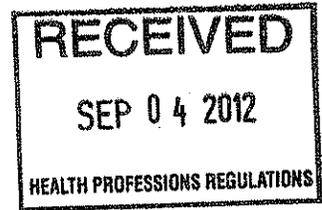


STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
DEPARTMENT OF HEALTH
THREE CAPITOL HILL
PROVIDENCE, RHODE ISLAND 02908



Department of Health	:	
Health Services Regulation	:	
Board of Nursing Assistants,	:	
v.	:	DOH Case Nos.: A.H. C11-677,
	:	A.H. C11-793, A.H. C12-325
	:	consolidated
	:	
Yva Fleurima Lic. # NA13354,	:	
Respondent.	:	

DECISION

I. INTRODUCTION

This matter arose pursuant to an Administrative Hearing Notice issued to Yva Fleurima (“Respondent”) by the Department of Health (“Department”) on January 30, 2012 concerning cases A.H. C11-677 and C11-793. A second Administrative Hearing Notice was issued to the Respondent by the Department on May 21, 2012 concerning case A.H. C12-325. At hearing on May 30, 2012, the two (2) matters were consolidated. The Respondent holds a license (“License”) as a certified nursing assistant (“CNA”) pursuant to R.I. Gen. Laws § 23-17.9-1 *et seq.* She also holds 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 undersigned¹ on April 26, May 30, and June 4, 2012. The parties timely filed briefs by July 20, 2012. Both parties were represented by counsel.

¹ 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 Respondent violated R.I. Gen. Laws § 23-17.9-8 and if so, what is the appropriate sanction.

IV. TESTIMONY AND MATERIAL FACTS

Donna Labonte (“Labonte”) testified on behalf of the Department. She testified that she has been a CNA for twelve (12) years and worked at the Pawtuxet Village Nursing Home (“Pawtuxet”) with the Respondent on July 21, 2011. She testified that Pawtuxet had two (2) CNA’s for each unit and each would be assigned to ten (10) residents and the resident (“Resident One”) at issue was an 85 year old woman with limited assistance who could care for her upper half but needed assistance for her lower help such as for walking and was the Respondent’s patient that day.

Labonte testified that she (Labonte) needed to go to the bathroom and went to the bathroom and found Resident One in the shower chair by herself with the water running. She testified that Resident One was upset that the Respondent had left her and not returned. She testified that she turned the shower off, dried Resident One off, helped clothe her, and helped her back to her room. She testified that the policy is not to leave

any resident in the shower unattended because of the risk of falling. She testified that she told Denise Silvia (“Silvia”), the Unit Manager, that day about the incidence.

Labonte testified she wrote a statement in January, 2012 about this incident because she was told that Pawtuxet could not find her original statement about it. See Department’s Exhibit Three (3) (Labonte’s January 26, 2012 statement). She testified she wrote a statement on July 21, 2011 about another incident but that statement did not mention the shower incident. See Department’s Exhibit Two (2) (Labonte’s July 21, 2011 statement). She testified that when she wrote her second statement in January, the Director of Nursing shortened it and it has inaccuracies in that she really dressed Resident One in the shower room and she does not know how long the resident had been in the shower and the statement does not say the water was running when she came in.

On cross-examination, Labonte testified that she thinks she found Resident One after breakfast. She testified that the shower room has linen, towels, facecloths, and lotion. She testified that the resident was sitting in a chair but the water was running but it was not going on the resident. She testified that terms of the “poop incident” as described in her July statement (Department’s Exhibit Two (2)) she was in the room next to the room that the Respondent was in and she heard a nurse tell the Respondent to clean the floor since a resident had pooped on the floor and the Respondent told the nurse that she (Respondent) had already told housekeeping but about ten (10) minutes later that nurse saw that the Respondent had not cleaned the poop and Respondent had gone for break. She testified that the nurse asked her (Labonte) to accompany her to see if the poop was cleaned up because if it was not completely cleaned up, housekeeping had said they would not sanitize the floor so the nurse had her come to be a witness.

Labonte testified that she informed the Respondent who was giving a resident a shower that the resident in 7A needed cleaning and the Respondent told her she would clean 7A after the shower and she (Labonte) did not help with 7A because she has issues with that resident. Labonte was not sure at first who the Respondent was showering but then agreed or assumed it was Resident One. She testified that she then went to room 15 for about ten (10) minutes and then had to go to the bathroom so returned to the rest room which is in the same room as the shower which is when she found Resident One in the chair with the water running and reported the incident to Silvia.

Labonte testified that the nurse was adamant that the Respondent clean up the poop. She testified that while the Respondent was showering Resident One, she told the Respondent that 7A needed to go to the bathroom but before the Respondent got there he had pooped on the floor and then the nurse went to get the Respondent to show her that she did not clean up the floor right. She testified that the Respondent had gone on break while she was helping Resident One get dressed. She testified that the poop on the floor was after the shower incident since 7A did not get to bathroom on time since Respondent was showering the patient. She also testified that she had her differences with the nurse Taesha² (who told Respondent to clean the poop).

Justine Grundy ("Grundy") testified on behalf of the Department. She testified she has been a CNA at Berkshire Nursing Home ("Berkshire") for 3½ years and on September 1, 2011, the Respondent was acting as a medication aide. Grundy testified that about 12:30 p.m. on that day she went to a room to assist a resident ("Resident Two") with her feeding. She testified that Resident Two was in her 90's, was frail, and only spoke Spanish. She testified that the Respondent came in with the medication

² Phonetic spelling.

crushed in the applesauce to give to Resident Two but she told the Respondent that the resident was not eating. She testified that the Respondent used a tongue depressor to try to get the medicine in the resident's mouth and then took the spoon off the tray and told the resident to take the medication but the resident did not respond. Grundy testified that the Respondent put the medicine on the spoon and tried to shove it into the resident's mouth and tried to open her mouth with the spoon and she (Grundy) could hear the spoon on the mouth. She testified that she left the room and told the nurse what had happened. She testified that a resident cannot be forced to take medicine. She testified later another CNA had seen Resident Two and a housekeeper translated for the resident who said that she was upset with what happened. See Department's Four (4) (Grundy statement). She testified that it was an unusual event and in her statement "med tech" refers to the Respondent and she thinks that the Respondent tried for about five (5) minutes to get the resident to take the medication but she left during it to tell the nurse. She testified that the Respondent did not try to coax the patient to take the medicine.

On cross-examination, Grundy testified that she had seen Resident Two receive medications before and sometimes she refused. She testified that the Respondent was able to get some of the medication in but not all. She testified that she was told later about the resident crying and heard the nurse being told what the translation had said (that the resident did not want the medication but it was shoved) but did not go back into the room. She testified that she heard the metal spoon clink on the teeth.³

Holly Branco ("Branco") testified on behalf of the Department. She testified that she is the Unit Manager, RN at Berkshire and oversees 56 beds and is charge of eight (8) to ten (10) nurses and about 24 CNA's and answers to the Director of Nursing. She

³ First part of 4/26/12 recording at one (1) hour and 24 minutes.

testified she has been at Berkshire for one (1) year and prior to that worked as a floating nurse at Fatima Hospital. She testified that Grundy was a permanent CNA when she (Branco) took up her position. She testified that she worked the relevant day and Grundy told her that the Respondent was trying to pry open the Resident Two's mouth to give medicine. She testified that the residents do not need to take their medicine and it is their right not to and the policy is not to force medicine. She testified that Grundy told her that Resident Two was crying so she went back with Grundy to the resident and she could see the crushed medicine and applesauce in the resident's mouth. She testified that she got the resident to drink and documented this.

Branco testified that later when other CNA's saw the resident, the resident was still crying so she reported this to the Director of Nursing, Linda Delcarpini ("Delcarpini"). She testified she did not ask the Respondent what had happened because it was now in the hands of her supervisor. See Department's Five (5) (Branco's statement). Branco testified that when she went in to see the resident that day she needed to address the applesauce and the medicine because of the safety issue that the resident could choke on what was still in her mouth so she got her to take sips of water.

Branco testified⁴ regarding a February 16, 2012 incident with a resident ("Resident Three") who has mid-way dementia and lucid periods and is aware of her dementia. She testified that on that day, Resident Three had walked up to her at the nurses' station which was unusual as that resident rarely leaves her room and told her that she had asked the medication aide why she needed her medicine and the medication aide would not answer her and shoved the pills in her face. She testified that was the first time

⁴ The testimony regarding the February, 2012 incident was on the second day of hearing when the two (2) matters were consolidated and after Branco had testified on direct and cross regarding the September, 2011 allegation.

she heard of the incident. She testified that she brought Resident Three to see Delcarpini and the resident told the same story but because the patient was Delcarpini's mother, Delcarpini stepped back from the investigation and called Joe Sousa ("Sousa"), the administrator. She testified that that procedure is to make a statement right away which she did. See Department's Exhibit 11 (Branco's 2/16/12 statement).

On cross-examination, Branco testified that Resident Two understood English. She testified the housekeeper translated to her what the patient had told the other CNA (who was not Grundy). She testified that Grundy was in the room when the housekeeper spoke with the patient. She testified that she (Branco) saw the patient crying with the applesauce in her mouth and that Grundy was there while she (Branco) consoled the patient. She testified that she told her boss (Delcarpini). She testified the applesauce was between the patient's gum and teeth and there was some was leaking out.⁵

On cross-examination on the second day of hearing, Branco testified that at the first hearing, she had testified the Respondent did not work on her floor after September incident but that was incorrect because she was working there for the February, 2012 incident. She testified that she did not ask the Respondent about the incident with Resident Three because she went to Delcarpini and that started the investigation. She testified that at the first hearing, she testified there were no other problems with the Respondent passing medication after the Resident Two incident but that was wrong. She testified that Delcarpini did not tell her to talk to Resident Three but rather Delcarpini's mother came and told her about the issue and she took her to see her mother (Delcarpini).

Branco testified that at one time she told the staff to keep an eye on the Respondent but after the Resident Two incident. She testified that she did not tell

⁵ Second tape of 4/26/12 hearing at 10 minutes.

Grundy that before the Resident Two incident because she had no reason to. She testified that Resident Three's patient notes do not indicate any change to the resident on February 12, 2012 and patient notes are supposed to indicate any changes in a patient's baseline behavior. She testified that her statement would be considered part of Resident Three's chart. See Respondent's Exhibit Seven (7) (Resident Three's patient notes).

On rebuttal after Respondent testified to first two allegations, Delcarpini testified on behalf of the Department. She testified that she is the Director of Nursing at Berkshire and started on August 31, 2011 but prior to that had been the Director of Nursing for seven (7) years at Charlesgate Nursing Home. She testified that Branco told her a CNA had witnessed another CNA forcing medications. She testified she spoke with the first CNA and Branco and had them write statements. She testified she spoke with the Respondent who told her she was slow and was hurrying to finish her medications.⁶ She testified she put the Respondent on three (3) day suspension and on her return put her in training with Lea Doren.⁷ She testified that at the meeting she explained to the Respondent what the complaint was about. She testified that she read her the complaint that a CNA had seen her force medication into a resident. She testified that the Respondent told her she never would have forced the medication.⁸ Delcarpini testified that she makes notes of conversations since she has 200 CNA's so if there are any disciplinary actions, she makes notes so she can remember. See Department's Exhibit Nine (9) (September 8, 2011 note to file about conversation).

On cross-examination, Delcarpini testified that Department's Exhibit Nine (9) about her conversation with Respondent did not reference Resident Two.

⁶ First hearing on 5/30/12 at 58 minutes.

⁷ Phonetic spelling.

⁸ First hearing on 5/30/12 at about one (1) hour.

Delcarpini testified on behalf of the Department.⁹ She testified that her mother (Resident Three) is at the nursing home and suffers from some dementia and is 92 years old. She testified that on the morning of February 16, 2012, she visited her mother who was upset because the medication aide (Respondent)¹⁰ had pushed her cup of medicine up to her mouth to take the medicine. She testified that her mother asks every day why she has to take the pills but she always takes the pills after being told why. She testified that her mother told her (Delcarpini) that she asked the medication aide why she had to take the pills and then demonstrated how the medication aide had pushed the cup up to her mouth. She testified that her mother did take the pills. She testified that she told Branco to look into the complaint because since it involved her mother. She testified that her mother can take her own medicine. She testified that Branco told her later what her mother had told Branco and Branco reported the investigation to her like any report to a family member. She testified that she referred Branco to Sousa who is above Delcarpini.

Sousa testified on behalf of the Department. He testified he has been the Administrator of Berkshire since August 1, 2011. He testified that in terms of Resident Three's complaint regarding the Respondent he was verbally told about it by Delcarpini and Branco separately but close in time. He testified that it was his understanding that Resident Three had complained that the Respondent had shoved pills in her mouth. He testified because of the relationship between the patient and Delcarpini, he told Delcarpini not to take part in the investigation. He testified the resident's story to Branco

⁹ Delcarpini was initially called for rebuttal regarding the September 1, 2011 allegation on the second day of hearing but on that day the two (2) matters were consolidated so she also testified on direct regarding the February 16, 2012 incident.

¹⁰ Delcarpini testified that Respondent was the only medication aide in that unit.

and Delcarpini was consistent and he spoke to Branco about it. He testified that he sent a report to the Department. See Department's Exhibit 12.

On cross-examination, Sousa testified that that did not speak to Resident Three. He testified that Branco told him that the Respondent shoved pills in the Resident Three's mouth which he does not think conflicts with the term "forcefully" contained in Respondent's Exhibit Six (6) (report to Department prior to Department's Exhibit 12).

On the first day of hearing, Donna Valletta, Administrator of the Nursing Assistant and Medication Aide Advisory Board, testified on behalf of the Department. She testified that the Board received the Pawtuxet complaint on April 26, 2011 and the Board recommended a reprimand on October 4, 2011 and the Respondent met with the board on January 10, 2012 because she disagreed with the reprimand recommendation. She testified that the Respondent has been licensed as a nursing assistant since April 20, 1993 and as a medication aide since July 1, 2008 which was the date when medication aide licensing began in Rhode Island. She testified that the Berkshire matter came in on October 14, 2011 after the Board's recommendation in the Pawtuxet matter so the Berkshire complaint was referred to the Legal Division.

After the matters had been consolidated, Valletta testified on direct again. She testified that the Board received a report on May 11, 2012 about the February incident and as the Board had just met May 8, 2011 and there was an on-going hearing, a decision was made to add this complaint to the hearing. She testified that the recommendation is now to revoke CNA and medication aide license which is based on information contained in a 2010 complaint,¹¹ the two (2) 2011 complaints, and the 2012 complaint so there is a concern about the similar allegations and a pattern of behavior. On cross-examination,

¹¹ No violations were found based on the 2010 complaint so it has not been considered in this decision.

Valletta testified that recommendation for sanctions is based on taking the complaints as true but would not change after hearing the testimony at hearing.

On the first day of hearing, the Respondent testified on her behalf. She testified that on July 21, 2011, she working at Pawtuxet as a float CNA and was split between two (2) floors. She testified that she was in charge of giving Resident One her shower and about 10:00 a.m. she went to her room and took her to the shower. She testified that after the shower she took Resident One to her room and dressed her. She testified she did not leave the resident in the shower unattended and there was no reason for her to since everything she needed for the shower was in the shower room. She testified that Labonte did not come into the shower while she was there. She testified that the Charge Nurse, Taesha, was giving her a hard time about some poop on the floor and that Labonte was helping Taesha give her (Respondent) a hard time.

The Respondent testified on September 1, 2011 she was passing medications at Berkshire and Branco was the Nurse Manager. She testified that she passed the medications to Resident Two who swallowed the medicine with no problem. She testified that she needed to crush the medicine. She testified there was no other CNA in the room when she gave the medicine. She testified that she did not see Resident Two crying and no one told her that the patient was crying. She testified that she (Respondent) would not get in trouble if the patient did not take medicine but rather would just have to report it. She testified that one cannot force a patient to take medicine but one should just encourage. She testified that for Resident Two, she checked the medication book, prepared the medication in applesauce, communicated with the patient, gave her the medicine, and then gave her juice with thickener in it to make sure she

swallowed. She testified that based on the report made about Resident Two, she was supervised by Lea for three (3) days passing medication.

The Respondent testified that she has 15 years experience in passing medication and was licensed as a medication aide when licensing was first required. She testified that she did not know that Resident Three was Delcarpini's mother and did not force the medication on her because she has no right to force medication and her rounds will go faster if a patient refuses medication. She testified that when she worked Branco's floor, she was called every fifteen (15) minutes interrupting her work as a medication aide which is not supposed to be interrupted. She testified that she never had problems with the other CNA's at Berkshire except on Branco's floor.

On cross-examination, the Respondent testified she had no idea why Labonte would lie at hearing about what happened. She testified that Grundy was not in the room when she gave Resident Two her medicine and she has no idea why Grundy would lie. She testified that she had no idea why Branco would lie that Resident Two was crying and upset and did not swallow her medicine. She testified that Lea observed her pass medication for three (3) days but did not tell her why she had to be observed. She testified that she was told to come to the office and Delcarpini did not tell her there was a complaint against her but asked for a statement and she provided a statement regarding tylenol for another patient and no one told her about the September 1, 2011 complaint or discussed medication problems. See Department's Exhibit Six (6) (9/7/11 statement). She testified that she never spoke to Delcarpini about it. She testified that when Lea performed the in-service training on passing medication, she understood from Lea that there had been a complaint which was why she was being observed but was not told the

name of the patient but she understood in speaking with Lea why she was being observed. She testified that she did not have any problem with Delcarpini or her mother and there no reason for Delcarpini to bring the complaint.

On re-direct examination, she testified that on her assignment sheet for September 1, 2011 she put a note about a problem with patient but not about Resident Two because as far as she was concerned that she knew, there was no incident that day. See Respondent's Exhibit Four (4) (9/1/11 assignment sheet). She testified that she knew she was suspended but did not know it was for Resident Two and only understood that it was about Resident Two when she heard from the Department.

V. DISCUSSION

A. Arguments

The Department argued that the testimony demonstrated that the Respondent left Resident Three unattended in the shower and forcefully passed medication to Resident Two and Three. The Department argued that the Respondent denied all the events and gave no explanation for why multiple witnesses from two (2) different nursing homes would give false testimony. The Department argued that the Respondent's testimony was contradictory regarding the reasons for her suspension from the nursing home and her denials of responsibility left no room for miscommunication or mistake.

The Respondent argued that Labonte's testimony should be disregarded as her memory regarding the poop incident was better than the shower incident and she apparently was dogging the Respondent about the poop incident. The Respondent argued that a letter of concern could be merited for Resident Two but that the Respondent already engaged in re-training with that Home. The Respondent argued that Resident

Three's allegation was based on a dementia patient and the allegations changed as the chain of reporting grew and the testimony was contradictory.

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:

(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 and may be disciplined for engaging in "conduct detrimental to the health, welfare, and safety of patients/residents in his/her care."¹²

¹² 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

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

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

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

i. Resident One

During the testimony, there was confusion over the timeline regarding the poop and the shower incidences. Labonte's testimony was that the Respondent was showering Resident One (1) and she (Labonte) told Respondent that 7A needed help to go to bathroom. Later, Labonte went to the bathroom and found Resident One alone in shower room unattended so helped her get dressed and back to her room. After that, Labonte witnessed the poop incident when the nurse told the Respondent to clean it up but the Respondent said housekeeping would. The Respondent's testimony was that she never left Resident One unattended in the shower. Labonte testified she wrote a report on the shower incident after it happened but it was lost so she wrote it again in January, 2012. However, she wrote a report on July 21, 2011 (Department's Exhibit Two (2)) about the poop incident in which she mentioned telling the Respondent while she was showering a resident that 7A needed assistance. That confirms that the poop incidence took place after the shower and corresponds with Labonte's testimony about talking to Respondent in the shower room. The progress report from July 21, 2011 (Respondent's Exhibit One (1)) also recorded the incident with Resident One (and the poop).¹³

The issue is whether the Respondent left Resident One in the shower unattended. The poop incident most likely explains how the Respondent ended up leaving the resident unattended. While the Respondent denies leaving the resident unattended, the evidence is she did. Taesha might have been on the Respondent's "case" but Labonte was not friends with Taesha. And it is not in a nursing home's and a manager's interest to make

¹³ At part one of the 4/26/12 hearing at 59 minutes, the parties agreed that Taesha (phonetic) Sebastian, the Charge Nurse, signed the progress note. The Unit Manager Denise Silvia's name is also on the note.

up incidences about staff that could come to the attention of the Department and result in discipline on staff. It may have been the Respondent thought that Labonte would help with the shower if she (Respondent) went to 7A to help out so left the resident there. (Indeed more collaboration from all employees might have been helpful). But the evidence is that Labonte told the Respondent about 7A while Respondent was showering Resident One. Later Labonte returned to the shower room and found Resident One unattended. Based on the evidence, the Respondent was in the shower with Resident One and went to help 7A but it was too late and the result was the Respondent left Resident One unattended in the shower and the poop incident.

ii. Resident Two

The Respondent testified that she did not force the medication on Resident Two. She denied it to Delcarpini (see Department's Exhibit Eight (8) and (9)) and at hearing. Grundy testified that she heard and saw the forcing. Branco testified that applesauce and medication had been left in the resident's mouth. Resident Two was clearly upset as she told another CNA what happened (the testimony about the translation). Another CNA also reported the resident was crying. See Respondent's Exhibit Five (5). Branco saw the resident crying.

Branco's and Grundy's testimony differed in whether Grundy returned to the room after Grundy reported it to Branco. However, Grundy's statement is consistent with her testimony about what she saw and also how she heard that resident was upset. (The statement implies that Grundy saw the resident crying but she testified that she heard about it from other CNA's).

The Respondent testified that she gave thickener to the resident to ensure swallowing. However, Delcarpini's statement said that the Respondent denied forcing the medication but that she (Respondent) said should have stayed to make sure the resident swallowed her medication. See Department's Exhibit Eight (8). The resident clearly had not swallowed her medicine as the applesauce and medicine was still in her mouth when Branco went in. The Respondent also indicated to Delcarpini as detailed in Delcarpini's notes that she was rushing.

The disparity between Grundy's, Branco's, and Respondent's testimony can be explained by finding that the Respondent did not think she had forced the medication. The Respondent perceived the incidence as she was hurrying and tried to give medication and moved on without checking to make sure the resident swallowed. See Department's Exhibit Eight (8). Branco's testimony was also slightly at odds with Grundy's regarding who went into the resident's room and she also failed to mention the February incident during her first cross-examination. However, Grundy's testimony about seeing and hearing the clinking spoon shows that the Respondent was not just coaxing the resident to take the medicine but was forcing her to. Grundy told the Respondent that the resident was not eating but the Respondent moved from using a tongue depressor to spoon to try to get the resident to take the medicine. In doing so, she tried to force the resident to take the medicine leaving the mixture in her mouth leaking out.

The Respondent's testimony varied over whether she understood the reason for Lea to observe her passing medication. At first, she testified that Lea just told her that she was there to observe but later testified that in speaking with Lea, she understood there had been a complaint but not the resident's name. She also testified that Delcarpini never

spoke to her about the complaint which is at odds with Delcarpini's testimony and Department's Exhibits Eight (8) and Nine (9). If a manager is sending an employee for re-training (as performed by Lea), it makes no sense not to tell the employee why. However, even if the Respondent was never told (and she was), such action would not change what Grundy saw and testified to. The Respondent used a tongue depressor to try to open the resident's mouth and then tried to use a spoon to force open the resident's mouth. Despite the Respondent's belief that there was no force, her actions constituted forcing medication.¹⁴

iii. Resident Three

This complaint is harder to evaluate than the first two (2) allegations. Resident Three complained to her mother (Delcarpini) and Branco that the Respondent had been forceful or pushed a cup up to her mouth. Resident Three suffers from some dementia. The Respondent testified that she did not force the medication on Resident Three. Of course, the Respondent's understanding of what constitutes force may be different from the resident's. According to Branco, Resident Three came out of her room and reported the incident. This is supported by Branco's statement at the time. See Department's Exhibit 11. Delcarpini testified that her mother told her what happened and she told Branco. Sousa testified that both Branco and Delcarpini reported it to him. Branco initially did not remember this incident at hearing when she testified that there were no other issues with Respondent after September, 2011. Appropriately, Delcarpini testified that she was not involved in the investigation. Sousa testified that the story told him by Branco and Delcarpini was consistent but that he never spoke to Resident Three.

¹⁴ Indeed, the Respondent admitted in closing that this incident should merit a letter of concern.

Thus, there is a question over what exactly transpired. Was the cup pushed into the resident's face? Held up in front of her? Or forcefully moved in front of her? Whatever the Respondent did with the cup upset the resident but the issue is not whether the Respondent upset the resident but whether her actions constituted force or were otherwise detrimental to the safety of the patient. Based on the evidence, it is hard to conclude that the Respondent's action were detrimental to the patient's health, welfare, or safety. While the Respondent may have been short or rude to Respondent Three, based on the lack of evidence,¹⁵ there cannot be a finding of a statutory violation.

F. Sanctions

The Respondent's actions as related to Resident One and Resident Two were detrimental to those residents' health, welfare, and safety.

Based on the forgoing, in terms of Resident One, 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 on her certified nursing assistant license.

Shortly after the Respondent's statutory violation with Resident One, the Respondent violated the statute in regard to her medication aide license in regard to Resident Two. The Respondent's testimony implied that her only problems stem from Branco's unit; however, the violation for Resident One was at a different nursing home.

While no statutory violation was found for Resident Three, the Respondent's testimony in general regarding the passing of medication and her explanations were inadequate regarding her understanding and process for medication passing. She

¹⁵ E.g. Branco spoke with Resident Three but when she initially testified about the September, 2011 incident, she did not remember the February, 2012 incident or that she had worked with Respondent after September, 2011; Sousa did not speak with Resident Three but only spoke to Branco and Delcarpini and the latter was not supposed to be involved in the investigation, etc.

indicated – almost by rote – that she knew she did not have to force medicine but failed to offer an understanding or explanation for the allegations concerning Resident Two. Grundy’s testimony was clear. The Respondent’s explanations were not.

Based on the forgoing, in terms of Resident Two, 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 on her medication aide license and her medication aide license is suspended for a minimum of six (6) months. The suspension shall be effective from 30 days after the effective date of this decision:

1. The Respondent may re-instate her medication aide license after six (6) months as long as she demonstrates the completion of at least sixteen (16) hours of continuing education (in addition to the regularly required continuing education to renew said license) related to the passing of medication, patient care, patient rights, and anger management. Prior to any re-instatement, the Respondent must submit proof of completion of said courses to the Department for its approval that the courses are consistent with the requirements of this decision.¹⁶

2. Upon the Respondent’s re-instatement of her medication aide license, the Respondent shall be on probation for a period of two (2) years and subject to the following conditions:

¹⁶ The Respondent may request approval for the courses she plans to take prior to taking the courses but must obviously also submit proof of completion of the courses prior to re-instatement.

A. The two (2) year probation period will be begin upon employment by Respondent as either a nursing assistant¹⁷ or medication aide in a licensed health care facility or by an agency providing the Respondent as a "float."

B. Upon employment, the Respondent shall notify the Department within ten (10) days of her employment. If she changes jobs at any time, she shall notify the Department of her new employer and its name and address or change in employment status within ten (10) days after any such change.

C. The Respondent shall not work in situations where she would not be supervised.

D. The Respondent shall notify the Department within ten (10) days of any potential complaints against her arising from a work situation.

E. During her probation period, the Respondent shall complete in addition to the continuing education requirements for renewal of medication aide license, a further ten (10) hours of continuing education classes in patient care and patient's rights.

3. If the Respondent fails to comply with the terms of this Decision, the Respondent may be subject to further disciplinary action.

4. The Respondent 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 medication aide, etc.

¹⁷ If the Respondent is currently working or obtains employment as a certified nursing assistant prior to reinstating her medication aide license, the probation period shall begin at that time and be subject to conditions set forth in this decision.

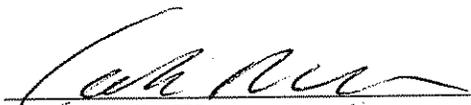
VI. FINDINGS OF FACT

1. The Respondent is licensed as a nursing assistant and medication aide pursuant to R.I. Gen. Laws § 23-17.9-1 *et seq.* and Licensing Regulation.
2. An Administrative Hearing Notice was sent by the Department to the Respondent on January 30, 2012 regarding the incidents with Residents One and Two.
3. After a hearing was begun under the Administrative Hearing Notice sent on January 30, 2012, the Department issued an Administrative Hearing Notice to the Respondent on May 21, 2012 regarding the incident with Resident Three.
4. On May 30, 2012, the two (2) Administrative Hearings were consolidated. A full hearing was held on April 26, May 30, and June 4, 2012.
5. Briefs were timely filed by July 20, 2012.
6. 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 sanctioned as set forth in the Decision with a reprimand on each license¹⁸ and suspension of the medication aide license with subsequent probation.

Entered this day 6th September, 2012.


Catherine R. Warren, Esquire
Hearing Officer

¹⁸ Each reprimand will be identified on the Respondent's relevant 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 4th day of September, 2012 that a copy of the within Decision and Notice of Appellate Rights was sent by first class mail to Laura Harrington, Esquire, Harrington Law Group, 250F Centerville Road, Warwick, RI 02886 and by hand-delivery to Jennifer Sternick, Esquire, Department of Health, Three Capitol Hill, Providence, RI 02908.

