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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **EDNA Q. NACION-ANDERSON** **aka EDNA QUIAMBAO NACION** **2553 Anacapa Drive, #107** **Costa Mesa, CA 92626** **Registered Nurse License No. 510570** Respondent.	Case No. 2011-703 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about April 11, 1995, the Board of Registered Nursing issued Registered Nurse License Number 510570 to Edna Q. Nacion-Anderson, also known as Edna Quiambao Nacion (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on February 28, 2013, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

6. Section 2761 of the Code states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
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> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.
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> . . . .

REGULATORY PROVISIONS

7. California Code of Regulations, title 16, section 1442 states:

> As used in Section 2761 of the code, "gross negligence" includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

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8. California Code of Regulations, title 16, section 1443 states:

As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

9. California Code of Regulations, title 16, section 1443.5 states:

A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

COSTS

10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

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FACTS

11. On June 6, 2007, Respondent was employed in the capacity of Assistant Coordinator of Nursing at Fairview Developmental Center (a State-administered long-term care facility for developmentally disabled adults, hereinafter "FDC"). Respondent had been employed by FDC for 11 years at the time of the incident. On the evening/early morning of the incident, Respondent was working as the night shift nursing supervisor. Respondent was covering the shift for another nurse; she did not typically work the shift and was not acquainted with many of the clients and Psychiatric Technicians on duty that night. Respondent's shift was to end at 0630.

12. Respondent was assigned to Central Nursing Services (CNS) at FDC. CNS is physically separate from the residential units. When nursing services are required, CNS is contacted by the Psychiatric Technicians (PT's) who have oversight of the clients in the residential units. The PT's have their own supervisory hierarchy and typically do not interact with CNS unless a nursing assessment is required. Pagers and telephones are used to notify CNS.

13. During the early morning hours of June 6, 2007, the night shift PT's in Residence 441, were making their rounds and dealing with clients who would frequently get out of bed in the middle of the night. Residence 441 is a locked residence for clients with a tendency to elope, or attempt escape. Client V.I. had to be put back to bed several times that night. V.I. was a profoundly retarded 50-year-old male who had been a resident of FDC since the age of 8. He was known to be harmless to other clients and staff, but exhibited episodes of self-harm. V.I. liked to roam around the residence and was active at night, pacing the hallways. He also habitually urinated on himself, his bed, or in the hallways rather than use the toilet. Whenever he urinated, he would remove (or try to remove) his pants. V.I. was unable to speak or vocalize pain, but could communicate with hand gestures, facial expressions, and yelling.

14. PT J.S. stated that he discovered V.I. on the floor next to his bed lying in a puddle of urine at around 0530. His pants were around his ankles; he was conscious but very lethargic. PT J.S. called for assistance and PT A.T. helped him clean up V.I., change his pajamas, lift him off the floor, and put him back in bed. The PT's noticed that V.I. would not bear his own weight. V.I. had no visible injuries. No notification to CNS was made at that time.

15. At around 0545, PT J.S. checked on V.I. again and noticed that V.I. was acting strange. He called PT F.L. into the room for a second opinion. PT F.L. stated in interviews that V.I. had tears on his face, was moaning, and would not move his head. PT F.L. tried to get a reaction from V.I. by offering him a soda, but he would not reach for it, which was unusual because V.I. loved soda. The two PT's agreed that something was not right. According to PT F.L., she was never told by PT J.S. that V.I. had fallen out of bed; all she knew was that he was found sitting in his own urine next to the bed and was cleaned, changed, and put back in bed. PT F.L. told PT J.S. that an incident report would be required. PT F.L. stated she contacted Respondent at 0550.

16. Respondent stated in an April 17, 2009, interview with a Department of Investigation (DOI) investigator that she was not notified until 0620. Respondent stated that the notification system at FDC was unreliable and she frequently got late (or no) notifications. According to Respondent, she is certain she was not notified until 0620 because she was in the middle of preparing her end-of-shift reports when she received the call. Respondent stated that the caller (she only knows it was a female), reported that there was an unwitnessed fall of a client in Residence 441 and that the client was found by his bed in a pool of his own urine. The caller also indicated that the doctor had not yet been called. According to Respondent, there was no urgency to the caller's voice or any indication that it was an emergency. Respondent did not obtain any additional information about the client from the caller because Respondent did not like to tie up the phone lines. Respondent told the DOI investigator that if she had known that it was urgent, she would have gone to Residence 441 and completed an assessment. Respondent remembered directing the female caller to notify the Medical Officer of the Day (MOD). Respondent was relieved at 0630 by the day shift R.N. Respondent told her relief that a client had fallen in Residence 441. The relief nurse went to Residence 441 to assist the client along with the MOD. (It was Respondent's [mistaken] belief that the relief R.N. would conduct the nursing assessment.) The MOD, who arrived before the relieving R.N., found client V.I. stiff, in pain, lethargic, with depressed respirations, low blood pressure, swelling to the neck, and an abrasion over his eye. Client V.I. died at a local hospital six days later from acute bronchopneumonia due

to post fracture of his cervical vertebra. Respondent told the investigator that there is nothing she would have done differently, but that if she had known it was urgent, she would have stayed past her shift to care for V.I.

17. Respondent acknowledged to the DOI investigator that she knows and understands FDC's policies on recognizing and responding to spinal cord injuries. Respondent stated that she would suspect a spinal cord injury if the patient is unable to move and if a fall is suspected, in which case she would call 9-1-1. Respondent would also monitor the patient's breathing, watch for respiratory slowing or depression, and watch for a drop in blood pressure or symptoms of lethargy, losing consciousness, severe pain, and inability to move or feel extremities.

18. According to the Respondent's FDC Duty Statement, Respondent's essential duties required her, among other things, to provide nursing monitoring of residents in the facility with significant and/or unusual medical needs; assist the Medical Officer of the Day, as needed; is available and responds to nursing emergencies and provides physical nursing assessment as needed; investigates special incidents and unusual occurrences, and ensures their proper documentation.

19. The FDC Policy Manual, Section 5, entitled "Clinical Services – Residential," subsection 5.5.5 (Incident and Client Injury Reporting) states:

> An incident is defined as any occurrence which is physically or psychologically harmful to a client and/or inconsistent with a client's expected behavior/condition or any occurrence that does, or has the potential of, compromising the individual's safety or adversely affecting the operation of the Center of the Department. . .

"Injury" includes "unexplained/change of conditions suggesting physical injury (e.g., limping, not eating, excessive lethargy, etc.)"

20. The FDC Procedure Manual, "*Incident/Unusual Occurrence Reporting*" states, in pertinent part, that the responsibility of the reporting employee is to notify the residence physician or MOD and nurse of any incident involving injury, complaints of pain, discomfort, suicide attempts or other incidents as medically necessary. The responsibility of the nurse is, upon request, to examine the individual immediately and record findings in the individual's record.

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21. The FDC Policy Manual, Section 5, entitled "Clinical Services – Residential," subsection 5.6.2 (Changes in Client's Medical Condition) states, in pertinent part:

> When there is a change in an individual's medical/physical condition that is considered to be unusual, the attending physician is promptly notified. Conditions considered to be unusual include, but are not limited to:
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> - Signs and/or symptoms of illness, such as an elevated temperature, nausea, vomiting, diarrhea, or complaints of pain or discomfort;
> - injury, such as fractures, lacerations, bruises, contusions and edema,
> - Accidents, such as ingestion of toxic substances and falls;
> - Behavior which is not typical, such as changes in gait, posture, eating habits, sleeping or instances of self-abusive or aggressive behavior;
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> . . . .

22. The FDC Procedure Manual, Section 6.8 entitled "First Aid" states:

> First Aid is the immediate, initial response staff should take to treat and prevent complications of injury or illness. First Aid should be initiated in response to superficial injuries, fainting, seizures, fractures, insect bites, human bites, falls, self-injurious behavior, and trauma. . . .

FIRST CAUSE FOR DISCIPLINE

(Incompetence)

23. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1) of the Code in that on or about June 6, 2007, Respondent performed her nursing duties in an incompetent manner when she failed to exercise the degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as follows:

a. Respondent failed to ensure that FDC staff, including the Psychiatric Technicians, had a reliable means of communication so that she could be contacted in an emergency;

b. Respondent failed to respond to a notification of an unwitnessed fall of a client as required by her Duty Statement, FDC policy and procedures, and her own training;

c. Respondent failed to promptly obtain necessary care for the client;

d. Respondent failed to perform a nursing assessment of the client, or ensure the assessment was performed by an R.N. under her supervision;

e. Respondent failed to obtain enough information from the reporting party to determine the extent of the client's injuries and/or symptoms, his prior history, level of functioning, and ability to communicate, in order to identify the need for an immediate assessment. Respondent stated that she did not like to tie up the telephone lines;

f. Respondent failed to provide competent nursing supervision of the FDC Psychiatric Technicians who are not qualified to conduct nursing assessments;

g. Respondent relied on the urgency of the reporting party's voice to indicate whether a nursing assessment was required rather than relying on her own experience and training;

h. Respondent failed to initiate an investigation or follow-up with the nursing staff or MOD on the outcome of the client;

i. Even though the client later died, Respondent stated that she would not have done anything differently, which indicates a distinct lack of understanding and/or ignorance of her role as a registered nurse in a clinical setting.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence)

24. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1) of the Code in that on or about June 6, 2007, Respondent performed her nursing duties in a grossly negligent manner as detailed in paragraph 23, above. Respondent's conduct was an extreme departure from the standard of care in that she failed to provide care or to exercise ordinary precaution in a situation which Respondent knew could have jeopardized the client's health or life. Client V.I. exhibited multiple symptoms of a spinal cord injury which were not apparent to the untrained Psychiatric Technicians. Had Respondent promptly responded and conducted an assessment of client V.I. when she first received notification of his unwitnessed fall, V.I. could have been immobilized and protected from further harm. Instead, Respondent waited for her relief to arrive and notified her of a client's fall in Residence 441, and then she left work for the day. Respondent did not notify or confer with the MOD before departing her shift. Respondent did not stay to assist her relief despite the fact that an emergency existed. Respondent's callous

disregard for the patient's well-being, her failure to follow FDC protocol and procedures, and her abandonment of her duties to the oncoming relief nurse constitutes gross negligence.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 510570, issued to Edna Q. Nacion-Anderson, also known as Edna Quiambao Nacion;

2. Ordering Edna Q. Nacion-Anderson to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 2/10/11

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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