IN THE MATTER OF	*	**BEFORE THE MARYLAND**
CLARENCE MILLER	*	**BOARD OF NURSING**
Certificate No.: A00127874	*	**OAG Case No.: 22-BP-045**

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ORDER FOR SUMMARY SUSPENSION OF CERTIFIED NURSING ASSISTANT/GERIATRIC NURSING ASSISTANT CERTIFICATE PURSUANT TO SECTION 10-226(c)(2) OF THE ADMINISTRATIVE PROCEDURE ACT

The Maryland Board of Nursing (the "Board") hereby orders the **SUMMARY SUSPENSION** of the certificate of **CLARENCE MILLER**, (the "Respondent"), Certificate Number **A00127874** to practice as a Certified Nursing Assistant/Geriatric Nursing Assistant in the State of Maryland. The Board takes this action pursuant to the authority of Maryland Code Ann., State Government Article ("SG") § 10-226(c)(2) (2021 Repl. Vol.), which provides:

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

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

INVESTIGATIVE FINDINGS AND REASONS IN SUPPORT OF SUMMARY SUSPENSION

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

1. On November 7, 2012, the Respondent was certified to practice as a Certified Nursing Assistant ("CNA")/Geriatric Nursing Assistant ("GNA") in the State of Maryland, certificate number A00037941. The Respondent's certificate is currently non-renewed and expired on March 28, 2022.

2. The Respondent practiced as a GNA at a nursing home (the "Nursing Home")[2] located in Baltimore, Maryland from November 2012 until January 11, 2021, when the Respondent was terminated from his employment.

3. The Board received a complaint by the Nursing Home's Director of Nursing ("Director of Nursing") on or about February 8, 2021, alleging the Respondent "was observed by another staff member kissing a resident on the face and head. Resident is not capable of giving consent."

4. At the time of the incident, the Resident was an 84-year-old female with diagnoses that included unspecified dementia, vascular dementia, and hemiplegia and hemiparesis. The Resident was assigned to room 223-1 at the Nursing Home.

5. According to a statement by a staff member (the "Staff Member") which was documented by the Nursing Home on December 15, 2020, the Staff Member reported, "When I did my rounds

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[1]The allegations set forth in this document are intended to provide the Respondent with reasonable notice of the Board's action. They are not intended as, and do not necessarily represent a complete description of the evidence, either documentary or testimonial, to be offered against the Respondent in connection with this action.

[2] For purposes of ensuring confidentiality, proper names have been omitted and replaced with generic placeholders. Upon written request, the Administrative Prosecutor will provide the information to the Respondent.

this morning, I saw a staff sitting at resident's bed side and he kissed the resident on the face/ head. I asked him what he was doing, he said I don't know."

6. According to a statement by the Respondent which was documented by the Nursing Home on December 15, 2020, the Respondent reported the following:

> Which rooms were assigned to you overnight? I was assigned to rooms 214 – 225-1-night shift of 12/14/2020 into 12/15/2020.
>
> Did a day shift [staff member] come into room 223 while you were providing care to 223-1? Yes
>
> I have a report that you were seen kissing the resident. Is that true – Yes
>
> Did she give you permission to kiss her? Yes
>
> What if the resident is not able to give permission? They tell me sad stories and I do that to cheer them up.
>
> Did you kiss 223-1 this morning Yes.
>
> . . . .
>
> . . . presented a list of residents on the 2nd floor so that staff can identify any resident staff had kissed overnight or in the past.
>
> [The Respondent] identified 222-1, 222-2, 224-1
>
> Would you consider it appropriate if you saw me kissing a resident? Yes if it is to lift them up.
>
> . . . .
>
> Do you wear your masks and face shield? I wear mask but not face shield all the time.
>
> For you to kiss a resident you must take off your mask and face shield. Did you take off you[r] mask and face shield to kiss the resident. Yes

7. The Respondent was charged with second degree assault in the District Court for Baltimore City, Maryland (Case Number 3B02431740). The case was subsequently transferred to the Circuit

Court for Baltimore City, Maryland (Case Number 821134002). On or about October 4, 2021, the Respondent pled guilty to, and received probation before judgment for second-degree assault, and was sentenced to one year of unsupervised probation and ordered to stay away from the Nursing Home and have no contact with the Resident.

8. According to the Application for Statement of Charges, dated December 15, 2020, written by an officer from the Baltimore City Police Department:

> On December 15, 2020 at approximately 8:41 am I responded to [the Nursing Home] for a complaint of a lewd act. Upon my arrival I spoke with the administrator of [the Nursing Home] who stated an employee, [Staff Member], had reported that she had seen another employee kissing a patient inside of her room. The employee was identified as Mr. Clarence Miller, and the patient was identified as [the Resident]. I spoke with [Staff Member], who advised that she had entered Room . . . at approximately 7:45 am and observed Mr. Miller sitting on [the Resident's] bed, leaning over her and kissing her face several times, and that it appeared that [the Resident] was holding her hands up as if to resist what Mr. Miller was doing. [Staff Member] stated that when she asked Mr. Miller what he was doing, he replied, "I don't know". [Staff Member] advised that she then reported what she had seen to the [Director of Nursing]. . . .
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> . . . [Staff Member] advised me it was at least 6 kisses to [the Resident's] face. [Staff Member] also advised [the Resident] had her hands up trying to stop Mr. Miller from kissing her. . . . [Staff Member] advised [the Resident] has a limited cognitive ability but that she comprehends enough to say yes or no to food. I attempted to speak with [the Resident], however she did not respond to my presence or attempted conversation with her. . . .

9. On December 17, 2021, the Board's investigator interviewed the Staff Member via telephone regarding the incident. During the interview the Staff Member reported the following:

a. She was told by another staff member that there were extra diapers in the dresser in the Resident's room.

b. When she entered the Resident's room it was dark.

c. She entered the Resident's room and walked straight to the dresser without realizing the Respondent was in the room.

d. After she had the diaper and was ready to leave the room she saw the Respondent sitting on the edge of the Resident's bed, leaning over the Resident, kissing the Resident's face area. The Staff Member said she could hear multiple kissing, pecking sounds.

Failure to Cooperate with the Board's Investigation

10. By letter dated March 15, 2021, sent to the Respondent's address of record, the Board notified the Respondent that the Maryland Board had received a complaint regarding the Respondent's practice. The Respondent was instructed to send a written response regarding the allegations to the Board within five days of receipt of the letter. The Respondent was informed that "[f]ailure to cooperate with a lawful investigation of the Board is a violation of the Nurse Practice Act (NPA) and could result in disciplinary action." The Board did not receive a written response.

11. On July 13, 2021, the Board issued a subpoena to the Respondent, via certified and regular mail, to the Respondent's address of record listed in the Board's database, commanding the Respondent to appear at the Board's offices on July 22, 2021 at 10:00 a.m. for an interview with the Board's investigator. The Respondent was further notified that "for failure to obey this summons . . . you may be subject to disciplinary action by the Board for failure to cooperate with a lawful investigation conducted by the Board." According to United States Postal Service tracking information, the certified letter was delivered on July 19, 2021. The Respondent failed to attend the interview.

12. On July 29, 2021, the Board's investigator spoke to the Respondent via telephone, at which time, the Respondent instructed the Board's investigator to send documents to a new address.[3] The Respondent also stated that he had an attorney.[4] The Respondent was informed to have his attorney send a letter of representation to the Board.

13. On November 18, 2021, the Board's investigator sent an email to the Respondent instructing the Respondent to contact the Board's investigator at his "earliest convenience" "relative to an interview." The Board's investigator did not receive a response from the Respondent.

14. On December 2, 2021, the Board issued a subpoena to the Respondent, via certified and regular mail, to the address listed for the Respondent on the criminal court's Application for Statement of Charges. The subpoena commanded the Respondent to appear at the Board's offices on December 16, 2021 at 10:00 a.m. for an interview with the Board's investigator. The Respondent was further notified that "for failure to obey this summons . . . you may be subject to disciplinary action by the Board for failure to cooperate with a lawful investigation conducted by the Board." According to United States Postal Service tracking information, as of October 27, 2022, the certified letter was still out for delivery, the letter sent by regular mail has not been

[3] Pursuant to Md. Code Ann., Health Occ. § 8-6A-08(j)(1) all certificate holders are required to "[w]ithin 60 days after a change has occurred . . . notify the Board in writing of any change in a name or address." The Board file does not indicate that the Respondent notified the Board in writing of a change of address.

[4] The Board's investigator received an email dated August 4, 2021, from an attorney (the "Attorney") reporting "my office has been retained to represent [the Respondent] in Baltimore City Circuit Court Case No. 821134002. [The Respondent] reached out to let me know that you were looking to speak with him regarding this case. I would be happy to answer any questions you have, so please let me know when would be a good time!" Then, on November 17, 2021, the Board's investigator received another email from the Attorney stating, "So sorry for the delay in getting back to you. Regarding the Board's investigation pertaining to [the Respondent], I did reach out to [the Respondent] and his family a few months back to inquire if they would like to retain our office to represent him in that matter, and I did not receive a response. As of today, we have only been retained to represent [the Respondent] in the criminal case against him, which has since been closed."

returned. The Respondent failed to attend the interview.

15. The Respondent was caught kissing one of his vulnerable residents. When questioned about it by the Nursing Home, the Respondent admitted that he did kiss the Resident. The Respondent further admitted that he had kissed several other residents and tried to justify his actions by stating that the residents tell him "sad stories" and he tries to "cheer them up." The Respondent further admitted to removing his face mask in order to kiss the Resident's face. The Respondent subsequently pled guilty to second-degree assault. The Respondent's practice shows a pattern of behavior that places clients under his care in danger and his continued practice constitutes a danger to the public health, safety, and welfare.

CONCLUSION OF LAW

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

ORDER

It is hereby:

ORDERED that pursuant to the authority vested in the Board of Nursing by Maryland Code Ann., State Govt. § 10-226(c)(2) (2021 Repl. Vol.) the certificate of **CLARENCE MILLER** to practice as a Certified Nursing Assistant/Geriatric Nursing Assistant in the State of Maryland is hereby **SUMMARILY SUSPENDED**; and be it further

ORDERED that there will be a Show Cause Hearing on **December 14, 2022 at 1:00 p.m.** before the Board at the Maryland Board of Nursing offices, 4140 Patterson Avenue, Baltimore, Maryland 21215: and be it further

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

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

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

ORDERED that this, "Order for Summary Suspension of Certified Nursing Assistant/Geriatric Nursing Assistant Certificate" is a **PUBLIC RECORD** pursuant to Md. Code Ann., General Provisions § 4-101 *et seq*. & § 4-333 (2019).

November 7, 2022
Date

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

Maryland Board of Nursing