MARYLAND STATE BOARD OF	*	**BEFORE TRACEE ORLOVE FRUMAN,**
SOCIAL WORK EXAMINERS	*	**AN ADMINISTRATIVE LAW JUDGE**
v.	*	**OF THE MARYLAND OFFICE**
MICHAEL DENNIS, LCSW-C,[1]	*	**OF ADMINISTRATIVE HEARINGS**
RESPONDENT	*	
LICENSE No.: 07605	*	**OAH No.: MDH-BSW2-87-24-26382**

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PROPOSED DECISION

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STATEMENT OF THE CASE

On August 13, 2024, the Maryland State Board of Social Work Examiners (State or Board) issued Amended Charges Under the Maryland Social Workers Act (Amended Charges) against Michael Dennis, LCSW-C (Respondent), for violations of the Maryland Social Workers Act (Act).[2] Md. Code Ann., Health Occ. §§ 19-101 through 19-407 (2021 & Supp. 2024).[3]

[1] Licensed Certified Social Worker-Clinical.
[2] On January 30, 2024, the Board issued Charges Under the Maryland Social Worker's Act (Charges). The Respondent filed a timely request for an evidentiary hearing, which was scheduled before the Board on August 9, 2024. On August 6, 2024, the Board canceled the evidentiary hearing and issued the Amended Charges, which superseded the Charges.
[3] Unless otherwise noted, all references to the Health Occupations Article cite the 2021 Volume and 2024 Supplement of the Maryland Annotated Code.

Specifically, the Board alleged that the Respondent violated the following provisions of the Health Occupations Article §§ 19-311(4),[4] and/or (5),[5] and/or (6),[6] and the Code of Maryland Regulations (COMAR) 10.42.03.03B(1),[7] and/or B(7),[8] and/or COMAR 10.42.03.05A,[9] and/or C.[10]

On November 15, 2024, the State filed a Motion for Partial Summary Decision (Motion) and a Motion to Exclude Documentary and Testimonial Evidence (Motion to Exclude). On December 2, 2024, the Respondent filed answers to both motions. On December 9, 2024, I held a remote hearing to hear argument from the State and the Respondent on the motions. On December 17, 2024, I issued a ruling denying the State's Motion and granting in part and denying in part the State's Motion to Exclude. By granting in part the State's Motion to Exclude, I excluded portions of Frederic Reamer, Ph.D.'s testimony[11] and Diane Donham's testimony in its entirety.

I held a hearing on January 27, 28, and 29, 2025, on the Webex videoconferencing platform. Health Occ. § 19-312. The Respondent was present and was represented by Nicholas Costello, Esquire. Kelly Cooper, Assistant Attorney General, represented the Board.

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[4] "Commits any act of gross negligence, incompetence, or misconduct in the practice of social work."
[5] "Engages in a course of conduct that is inconsistent with generally accepted professional standards in the practice of social work."
[6] "Violates any provision of this title or regulations governing the practice of social work adopted and published by the Board."
[7] "A licensee may not: (1) Participate or condone dishonesty, fraud, deceit, or misrepresentation[.]"
[8] "A licensee may not: (7) Share with another individual a confidence revealed by a client without a client's consent, except if there is danger to self or to another individual, or for a compelling professional reason[.]"
[9] "A licensee may not enter into a dual relationship with a client or an individual with whom the client has a close personal relationship."
[10] "The licensee may enter into a nonsexual relationship with an individual with whom the licensee's prior professional contact: (1) was of a brief, peripheral, or indirect nature; and (2) did not constitute a therapeutic relationship."
[11] Specifically, I excluded the Dr. Reamer's testimony as to (1) any aspect of the case resolution conference that occurred before the Board, including but not limited to his opinion about the propriety of the Board's settlement recommendation; (2) the Respondent's credibility; (3) the Board investigator's interview techniques; and (4) the propriety of the Respondent's documentation of abuse and/or neglect allegations in client notes.

Procedure is governed by the contested case provisions of the Administrative Procedure Act, the Rules of Procedure for Board Hearings, and the Rules of Procedure of the Office of Administrative Hearings (OAH). Md. Code Ann., State Gov't §§ 10-201 through 10-226 (2021 & Supp. 2024), COMAR 10.42.04; COMAR 28.02.01.

ISSUES

1. Whether the Respondent seeing clients in their rooms in the presence of a roommate violated the Health Occupations Article § 19-311(4) and/or (5) and/or (6) and the Board's regulations, specifically COMAR 10.42.03.03B(7)?
2. Whether the Respondent return to Peace Healthcare at Dennett Road Manor (Dennett Road or the nursing home) on April 27, 2023 and May 10, 2023 violated the Health Occupations Article § 19-311(4) and/or (5) and/or (6) and the Board's regulations, specifically COMAR 10.42.03.03B(1)?
3. Whether the Respondent, identifying himself a patient representative, violated the Health Occupations Article § 19-311(4) and/or (5) and/or (6) and the Board's regulations, specifically COMAR 10.42.03.05A and/or C.
4. If so, what sanctions are appropriate?

SUMMARY OF THE EVIDENCE

Exhibits

I admitted the following exhibits into evidence on behalf of the Board:[12]

St. Ex. 1 - Complaint, dated May 15, 2023 (pp. 1-3)

St. Ex. 2 - *Subpoena Duces Tecum* to Supportive Care, LLC (Supportive Care) for the Respondent's personnel file, dated June 12, 2023 (p. 4)

[12] The Board's exhibits were pre-marked as State's Exhibits (St. Ex.). For consistency, I will retain that designation.

St. Ex. 3 - Personnel records for the Respondent received from Supportive Care, received June 29, 2023 (pp. 5-41)

St. Ex. 4 - *Subpoena Duces Tecum* to Dennett Road for the Respondent's contact notes and No Trespass letter, dated June 23, 2023 (p. 42)

St. Ex. 5 - Records received from Dennett Road, undated (pp. 43-128)

St. Ex. 6 - Leona Knotts, RN – Interview Transcript, held June 22, 2023 (pp. 129-139)

St. Ex. 7 - Elizabeth Goldsborough, Nursing Home Administrator – Interview Transcript, held June 23, 2023 (pp. 140-149)

St. Ex. 8 - Teresa White, [former] Vice President of Clinical Services – Interview Transcript, held June 23, 2023 (pp. 150-159)

St. Ex. 9 - Kara Sadler, Vice President of Operations/Regional Director, Supportive Care – Interview Transcript, held June 27, 2023 (pp. 160-167)

St. Ex. 10 - Garrett County Sheriff's Office Incident Report, incident date May 10, 2023 (pp. 168-171)

St. Ex. 11 - Request for Response sent to the Respondent, dated June 12, 2023 (p. 172)

St. Ex. 12 - Written response received from the Respondent with attachments, dated June 19, 2023 (pp. 173-217)

St. Ex. 13 - Correspondence from the Respondent's attorney regarding investigative interview, dated July 3, 2023 (p. 218)

St. Ex. 14 - The Respondent's Interview Transcript, held July 11, 2023 (pp. 219-245)

St. Ex. 15 - Written response by Cindi Green, Director of Nursing (DON), Dennett Road, received August 2, 2023

St. Ex. 16 - Correspondence between Board Investigator and Ms. Sadler, dated July 2023 (pp. 248-251)

St. Ex. 17 - Correspondence between Board Investigator and Mikaela Bernard, LMSW,[13] dated July 2023 (pp. 252-253)

[13] Licensed Masters Social Worker.

St. Ex. 18 - Correspondence between Board Investigator and Shuli Lachman, Chief Marketing Officer, Supportive Care, and Ms. Sadler, with attachment, dated December 2023 (pp. 254-258)

St. Ex. 19 - The Respondent's licensing information, undated (pp. 259-262)

St. Ex. 20 - Report of Investigation, dated July 20, 2023 (pp. 263-271)

St. Ex. 21 - Charges, dated January 30, 2024 (pp. 272-289)

St. Ex. 22 - Notice of Hearing, dated May 22, 2024 (p. 290)

St. Ex. 23 - Notice of Hearing, sent via email on May 22, 2024 (p. 291)

St. Ex. 24 - Amended Charges, dated August 13, 2024 (pp. 292-305)

I admitted the following exhibits into evidence on behalf of the Respondent:

Resp. Ex. 1 - The Respondent's Resume, Education, Training, Credentialing Records, undated (pp. 1-52)

Resp. Ex. 2 - *Curriculum Vitae* and Biography of Frederic Reamer, Ph.D., undated (pp. 53-190)

Resp. Ex. 3 - Opinion of Dr. Reamer, undated (pp. 191-196)

Resp. Ex. 4 - Garrett County Lighthouse, Inc. Letter of Support, undated (pp. 197-199)

Testimony

The Board presented the following witnesses: Ms. Lachman; Ms. Goldsborough; Ms. White; and Kara Brooks Tyson, Director of Compliance and Investigations, Board.

The Respondent testified and presented the following witnesses: Dr. Reamer, whom I accepted as an expert in social worker ethics; ethical codes of social workers; standards of practice of social workers; and commonly accepted practices of social workers, and Ms. Bernard.

PROPOSED FINDINGS OF FACT[14]

Having considered all of the evidence presented, I find the following facts by a preponderance of the evidence:

1. At all times relevant to this proceeding, the Respondent was an LCSW-C in the State of Maryland under license number 07605. The Respondent was originally licensed in the State of Maryland on October 17, 1992. His license is currently active and is scheduled to expire on October 31, 2026.

2. On January 17, 2022, the Respondent began working as an independent contractor for Supportive Care, a company that hires providers to do talk therapy and medication management in nursing homes and some assisted living facilities.

3. The Respondent was assigned to work at Dennett Road from February 2022 to March 2023, to provide social work services to the residents. Dennett Road was a ninety-nine-bed skilled nursing facility that provided rehabilitation and long-term care services to its residents.

4. The Respondent worked ten-to-twenty hours per week at Dennett Road.

5. At all times relevant, the Respondent operated a private, social work practice through which he saw clients separate from his employment with Supportive Care.

6. During his assignment at Dennett Road, the Respondent provided social work services to E.Z. and P.T., who were residents at the nursing home.[15]

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[14] My proposed findings, analysis, and proposed legal conclusions are based upon consideration of all of the parties' arguments and the credible evidence of record. All testimonial and documentary evidence was considered and given the weight it was due, regardless of whether it has been recited, cited, referenced, or expressly set forth in the Decision. *See, e.g.*, *Walker v. Sec'y of Health & Human Servs.*, 884 F.2d 241, 245 (6th Cir. 1989) (an administrative law judge need not address every piece of evidence in the record); *Mid-Atl. Power Supply Ass'n v. Md. Pub. Serv. Comm'n*, 143 Md. App. 419, 442 (2002) (emphasizing that "[t]he Commission was free to accept or reject any witness's testimony" and "the mere failure of the Commission to mention a witness's testimony" does not mean that the Commission "did not consider that witness's testimony").

[15] To ensure confidentiality, I will refer to residents by their initials. Their full names are contained in the record.

7. E.Z. was an amputee who was admitted to Dennett Road for wound care. E.Z. did not suffer from any cognitive impairments. One of E.Z.'s goals was discharge. In order to be discharged, E.Z. needed to learn how to transfer herself out of bed. E.Z. also had a history of refusing to get out of bed.

8. E.Z.'s daughter was her power of attorney and attended care plan meetings.

9. A social work note written by Christi Markwood for E.Z. on March 10, 2023 stated, "Her discharge plan is to return home, however, that does not seem to be feasible at this time d/t the amount of care she requires." St. Ex. 5, p. 100.

10. The Respondent documented in his notes that E.Z. often expressed frustration about remaining at the nursing home and a desire to go home. In the Respondent's note on March 15, 2023, he wrote "Pt. endorsed frustration over having to remain in SNF.[16] Pt. was advised [by] her Dr. that more healing needs to occur." St. Ex. 5, p. 79.

11. P.T. was a quadriplegic who was admitted to Dennett Road for treatment of infected pressure sores. Prior to his admission to Dennett Road, P.T. lived in an apartment and had a caregiver to assist him with his care needs. P.T. did not suffer from any cognitive impairments. One of P.T.'s goals was to be discharged, but he needed to be accepted into a Medicaid waiver program for at-home services.

12. On a date not clear from the record but before March 17, 2023, P.T. had to give up his apartment due to the long delay with obtaining a Medicaid waiver, which the Respondent knew at that time.

[16] Skilled nursing facility.

13. On April 4, 2023, Ms. Markwood documented P.T.'s desire to return to the community and stated P.T. is "on the waiting list for the Medicaid Waiver Program. However, to this writer's knowledge, 24-hour care cannot be provided which is what [P.T.] requires." St. Ex. 5, p. 113.

14. The Respondent did not attend plan of care meetings for the residents and did not have access to their medical records. Dennett Road staff reviewed and scanned his notes into the residents' records, although sometimes it was days later.

15. The Respondent worked at Dennett Road during a time when COVID restrictions were still in place and residents were confined to their room to prevent the spread of infection.

16. The Respondent provided services to approximately one-third of his assigned residents in their rooms with their roommates present. The Respondent took steps to protect the residents' confidentiality by obtaining their consent, pulling the curtain closed between the beds, turning on the television or radio, and speaking quietly. This is an acceptable practice exercised by social workers and other providers in a nursing home setting.

17. Dennett Road administrators never told the Respondent that he was not permitted to see residents in their rooms in the presence of a roommate. Dennett Road administrators never provided the Respondent with a private space to meet with residents outside of their rooms.

18. On two occasions, October 26, 2022 and March 8, 2022, Ms. Goldsborough notified Supportive Care by email of concerns she had about the Respondent's conduct. Specifically, Ms. Goldsborough stated that the Respondent frequently accused staff of abuse, told residents with dementia and no community support that they can leave the nursing home whenever they want, which caused them to become upset, and convinced one resident that she and the Respondent were a couple.

19. Ms. Goldsborough did have a personal conversation with the Respondent about the concerns she raised in her email to Supportive Care.

20. The Respondent and Dennett Road staff disagreed about how the Respondent documented and reported allegations of abuse and neglect in the nursing home, which caused conflict between the Respondent and Dennett Road administration, particularly with Ms. Goldsborough.

21. Ms. Bernard was employed as a social worker at Dennett Road from October 2021 to December 2022.

22. Ms. Goldsborough "got upset" with Ms. Bernard for documenting in her notes when residents expressed being unhappy about staff shortages and not being taken to the bathroom enough.[17] Ms. Goldborough told Ms. Bernard not to include that information in her notes because it would cause the nursing home to be "red-flagged"[18] by the State.[19]

23. Ms. Goldsborough told the Respondent not to document in his notes anything that would "red-flag" the facility for abuse and/or neglect.[20] Ms. Goldsborough wanted the Respondent to report any allegations of abuse and/or neglect directly to her or the DON without documenting it in his notes.

24. On January 13, 2023, Supportive Care notified the Respondent that his January 6, 2023 progress note for P.L., which stated that P.L. "get's [sic] so frustrated when aids [sic] treat him like he's helpless," triggered an investigation at the nursing home. St. Ex. 3, pp. 40-41. Supportive Care advised the Respondent that Dennett Road requested that in the future, he report to the DON if the patients are making comments about staff.

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[17] Testimony of Ms. Bernard.
[18] Neither party explained this term.
[19] *Id.*
[20] Testimony of the Respondent.

25. During his assignment at Dennett Road, the Respondent made four reports of abuse and/or neglect. The Respondent's last report was made two days before Dennett Road terminated his assignment and involved an allegation of neglect of J., a bedridden resident. The Respondent documented the allegation in a progress note for J. and attempted to report it first to the staff social worker, who was not available, then to the administration before he left for the day, and finally by telephone. He was unable to speak to anyone.

26. The Respondent reported all other allegations of abuse and/or neglect to the Dennett Road administration, in addition to documenting it in his notes for the resident.

27. On March 23, 2023, Dennett Road terminated the Respondent's contract and requested that Supportive Care provide a different therapist.

28. The Respondent expressed to Ms. Sadler, his supervisor at Supportive Care, that he believed he had an ethical responsibility to help facilitate the residents' transition to a new therapist. Ms. Sadler agreed to contact Dennett Care about the Respondent's request.

29. On March 23, 2023, Ms. Sadler and the Respondent had the following text exchange regarding the Respondent returning to Dennett Road:

> **Ms. Sadler**: Hey Mike... Definitely not going to be able to go back into the building. I got a call from regional with Peace Healthcare. Your last note prompted a state reportable and full investigation.
>
> **The Respondent**: OK thanks. I assumed documenting this in the case record was why they requested I be replaced. I tried to report this to them before I left, just as I told them I would, but no one was available.
>
> **Ms. Sadler**: Well at least you know that the state reportable that is happening and full investigation means it's being looked into.
>
> **The Respondent**: This is true. And I did nothing wrong. I would like to go back to doing my job when this is resolved.

St. Ex. 3 at pp. 37-39.

30. On a date not clear from the record, but prior to the Respondent's termination from Dennett Road, the Respondent discussed providing private, in-home psychotherapy to P.T. and E.Z. once they were discharged.

31. On at least two occasions between March 23, 2023 and April 27, 2023, the Respondent went to Dennett Road to check on P.T. and E.Z. and the status of their discharge.

32. On a date not clear from the record, but before April 27, 2023, a new social worker was assigned to provide services to P.T. and E.Z.

33. On April 27, 2023, the Respondent went back to Dennett Road in his capacity as a social worker to do intake assessments on P.T. and E.Z.

34. On April 27, 2023, the Respondent determined E.Z. was "moderately to severely depressed" based on his intake assessment. St. Ex. 12, p. 193.

35. On April 27, 2023, P.T. and E.Z. signed documentation for the Respondent to bill their insurance for services, a contractual agreement for the Respondent to provide therapy to them, and a consent form to allow Dennett Road to release certain records to the Respondent, which the Respondent signed as a witness.

36. While the Respondent was in P.T.'s room, Ms. Green asked to speak with the Respondent. Ms. White waited outside of the room but could hear their conversation. Ms. Green asked the Respondent if he was there for personal or professional reasons, and the Respondent stated that he was at the nursing home for professional reasons.

37. Shortly thereafter, the Respondent went to the nursing office and met with Ms. White, Ms. Green, and Ms. Goldsborough. The Respondent reiterated that he was at Dennett Road for professional reasons and, when asked, refused to name the residents he came to see,

citing confidentiality. The Respondent provided the releases for medical records signed by P.T. and E.Z.

38. Ms. White explained that for the Respondent, an outside provider, to see a resident in the nursing home, he must first complete the credentialing process and obtain a physician order. Ms. Goldsborough also reiterated the process.

39. Ms. White also explained to the Respondent that Medicaid or Medicare would only pay for one provider. The Respondent responded that it was not her (Ms. White's) concern and that Medicaid or Medicare would pay one or the other (him or the nursing home).

40. On May 1, 2023, Ms. Goldsborough emailed the Respondent an application for privileges to provide services to Dennett Road residents.

41. On May 1, 2023, the Respondent responded to Ms. Goldsborough's email and declined to complete it. The Respondent stated that the application for privileges did not apply to him because the application was for physicians.[21]

42. On May 2, 2023, Ms. Goldsborough responded to the Respondent and notified him that the credentialing process applied to him because he is a licensed health professional. She reiterated that "[u]ntil you have been approved for privileges we cannot allow you to see residents at the facility." St. Ex. 5, p. 47.

43. On May 10, 2023, the Respondent returned to Dennett Road and brought with him pizza bread[22] because it was around mealtime.

44. While the Respondent was speaking with E.Z. in her room, a nurse came in and asked to speak with the Respondent. The Respondent told the nurse that he was meeting with his client, and he would speak with her when he is finished. The nurse told the Respondent that if he

[21] The application was titled, "Physician Privileging Application." St. Ex. 5, pp. 50-55.
[22] The Respondent described pizza bread as Italian bread with sauce and cheese in a small six-by-six box.

did not speak to her, she would call the police. The Respondent declined to speak to the nurse, so she called the police.

45. The Garrett County Sheriff's Office responded to Dennett Road. The Respondent spoke to the deputies and told them he was at the nursing home as a patient representative. Shortly thereafter, he agreed to leave the premises.

46. On May 11, 2023, Ms. Goldsborough sent the Respondent a Letter of No Trespass, which advised the Respondent that he had "no right, either expressed or implied, to be IN or ON the" Dennett Road property. St. Ex. 5, p. 43 (emphasis in original).

47. On May 12, 2023, the Respondent sent Ms. Goldsborough letters advising her that E.Z. and P.T. requested that he be their "patient representative relative to services provided to" them at Dennett Road. St. Ex. 5, pp. 63-64.

48. On May 15, 2023, Ms. Goldsborough filed a complaint against the Respondent with the Board.

49. On May 23, 2023, Ms. Goldsborough documented in E.Z.'s chart, "Met with resident to discuss letter facility received from [the Respondent] stating he was taking over as resident's representative. Resident stated she wanted her daughter, Carey Williams, to be her representative.[23] Stated [the Respondent] and her were just friends and she didn't want him making decisions regarding her care." St. Ex. 5, p. 102.

50. On May 23, 2023, Ms. Goldsborough documented in P.T.'s chart, "Facility received letter from [the Respondent] stating he was now acting as resident representative. Spoke to [P.T.] regarding the letter, [P.T.] stated he did not want [the Respondent] as his representative." *Id.* at p. 108.

[23] E.Z.'s daughter was her power of attorney.

51. The Respondent never attempted to gain control of the finances or medical decisions of E.Z. or P.T.

DISCUSSION

Legal Framework

The Maryland General Assembly has empowered the Board to adopt rules, regulations and a code of ethics, and to investigate alleged violations. Md. Code Ann., Health Occ. § 19-205 (2021 & Supp. 2024). The Charges under the Act allege statutory and regulatory grounds for discipline as follows:

> Subject to the hearing provisions of § 19-312 of this subtitle, the Board may deny a license to any applicant, fine a licensee, reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the applicant or licensee:
>
> . . .
>
> (4) Commits any act of gross negligence, incompetence, or misconduct in the practice of social work;
>
> (5) Engages in a course of conduct that is inconsistent with generally accepted professional standards in the practice of social work; [and]
>
> (6) Violates any provision of this title or regulations governing the practice of social work adopted and published by the Board[.]
>
> . . .

Health Occ. § 19-311(4), (5), and (6).

The State alleges under section 19-311(6), above, the Respondent violated the following regulations:

> COMAR 10.42.03.03 Responsibilities to Clients
>
> B. The licensee may not:
>
> (1) Participate or condone dishonesty, fraud, deceit, or misrepresentation;
>
> . . .

(7) Share with another individual a confidence revealed by a client without a client's consent, except if there is a danger to self or to another individual, or for a compelling professional reason[.]

COMAR 10.42.03.05 Relationships

A. A licensee may not enter into a dual relationship with a client or an individual with whom the client has a close personal relationship.

. . .

C. The licensee may enter into a nonsexual relationship with an individual with whom the licensee's prior professional contact:

(1) Was of a brief, peripheral, or indirect nature; and

(2) Did not constitute a therapeutic relationship.

Burden of Proof

In this matter, the Board has the burden to demonstrate, by a preponderance of the evidence, that the licensee has committed the alleged violation(s) of the Act. COMAR 10.42.04.06C(2). To prove an assertion or a claim by a preponderance of the evidence means to show that it is "more likely so than not so" when all the evidence is considered. *Coleman v. Anne Arundel Cnty. Police Dep't*, 369 Md. 108, 125 n.16 (2002).

Based upon the testimony and evidence presented, I find that the Respondent committed an act of misconduct in the practice of social work. I do not find that the State showed that the Respondent engaged in a course of conduct that is inconsistent with generally accepted professional standards in the practice of social work. I also did not find that the Respondent violated regulations governing the practice of social work, as alleged by the State.

Analysis

The State advanced two main issues that it argued amounted to violations of the Act and the applicable regulations: (1) the Respondent treated residents in the presence of their roommate; and (2) the Respondent returned to Dennett Road on April 27, 2023 and May 10,

2023, in his capacity as a social worker, after being told not to do so, and stated he was a patient representative.[24] The Respondent vehemently denied any wrongdoing.

Treating Residents in the Presence of a Roommate

The evidence is undisputed that the Respondent provided social work services to residents in their rooms. The Respondent testified that many residents were frail, had mobility issues, or were bedridden. Furthermore, the Respondent worked at Dennett Road when COVID restrictions were still in place, and residents were confined to their rooms to control the spread of infection. The Respondent also testified that when he met with a resident in their room with a roommate present, he took precautions to protect confidentiality. The Respondent explained that he first obtained the resident's permission to proceed with a roommate present, and if they agreed, he pulled the curtain closed between the beds, turned on the radio or television, sat next to the resident, and/or spoke quietly. The Respondent noted that if a resident was mobile, they could sometimes find a corner to speak privately, but he was never given a private space to meet with a resident. I found the Respondent's testimony to be credible. He answered questions on this subject confidently and without hesitation. In addition, his testimony during the hearing was consistent with the testimony he provided to the Board's investigator on July 11, 2023. *See* St. Ex. 14, p. 223.

The Respondent offered Dr. Reamer, whom I accepted as an expert in social worker ethics, ethical codes of social workers, standards of practice of social workers, and commonly accepted practices of social workers. Dr. Reamer is a prolific publisher of materials on professional ethics and has presented at 732 in-person and remote lectures and continuing education seminars on professional ethics. Dr. Reamer's testimony was authoritative and

[24] For clarity, I analyzed the patient representative matter as a third issue.

unambiguous, and I found him highly credible. He testified that HIPAA[25] allows for incidental uses and disclosures of protected health information in challenging situations when it might be difficult to fully protect privacy, such as having to see nursing home residents in a room with a roommate present. Dr. Reamer's "very clear opinion" was that the Respondent acted consistently with widely accepted standards of care in the social work profession to protect resident confidentiality in these situations because the Respondent took "all reasonable and prudent precautions." Testimony of Dr. Reamer.

Ms. White, who was vice president of clinical services at Dennett Road at the time of the Respondent's assignment and has twenty-eight years of nursing experience, testified on behalf of the State primarily regarding the Respondent's return to the nursing home on April 27, 2023. When asked on cross-examination about the Respondent's practice of seeing residents in their rooms with a roommate present, and using mitigating precautions to protect confidentiality, Ms. White said, "Yes, that's appropriate. Absolutely, I can say without question. It's appropriate." Testimony of Ms. White. I found Ms. White extremely credible and unequivocal in her testimony on this issue, and I gave her testimony great weight considering she was a State's witness yet her testimony supported the Respondent's position.

In contrast, Ms. Goldsborough, on behalf of the State, testified that the Respondent violated the residents' confidentiality by providing services in their rooms with a roommate present. Ms. Goldsborough testified that therapy sessions are conducted, "most of the time, in residents' rooms," and if there is a roommate in the room, therapy can be provided in a "boardroom" or "office spaces." Testimony of Ms. Goldsborough. However, on cross-examination, she acknowledged that seeing patients in their rooms with a roommate present is a normal practice and she has never filed a complaint against a provider, other than the

[25] Health Insurance Portability and Accountability Act of 1996.

Respondent, for doing so. *Id.* When pressed about why she filed a complaint[26] about the Respondent doing something that all other providers normally do, Ms. Goldsborough stated, "[The Respondent] would not share information with us to hep us provide better care because he said it was privacy." *Id.*

I did not find Ms. Goldsborough to be credible. Ms. Goldsborough, who appeared by audio because her camera was not working, displayed a defensive demeanor and took long pauses before answering questions that belied her position. In light of Ms. White's testimony, which corroborated the Respondent's testimony, I gave no weight to Ms. Goldsborough's testimony that the Respondent could have met with residents in a boardroom or a private office, nor do I believe that anyone, including Ms. Goldsborough, ever offered the Respondent a private space to meet with residents. Ms. Goldsborough's testimony that she had never filed a complaint about anyone other than the Respondent about meeting with a resident with a roommate present led me to believe that Ms. Goldsborough did not have a valid concern about confidentiality, but rather, she disliked the Respondent.

The Respondent did not violate the confidentiality of residents when he provided social work services in their rooms, in the presence of a roommate. Based on the foregoing, I find the State has not shown the Respondent is in violation of Health Occ. § 19-311(4), (5) or (6) or the Board's regulations, specifically COMAR 10.42.03.03B(7).

The Respondent's April 27, 2023 and May 10, 2023 Visits to Dennett Road

When Ms. Sadler contacted the Respondent to notify him that Dennett Road terminated his assignment, the Respondent told Ms. Sadler that he wanted to return to the nursing home to help transition the residents to their new provider. *See* St. Ex. 14, p. 225.

[26] The Respondent's alleged violation of resident confidentiality came to the Board's attention when Ms. Goldsborough included the allegation in her complaint to the Board. *See* St. Ex. 1, p. 2.

The Respondent expressed that he felt he had an ethical responsibility to transition his clients. *Id.* He asked Ms. Sadler if she would inquire about that possibility with Dennett Road. *Id.* That same day, Ms. Sadler informed the Respondent via text message that he was "[d]efinitely not going to be able to go back into the building." St. Ex. 3, p. 37. The Respondent expressed that he was not surprised that the nursing home administration did not want the Respondent to return. *See* St. Ex. 14, p. 225.

Despite the message from Ms. Sadler that he would not be able to return to Dennett Road, the Respondent did so anyway, multiple times. The Respondent testified that he returned to "once or twice" between March 23, 2023 and April 27, 2023 to check on E.Z. and P.T.'s discharge status. Testimony of the Respondent; *see also* St. Ex. 14, p. 226.[27] If the nursing home administration was aware of those visits, it did not take issue with the Respondent being in the building at those times, as Ms. Goldsborough did not mention those visits in her complaint to the Board or in her testimony. The Respondent testified that he understood Ms. Sadler's March 23, 2023 text message to mean that he was not permitted to return to the nursing home to transition his clients to a new therapist.[28] *See also* St. Ex. 14, p. 225. If the Respondent was barred from returning to the nursing home at all, whether for personal or professional reasons, that was not made entirely clear until after his May 10, 2023 visit.

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[27] During the Respondent's interview with the Board's investigator, he stated that he returned to Dennett Road "at least three times" to check on the status of his clients' discharge. St. Ex. 14, p. 226.

[28] There is no direct evidence before me that the Respondent defied the nursing home administrations' response to his request on that matter, as his visits were to check on E.Z. and P.T.'s discharge status. The State did not allege that he did anything more during those visits. The Respondent testified adamantly about his perceived ethical responsibility to transition his clients to a new therapist, but he appeared to have abided by the nursing home's decision not to permit him to do that. Instead, he focused his visits on establishing E.Z. and P.T. as his private clients.

When the Respondent returned on April 27, 2023, he represented to the nursing home staff that he was there in his professional capacity, not for a personal visit. The Respondent was there to conduct intake assessments on E.Z. and P.T. because he believed their discharge was imminent, and he needed to complete documentation to ensure that he could bill their insurance and obtain copies of their records from Dennett Road. Even though the Respondent was not providing psychotherapy, he was practicing social work,[29] which he acknowledged both in his testimony and when asked by nursing home staff. Dr. Reamer testified that standard social work services includes not just counseling, but also case advocacy, case work services, and service coordination. The Respondent also testified that social work services include consultation, case management, psychoeducation, information and referral.

Despite appearing at Dennett Road as a social worker, the Respondent was not immediately asked to leave, even after he told Ms. Green, which Ms. White overheard, that he was there professionally, not personally. Testimony of Ms. White; *see also* State Ex. 8, p. 152. Rather, as Ms. White testified, she explained the credentialing process to the Respondent. Ms. White also testified that she did not want to block the Respondent from seeing his clients, but there were processes in place that had to be followed in order to allow him access to the nursing home. To Ms. White's knowledge, the Respondent was not barred from Dennett Road at this time. *See* St. Ex. 8, p. 153. Further, it is undisputed that a resident could see whatever private provider he or she wished, so long as that individual was credentialed by the nursing home and there was a physician order. *See* Testimony of Ms. White.

[29] Under the Act, the practice of social work includes assessment, planning, intervention, evaluation of alternative intervention plans, case management, information and referral, counseling that does not include diagnosis or treatment of behavioral health disorders, advocacy and consultation. Health. Occ. § 19-101(n).

According to Ms. White, a resident could even potentially leave the nursing home to see an outside provider, as long as the provider was licensed. *Id.* The evidence clearly demonstrated that, on April 27, 2023, the only thing keeping the Respondent from seeing private clients at Dennett Road was the credentialing process and a physician order.

I conclude that the Respondent did not violate the Act or any pertinent regulations when he visited P.T. and E.Z. at Dennett Road on April 27, 2023. Despite being present in his professional capacity, and engaging in the practice of social work, the Respondent was not in violation of any order that he not enter the nursing home. He was honest about his reason for being there (to see his clients), and until he was told by Ms. White and Ms. Goldsborough, he was unaware of the requirement that he be credentialed by the nursing home.[30]

The Respondent's return to the nursing home on May 10, 2023 leads to a different conclusion. On May 1, 2023, Ms. Goldsborough emailed the Respondent and provided the application for privileges to begin the credentialing process, so the Respondent could see clients in the nursing home as an outside provider. *See* St. Ex. 5, pp. 48-55. That same day, the Respondent replied to Ms. Goldsborough's email declining to complete the application for privileges. *Id.* at pp. 47-48. Ms. Goldsborough then, clearly and unequivocally, notified the Respondent, on May 2, 2023, that "[u]ntil you have been approved for privileges we cannot allow you to see residents at the facility." *Id.* at 47.

[30] The Respondent argued that he did not learn about the credentialing requirement until Ms. Goldsborough's email on May 1, 2023. That is of no import. Although I found Ms. White's testimony credible that she told him on April 27, 2023, and I note that this was consistent with what she told the Board's investigator less than two months after the incident in June 2023, the relevant fact remains that the Respondent knew about the credentialing requirement before May 10, 2023.

Again, it is undisputed that the Respondent returned to Dennett Road on May 10, 2023, after he was notified that he was not permitted to see clients as a social worker in the nursing home until he was credentialed. The Respondent testified that he understood Ms. Goldsborough's May 2, 2023 email to mean that he could not see E.Z. and P.T. for therapy, which he was not intending to do anyway. The Respondent's interpretation of Ms. Goldsborough's email was self-serving and antithetical to his testimony that practicing social work is more than providing therapy. The Respondent was undoubtedly acting as a social worker on May 10, 2023.

The Respondent argued that under state and federal law, residents are permitted to have visitors of their choice at the nursing home. While that may be true, the Respondent was not merely a "visitor," but rather a social worker appearing in his professional capacity in blatant opposition to the well-documented and clearly communicated instructions from the nursing home that he was not permitted to do so without first obtaining privileges.

The Respondent testified that he was visiting his clients to tell them that it would be a while before he would be able to see them privately in their homes, which is illogical considering there was no indication that either E.Z. or P.T. were on the verge of discharge, despite the Respondent's statements otherwise.[31] *See* Findings of Fact 9-10 and 11-13. The Respondent also notified E.Z. and P.T. on May 10, 2023, that he was approved by the State to provide them with psychotherapy services. *See* St. Ex. 12, p. 196. In addition, the Respondent discussed with E.Z. and P.T., and later documented in letters to Ms. Goldsborough, becoming their "personal representative." St. Ex. 5, pp. 63 and 64.

[31] *See also* St. Ex. 12, p. 187 ("I was checking up on my self-referred and Medicaid Approved Patients [sic] to check on their wellbeing and advise them of the status of their case.")

The Respondent testified extensively about his commitment to ethics and protecting his clients' rights but demonstrated a total disregard for the nursing home's policies and procedures. The Respondent steadfastly pursued the protection of his clients' rights as nursing home residents and was clearly concerned about their wellbeing. However, he was equally steadfast in his refusal to cooperate and follow the nursing home's requirement that he be credentialed. Ms. Goldsborough and Ms. White testified that *every* outside provider is credentialed for the protection of the residents. The nursing home did not single out the Respondent, nor was the nursing home attempting to prevent the Respondent from ever seeing his clients.

Dr. Reamer testified that a social worker should not allow an employing organization's policies, procedures, or administrative orders to interfere with the social worker's ethical practice. He further testified that a social worker's code of ethics applies across settings and employers. I do not infer from his testimony that a social worker can do whatever he wants, in violation of an employer's policies and procedures, which the Respondent did not assert were illegal or unethical.[32] The Respondent simply did not believe he was subject to the nursing home's credentialing procedure, refused to cooperate, and then blamed the nursing home for preventing him from seeing his clients. That is a distortion of the facts that is not substantiated by the evidence.

Further, if the Respondent wanted to share information with his clients, he could have contacted them via telephone or by sending a letter. The Respondent testified that he frequently spoke on the telephone with P.T., although it was not ideal because P.T. needed assistance with charging his phone or it was sometimes out of his reach.

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[32] I also note, for context, that Dr. Reamer does not have experience working in nursing homes and his knowledge of that field of social work is from consulting with individuals in that setting about ethics, not policies and procedures specific to long-term care facilities.

The Respondent also sent letters to his clients, although he alleged that his clients did not receive the letters or they were intercepted and read by the nursing home.[33] *See* St. Ex. 12, p. 196-199. Dr. Reamer testified that to avoid abandoning a client, a social worker must make sure that the client's needs and preferences are met, and the client is aware of his or her options for treatment. He testified that a letter is not sufficient, rather, it requires a conversation. Although I have no reason to doubt Dr. Reamer's testimony, this was not the context of the Respondent's May 10, 2023 visit. The clients knew their options, as the Respondent had already met with them at least three times, maybe more, since Dennett Road terminated his assignment. The Respondent was not discussing his clients' options for transitioning them to a new social worker, rather he perceived them as his own private clients and was attempting to see them in that respect.

I conclude that by returning to the nursing home on May 10, 2023, the Respondent committed an act of misconduct in the practice of social work, in violation of Health Occ. § 19-311(4).

Patient Representative

The State took issue with the Respondent identifying himself a "patient representative," and argued that this created an improper dual relationship with E.Z. and P.T. The Respondent called himself a patient representative when he spoke to the police on May 10, 2023 (St. Ex. 10, p. 169), and then on May 12, 2023, he notified the nursing home that E.Z. and P.T. designated him as their patient representative "relative to services provided [to them at the nursing home]."

[33] The Respondent did not testify when he sent letters to his clients that they did not receive. The Respondent's clients did not testify, and were not interviewed by the Board's investigator, so there was no evidence before me that they did not receive the Respondent's letters, nor was there any evidence that the nursing home intercepted and read any letters that the Respondent mailed to E.Z. and P.T. As a result, I gave no weight to the Respondent's testimony that he mailed letters to his clients that they did not receive, and that the nursing home intercepted and resident his clients' mail.

See St. Ex. 5, pp. 63-64. The Respondent did not dispute these facts but disagreed that being a patient representative created a dual relationship in violation of the Act and pertinent regulations.

When interviewed by the Board's investigator, the Respondent described a patient representative as someone who "does whatever the patient requests them to do within the guidelines of the law. A patient representative has no authority to make any decisions whatsoever for a client. It can be a volunteer. It can be an advocate. But they have no authority to make decisions whatsoever." St. Ex. 14, p. 232. The Respondent testified that the matter of him serving as their patient representative came about because both E.Z. and P.T. needed a support person to attend their plan of care meetings. The Respondent further testified that E.Z. and P.T. were unfamiliar with their plans of care and were afraid of retaliation from the nursing home if they attended meetings and complained about their care. This is relevant to the extent that it illustrated how the Respondent intended to function in the role of patient representative. Further, the evidence is clear that the Respondent never attempted to take control of his clients' finances or medical decisions. Also, there was no evidence that the Respondent benefited financially from calling himself a patient representative.

Dr. Reamer testified that using the term patient representative alone does not constitute a dual relationship. Rather, Dr. Reamer testified that one must also consider the Respondent's actions relative to being a patient representative. The Respondent was always transparent that the purpose of his relationship with E.Z. and P.T., whether as a social worker or a patient presentative, was to be an advocate for his clients. Dr. Reamer provided the analogy that the Respondent took off one hat (providing psychotherapy through Support Care at Dennett Road) and putting on another hat (advocating for the residents privately), both of which are components

of the practice of social work. I find Dr. Reamer's testimony was logical and supported by the evidence.

In the Amended Charges and during the hearing, the State did not provide a legal definition for a patient representative, nor did the State offer any expert testimony on this issue. The State's witnesses did not know the definition of a patient representative. Ms. Goldsborough testified that a patient representative is the person who the patient chooses to make decisions for them. She testified that her understanding of a patient representative was from "Maryland law," because she took several courses on it, but was unable to name the law because she is not a lawyer. Ms. Goldsborough then testified that she understood the term patient representative as it is used under Maryland's law on advanced directives. Nevertheless, the State argued that calling oneself a patient representative, apparently without even taking any action in furtherance of that designation, is sufficient to create an improper dual relationship.

The State argued that E.Z. and P.T. did not want the Respondent to be their patient representative, and Ms. Goldsborough documented this in their respective charts. As E.Z. and P.T. did not testify during the hearing, I decline to rely on what Ms. Goldsborough said E.Z. and P.T. told her, as I did not find Ms. Goldsborough to be a reliable witness. The evidence indicated that the Respondent had a good rapport with E.Z. and P.T. and they wanted him to be their therapist when they were discharged. I decline to opine on E.Z. and P.T.'s understanding of what it meant for the Respondent to be their patient representative because it is immaterial to the question of whether calling oneself a patient representative creates a dual relationship in this matter.

I conclude that when the Respondent identified himself as a patient representative he did not create or enter into an inappropriate dual relationship with E.Z. or P.T., in violation of Health Occ. § 19-311(4), (5), or the Board's regulations, specifically COMAR 10.42.03.05A or C.

I do not find that the State showed that the Respondent engaged in a course of conduct inconsistent with generally accepted professional standards in the practice of social work, in violation of Health Occ. § 19-311(5), as the State did not present any expert, documentary, or testimonial evidence about which "accepted professional standards" were allegedly violated.

I do not find that the State showed that the Respondent participated in or condoned dishonesty, fraud, deceit, or misrepresentation, in violation of COMAR 10.42.03.03B(1). The State did not present any expert, documentary, or testimonial evidence that the Respondent's conduct was dishonest, fraudulent, deceitful or that he misrepresented himself.[34]

Sanctions

The Board may impose disciplinary sanctions and/or a monetary penalty against a licensee who is found to have violated the Act. Health Occ. §§ 19-311, 19-311.1; COMAR 10.42.03.07, COMAR 10.42.09.03. The Board's regulations contain a matrix of sanctions in COMAR 10.42.09.04, factors to be taken into account when assessing a monetary penalty in COMAR 10.42.04.11B,[35] and considerations that may mitigate or aggravate otherwise appropriate sanctions in COMAR 10.42.09.05. The Board is seeking a revocation of the Respondent's license to practice social work.

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[34] The State alleged that on May 10, 2023, the Respondent attempted to disguise himself as a pizza deliveryman and shielded his face with a pizza box and/or a two-liter soda bottle. None of the State's witnesses, nor anyone interviewed by the Board's investigator, observed this alleged disguise attempt firsthand. I gave this argument no weight.

[35] A licensee who is found to have violated the Act is liable to pay costs, which also is taken into account when determining a monetary penalty under this regulation. Health Occ. § 19-312(f), COMAR 10.42.04.12.

Considering the State failed to meet its burden as to the majority of the charges alleged in the Amended Charges, I find revocation of the Respondent's license to practice social work to be inappropriate. For a violation of section 19-311(4) of the Health Occupations Article, the matrix in COMAR 10.42.09.04A provides for a minimum sanction of "probation for one year, or a $1,000 fine, or both," and a maximum sanction of "revocation, or a $10,000 fine, or both."

COMAR 10.42.09.05 addresses mitigating and aggravating factors, as follows:

> Depending on the facts and circumstances of each case, and to the extent that they apply, the Board may consider the following aggravating and mitigating factors in determining whether the sanction in a particular case should fall outside the range of sanctions established by the guidelines. These factors may include, but are not limited to, the following:
>
> A. Mitigating Factors:
> (1) The licensee's lack of a prior disciplinary record;
> (2) The licensee self-reported the violation to the Board;
> (3) The licensee's full and voluntary admissions of misconduct to the Board and cooperation during Board proceedings;
> (4) Implementation of remedial measures to correct or mitigate harm arising from the misconduct;
> (5) Timely good-faith effort to make restitution or to rectify consequences of misconduct;
> (6) Evidence of rehabilitation or rehabilitative potential;
> (7) Absence of premeditation to commit the misconduct;
> (8) Absence of potential harm to public or adverse impact; and
> (9) The licensee's conduct was an isolated incident and not likely to recur.
>
> B. Aggravating Factors:
> (1) The licensee has a previous criminal or administrative disciplinary history;
> (2) The violation was committed deliberately or with gross negligence or recklessness;
> (3) The violation had the potential for, or caused, serious patient or public harm;
> (4) The violation was part of a pattern of detrimental conduct;
> (5) The licensee was motivated to perform the violation for financial gain;
> (6) The vulnerability of the clients;
> (7) The licensee lacked insight into the wrongfulness of the conduct;
> (8) The licensee committed the violation under the guise of treatment; and
> (9) Previous attempts at rehabilitation of the licensee were unsuccessful.

C. The existence of one or more of these factors does not impose on the Board or an Administrative Law Judge any requirement to articulate its reasoning for not exercising its discretion to impose a sanction outside of the range of sanctions set forth in this chapter.

D. Nothing in this regulation requires the Board or an Administrative Law Judge to make findings of fact with respect to any of these factors.

Of the mitigating factors listed above, only the Respondent's lack of prior disciplinary record applies. *See* St. Ex. 20, p. 263. Three aggravating factors are present: the violation was committed deliberately; the clients were vulnerable; and the licensee lacked insight into the wrongfulness of the conduct. The mitigating and aggravating factors are, therefore, unbalanced. Throughout the hearing, the Respondent vehemently denied any wrongdoing and asserted that all of his actions were in the best interests of his clients.

Considering all the above, I do not find that revocation is appropriate. However, considering the presence of three aggravating factors, I find that a sanction greater than the minimum sanction is appropriate. Therefore, I recommend a six-month suspension of the Respondent's license to practice social work and probation for one year.

PROPOSED CONCLUSIONS OF LAW

Based on the foregoing Proposed Findings of Fact and Discussion, I conclude as a matter of law that the Respondent violated section 19-311(4) of the Health Occupations Article. Md. Code Ann., Health Occ. § 19-311 (2021 & Supp. 2024). I further conclude that the Respondent did not violate sections 19-311(5) or (6) of the Health Occupations Article, or COMAR 10.42.03.03B(1) or (7), or COMAR 10.42.03.05A or C. *Id.*

I further conclude that the Respondent is subject to a six-month suspension, followed by a one-year period of probation for the cited violations. Md. Code Ann., Health Occ. § 19-311 (2021 & Supp. 2024); COMAR 10.42.03.07; COMAR 10.42.09.03-.05.

PROPOSED ORDER

I **PROPOSE** that Amended Charges filed by the Maryland State Board of Social Work Examiners against the Respondent on August 13, 2024 be **UPHELD in part** and **DISMISSED in part.**

I further **PROPOSE** that the Respondent's license to practice social work be **SUSPENDED** for a period of six months.

I further **PROPOSE**, upon termination of the suspension, that the Respondent be placed on probation for a minimum of one year.

April 28, 2025
Date Decision Issued

Tracee Orlove Fruman
Tracee Orlove Fruman
Administrative Law Judge

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NOTICE OF RIGHT TO FILE EXCEPTIONS

Any party adversely affected by this proposed decision may file written exceptions with the State Board of Social Work Examiners within fifteen (15) days after issuance of this decision. COMAR 10.42.04.06D. Within ten (10) days of the filing of exceptions, the opposing party may file an answer. *Id.* The Board will review timely exceptions prior to rendering the final agency decision. Md. Code Ann., State Gov't §§ 10-216, 10-221 (2021); COMAR 10.42.04.06D-E. The Office of Administrative Hearings is not a party to any review process.

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