Circuit Court for Baltimore City
Case No. 24-C-23-003276

UNREPORTED*

IN THE APPELLATE COURT

OF MARYLAND

No. 0656

September Term, 2024

IN THE MATTER OF THE PETITION OF
KHADIDIA DIAW

Berger,
Nazarian,
Ripken,

JJ.

Opinion by Nazarian, J.

Filed: March 6, 2026

* This is an unreported opinion. This opinion may not be cited as precedent within the rule of stare decisis. It may be cited for persuasive value only if the citation conforms to Maryland Rule 1-104(a)(2)(B).

After finding that Khadidia Diaw had violated the Maryland Nurse Practice Act (the "Act"), the State Board of Nursing (the "Board" or "agency") revoked her license to practice as a licensed practical nurse ("LPN") and her certificate to practice as a certified nursing assistant/geriatric nursing assistant/certified medicine aid ("nursing certificate") for a minimum of two years, denied her application for a registered nurse ("RN") license for a minimum of three years, imposed a monetary penalty of $2,000.00, and required Ms. Diaw to complete six practical courses. She petitioned the Circuit Court for Baltimore City for judicial review of the Board's final decision. During those proceedings, the circuit court quashed her subpoenas for audio recordings of the administrative hearing, denied her request to have the hearing in person, and affirmed the agency's decision. Ms. Diaw appeals each ruling and we affirm.

I. BACKGROUND

In April 2020, Ms. Diaw worked as an LPN in a skilled nursing facility (the "Facility") in Baltimore County. On April 19, 2020, one of the patients under her care was a paraplegic long-term care resident who had tested positive for COVID-19 a few days earlier (the "Patient"). In March 2019, the Patient had completed a Maryland Medical Orders for Life-Sustaining Treatment form ("MOLST")[1] and elected to receive CPR in the event of cardiac and/or pulmonary arrest, reflecting a "full code" status in his medical record. Additionally, his MOLST ordered the Facility to send him to the hospital if he

[1] A MOLST is a medical order that directs emergency medical services ("EMS") and other medical personnel on a patient's life-sustaining treatment choices, including the use of cardiopulmonary resuscitation ("CPR").

presented "severe symptoms that [couldn't] be controlled." The Patient was involved in his own care planning meetings and had shared his preference to receive "aggressive care at all costs" on April 17, 2020, during a telemedicine appointment with his primary care provider, Optum.[2] At that time, his provider considered him low risk for needing intubation or an Intensive Care Unit ("ICU") level of care or for dying from COVID-19, found him capable of "nuanced medical decision making," went over his MOLST, and discussed his COVID-19 diagnosis, care goals, and hospitalization preferences with him:

> - Focus on aggressive care at all costs. The Patient has been informed that aggressive care plan is a time limited trial, with reassessment at regular intervals for success or failure of the treatment plan[.]
> - Patient WOULD want to be *moved to the ICU* if clinically worsens.
> - Patient WOULD want a breathing tube (intubation) if breathing worsens.
> - Patient WOULD want vasopressors in the event of very low blood pressure (shock).
> - Patient WOULD want CPR if their heart stopped working.

On the morning of April 19, the Patient exhibited signs of "delirium" and a "change in mental status." The Facility called his sister, his authorized contact in case of illness, emergency, or death,[3] and she instructed them to treat him "in-house" instead of sending him to the emergency room. The Facility called Optum, which ordered x-rays, bloodwork,

[2] Optum is an outside agency that staffs the Facility with contracted doctors and nurse practitioners.

[3] The Patient's medical record didn't contain formal documentation that his sister had legal authority to act as his healthcare power of attorney and the Facility's records didn't identify her as that type of contact.

and additional monitoring and medical interventions. That afternoon around 4:00 p.m., the Patient's geriatric nursing assistant ("Ms. A") told Ms. Diaw his blood pressure was low. Around 5:00 p.m., Ms. A observed the Patient breathing slowly; as she left to get Ms. Diaw, she walked into his room. Ms. A left to resolve a dispute between two other residents and didn't return.

Ms. Diaw reported the following account of events: After Ms. A told her the Patient's blood pressure was low, she checked and found his vitals normal. At 5:01 p.m., she entered his blood pressure reading into his record. Around that time she returned to his room and found him breathing but unresponsive. She tried to rouse him by rubbing ice cubes on his chest. When he still didn't respond, she called the nurse educator and shift supervisor ("Ms. F") and asked her to look at him. Ms. F told her to call Optum because her shift had ended and she was leaving. Ms. Diaw left his room to call Optum from the nurse's station, but they kept her on hold for fifteen to twenty minutes. While on hold, she did some recordkeeping on the computer. She didn't call 911. Optum answered and told her to recheck his blood sugar. When she went back to his room around 5:25 p.m., he wasn't breathing. Ms. Diaw left his room to get her stethoscope, and while walking she called Ms. F and the Director of Nursing ("Ms. J") and other nurses for assistance before going back to his room and assessing him further at 5:33 p.m. She didn't detect a pulse and asked an RN who was on site ("Ms. L") to come and verify the absence of pulse and respiration. Ms. F came back to the Facility around 5:30 p.m. and they performed CPR on him.

An hour later, at 6:25 p.m., someone called 911. Paramedics with the Baltimore County Fire Department arrived at 6:35 p.m., detected no respiratory sounds, and pronounced the Patient dead. The Facility terminated Ms. Diaw's employment for gross misconduct.

A. Board Proceedings

On April 30, 2020, the Board received a complaint from Ms. J alleging that Ms. Diaw had failed to follow Facility protocols for a patient with "full code" status. The complaint included his MOLST, written statements from Ms. Diaw and three other employees, and the Facility's Cardiac and/or Respiratory Arrest policy. After its investigation, the agency notified Ms. Diaw of its intent to summarily suspend her LPN license and scheduled a pre-deprivation show cause hearing. After the hearing, the Board suspended her LPN license outright in the interests of the public health, safety, and welfare and afforded her an opportunity to request an evidentiary hearing before the agency on the merits of the summary suspension order. The Board issued two charging documents as well. The *first* charged Ms. Diaw's LPN license and nursing certificate with violations of the Act, including acting in a manner that was "inconsistent with [the] generally accepted professional standards" for LPNs, engaging in conduct that violated the professional code of ethics, failing to know and comply with Facility procedures, and doing so while holding an expired or lapsed nursing certificate. The *second* charging document denied Ms. Diaw's application for an RN license based on the same alleged violations. Both documents notified her of the opportunity to request an evidentiary hearing before the agency. In

response to her hearing request, the Board heard the matter on November 16 and December 13, 2022.

Ms. Diaw, her counsel, and agency counsel appeared before a quorum of the Board for a hearing on the charges, the initial denial, and the summary suspension order. Ms. J testified about the Facility's cardiac and respiratory arrest procedure. Under that policy, if a full code patient experiences arrest while alone, staff must assess the patient for certain "obvious clinical signs of irreversible death," and if there are none, staff must initiate CPR, employ Automated External Defibrillators ("AED"), and contact emergency services. Staff must "[c]all for assistance, alert the licensed nurse and CPR, [AED] certified staff, prepare the patient for CPR, AED while determining the presence of a do not resuscitate [("DNR")] order." They must designate someone to record the events in a CPR/AED "flow sheet," which becomes part of the patient's medical record. They must continue to give CPR until either the patient resumes breathing, they discover a DNR, they transfer care to EMS, the patient is pronounced dead, or the rescuer is unable to continue CPR because of exhaustion, dangerous hazards in the environment, or because doing so would place another in jeopardy. The purpose of the policy is to "ensure [the] patient's wishes are followed in the event of cardiac arrest." Additionally, staff must record when they found the patient without a pulse and spontaneous respirations, any significant clinical events preceding the arrest, the patient's DNR status, the presence of any end-stage, terminal, or advanced medical conditions, a description of the patient's condition upon discovery, the reason for withholding CPR, and their notice to the patient's physician and family. The policy doesn't

apply when a patient is breathing but unresponsive.

Ms. J testified about a note Ms. Diaw entered into the Patient's medical record on April 19 at 9:39 a.m. that didn't reflect his deteriorated condition. Ms. Diaw had documented that the Patient was alert, had no change or decline in mental status, was oriented to person, place and time, had "clear speech" and clear lung sounds. Nor did the Patient's medical record support her account of the vital checks she said she performed that day. Moreover, Ms. J explained that Ms. Diaw had been subject to a performance improvement plan two years earlier for failing to evaluate and document a change in condition for two patients.

Ms. J testified about the investigation she conducted after the Patient's death. She had interviewed and received statements from other staff that had worked with Ms. Diaw on April 19, including Ms. F and Ms. S, another staff member who had attended to the Patient that morning. Board counsel submitted into evidence notes of an interview she had with Ms. Diaw on April 20. At that interview, Ms. Diaw told her and other members of the Facility's leadership team that she hadn't initiated CPR because she didn't think staff was supposed to perform CPR on COVID-positive patients. The Facility didn't have a different CPR policy for COVID residents.

Ms. L testified next. On April 19, she worked the 3:00 p.m.–11:00 p.m. shift. Early in her shift, Ms. Diaw asked her to confirm whether the Patient had died. She entered his room, checked him, and said he didn't have a pulse or respiration. Ms. L asked Ms. Diaw if they would be starting CPR, and Ms. Diaw told her there was "no code" for the Patient.

Ms. L told her to call his family, but she asked Ms. L to do it. Ms. L called the Patient's sister around 5:38 p.m.

Ms. F testified about her recollection from that day. She had worked from 9:00 a.m. to 5:00 p.m. in her weekend role as nurse administrator. That morning, Ms. Diaw asked her to come look at the Patient. Ms. F said that the Patient told her that he wasn't feeling well and that he was otherwise awake and alert. He received intravenous ("IV") fluids and the Facility sent out his bloodwork. Ms. F left the Facility when her shift ended. Around 5:30 p.m., Ms. Diaw told her over the phone that she thought the Patient "had passed." Ms. F told her to make sure and then to tell his family. She asked twice if Ms. Diaw had initiated CPR, but Ms. Diaw didn't answer. Ms. F didn't return to the Facility again that day. As a matter of practice, she said it was "preferable" for staff to perform compressions only on COVID-positive patients and avoid breathing into their mouths directly. Each crash cart had "ambu bags" that staff could use to perform artificial ventilation on a patient without risk of COVID exposure, and ambu bags are part of the CPR certification curriculum.

EMS paramedic Kathryn Smith testified about what she observed when she responded to the 911 call. No one was performing CPR or using AEDs on the Patient when she entered his room. He had lividity, which is when blood begins to pool and settle after someone has been in a position for an extended period without a pulse or heartbeat. His lividity met the criteria for pronouncement of death, and she did so at the scene.

The Board's nurse investigator, Sophia Mullins, testified about her investigative report and interviews of Ms. J, Ms. F, Ms. L, and the Facility's director ("Mr. R"). She had

obtained a lower appeals decision issued by the Maryland Department of Labor (the "Department") regarding Ms. Diaw's application for unemployment benefits. The Department had found that Ms. Diaw had told Mr. R that she hadn't initiated CPR on the Patient "because she was unsure of what to do in the COVID-19 pandemic." Mr. R told Ms. Mullins that Ms. Diaw said she didn't think she had to perform CPR because of the pandemic and because she wasn't properly trained for that. Ms. L said that when she asked if the Patient was full code, Ms. Diaw told her he had COVID and there was no CPR. Ms. J said she couldn't remember whether Ms. F had returned to the Facility or performed CPR on the Patient with Ms. Diaw. Ms. Mullins didn't find evidence that Ms. F had come back and given him CPR.

Ms. Mullins testified about her interview of Ms. Diaw. Ms. Diaw told her that she had checked the Patient's vitals around 4:00 p.m., but his medical record didn't show a vital check. On the morning of April 19, Ms. Diaw said the Patient was weak, lethargic, and wheezing audibly, but her documentation didn't match her observation. In an email dated November 11, 2021, Ms. Diaw indicated that she had performed CPR on the Patient. During their interview, she said that Ms. F came back to the Facility, they gave him CPR, and they stopped when the paramedics arrived. She didn't initiate CPR before that. The nursing note Ms. Diaw wrote after his death didn't state that anyone had performed CPR. Ms. Mullins couldn't find any documentation in the Patient's record of what happened between 5:00 p.m., when Ms. Diaw found him unresponsive, and 6:35 p.m., when EMS arrived. The Board rested its case.

Another LPN who worked on Ms. Diaw's floor that day testified briefly on her behalf. She saw Ms. F at the Facility sometime between 7:00 p.m. and 9:00 p.m., when she asked her to finish administering medications to Ms. Diaw's patients because Ms. Diaw had gone home.

Ms. Diaw testified on the second day of the hearing. When she arrived for her shift on April 19, she said, the outgoing nurse told her that the Patient had deteriorated and was having trouble breathing, but she saw him before 8:00 a.m. and he was still talking, drinking, taking medicine, and eating. Around 9:30 a.m., she asked Ms. F to check on him because he looked weak and wasn't his normal self. Ms. F called Optum, they put in orders, and Ms. Diaw began implementing them. She checked the Patient's blood sugar at noon and again at 4:00 p.m. and had no concerns. After Ms. A reported a concern about his blood pressure, she checked his vitals again and found them normal. When she returned to take his blood sugar, she found that he was unresponsive and breathing slowly. She called the nurse practitioner at Optum, they placed her on hold for about twenty minutes, and while on hold she worked on documentation and input the Patient's vital signs. When she returned, he looked like he had been deceased for several hours. She called other staff using her cell phone, set the Patient's bed to CPR mode, went out to the hallway, called out for help, and ran into Ms. L. They "all were in the room and started CPR," but didn't have the pads to use the AED machine. Ms. A brought AED pads from the first floor. Ms. Diaw did chest compressions, Ms. A applied the ambu bag, and Ms. F worked with the AED machine. After EMS relieved them, she started documenting the events, but then Ms. F

told her she had to leave.

On cross-examination, Board counsel questioned Ms. Diaw about her implementation of the Patient's orders. Ms. Diaw testified that she put the order for IV fluids in at 9:45 a.m. and started the fluids at 3:00 p.m. But at 12:45 p.m., she had initialed an order and indicated that the Patient's IV line had been put in and that he was ready for IV fluids. Ms. Diaw insisted she hadn't put the IV line in, someone else had, and her initials didn't mean that the Patient had his IV line in at 12:45, only that she had done "[her] part" and implemented the order at that time. She didn't put in the order to take the Patient's bloodwork until 12:30 p.m., even though Optum had ordered it at 9:30 a.m., or enter the orders to monitor his blood pressure, temperature, or respiration until 3:00 p.m. To explain the absence of any electronic record of the vital checks she said she performed early that morning, Ms. Diaw said she documented those checks on paper. She testified that she knew the Patient had a full code status.

The administrative record included statements from Ms. L, Ms. F, and Ms. A, all written immediately after the Patient died. Ms. A didn't report giving him CPR. Ms. F's statement didn't report giving him CPR either, only that Ms. Diaw notified her around 5:30 p.m. that she thought the Patient had passed, that Ms. F told her to make sure and call his family, and that she asked Ms. Diaw twice whether she initiated CPR with no response. Ms. L's statement recounted that Ms. Diaw asked her to come to the Patient's room to confirm that he had no pulse or respiration, then she asked about his code status, and Ms. Diaw told her he was "no code." The record included also Ms. Diaw's statement to Mr. R

the day after the Patient died. There, Ms. Diaw provided a detailed timeline of her interactions that didn't include giving him CPR, either alone or with Ms. A or Ms. F. And her nursing note of the incident, written at 6:57 p.m. on April 19, didn't mention CPR at all. Even so, in her testimony and statements to the Board, Ms. Diaw said that she, Ms. F, and Ms. A performed CPR on the Patient for forty-five minutes until EMS arrived.

Next, the Board asked Ms. Diaw questions. In response, she testified that she didn't call 911 when she found the Patient unresponsive; that when she came back and he wasn't breathing, she put the bed into CPR mode but didn't start CPR and left his room; and, at the time, her CPR certification was expired because she hadn't renewed it.

B. Board Decision

After the hearing, the Board issued a final decision and order dated June 12, 2023, that revoked Ms. Diaw's LPN license and nursing certificate and denied her application for an RN license. *First*, the Board found, by a preponderance of the evidence, that she had violated Md. Code (1981, 2021 Repl. Vol.), § 8-316(a)(8) of the Health Occupations Article ("HO") when (1) she left an unresponsive patient alone and unmonitored, failed to seek any onsite assistance, and didn't call 911; (2) failed to perform CPR on an unresponsive patient who had a full code status; and (3) failed to document a patient's condition fully and accurately in his medical record.[4] *Second*, the agency determined that Ms. Diaw violated the professional code of ethics and HO § 8-316(a)(25) by "failing to

[4] HO § 8-316(a)(8) allows the Board to revoke the practical nursing license of a licensee who acts in a manner "inconsistent with generally accepted professional standards" for the practice of licensed practical nursing.

assume responsibility and accountability for her individual nursing judgments and actions" and "engaging in unprofessional conduct."[5] *Third*, the Board concluded that her failure to demonstrate knowledge of and comply with Facility protocols when she didn't perform CPR on the Patient despite his full code status or document mandatory information about his cardiac/respiratory arrest violated HO § 8-316(a)(30).[6] *Fourth*, the agency found that the expiration of Ms. Diaw's nursing certificate violated HO § 8-6A-10(a)(26).[7] *And lastly*, the Board concluded that her conduct violated HO §§ 8-316(a)(10) and 8-6A-10(a)(20).[8] By a preponderance of evidence, the Bound determined also that summary suspension of Ms. Diaw's LPN license had been necessary to protect the public health, safety, and welfare and affirmed its summary suspension order.

The Board acknowledged that this incident happened at the beginning of the COVID-19 pandemic, a reality it took into consideration during the fact-finding process and its determination of appropriate sanctions. As an adjudicatory body comprised mainly of nurses, the agency expressed intimate understanding of the burdens, staffing shortages, and fears nurses faced during the pandemic. Still, the Board expressed extreme concern with Ms. Diaw's "substantial lack of honesty, accountability, and critical thinking, and her

[5] HO § 8-316(a)(25) authorizes the Board to revoke licensure for conduct that violates the professional code of ethics.

[6] HO § 8-316(a)(30) allows license revocation for violating Board regulations or orders.

[7] HO § 8-6A-10(a)(26) prohibits certificate holders from committing an act that would be grounds for disciplinary action while holding an expired or lapsed nursing certificate.

[8] Any violation of the Act can result in revocation of an LPN license, HO § 8-316(a)(10), or a nursing certificate. HO § 8-6A-10(a)(20).

gross departure from accepted practice standards" and her failure to demonstrate a capacity to acknowledge and learn from her mistakes.

Based on concerns of public health and safety, the Board concluded that Ms. Diaw's conduct warranted revocation of her LPN license and nursing certificate for a minimum of two years, denial of her application for an RN license for a minimum of three years, a monetary penalty, and an order to complete certain coursework before she can seek reinstatement of licensure. Ms. Diaw petitioned the Circuit Court for Baltimore City for judicial review of the agency's decision.

C. Circuit Court Proceedings

The circuit court scheduled a virtual hearing on Ms. Diaw's petition. Before the hearing, Ms. Diaw subpoenaed the Board's Executive Director, its attorney, and CRC Salomon, Inc.[9] to produce audio recordings of her administrative hearing. The Board filed a motion to quash the subpoenas issued to the agency. In the meantime, Ms. Diaw objected to having a virtual hearing and asked for it to happen in person "to alleviate burdens placed on [her]." The court didn't respond to her objection and issued a virtual hearing notice ten days later. Ms. Diaw filed a second objection, asserting that a remote hearing would burden her and that she had had a difficult time attending the last virtual hearing before the court. The court didn't respond.

A few days later, the parties appeared for their virtual hearing. As a preliminary matter, Ms. Diaw raised the issue of her subpoenas. She said she wanted to "supplement

[9] CRC Salomon, Inc. is the company that transcribed the hearing.

the record" with audio recordings of the administrative hearing because "the transcript had multiple errors in it." The Board argued that it was unclear what errors the transcripts contained given that the court reporting service had attested to them and that the Maryland Rules didn't allow her to supplement transcripts that were in the administrative record already. The court denied Ms. Diaw's request and quashed the subpoenas, reasoning that there was no apparent error in the transcripts, the court reporter attested to them being a true record of the proceedings, and the rules didn't allow it to supplement the record. Ms. Diaw asked to introduce evidence of the parties' pre-trial settlement discussions to show that the agency's decision was retaliatory. The Board objected, arguing that pre-trial settlement discussions are confidential. The Court agreed and denied her request.

Ms. Diaw presented oral argument and addressed questions from the court. She argued that the Board failed to consider that the Patient's death occurred at the onset of the pandemic, failed to conduct a thorough investigation, and failed to provide sufficient evidence that she was at fault for his death. She maintained that she couldn't have called 911 without a physician's order, despite the directives in the Patient's MOLST; that she couldn't have gotten help because there was no staff around; and that the agency's decision was too harsh. Counsel for the Board argued that substantial evidence supported the agency's findings; that Ms. Diaw was the only person to claim that she had performed CPR on the Patient but had admitted to not giving CPR originally; that there is no evidence to corroborate her story; and that the evidence contradicts her version of events directly, supporting the Board's determination that her testimony had lacked credibility.

During the Board's argument, Ms. Diaw's computer disconnected, causing the court to pause the proceedings until she returned. The court assured her that "as soon as [she] dropped off the call[,] [it] needed to stop the proceedings, so [she] didn't miss anything." At this point, she reiterated her objection to the hearing being held remotely. She asked to postpone the hearing so she could pursue the audio recordings, contesting the accuracy of Board counsel's description of her testimony. The court denied her request. Then she asked to postpone the hearing because she didn't have "good [internet] service" and was having trouble staying connected. The court said that it hadn't had any problem hearing her argument and resumed the hearing.

On April 24, 2024, the circuit court affirmed the Board's final decision. The court found the administrative record to "overwhelmingly demonstrate[]" substantial evidence for the agency's conclusion that Ms. Diaw committed "serious violations" of the Act. Based on the serious nature of those violations and the Board's adherence to its sanctioning guidelines, the circuit court was "unable to conclude that [its] sanctions were so extreme and egregious to be arbitrary and capricious." Ms. Diaw noted a timely appeal.

II. DISCUSSION

Ms. Diaw presents ten issues[10] on appeal which we rephrase and condense into two:

[10] Appellant phrased her Questions Presented as follows:

1. The Judge made his decision after a remote hearing was held on 4-16-24 that I objected to multiple times.

Continued . . .

first whether there is substantial evidence in the record to support the Board's final decision and imposition of sanctions; and *second*, whether the circuit court abused its discretion in proceeding with a remote hearing and quashing her subpoenas. We hold that the agency's action drew from substantial evidence and wasn't arbitrary or capricious and that the circuit

2. What is the point of holding the case SUB-while going over inaccurate information.
3. The MBON did not take into account the amount of stress we were under that led to OUR poor memory.
4. Why does the MBON need due deference when they can simply look at the evidence?
5. The MBON did not take into account the Covid-19 Pandemic.
6. After an administrative agency makes a decision it is almost impossible to have it overturned.
7. Does the MBON high level of deference also grant them psychic ability?
8. [T]he MBON took no evidence as evidence.
9. The MBON favors the people they have a relationship with.
10. Is it time for [l]aws governing [a]dministrative [a]genc[ies] [to] be changed?

The Board phrased its questions presented as follows:

1. Was the Board's [d]ecision based on substantial evidence in the record, which included all medical records associated with the patient in question, personnel and staffing records, numerous witness statements and Board interviews, and testimony before the Board?
2. Did the Board act within its discretion in imposing its sanctions after finding that Ms. Diaw violated six disciplinary grounds in the Nurse Practice Act, such that its sanctions were not "extreme and egregious"?
3. Did the circuit court act within its discretion when it held a remote hearing to hear oral argument on the petition for judicial review and when it quashed Ms. Diaw's subpoenas for audio recordings of the evidentiary hearing before the Board when the record is complete, there is no law authorizing the court to supplement the record with additional evidence, and there are no alleged material errors in the transcript?

court's rulings didn't abuse its discretion.

In general, our review of an administrative agency decision focuses on whether "'there is substantial evidence in the record as a whole to support [its] findings and conclusions . . . .'" *Maryland State Bd. of Nursing v. Sesay*, 224 Md. App. 432, 457 (2015) (*quoting Regan v. Bd. of Chiropractic Exam'rs*, 120 Md. App. 494, 508 (1998), *aff'd*, 355 Md. 397 (1999)). If a reasoning mind could reach the same conclusion as the agency based on the facts of record, the agency's decision rests on substantial evidence and we have no authority to overturn it. *Id.* (*citing Liberty Nursing Ctr., Inc. v. Dep't of Health & Mental Hygiene*, 330 Md. 433, 443 (1993)); *see Burke v. Md. Bd. of Physicians*, 250 Md. App. 334, 344 (2021) (Because it is the agency who resolves conflicting evidence, we presume its decision is valid and review it in the light most favorable to the agency. (*citing Maryland Aviation Admin. v. Noland*, 386 Md. 556, 571 (2005))). When an agency exercises its discretion to impose a sanction, we will disturb that decision only if it is arbitrary or capricious. *Mesbahi v. Md. State Bd. of Physicians*, 201 Md. App. 315, 330–31 (2011) (*citing Spencer v. Md. State Bd. of Pharmacy*, 380 Md. 515, 529 (2004)). That is a high bar, and we reverse only when an agency's action is "'extreme and egregious.'" *Board of Physician Quality Assurance v. Mullan*, 381 Md. 157, 171 (2004) (*quoting Maryland Transp. Auth. v. King*, 369 Md. 274, 291 (2002)). Lastly, questions about whether to hold virtual hearings or quash subpoenas are entrusted to the circuit court's judgment, and we review those decisions for abuse of discretion. *See* Md. Rule 21-201(a) (courts have the discretion to permit or require remote electronic participation); *Morrill v. Md. Bd. of*

Physicians, 243 Md. App. 640, 648 (2019) (*citing Unnamed Att'y v. Att'y Grievance Comm'n*, 409 Md. 509, 520 (2009)).

A. The Circuit Court Did Not Err In Affirming The Board's Decision Where Substantial Evidence Supported The Agency's Disciplinary Action And Board Guidelines Informed Its Determination Of Appropriate Sanctions.

Ms. Diaw asserts that the Board's investigation was incomplete and that she observed protocol when she didn't call 911. She suggests that the agency didn't consider sufficiently how the pandemic impaired staff's ability to meet patient needs; that it concluded wrongly that her documentation from that day was missing because she had testified to documenting via paper; and that even though her documentation practices and inconsistent statements were no different than those of her coworkers, the Board judged her credibility negatively due to bias. She maintains that she knew the Facility's procedures, but that no one knew how to proceed with the work, including performing CPR, during the pandemic, and that there was insufficient evidence for the agency to conclude that she hadn't performed CPR.

The Board asserts that substantial evidence supported its finding that Ms. Diaw failed to perform CPR on a patient with full code status and that no evidence corroborated her claim that she had done so. Despite her misgivings about the quality of the agency's investigation, it argues, Ms. Diaw had an opportunity to present evidence and subpoena witnesses to persuade the Board of her claims at the administrative hearing. The Board maintains also that substantial evidence supported its findings that she left an unresponsive patient alone, failed to seek onsite assistance, and didn't call 911. Finally, its conclusions

that Ms. Diaw failed to document the Patient's medical record fully and accurately; violated the professional code of ethics by not assuming responsibility for her exercise of judgment, complying with practice standards, or demonstrating honesty and accountability; and failed to demonstrate knowledge of or compliance with Facility procedures all relied on substantial evidence in the record. We agree with the Board.

Looking at the administrative record as a whole, *Sesay*, 224 Md. App. at 457, we conclude that a reasoning mind could reach the Board's determination that Ms. Diaw acted in a manner inconsistent with generally accepted professional standards in nursing. *See id.* It is undisputed that she left the Patient alone and unmonitored in an unresponsive state for at least fifteen minutes instead of calling 911. The Patient had a MOLST that ordered health providers to send him to the hospital in the event of "severe symptoms that cannot be controlled," that she was aware of this directive, and that she disregarded it when she found him unresponsive. And there is no legal instrument of record to dispute that the Patient was his own healthcare decisionmaker and that his care directives controlled. On this evidence alone, the agency could conclude reasonably that her actions on April 19, 2020, were inconsistent with professional nursing standards.

The record supported the agency's finding that Ms. Diaw "made no efforts to seek assistance from any [onsite] individual." The Board heard testimony from Ms. J that there were five other staff on the unit and additional staff members in another unit. Yet other than her phone call at 5:00 p.m. to Ms. F as she was leaving the Facility, there is no corroborating evidence that Ms. Diaw tried to get help from any onsite staff even though

she testified to having other nurses' phone numbers in her cell phone.

Substantial evidence supported the Board's determination that Ms. Diaw failed to perform CPR on the Patient. There were several inconsistencies between her pre- and post-investigation statements on this topic and they undermined her credibility. In her pre-investigation statements to the Facility, she denied performing CPR. The Patient's medical record is consistent with her initial account—there was not a single indication that anyone had given him CPR, not even in her nursing note about his death. Her initial statements match the sworn testimonies of Ms. J and Ms. L, Ms. J's notes from her April 20 meeting with Ms. Diaw, Ms. L's April 20 statement, Mr. R's sworn testimony to the Department and his statement to Ms. Mullins, and Paramedic Smith's contemporaneous documentation and testimony. Even by her own account, Ms. Diaw didn't start CPR immediately after she saw that the Patient wasn't breathing—she put the bed into CPR mode and held off until others arrived.

Ms. A and Ms. F didn't corroborate Ms. Diaw's CPR claim. Ms. A's April 19 statement doesn't mention it; in fact, it states that she hadn't been able to return to the Patient's room after she reported his slow breathing. According to Ms. F's April 23 statement, she left the Facility at 5:00 p.m., Ms. Diaw called her and said that the Patient had passed away around 5:30 p.m., and when Ms. F asked if she had given him CPR, Ms. Diaw didn't reply. At the hearing, Ms. F testified that she didn't return to the Facility and Ms. Mullins found no evidence that she had.

The administrative record contradicts Ms. Diaw's CPR claim directly. In her first

post-investigation statement to the Board, dated October 18, 2021, she wrote that she initiated CPR around 5:30 p.m. In her interview with Ms. Mullins, she reported doing chest compressions until EMS arrived and that she, Ms. A, and Ms. F should have begun administering CPR by 5:45 p.m. Her testimony at the hearing set a similar timeline of performing CPR from approximately 5:45 p.m. until EMS arrived at 6:35 p.m. But Ms. L documented in the Patient's medical record that she notified the family of his death at approximately 5:38 p.m. And at 6:13 p.m. Ms. Diaw entered a blood glucose reading into his record. The timing of these entries contradicts her testimony that she performed CPR from 5:45 p.m. until 6:35 p.m.

Moreover, a reasoning mind could have reached the Board's conclusion that Ms. Diaw failed to document fully and accurately the Patient's condition and her administration of care. Her documented assessment of his condition on the morning of April 19 didn't match her own testimony of how he presented that day; Optum's orders are the only evidence that he experienced a change of condition. Ms. Diaw's testimony about the number of times she checked the Patient's blood sugar and vitals doesn't match his electronic medical record; she states that she wrote them down on paper. But she was responsible for entering any paper documentation into his electronic record to maintain a contemporaneous picture of his care and condition that remained visible to all Facility staff. She testified that while the Patient was unresponsive, she caught up on his documentation not only from earlier that day, but also the day before. And she even testified that when she signed off on him receiving an IV line at 12:45 p.m., that entry didn't really mean that the

IV line had been put in at that time.

Ms. Diaw's excuses generated ample evidence for the Board to find that she violated the professional code of ethics by failing to show accountability for her exercise of judgment. For example, even though the MOLST had ordered the Facility to transfer the Patient to the hospital if he presented severe, uncontrollable symptoms and Ms. Diaw had found him unresponsive around 5:00 p.m., she admitted that she didn't call 911. She insisted that the MOLST no longer controlled after the Patient's sister told the Facility not to send him to the hospital that morning and that she was following Ms. F's orders:

> [THE BOARD]: So, is there a reason why you would not follow the patient's MOLST orders? Why are you calling the nurse practitioner [at Optum] to get orders?
>
> [MS. DIAW]: Because that's what I was directed to do by—
>
> [THE BOARD]: So, he has a MOLST though that overrides anything else that you're told?
>
> [MS. DIAW]: Yeah.
>
> ****
>
> [THE BOARD]: So, why didn't you not call the nurse practitioner, but call 911 and have this patient transported to the ER?
>
> [MS. DIAW]: Because from my understanding, what [Ms. F] told me about him not being sent to the—to the hospital and her speaking to the family, makes it seem to me like—I don't know if they changed the MOLST because at our facility we can change the MOLST during the weekend and we have done that before. You can call the doctor and change the MOLST. But, like I said, I didn't—
>
> [THE BOARD]: But don't you know the current MOLST of that patient?
>
> [MS. DIAW]: The current MOLST—when I first came in, I was told he was full code, you know, everything goes. [Ms. F] came back and stated that she spoke with [the Patient's]

sister—the sister and the sister said not to send him. I didn't—

[THE BOARD]: But you have a physician's order, not a sister's order.

[MS. DIAW]: Well, that—they can—

[THE BOARD]: This is your order.

[MS. DIAW]: That's the order, but you can—

[THE BOARD]: This is the patient's wishes.

[MS. DIAW]: Yeah, but you can put a new order. There—you can put a new order.

[THE BOARD]: But you don't have an order. So, why didn't you follow the [MOLST] order?

[MS. DIAW]: From what I was told, we did have a new order when [Ms. F] said—

[THE BOARD]: But who—but who has precedent, [Ms. F] or the MOLST?

[MS. DIAW]: Whatever the MOLST is at the time.

[THE BOARD]: This [MOLST], right?

[MS. DIAW]: Not after [Ms. F] sat there and said that the—there was changes.

[THE BOARD]: But there's no changes. This is his MOLST.

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[MS. DIAW]: We can verbally take an order because we don't have in-house—

[THE BOARD]: Did you take an order?

[MS. DIAW]: I didn't. My supervisor did.

[THE BOARD]: From a doctor? Is there anything written?

[MS. DIAW]: I'm not—I wasn't sure at the time.

[THE BOARD]: So, you have this [MOLST]. This [MOLST] is the only thing you have.

[MS. DIAW]: I—

[THE BOARD]: You can't take a verbal order from an RN.

[MS. DIAW]: I wasn't taking the verbal order.

[THE BOARD]: Well, you are.

> [MS. DIAW]: I—
>
> [THE BOARD]: If she says there's changes not to do something, you're taking her order over a physician's order, which is written.
>
> [MS. DIAW]: No. I—
>
> [THE BOARD]: Because there's nothing written to change this MOLST order.
>
> [MS. DIAW]: But I didn't know that. I didn't know that. I wasn't in the position to sit there and be able to check after my supervisor. I already had enough work. So, for me to sit there and add extra work to verify what my supervisor does, that's not—I mean—
>
> [THE BOARD]: You don't have—
>
> [MS. DIAW]: That's not possible.
>
> [THE BOARD]: —to do that because you've got this.
>
> [MS. DIAW]: That was from this morning.
>
> [THE BOARD]: Your only extra work you have to do is call 911.
>
> [MS. DIAW]: Not after they told me not to send him to the hospital. What would calling 911 do if he can't go to the hospital?
>
> [THE BOARD]: Okay. All right. Are there any other questions from the Board members?

Ms. Diaw's testimony reinforced the Board's conclusion that she violated the professional code of ethics based on her refusal to own or even recognize the flaws in her reasoning and her insistence that her supervisor was responsible for her exercise of judgment. Even in her brief to this Court, she posits that she couldn't have sent the Patient to the hospital without an explicit order from a physician. And she maintains still, as she did before the Board, that the unit clerk, not her, was responsible for calling 911.

Ms. Diaw's explanation for why she didn't start the Patient's IV fluids on time is

another instance of her unwillingness to own her actions that day. She testified that she put his order in at 9:45 a.m., learned he had received his IV line around 3:00 p.m., and then started his fluids immediately. But at 12:45 p.m., she signed off on the order for his IV line placement, indicating that the order had been completed and that she didn't administer his fluids for another two hours. She insisted repeatedly that her initials didn't mean that he had gotten his IV line at 12:45 p.m., but only that she had done "[her] part" of implementing the order at that time. She maintained that her sign off didn't mean the order had been fulfilled if the service had been performed by an outside contractor, which had been the case. Yet she testified later that when she signs off on orders for services performed by other staff, her signature means that the order got done. And eventually she testified that by signing off on the IV order at 12:45 p.m., she had ensured that the IV line had been placed, only to deny later that his IV line was in place at 2:00 p.m.

Ms. Diaw's refusal to acknowledge wrongdoing persisted in her answers to the Board's questions. The Board asked her why she didn't start performing CPR on a patient in cardiac arrest after she put the bed into CPR mode. Her answer was that no one came when she called for help. With regard to her expired CPR certification, she said she knew her certificate had expired and that she was responsible for maintaining it. But then she said she had called the Facility's corporate office to get recertified and that they were responsible for scheduling her training. When the agency asked why she didn't try to get certified from a safety training center, she said she didn't need to because she had already called the corporate office. Then she said the safety training center wasn't available during

the pandemic. A Board member pointed out that it was, and she said she didn't know that it was an available resource. When another member asked her to explain her thinking when she left the Patient alone for fifteen minutes while unresponsive and worked on documentation, she said there was nothing else for her to do:

> [THE BOARD]: So, assuming he's still breathing and he's very bad at 5:00, my question is what is your thought process for sitting in the nurse's station and documenting from two day[s'] worth of documentation while your patient is very bad? I'm just asking your thought process of—of why you thought that was important at that time.
>
> [MS. DIAW]: I didn't think that that was important at the time. But I'm sitting here on the phone waiting for the nurse practitioner so I can get an order. That's what I'm doing, right? I can't do any type of interventions without an order, right? I called the people. I called [Ms. F] and she stated she was leaving, right? I asked for assistance so I wouldn't have to sit there. I also stated that the nurse's station is—his room and the nurse's station are far. So, what I was doing was talking to the nurse. My rationale for getting on the computer is because what else could I have done while I'm waiting for the nurse practitioner?
>
> [THE BOARD]: So, you knew you needed help?
>
> [MS. DIAW]: Yes.
>
> [THE BOARD]: But yet you still were as far away from your patient's room that needed help as possible at—that was—that was—
>
> [MS. DIAW]: That was the direction I got, was to call Optum and get an order so we could implement—but I didn't have help. We were during—during COVID we were short staffed already and then the staff that we did have have stated multiple times that they did not come to help me. So, at that point, you know, I was stuck waiting for an order because if I—if I would have done an intervention without an order then you guys would been saying—
>
> [THE BOARD]: What kind of order were you expecting?

> [MS. DIAW]: I mean, send him to the hospital. Anything.
>
> ****
>
> [THE BOARD]: So, you went to the—to the nurse's station to get the phone number for Optum, correct?
>
> [MS. DIAW]: I went to call them, yeah.
>
> [THE BOARD]: So, you had a cellphone?
>
> [MS. DIAW]: Yeah.
>
> [THE BOARD]: You could not have gotten the number, taken your cellphone, and gone back to your patient's room to be with your patient?
>
> [MS. DIAW]: I could have, but I don't believe Optum has our—our facility when we call and they already have the knowledge of us. I don't think we can call from our cellphones.

Finally, there was substantial evidence in the record from which a reasoning mind could find that Ms. Diaw breached her obligation to know and comply with the Facility's procedures. The Facility requires staff to perform CPR/AED in the event of cardiac or pulmonary arrest if a patient doesn't have a DNR in their medical record. It is undisputed that the Patient's record reflects his full code status and that Ms. Diaw was aware of it. Ms. Diaw violated the Facility's policy when she disregarded his MOLST. And from the note Ms. Diaw wrote at 6:57 p.m. on April 19, we can see, as the Board did, that she failed to include the information required under the Facility's procedures for documenting a cardiac event.

The Board's sanctions weren't arbitrary or capricious. Although justification is not required, *see Noland*, 386 Md. at 581, the Board detailed why it found revocation of licensure, denial of Ms. Diaw's application for an RN license, and a monetary penalty appropriate in this case. The agency acknowledged the impact of the pandemic, but didn't

find that it should override the significance of her misconduct, and it remained "extremely concerned with [her] substantial lack of honesty, accountability, and critical thinking, and her gross departure from accepted practice standards in this case, which involved a Patient's death." Based on the evidence adduced at the administrative hearing, the Board concluded that allowing her to continue practicing would endanger the public and imposed sanctions based on agency guidelines and the serious nature of her violations. On this record there is no basis for us to conclude that its actions were "'extreme and egregious.'" *Mullan*, 381 Md. at 171 (*quoting* 369 Md. at 291). For these reasons, we hold that the circuit court affirmed the agency's final decision appropriately.

B. The Circuit Court Didn't Abuse Its Discretion When It Quashed Ms. Diaw's Subpoenas And Proceeded With A Virtual Judicial Review Hearing.

Ms. Diaw argues that the circuit court abused its discretion when it quashed her subpoenas despite "multiple errors and indiscernible statements" in the transcripts of the administrative hearing. She contends that these errors threatened to "change the meaning of [her] statement[s]," which mattered since the Board hadn't viewed her in a credible light, and that EMS Smith had testified to the Patient being "white" when he wasn't, yet the transcript had "conveniently" left that out. The agency counters that there is no court rule that allows a party to issue a subpoena during a judicial review proceeding or the court to add evidence to the administrative record on its own. And even if Ms. Diaw could supplement the record through the administrative process, she didn't point to any specific or material errors in the transcript that would warrant doing so. The Board is right.

No Maryland Rule permits a circuit court to supplement the administrative record in a judicial review proceeding through the civil subpoena process. The record before the court consists of the transcript of the administrative hearing and all papers and exhibits submitted to the agency tribunal unless the parties stipulate to omissions. Md. Rule 7-206(b). After the agency transmits the administrative record to the court, Md. Rule 7-206(d), each party must file a memorandum providing the question for review, the material facts, and their argument. Md. Rule 7-207(a). From there, the court hears oral arguments, but generally no additional evidence for or against the agency's decision can come in at the hearing. Md. Rule 7-208(a), (c). Before the hearing, the court can order the agency to "take additional evidence" if it determines that the evidence is material to the issues decided by the agency and there are good reasons for why it didn't come before the agency sooner. Md. Code (1984, 2021 Repl. Vol.), § 10-222(f)(2) of the State Government Article. Through that process, not a court subpoena, the agency may modify its findings and final decision based on the additional evidence. *Id.* at § 10-222(f)(3). But it is the agency, not the court, that decides whether the new evidence makes a difference. Modification or not, the role of the court stays the same—to determine whether substantial evidence supported the agency's final decision.

Even if Ms. Diaw had utilized this administrative process, her quest for the audio recordings would have failed. Audio recordings of a hearing the Board experienced for itself is not new evidence that was likely to make a difference in the agency's decision. As a result, they were not material to the issues that came before the Board for adjudication.

The circuit court had no legal basis to grant Ms. Diaw's request and didn't abuse its discretion by quashing her subpoenas.

Lastly, Ms. Diaw contends that the circuit court didn't follow court guidelines for conducting remote hearings when it heard her petition for judicial review. The Board argues that the court complied with the Maryland Rules reasonably and acted within its discretion to hold the hearing remotely. We hold that the circuit court didn't abuse its discretion when it held a virtual judicial review hearing in the first instance and denied Ms. Diaw's request to convene a second in-person hearing.

The Maryland Rules set the framework for deciding whether to allow or require remote electronic participation in civil proceedings. When a circuit court intends to conduct virtual hearings in a particular case, it must give the parties notice of its intention and "a reasonable opportunity to object." Md. Rule 21-103(b). An objecting party must, in turn, give the court and the non-objecting party "specific grounds" for their objection. *Id.* When the court receives an objection in writing or on the record, it must consider and make findings on "whether remote electronic participation would be likely to cause substantial prejudice to a party or adversely affect the fairness of the proceeding" before deciding whether to require it. Md. Rule 21-201(b). The court may mandate remote electronic participation only after it has resolved the objection. Md. Rule 21-201(a).

In this case, Ms. Diaw objected twice in writing to the court's plan to hold virtual proceedings, but neither objection stated specific grounds, as required by Rule 21-103(b). The reason for her first objection was to "to alleviate burdens placed on [her]" and her

second objection stated only that "having the hearing remote would be a burden on [her]" and that she had "already had difficulty" at an earlier remote hearing in January. In her brief to this Court, Ms. Diaw explained further that because of the "technical difficulties" she experienced at that hearing the court couldn't hear her and the Board's counsel had to call her on the phone and act as a "relay."[11] But she didn't provide those details to the circuit court when she filed her objections, and we note that the judge who ordered remote participation for the judicial review hearing differed from the one who heard the parties in January. Ms. Diaw's written objections didn't explain how remote participation would burden her substantially, what "technical difficulties" occurred at the last hearing, why they were likely to reoccur and, if they did, why that would taint the fairness of the proceedings. As a result, the court had no specific grounds from which it could make the findings mandated by Rule 21-201(b).

When Ms. Diaw renewed her objection on the record after she presented her oral argument, the circuit court appeared to consider substantial prejudice and fairness before it ruled ultimately to finish the virtual hearing. Even though Ms. Diaw's computer disconnected during the Board's oral argument, the transcript shows that the court paused the proceedings until she reconnected. When she came back, she renewed her objection to the hearing being held remotely and told the court about the challenges she faced at the last remote hearing. She asked for a second, in-person hearing because she didn't have "good [internet] service" and was having a problem participating, as shown by the "connection

[11] The record doesn't contain a transcript of the January proceedings.

issues" she had earlier and her lost connection during the agency's argument. The court said it hadn't had a problem hearing her oral argument and didn't see a basis for conducting a second hearing. Although its statements didn't follow the wording of Rule 20-201 exactly, they didn't have to, *see South Easton Neighborhood Ass'n, Inc. v. Town of Easton*, 387 Md. 468, 495 (2005) (Reviewing courts look for whether actual consideration of the necessary legal factors is apparent from the record.), because we can see that considerations of substantial prejudice and fairness of the proceedings grounded the court's thinking.

Given the limited role of circuit courts in reviewing agency decisions and the fact that a judicial review hearing is a non-evidentiary proceeding that doesn't involve credibility assessments, that such proceedings comprise only of oral arguments, that Ms. Diaw renewed her objection after she had presented her oral argument already, and the court had no trouble hearing her, we cannot say that no reasonable person would have shared the court's view that reconvening the parties for a second, in-person hearing was unwarranted. *See Maryland Bd. of Physicians v. Geier*, 451 Md. 526, 544 (2017) (citation omitted).

JUDGMENT OF THE CIRCUIT COURT FOR BALTIMORE CITY AFFIRMED. APPELLANT TO PAY COSTS.