STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
DEPARTMENT OF HEALTH
HEALTH SERVICES REGULATION
BOARD OF NURSE REGISTRATION AND NURSING EDUCATION
THREE CAPITOL HILL
PROVIDENCE, RI 02908

In the Matter of:	:	
Chandra Ghetti, LPN10729	:	**C17-0360; C16-558**
Respondent.	:	

ORDER REVOKING LICENSE

I. Introduction

The above-entitled matter came before the Board of Nurse Registration and Nursing Education ("Board") pursuant to a Notice of Charges and Administrative Hearing ("Notice") issued on June 19, 2017 by the Board to Chandra Ghetti ("Respondent"). The Respondent holds a license ("License") as a licensed practical nurse in the State of Rhode Island pursuant to R.I. Gen. Laws § 5-34-1 *et seq*. A hearing was scheduled for July 10, 2017 at which time the Respondent did not appear at hearing. Pursuant to Section 5.6 of the *Rules and Regulations Pertaining to Practices and Procedures Before the Department of Health* ("Hearing Regulation"), service may be made by hand-delivery or first class mail and service is complete upon mailing, even if unclaimed or returned, when sent to the last known address of the party. In this matter, notice was sent to the Respondent's last known address by first class and certified mail.[1] Since the Respondent was adequately noticed of hearing, a hearing was held. Additionally, Section 12.9 of the Hearing Regulation provides that a judgment may be entered based on pleadings and/or

[1] See Department's Exhibit One (1) (Notice and tracking sheets).

evidence submitted at hearing by a non-defaulting party. The Board was represented by counsel who rested on the record.

II. Jurisdiction

The Board has jurisdiction over this matter pursuant to R.I. Gen. Laws § 5-34-1 *et seq.*, *Rules and Regulations for the Licensing of Nurses and Standards for the Approval of Basic Nursing Education Programs* ("Licensing Regulation"), and the Hearing Regulation.

III. Material Facts and Testimony

Stephanie Campbell ("Campbell"), RN, testified on behalf of the Board. She testified that she is the Director of Nursing at the nursing home where Respondent worked. She testified that on February 5, 2016 the Respondent worked a double shift, and would have been the only person who had access to narcotics on her wing. She testified that the Respondent recorded the administration of medicine for patient JB. She testified that there was a discrepancy regarding the pills given JB between the handwritten notes for JB and the notes in the EMAR (Electronic Medication Administration Record). See Department's Exhibits Six (6) (handwritten notes) and Seven (7) (EMAR). She testified that there were two (2) administrations of medicine entered into the EMAR, but the handwritten notes indicated six (6) pills were given to said patient during that time period. She testified that the Respondent would be the only one on duty at that time who had access to the medicine for patient JB.

Campbell further testified that it was discovered that the Respondent on February 19, 2016 signed for a pharmacy delivery of 30 oxycodone pills for patient OL's prescription, but there was no record at the nursing home of the delivery. She testified that the pharmacy record showed the Respondent signed for the delivery but there was no corresponding receipt for the nursing home. See Department's Exhibits Nine (9) (pharmacy delivery receipt showing Respondent's signature).

Campbell testified that Kerri Faye ("Faye"), RN, worked on February 21, 2016 and noticed that night there were nine (9) oxycodone pills for patient KR when she left her shift and was replaced by Respondent, but the next day when Faye came on duty the count was one (1) pill when based on the patient's prescription, there should have been more pills left. She testified that Kaye informed her of the discrepancy in the pill count. She testified that when asked about the discrepancy, the Respondent blamed students, but the facility did not have students that night in the nursing home. She testified that for the period that the Respondent was on duty, there were several unidentified signatures on the narcotic log and two (2) that were identifiable as Respondent's. See Department's Exhibits 12 (Faye's affidavit explaining the discrepancy in the pill count for patient KR from when Respondent was on-duty and how Respondent told her it was due to students and copy of the narcotic log showing five (5) unidentified signatures on lines 14-18 for that night and Respondent's two (2) identified signatures); 13 (narcotic log) and 14 (EMAR showing only two (2) pills given to patient KR that night).

Lakesha Lopez, RN at the nursing home, testified on behalf of the Department. She testified that Kerri Faye reported to her about patient KR and how there had been nine (9) pills left and since the prescription was for every four (4) hours, there should have been five (5) left, but it was down to zero. See Department's Exhibit 17 (shift count).

Genevieve Kuada, licensed practical nurse, testified on behalf of the Department. She testified that she worked at the nursing home where the Respondent worked and on February 22, 2017, she took count from Respondent as she (Kuada) came onto the shift and Respondent's shift ended. She testified that the count is based on reconciling the narcotics left in the blister pack with the paper log. See Department's Exhibits 13 (February narcotic log) and 18 (blister pack).

Margaret Clifton, Board Manager, testified on behalf of the Department. She testified that as part of the investigation of Respondent, the Department received information from another nursing home where the Respondent also had worked that on April 22, 2016, the Respondent had diverted oxycodone and torn out the page from the narcotic log corresponding to when she was on duty and the drugs went missing. See Department's Exhibit 23 (Department investigation); 24 (Respondent's response); and 25 (nursing home investigative file). She further testified that the Respondent ignored the Board and Board was seeking revocation of her License.

IV. Discussion

The Department argued that the Respondent violated R.I. Gen. Laws § 5-34-24(3) (unfit or incompetent by reason of negligence or habits); R.I. Gen. Laws § 5-34-24(4) (habitually intemperate or addicted to habit-forming drugs); R.I. Gen. Laws § 5-34-24(6)(ii) (willfully making or filing false reports); R.I. Gen. Laws § 5-34-24(6)(iv) (failure to furnish appropriate details of a client's nursing needs); and R.I. Gen. Laws § 5-34-24(6)(v) (willfully disregarding standards of nursing practice and failing to maintain standards of nursing profession by failing to document in medical records patient in care)[2] by diverting controlled substances.

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[2] R.I. Gen. Laws § 5-34-24 provides in part as follows:

> Grounds for discipline of licensees. – The board of nurse registration and nursing education has the power to deny, revoke, or suspend any license to practice nursing; to provide for a non-disciplinary alternative only in situations involving alcohol or drug abuse or to discipline a licensee upon proof that the person is:
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> (3) Unfit or incompetent by reason of negligence or habits;
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> (4) Habitually intemperate or is addicted to the use of habit-forming drugs;
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> (6) Guilty of unprofessional conduct which includes, but is not limited to, all of the above and also:
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> (ii) Willfully making and filing false reports or records in the practice of nursing;
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> (iv) Failure to furnish appropriate details of a client's nursing needs to succeeding nurses legally qualified to provide continuing nursing services to a client;
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> (v) Willful disregard of standards of nursing practice and failure to maintain standards established by the nursing profession.

Based on the pleadings and exhibits and testimony at hearing, it is undisputed that the Respondent while acting as a registered nurse diverted controlled substances on February 5, 2016 in relation to patient JB, February 19, 2016 in relation to the pharmacy delivery, February 21, 2016 in relation to patient KR, and April 22, 2016.

The Board unanimously found that based on the forgoing, the Respondent violated R.I. Gen. Laws § 5-34-24(3), (4), and (6)(ii), (iv) and (v). The Board dismissed the charges against the Respondent in paragraph two (2) of the Notice.

V. ***Conclusion***

After hearing and based on the forgoing, the Board made the following orders:

1. The Respondent's License is revoked.
2. If the Respondent, in future, re-applies for the License (or be reinstated), the Respondent must appear the Board as part of any such application.

By Order of the Board,

Jessica Brier, RN
President

Entered this 28th day of July, 2017.

NOTICE OF APPELLATE RIGHTS

PURSUANT TO R.I. GEN. LAWS § 5-34-28, APPEALS OF DECISIONS ARE GOVERNED BY THE ADMINISTRATIVE PROCEDURES ACT, R.I. GEN. LAWS § 42-35-1 *et seq.* 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 DECISION 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 3rd day of ~~July~~ August, 2017 that a copy of the within Order and Notice of Appellate Rights was sent by first class mail, postage prepaid and registered mail, return receipt requested to Ms. Chandra Ghetti, 192 Robinson Avenue, Pawtucket, RI 02861 and via electronic delivery to her email on record with the Department and by hand-delivery to Julie Sacks, Esquire, Department of Health, Three Capitol Hill, Providence, RI 02908.