IN THE MATTER OF	*	**BEFORE THE MARYLAND**
GARY KERKVLIET, M.D.	*	**STATE BOARD OF**
Respondent	*	**PHYSICIANS**
License Number: D45708	*	**Case Number: 2224-0022B**

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CONSENT ORDER

On November 12, 2024, Disciplinary Panel B ("Panel B") of the Maryland State Board of Physicians (the "Board") charged **GARY KERKVLIET, M.D.** ("the Respondent"), License Number D45708, under the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. §§ 14-101 *et seq.* (2021 Repl. Vol. and 2023 Supp.).

Specifically, Panel B charged the Respondent with violating the following statutory and regulatory provisions:

Health Occ. § 14-404. Denials, reprimands, probations, suspensions, and revocations – Grounds.

(a) *In general.* -- Subject to the hearing provisions of § 14-405 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum of the disciplinary panel, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:

(3) Is guilty of:

(ii) Unprofessional conduct in the practice of medicine;

. . .

(11) Willfully makes or files a false report or record in the practice of medicine; . . .

(43) Except for the licensure process described under Subtitle 3A of this title, violates any provision of this title, any rule or

> regulation adopted by the Board, or any State or federal law pertaining to the practice of medicine[.]

Title 42 of the Code of Federal Regulations, § 483.30(b) provides:

> A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. . . .
>
> (b) Physician visits. The physician must—
>
> (1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section;
>
> (2) Write, sign, and date progress notes at each visit; and
>
> (3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.

On January 29, 2025, Panel B was convened as a Disciplinary Committee for Case Resolution ("DCCR") in this matter. Based on negotiations occurring as a result of this DCCR, the Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law, Order, and Consent.

FINDINGS OF FACT

Panel B finds:

I. BACKGROUND

1. At all relevant times, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent originally was licensed to practice medicine in Maryland on February 8, 1994, under License Number D45708. The Respondent's license is current through September 30, 2026.

2. The Respondent currently has no board certifications.

3. The Respondent worked as the Medical Director of a long-term care and nursing home facility ("Facility A") in Baltimore County, Maryland from September 1, 2022 until his termination on July 10, 2023[1]. From on or about February 1, 2023 until June 30, 2023, the Respondent also served as the attending physician for 31 residents located on a unit (the "Unit") of Facility A.

4. At all relevant times, Facility A was owned by a health care corporation ("Entity A") that operates Facility A, a hospital and a network of community health centers.

A. Disciplinary History

5. On July 27, 2018, the Respondent entered into a public Consent Order with the Board wherein he was reprimanded, placed on probation for a minimum of three years, prohibited from prescribing opioid medications except in emergency cases, prohibited from certifying patients for the medical use of Cannabis, successfully complete courses in opioid medication prescribing and medical documentation, and concluded as a matter of law that the Respondent failed to meet standards as determined by appropriate peer review for the delivery of quality medical care in violation of Health Occ. § 14-404(a)(22), and failed to keep adequate medical records as determined by peer review in violation of Health Occ. § 14-404(a)(40). Specifically, the Board opened an investigation and ordered a

[1] To ensure confidentiality and privacy, the names of individuals and entities involved in this case, are not disclosed in this Consent Order.

practice review after receiving a complaint that the Respondent prescribed to a controlled substances-dependent patient excessive doses of opioids and benzodiazepines.

6. On March 13, 2017, Panel B charged the Respondent with engaging in unprofessional conduct in the practice of medicine in violation of Health Occ. § 14-404(a)(3)(ii) after investigating a complaint that the Respondent had self-prescribed medications. The Board's investigation revealed that the Respondent had prescribed 17 different medications to himself and 11 different medications to a family member. On September 5, 2017, the Respondent entered into a public Consent Order with the Board to resolve the charges under the terms of which he was reprimanded.

II. THE COMPLAINT

7. The Board initiated an investigation of the Respondent after receiving a Mandated 10-Day Report (the "Report") from Facility A on July 21, 2023. The Report stated the Respondent involuntary resigned from employment at Facility A "while the subject of an inquiry, under investigation, or threat of investigation."

III. BOARD INVESTIGATION

8. As part of its investigation, Board staff conducted under-oath interviews with eight employees of Facility A and/or Entity A as well as the Respondent, received a written response from the Respondent, obtained the Respondent's Quality Assurance/Risk Management file from Facility A, received staffing lists from Facility A, obtained complete medical records for two patients ("Patient 1" and "Patient 2") at Facility A, and obtained the Respondent's Prescription Drug Monitoring Program Report.

9. The investigation revealed that on or about September 1, 2022, the Respondent became the medical director of Facility A.[2] Beginning February 1, 2023, the Respondent also assumed attending physician responsibilities for approximately 30 patients on a Unit located at Facility A.

10. At all relevant times, it was the policy of Facility A for the attending physician personally to visit each patient every 30 days and document the encounter in the patient's electronic medical record ("EMR").

11. In July 2023, it was reported to the nursing home administrator of Facility A that between February 2023 to June 2023, the Respondent was not in compliance with conducting monthly patient visits and documenting the encounters in the EMR. Based on this information, the nursing home administrator ordered an investigation.

12. Facility A's investigation revealed that "31 of the current medical records for the residents under the care of Dr. Kerkvliet were found to be out of compliance with the routine monthly visits as evidenced by lack of a completed Physician Progress Note. An additional 8 records of discharged residents were found to be out of compliance." Facility A's investigation concluded that "Dr. Kerkvliet failed to meet the requirements for timely physician visits as evidenced by late or missing physician progress notes."

13. On or about July 5, 2023, Facility A interviewed the Respondent as part of its investigation. After the interview, the Respondent made late entry notes in some patients' electronic medical records based on notes from purported earlier visits that were

[2] The responsibilities of a medical director are set forth in the Code of Maryland Regulations, 10.07.02.16.

reportedly being maintained in the form of Word documents on Dr. Kerkvliet's computer. The Respondent was unable to produce the Word documents pertaining to the earlier patient visits immediately upon request by Facility A.

14. Facility A's investigation also discovered that the Respondent documented that he visited Patient 1 and Patient 2 prior to their transfer to the Unit.

15. The Respondent documented that he evaluated Patient 1 on the Unit on March 24, 2023, April 24, 2023, May 22, 2023 and June 24, 2023. However, Patient 1 was not admitted to the Unit for which the Respondent was responsible until June 5, 2023, and was seen weekly by another physician at Facility A up until the transfer to the Unit.

16. Patient 2 was transferred to the Unit for which the Respondent was responsible on March 24, 2023. Another physician at Facility A has notes documenting care of Patient 2 up until March 22, 2023. However, the Respondent documented in the EMR on July 3, 2023 that he visited Patient 2 on February 19, 2023; documented in the EMR on April 30, 2023 that he visited Patient 2 on February 20, 2023; documented in the EMR on July 5, 2023 that he visited Patient 2 on April 18, 2023; documented in the EMR on July 5, 2023 that he visited Patient 2 on May 18, 2023; and documented in the EMR on July 6, 2023 the he visited Patient 2 on June 21, 2023.

17. In his written response, the Respondent stated he "visited the unit at least once monthly from February-June 2023 during which time he evaluated and/or checked progress for each of the 30 residents on the unit." The Respondent acknowledged he failed "to maintain adequate medical records for the inpatient residents on his assigned unit." The Respondent stated "his role as Medical Director became increasingly stressful at times,

overwhelming due to the myriad of administrative and clinical responsibilities, most of which he did not appreciate or anticipate when he first accepted the position of Medical Director." The Respondent stated the "EMR system used to document inpatient resident progress, was unfamiliar and unwieldly." The Respondent explained that once "he got behind in his records, he was unsure how to catch up, and ultimately, that error became a vicious cycle."

18. In his interview, the Respondent stated it was his understanding that he was expected to visit patients on the Unit every other month. The Respondent stated that he in fact did personally visit all patients on the unit in February 2023 and April 2023. The Respondent stated that June 2023 was "overwhelming" and a "disaster" and he only was able to visit 4-5 patients on the Unit.

19. The Respondent stated that when he did visit patients on the Unit, he primarily would make handwritten notes with the intention "to get them into Word" so he "could copy and paste it right into the" EMR. However, and as confirmed by Facility A's investigation, the Respondent failed to contemporaneously enter patient encounters in the EMR. The Respondent admitted in his interview that 90 patient notes were missing in the EMR spanning over three months.

20. In July 2023, when asked by Facility A to produce his handwritten notes and/or Word documents of patient visits, the Respondent stated he "couldn't find them" and did not "know where they were at the moment."

21. The Respondent did not bill for any patient visits between February 2023 to June 2023.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, Disciplinary Panel B concludes as a matter of law that the Respondent: is guilty of unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)3)(ii). Panel B dismisses the charges under Health Occ. §§ 14-404(a)(11) and (43).

ORDER

It is thus, on the affirmative vote of a majority of the quorum of Panel B, hereby:

ORDERED that Respondent is **REPRIMANDED**; and it is further

ORDERED that the Respondent is placed on probation[3] until he complies with the following probationary terms and conditions:

1. The Respondent is required to take and successfully complete two courses: (i) a board-approved course in record-keeping; and (ii) a board-approved course in medical ethics. The following terms apply:

   (a) it is the Respondent's responsibility to locate, enroll in and obtain the disciplinary panel's approval of the course before the course has begun;

   (b) the Respondent must provide documentation to the disciplinary panel that the Respondent has successfully completed the course;

   (c) the course may not be used to fulfill the continuing medical education credits required for license renewal;

   (d) the Respondent is responsible for the cost of the course.

[3] If the Respondent's license expires during the period of probation, the probation and any conditions of probation, will be tolled.

2. The Respondent shall pay a civil fine of **FIVE THOUSAND DOLLARS ($5,000.00).** The Payment shall be by money order or bank certified check made payable to the Maryland Board of Physicians and mailed to P.O. Box 37217, Baltimore, Maryland 21297. The Board will not renew or reinstate the Respondent's license if the Respondent fails to timely pay the fine to the Board; and it is further

ORDERED that the Respondent shall not apply for early termination of probation; and it is further

ORDERED that a violation of probation constitutes a violation of the Consent Order; and it is further

ORDERED that after the Respondent has complied with all terms and conditions of probation, the Respondent may submit to the Board a written petition for termination of probation. The Respondent may be required to appear before the disciplinary panel to discuss his petition for termination. After consideration of the petition, the disciplinary panel may grant the petition to terminate the probation, through an order of the disciplinary panel, if the Respondent has complied with all probationary terms and conditions and there are no pending complaints relating to the charges; and it is further

ORDERED that if the Respondent allegedly fails to comply with any term or condition imposed by this Consent Order, the Respondent shall be given notice and an opportunity for a hearing. If the disciplinary panel determines there is a genuine dispute as to a material fact, the hearing shall be before an Administrative Law Judge of the Office of Administrative Hearings followed by an exceptions process before a disciplinary penal; and if the disciplinary panel determines there is no genuine dispute as to a material fact,

the Respondent shall be given a show cause hearing before a disciplinary panel; and it is further

ORDERED that after the appropriate hearing, if the disciplinary panel determines that the Respondent has failed to comply with any term or condition imposed by this Consent Order, the disciplinary panel may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, or suspend with appropriate terms and conditions, or revoke the Respondent's license to practice medicine in Maryland. The disciplinary panel may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine on the Respondent; and it is further

ORDERED that the Respondent is responsible for all costs incurred in fulfilling the terms and conditions of this Consent Order; and it is further

ORDERED that the effective date of the Consent Order is the date the Consent Order is signed by the Executive Director of the Board or her designee. The Executive Director or her designee signs the Consent Order on behalf of the disciplinary panel which has imposed the terms and conditions of this Consent Order; and it is further

ORDERED that this Consent Order is a public document. See Health Occ. §§ 1-607, 14-411.1(b)(2) and Gen. Prov. § 4-333(b)(6).

02/25/2025
Date

Signature On File

Christine A. Farrelly, Executive Director
Maryland State Board of Physicians

CONSENT

I, Gary Kerkvliet, M.D., acknowledge that I have consulted with counsel before signing this document.

By the Consent, I agree to be bound by this Consent Order and all its terms and conditions and understand that the disciplinary panel will not entertain any request for amendments or modifications to any condition.

I assert that I am aware of my right to a formal evidentiary hearing, pursuant to Md. Code Ann., Health Occ. 14-405, and Md. Code Ann., State Gov't 10-201 *et seq.* concerning the pending charges. I waive this right and have elected to sign this Consent Order instead.

I acknowledge the validity and enforceability of this Consent Order as if entered 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 behalf, and to all other substantive and procedural protections as provided by law. I waive those procedural and substantive protections. I acknowledge the legal authority and the jurisdiction of the disciplinary panel to initiate these proceedings and to issue and enforce this Consent Order.

I voluntarily enter into and agree to comply with the terms and conditions set forth in the Consent Order as a resolution of the charges. I waive any right to contest the Findings of Fact and Conclusions of Law and Order set out in the Consent Order. I waive all rights to appeal this Consent Order.

I sign this Consent Order, without reservation, and fully understand the language and meaning of its terms.

Signature On File

2-22-2025
Date

Gary Kerkvliet, M.D.

NOTARY

STATE OF Maryland.

CITY/COUNTY OF Baltimore,

I HEREBY CERTIFY that on this _____ day of _____ 2025, before me, a Notary Public of the foregoing State and City/County, personally appeared Gary Kerkvliet, M.D., and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed.

AS WITNESSETH my hand and notarial seal.

RAJAN SUNAR NOTARY PUBLIC EXPIRES: 12/02/2028 BALTIMORE COUNTY, MD

_____

Notary Public

My Commission expires: 02-12-2028