BEFORE THE VIRGINIA BOARD OF LONG-TERM CARE ADMINISTRATORS

IN RE: **MABLE B. LEOLA JONES, A.L.F.A**
License Number: **1706-000478**
Issue Date: **January 23, 2009**
Suspension Date: **April 24, 2018**
Case Numbers: **182338, 182409, 184328, 186105**

NOTICE OF FORMAL ADMINISTRATIVE HEARING AND STATEMENT OF ALLEGATIONS

You are hereby notified that a Formal Hearing has been scheduled before the Board of Long-Term Care Administrators ("Board") regarding your license to practice as an assisted living facility administrator in the Commonwealth of Virginia.

TYPE OF PROCEEDING:	This is a formal administrative hearing before a panel of the Board.
DATE AND TIME:	**June 28, 2018** **12:00 P.M.**
PLACE:	Virginia Department of Health Professions Perimeter Center - 9960 Mayland Drive 2nd Floor - Virginia Conference Center Henrico, Virginia 23233

LEGAL AUTHORITY AND JURISDICTION:

1. This formal hearing is being held pursuant to Virginia Code §§ 2.2-4020, 2.2-4024(F), and 54.1-2400(11). This proceeding will be convened as a public meeting pursuant to Virginia Code § 2.2-3700.

2. At the conclusion of the proceeding, the Board is authorized to take any of the following actions:

- Exonerate you;
- Reprimand you;
- Require you to pay a monetary penalty;
- Place you on probation and/or under terms and conditions;
- Continue the suspension of your license;
- Revoke your license.

ABSENCE OF RESPONDENT AND RESPONDENT'S COUNSEL:

If you fail to appear at the formal hearing, the Board may proceed to hear this matter in your absence and may take any of the actions outlined above.

RESPONDENT'S LEGAL RIGHTS:

You have the right to the information on which the Board will rely in making its decision, to be represented by counsel at this proceeding, to subpoena witnesses and/or documents, and to present relevant evidence on your behalf.

COMMONWEALTH'S EXHIBITS:

Enclosed is a copy of the documents that will be distributed to the members of the Board and will be considered by the Board when discussing any allegations with you and when deliberating on your case. **These documents are enclosed only with the notice sent by UPS. Please bring these documents with you to the formal hearing.**

FILING DEADLINES:

1. Deadline for filing exhibits: **May 30, 2018.** Submit 5 copies of all documents you want the Board to consider to Kathleen A. Petersen, Board of Long-Term Care Administrators, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233. Exhibits may not be sent by facsimile or e-mail.

The Commonwealth must file any objections to your submissions in writing, addressed to Kathleen A. Petersen at the Board office, no later than **June 6, 2018**. If no objections have been received by **June 6, 2018**, the evidence will be distributed to the Board members for their review, and will be considered by the Board as evidence when it deliberates upon your case. If the Commonwealth raises objections, you have until **June 13, 2018**, to file your response to the objections, in writing and addressed to Kathleen A. Petersen at the Board office. The Chair of the proceeding will rule on the motion.

2. Deadline for filing motions: **May 30, 2018**, addressed to Kathleen A. Petersen at the above address.

3. Deadline for filing any objections to the Commonwealth's exhibits, in writing, to Kathleen A. Petersen at the above address: **May 30, 2018**. If you do not file objections by this date, the exhibits will be distributed to the Board members for their review prior to your hearing, and will be considered by the Board as evidence when it deliberates on your case. If you do file objections, the Commonwealth has until **June 6, 2018** to file a response to the objections, in writing, and addressed to Kathleen A. Petersen at the Board office. The Chair of the proceeding will rule on the motion. NOTE: failure to object to the distribution of the Commonwealth's exhibits prior to the proceeding will not affect your right to contest any information contained in those exhibits at the proceeding.

REQUEST FOR A CONTINUANCE:

Absent exigent circumstances, such as personal or family illness, a request for a continuance after **May 30, 2018** will not be considered. If you obtain counsel, you should do so as soon as possible, as a motion for a continuance due to the unavailability of counsel will not be considered unless received by **May 30, 2018**.

STATEMENT OF ALLEGATIONS

The Board alleges that:

1. At all times relevant hereto, Mable B. Leola Jones, A.L.F.A., was licensed to practice as an assisted living facility administrator at Jones & Jones Assisted Living Facility, 7804 Forest Hill Avenue, Richmond, Virginia ("JJ-1"), except during the time period from June 21, 2017 through September 19, 2017, when her license was suspended by a Board Order entered June 21, 2017 ("2017 Order").

2. Notwithstanding the fact that Ms. Jones was sanctioned under the 2017 Order based on the Board's findings that she failed to maintain a safe and healthy environment for residents and violated multiple laws and regulations governing the operation of an assisted living facility, including failure to adequately address a bedbug infestation, Ms. Jones continued to administer her assisted living facility in violation of the Board's laws and regulations, as evidenced by Allegations #3 through #6 below. Such continued misconduct constitutes a violation of Term No. 3(c) of the 2017 Order, which mandated that Ms. Jones comply with all laws and regulations governing the practice of assisted living facility administration in the Commonwealth.

3. Ms. Jones violated Virginia Code § 54.1-3102, 18 VAC 95-30-210(1) and (2) of the Regulations Governing the Practice of Assisted Living Facility Administrators ("Regulations"), and the 2017 Order in that, from June 21, 2017 to September 19, 2017, she practiced and held herself out as an assisted living facility administrator even though her assisted living facility administrator license was suspended under the 2017 Order during that time period. Specifically, Ms. Jones met with the family of Resident A, a 74-year-old diagnosed with dementia, hypertension, cancer, and history of stroke, on or about July 25, 2017, to discuss and review with them the care that Resident A was receiving at an assisted living facility next to and on the same campus as JJ-1 (i.e., 7806 Forest Hill Avenue, Richmond, Virginia), which was owned and operated by Ms. Jones' limited liability company and nominally administered by her daughter. The family expressed concerns that Resident A was not being assisted with his medical

appointments for cancer treatment, as provided for under his Resident Agreement with Ms. Jones dated on or about July 5, 2016; that the facility was infested with bedbugs, which "ate [Resident A] up from his legs to his chest to his back;" that unauthorized amounts were taken out of Resident A's auxiliary account; and that no action had been taken when the family reported Resident A's wallet and identification documents (including his social security card) had been stolen. During this meeting, Ms. Jones failed to inform the family that her assisted living facility administrator license had been suspended or that she was not the named administrator of the facility in which Resident A resided. Instead, she deceptively presented herself to Resident A's family as the administrator responsible for Resident A's care, as demonstrated on an audiotape recording made by the family of this meeting with Ms. Jones.

4. Ms. Jones violated 18 VAC 95-30-210(1) and (2) of the Regulations in that, while acting as the assisted living facility administrator of JJ-1, she practiced in a manner that constituted a danger to the health, safety, and welfare of the residents, the public, and others and failed to comply with laws and regulations governing the administration of an assisted living facility, as set forth below:

a. With respect to Resident B, a 59-year old diagnosed with hypertension, psychosis, schizoaffective disorder, epilepsy/seizure disorder, memory loss, history of traumatic brain injury, and difficulty speaking and comprehending:

i. After Resident B was involved in an altercation with another resident on or about January 26, 2017, Ms. Jones failed to ensure that adequate care was provided to Resident B. Specifically, after the resident returned to JJ-1 following transport to and treatment at the emergency room, Ms. Jones failed to obtain and/or document any follow-up care regarding the chest wall contusion, facial and scalp lacerations, and bruising that Resident B suffered in the altercation, as directed in the emergency room discharge documents.

ii. Ms. Jones failed to ensure that Resident B's record was complete and accurate, as required under 22 VAC 40-72-560(A) of the Virginia Department of Social Services' ("VDSS") Standards for Assisted Living Facilities ("DSS Standards") (currently found at 22 VAC 40-73-

560(A), effective February 1, 2018), in that it contained conflicting information regarding his whereabouts following his altercation with another resident on or about January 26, 2017. Specifically, Resident B's nursing notes for January 26, 2017 inexplicably document that he was concurrently taken to the emergency room and jailed at the same time.

iii. In violation of 22 VAC 40-72-360(B) of the DSS Standards (currently found at 22 VAC 40-73-330(B), effective February 1, 2018), Ms. Jones failed to obtain (or document obtaining) a mental health screening or evaluation or to take any other appropriate action in response to Resident B's display of behaviors or patterns of behavior indicative of mental illness, intellectual disability, substance abuse, or a behavioral disorder that raised concerns for the health, safety, or welfare of either Resident B or others, as evidenced by, among other things, the January 26, 2017 altercation described above. Moreover, Ms. Jones failed to ensure (or document) that monthly mental health screenings/assessments were provided for Resident B, as set forth in his yearly Uniform Assessment Instrument.

iv. In violation of 22 VAC 40-72-440(I) and -560(A) of the DSS Standards (currently found at 22 VAC 40-73-450(F) and -560(A), effective February 1, 2018), Resident B's Individualized Service Plan was not adequately updated annually, e.g., no modifications were documented thereto after 2012, although there had been significant changes in the resident's condition since that time, including Ms. Jones' report that the resident was no longer able to manage his own finances and a nursing note from May 12, 2017 documenting the resident was noncompliant with his care and drinking alcohol every day.

v. Ms. Jones failed to ensure that Resident B received routine medical treatment, in violation of 22 VAC 40-72-460 of the DSS Standards (currently found at 22 VAC 40-73-470, effective February 1, 2018). Specifically, although Resident B was diagnosed with a nodule on his lung via x-ray on February 19, 2016, there is no documentation in the resident's record indicating that Ms. Jones assisted or instructed other staff to assist Resident B in obtaining recommended and

expected follow-up medical care pertaining to this diagnosis, as provided for in the Resident Agreement executed on or about May 5, 1999 (i.e., facility to provide assistance with doctors' appointments). Moreover, Resident B reported to an investigator for the Department of Health Professions ("Investigator") on or about August 21, 2017 that he had not "seen the doctor in a long time."

vi. In an interview with the Investigator on or about August 21, 2017, Resident B reported that the JJ-1 facility was "full of bed bugs," that the infestation had never stopped, and that the air conditioning in the facility was frequently broken.

b. With respect to Resident C, a 79-year-old male diagnosed with dementia, blindness in his right eye, glaucoma, hypertension, diabetes, impaired hearing, and history of stroke and bilateral partial amputation of his feet, who required assistance with transfers and mobility:

i. Despite the foregoing diagnoses indicating potential serious cognitive impairment preventing Resident C from recognizing danger or protecting his own safety and welfare, which would necessitate restricting Resident C's freedom of movement and require, among other things, staff supervision on any trips away from the facility and while the resident was outside, as per 22 VAC 40-72-990, -1000, -1020, -1030, and -1130 of the DSS Standards (currently found at 22 VAC 40-73-1000, -1010, -1020(B), -1040(A), -1050(A), and -1150(A), effective February 1, 2018), Ms. Jones failed to perform or ensure that behavioral observations were performed and documented to determine whether Resident C had such a serious cognitive impairment triggering the applicability of the foregoing DSS standards.

ii. On or about October 18, 2017, Resident C, while unaccompanied by any JJ-1 staff, was struck and killed by a moving car while he was crossing a major four-lane street near the facility. In violation of 22 VAC 40-72-100(A) of the DSS Standards (currently found at 22 VAC 40-73-70(A), effective February 1, 2018), Ms. Jones failed to report this incident to VDSS within 24 hours of Resident C's death.

iii. Ms. Jones failed to ensure or document that Resident C received necessary medical services prior to his death.

c. With respect to Resident D, a 27-year-old female diagnosed with diabetes, bipolar disorder, and borderline personality disorder:

i. Ms. Jones allowed Resident D to continue to reside at the facility until on or about November 24, 2017, even though this resident had an extensive history of physically assaulting other residents, including one physical altercation that led to Resident D's arrest and issuance to her then-roommate of an emergency protective order on or about March 20, 2017.

ii. Although Resident D displayed violent behavior towards other residents on several occasions after being admitted to the facility on or about April 17, 2015, Ms. Jones failed to conduct or request, in a timely manner, an assessment or re-assessment of Resident D regarding the appropriateness of her continued placement at the facility, nor did she timely discharge Resident D from the facility as a threat to the health, safety or welfare of other residents, as provided for under 22 VAC 40-72-420(E) of the DSS Standards (currently found at 22 VAC 40-73-430(E), effective February 1, 2018). Instead, in Resident D's Uniform Assessment Instrument (dated January 24, 2017), staff erroneously and falsely reported that there had been no behavioral interventions with Resident D since her admission and that she did not cause problems.

iii. Despite her propensity for violence as described above, Ms. Jones assigned or allowed Resident D to be moved to share a room with Resident E, an extremely frail, non-verbal 86-year-old female who had recently fractured her hip and was diagnosed with chronic obstructive pulmonary disorder, schizophrenia, dementia, and incontinence. This arrangement clearly was not in Resident E's best interest and exposed her to potential harm from her roommate.

iv. In or about December 2017, Resident D secretly recorded a videotape of nursing staff at JJ-1 roughly handling and repeatedly yelling at Resident E while forcing her to stand up from her wheelchair while changing her clothes and adult diaper. Resident E appears to cry out in pain several

times while being handled so aggressively by nursing staff. Resident D then posted this video, which showed moments of Resident E in the nude, on YouTube, a clear violation of Resident E's privacy rights of which Ms. Jones and/or her staff were or should have been aware.

d. With respect to Resident F, a 27-year-old male admitted to the facility on or about April 17, 2015 with diagnoses of diabetes, attention deficit hyperactivity disorder, mood disorder, and organic affective disorder:

i. There are no Individualized Service Plans or Uniform Assessment Instruments present in the resident file that Ms. Jones provided the Investigator, as required under 22 VAC 40-72-430(A) and -440(A) & (I) of the DSS Standards (currently found at 22 VAC 40-73-440(A) and -450(A) & (F), effective February 1, 2018).

ii. Nursing notes in Resident F's record indicate that, even though his documented blood-sugar readings were erratic, the resident was allowed to continue to self-administer his insulin without any follow-up medical treatment or assessment regarding this issue.

iii. Although Resident F assaulted his wife, Resident D, on or about November 18, 2015, and thereafter Resident F was arrested and Resident D obtained a protective order against him, Ms. Jones' response to this incident was limited to moving Resident F to another part of the facility.

e. In violation of 22 VAC 40-72-850(E) of the of the DSS Standards (currently found at 22 VAC 40-73-870(D), effective February 1, 2018), Ms. Jones failed to properly treat the JJ-1 facility for bedbugs, as evidenced by a continuing bedbug infestation which a newly hired pest exterminator described as "deplorable" at his first facility visit in May 2017. Specifically:

i. The pest exterminator hired by Ms. Jones reported that she and her staff were not cooperative with his extermination efforts and the facility generally was not made ready for treatment prior to his arrival at the facility, even though he notified Ms. Jones or her staff ahead of time that he was coming to provide treatment. Ms. Jones' failure to properly address this vermin

problem has led to residents being constantly bitten by bedbugs over their entire body (*see, e.g.*, reports by or concerning Resident A and Resident B described above).

ii. On or about December 8, 2017, a VDSS inspector reported that a recent inspection of JJ-1 found bedbugs in two resident rooms.

f. On multiple occasions between about September 2016 and June 2017, Ms. Jones used funds she had received as the Social Security payee on behalf of residents to pay for her own personal expenses, such as restaurant outings, casino gambling, vacations, as well as credit card bills in another individual's name, in violation of 22 VAC 40-72-150(2) and (4) of the DSS Standards (currently found at 22 VAC 40-73-80(2) and (5), effective February 1, 2018). Specifically:

i. Ms. Jones transferred money from the account designated to receive direct deposits of residents' Social Security funds to the business account for JJ-1, from which she then withdrew money to pay for these personal expenses.

ii. By her own admission, Ms. Jones did not keep an accurate written accounting of her business spending for the facility or her personal spending. When asked about her ability to maintain an accurate accounting of income, including money received for residents, and expenditures, both personal and business, without such documentation, she stated to the Investigator that "I just know."

g. By her own admission, during the course of her employment as administrator of JJ-1 during 2016 and 2017, she failed to report to the VDSS' regional licensing office approximately 235 calls for help made by her facility to the City of Richmond Police Department and/or City of Richmond Fire/EMS, in violation of 22 VAC 40-72-100 of the DSS Standards (currently found at 22 VAC 40-73-70, effective February 1, 2018). These unreported incidents included criminal activity of or against residents (including assault and battery, malicious wounding, and theft/robbery), resident injury or death (e.g., Resident G's demise on or about January 11, 2016), resident physical and/or mental illness requiring emergency treatment/intervention, and resident elopements (e.g., Resident I went missing on or about December 4, 2017).

h. Ms. Jones has routinely and continuously failed to comply or ensure compliance with DSS standards at her assisted living facility, as evidenced by the fact that the VDSS reported (as of February 27, 2018) regulatory violations during 12 of 14 VDSS inspections performed at her facility from July 2015 to October 2017.

i. As reported in a June 9, 2017, VDSS inspection of Ms. Jones' assisted living facility, Ms. Jones failed to ensure that Resident H's medication was administered in accordance with the prescriber's instructions, in violation of 22 VAC 40-72-670(C) (currently found at 22 VAC 40-73-680(D), effective February 1, 2018). Moreover, Ms. Jones failed to ensure that toilet tissue was available and accessible to each commode in the facility or that soap was available and accessible to each face/hand washing sink, in violation of 22 VAC 40-72-900 of the DSS Standards (currently found at 22 VAC 40-73-925) of the DSS Standards, effective February 1, 2018).

j. Ms. Jones continued to operate her assisted living facility in violation of applicable laws and regulations as indicated by numerous repeat and new violations of DSS standards noted in a VDSS monitoring inspection conducted on February 23, 2018. Such violations included the following:

i. In violation of 22 VAC 40-73-40(A) of the DSS Standards, Ms. Jones failed to ensure that two staff members were counting out the controlled medications at the end of each shift, as per facility policy.

ii. In violation of 22 VAC 40-73-430(H)(1) of the DSS Standards, there was no evidence in Resident J's file that appropriately completed and dated discharge documentation had been submitted to the resident, his legal representative, or a contact person.

iii. Ms. Jones failed to ensure that numerous Individualized Service Plans were timely signed and dated by residents or their legal representatives, as required under 22 VAC 40-73-450(E) of the DSS Standards.

iv. Ms. Jones failed to ensure that residents' Individualized Service Plans were reviewed and updated at least once every 12 months or as needed to reflect changes in resident conditions, as required under 22 VAC 40-73-450(F) of the DSS Standards.

v. Based on a foul odor that was emanating from a resident on February 23, 2018 during medication administration and later at lunch, Ms. Jones failed to ensure that a plan was established and implemented to address the resident's hygiene needs, in violation of 22 VAC 40-73-460(H)(4) and (I) of the DSS Standards.

vi. Ms. Jones failed to ensure that the rights and responsibilities of residents in assisted living facilities were reviewed annually with each resident or his/her legal representative, in violation of 22 VAC 49-73-550(G) of the DSS Standards.

vii. Ms. Jones failed to ensure that a valid medication order from a physician or other licensed prescriber was received prior to staff administering medications to residents, in violation of 22 VAC 40-73-650 of the DSS Standards.

5. Ms. Jones violated 18 VAC 95-30-210(1) and (3) of the Regulations in that she was convicted of two felonies, i.e., credit card theft and credit card fraud, in the Circuit Court of Henrico, County, Virginia, on October 14, 1985, and failed to disclose these convictions on her 2008 application for licensure as an assisted living facility administrator. These felony convictions related to Ms. Jones' theft of a credit card from a patient while working as a practical nurse and her use of such credit card from April 18, 2015 to May 18, 2015 to charge multiple items purchased for herself from a retail store without the patient cardholder's knowledge or consent.

6. Ms. Jones violated Term No. 3(b) of the 2017 Order, which required her to "submit all survey inspections to the Board within ten days of her response and/or completed plan of correction" during her period of probation, in that she did not submit certain survey inspections in a timely manner (see, e.g. inspection reports dated October 17, 2017, December, 18, 2017, January 6, 2018, February 3, 2018, and February 9, 2018 were not submitted to the Board until February 23, 2018) and failed to submit any VDSS

survey reports for inspections conducted on the following dates: September 25, 2017, September 27, 2017, October 22, 2017, November 13, 2017, and February 23, 2018.

Corie E. Tillman Wolf, J.D.
Executive Director
Virginia Board of Long-Term Care Administrators

April 24, 2018
Date