**STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS**
**DEPARTMENT OF HEALTH**
**THREE CAPITOL HILL**
**PROVIDENCE, RHODE ISLAND 02908**

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HEALTH PROFESSIONS REGULATIONS

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| **Department of Health**<br>**Health Services Regulation**<br>**Board of Nursing Assistants,**<br><br>**v.**<br><br>**Maima David, Yama Ndimbalan, and Brenda Pugh,**[1]<br>**Respondents.** | **DOH Case No.: A.H. C11-744**<br>**DOH Case No.: A.H. C11-748**<br>**DOH Case No.: A.H. C12-143** |

# DECISION

## I. INTRODUCTION

This matter arose pursuant to an Administrative Hearing Notice issued to Yama Ndimbalan ("Ndimbalan") by the Department of Health ("Department") on March 29, 2012 and an Administrative Hearing Notice issued to Brenda Pugh ("Pugh") (collectively "Respondents") by the Department on March 29, 2012. The matters were consolidated for hearing. The Respondents are licensed as certified nursing assistants pursuant to R.I. Gen. Laws § 23-17.9-1 *et seq.* and each hold an endorsement as a medication aide pursuant to the *Rules and Regulations Pertaining to Rhode island Certificates of Registration for Nursing Assistants, Medication Aides, and their Approval of Nursing Assistant and Medication Aide Training Programs* ("Licensing Regulation"). A full hearing on this matter was held before the undersigned[2] on June 20 and July 13 and 18, 2012. The parties rested on the record. All parties were represented by counsel.

[1] After the second day of hearing, Maima David entered into a consent order with the Department on July 17, 2012 so this decision only concerns the remaining two (2) respondents.
[2] Pursuant to a delegation of authority by the Director of the Department of Health.

## II. JURISDICTION

The administrative hearing was held pursuant to R.I. Gen. Laws § 42-18-1 *et seq.*, R.I. Gen. Laws § 23-17.9-1 *et seq.*, R.I. Gen. Laws § 42-35-1 *et seq.*, and the *Rules and Regulations of the Rhode Island Department of Health Regarding Practices and Procedures Before the Department of Health and Access to Public Records of the Department of Health.*

## III. ISSUE

Whether the Respondents violated R.I. Gen. Laws § 23-17.9-8 and if so, what are the appropriate sanctions.

## IV. TESTIMONY AND MATERIAL FACTS

Audrey Longo ("Longo")[3] testified on behalf of the Department. She testified that she was employed at Fatima Hospital as a registered nurse ("RN") on June 22, 2011 and at approximately 1:50 p.m. a patient ("Patient One") from Berkshire Nursing Home ("Home") was admitted and she took the patient's vital signs and past medical history. See Department's Exhibits Five (5) and Six (6) (ER admission record and ER summary report).[4] She testified that she obtained the patient's medication history from the Home.

Longo testified that at the time she was not familiar with Exelon but is now familiar with it and it is a clear transparent medical patch about the size of a nickel for Alzheimer's that is applied daily and topically. She testified that she found three (3) Exelon patches on the front of the patient and one (1) patch on her back. She testified

[3] In some documents Longo is also known as Audrey Derry.

[4] During the course of the hearing, there were various objections from the attorneys if the exhibit offered was not relevant to their clients. As there were three (3) respondents, it was understood that not all exhibits would be relevant to all three (3) but might only be relevant to an allegation against one of the Respondents.

that the patches were dated which she entered in the GMERS report that she gave Carolyn DeSpirito, the Risk Manager. See Department's Exhibit 18 (GMERS report).

Longo testified that a patient should only have one (1) Exelon patch on and the old one should be removed before a new one is put on. She testified she showed the patches to Tara Nimiroski, the Nurse Practitioner. She testified that she called the Home at about 4:55 p.m. to inform about the patches and spoke to the Charge Nurse. She testified that Patient One passed away and she filled out a GMERS report which needs to be filled out any time an incident occurs, whether patient related or not. See Department's Exhibit Seven (7) (admission history and exam form with information about the four (4) Exelon patches).

On cross-examination, Longo testified that she discovered the patches about three (3) hours after said patient's admission, removed them, and disposed of them. She testified that she entered the patches' dates into the GMERS report. She testified that she knew the patches were Exelon because they said the word, "Exelon" and the dosage.

Elizabeth James ("James") testified on behalf of the Department. She testified that she is a Nursing Care Evaluator at the Department and has been a RN since 1987 and responsibilities include inspecting long-term care facilities and assessing compliance with Medicare requirements. She testified that on June 24, 2011 she received the Fatima Hospital report about the Exelon patches and was told to go to the Home on Monday, June, 27. See Department's Exhibit Eight (8) (patient abuse reporting form from Fatima Hospital). She testified that she was accompanied by another RN during the investigation. She testified that the Department's final investigative report refers to Patient One as Resident One. See Department's Exhibit Ten (10) and 17 (final report).

James testified she made an unannounced inspection on June 27 at the Home, met the Director of Nursing, and observed a medication aide pass medicine who did not make a complete inspection for an Exelon patch before putting on a new patch. She testified she spoke to the Director of Nursing and received a list of the sixteen (16) patients who had patches and she and the Director of Nursing inspected all of those patients. She testified that Patient Six had two (2) patches, one dated June 23, 2011 and one dated June 27, 2011. See Department's Exhibit Nine (9).

James testified that the Home's patients' medical records show the medications given, the date given, who administered the medicine, and the location administered. She testified that she requested from the Home a ledger of the initials of the staff who worked as a medication aide on the relevant days and Pugh had initialed for the June 24 patch. See Department's Exhibits Nine (9) (Patient Six's medical record) and 12 (medbook signature sheet ledger). She testified that she also obtained a list of staff assignments from the Home and Pugh worked on June 24. See Department's Exhibit 13 (staff assignments for the Home).

James also testified that she reviewed Patient One's medical records. See Department's Exhibit 15. She testified that Ndimbalan administered patches on the days after the dated patches[5] found on Patient One so on June 17, 18, and 19[6] but no site location was indicated on the medical records. See Department's Exhibit 15 (administration dates of Exelon highlighted indicating the dates following the dates of patches found). The Department also submitted the manufacturer's insert for the Exelon packaging. See Department's Exhibit 16.

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[5] June 16, June 18, June 20, and June 22 were the dates on the Exelon patches. See Department's Exhibit 18 (GMERS report). See also Department's Exhibits Eight (8) 10, and 17.

[6] As the patient died on June 22, 2011, no patch was administered the next day.

On cross-examination, James testified that she did not prepare Respondent's Exhibit One (1) (Department investigative report). She testified that there is a difference between the medication administration record ("MAR") for Patient One obtained from the hospital and from the Home. See Department's Exhibit 15 (Home's MAR) and Respondent's Exhibit Two (2) (hospital's MAR) (the two (2) forms are identical except that the hospital's MAR has no entry on June 22, 2012 for the Exelon patch and the Home's MAR has an entry on June 22, 2012 of initials in a circle). She testified that initials with a circle around them is a standard notation that medication was held and not given. She testified the fact that the initials do not appear on the hospital's copy could be explained by the fact that the Home could have documented it later after the MAR was sent to the hospital. She testified that later documentation is acceptable though not best practices. She testified that she identified the people who placed the patches based on the medical records. She testified that for Patient Six, the patches were dated and initialed. She testified that the home's in-service training (Department's Exhibit 11) included training on Exelon patches.

On redirect, James testified that Patient Six was on the second floor and Department's Exhibit 13 indicated that Pugh worked the second floor that day. She testified that physicians, nurses and pharmacists rely on each individual patient's MAR for information on medication and dosages. On re-cross James testified that one of duties of a LPN is to see that a patient is properly medicated. She testified that the nurse's notes for Patient One do not indicate any information about the patches. See Respondent's Exhibit Three (3).

Carolyn DeSpirito ("DeSpirito"), Director of Risk Management for St. Joseph's Hospital, testified on behalf of the Department. She testified that all hospitals in the State use the GMERS reporting system. She testified anyone at the hospital can input an event such as an allegation of abuse, malfunction of equipment, or anything relating to patient safety. She testified that in June 20, 2011, Longo made a GMERS report about Patient One. See Department's Exhibit 18. She testified that one needs a password and ID to enter the system. She testified that the report gave the dates that Exelon patches were found on Patient One and when she received this report, she reviewed said patient's medical records and submitted a report to the Department See Department's Exhibit Eight (8).

On cross-examination, DeSpirito testified that she probably only spoke with Longo after she made the report to the Department since reports to the Department must be made within 24 hours of an incident. She testified that the report was exclusively complied by Longo.

Donna Valletta ("Valetta") testified on behalf of the Board. She testified that she is Board Administrator for the Board of Nursing Assistants and Medication Aides and is responsible for licensing and compliance. She testified the Board's recommendation is to revoke the Respondents' medication aide registrations. See Department's Exhibits 23 and 24 (Respondents' licensing history).[7] She testified that the Respondents responded in writing to the Department regarding the complaints against them. See Department's Exhibits 20 and 22.

[7] The Respondents received medication aide endorsements in July, 2008 when such licensing started.

On cross-examination, Valetta testified that the Board rejected the suggestion of reprimand for the Respondents and the allegations against the Respondents are about misapplied medication and she cannot speak to what their thought processes were.

Ndimbalan testified on her behalf. She testified that she has worked at the Home for ten (10) years and is currently employed there. She testified that based on Department's Exhibit 15, she administered the Exelon patch to Patient One on June 17, 19, 20, and 21. She testified that before she applies patches, she checks the patient's body for previous patches and removes old patches. She testified she always put her initials and date on patches and puts patches on the front rotating sides, left and right. She testified she did not work on June 18 and on June 22, she did not patch Patient One because she was working elsewhere in the building. She testified that Patient One had a dressing put on every day by a nurse. She testified that she knows she removed the June 20 patch on June 21 because she always removes the old patch before putting on the new patch and has been doing it for 10 years without incident.[8] She testified she does not know why the hospital found the patches.

On cross-examination, Ndimbilan testified that she worked on June 17 so removed the June 16 patch, worked June 19 and removed the June 18 patch, and worked June 21 and removed June 20 patch. She testified that she did not work on June 18. She testified that she was the medication aide that James observed and her examination of the patient was not cursory as she knew where she had put the patch on the previous day so looked there and it was not there which had never happened to her before.

Pugh did not testify and did not appear at the hearing on July 13 or 18.

[8] July 18, 2012 hearing at 1 hour 53-55 minutes.

## V. DISCUSSION

### A. Arguments

In closing, Pugh's attorney argued that there was no injury to the Patient Six so there was no danger to the patient's health, safety, or welfare and the Department has not proved its case but if it is proved, the Respondent has made one (1) mistake in four (4) years of licensing as a medication aide.

In closing, Ndimibalan's attorney argued that while hearsay is admissible in an administrative hearing, the evidence was not inherently reliable since the best record would be the patches or photographs of the patches. He argued that the hospital records state there were four (4) patches on Patient One but not the dates and the only record that has the dates is the abuse report and it is not part of the hospital's records. He also argued that there is a discrepancy between the hospital's record showing a patch on June 22 and the Home's record showing no patch on June 22. He argued that the Department had not proved its case against Ndimbalan.

In closing, the Department's attorney argued that the Department's Exhibit 13 shows that Pugh worked on the relevant day, initialed Patient Six's medical records that day, and confirmed she worked that day to the Department. The Department argued that there are several statutory provisions that Pugh did not comply with including acts that are inconsistent with health and safety of patients and the Board which is made up of clinicians recommended revocation of Pugh's medication aide license.

In closing, the Department's attorney argued that Patient One's patches and dates were recorded in the GMERS report and the testimony and evidence is consistent with those dates. She argued that the fact the Respondent was not working on June 18

explained why the June 17 patch was removed. She argued that James explained the discrepancies between the hospital's and the Home's MAR record and the Board recommended revocation of Ndimbalan's medication aide license.

**B. Legislative Intent**

The Rhode Island Supreme Court has consistently held that it effectuates legislative intent by examining a statute in its entirety and giving words their plain and ordinary meaning. *In re Falstaff Brewing Corp.*, 637 A.2d 1047 (R.I. 1994). If a statute is clear and unambiguous, "the Court must interpret the statute literally and must give the words of the statute their plain and ordinary meanings." *Oliveira v. Lombardi*, 794 A.2d 453, 457 (R.I. 2002) (citation omitted). The Supreme Court has also established that it will not interpret legislative enactments in a manner that renders them nugatory or that would produce an unreasonable result. See *Defenders of Animals v. DEM,* 553 A.2d 541 (R.I. 1989) (citation omitted). In cases where a statute may contain ambiguous language, the Rhode Island Supreme Court has consistently held that the legislative intent must be considered. *Providence Journal Co. v. Rodgers*, 711 A.2d 1131, 1134 (R.I. 1998). The statutory provisions must be examined in their entirety and the meaning most consistent with the policies and purposes of the legislature must be effectuated. *Id.*

**C. Standard of Review for an Administrative Hearing**

It is well settled that in formal or informal adjudications modeled on the Federal Administrative Procedures Act, the initial burdens of production and persuasion rest with the moving party. 2 Richard J. Pierce, Administrative Law Treatise § 10.7 (2002). Unless otherwise specified, a preponderance of the evidence is generally required in order to prevail. *Id.* See *Lyons v. Rhode Island Pub. Employees Council 94*, 559 A.2d

130, 134 (R.I. 1989) (preponderance standard is the "normal" standard in civil cases). This means that for each element to be proven, the fact-finder must believe that the facts asserted by the proponent are more probably true than false. *Id.* When there is no direct evidence on a particular issue, a fair preponderance of the evidence may be supported by circumstantial evidence. *Narragansett Electric Co. v. Carbone*, 898 A.2d 87 (R.I. 2006).

**D. Statutes**

R.I. Gen Laws § 23-17.9-8 provides as follows:

> Disciplinary proceedings. – The department may suspend or revoke any certificate of registration issued under this chapter or may reprimand, censure, or otherwise discipline or may deny an application for registration in accordance with the provisions of this section upon decision and after a hearing as provided by chapter 35 of title 42, as amended, in any of the following cases:
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>
> (5) Has engaged in conduct detrimental to the health, welfare and safety of patients/residents in his or her care.

The Department's Licensing Regulation provides that those certified as nursing assistants may obtain a registration as a medication aide. No one may be registered as a medication aide without being registered a nursing assistant. Section 6 of the Licensing Regulation provides that a medication aide must comply with R.I. Gen. Laws § 23-17.9-8 (5) and may be disciplined for engaging in "conduct detrimental to the health, welfare, and safety of patients/residents in his/her care."[9]

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[9] Section 6 of the Licensing Regulation provides in part as follows:

> Section 6.0 Denial, Revocation or Suspension of Registration/Disciplinary Proceedings: Nursing Assistants and Medication Aides
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> 6.1 Pursuant to the statutory provisions of sections 23-17.9-8 and 23-17.9-9 of the Rhode Island General Laws, as amended, the Department may deny, suspend or revoke any registration issued hereunder or may reprimand, censure or otherwise discipline an individual who has been found guilty of violations of the Act or the rules and regulations herein, in accordance with section 23-17.9-8 of the Rhode Island General Laws, as amended, and upon

### E. Whether the Respondents Violated R.I. Gen. Laws § 23-17.9-8

#### i. Yama Ndimbalan

Ndimbalan is accused of not removing the June 16, 18, and 20 Exelon patches from Patient One.

Ndimbalan argued that the GMERS system is not a hospital record and not inherently reliable. However, the GMERS reporting system is used by all hospitals in the State and hospitals are statutorily mandated to report certain incidences to the Department. DeSpirito testified that the hospital has 24 hours to make such reports and she used the GMERS report for Patient One to make the report to the Department. There was no evidence in this matter to show that Longo's GMERS report that she made after discovering the patches was not inherently reliable. While Longo could not remember the patches' dates off the top of her head, she testified as to finding the patches, telling the Nurse Practitioner, discovering what Exelon was, and making the GMERS report. The GMERS report can be relied on for the dates of the patches.

Ndimbalan admits that she worked on June 17, 19, and 21 which were the days after the dates on the found patches.[10] Interestingly, she did not work on June 18 and no patch dated June 17 was found indicating that whoever worked on June 18 removed the June 17 patch. Ndimbalan testified that she always removes patches so knows she

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decision and after hearing as provided pursuant to section 11.0 herein in any of the following cases:

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e) has engaged in conduct detrimental to the health, welfare, and safety of patients/residents in his/her care.

[10] The hospital found a June 22 patch on Patient One but as she died that day a patch would not have been administered on June 23. The Home's records indicated no patch was given to the patient on June 22. Presumably, a patch was given that day before the patient was transferred to the hospital and when later documentation was made at the Home, it was assumed no patch was given that day since the patient had died. James indicated that later documentation is allowed but is not best practices. Presumably, with the patient being transferred, the Home's documentation was made later that day and not simultaneously.

removed them those days. She also testified that when James observed her she knew where she had put the patch previously so looked there. It could be that when Ndimbalan checked Patient One she assumed she knew where the previous day's patches were located and assumed they fell off and did not think they were missing. Regardless, Ndimbalan worked the relevant days and did not remove the June 16, June 17, and June 20 patches found at the hospital on Patient One.

A patient is to only have one (1) Exelon patch on at a time. See Department's Exhibit 16 (Exelon manufacturer's instructions). Ndimbalan's failure to remove the three (3) patches was detrimental to the health, welfare and safety of the patient in her care.

**ii. Brenda Pugh**

Pugh is accused of not removing the June 23 patch on June 24 from Patient Six. Pugh did not appear at the last two (2) days of hearing and did not testify. Her attorney argued that it was questionable whether Pugh worked the day at issue. However, Pugh informed the Department she worked on June 24. See Department's Exhibit 22. The staffing records of the home indicate that Pugh worked that day on the second floor where Patient Six was located. See Department's Exhibit 13. Pugh initialed Patient Six's medical records that she gave the patient Exelon on June 24. See Department's Exhibit Nine (9). Pugh worked on June 24 and was responsible for removing the June 23 patch which was not removed and was found by James during her inspection.

Pugh's attorney argued that no harm came to Patient Six. However, the issue is not whether a patient had an actual injury but whether the conduct was detrimental to the patient's health and safety. A patient is to only have one (1) Exelon patch on at a time.

See Department's Exhibit 16. Pugh's failure to remove the June 23 patch was detrimental to the patient Six's health, welfare and safety who was in her care.

**F. Sanctions**

**i. Yama Ndimbalan**

Ndimbalan has worked has a nursing assistant for ten (10) years and has been licensed as a medication aide for four (4) years. Her testimony is that based on her experience, she has always looked for patches so looked for Patient One's patches. The evidence says otherwise. However, prior to this complaint, she has not had any discipline on either license. Therefore, the following sanctions are imposed –

1. Ndimbalan's medication aide license is hereby suspended for fifteen (15) months commencing thirty (30) days from the date of this decision.

2. In order to reinstate her medication aide, Ndimbalan must re-train and re-test as a medication aide prior to the suspension being lifted.[11]

3. Once her license is reinstated, she shall be on probation for two (2) years and during that two (2) period must keep the Department informed of where she is employed and if she changes employment she must notify the Department within ten (10) days. Ndimbalan may petition the Nursing Assistant Advisory Board/Department for early relief from probation which may be discretionally granted upon a finding that she has demonstrated satisfactory competency as a medication aide, etc.

4. If Ndimbalan fails to comply with the terms of this Decision, she may be subject to further disciplinary action.

[11] Thus, if she fails to re-train and re-test prior to fifteen (15) months, her license will stay suspended.

### ii. Brenda Pugh

Pugh did not appear at two (2) of the three (3) days of hearing. She did not testify. She provided no testimony about her experience as a nursing assistant or medication aide or an explanation of what may have happened that day. Thus, Pugh's medication license shall be revoked pursuant to R.I. Gen. Laws § 23-17.9-8.

## VI. FINDINGS OF FACT

1. The Respondents are licensed as nursing assistants and medication aides pursuant to R.I. Gen. Laws § 23-17.9-1 *et seq*. and the Licensing Regulation.

2. An Administrative Hearing Notice was issued to each Respondent regarding allegations relating to the administration of Exelon. The matters were consolidated for hearing.

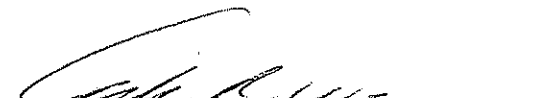
3. A full hearing was held on June 20, July 13, and July 18, 2012.

4. The facts contained in Section IV and V are reincorporated by reference herein.

## VII. CONCLUSIONS OF LAW

Based on the forgoing, the Respondents violated R.I. Gen. Laws § 23-17.9-8 and pursuant to R.I. Gen. Laws § 23-17.9-8, Pugh's medication license is revoked and Ndimbalan's medication aide license is suspended as set forth above in the Decision.

Entered this day 17th August, 2012.



Catherine R. Warren, Esquire
Hearing Officer

## NOTICE OF APPELLATE RIGHTS

**THIS DECISION CONSTITUTES A FINAL ORDER OF THE DEPARTMENT OF HEALTH PURSUANT TO R.I. GEN. LAWS § 42-35-12. PURSUANT TO R.I. GEN. LAWS § 42-35-15, THIS ORDER MAY BE APPEALED TO THE SUPERIOR COURT SITTING IN AND FOR THE COUNTY OF PROVIDENCE WITHIN THIRTY (30) DAYS OF THE MAILING DATE OF THIS DECISION. SUCH APPEAL, IF TAKEN, MUST BE COMPLETED BY FILING A PETITION FOR REVIEW IN SUPERIOR COURT. THE FILING OF THE COMPLAINT DOES NOT ITSELF STAY ENFORCEMENT OF THIS ORDER. THE AGENCY MAY GRANT, OR THE REVIEWING COURT MAY ORDER, A STAY UPON THE APPROPRIATE TERMS.**

## CERTIFICATION

I hereby certify on this 17th day of August, 2012 that a copy of the within Decision and Notice of Appellate Rights was sent by first class mail to Matthew Brier, Esquire, 2 Dexter Street, Pawtucket, RI 02860 and Bernard P. Healy, Esquire, 750 East Avenue, Pawtucket, RI 02860 and by hand-delivery to Jennifer Sternick, Esquire, Department of Health, Three Capitol Hill, Providence, RI 02908.

Linda Eaton