COMMONWEALTH of VIRGINIA

David E. Brown, D.C.
Director

Department of Health Professions
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

www.dhp.virginia.gov
TEL (804) 367-4400
FAX (804) 527-4475

July 23, 2015

Ramatu Sesay
7863 Riverdale Road, Apt. #102
New Carrollton, MD 20784

CERTIFIED MAIL

DUPLICATE COPY
VIA FIRST CLASS MAIL
DATE 7/23/15

RE: Certificate No.: 1401-157459

Dear Ms. Sesay:

Pursuant to Section 54.1-2409 of the Code of Virginia (1950), as amended, ("Code"), you are hereby given notice that your certification to practice as a certified nurse aide in the Commonwealth of Virginia has been mandatorily suspended by the enclosed Order entered July 23, 2015. You are hereby advised that, pursuant to Section 54.1-2409.1 of the Code, any person who practices a profession or occupation after having their license or certificate to do so suspended shall be guilty of a felony. Please return your certificate to Jay P. Douglas, Executive Director of the Virginia Board of Nursing, at the above address, immediately upon receipt of this letter.

Section 54.1-2409 of the Code further provides that you may apply to the Board of Nursing ("Board") for reinstatement of your certificate, and shall be entitled to a hearing not later than the next regular meeting of the Board after the expiration of sixty days from the receipt of such reinstatement application. You have the following rights, among others: to be represented by legal counsel, to have witnesses subpoenaed on your behalf, to present documentary evidence and to cross-examine adverse witnesses. The reinstatement of your certificate shall require the affirmative vote of three-fourths of the members of the Board of Nursing present at the hearing.

Should you wish to petition the Board of Nursing for reinstatement of your certificate, contact Jay P. Douglas, Executive Director, at the above address or (804) 367-4639.

Sincerely,

Jaime H. Hoyle, Esquire, Chief Deputy Director
Department of Health Professions

Enclosures
Case #163965

VIRGINIA:

BEFORE THE DEPARTMENT OF HEALTH PROFESSIONS

IN RE: RAMATU SESAY, C.N.A.
Certificate No.: 1401-157459

ORDER

In accordance with Section 54.1-2409 of the Code of Virginia (1950), as amended, ("Code"), I, Jaime H. Hoyle, Esquire, Chief Deputy Director of the Virginia Department of Health Professions, received and acted upon evidence that the certificate of Ramatu Sesay, C.N.A., to practice as a certified nurse aide in the State of Maryland was revoked by a Final Decision and Order of Revocation dated February 10, 2014. A certified copy of the Final Decision and Order of Revocation is attached to this Order and marked as Commonwealth's Exhibit No. 1.

WHEREFORE, by the authority vested in the Director of the Department of Health Professions pursuant to Section 54.1-2409 of the Code, it is hereby ORDERED that the certificate of Ramatu Sesay, C.N.A., to practice as a certified nurse aide in the Commonwealth of Virginia be, and hereby is, SUSPENDED.

Upon entry of this Order, the certificate of Ramatu Sesay, C.N.A., will be recorded as suspended. Should Ms. Sesay seek reinstatement of her certificate pursuant to Section 54.1-2409 of the Code, she shall be responsible for any fees that may be required for the reinstatement and renewal of her certificate prior to issuance of her certificate to resume practice.

Pursuant to Sections 2.2-4023 and 54.1-2400.2 of the Code, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record and shall be made available for public inspection and copying upon request.

Jaime H. Hoyle, Esquire, Chief Deputy Director
Department of Health Professions

ENTERED: 7/23/15

COMMONWEALTH of VIRGINIA

David E. Brown, D.C.
Director

Department of Health Professions
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

www.dhp.virginia.gov
TEL (804) 367- 4400
FAX (804) 527- 4475

CERTIFICATION OF DUPLICATE RECORDS

I, Jaime H. Hoyle, Esquire, Chief Deputy Director of the Department of Health Professions, hereby certify that the attached Final Decision and Order of Revocation dated February 10, 2014, regarding Ramatu Sesay, C.N.A., are true copies of the records received from the Maryland Board of Nursing.

Jaime H. Hoyle, Esquire

Date: 7/23/15

IN THE MATTER OF		*	BEFORE THE
		*	
RAMATU SESAY		*	MARYLAND BOARD
		*	
Certificate Nos.	A00038572/	*	OF NURSING
	MT0019807	*	

****

FINAL DECISION AND ORDER OF REVOCATION

I. PROCEDURAL BACKGROUND

On or about February 3, 2011, the Maryland Board of Nursing (the "Board") received a complaint from a nurse from a county agency in Montgomery County, Maryland regarding the practice of Ramatu Sesay (the "Respondent"). The Board conducted an investigation, and, based upon that investigation, on September 28, 2011, the Board notified the Respondent that it was charging both her certified nursing assistant ("CNA") and her medication technician ("MT") certifications with several violations of the Maryland Nurse Practice Act. Specifically, the Board charged both the Respondent's CNA and MT certificates with violations of Md. Code Ann., Health Occ. ("H.O.") § 8-6A-10(a):

> (7) Fails to file or record any health record that is required by law;
>
> (9) Has violated any order, rule or regulation of the Board relating to the practice or certification of a nursing assistant or medication technician, specifically COMAR 10.39.07.02.A.(4) and (7) and COMAR 10.39.07.02.B.(2);
>
> (13) Has acted in a manner inconsistent with the health or safety of a person under the applicant or certificate holder's care;
>
> (14) Has practiced as a nursing assistant or medication technician in a manner which fails to meet generally accepted standards for the practice of a nursing assistant or medication technician;
>
> (19) Performs certified nursing assistant or certified medication technician functions incompetently; and

(25) Fails to comply with instructions and directions of the supervising registered nurse or licensed practical nurse.

The Board's charging document also notified the Respondent of the Respondent's opportunity to request an evidentiary hearing before the Board regarding its charges. On November 1, 2011, the Respondent requested an evidentiary hearing. By letter dated October 21, 2013, the Board notified the Respondent that an evidentiary hearing had been scheduled before the Board on December 17, 2013. On December 17, 2013, a quorum of the Board was present and an evidentiary hearing was held. Karen Malinowski, Administrative Prosecutor, was present and presented the State's case against the Respondent. Despite requesting a hearing before the Board, the Respondent failed to appear.

Evidentiary Exhibits and Witnesses

State's Exhibits:

1. a. Maryland Board of Nursing Complaint Form, received February 3, 2011 (7 pages).
   b. Online Licensure Verification Printouts for the Respondent (2 pages).

2. Incident Documentation from Employer A (59 pages).

3. a. Written Statement from Nurse P, dated February 14, 2011 (2 pages).
   b. Written State from the Respondent, dated March 25, 2011 (1 page).
   c. Maryland Board of Nursing Report of Investigation, dated May 5, 2011 (3 pages).

4. a. Letter from the Board to the Respondent, Re: Notice of Agency Action-Charges under the Maryland Nurse Practice Act, dated September 28, 2011 (12 pages).
   b. The Respondent's Request for a Hearing, dated November 1, 2011 (1 page).
   c. Letter from the Board to the Respodnent, Re: Notice of Hearing, dated October 21, 2013 (13 pages).

State's Witnesses:

1. Investigator, Maryland Board of Nursing.

Respondent's Exhibits:

None submitted.

Respondent's Witnesses:

None.

II. FINDINGS OF FACT

The Board makes the following findings of fact based upon the entirety of the record:

1. On or about March 22, 2001, the Board issued a certificate to practice as a certified nursing assistant to the Respondent. (*See* State's Exhibit 1, p. 08). On or about August 28, 2002, the Board issued a certificate to practice as a medication technician in the State of Maryland to the Respondent. (*See* State's Exhibit 1, p. 09).

2. On or about February 3, 2011, the Board received a complaint from an assisted living facility in Rockville, Maryland (the "ALF"). (*See* State's Exhibit 1, p. 01). The complainant, a community health nurse with the Montgomery County ("Nurse A"), alleged that multiple nursing deficiencies were found during her January 1, 2011 visit to the ALF. (*See* State's Exhibit 1, pp. 04-06).

3. According to documentation submitted by the ALF, the Respondent was hired in 2009 as a "caregiver" and responsible for:

> all aspects of resident care such as bathing, toileting, laundry, dressing, food preparation, housekeeping, wound dressing, grooming, daily resident activities, exercising, medication management and any other services and functions required to ensure the best quality of life of [the ALF's] residents.

(State's Exhibit 2, p. 010).

Resident A's Flight Attempts

4. In 2010, Resident A, a 77-year-old female, was admitted to the ALF with diagnoses of dementia, renal failure, hypothyroidism, and leukemia. (*See* State's Exhibit 2, p. 013). Because of

her dementia, Resident A's physician certified her as mentally incompetent. (*See* State's Exhibit 2, p. 014).

5. Upon her admission to the ALF, on September 20, 2010, the assisted living manager conducted an assessment of Resident A, indicating that she needed "supervision, or stand-by, or set-up, or cuing and coaching" for use of stairs, completion of bathing, and completion of grooming. (*See* State's Exhibit 2, p. 015). The assessment also indicated that Resident A was unable to prepare her own meals and that she was an "occasional" wandering risk. (*See* State's Exhibit 2, pp. 016-017). Resident A's "Level of Care Scoring Tool" prepared on September 23, 2010 and Resident A's "Resident Service Plan" also indicated that Resident A was a wandering risk. (*See* State's Exhibit 2, pp. 021; 023; 025-026). Specifically, the Resident Service Plan noted the ALF's "Expected Outcomes of Services Provided" as: "Alarms on all doors (windows especially in [Patient A's] room – prevent flight/escape; Care-giver monitors through the day. Windows in room are sealed." (State's Exhibit 2, p. 027).

6. According to a "Facility Incident Report" written by the assisted living manager, on September 19, 2010, Resident A

> exited her room around 1 or 2am by opening her bedroom window and punching out the window screen. She walked to the street and hitched a ride to her [daughter's] home in Gaithersburg. [Patient A] was returned back to [the ALF] by her daughter [ ] around 3am.

(State's Exhibit 2, p. 028). According to the report, the Respondent was "unaware" of Resident A's escape and was later notified by Resident A's daughter. (*Id.*).

7. According to a "Facility Incident Report" written by the assisted living manager, on October 7, 2010, Resident A:

> possibly escaped out of the front (main) door which may have been left unlocked after [another resident] went out to have his midnight smoke. [Montgomery] County Police returned [Resident A] back to our home around 4am. She was cooperative, in good spirits and went straight to bed.

(State's Exhibit 2, p. 029). The report indicated that the Respondent alerted the assisted living manager of the situation at 5 a.m., and that the Respondent was instructed to "stay with [Resident A] until she was sure that [Resident A] was sound asleep." (*Id.*).

8. According to a "Facility Incident Report" written by the assisted living manager, on December 24, 2010, the

> [n]eighbor across the street was visited by [Resident A] around midnight. [The ALF's owner] was contacted who called the [assisted living manager]. Neighbor attempted to knock on the door, but [the Respondent] would not open it as per orders. The [assisted living manager] contacted neighbour [*sic*] who confirmed that [Resident A] was at their home. [The assisted living manager] called [the Respondent] and instructed her to help bring [Resident A] back home.

(State's Exhibit 2, p. 031).

Medication Administration Documentation for Resident A

9. The Respondent also maintained Resident A's medication administration records ("MAR"). According to Resident A's November 2010 MAR, Resident A was ordered to take 325mg of Tylenol "two (2) tablets by mouth every 4-6 hrs *as needed* for pain." (State's Exhibit 2, p. 038) (emphasis added). According to the MAR, the Respondent documented the administration of Tylenol to Resident A every day from November 16, 2010 through November 31, 2010.[1] (*Id.*). In testimony from the Board's Investigator, who is a registered nurse, the Investigator testified that medications administered "as needed" or "PRN" are not documented as other "standing" medications

[1] The Board notes that November only has 30 days, yet, inexplicably, the Respondent documented medication administration for a non-existent date.

are documented. (*See* Transcript, pp. 31-32). According to the Investigator, in addition to documenting the administration, the person administering the PRN medication would also have to document the circumstances why that medication was being administered to the patient. (*See* Transcript, p. 31). The Respondent failed to document the circumstances of the Tylenol administration on the Resident A's November MAR. (*See* State's Exhibit 2, pp. 036-040). The Board also notes that, on November 17, 2010, Resident A's physician ordered that Resident A take one multivitamin each day (*see* State's Exhibit 2, p. 041), but that the MAR failed to transcribe that order. (*See* State's Exhibit 2, pp. 036-040).

10. In Resident A's MAR for December 2010, the Respondent again failed to properly document for the daily administration of a PRN medication. (*See* State's Exhibit 2, pp. 044-049).

11. On December 18, 2010, the ALF's delegating nurse wrote a memorandum to the assisted living manager regarding the Respondent. (*See* State's Exhibit 2, p. 051). The memorandum stated that the delegating nurse reviewed with the Respondent:

a. How to chart PRN/stat orders and medication omissions.

b. How to transcribe orders (new) on MAR from Rx.

c. How to document accurately and in a timely manor [*sic*].

d. All clients' notes are to be filed in his/her chart in the approp. place.

(State's Exhibit 2, p. 051).

12. According to Resident A's MAR for January 2011, Resident A had a PRN order for Tylenol from January 1, 2011 until January 13, 2011. (*See* State's Exhibit 2, p. 054). On January 14, 2011, the Tylenol PRN order was modified to a standing order for Tylenol 500mg, 2 tablets every 4 to 6 hours. (*Id.*). Despite having been counseled by the delegating nurse on PRN charting, the

Respondent failed to properly chart the PRN administration from January 1, 2011 through January 13, 2011. (*See* State's Exhibit 2, p. 055). Upon the modification of the PRN order to a standing order, however, the Respondent began incorrectly documenting the administration as if it were PRN administration. (*Id.*). In addition, on January 5, 2011, Resident A's physician ordered two new prescriptions for Resident A: Ducolax and Miralax. (*See* State's Exhibit 2, p. 058). The new prescriptions were not transcribed on Resident A's January 2011 MAR. (*See* State's Exhibit 2, pp. 052-057).

The Board's Investigation

13. During the Board's subsequent investigation into the Respondent's practice, the ALF's delegating nurse sent a letter to the Board Investigator, stating:

> I received a call from [Nurse A] from [Adult Protective Services] regarding [Resident A].
>
> I was aware that [Resident A] had a problem with wandering when I first saw her on 3rd Nov. 2010, however, I was never informed that she had physically left the premises at any time – just that an attempt was made to climb out of the window.
>
> Chart contents in the [ALF] needed to be organized correctly by [the Respondent] and [the assisted living manager] was notified. Since then, it has been an ongoing process. [Illegible] notes that were not in the chart were misfiled by [the Respondent] and are now in her chart. There was no folate in the medication box for the client when I visited the [ALF]. My subsequent visit on the 18 Dec. 2010, I spoke with [the Respondent] about charting of Tylenol, she had given [Resident A] Tylenol once per day not three times – she was to correct that and write a note explaining the error in charting.
>
> Medication protocol and documentation was again reviewed with [the Respondent] and [the assisted living manager] notified.

(State's Exhibit 3, pp. 069-070).

14. The evidence before the Board presents a very stark image of a nursing assistant and medication technician who was ill-equipped to perform even the most basic CNA/MT skills, in this case: client management and documentation. It is unfortunate that the Respondent did not appear for the hearing. The Board would have liked to hear from the Respondent about how and why she seemed to lack very basic skills required of a certificate holder and, perhaps, mitigate the evidence presented by the State. Instead, the Board is only left with evidence that indicates that Resident A was a well-documented wandering risk and that the Respondent knew or should have known of that risk and, despite that knowledge and on at least three separate occasions, Resident A left the ALF unattended while the Respondent should have been closely monitoring her. Resident A's flights from the ALF could have had serious and grave consequences, which the Respondent should have understood upon Resident A's admission. The Board finds that the Respondent's repeated failure to protect and prevent Resident A, a vulnerable adult suffering with dementia, from wandering out the ALF violates H.O. § 8-6A-10(a)(13).

15. The Respondent repeatedly failed to properly document medication administration on Resident A's MAR. Specifically, the Respondent failed to properly transcribe physician orders and failed to properly document PRN administration. The Board finds that, because the Respondent failed to record Resident A's health record as required by law, the Respondent violated H.O. § 8-6A-10(a)(7).

16. The delegating nurse attempted to remediate the Respondent's poor documentation skills on at least one occasion, but it appears that the Respondent did not comprehend and, therefore, did not comply with the delegating nurse's instructions. As such, the Board finds that the Respondent violated H.O. § 8-6A-10(a)(25).

17. In both her failure to adequately protect and prevent Resident A, a vulnerable adult with a preclusion to wander away, from leaving the ALF unattended and her failure to properly document medication administration, the Board finds that the Respondent practiced in a manner that plainly fails to meet generally accepted standards for the practice of a nursing assistant and a medication technician. Thus, the Board finds that the Respondent violated H.O. § 8-6A-10(a)(14).

18. The Respondent's misconduct was not a singular occurrence. The Respondent allowed Resident A to escape the ALF on at least three occasions, and at least one attempt was made by the delegating nurse to remediate the Respondent's poor documentation. Occurrence after occurrence and warning after warning, the Respondent failed to correct her course and take measures to practice in a safe and diligent manner. Accordingly, the Board finds that the Respondent is professionally incompetent and has violated H.O. § 8-6A-10(a)(19).

19. In its discretion and because it would be duplicative, the Board does not find that the Respondent violated H.O. § 8-6A-10(a)(9) and the Board will dismiss that charge.

20. The Board finds that the Respondent's misconduct falls within category F.(3) of the Board's sanctioning guidelines. *See* COMAR 10.27.26.07.F.(3). The range of potential sanctions under category F.(3) is suspension for one (1) year to revocation. *Id.* The applicable range of potential monetary penalties is $300 to $500. *Id.*

III. CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes that the Respondent violated Md. Code Ann., Health Occ. § 8-6A-10(a):

(7) Fails to file or record any health record that is required by law;

(13) Has acted in a manner inconsistent with the health or safety of a person under

the applicant or certificate holder's care;

(14) Has practiced as a nursing assistant or medication technician in a manner which fails to meet generally accepted standards for the practice of a nursing assistant or medication technician;

(19) Performs certified nursing assistant or certified medication technician functions incompetently; and

(25) Fails to comply with instructions and directions of the supervising registered nurse or licensed practical nurse.

IV. ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, it is hereby:

ORDERED that the charge issued by the Board in its September 28, 2011 "Notice of Agency Action" alleging a violation of H.O. § 8-6A-10(a)(9) is hereby **DISMISSED**; and it is further

ORDERED that the certificate of the Respondent, Ramatu Sesay, Certificate Number A00038572, to practice as a nursing assistant is hereby **REVOKED**; and it is further

ORDERED that the certificate of the Respondent, Ramatu Sesay, Certificate Number MT0019807, to practice as a medication technician is hereby **REVOKED**; and it is further

ORDERED that this document is a **PUBLIC DOCUMENT** under Md. Code Ann., State Gov't § 10-617(h) (2009 Repl. Vol.).

February 10, 2014
Date

Patricia A. Noble, Executive Director
Maryland Board of Nursing

NOTICE OF APPEAL RIGHTS

Any person aggrieved by a final decision of the Board under H.O. § 8-6A-10 may take a direct judicial appeal within thirty (30) days as provided by H.O. § 8-6A-11, Md. Code Ann., State Gov't § 10-222, and Title 7, Chapter 200 of the Maryland Rules, including Md. Rule 7-203 ("Time for Filing Action").