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

Respondent finally went to see Patient A after her co-worker had gone to get her. She testified that Patient A was actively coughing up "frothy phlegm". At approximately 5:15, she and her co-worker Aretha Jackson were in Patient A's room waiting for the Respondent who has been summoned by Tammy Keodone "to come immediately." She testified that the Respondent entered the room with some cough medicine in a little medicine cup and said, "Have some cough medicine." Oliver added that Patient A couldn't swallow the cough medicine. The Respondent then ordered vital signs and we "ran to get the cuff, the pulse-ox and the thermometer." The Respondent then said, "Let's get some O2 on her", according to Oliver. Oliver went to get the oxygen console. When she returned there were some commotion and the Respondent was grabbing my co-worker and throwing her towards the doorway. She said that they got the O2 on the patient and the Respondent went to get the "nursing supervisor". Oliver stayed in the room with the nursing supervisor while the Respondent went to call 911. Oliver and the RN on duty attempted to "suction" the patient in order to clear the airway but the patient expired during this process.

During cross-examination, Oliver stated that the Respondent asked her to get the vital signs after the cough medicine she was attempting to administer ran down Patient A's chin. She testified further that the nurse's station was about 25 feet from Patient A's room. Counsel unsuccessfully attempted to get Oliver to say that the Respondent could hear what was going on in Patient A's room. Oliver did admit that the nurses station was located where the charge nurse could see the white blinking hall light and the blinking light outside a patient's room when a patient pushes the alarm button.

Oliver denied having a conversation with co-workers about "keeping their story together" in order to "get" her. Oliver admitted taking two fifteen-minute breaks and one for about 20 minutes. Her co-workers were on the floor at the time because they are not allowed to take breaks together. She said that she didn't summon anyone else because see felt her chain of command was to the charge nurse. During this overnight shift the Respondent took Oliver down the hall to a patient whose bed was left up. Oliver said that the Respondent was trying to point out something that she had not completed correctly. She did not mention Patient A to the Respondent at this time, she testified, "Because she was trying to point out something to me that she claimed that I had done."

Tammy Keodone, CNA

Tammy Keodone worked as certified nursing assistant for over three years during which time she was an employee of Oakland Grove Healthcare Center. She was on duty with her co-workers on July 9, 2004 during the 11-7 shift. She testified that she did not discuss Patient A with her co-workers until about 4:30 or 5:00 when they said that the charge nurse "still hadn't gone into the room". She recalled the conversation between Oliver and the Respondent because she heard the Respondent tell Oliver that she "went out for an x-ray and it was negative". She said that we went in to see Patient A and Linda Oliver was in there. "I said, all right, I'm going to tell Gloria she needs to come in here.... I went up to Gloria and said, "You need to go see [Patient A] something is wrong with her." Gloria said, "I'll be there". Later, she was approached by Aretha who told her that "she (Respondent) just hit me, pushed, shoved me out of the room."

Keodone testified that she had a friendly relationship with Oliver and Jackson at work but did not socialize with either of them outside of the workplace. She said that the

Respondent and Jackson didn't get along well but did not know why. She said she and the Respondent got along well.

Keodone testified that Patient A's light came on at least three times during the shift. She said that she was busy with the 59 other patients on the floor who needed her attention and therefore was unaware of what was transpiring between Patient A and the other two nursing assistants. She testified that she didn't take her breaks outside as the other nursing assistants did. She would "read" a novel right in front of the charge nurse desk where she would keep an eye on the floor and respond to lights or patient "alarms" that might ring. Keodone was cross-examined about a statement that was provided to the Department of Attorney General during part of its investigation. She admitted that the statement she gave regarding Patient A at 1:00 in the morning should have read 11:00 in the morning. She testified that Patient A told her that she "didn't feel well". She didn't reveal this conversation to her coworkers because the patient was able to speak for herself. She stated that the first time that she spoke with the Respondent about Patient A was 4:30 am when the other nursing assistants asked her to intervene. She found the Respondent making "med rounds" She stated that the patient's blood oxygen levels by the time the Respondent assessed the patient were "very low". She testified that the two nursing assistants spoke to her about the Respondent's lack of attention twice.

Aretha Leola Jackson, CNA

Aretha Jackson testified that she has been a certified nursing assistant for four years. She had not worked since last August but was employed previously at the Oakland Grove Healthcare Center. She had been employed three for three months prior to July 9, 2004. She had worked as a nursing assistant for approximately 17 years. She worked the

11 to 7 shift with Oliver and Keodone and was supervised by charge nurse Gloria Baillargeon. She testified that during this time she had only one personal dispute with the Respondent. She arrived at the center and didn't see Patient A until 1:00 am when she went her room woke her to "change her". Later, she rang the buzzer. Oliver went to answer and came back telling Jackson and Keodone that Patient A was having difficulty breathing. She said that they didn't do anything but Oliver went to tell the Respondent because she was the charge nurse. The Respondent did not assess the patient at that time. About 2:30, the patient's light went on again. Again, the Respondent did not go to Patient A's room. After the second ring Oliver came running by with a cloth with "two big green chunks" and went to show the Respondent. The Respondent remained unmotivated and didn't go to the patient's bedside. By the third ring "we all jumped" (the three nursing assistants) and "went in there together". Jackson testified that Patient A was spitting up, green-brownish liquid. After observing this, Keodone then went to get the Respondent to attend to Patient A. When asked what bothered her the most, Jackson answered, "the fact that she was neglected...by Gloria." (Oct. 3 transcript page 58)

Jackson admitted that the senior nurse, Loraine (Mariscal) Beauregard, RN, when she first came to work, had disciplined her that night. The "Employee Disciplinary Notice" (Respondent's Exhibit 3) notes that Jackson was given a "verbal warning" for four episodes of absenteeism in the last 30 days. Jackson, refused to sign the form, according to testimony and a hand-written note at the bottom of the form initialed by Mariscal. Jackson continued to work for Oakland Grove for another month when she fell and was injured at work. She hasn't returned to work at the center.

Jackson testified that she would have gone to Mariscal about the neglect of Patient A earlier had she known that she was able to do so. She went to the Respondent because she felt the Respondent was the proper person to whom to report the patient's condition.

Jackson was cross-examined on the events surrounding the patient's death when her pulse-oxygen levels were falling. Her memory of all her specific assignments on that night over a year ago was not clear. For instance, she didn't recall which nursing assistant was charged with taking vital signs.

Lorraine Mariscal Beauregard, RN

The defense began its case by presenting the registered nurse in charge of the facility on the 11-7 shift, Lorraine Mariscal Beauregard, aka, "Lori". She testified that she is a graduate of the "*Rhode Island*" school of nursing in approximately 1982. The remainder of her hesitant testimony is as follows: Her shift typically begins by getting a "report" for patients in the whole building and another for the "floor". She indicated that she was the nurse in charge of all the patients for the 11-7 shift. She said her policy for complicated medical problems with patients is "when in doubt, send them out."

She testified that she was had been acquainted with the Respondent for several years. She indicated that the Respondent paid attention to details. She said she did not know the Respondent outside of work. She has known Aretha Jackson for less than a year. She said that she had to discipline her for absenteeism and that Jackson had difficulty following directions. When pressed on that issue she said that when she was told to do paperwork she had to be reminded later to do it.

She testified that in the early morning hours of July 9th, the Respondent summonsed her to attend to a "patient in distress" and to deal with "trouble with her staff." (*Transcript of November 1,4 page 20)* Mariscal said that Patient A was "non-verbal" when she arrived. She recalled the events this way: "At 5:00 am O2 was administered. Patient A "was very poor when I came in. Very low pulse Ox, a lot of mucus, and difficulty breathing. She needed immediate hospitalization. She was a DNR." The rescue was called and arrived within 10 minutes. She testified that the "CNAs" made no attempt to reach her. She acknowledged that the CNAs were upset. I told them that we "did what we could" but they "remained upset," she said.

Respondent Gloria Baillargeon, LPN

The Respondent testified that she had been a licensed practical nurse since 1999 after graduating from CCRI. She went to work at Oakland Grove shortly after and worked there until 2004. She has three children ages 36, 34, 27 years old. She was previously employed as a nurse's aid working as a "med tech".

She had worked the third floor since 1999 and had known Patient A since that time. She said that she had to treat the patient for cellulitis at 1:00 am and when she woke the patient up she was upset. She said the patient was coughing at that time and refused cough syrup. She testified that she saw the CNAs on the hall at 1:00 and "no one expressed concerns about the patient then. She said the CNAs all took their breaks in succession: Oliver first, followed by Jackson and Keodone who did not leave the floor.

The Respondent's testimony concerning the facts and circumstances around Patient A's demise was starkly contrasting to that of the CNAs. For instance, the Respondent's version of Patient A's condition around 5:00 am was that she was "up and

responsive" and that she gave the patient cough syrup. The Medical Administration Record indicates that Lasix was given at this time also.

The Respondent's testimony, taken with her written statement and the medical record indicates a profound lack of veracity and competence. She testified that Patient A was not coughing. She said that Oliver told her that Patient A was having trouble breathing.

Patient A's medical chart Narrative Nursing Notes for July 9th are bereft of competent and acceptable notes. The only notation in Patient A's chart by the Respondent is "Fournier and Fournier pick up at 7:05". Fournier and Fournier is a funeral home. At the hearing, the Respondent proffered some hand-written notes she claimed to have kept herself.

They read, "1 am coughing refused cough syrup 5 am Tammy came a get me cough syrup and pulse Ox 80% accu √ 254 O2 (sat) 70% Ms. Moril still alert at 5 am 5-10 condition rapidly deteriorate called supervisor". Why the Respondent began keeping a "private note" on Patient A at 1:00 am was not explored or explained.

The Respondent provided a statement to the facility administration regarding the care rendered to Patient A. Her statement to the facility (State's exhibit 1) demonstrates a clearly out of control situation. She claims to have visited Patient A at 1:00 am to administer cough medicine. She said no one called or spoke to her until 5:00 am when Keodone came to get her because Patient A had difficulty breathing. Her pulse Ox reading at that time was 70%. By then, Jackson was raising her voice and trying to get someone to call 911. The Respondent said she screamed "Aretha get out of this room!" Her pulse Ox after the Patient A had been administered O2 had dropped to 60%.

Respondent's testimony was that she attempted to give Patient A "cough syrup" during this time. Patient A's medical chart indicates that she was administered "Lasix" at this time also. Within 10 minutes of the Respondent's attempts to treat Patient A, she became "unresponsive", according to nurse Mariscal's 5:10 am entry in the record.

After giving careful consideration to the testimony provided by the Respondent, her written statement to the facility, her private "note" of the incident and the poorly documented medical record, the Respondent's testimony appears wholly unreliable and self-serving. The defense averment that the three CNAs were "out-to-get the Respondent" lacks a minimally explainable basis. This supposition is predicated on the fact that one CNA, Jackson, was disciplined for 4 days of absenteeism. It offers neither an explanation for the desperate pleas of the other two for the Respondent to attend to Patient A nor any real connection of the 3 workers besides the fact that they worked together. The only worker that didn't get along with the Respondent appears to be Jackson. The defense proffers no motive for them to lie other than the finger pointing got "out of control".

The evidence in this case reveals a Respondent who professes to care deeply for her patients but whose care appears ministerial and regimented. She was clearly beyond her skill level when she finally attended to the patient. She testified that Patient A was "still alert" at 5:00 am. At this time Patient A's condition deteriorated to the point where her pulse ox was approximately 70. The Respondent administered "cough syrup" that drooled down Patient A's chin. She attempts to portray Patient's condition as "up and responsive...not coughing" at 5:00 am but the data in the chart and the Respondent own private note suggests otherwise. The CNAs have a markedly different description of Patient A at this time. Keodone described her as "nothing like ...when I came on the

shift. Her eyes were rolled back, she looked like she was having trouble breathing." Jackson described her as "barely able to breathe". And Oliver said Patient A was "coughing up frothy phlegm, having a great difficulty breathing, coughing and very obviously in distress".

The Respondent's insistence that none of the CNAs alerted her to Patient A's condition during the overnight hours was in stark contrast to the testimony of three credible witnesses. In an attempt at self-rehabilitation, the Respondent testified that she "peeked" into Patient A's room while making rounds. No one on the floor saw the Respondent "peek" into the darkened room. Respondent's averments at this point in her testimony challenge one's sense of responsibility and veracity.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. The Respondent is a Licensed Practical Nurse who has worked at Oakland Grove Healthcare Center since 1999.

2. She was the charge nurse on duty on July 8-9 for the 11pm to 7 am shift when Patient A experienced breathing difficulties between 1:00 am and 5:10 am when the patient ultimately expired.

3. The Respondent was notified at least three times between 1 am and 5 am by the CNAs that Patient A was experiencing difficulties.

4. The Respondent owed a professional duty to attend to Patient A the first time she was notified that Patient A was in distress.

5. Rather that attend to Patient A, the Respondent went about her duties delivering medications and making rounds. She ignored the prodding of her CNAs to attend and assist Patient A.

6. Respondent's treatment of Patient A throughout the evening of July 9 fell below the minimum standards of acceptable care.

7. Respondent's record keeping of the care rendered to Patient A was poor. Keeping a "private note" on Patient A was simply an attempt to avoid the realities associated with the Respondent's neglect of Patient A.

8. After hours of neglect by the Respondent, when Patient A was in crisis and one member of her CNA staff panic stricken, the Respondent screamed at the nursing assistant and shoved her out of the patient's room.

9. The CNAs on staff have no credible motive to misrepresent the facts under oath. The CNAs provided reliable and credible testimony regarding the events of that evening.

10. The Investigating Committee of the Board has met its burden of proving with a preponderance of the credible evidence that the Respondent willfully disregarded the standards of nursing practice and failed to maintain standards established by the nursing profession. Respondent's professional actions related to the care and treatment of Patient A constitute unprofessional conduct as defined in R.I.G.L. § 5-34-24(6)(v).

ORDER

The Board of Nurse Registration and Nursing Education hereby Revokes the License to practice Licensed Practical Nursing in the State of Rhode Island that was issued to Gloria Baillargeon.

By Order of The Board,

President, Board of Nurse Registration
and Nursing Education

Charles Alexandre, RN
Chief, Health Professions Regulation

If you are aggrieved by this final agency order, you may appeal this final order to the Rhode Island Superior Court within thirty (30) days from the date of mailing of this notice of final decision pursuant to the provisions for judicial review established by the Rhode Island Administrative Procedures Act, specifically, R.I. Gen. Laws § 42-35-15.

CERTIFICATION

This is to certify that a copy of this Order has been sent to the Respondent through her Counsel James E. O'Neill, Esq., The Meadows, Suite, A-103, 1130 Ten Road, North Kingstown, RI 02852 and to Gregory Madoian, Esq., Division of Legal Services, Department of Health, 3 Capitol Hill, Providence, RI 02908 on this 30 TH day of November 2005.

Grace W. McIntyre, Esq.
Hearing Officer