 7, 2011, the Board's Investigator sent the Respondent notice, at her address of record, that the Board was investigating a complaint regarding her practice while employed at ALF A. The letter states the following:

> "The Complaints and Investigations Division of the Maryland Board of Nursing is investigation a complaint concerning your practice. It is alleged that while employed as a Certified Medication Technician at (ALF A) you practiced negligent care which risked the health and safety of the individuals under your care. If true, this would constitute a violation...and could result in disciplinary action. Please respond with a written explanation of this incident within ten days of the date of this letter....Failure to cooperate with a lawful investigation of the Board is a violation of the Nurse Practice Act."

18. The Board received no contact and no response from the Respondent.

19. The Board sent the letter to the Respondent three more times on July 22, 2011, August 9, 2011, and September 7, 2011. The Board received no contact or response from the Respondent.

20. According to the Summary Statement of Deficiencies, there was no documentation or DN Assessment for Resident A; no Resident Assessment Tool for Resident A; no Service Plan for Resident A; no admission notes for Resident A; and no weekly care notes for Resident A.

Exhibit A

21. The OHCQ Surveyor reported that the ALM failed to obtain a physician's order for the care of Resident A. Under COMAR 10.07.14.35, a resident of an ALF has a right to "receive treatment, care, and services that are adequate, appropriate, and in compliance with relevant State, local and federal laws and regulations."

22. Med Tech A stated that at some point she recalls the Respondent showing her a bed sore on Resident A. Med Tech A told the Board's Investigator that they reported it and the Respondent was given some ointment to put on Resident A's sore. Med Tech A denied treating Resident A's wound or knowing the extent of such wounds. Med Tech A told the Board's Investigator that "they always had him bandaged up."

23. There is no documentation that the staff at ALF A was trained regarding wound care. When interviewed by the Board's Investigator, a staff member ("Med Tech A")[9] stated that she only met the DN once and never received any training from the delegating nurse. There is no documentation that Resident A was ever turned or repositioned.

24. According to the Summary Statement of Deficiencies, Resident A had orders to receive a diabetic diet. The OHCQ Surveyor reported that this requirement was not met as evidenced by the lack of appropriate diabetic diet and the Resident's serum blood glucose level of 480 mg/dL upon his admission to Hospital A.

25. According to the ALM, all residents at ALF A received a low-sodium diet.

26. When asked by the Board's Investigator about the lack of signed orders for Resident A's diet, medication, and treatment, the DN said that she did not provide instructions for a diabetic diet for Resident A because she was not aware of the need. The DN told the

[9] To ensure confidentiality, the names of the staff member, referred to as Med Tech A, is not set forth in this Order for Summary Suspension and Notice of Charges. The staff member's name is available to the Respondent upon request to the Administrative Prosecutor.

Exhibit A

Board's Investigator that she did not know what the ALM fed the residents and that it was the ALM's responsibility and not her responsibility (the DN's).

27. When asked by the Board's Investigator about Resident A's required diabetic diet, Med Tech A stated that she was unaware of Resident A's diabetic diet because she never saw a physician's order for Resident A or any other resident. Med Tech A stated that the Respondent and the ALM "did all the records and documentation."

MEDICATION MANAGEMENT AND ADMINISTRATION

28. During the interview with the Board's Investigator, Med Tech A stated that all medications in ALF A were administered and signed off by the Respondent.

29. The only MARs received from ALF A were the 6 pages of MARs for Resident A, all of which were signed with the Respondent's initials. Med Tech A admitted that she did administer medications once or twice, but that these were signed off by the Respondent because that was how the ALM wanted it. Med Tech A stated that the Respondent took care of all the MARs and she (Med Tech A) had no knowledge of whether the documents were accurate and in accordance with physicians' orders.

30. According to the OHCQ Survey Report, Resident A was taking the following medications: Docusate Sodium 100 mg; Ranitidine 150 mg; Seroquel 100 mg; Benzatropine 1 tab; Metoprolol 25 mg; Haloperidol 5 mg; Lisinopril 20 mg; Plavix 75 mg; Simvastatin 40 mg and enteric coated aspirin 81 mg.

31. Under COMAR 10.07.14.29.F, the ALM is required within 14 days of a resident's admission to consult with a primary care physician; a licensed pharmacist; a certified registered nurse practitioner; or a registered nurse (who may be the delegating nurse) to review a new resident's medication regime.

Exhibit A

32. The OHCQ Surveyor reported in the Summary Statement of Deficiencies, that the requirement under COMAR 10.07.14.29.F was not met in that "nursing (was) deficient for not providing medication review for a resident upon admission" and documents received from the ALM indicated that no initial medication review was conducted for Resident A within 14 days of his admission.

33. In addition, the OHCQ Surveyor reported that the ALM failed to arrange for a license pharmacist to conduct an on-site review of Resident A's medications as required under COMAR 10.07.14.29.I for any patient who is receiving nine (9) or more medications.

34. Respondent's failure to document and maintain Medication Administration Records on all residents she was administering medications to; her failure to obtain physicians' orders for medications for all residents for which she was administering medications; failure to administer medications in accordance with the physicians' orders for those resident who did have orders; failure to ensure that the delegating nurse conducted the proper medication review and oversight for all residents; and failure to ensure that a pharmacist conducted an on-site review for residents receiving more than 9 medications makes the Respondent's practice as a medication technician a danger to all patients under her care. Furthermore, Respondent's application of ointment and bandaging a resident's wounds without proper training was beyond Respondent's scope of practice and skills. Respondent's failure to recognize the overall deterioration of a resident's condition, and failure to report such condition contributed to the overall neglect of the resident. Based on the information in paragraphs 1 through 33 the Board finds that the public health, safety or welfare imperatively requires emergency action in this case.

Exhibit A

35. Based on the allegation of fact[10] under Background and in paragraphs 1 through 33, the Board voted to charge Respondent with violations of the Nurse Practice Act (the "Act"), Md. Code Ann., Health Occupations Article, §§ 8-101 *et. seq.* (2009 Repl. Vol.) as listed below. The pertinent provisions of Health Occupations Article § 8-6A-10 (a), and the violations under which the above allegations of fact in paragraphs 1 through 33 are brought and for which the Board has charged Respondent, are as follows:

> (a) *Penalties* - Subject to the hearing provisions of § 8-317 of this title, the Board may . . . reprimand any certificate holder, place any certificate holder on probation, or suspend or revoke the certificate of a certificate holder, if the applicant or certificate holder:
>
> (7) Fails to file or record any health record that is required by law;
>
> (13) Has acted in a manner inconsistent with the health or safety of a person under the applicant or certificate holder's care;
>
> (14) Has practiced as a...medication technician in a manner which fails to meet generally accepted standards for the practice of...medication technician;
>
> (15) Has physically, verbally, or psychologically abused, neglected, or otherwise harmed a person under the applicant or certificate holder's care;
>
> (19) Performs certified nursing assistant or certified medication technician functions incompetently;
>
> (24) Fails to cooperate with a lawful investigation conducted by the Board;
>
> (29) Engages in conduct that violates the code of ethics; to wit,
>
> COMAR 10.39.07.02 A. A certificate holder shall:
>
> (1)Respect the human dignity and uniqueness of a client and provide services unrestricted by consideration of social or

[10] The statements of your conduct with respect to the events identified herein are intended to provide notice of the alleged charges. This information is not intended as, and does not necessarily represent a complete description of the evidence, either documentary or testimonial, to be offered against you in connection with the events or patients.

Exhibit A

economic status, religious affiliation, personal attributes, or the nature of health problems.

(5) Maintain practice competence;

COMAR 10.39.07.02 B. A certificate holder may not, when acting in the capacity or identity of a certificate holder:

(3) Engage or participate in an action that violates or diminishes the civil or legal rights of a client.

(4) Assumes duties and responsibilities without adequate preparation or maintaining competence;

(30) Performs activities that exceed the education and training of the certified nursing assistant or certified medication technician;

The applicable section of SG § 10-226 (c) (2) provides that:

(2) 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.

CONCLUSIONS OF LAW

Based on the foregoing investigative information, the Board finds that the public health, safety or welfare imperatively requires emergency action in this case, pursuant to Md. Code Ann., State Gov't. § 10-226 (c) (2) (2009 Repl. Vol.).

ORDER

It is, by a majority of a quorum of the Maryland Board of Nursing:

ORDERED that, pursuant to the authority vested in the Board by Md. Code Ann.,

Exhibit A

Health Occ., § 8-6A-10 (a) (2009 Repl. Vol.) and Md. Code Ann., State Gov't., § 10-226 (c)(2) (2009 Repl. Vol.), the certification of **KRYSTAL WILLIAMS,** an individual certified to practice as a **CERTIFIED MEDICATION TECHNICIAN**, is hereby **SUMMARILY SUSPENDED**; and be it further

ORDERED that, there will be a Show Cause Hearing on **Tuesday, December 13, 2011** at **10:00 a.m.** before the Board at the Board of Nursing, 4140 Patterson Avenue, Baltimore, Maryland 21215, for Respondent to have the opportunity to show cause as to why her certificate should not be suspended; and be it further

ORDERED that, if Respondent's certificate is suspended following a Show Cause Hearing, upon a written request by Respondent, an evidentiary hearing to consider the merits of this Summary Suspension and charges cited in this Order will be held at the Board of Nursing, within a reasonable period of time from the date upon which the Board receives the written request; and be it further

ORDERED that, if Respondent requests an evidentiary hearing before the Board, Respondent must make the request in writing within thirty (30) days from the date of notice of the Board's decision after the Show Cause Hearing. If a request for hearing is not received within thirty (30) days from the date of notice of the Board's decision after the Show Cause Hearing, Respondent waives all rights now and in the future to any hearing with respect to this Order or the associated charges, or to any proceedings that would contest the validity of the factual allegations of this Order for Summary Suspension and to any appeals; and be it further

ORDERED that, if a request for hearing is not received within thirty (30) days from the date of notice of the Board's decision after the Show Cause Hearing, a Final Order for

Exhibit A

Revocation of Certification(s), including Findings of Fact and Conclusions of Law, will be issued to Respondent; and be it further

ORDERED that, in the event Respondent requests an evidentiary hearing, the proceeding before the Board will be conducted in accordance with the Administrative Procedure Act ("APA"), Md. Code Ann., State Gov't., § 10-201 et seq. (2009 Repl. Vol.), § 8-317 of the Act and regulations promulgated by the Board at COMAR 10.27.02. The APA gives Respondent the right to be represented by counsel authorized to practice law in Maryland, to request subpoenas for evidence and witnesses, to call witnesses, to present evidence, to cross examine every witness called by the Board, to obtain a copy of the hearing procedure upon written request, and to present summation and argument. Unless otherwise prohibited by law, Respondent may agree to the evidence and waive her right to appear at the hearing; and be it further

ORDERED that, for purposes of public disclosure, as permitted by Md. Code Ann., State Gov't., § 10-617(h) (2009 Repl. Vol.) this document consists of the foregoing Summary Suspension of Certified Medication Technician Certificate and Notice of Charges and that the Board may disclose this document to any national reporting bank or other entity to whom the Board is mandated to report; and be it further

ORDERED that, this Order is a public document pursuant to Md. Code Ann., State Gov't. §§ 10-601, *et. seq.*, (2009 Repl. Vol).

November 18, 2011
Date

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

Executive Director
Maryland Board of Nursing

Exhibit A