IN THE MATTER OF	*	**BEFORE THE**
ERIN E. DERENICK, P.T.	*	**MARYLAND BOARD OF**
Respondent	*	**PHYSICAL THERAPY**
	*	**EXAMINERS**
License Number: 21989		**Case Number: PT-12-31**

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CONSENT ORDER

On March 22, 2013, the State Board of Physical Therapy Examiners (the "Board") charged Erin E. Derenick, P.T. (the "Respondent") (D.O.B. 11/04/1982), License Number 21989, with violations of certain provisions of the Maryland Physical Therapy Act (the "Act"), Md. Health Occupations ("H.O.") Code Ann. §§ 13-101 *et seq.* (2009 & 2012 Supp.).

Specifically, the Board charged the Respondent with violations of the following provisions of H.O. § 13-316:

13-316. Denials, reprimands, probations, suspensions, and revocations – Grounds.

> Subject to the hearing provisions of § 13-317 of this subtitle, the Board may deny a license, temporary license, or restricted license to any applicant, reprimand any licensee or holder of a temporary license or restricted license, place any licensee or holder of a temporary license or restricted license on probation, or suspend or revoke a license, temporary license, or restricted license if the applicant, licensee or holder:
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> ...
>
> (12) Willfully makes or files a false report or record in the practice of physical therapy or limited physical therapy;
>
> (14) Submits a false statement to collect a fee;
>
> (15) Violates any provision of this title or rule or regulation adopted by the Board;

(19) Commits an act of unprofessional conduct in the practice of physical therapy or limited physical therapy[.]

On June 18, 2013, a conference with regard to this matter was held before the Board's Case Resolution Conference ("CRC"). As a result of the CRC, the Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1 At all times relevant hereto, the Respondent was and is licensed to practice physical therapy in the State of Maryland. The Respondent was originally licensed to practice physical therapy on September 14, 2006. The Respondent obtained her master's degree in physical therapy in 2006 and her doctoral degree in 2009.

2 The Respondent had been employed by a home health care provider ("Provider") from November 2010 to June 2012.

3 On or about June 21, 2012, the Board received notification from the Provider that the Respondent's employment had been terminated after an internal investigation revealed that in May and June 2012, the Respondent falsified documentation regarding the amount of time she spent with patients and had forged the signature of a patient on a treatment form.

4 The Provider has a computerized documentation system in which the times a physical therapist begins and ends a patient's treatment (referred to as "'open' and 'close' or "In" and "Out" times") are recorded when the therapist logs in and

out of the system. The patient is asked to sign an activity sheet, which is electronically time-stamped, as evidence he or she was treated.

5 The Provider's investigation initially revealed that on May 31, 2012, the Respondent claimed to have worked more hours than usual. Further investigation revealed that the In and Out times generated by the Respondent did not correspond to the time-stamped signatures of several of the Respondent's patients. For example, on May 31, 2012, the Respondent documented 9:33[1] as the In time for a patient and 10:38 as the Out time; the patient's signature is time-stamped 9:53. The Respondent documented the open and close times for her next patient to be 11:09 and 12:07, yet the patient's signature was obtained at 9:54, one minute after the first patient's signature was recorded.[2]

6 On May 31. 2012, the Respondent documented on her daily Activity Log[3] that she worked 16.5 hours, which included one-half hour of "documentation" time from 6:00 to 6:30, and three hours of "documentation" time from 19:30 to 22:30. She documented that she had provided therapy to her last patient of the day from 17:54 to 19:00; however, that patient's time-stamped signature was obtained at 2:49.

7 The Respondent signed the attestation at the bottom of the Activity Log which states: "[t]he information documented above is a true and accurate record of visits performed and mileage traveled in the course of patient care."

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[1] These records use the 24-hour clock convention of timekeeping.
[2] The patients live in towns at least 10 minutes apart.
[3] The Activity Log lists the patients seen on a particular day, the visit code, the In/Out times, odometer readings and total mileage. The Respondent hand wrote the entries on the Activity Logs reviewed herein. The patient Activity Sheet is an electronic record that contains, *inter alia,* the patient's name, address and the date of service. The patient signs the form and the date and time of the signature is electronically stamped.

8 The Provider's investigation further revealed that the Respondent had forged a patient's name on an Activity Sheet dated June 5, 2012, misspelling the patient's name.

9 On June 14, 2012, a Provider management director ("Director") met with the Respondent to discuss the discrepancies in her records. The Respondent stated that the clock in her computer runs slow and fast. She stated that she had reported the problem to the Provider's Information Technology ("IT") division and was told that a defective computer battery was the cause. The Director later verified with IT that the Respondent had not made an inquiry about her computer clock, as she had claimed.

10 At the June 14, 2012 meeting, the Director showed the Respondent the June 5, 2012 Activity Sheet. The Respondent asked if she could keep her job if she admitted to signing the patient's name. The Director asked the Respondent if she was admitting to signing the patient's name. The Respondent replied that she could not remember. The Director then instructed the Respondent to sign the patient's name on a piece of paper. The Respondent complied and noted that the sample she provided was similar to the signature on the June 5, 2012 Activity Sheet.

11 At the conclusion of the meeting, the Director informed the Respondent that there was no plausible explanation for the discrepancies in the Respondent's documentation and that the Respondent was terminated.

12 On December 5, 2012, Board investigatory staff interviewed the Respondent under oath.

13 During the interview, the Respondent admitted that she had signed the patient's name on the June 5, 2012 Activity Sheet. The Respondent recalled that it was a "rush visit" and she had realized that the patient had not signed the activity sheet only when she reached the home of her next patient.

14 At first, the Respondent stated that she had not been trained about how to handle this type of situation, but later stated that she had not received "thorough training." The Respondent acknowledged that she had not called the Provider office for assistance.

15 The Respondent stated that she did not know how to fix the situation and "a little being overwhelmed and poor judgment, *(sic)* I signed it."

16 Board staff reviewed with the Respondent the In/Out times she had written on her Activity Logs as compared to the time the patient signatures were electronically stamped on the patient Activity Sheets for May 31 and June 7, 2012. The charts below summarize the documents.

May 31, 2012 – Respondent claimed 16.5 total hours worked

Patient	**Activity Log In**	**Activity Log Out**	**Signature time**
Documentation	6:00	6:30	n/a
1	6:51	7:59	8:31
2	8:20	9:18	8:33
3	9:33	10:38	9:53
4	11:09	12:07	9:54
5	12:26	13:24	11:20
6	13:45	14:43	11:53

7	15:04	16:01	13:14
8	16:17	17:20	13:31
9	17:45	19:00	14:49
Documentation	19:30	22:30	n/a

June 7. 2012 – Respondent claimed 13 total hours worked

Patient	**Activity Log In**	**Activity Log Out**	**Signature time**
Documentation	6:30	7:00	n/a
1	7:21	8:20	9:20
2	8:35	9:33	9:28
3	10:04	11:00	10:34
4	11:21	12:25	11:21
5	12:52	14:00	12:33
6	14:16	15:15	12:34
7	15:46	16:44	15:26
Documentation	17:00	19:30	n/a

17 The In/Out times on the Respondent's Activity Logs correspond to the In/Out times on the patients' Activity Sheets. The Respondent stated that she is able to manually enter the In/Out times on the Activity Sheets, but that the patient signature time stamp is automatically generated by the computer.

18 The Respondent stated that she was under "overwhelming" pressure by the Provider to provide therapy for one hour to each patient.

19 The Respondent further stated that, in her professional opinion, most of her patients cannot tolerate therapy for one hour.

20 The Respondent acknowledged that she provided therapy to patients for less than one hour, but "made the poor judgment of saying I was there longer than I had been...," which "...can shift some of the times of when I'm there with a patient." *(sic)*

21 The Respondent claimed that she had worked 16.5 hours on May 31, 2012 and 13 hours on June 7, 2012. When Board staff asked about overtime, the Respondent stated that she believed she was paid by the visit and did not know how overtime was calculated.

22 When Board staff inquired how patient signatures could be time-stamped a minute apart on separate Activity Sheets, the Respondent stated that it could be "human error" and explained that she may not have pressed the computer stylus firmly enough to register her acceptance of the patient's signature when the patient signed the Activity Sheet. The Respondent explained that when this occurred, she would realize the signature had not been accepted when she opened her computer at her next visit and would press the stylus again at that time, thereby accounting for the later signature time stamp.

23 When asked how the remainder of her treatment notes could be trusted after she acknowledged to have falsified the treatment times, the Respondent stated, "I guess besides my telling you and speaking with the patient." *(sic)*

24 The Respondent acknowledged that she had been untruthful during her meeting with the Director, stating that she was upset and dealing with postpartum depression.

CONCLUSIONS OF LAW

The Respondent's conduct constitutes, in whole or in part, violations of the following provisions of the Physical Therapy Act: willfully making or filing a false report or record in the practice of physical therapy, in violation of H.O. § 13-316(12); submitting a false statement to collect a fee, in violation of H.O. §13-316(14); violating any provision of this title, in violation of H.O. § 13-316(15) and committing an act of unprofessional conduct in the practice of physical therapy, in violation of H.O. § 13-316(19).

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 20th day of August, 2013, by a majority of the quorum of the Board:

ORDERED that the Respondent shall be suspended for six months, all but one month (30 days) stayed. The active portion of the suspension shall be consecutive days and shall be completed within one year of the date of this Order; and it is further

ORDERED that the Respondent shall be placed on probation for a minimum of two years and until the Respondent complies fully with the following terms and conditions:

a. For at least the first year of her probation, the Respondent will meet on a monthly basis with a clinical supervisor for the purpose of reviewing her documentation, including billing records. The Respondent shall provide the supervisor with a copy of the Consent Order;

b. The Respondent shall ensure that the clinical supervisor submits reports to the Board on a monthly basis for the first six months regarding the Respondent's work quality and compliance with the Maryland Physical Therapy Act and the Board's regulations. After six months, these reports shall be submitted to the Board on a quarterly basis;

c. Within the first year of probation, the Respondent shall successfully pass the Board's closed-book law examination with a passing score of 80 percent;

d. After a minimum of one year, the Respondent may petition the Board to terminate the condition that her documentation be reviewed by a clinical supervisor;

e. After a minimum of two years, the Respondent may petition to the Board to terminate her probation after demonstrating that she has complied with all of the terms and conditions of the Consent Order;

f. The Respondent shall not practice in a home-health setting during the course of probation;

g. The Respondent is responsible for all costs associated with the Consent Order;

h. The Respondent shall practice in accordance with the laws and regulations governing physical therapy; and it is further

ORDERED that for purposes of public disclosure, as permitted by Md. State Gov't Code Ann. §10-617(h)(2009 Rep. Vol., 2011 Supp.), this document consists of the contents of the foregoing Findings of Fact, Conclusions of Law and Order and that the Board may also disclose same to any national reporting data bank to which it is mandated to report.

08/20/13
Date

John F. Baker, P.T.
Chair
Maryland Board of Physical Therapy Examiners

CONSENT

I, Erin E. Derenick, PT, acknowledge that I am represented by counsel and have consulted with counsel before entering this Consent Order. By this Consent and for the purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by the law. I agree to forego my opportunity to challenge these allegations. I acknowledge the legal authority and jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I affirm that I am waiving my right to appeal any adverse ruling of the Board that I might have filed after any such hearing.

I sign this Consent Order after having an opportunity to consult with counsel, voluntarily and without reservation, and I fully understand and comprehend the language, meaning and terms of the Consent Order.

7/23/13
Date

Erin E. Derenick, PT
Respondent

STATE OF MARYLAND
CITY/COUNTY OF Harford

I HEREBY CERTIFY that on this 23rd day of July 2013, before me, a Notary Public of the foregoing State and City/County personally appeared Erin E. Derenick, PT, and made oath in due form of law that signing the foregoing Consent Order was her voluntary act and deed.

AS WITNESSETH my hand and notarial seal.

CAMILLA JEAN ROGERS NOTARY PUBLIC HARFORD COUNTY, MD

Notary Public