IN THE MATTER OF	*	**BEFORE THE STATE**
MARIAN ELIZABETH SINCLAIR, LCSW-C	*	**BOARD OF SOCIAL WORK**
Respondent	*	**EXAMINERS**
License Number: 07149	*	**Case No. 2014-1942**

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CHARGES UNDER THE MARYLAND SOCIAL WORK ACT

The Maryland Board of Social Work Examiners (the "Board") hereby charges, **MARIAN ELIZABETH SINCLAIR, LCSW-C (the "Respondent"), License Number 07149**, with violating the Maryland Social Workers Act (the "Act") codified at Md. Code Ann., Health Occupations ("Health Occ.") §§ 19-101 *et seq.* (2014 Repl. Vol.) and Code Md. Regs. ("COMAR"), tit. 10, § 42.03.01 *et seq.*

The pertinent provision of the Act provides the following:

H.O. § 19-311. Denials, reprimands, suspensions, and revocations - Grounds.

Subject to the hearing provisions of §19-213 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;

(6) Violates any provision of this title or regulations governing the practice of social work adopted and published by the Board;

(20) Fails to maintain adequate patient records; [and]

(21) Fails to comply with the maintenance, disclosure, and destruction of medical records as required under Title 4, Subtitles 3 and 4 of the Health-General Article[.]

The pertinent provisions of COMAR provide the following:

COMAR 10.42.03.03 Responsibilities to Clients.

A. The licensee shall:

(5) Maintain documentation in the client's record which:

(b) Accurately reflects the services provided, including treatment plans, treatment goals, and contact notes;

(c) Indicates the time and date the services were provided; [and]

(e) Is sufficient and timely to facilitate the delivery and continuity of services to be delivered in the future;

COMAR 10.32.03.06. Standards of Practice.

A. Professional Competence. The licensee shall:

(1) Limit practice to the areas in which the licensee has gained proficiency through education, training, and experience; [and]

(7) Document and maintain appropriate records of professional service, supervision, and research work[.]

ALLEGATIONS OF FACT[1]

The Board bases its charges on the following facts that the Board has reason to believe are true:

I. Background

1. The Respondent was initially licensed to practice clinical social work on November 18, 1991. Her license is non-renewed having expired on October 31, 2015.

[1] The statements of the Respondent's conduct with respect to the matters identified herein are intended to provide the Respondent with notice of the alleged charges. They are not intended as, and do not necessarily represent, a complete description of the evidence, either testimonial or documentary, to be offered against the Respondent in connection with these charges.

2. The Respondent's license was previously reprimanded in 2007 after it came to the Board's attention that she practiced social work without a license from November 1, 2003 until July 17, 2007. The Respondent was also fined $1000.

3. At all times relevant, the Respondent was practicing clinical social work at Clinic A, a non-profit mental health clinic, with locations in Centreville, Cambridge and St. Michaels, Maryland. The Respondent was working at the St. Michaels location.

4. The Respondent was hired as a full-time therapist at Clinic A on July 13, 2010.

II. Current Allegations

5. On or about April 7, 2014, the Board received a complaint from the Clinical Director ("the complainant") of Clinic A regarding the Respondent's practice. According to the complaint, the Respondent was terminated from her employment at Clinic A after admitting to unlocking the drug cabinet and dispensing an undetermined quantity of prescription drug samples to a client ("Client A"). The Respondent did not document dispensing medication to the client. In addition, the complaint states that Clinic A conducted a peer review of the Respondent's client records and found that documentation was missing or incomplete.

6. Thereafter, the Board initiated an investigation.

Unauthorized Dispensing of Medication

7. On October 22, 2014, Board staff interviewed Employee A, an administrative assistant at Clinic A. According to Employee A, on February 19, 2014, she observed the Respondent, Client A, and another therapist, Employee B, walking down the hall. Employee A stated that the Respondent entered Employee A's office

and obtained a set of keys from Employee A's desk. The keys opened the door to another office with which Clinic A shares space. When the Respondent returned, she was carrying "an armful of white boxes," which Employee A believed to be medication samples.

8. At the time, there were no medical practitioners present onsite at Clinic A.

9. According to Employee A, the Respondent gave the boxes to Client A.

10. Employee A reported her observations to her direct supervisor, Employee C, the Finance Director of Clinic A.

11. On March 4, 2014, the Respondent was notified that her employment at Clinic A was suspended pending an investigation.

12. On March 4, 2014, the Respondent met with Employee C as part of Clinic A's investigation. During the meeting, the Respondent admitted to giving sample medication to Client A. Specifically, the Respondent stated that she gave a 12-day supply of Seroquel XR 300mg[2] to Client A.

13. The Respondent failed to document in the chart having given Client A medication samples.

14. A review of Client A's chart revealed that Client A had an appointment with Employee B on February 19, 2014. The Respondent was not Client A's therapist.

15. Employee B documented that Client A "reports taking medication as prescribed. Client reports her Seroquel prescription was denied at Rite Aid because of preauth. Therapist sent prescriber an email notifying her of situation."

16. A review of Client A's Medication Record revealed that on February 18, 2014, a nurse practitioner ("Employee D") prescribed Seroquel XR 400mg to Client A.

[2] Seroquel is...

17. On or about December 10, 2014, the Board's investigator interviewed the Respondent. The Respondent stated that she "had permission from both the psychiatrist and the nurse practitioner who worked in the office to dispense medication samples to patients who were--had standing orders."[3] The Respondent further stated that she "just needed to document it in the chart and have it co-signed by the prescriber the next time they were in the office[.]"

18. The Respondent stated that Client A approached her on February 19, 2014 and asked for medication samples. According to the Respondent, the providers at Clinic A had been giving Client A samples of her medication regularly because they were having difficulty getting Medicaid to authorize the prescription.

19. The Respondent further stated that she asked Employee A to pull Client A's chart so the Respondent could document the medication samples. However, the Respondent stated that she became busy with another client and forgot to document giving Client A medication samples.

20. The Respondent also stated that she had previously given Client A medication samples "two or three times" and always documented in Client A's chart.

21. A review of Client A's medication record revealed documentation by other practitioners, but not the Respondent.[4]

22. The Respondent's personnel file includes email correspondence between Employee B and Employee D regarding Client A's need for medication. Employee B notified Employee D that the Respondent gave Client A samples of her medication.

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[3] At the time of this incident, the psychiatrist was no longer employed at Clinic A.
[4] Client A's chart reflected other instances when medical practitioners dispensed samples on multiple occasions.

23. Employee D emailed the complainant expressing concern about the Respondent's practice of dispensing medication samples to clients. Employee D was concerned regarding whether Client A was receiving the correct medication, dosages, instructions and whether proper documentation was completed.

24. On March 4, 2014, Clinic A notified the Respondent that her employment was suspended pending an investigation into her conduct.

Documentation Deficiencies

25. On or about March 4, 2014, Clinic A conducted a peer review of the Respondent's charts.

26. The peer review revealed many deficiencies in the Respondent's charts, including but not limited to:

a. Missing identifying information on contact notes;

b. Treatment plans were incomplete

c. Treatment plans were not updated;

d. Disability forms were completed for clients without proper releases provided;

e. Clients seen multiple times on the same day;

f. Missing custody documents or noted contact with second parent;

g. Case load was not updated to reflect administrative discharges;

27. On November 18, 2015, the Board's investigator conducted an interview of Employee E, a social worker at Clinic A who conducted the peer review of the Respondent's client charts.

28. According to Employee E, the Respondent's documentation was poor. Employee E further stated that the Respondent had been asked on multiple occasions or over a year to bring her charts into compliance.[5]

29. The Respondent's personnel file also contained a review of the Respondent's client charts dated August 23, 2013.

30. The August 23, 2013 chart review identified the following deficiencies:

a. Missing social security numbers;

b. Missing diagnosis;

c. Duration of visit not recorded;

d. Missing current authorization forms;

e. Missing information on activity log; and

f. Inconsistent coding.

31. On March 11, 2014, the Respondent was notified that her employment was terminated due to her "unauthorized handling of medications and to ongoing issues related to documentation."

32. The Respondent's conduct, as described above constitutes, in whole or in part, a violation of H.O. §§ 19-311(4) and/or (5) and/or (6) and/or (20) and/or (21), as well as COMAR 10.42.03.03A(5)(b) and/or (5)(c) and/or (5)(e) and/or COMAR 10.42.03.06A(1) and/or (7).

[5] The Respondent's August 2012 performance evaluation states that the Respondent was deficient in completing individual treatment plans (ITP). The Respondent's December 2013 performance evaluation states that the Respondent must continue to address timely completion of ITPs and outcome measurement scales (OMS).

NOTICE OF POSSIBLE SANCTIONS

If, after a hearing, the Board finds that there are grounds for action under H.O. §§ 19-311(4) and/or (5) and/or (6) and/or (20) and/or (21), as well as COMAR 10.42.03.03A(5)(b) and/or (5)(c) and/or (5)(e) and/or COMAR 10.42.03.06A(1) and/or (7), the Board may impose disciplinary sanctions against the Respondent's license, including revocation, suspension, or reprimand, and may place the Respondent on probation, and/or may impose a monetary fine under §19-311.1.

NOTICE OF CASE RESOLUTION CONFERENCE

A case resolution conference in this matter has been scheduled for **Tuesday, June 21, 2016 at 10:00 a.m.** in Room 105 at the Board's office, 4201 Patterson Avenue, Baltimore, Maryland 21215. The nature and purpose of the case resolution conference are described in the attached letter to the Respondent.

If the case cannot be resolved at the case resolution conference, a hearing in this matter will be scheduled either at the Board's office at 4201 Patterson Avenue, Baltimore, Maryland 21215 or at the Office of Administrative Hearings, Administrative Law Building, 11101 Gilroy Road, Hunt Valley, Maryland 21031. The hearing will be conducted in accordance with § 19-312 of the Act and Md. State Gov't. Code Ann. § 10-201 *et seq.* (2014 Repl. Vol.).

5/13/2016
Date

Mark Lannon, LCSW-C, Board Chair
State Board of Social Work Examiners