

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

**Department of Health
Health Services Regulation
Board of Nursing Assistants,**

DOH Case No.: A.H. C11-739

v.

**Dorothy Sharpe, Lic. # NA27637,
Respondent.**

DECISION

I. INTRODUCTION

This matter arose pursuant to an Administrative Hearing Notice (“Notice”) issued to Dorothy Sharpe (“Respondent”) by the Department of Health (“Department”) on January 24, 2012. The Respondent is licensed as a certified nursing assistant pursuant to R.I. Gen. Laws § 23-17.9-1 *et seq.* A full hearing on this matter was held before the undersigned¹ on March 8 and 14, 2012. The parties rested on the record. Both parties were represented by counsel.

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* (“DOH Regulation”).

¹ Pursuant to a delegation of authority by the Director of the Department of Health.

III. ISSUE

Whether the Respondent violated R.I. Gen. Laws § 23-17.9-8 and if so, what is the appropriate sanction.

IV. TESTIMONY AND MATERIAL FACTS

Cheryl Deshaies (“Deshaies”) testified on behalf of the Department. She testified that she is licensed as a Certified Nursing Assistant (“CNA”) and has been employed for the last four (4) years at North Bay Manor (“North Bay”) and on August 16, 2011, she worked the 3:00 p.m. to 11:00 p.m. shift. She testified that when she arrived at work, she did rounds with the Respondent and passed the room of the patient (“Patient”) and smelled diarrhea. She testified that the Respondent told her that the Patient had diarrhea earlier so she (Deshaies) assumed that the Patient had just been changed. She testified that the Respondent said that the Patient probably needed to be changed so that she (Deshaies) told the Respondent that when Nathan Dumont (“Dumont”), another CNA, came in, she (Deshaies) and Dumont would take care of it.

Deshaies testified that after the Respondent left, she (Deshaies) went into the Patient’s room and the Patient was crying and very upset and told her that she had been waiting since around noon to be changed. She testified that the Patient told her that she (Patient) had told the Respondent that she needed to be changed. She testified when Dumont arrived, they changed the Patient because two (2) people are needed to operate the hooyer lift which was required to lift the Patient to be changed. She testified that the Patient was changed about 3:15 p.m. or 3:30 p.m. and that there was much diarrhea and urine and there was an unusual amount of diarrhea. She testified that the Patient told her that she (Patient) did not have her call bell. She testified that the regular practice is to

give call bells to all residents so they have access to a call bell. She testified the Patient cannot walk and is confined to a wheel chair so could not retrieve the call bell. She testified that the call bell was on the rail on the other side of the bed (on the right hand side of the bed) out of reach of the Patient.

On cross-examination, Deshaies testified that when she outside the room, she did not speak to the Patient and the Patient would not have been able to see her from the room. She testified that when she went into the room, the Patient started crying and said she had diarrhea since noon and had told the Respondent she needed to be changed at noon. She testified that the Patient's back side was wet and when she and Dumont lifted the Patient by the hoist, her back was covered with diarrhea. She testified that the Patient was sitting with her right arm next to the bed.² She testified that in general after a diarrhea accident, one can smell it and sometimes one can see it. She testified that she did not see the diarrhea until they used the hoist. She testified in the four (4) years of working with the Patient, the Patient has never called into the corridor.

On re-direct examination, Deshaies testified that when she changed the Patient there was diarrhea from the middle of her back to her knees and the urine helped spread the mess and they gave her bed bath. She testified that the Patient clearly been sitting in the diarrhea a while because the diarrhea had gotten crusty. She testified that if someone is changed right after a diarrhea accident, one does not have to change clothes and there is not such a mess. On re-cross examination, Deshaies testified that the volume of diarrhea changes from person to person but one can tell if diarrhea is fresh or old.

Dumont testified on behalf of the Department. He testified that he currently works at another nursing home but before that worked for three (3) years at North Bay.

² At about 17 minutes of the first tape of the first day of hearing.

He testified that he worked the 3:00 to 11:00 p.m. shift on August 16, 2011 and arrived at about 3:15 p.m. He testified that he walked by the Patient's room and she called him and told him that she had been sitting since noon in her urine and feces and needed to be changed. He testified that he went to find Deshaies who had already heard about it and was looking for him. He testified that the Patient was soaked in urine and diarrhea and was a little red and there was urine on her pants and they gave her a bed bath.

On cross-examination, Dumont testified that the Patient was soaked and it was visible because one could see her pants were wet. He testified that the Patient could see out into the hall and the call bell was on the rail next to the Patient and that call bells are mostly tied to bed rails unless the patients are not nearby. He testified that the Patient told him that she had been put in her room after lunch and needed to be changed at that time and she had told the Respondent she needed to be changed.

On re-direct examination, Dumont testified that when he arrived Deshaies was looking for him because she already knew about the Patient and she could have moved the call bell. On re-cross examination, he testified that the Patient usually used the call bell and this was the only day she ever called out to him.

Donna Veasey ("Veasey") testified on behalf of the Department. She testified that she was the Charge Nurse on August 16, 2011 from 7:00 a.m. to 3:00 p.m. She testified that when she came to work on August 17, 2011, she was told by the overnight Charge Nurse that there had been an incident the day before with the Patient. She testified that she asked the Patient what happened and the Patient told her that the Respondent never came back to change her and she did not have her call light. Veasey testified that she asked the Respondent what happened and the Respondent told her that

when she went to get her car keys, the Patient told her she was dirty and she told Deshaies that she (Respondent) would help change the Patient but Deshaies said she would get Dumont. Veasey testified that she sent Respondent and the pool³ CNA upstairs at around the change of shift to bring the patients downstairs so it could have been a bit after 3:00 p.m. when Respondent got her car keys. She testified that the Respondent also told her that she (Respondent) forgot to give the Patient her call light.

On cross-examination, Veasey testified that near 3:00 p.m., the Respondent and the pool CNA went upstairs to bring patients down but the Respondent returned quickly since the patients were not ready. She testified that the Patient never told her how long she had been sitting in the diarrhea. She testified that the Patient eats from 12 noon to 1:00 p.m. She testified that she did not know the Patient as someone to call out but also testified that she did not think the Patient could have been sitting since noon because she would have told someone. She testified that the Respondent told her she might have forgotten to give the Patient the call light and the Respondent was not sure if she tied the call light to the wheelchair. She testified that her understanding was that the Respondent forgot to move the call light from the bed to the wheelchair when the Patient was watching television at 1:00 p.m.⁴ On re-direct examination, Veasey testified that the Patient is not the type to call out and she (Veasey) would think that the Patient normally would tell someone when something was wrong when being checked in her room.

Donna Valletta, Administrator to the Nursing Assistant Advisory Board, testified on behalf of the Department. She testified that the Board received a complaint (See Board's Exhibit Five (5)) about this incident on September 13, 2011 and it was forwarded

³ The pool CNA is a CNA from an agency used to ensure the home has a full staff of CNA's for a shift.

⁴ At about 44 to 45 minutes of the second tape of the first day of hearing.

to the Respondent on September 16, 2011 and on January 10, 2012 the Board met with the Respondent. She testified in light of the incident the Board recommends a reprimand be imposed for the violation which is a typical recommendation in this type of case.

The Respondent testified on her behalf. She testified that she has been a CNA since 2000 and has worked full-time at North Bay since 2003 and on August 16, 2011, she worked the 7:00 a.m. to 3:00 p.m. shift on the first floor. She testified that the first time she saw the Patient that day was about 2:00 p.m. in the dining room after her (Respondent's) break from about 1:15 to 1:45 p.m. She testified that she saw two (2) residents in the dining room and the Patient asked to be taken back to her room so she (Respondent) pushed her in wheel chair back to her room. She testified she did not smell anything and she would have smelled an accident right away and the Patient did not tell her she had an accident. She testified that she placed the Respondent in between the two (2) beds in her room so that the Patient's left hand was in reach of the call bell tied to the bed rail. She testified that when she left the Patient's room, the Patient did not tell her anything and she did not smell anything. She testified that she did not place the call light in the Patient's hand because it was not safe to put it in the Patient's hand because the Patient always fall asleep and the call light would fall on the floor.⁵

The Respondent testified that after she left the Patient, she helped another patient across the hall and then Veasey asked her to take patients upstairs to a music program which she did with the help of the pool CNA. She testified she then went downstairs to the first floor and started her reports and then went to room 12 because room 12 had requested her, then she went to room 10 and gave that patient a glass a water, then did

⁵ Approximately nine (9) minutes into the recording of the second day of hearing.

some more reports, then went to room 17 and then went back to computer, and then went to room five (5) where the patient was trying to get out of the bed.

The Respondent testified that she keeps her car keys in the Patient's room so her routine is at 2:50 or 2:55 p.m. she goes to the Patient's room for her car keys and asks her if she wants ginger ale or cookies which she did that day. She testified that the Patient was in the same position where she had left her next to the call light and the Patient told her that she had an accident. She testified that she could not see anything but she could smell it and she told the Patient she would return with help and promised her she would be back.⁶ She testified that she told Veasey that she needed help but did not tell her why and Veasey told her to go upstairs to get patients. She testified she told Veasey that she was tired and exhausted and couldn't the second shift do it but she went upstairs with Deshaies but the patients were not ready so they went back downstairs.

The Respondent testified she checked her computer and was done for the day and then went back to the Patient and thought someone else had helped her but she (Respondent) still smelled it so said she would get help.⁷ She testified that she found Deshaies and asked her if she knew who was assigned to the Patient but that it did not matter since she (Respondent) would stay and help change the Patient because of diarrhea. She testified that Deshaies told her that it was past 3:00 p.m. and she (Respondent) looked tired so she (Deshaies) would ask Dumont for help. She testified that she told Deshaies to ensure that the Patient was changed because the Patient and her family always complain and if the Patient was not changed she (Respondent) would get in "big, big trouble" which is why she wanted to stay. She testified that Deshaies is a

⁶ At about 15 minutes on second day of hearing.

⁷ About 18 minutes on second day of hearing.

“tough cookie” so she went home but her big mistake was listening to Deshaies and going home. She testified that she spoke to the Patient again before she left and told her that Deshaies and Dumont would take care of her and that Deshaies told her to go home and the Patient said that was alright and to go home. She testified that did not tell Veasey that the Patient needed changing because CNA’s handle changing.

The Respondent testified that she did not leave the Patient away from her call bell. She testified that she could not have seen the Patient at noon since she was assigned to a different dining room. She testified that she would not leave a Patient in diarrhea. She testified that the Patient would not yell into the hall but would call a person by name if she saw them and that the Patient never called out between 2:00 and 3:00 p.m.

On cross-examination, the Respondent testified that she previously met with the investigative committee for the Nursing Assistant Advisory Board but was nervous and did not remember everything she told the committee. She testified that she did have a conversation with the Patient where the Patient told her (Respondent) that she had an accident and she (Respondent) said she did not smell it but the conversation was not after lunch. She testified that it busy that afternoon and the pool CNA was on from two 2:00 to 3:00 p.m. and it often it feels like one has to babysit pool CNA’s. She gave varying testimony regarding how many people are needed for a hoyer lift.

The Respondent testified that she was at another dining room from 11:00 a.m. to sometime after noon and helped take patients back to their rooms after lunch. She testified that the other CNA came off her break at 12:45 p.m. so she (Respondent) took her break at 1:00 or 1:10 or 1:15 p.m. She testified that the Patient did not say anything to her when she brought her back to her room. She testified that there is not a call light in

the Patient's hand but it is always tied up to bed rail and that the Patient always sits between the beds. She testified that the next day, she told Veasey that she forgot to give the Patient the call light.⁸ She testified that when she checked on the Patient before she left and asked her about the ginger ale and cookies, the Patient told her she had an accident and she (Respondent) told her she did not smell anything⁹ but when she went back to the room for her car keys, she could smell something.

The Respondent testified that the next day, Veasey confronted her about the incident and she told Veasey that she smelled the accident before she left and also told Veasey that she forgot to give the call light to the Patient by which she meant she did not give it to the Patient's hand because they are trained not to give it to patients in-hand so while she "forgot," the call light was tied to the bed for the Patient to reach. She also testified that the unit was very busy with no one to help and does the best she can.¹⁰

V. DISCUSSION

A. **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

⁸ At about 38 minutes in the second day of hearing.

⁹ At about 39 minutes in the second day of hearing.

¹⁰ Approximately 43-45 minutes of the second day of hearing.

(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.*

B. 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).

C. 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:

(5) Has engaged in conduct detrimental to the health, welfare and safety of patients/residents in his or her care.

D. Arguments

In closing, the Respondent argued that this matter comes down to the Patient's statement and the Respondent's testimony and a battle of the shifts. The Respondent argued it was unbelievable that the Patient had an accident at noon and sat in it until 2:00 p.m. when the Respondent returned the Patient to her room and nothing was done. The Respondent argued that it is more reasonable to that the Patient felt she waited too long to be changed after she told the Respondent at about 3:00 p.m. that she had an accident. The Respondent also argued that Dumont's testimony regarding the call light was credible. The Respondent requested the allegations be dismissed.

In closing, the Department argued that the Patient's complaint to staff members about waiting to be changed was consistent and was corroborated by the physical evidence and the Respondent admitted to Veasey that she did not give the Patient her call light. The Department requested a reprimand be imposed.

E. Whether the Respondent Violated R.I. Gen. Laws § 23-17.9-8(5)

On August 17, 2011, the day after the incident, Deshaies wrote in her statement that the Patient told her that at lunchtime (noon) that she (Patient) told the Respondent that she had diarrhea and needed to be changed and the Respondent took her to her room and never changed her. See Respondent's Exhibit A. At hearing, Deshaies testified that when she saw the Patient after 3:00 p.m. on August 16, 2011, the Patient was upset and crying and told her that she had told the Respondent that she needed to be changed and had been waiting since about noon to be changed.

On August 17, 2011, Dumont wrote in his statement that the Patient told him that she (Patient) asked the Respondent around noon to be changed and that was clearly not

done. See Respondent's Exhibit B. At hearing, Dumont testified that on August 16, 2011, the Patient told him that she had been put in her room after lunch and needed to be changed then and she had told Respondent that she needed to be changed.

On August 17, 2011, Veasey wrote in her statement that the Patient told her that the Respondent left her (Patient) in her room after lunch sitting in diarrhea without a call light and needing to be changed. See Board's Exhibit Two (2). At hearing, Veasey testified that on August 17, 2011, the Patient told her that the Respondent never came back to change her but did not say how long she had been waiting.

Based on the statements and testimony of Deshaies and Dumont, the Patient told the same version of events to them: the Respondent took her back to her room around lunchtime (around noon), the Patient needed to be changed and told the Respondent, the Respondent knew that the Patient needed to be changed, and the Respondent never changed her.¹¹ While Veasey testified that the Patient did not tell her how long she had been waiting, her testimony was that the Patient had been waiting and the Patient was watching television at 1:00 p.m. (presumably what the Patient had told her) and Veasey's statement indicates that it was after lunch.

Deshaies testified that when she and Dumont changed the Patient, the Patient's backside was wet and from the middle of her back to the knees was covered in diarrhea. She testified that the Patient had clearly been sitting in the diarrhea awhile because the diarrhea had become crusty. She testified that if someone is changed right after an accident, there usually is not such a mess and would not need a change of clothes.

¹¹ Dumont mentioned in his statement that the Patient was very upset and he and Deshaies comforted her. Deshaies mentioned in her statement that the Patient was very grateful and could not thank them enough.

Dumont testified that the Patient was soaked in urine and diarrhea and her pants were visibly wet. They both testified that they had to give the Patient a bed bath.

Based on Deshaies' and Dumont's testimony, the Patient could not have been sitting in diarrhea and urine from about 2:55 or 3:00 p.m. to 3:15 or 3:30 p.m.¹² when Deshaies and Dumont changed the Patient. For the urine to soak through so it could be seen and for the diarrhea to spread the way it spread and become crusty, the Patient had to be sitting for a longer period of time.

The Respondent's testimony was that the Respondent said for the first time at about 2:50 or 2:55 p.m. that she needed to be changed.¹³ Deshaies' testimony was that she was with Respondent outside the Patient's room at about 3:00 p.m. and the Respondent told her that the Patient had diarrhea so she (Deshaies) assumed that it was a recent accident so she would take care of it.

The Respondent testified that she told Deshaies that she would stay late to change the Patient. However, this is in contrast to her testimony that at about 2:55 p.m. she protested to Veasey that she had to go upstairs to retrieve the patients because she was tired and could the next shift go. The Respondent testified that Deshaies told her to go home since she was tired. Since Deshaies assumed it was a new accident and Dumont would be there, Deshaies' statement that she would take care of it makes sense.

¹² Dumont testified he arrived around 3:15 p.m. and he and Deshaies changed the Patient very shortly after Dumont's arrival. Deshaies testified the Patient was changed about 3:15 or 3:30 p.m.

¹³ On direct examination, the Respondent testified that when she went to the Patient's room to ask about the cookies and ginger ale, the Patient said she had an accident but the Respondent did not see anything but smelled it. On cross-examination, the Respondent testified that the first time she went in the Patient's room was when she had the conversation where the Patient told her she had an accident and the Respondent said she did not smell anything. The conversation between the Patient and the Respondent when the Respondent tells the Patient in response to the Patient saying she had an accident, that she did not smell anything is referenced in the complaint filed with the Department. The complaint filed by the Patient states that when the Patient told the Respondent about her accident, the Respondent stated, "I can't smell anything" and the Patient replied, "I can feel it." See Board's Exhibit Five (5). Only on cross-examination did the Respondent acknowledge she had said she could not smell it. Her testimony puts the conversation at about 2:50 or 2:55 p.m. rather than after lunch.

What does not make sense is the Respondent's testimony that she told Deshaies to make sure Deshaies changed the Patient because the Patient and her family complain a lot and she (Respondent) would be in "big, big trouble" if the Patient was not changed. Would the Respondent be in big trouble because of a 15-30 minute delay to which she testified was the delay in changing; a delay that could be explained by needing at least two (2) people for the lift.¹⁴ Did the Respondent think Deshaies (who she described as tough cookie) and Dumont would not change the Patient? If the Respondent was so concerned about getting in trouble why did she not stay with Deshaies or at least tell Veasey that the Patient needed changing so that she would be in the clear if no one changed the Patient on the next shift.

Additionally, the Respondent testified that when she came back downstairs after finding the patients did not need to be brought back downstairs, she assumed that someone had changed the Patient. Her testimony was that she told the Patient she would come back to help her but went upstairs when told to by Veasey without telling Veasey that the Patient needed to be changed and then assumed someone had changed the Patient when she (Respondent) knew she had not notified anyone at that time that the Patient needed changing. It is not believable that the Respondent went from assuming someone had changed the Patient when the Respondent had not even told anyone about the Patient needed changing and at least two (2) people were needed to change the Patient to telling Deshaies a few minutes later to make sure she (Deshaies) changed the Patient or else she (Respondent) would be in trouble. While the Respondent testified that CNA's handle changing, if it was so important to ensure Deshaies changed the Patient, one would think that the Respondent might mention the Patient's need to Veasey (or the new shift nurse).

¹⁴ Her testimony was that she found out about 2:55 or 3:00 p.m.

Furthermore, the Respondent's testimony is that the Patient told her that it was fine to go home even though the Patient needed to be changed. It is also hard to reconcile the Respondent's account of her pleasant conversation with the Patient at about 3:00 p.m. when a short time later (minutes) the Patient is crying and upset.

Veasey testified that she could not believe the Patient would be sitting there for hours not calling for help. Deshaies, Dumont, Veasey, and the Respondent all agreed that the Patient is not the type of person to yell out into the hall. Dumont testified that the only time the Patient ever called to him and did not use her call light was the day of the incident. The Respondent testified that the Patient sometimes would call out to a person by name. The Department argued that the reason the Patient did not use her call light was because she did not have it. Deshaies testified that the Patient was between the wall and bed with her right hand next to the bed and the call light out of reach tied onto the bed rail on the other side of the bed. The Respondent testified that the Patient was between the beds with the call light in reach to her left. Dumont went into the room after Deshaies was there and testified that the call light was in reach but Deshaies may have moved it or the Patient and more likely she moved the Patient as Dumont testified that the Patient could see into the hall when Deshaies testified that the Patient could not see out into the hall while she (Deshaies) was there with the Respondent.

The Respondent testified that she told Veasey she forgot to give the Patient the call light. Veasey wrote in her statement and testified that the Respondent told her that she forgot to give the Patient a call light. At hearing, the Respondent explained her admission by explaining that she did not put the call light in the Patient's hand and just said to Veasey that she forgot. Veasey offered an explanation that the Respondent did

not tie the call light to the wheelchair but the Respondent did not offer that explanation. The Respondent testified that they are trained not put the call light in the patients' hands. If the Respondent would never put the call light in the Patient's hand, the explanation that when she said she forgot to give the Patient the call light, she really meant she did not give it in-hand does not make sense. It is more logical that the call light was on the right-hand side of the bed where Deshaies testified it was and where the Respondent testified it is always placed but that the Respondent placed the Patient on the other side of the bed (perhaps being in a hurry) so that the Patient was not next to the call light.

At hearing, the Respondent could not remember what she had told the Investigatory Committee in January, 2012 but interestingly, she was very specific over which rooms she went to between 2:00 p.m. and 3:00 p.m. on August 16, 2011. The Respondent's testimony also indicated that it was very busy and she was essentially on her own the last hour because she only had a pool CNA with her. Ironically, that testimony cuts against the Respondent in that it is more likely that after she brought the Patient back from lunch, she found out about the Respondent's accident¹⁵ and either ignored it or forgot about finding someone else to help her with the hooyer lift.

The testimony and evidence demonstrates that the Patient waited to be changed long enough for her diarrhea to spread up her back and down her knees and become crusty and for the urine to soak through her clothes. Lunch is between 12 noon and 1:00 p.m. The Respondent testified she took the Patient to her room at 2:00 p.m. but denied that the Patient needed changing at that time. Clearly, the Patient needed changing earlier than 3:00 p.m. The accident may not have happened at 12:00 noon but the Respondent

¹⁵ That is when she would have had her conversation referenced in footnote fourteen (14) that the Respondent placed later in the day. Based on the spread of the diarrhea and urine, that conversation had to be earlier than 3:00 p.m. The Patient was visibly wet at 3:15 p.m.

was clearly notified by before 2:00 p.m. by the Patient that she needed changing and the Respondent failed to change the Patient or ensure she was changed in a timely fashion and also failed to leave the call light in reach of Patient. Both actions were detrimental to the Patient's health, welfare, and safety.

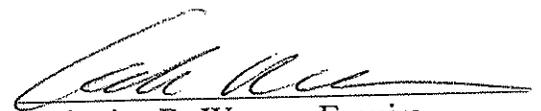
VI. FINDINGS OF FACT

1. Respondent is licensed as a nursing assistant pursuant to R.I. Gen. Laws § 23-17.9-1 *et seq.*
2. An Administrative Hearing Notice was to the Respondent by the Department on January 24, 2012.
3. A full hearing on this matter was held on March 8 and 14, 2012 with the parties resting on the record.
4. The facts contained in Section IV and V are reincorporated by reference herein.

VII. CONCLUSIONS OF LAW

Based on the forgoing, the Respondent violated R.I. Gen. Laws § 23-17.9-8 and pursuant to R.I. Gen. Laws § 23-17.9-8, the Respondent is issued a reprimand.¹⁶

Entered this day 11^R April, 2012.


Catherine R. Warren, Esquire
Hearing Officer

¹⁶ The Reprimand will be identified on the Respondent's certification and in her licensing file and on the Department's licensing website.

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 11th day of April, 2012 that a copy of the within Decision and Notice of Appellate Rights was sent by first class mail to Kevin Reall, Esquire, 303 Jefferson Blvd, Warwick, RI 02888 and by hand-delivery to Jennifer Sternick, Esquire, Department of Health, Three Capitol Hill, Providence, RI 02908.

