

DEPARTMENT OF HEALTH
DIVISION OF HEALTH SERVICES REGULATION

IN THE MATTER OF
RICHARD CAREW, N.A

A.H. FILE NO. (HSR) 2001-7

Appearing for the Department of Health: Gregory Madoian, Esq.
Respondent Richard Carew, N.A. appeared Pro Se.

DECISION AND ORDER

THIS MATTER was set down for an administrative hearing pursuant to an Administrative Hearing Notice filed by the Chief of Health Professions Regulation which charged Richard Carew, N.A. (hereinafter "Respondent") with violations of R.I.G.L. § 23-17.9-8 which were alleged to have occurred on diverse dates. Specifically, the Respondent was charged with the following:

- Handling a resident in a rough manner and laughing at the resident on 2 October 2000 and other dates.
- Sleeping on duty in September 2000
- Failing to take vital signs (temperature) of a patient of a resident as directed by a nurse.
- Leaving a resident with dried feces on hands, buttocks and bed linen on 16 August 2000.
- Gatching a bed of a resident without a physician's order or being instructed to do so by a nurse in August 2000.

- Leaving a drink in the room of a diabetic resident without waking the resident and making certain that the resident consumed the drink in August 2000.
- Failed to complete a resident's records in a timely basis in August of 2000.
- Failing to remove dirty towels from a resident's bed in August 2000.
- Documented in a resident's records in May of 2000 that a resident was given a shower when the shower had not been given and documented the resident consumed a meal when the meal had not been consumed.

The Hearing Notice charges that these actions violate R.I.G.L. § 23-17.9-8(1) for being unfit or incompetent by reason of negligence, habits or other causes and (5) for engaging in conduct detrimental to the health, welfare and safety of patients/residents in his care.

This hearing was conducted over a period of months beginning August 9, 2001 and concluded with final argument on November 6, 2001.

Brief History

The Respondent was a native of Liberia, Africa before immigrating to the United States in 1983. In Liberia, the Respondent obtained a Higher Teacher Certificate and taught a Boys Town and the MCSS School system. He worked also for the Ministry of Social Welfare and testified he was an editorial writer and health educator for the Health Education Division in the Division of Health and Social Welfare. Following his migration to the United States, he attended the St. Augustine College in North Carolina and worked in the St. John's Health Services as a nursing assistant. He obtained additional training in Grooming Techniques for Alzheimer's Abusive Patients and in Understanding Alzheimer's Disease. He became a licensed Nursing Assistant in Rhode Island in 1997. He worked for a placement agency, which placed him in various centers

in Massachusetts, before he was placed in the Coventry Health Center, Coventry, Rhode Island. He worked at the center on the 3 p.m. - 11 p.m. shift and often stayed on to work the 11 p.m. - 7 a.m. shift. He testified that he often worked 80-100 hours per week. Sometime in late spring of 2000 the Respondent began to have differences with the administrative staff which lead, ultimately, to this administrative hearing.

Summary of the Testimony

The Respondent testified first under examination by Mr. Madoian. The Respondent testified that he was transferred from the Alzheimer's Unit in the health center to another floor. He said that he asked for the transfer following two incidents on the floor, which he considered "not appropriate". He informed the administrative staff at the facility that he would either "go" or "be transferred". He was then transferred off of the Alzheimer's floor. He requested also that he be permitted one assignment rather than "floating" because he didn't like irregularity and the staff that float "are not acting nice to the residents, and they are very abusive." He was assigned to Two East and during overtime shifts he often worked on Two South. He testified that he and another certified nursing assistant (CNA) would have 28-30 patients to care for during his shift. In May he and another CNA from a placement agency were responsible to bathe and feed patients and document in the patients record that it was done. He denied that he would ever write in a record that a meal was consumed when it had not been. He said that he would notify the nurse if a meal had not been eaten.

He testified that he worked a double shift on October 2, 2000 with another CAN. He acknowledged that he recalled the patient's names regarding whom he is alleged to have laughed at and handled in a rough manner. For the record, they will be referred to as

patients A and B from room 268. The Respondent denied laughing at the patient A saying, "I wouldn't laugh at him. I don't know what could happen to me or my family. I wouldn't do that, sir." He acknowledged that patient frequently joked with him and say that they miss him. But he denied ever laughing at the patient. He denied also that he handled the roommate, patient B, in a rough manner (with the bedpan). He denied that this patient used a bedpan as he able to walk and use the bathroom facility on his own. The Respondent denied sleeping on while on duty on the 11 p.m. - 7 a.m. the second part of a double shift. He claimed that he has worked many double shifts and often goes without taking a break because he treats the patients "like his own blood". The Respondent said that he doesn't smoke and doesn't take the smoking break that many of his coworkers take. The Respondent broke down in tears at times during his testimony. Regarding his failure to take vital signs (patient temperature), the Respondent claimed that the charge nurse told him that one of the other CNAs would take the vital signs. He said that because he doesn't smoke he was given about 20 patients on the day in question. He claimed that the other CNAs took care of only ten. He claimed that he had to bathe some of the patients and that a resident was returning from a visit to the hospital. He was preparing the patient for a shower when he was asked to take the vital signs of a patient. He claimed that he didn't refuse to take the vital signs but that he couldn't leave his patient naked and unattended to go and take a temperature. He claimed that he took the temperature about 30 minutes after being asked.

Regarding leaving fecal matter on one of the patients, the Respondent remembered the patient well. He testified that she was an Alzheimer's patient who was in her late 70s. He said that he remembered her from working on the Alzheimer's unit. He said that she was

more confused than normal. She had frequent loose bowels and he had cleaned her "more than three times". He claimed that she was full of feces when he arrived on his shift. He claimed that he changed her bed linen and cleaned her from "head to her toes" at about 3 p.m. He next saw the patient at about supper time or 5 p.m. He said that she was "messed up again." He said he checked in on the patient every fifteen minutes because of a physician's orders to check her position. The patient was required to have pillows in order to keep her safe, according to the Respondent. She was showered about 5:30 p.m. Following this cleaning, the patient had two more bowel movements after which the Respondent cleaned her. He denied leaving the patient dirty with feces at any time. Next to testify was Kim Hansen, Director of Nurses, at the facility. She has been a registered nurse since 1977. She recalled getting complaints about the Respondent from Brenda Verville, a nurse who worked with the Respondent in the Alzheimer's unit. Following receipt of these complaints in May, Hansen held a meeting with the Respondent regarding his duties. He was then transferred to another unit. Her next contact with the Respondent was in August when the evening nurse supervisor complained that the Respondent failed to perform his evening chores such as cleaning the refrigerator or washing wheelchairs. Additionally, she was notified that on August 16, a patient was found with dried feces on her hands and the bed. She was found at 11 when the next nurse came on duty. The complaint alleged also that the Respondent raised the gatch on a bed after being told by a nurse not to raise it. Additionally, the complaint alleged that the Respondent left drinks in the room of a brittle diabetic and left dirty towels and face cloths in the bed of a resident. Another complaint was raised by patients A and B, which was discussed earlier in this decision. At this point the Respondent was

suspended from the facility pending the outcome of an investigation. According to Hansen, Patient A's roommate confirmed the statement regarding verbal abuse. "at this point we terminated Mr. Carew because we did not disprove the verbal abuse complaint." She testified that these patients were both alert and oriented. "They both said the same thing that Richard frequently came into the room and teased them, made rude comments, was always quote 'playing games on them' was their statement". She said that the Departments of Health and Attorney General conducted interviews with the patients and that the stories remained the same. No documents were entered into the record regarding these agency interviews.

During cross examination by the Respondent, Hansen explained that Patient A had passed away but her memory of him was that he was weak with kidney failure and needed a lot of assistance. She did not know whether patient B used a bedpan but said that patient A did at times. While Hansen appeared frustrated with the Respondent and sarcastic at times, she appeared to be sincere and credible. A dispute arose as to whether patient A could walk or whether he used a wheel chair. According to the Respondent, the patient could walk with the assistance of a three-wheel walker. Hansen was under the impression that he was wheel chair bound and needed a bedpan. This disagreement is relevant as to the allegation regarding roughness with the bedpan. Patient B did not testify at the hearing due to his age and physical status. In light of the Respondent's lack of access to the corroborating witness and that the statements offered by Hansen are hearsay, less weight was given to Hansen's testimony regarding patients A and B. On cross examination, nurse Hansen did admit that diabetic patient A was not seen by the 11 p.m. - 7 a.m. nurse who had discovered that he had not consumed his snack or drink for

over two hours after starting her shift. Hansen had no explanation for this time delay. Apparently, no one else noticed that the patient hadn't consumed his drink or snack either. It is unclear from the record how long the patient went without eating or drinking after his insulin injection. He was found with a highly elevated blood sugar and in a diaphoretic reaction.

Hansen testified also that patients A and B confirmed that the Respondent referred to them as "grumpy old men" and that he had laughed at them. She said that the Department of Health and the Department of Attorney General investigated this matter. Neither of these investigative reports became part of the record and therefore it is unknown whether these reports corroborate Hansen's investigation. The Respondent alleged, inter alia, that the complaint filed against him by the facility were motivated by "racial profiling" because he is a man of color; that the documentation regarding the care he delivered was "altered"; and that the complaints were retaliatory because he brought patient care deficiencies to the attention of the facility administrators. Hansen denied these charges and stated that her investigation resulted from staff complaints and patient claims of verbal abuse. An original and a copy of a nursing flow sheet were entered into the record for comparison in order to attempt to ascertain whether the records were "falsified". The Respondent's allegations regarding this issue were not substantiated. In fact, the original record appeared clean without any evidence of the kinds of alterations often seen when letters are changed or written over.

Testifying next was Brenda Verville, RN who was a Charge Nurse on the Alzheimer's Unit, Three North. She testified that patient E.B. was an end of life dementia patient who was due for a shower that evening. The Respondent had asked if he could leave the floor

to go to another floor where he was also working. Another CAN brought to her attention that patient E.B. was in a "cardiac chair" along a wall. The patient was brought into a room and it was discovered that he was in a urine-soaked sweat pants. Also, she noted that the patient was on comfort measures only and could not take food orally because of his stage of dementia. She noted that the Respondent charted that he had fed E.B. but the patient was unable to swallow due to "dysphasia".

On cross-examination, Verville said that she had left Coventry Health Center due to "ethical reasons". She said that she was not happy with the way residents received care at Coventry Health Center. "It became an ethical and professional problem with me," she testified. She admitted that the facility did not provide adequate CNAs to work on the floors and said it was one of the reasons that she left. One of the Respondent's defenses is that the facility retaliated when he brought to Verville's attention 12 patients with bedsores. Verville was certain that there was never an evening when the staff reported 12 patients with bedsores. "One maybe, two maybe, but no one came to me and said that there were 12 people with blisters....I would have resigned that night. I probably would have called the Health Department myself if 12 wounds were reported to me". She did admit that there were patients who were receiving wound treatment protocols, however. "He [the Respondent] could have taken a patient in to bathe them (sic), take the brief off and find blood in it because there were patients who had skin breakdowns receiving protocol treatments."

The Respondent concluded with a monologue about how white CNAs cared for patients improperly and dressed unprofessionally. "Before I go to the nursing home, I make sure that my body is taken care of properly, (I'm) properly dressed (and) neat...I'm well

prepared because I'm playing with someone's life." He alleged that the white CNAs hit patients and were not disciplined for it. The Respondent vehemently denies charting that E.B. ate a portion of his meal. He claimed that someone else was doing the charting that evening because they were split into teams. Verville denied that there was a policy in place, which allowed someone else to sign the Respondent's name. Verville could not recollect whether the Respondent signed the Input and Output form that documents food and liquid intake and urinary and bowel output. "Truthfully, at this point I don't recollect," Verville testified. She added, "It had to be his signature because that's what I wrote in my documentation to be turned in to the Supervising R.N."

The Respondent took the witness stand in his defense and testified that he has been a nursing assistant for 17 years in the United States. He has a D.B.S. Degree in Health Education and two years of nursing education at the University of North Carolina Central. He said that he has worked for 13 years in Raleigh and Chapel Hill as a nursing assistant. He transferred to Providence, Rhode Island in 1997 to join a family. He said that he continued to work as a nursing assistant. He testified that he loves his profession and was greatly surprised at the complaints leveled against him. He testified that he has not had any prior difficulties or discipline imposed. He testified that he takes his job seriously and prefers to address people formally with "sir" or "Ma'am" and not slang terms that he hears others use. He claims that he specifically requested to work on the Alzheimer's Unit because of his special training. He said he was disappointed with the center that employed him because he worked 16 hours per day because the residents needed him and the center was short of staff. He testified that he was one of two "blacks" working at the center. He said he was transferred on May 29 from the Alzheimer's Unit

because he had witnessed two white CNAs molesting a patient "physically with their hands". He said that he complained about this incident and said he must either be transferred or he will "go". He said he followed the "chain of command" in his complaints. He said that in October/November of last year there was a hearing in which he disclosed the molestation and the way the "white" CNAs were treating patients. He claimed that other people were falsifying his signature. He claimed that other CNAs were doing the "book" or charting what was done for patients at the beginning of the shift or before their duties to the patients were completed. He testified that his training was that charting was done "after the shift" not before. He claimed that many of his complaints were referred to the Division of Facilities Regulation at the Department of Health. He said he refused to permit others CNAs to sign his name on the charts because event though they work as a team "he is responsible". He denied vigorously making fun of patients and was at times teary in his defense. After considerable discussion regarding a cassette tape that the Respondent made of conversation with his supervisor, the cassette was admitted into evidence. A review of the contents of the tape revealed little of probative value relative to the charges. Much of the conversations were muted by background noises, the parties were not identified and the tape lacked the type of authentication minimally required for consideration as evidence. Accordingly, I am unable to consider this tape recording. The Respondent testified that Nurse Hansen knew that patient A did not use a bedpan but she added the statement "rough with the bedpan" to the complaint filed against him. According to the Respondent, patient A used the restroom himself and used a "urine liner" at night, which was measured and emptied by the staff. He stated that he weighed patients A and B cleaned them up, took vital signs

and offered them coffee. When he reported to work the following day he was informed that the Director of Nursing wanted to speak with him and he was ushered into the Administrators office. He was then confronted with the allegation of roughness and making fun of the patients. He submitted evidence that purported to show that the residents didn't use a bedpan and used a walker with wheels. He said the allegation regarding a failure to document involved refusing to chart before the shift ended. It was not a failure to document. He claimed also that the charge nurse gave him more patients because he "refused to go into the smoking room".

He repeated his defense that he was overburdened with patients that needed a lot of care and that it was impossible to respond immediately to every order of the nurse. Regarding the drink that was not consumed by diabetic patient A, the Respondent testified that the patient asked him to put the drink down and he would consume it later. The patient was reported to have had a high sugar level that day. He said that the nurse was nowhere to be found. He said he couldn't force the resident to drink it and he wanted to speak with the nurse about the situation but couldn't find her right away. Later, when he was taking vital signs of other patients, he told the nurse that patient A hadn't consumed the drink.

Next to testify was Lori Round, RN, a supervisor in the Division of Facilities Regulation. Round testified that her division had a compliant investigation about the facility and that there was an allegation that the facility was understaffed, that dependent residents were being left in bed because there was a lack of cardiac chairs and not enough staff to wash and turn residents resulting in an increase of skin breakdown (bedsores). She testified that in April and May of 2000 her records show a decrease in the amount of bedsores.

The Respondent concluded his case by saying that he refused to sign his performance report because they were inaccurate.

Findings of Fact

1. The Respondent appeared well groomed and polite throughout the conduct of the administrative hearing.
2. The Respondent is a licensed CNA with 17 years of clinical experience and has been practicing in Rhode Island since 1997. He has advanced training in caring for Alzheimer's patients.
3. Prior to this hearing, the Respondent had an unblemished record of service as a CNA.
4. The Respondent was properly served the administrative hearing notice dated 1/30/01.
5. For good cause, the administrative hearing was continued until it commenced on August 9, 2001.
6. The facility, Coventry Health Center, had chronic staffing shortages that lead to inadequate patient care. On certain weekends, the staffing shortages were at dangerously low levels as evidenced by a Health Department survey team.
7. The Respondent clashed with nursing staff and supervisors over poor care given to some of the residents of the facility.
8. The witnesses appearing on behalf of the facility appeared genuine and concerned about patient care and the issues relating to the Respondent.

9. The nursing staff appeared to be frustrated with and hostile to the Respondent during their testimony.
10. The Respondent lacked the capacity to give himself an adequate defense and appeared Pro Se. His defense lacked cohesiveness and lacked appropriate evidence to support his defense.
11. The testimony of Kim Hansen, RN, regarding her investigation of Patients A and B was largely hearsay. She appeared genuine and appropriately concerned about the welfare of patients under her care.
12. The testimony of Brenda Verville, RN was probative as to the conditions existing at the health center and her reasons for leaving. She appeared genuine and appropriately concerned about patient welfare. She could not remember what the Respondent documented regarding patient E.B.
13. At times the CNA staff completed their charting before services were rendered. Additionally, at times, the CNA staff signed each other's names.
14. Licensed CNAs are individually and solely responsible for patient care delivery and charting this care appropriately. Regardless of whether the CNAs work as a "team", none of the CNAs may sign another's name or make charting decisions on behalf of another licensed professional without documenting such.
15. The Department of Health attorney stipulated that no negative information about the Respondent was received from the sons of patients A and B.
16. The Respondent had an unwillingness to accept constructive criticism, involved himself in decisions outside his area of expertise and was argumentative with the nursing staff.

17. There is insufficient evidence to support the charge that the Respondent was sleeping on duty as no one with firsthand knowledge testified regarding this charge.
18. There is insufficient evidence to support the charge that the Respondent handled a patient in a rough manner and laughed at the patient.
19. There is sufficient evidence to conclude that the Respondent failed to take vital signs of a patient as directed by a nurse.
20. There is credible evidence that a patient had fecal matter on her hands, buttocks and bed linen but it is insufficient to charge that the Respondent is unfit or negligent or has engaged in conduct which is detrimental to the health welfare and safety of patients in his care. The Respondent had reasonable and compelling explanations for this situation.
21. There is sufficient evidence to demonstrate that the Respondent gatched the foot of a patient's bed without being instructed to do so by a nurse or physician.
22. There is evidence that the Respondent left a drink in the room of a diabetic patient. There is no credible evidence that this was negligent under the circumstances existing on the floor at that time. No testimony was presented which indicated that he had a duty to make sure the resident drank the drink. Credible evidence is documented that the patient's blood sugar dropped to a dangerously low level. Credible evidence exists that indicates that no qualified nurse looked after this seriously ill patient for a number of hours. Credible evidence exists also that indicates this facility operated with dangerously low staffing at certain times and minimal staffing at other times. It is the

Responsibility of these facilities to insure that a qualified licensed professional sees critically ill patients regularly and often. Leaving this level of responsibility in the hands of CNAs is unacceptable. Accordingly, this charge is dismissed.

23. There is sufficient evidence to indicate that the Respondent made or failed to correct inaccurate notations in a patient's records which indicated that a patient received a shower when none had been given and that the patient consumed a meal when the resident had not done so. The Respondent's explanation for this is not acceptable. The licensee has the sole Responsibility to insure that correct and timely charting is completed on each patient.
24. There is sufficient evidence in the record to indicate that the Respondent left dirty linen and towels in the room of a resident and he did not complete a resident's record in a timely manner.
25. There is no credible evidence that the Respondent was a victim of racial profiling or that his charts were altered or falsified. There is some evidence that the Respondent had difficulties working collaboratively with the facility staff. The reasons for this difficulty were not developed on the record.

Standard of Proof

The standard of proof required in an administrative hearing in Rhode Island is the preponderance of the evidence. "Preponderance is defined as evidence which is of greater weight than its opposition. It is evidence which, as a whole, shows that the fact to be proved is more probable than not. H.C.Black, Black's Law Dictionary (6th Ed. 1990).

Miele v. Board of Medical Licensure and Discipline, RI Super 1991.

Conclusion of Law

After applying the applicable standard of proof to the facts presented at the hearing, I conclude that the Respondent is guilty of violating R.I.G.L. § 23-17.9-8 in that he has engaged in conduct detrimental to the health, welfare and safety of patients/residents in his care as described in the Findings of Facts.

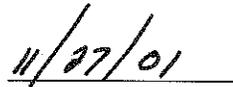
Mitigating Factors

The Respondent has made what he obviously believes to be a sincere effort to care for his patients appropriately under extraordinarily poor circumstances. Substantial evidence appears in this record that Coventry Health Center operated with dangerously low staffing, permitted CNAs to work up to 100 hours per week and ultimately lost the support of caring registered nurses and certified nursing assistants who left the facility for some of the same reasons regarding which the Respondent complained. The Respondent in this matter is well trained, groomed and appears polite and formal. The Respondent appears to truly enjoy his profession and takes pride in his work. After considering the testimony of the witnesses and the record as a whole, it appears that some of the Respondent's difficulties involved attempting to work too many hours, accepting too much responsibility to provide staffing when there was a shortage and difficulty accepting constructive criticism. There is substantial evidence in the record indicating that this was a very challenging place to work. The Respondent's 17 year work history is unblemished, according to the record.

ORDER

The Respondent will remain on probation for a period of two years during which time he shall obtain training or counseling on working collaboratively with other health care professionals. The Respondent shall not work in excess of 50 hours as a Certified Nursing Assistant during the probationary period.


Bruce McIntyre, Esq.
Hearing Officer


Date

CERTIFICATION

This is to certify that on the 27th day of November 2001 a copy of this Administrative Decision and Order was sent to the following:

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