

Division of Professional Regulation

**A.H. FILE NO.
(HSR) 2005-18**

**Board of Nurse Registration
and Nursing Education**

In the Matter of Gloria Baillargeon, LPN

For the Board: Gregory Madoian, Esq.
For the Respondent: James E. O'Neill, Esq.

DECISION AND ORDER

This matter came to be heard before the Board of Nurse Registration and Nursing Education (the "Board") pursuant to an Administrative Hearing Notice issued by an Investigating Committee of the Board. The Respondent, Gloria Baillargeon, LPN, was charged with violating the nursing practice act while on duty at the Oakland Grove Health Center, Woonsocket, Rhode Island. Specifically, the Respondent was charged with "Unprofessional Conduct" for violating *R.I.G.L. § 5-34-24(6)(v)* "Willful disregard of standards of nursing practice and failure to maintain standards established by the nursing profession." According to the Investigating Committee, the Respondent failed to assess a patient who was experiencing difficulty breathing; failed to document any changes in the patient's condition at the facility and failed to intervene in a timely manner.

This sad case involves the death of a 93 year-old resident ("Patient A") at the skilled nursing care facility. The charges arose out of the care rendered to Patient A during the early morning hours of July 9, 2004. The Respondent was the charge nurse

(Licensed Practical Nurse (LPN)) on a floor with over 60 patients who depended on her for skilled care. She was assisted by three Certified Nurse Assistants (CNAs) who were her “eyes and ears” on the floor for the 11 pm to 7 am shift. A Registered Nurse was also on site during this shift. The RN made rounds on all the floors and was the senior nurse on duty to assist when acute problems arose. In operational essence, the CNAs reported to the LPN and the LPN reported to the RN. The Respondent staffed the nursing station where patient charts were kept, staff assignments were done and other organizational functions were completed. The nursing station is directly across the hall from the patient dining room and a small private office that was used for confidential conversations. The floor was divided into four sections with numerous beds as follows: East, 10 beds; South, 21 beds; North, 16 beds; and West, 14 beds. *(Respondent’s Exhibit 4)*. The central complaint giving rise to these charges is that the Respondent was alerted by the CNAs on the floor that Patient A was experiencing difficulty breathing between 1 am and 5 am and that the Respondent failed to assess and assist the patient whose condition appeared to be worsening in the opinion of the CNAs. The CNAs alleged that when the Respondent finally came to assist, the patient’s condition has deteriorated to the point where she died before the rescue arrived.

The theory proffered by the defense is that Patient A’s demise was sudden, beginning near 5:00 am, and that she died quickly

Summary of the Testimony

Linda Mary Oliver, CNA

The first witness to testify before the Board was Linda Mary Oliver, who worked the 11:00 pm to 7:00 am shift at the Oakland Grove Health Center. She described her

duties as checking on residents with two other co-workers, Aretha Jackson and Tammy Keodone, by making rounds at 1:00, 3:00 and 5:00 in the morning. She explained that they answered call lights and alarms and were the “eyes and ears” for the charge nurse. She explained that they were responsible for about 60 patients. The duties were divided among them wherein one was responsible for vital signs, another for “I and Os” and the other takes care of “alarms”. Oliver testified that she knew Patient A well because she had cared for her for about 8 months. She described the patient as an alert 92 year old who needed assistance moving with her walker and certain other basic tasks. At approximately 12:30 am on the night in question, Oliver testified that she noticed Patient A coughing and sounding “rattly in her chest.” She stated that she went to the Respondent who was the “charge nurse” and reported her findings. The Respondent’s reply was that Patient A “had gone for a chest x-ray the day before and that it had come back negative,” according to Oliver. She added that the Respondent did not go to see the patient at that time. At approximately 1:15 she went back to the charge nurse and told her that “the x-ray may have come back negative but Patient A sound pre-pneumonia”. She said that she didn’t see the Respondent attend to Patient A but merely shook her head. Oliver said that she had gone into Patient A’s room about four times during the shift. She testified that she saw the patient’s breathing becoming “more labored” and “she was “coughing”. She noted that she was concerned that the patient was “declining quickly”. She alerted the Respondent “three more times after 1:15”. She testified that she was so concerned that she told the Respondent that Patient A “wanted to see her right away.” She said this was a lie but she told the Respondent this because “I felt that I wasn’t being heard”. She told the Respondent this in the hope that she would come immediately. The

