STATE OF MAINE
BOARD OF NURSING
158 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0158

PAUL R. LEPAGE
GOVERNOR

MYRA A. BROADWAY, J.D., M.S., R.N.
EXECUTIVE DIRECTOR

IN RE: Carline Anderson, R.N.) **DECISION &**
Disciplinary Action) **ORDER**

I. PROCEDURAL HISTORY

Pursuant to the authority found in 32 M.R.S. Sec. 2105-A(1-A)(D), *et seq.*, 5 M.R.S. Sec. 9051, *et seq.* and 10 M.R.S. Sec. 8003, *et seq.*, the Maine State Board of Nursing (Board) met in public session at the Board's hearing room located in Augusta, Maine at 1:00 p.m. on August 15, 2011. The purpose of the meeting was to conduct an adjudicatory hearing to determine whether to take disciplinary action against Carline Anderson's license to practice registered professional nursing. A quorum of the Board was in attendance during all stages of the proceedings. Participating and voting Board members were Chair Pro Tem Margaret Hourigan, R.N., Ed. D.; Robin Brooks (public representative); Susan C. Baltrus, M.S.N., R.N.B.C., C.N.E.; Carmen Christensen, R.N.; and Valerie Fuller, A.P.R.N. John Richards, Assistant Attorney General, presented the State's case. Nurse Anderson was present and not represented by an attorney. James E. Smith, Esq. served as Presiding Officer.

The Board first determined that none of the Board members had conflicts of interest which would bar them from participating in the hearing. The Board then took official notice of its statutes and Rules, and subsequent to the State's opening statement, State's Exhibits 1-5 were admitted into the Record. The Board then heard the testimony, reviewed the submission of exhibits, and considered the parties' closing arguments, after which it deliberated and made the following findings of fact by a preponderance of the credible evidence and conclusions of law regarding the alleged violations.

II. FINDINGS OF FACT

Respondent Carline Anderson, a 57-year-old resident of Sanford, Maine, has been licensed in Maine as a Registered Professional Nurse since August 14, 1995. Her license was most recently renewed on August 12, 2010 and expires on August 15, 2012.

Nurse Anderson was hired in her professional capacity by Southridge Living and Rehabilitation Center (Southridge) on April 20, 2009. She worked there until her termination on July 15, 2009.

The termination occurred due to the following incident, which took place at the facility on July 9, 2009: At approximately 5:15 p.m., B, a 101-year-old patient confined to a wheelchair at Southridge, was eating her pureed food in the dining room when she began to choke. Tashia Stevens, a Certified Nursing Assistant (CNA), immediately notified supervising Nurse Anderson of the emergency. At that time, Nurse Anderson was at her desk approximately 125 feet away from B and talking to her sister on her cell phone regarding the status of their mother

who apparently had been rushed to the hospital. Nurse Anderson informed CNA Stevens that, "This had better be an emergency" and then told her to take B to B's room and put her in bed. CNA Stevens did not observe Nurse Anderson assess B, but the licensee did reiterate that B was under "Do Not Resuscitate" and "Do Not Intubate" advanced directives. The licensee further surmised that B had died as a result of her choking.

At some time during the choking event, Certified Medication Technician Kronsgak Vattansil was also in the dining room and noticed B's face turning black and blue. He removed her from the dining room and began performing the Heimlich maneuver, which was unsuccessful. Nurse Anderson arrived and stated to the staff, "Stop what you're doing and get her to her bed. She's already dead." Mr. Vattansil then, without receiving any instruction from the licensee, told another employee to call 911, transported B to her room, and cleared her airway, which was apparently clogged with peanut butter. Mr. Vattansil estimated the choking event occurred in less than 10 minutes. B eventually was examined at the local hospital and recovered from this incident.

Eric Pooler is the administrator at Southridge. He testified that on the day of the incident, a resuscitation policy was in place at the facility. That policy requires an assessment, which is beyond the scope of a CNA's training, be made. No assessment was made by Nurse Anderson. The administrator offered that it was difficult to understand why Nurse Anderson did not leave her desk and assess and assist B in her time of distress.

Nurse Anderson recited a different version of the day's events. She testified that she went to B's room, found her sitting in a chair, noticed that B was blue, had no carotid pulse and was drooling. She thought B had passed away and resuscitation would be futile, especially considering the "Do Not Resuscitate" directive. She did not recommend calling 911 since she believed B was dead.

At some point in her testimony, Carline Anderson stated that she became aware of B's recovery, in her opinion due most likely to the peanut butter being dislodged when B was jolted by the medication technician's placement of B on B's bed. She also stated that she had begun the Heimlich maneuver by placing her knee behind the woman's back and thrusting.

There is no evidence to demonstrate that Nurse Anderson documented any efforts at assessment, including taking B's pulse or performing the other efforts that she testified to. She was terminated on July 15, 2009 "based on her failure to respond to a life and death emergency situation both in a timely fashion and failure to follow CPR protocol." The Board found the testimony of both CNAs to be more credible than the recitation of Nurse Anderson.

III. CONCLUSIONS OF LAW

Based on the above facts and those found in the record but not alluded to herein, and utilizing its experience and training, the Board, by a vote of 5-0, concluded that Carline Anderson, R.N. violated the provisions of:

1. 32 M.R.S. Sec. 2105-A(2)(E)(1 and 2) and Board Rules Chapter 4, Sec. 1.A.(5)(a) and (b) (Incompetent Conduct... by engaging in conduct that evidences a lack of ability or fitness to discharge the duty owed by a licensee to a client or patient or the general public and by engaging in conduct that evidences a lack of knowledge or inability to apply principles or skills to carry out the practice for which the licensee is licensed).

2. 32 M.R.S. Sec. 2105-A (2) (F) and Board Rules Chapter 4, Sec. 1.A. (6) (Unprofessional Conduct. A licensee is considered to have engaged in unprofessional conduct if the licensee violates a standard of professional behavior that has been established in the practice for which the licensee is licensed).
3. 32 M.R.S. Section 2105-A (2) (H) and Board Rule Chapter 4, Disciplinary Action and Violations of Law, Sections 1.A. (8). (A violation of this chapter or a rule adopted by the board).
4. Board Rule Chapter 4, Sec. 3. (Definition of Unprofessional Conduct. Nursing behavior which fails to conform to legal standards and accepted standards of the nursing profession, and which could reflect adversely on the health and welfare of the public shall constitute unprofessional conduct and shall include, but not be limited to, the following:

    1) Board Rule Chapter 4, Section 3(B) as evidenced by: Carline Anderson's assumption of duties and responsibilities within the practice of nursing without adequate preparation or when competency has not been maintained.

    2) Board Rule Chapter 4, Section 3(F) as evidenced by: Carline Anderson's failure to take appropriate action or to follow policies and procedures in the practice situation designed to safeguard patients.
5. The Board found that Carline Anderson did not intentionally violate the fraud provisions in 32 M.R.S. Sec. 2105-A (2) (A) when she obtained her license to practice registered professional nursing.

IV. SANCTIONS

The Board expressed its concern that Nurse Anderson did not appear to be focused on the emergency at the time of the choking incident. She did not take responsibility for any of her acts or omissions regarding that event. Additionally, the Board took into account the January 6, 2010 "Letter of Concern" in which it communicated to Nurse Anderson the Board's "concern regarding *the importance of professional demeanor as interpreted by other people and thinking professionally before speaking.*" (emphasis in original) The letter was a result of the licensee's response to information submitted by Durgin Pines through letter dated April 24, 2009; Maine Veterans' Homes, Scarborough through letter dated June 1, 2009; and Kennebec Nursing and Rehabilitation Center through FAX dated June 5, 2009.

The Board, by the following votes, ordered the below sanctions for the above violations:

1. Carline Anderson's Registered Professional Nurse's license is hereby **SUSPENDED** for a period of one year from August 15, 2011 until midnight of August 14, 2012. During that time, she shall complete and pass courses pre-approved by the Board's Executive Director which specifically relate to assessment, documentation, and communication. The suspension may be lifted in the event that Nurse Anderson complies with the above course requirements before August 14, 2012. (VOTE: 4-1, the dissent would vote for probation instead of suspension)
2. Carline Anderson shall serve a one-year period of probation to commence immediately after her term of suspension is satisfied and after she has obtained employment as a nurse. During her probation, Nurse Anderson shall be permitted to practice her profession solely under the direct supervision of a professional registered nurse

who shall submit quarterly reports to the Board regarding the licensee's practice relating to assessment, documentation, and communication. (VOTE: 5-0)

3. Any violation of the terms of probation shall be grounds for further disciplinary action.
4. The Board staff shall flag any application by Nurse Anderson regarding her lapsed practical nursing license.

SO ORDERED.

Dated: 9/18/11

Margaret Hourigan, R.N., Ed. D.
Chair Pro Tem, Maine State Board of Nursing

V. APPEAL RIGHTS

Pursuant to the provisions of 5 M.R.S. Secs. 11001 and 11002, any party that decides to appeal this Decision and Order must file a Petition for Review within 30 days of the date of receipt of this Order with the Superior Court having jurisdiction. The petition shall specify the person seeking review, the manner in which s/he is aggrieved and the final agency action which s/he wishes reviewed. It shall also contain a concise statement as to the nature of the action or inaction to be reviewed, the grounds upon which relief is sought and a demand for relief. Copies of the Petition for Review shall be served by Certified Mail, Return Receipt Requested upon the Maine State Board of Nursing, all parties to the agency proceedings, and the Maine Attorney General.