The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Division of Health Professions Licensure
Board of Registration in Nursing
239 Causeway Street, Suite 500, Boston, MA 02114

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May 20, 2015

Nascet Iloba
redact

VIA FIRST CLASS AND CERTIFIED MAIL RETURN
RECEIPT REQUESTED NO. 7012 3460 0001 7330 8395

RE: *In the Matter of Nascet Iloba*, Docket No. NUR-2012-0122
License No. LN85571

Dear Mr. Iloba:

Please find enclosed the following documents issued by the Board of Registration in Nursing on May 20, 2015 and effective **May 30, 2015**:

(1) Final Decision and Order
(2) Ruling on Respondent's Objections to the Tentative Decision
(3) Tentative Decision

The Final Decision and Order constitutes full and final disposition of the above-referenced complaint, as well as the final agency action of the Board. Your appeal rights are noted on page 4.

Please note that as of the effective date, your license status will change to **Probation**. It will remain in a probationary status until the Board notifies you of a change in license status in accordance with the terms of the order. Please direct all questions, correspondence and documentation relating to probation requirements to the attention of Karen Fishman, Probation Monitor, at the address above. You may also contact Ms. Fishman at (617) 973 – 0951. You may contact Vita Berg, Chief Board Counsel at (617) 973 – 0950 with any other questions that you may have concerning this matter.

Sincerely,

Rula Harb, MSN, RN
Executive Director, Board of Registration in Nursing

Encl.

cc: Richard Banks, Prosecuting Counsel
Richard Camann, Esq.
Karen Fishman, Probation Monitor

I do hereby certify the foregoing to be a true and certified copy of the document on file with the Massachusetts Board of Registration in Nursing.

Authorized Signature Date 5/26/15

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, SS

BOARD OF REGISTRATION IN NURSING

In the Matter of NASCET ILOBA License No. LN85571 License expires: 7/9/15	Docket No. NUR-2012-0122

FINAL DECISION AND ORDER

FINAL DECISION

On February 18 and 20, 2014, the Board held a formal adjudicatory hearing in this matter before Administrative Hearings Counsel ("AHC") Stephanie Carey. On November 25, 2014[1], the AHC issued a Tentative Decision containing her findings of fact, credibility determinations, conclusions of law and a discussion explaining the AHC's rationale. On December 31, 2014, the Board received the Respondent's Objections to Tentative Decision[2]. The Board has reviewed and carefully considered the Tentative Decision and the Respondent's objections.

The Board hereby adopts the Tentative Decision, including all findings of fact, credibility determinations, conclusions of law and discussion contained therein, as the Board's Final Decision. The Board rejects the Respondent's objections, for the reasons set forth in the Board's Ruling on Respondent's Objections to Tentative Decision, issued concurrently with this Final Decision and Order.

[1] The Board recognizes that on November 25, 2014, the AHC mailed the Tentative Decision to Respondent's Counsel using an incorrect address. The AHC mailed the Tentative Decision to the correct address on December 11, 2014.

[2] Although 801 CMR 1.01(11)(c) requires objections to be filed within thirty days of the issuance of a Tentative Decision, the Board accepts the objections filed on December 31, 2014 based on the circumstances noted in footnote 1.

ORDER

Based on its Final Decision, the Board orders Respondent's license to practice as a Licensed Practical Nurse in Massachusetts, License No. LN85571 placed on **Probation** for a minimum of **one (1) year** ("Probation Period") [3]. The Probation Period shall begin on the effective date of this Order, set forth below. The Probation Period will not be terminated until and unless the Respondent has engaged in monitored nursing practice as set forth below after the Effective Date for at least twelve (12) months.

During the Probation Period, the Respondent shall comply with all of the following requirements to the Board's satisfaction:

a. Within thirty (30) days of the Effective Date of the Order, the Respondent shall notify the Board's Probation Monitor in writing if the Respondent is not employed in a nursing position;

b. Comply with all laws and regulations governing the practice of nursing, and not engage in any continued or further conduct and actions as set forth in the above Decision;

c. Maintain active employment in a position that requires a nursing license for a minimum average of twenty (20) hours per week throughout the Probation Period (active practice requirement);

d. accept any home care, travel or temporary staffing assignment, or practice in any setting where consistent, on-site supervision of the Respondent by a qualified licensed nurse is not in place;

e. While practicing as a nurse, receive direct supervision from a licensed nurse who must have at least one (1) year of clinical nursing practice experience, no open complaints, no past discipline of the nurse's license, and who is physically located at all times in each facility in which the Respondent practices nursing.

f. Within thirty (30) days of the Effective Date and within thirty (30) days of any subsequent employment commenced during the Probation Period, the Respondent shall:
   i. review this Probation Order with each of the Respondent's nursing supervisors, and
   ii. arrange for each nursing supervisor to submit directly to the Board within this time period a completed and signed "Supervisor Verification Form" (Form 1) provided by the Board;

[3] The Board's Order is consistent with Orders issued in the following comparable matters: *Matter of Francis Sears*, RN-01-187 (2004) and *Matter of Ellen O'Connor*, LN-05-129 (2008).

g. Arrange for each nursing supervisor to submit directly to the Board *quarterly* written reports using the "Supervision Report Form" (Form 2) provided by the Board attesting to:
   i. the Respondent's satisfactory nursing practice, reliability and attendance and specifically addressing Respondent's work with patients that gave rise to this Final Decision, including any errors and incidents, and
   ii. the Respondent's completion of an average of at least twenty (20) hours of work in a nursing position per week during the quarter, specifying the beginning and end date of the report period;

   The Respondent is responsible for ensuring that these reports on the required form are received by the Board commencing ninety (90) days after the Effective Date and on the first day of every third month thereafter;

h. Notify the Board in writing within ten (10) days of any change in the Respondent's employment status, including each change in Employer, each resignation or termination, and the name, address and telephone number of each new Employer;

i. Notify the Board in writing within ten (10) days of each change in the Respondent's name and/or address; and

j. Timely renew his license to practice nursing.

k. A comprehensive mental health evaluation of the Respondent conducted by a licensed mental health provider which meets the requirements set forth in Attachment B 2.

l. Submit certified documentation, within six months after the Effective Date of this Order, of the completion of the following Continuing Education (which shall be in addition to the continuing education requirements for license renewal):
   i. Six (6) Contact Hours in Caring for the Cognitively Impaired Patient;
   ii. Three (3) Contact Hours in Critical Thinking;
   iii. Six (6) Contact Hours in Ethical Legal Principles of Nursing;
   iv. Three (3) Contact Hours in Patient Rights;
   v. Three (3) Contact Hours in Therapeutic Communication; and
   vi. Three (3) Contact Hours in Professional Boundaries.

In the event that the Respondent fails to comply with the terms of this order, the Board may suspend the Respondent's nursing license, modify the terms of this order, or take other disciplinary action as the Board in its sole discretion deems necessary for the protection of the public health, safety and welfare.

The Board voted to adopt the within Final Decision by Default at its meeting held on May 13, 2015, by the following vote:

In favor:	A. Alley, BSN, RN; M. Beal,RN/NM; P. Gales, RN; K. Gehly, RN; S.Kelly, RN/NP; J. Killion, LPN; A. Peckham, RN, MSN; C. Simonian, Pharm.D., R.Ph.; S. Taylor, MSN, RN; C. Tebaldi, RN, MS; C. Urena, LPN
Opposed:	None
Abstained:	None
Recused:	None
Absent:	B. Levin, RN; E. Richard Rothmund

The Board voted to adopt the within Final Order by Default at its meeting held on May 13, 2015, by the following vote:

In favor:	A. Alley, BSN, RN; M. Beal,RN/NM; P. Gales, RN; K. Gehly, RN; S.Kelly, RN/NP; J. Killion, LPN; A. Peckham, RN, MSN; C. Simonian, Pharm.D., R.Ph.; S. Taylor, MSN, RN; C. Tebaldi, RN, MS; C. Urena, LPN
Opposed:	None
Abstained:	None
Recused:	None
Absent:	B. Levin, RN; E. Richard Rothmund

EFFECTIVE DATE OF ORDER

This Final Decision and Order by Default becomes effective upon the tenth (10^{th}) day from the date it is issued (see "Date Issued" below).

RIGHT TO APPEAL

Respondent is hereby notified of the right to appeal this Final Decision and Order Default to a Superior Court with jurisdiction pursuant to M.G.L. c. 30A §§ 14. Respondent must file his appeal within thirty (30) days of receipt of notice of this Final Decision and Order by Default.

Board of Registration in Nursing,

Date Issued: May 20, 2015

Rula Harb, MSN, RN
Executive Director

Notified:

VIA FIRST CLASS AND CERTIFIED MAIL RETURN RECEIPT REQUESTED NO.
Nascet Iloba
redact

VIA FIRST CLASS MAIL
Richard L. Camann
Camann & Callahan
328 Broadway – Suites 211-213
Lynn, MA 01904

BY HAND DELIVERY
Richard Banks, Esq.
Prosecuting Counsel
Department of Public Health
Division of Health Professions Licensure
239 Causeway Street
Boston, MA 02114

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, SS

BOARD OF REGISTRATION IN NURSING

In the Matter of	
NASCET ILOBA	Docket No. NUR-2012-0122
License No. LN85571	
License expires: 7/9/15	

RULING ON RESPONDENT'S OBJECTIONS TO TENTATIVE DECISION

On February 18 and 20, 2014, the Board held a formal adjudicatory hearing in this matter before Administrative Hearings Counsel ("AHC") Stephanie Carey. On November 25, 2014[1], the AHC issued a Tentative Decision containing her findings of fact, credibility determinations and conclusions of law. On December 31, 2014, the Board received the Respondent's Objections to Tentative Decision[2]. On March 26, 2015, Prosecuting Counsel filed a Motion for Leave to Late File Responses to Objections[3]. Based on the Board's resolution of the Objections, the Board denies Prosecuting Counsel's motion.

The Board has reviewed and carefully considered the Tentative Decision and the Respondent's objections. The Board has determined that the objections are without merit. The Board is not required to address each of Respondent's objections or provide a specific response for rejecting the objections. See *Arthurs vs. Board of Registration in Medicine*, 383 Mass. 299, 315-316 (1981) and *Weinberg vs. Board of Registration in Medicine*, 443 Mass. 679, 687 (2005). While declining to address each objection individually, the Board responds as follows:

In his objections, the Respondent contends that the Hearing Officer did not make certain findings about Resident A, based findings that "Resident A was truthful" on other witnesses' beliefs, and did not weigh Resident A's failure to testify and that these factors all detract from the reliability of the hearsay evidence about Resident A's observations. The Respondent further contends that since the Hearing Officer relies entirely on hearsay which is unreliable, the Tentative Decision is "arbitrary, capricious and against the weight of the evidence."

[1] The Board recognizes that on November 25, 2014, the AHC mailed the Tentative Decision to Respondent's Counsel using an incorrect address. The AHC mailed the Tentative Decision to the correct address on December 11, 2014.

[2] Although 801 CMR 1.01(11)(c) requires objections to be filed within thirty days of the issuance of a Tentative Decision, the Board accepts the objections filed on December 31, 2014 based on the circumstances noted in footnote 1.

[3] 801 CMR 1.01(11)(c) requires responses to objections to be filed within twenty days of receipt of the objections. The deadline for such responses was January 20, 2015.

The Respondent contends that the hearing officer erred by failing to make certain factual conclusions about Resident A's medical and psychological status. One of these was the failure to conclude that Resident A was "on such drugs" [morphine and oxycodone] at the time of the incident. Another was the failure to conclude that Resident A has "additional severe psychological issues ... such as accusatory behavior, negative thinking and personalization." Notably, the Respondent offers no legal basis for these claims of error. The evidence presented as to these facts was not legally conclusive[4]. Moreover, even if the Hearing Officer had concluded the facts as proposed by the Respondent, it remains the fact that the Respondent offered no expert opinion testimony to support a finding that Resident A's use of prescribed medications or mental health conditions would have adversely impacted Resident A's ability to observe the Respondent's conduct and accurately report those observations.

The Respondent argues that "no expert testimony is necessary to derive an accurate inference from those diagnoses" because it is "within the scope of judicial knowledge of a hearings officer for the Department of Public Health." However, the Respondent is incorrect. In fact, it would be error for a hearing officer to draw inference with respect to the impact that medications or mental health conditions might have on a particular person's behavior in the absence of an expert opinion to that effect. *See Doe vs. Sex Offender Registry Board*, 452 Mass. 764, 776 (2008)("inappropriate for the board or a hearing officer to use or reference the DSM-IV in its assessment of an offender's risk of reoffense, at least without the benefit of testimony or a report by an expert with appropriate psychiatric or psychological training and experience"). It is a well established principle that a board may use its expertise in evaluating the complexities of technical evidence, but it may not use its expertise as a substitute for evidence in the record. *D'Amour vs. Board of Registration in Dentistry*, 409 Mass. 572, 585 (1991); *Morris vs. Board of Registration in Medicine*, 405 Mass. 103, 113 (1989); *Arthurs vs. Board of Registration in Medicine*, 383 Mass. 299, 310 (1981). "An agency or board may not sit as a silent witness where expert testimony is required to establish an evidentiary basis for its conclusions." *Daniels v. Board of Registration in Medicine*, 418 Mass. 380, 389-390 (1994).

The Respondent further contends that the Hearing Officer erred by finding that witnesses considered Resident A to be truthful, failing to draw a "negative inference[5]" from Prosecuting Counsel's failure to call Resident A as a witness and failing to accord reduced credibility to hearsay evidence. Again, the Respondent offers no legal basis for these claims of error.

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[4] There was no evidence that the facts concerning Resident A's medications or mental health were previously determined in a prior adjudicatory proceeding. *Compare, Kobrin vs. Board of Registration in Medicine*, 444 Mass. 837 (2005). Based on the absence of expert opinion connecting Resident A's medications and mental health to the ability to observe and report, it is not necessary that the Board determine whether the overwhelming weight of the evidence supported such findings as that Respondent contends.

[5] The Respondent's use of the phrase "negative inference" is inapt in this context. A negative inference may be drawn from a refusal to testify based on the 5th Amendment privilege against self-incrimination. *Frizado v. Frizado,* 420 Mass. 592, 596, (1995).

It is well established that "[s]ubstantial evidence may be based on hearsay alone if that hearsay has indicia of reliability." *Covell v. Department of Social Servs.*, 439 Mass. 766, 786 (2003). According lesser weight to reliable hearsay evidence simply because it is hearsay runs contrary to this principle, as there is no requirement that evidence be submitted in the form of live testimony. "While live testimony may provide the optimal opportunity for the assessment of credibility[6], the fact that parties before an agency may have differing versions of critical events does not make live testimony the sine qua non for satisfying the substantial evidence test." *Covell vs. Dept. of Social Services*, 439 Mass. 766, 787 (2003)[7].

It is the duty of the hearing examiner to assess the reliability of exhibits introduced in evidence and draw therefrom all reasonable inferences." *Doe v. Sex Offender Registry Bd.*, 87 Mass.App.Ct. 1107 (2015) (table), 2015 WL 808411, *2. Indicia of reliability include general plausibility and consistency of the victim's or witness's story, the circumstances under which it is related, the degree of detail, the motives of the narrator, the presence or absence of corroboration and the like. *Doe v. Sex Offender Registry Bd.*, 85 Mass.App.Ct. 1118 (2014) (Table), 2014 WL 1813522, *1; *J. P. B. v. Department of Children & Families*, 83 Mass.App.Ct. 1111, 982 N.E.2d 73 (2013) (Table), 2013 WL 425158, *2. Reliability is met where the hearsay is corroborated by a defendant's admissions. *Doe v. Sex Offender Registry Bd.*, 86 Mass.App.Ct. 1114 (2014) (Table), 2014 WL 4922605, *1. In this instance, there was evidence of bruising on Resident B's upper right arm and evidence that the Respondent reported that he saw Resident A observing him and sought to reassure Resident A. There was evidence that Resident A was interviewed by two individuals who testified in this proceeding, but no evidence that Resident A's story was inconsistent from one interview to the next. Although there was some evidence concerning Resident A's medications and mental health, there was no expert opinion connecting this evidence to Resident A's ability to observe and report. On the basis of this evidence, it would not be error for the Hearing Officer to determine that Resident A's hearsay statements were sufficiently reliable to constitute substantial evidence supporting the findings in the Tentative Decision.

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[6] It is important to distinguish between the assessment of credibility of evidence generally, and the assessment of credibility of a live witness. Where live witnesses do testify at an agency hearing, a decision relying on their relative credibility cannot be made by someone who was not present at the hearing. However, this does not mean that credibility disputes can only be resolved by live testimony. Covell vs. Dept. of Social Services, 439 Mass. 766, 787, fn19 (2003).

[7] Also to be considered is whether there are valid policy reasons against calling certain classes of witnesses, e.g., children or other vulnerable populations, to testify absent a "compelling reason." *See Covell vs. Dept. of Social Services*, 439 Mass. 766, 787, fn20 (2003).

The Board voted to adopt this Ruling on Respondent's Objections to Tentative Decision at its meeting held on May 13, 2015 by the following vote:

In favor:	A. Alley, BSN, RN; M. Beal,RN/NM; P. Gales, RN; K. Gehly, RN; S.Kelly, RN/NP; J. Killion, LPN; A. Peckham, RN, MSN; C. Simonian, Pharm.D., R.Ph.; S. Taylor, MSN, RN; C. Tebaldi, RN, MS; C. Urena, LPN
Opposed:	None
Abstained:	None
Recused:	None
Absent:	B. Levin, RN; E. Richard Rothmund

Board of Registration in Nursing,

Date Issued: May 20, 2015

Rula Harb, MSN, RN
Executive Director

Notified:

VIA FIRST CLASS AND CERTIFIED MAIL RETURN RECEIPT REQUESTED NO. 7012 3460 0001 7330 8395
Nascet Iloba
redact

VIA FIRST CLASS MAIL
Richard L. Camann
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BY HAND DELIVERY
Richard Banks, Esq.
Prosecuting Counsel
Department of Public Health
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239 Causeway Street
Boston, MA 02114

COMMONWEALTH OF MASSACHUSETTS

Suffolk, ss. Board of Registration in Nursing

In the Matter of Nascet Iloba LN License No. 85571 License Expires: 7/9/15	)	Docket No. NUR-2012-0122

BOARD'S TENTATIVE DECISION [1]

On January 24, 2013, the Board of Registration in Nursing ("Board") issued an Order to Show Cause ("OTSC")[2] to Nascet Iloba ("Respondent"), a Licensed Practical Nurse ("LN") licensed by the Board. The OTSC directed Respondent to appear and show cause why his license to practice as an LN should not be suspended, revoked, or otherwise disciplined pursuant to Massachusetts General Laws ("G.L.") Chapter 112, § 61 and Board regulations at 244 CMR 9.03, based on allegations that Respondent struck Resident B with force on her right upper/inner arm while yelling "stop" at Resident B.[3] Respondent filed an Answer to the Order to Show

[1] Pursuant to 801 CMR 1.01 (11)(c), the Board issues this Tentative Decision in the first instance. Parties may file objections within thirty (30) days of the filing of this tentative decision. Any objections filed must include written argument in support of the objections as the Board will not hold a hearing on the objections. Each party may file a response to opposing counsel's objections within twenty (20) days of receipt of those objections.

[2] In the OTSC, Resident A was described as the roommate of Resident B. However, during the proceedings, Resident A was correctly identified as a resident occupying a room adjacent to Resident B's room and neither Respondent nor Prosecuting Counsel raised any objections to this identification.

[3] Portions of ¶¶ 7 and 8 of the OTSC allege that Respondent yelled "stop" at Resident B, and that Respondent's comment was heard by Resident B's roommate. The Board concludes that as there was insufficient evidence presented to support the allegations, they are DISMISSED.

Cause on February 19, 2013. On February 18 and 20, 2014, the Board held a formal adjudicatory hearing before Administrative Hearings Counsel ("AHC") and Presiding Officer Stephanie B. Carey, Esq., pursuant to G.L. c. 30A, §§ 10 and 11 and 801 CMR 1.01 *et seq.*[4] Prosecuting Counsel was Richard Banks, Esq. Respondent was present and represented by Richard Camman, Esq. On April 7, 2014, Prosecuting Counsel and Respondent filed post-hearing briefs.

The following witnesses testified at the hearing:

For Prosecution:

1. Kathleen M. Walsh, M.Ed, LCSW Investigator, Department of Public Health ("DPH"), Division of Health Care Quality ("DHCQ")
2. Erin Cook, Licensed Social Worker ("LSW")
3. Donna Cecchin, Director of Nursing, Eastpointe Nursing Care Center ("Eastpointe")

For Respondent:

4. Nascet Iloba, Respondent
5. Mary Ngebeh, Certified Nursing Assistant ("CNA")

The following exhibits were admitted into evidence:

1. Order to Show Cause, January 24, 2013
2. Respondent's Answer to Order to Show Cause, filed February 19, 2013
3. Eastpointe Incident Report, re: Resident B, November 4, 2011
4. Pain Assessment re: Resident B, November 4, 2011
5. Medication Orders re: Resident A, November 1, 2011 – November 30, 2011

[4] During the proceedings, Respondent filed an oral Motion to Dismiss based on Prosecuting Counsel's assertion that he would not call Resident A as a witness during these proceedings. Respondent's Motion to Dismiss was taken under advisement and the Board now rules that Respondent's Motion to Dismiss is DENIED.

6. Medical Psychotherapy Follow-Up Visit re: Resident A, October 31, 2011

7. Eastpointe Investigation Report, #11-0899 re: (Resident A complaint), July 19, 2011

8. Incident Report Form, re: (Resident A complaint), October 9, 2012

9. Long Term Care ("LTC") Fax Report Form re: (Resident A complaint), April 24, 2013

10. LTC Fax Report Form, re: (Resident A complaint), June 6, 2013

11. Statement of Donna Cecchini, re: Interview with Respondent, November 7, 2011

12. Statement of Erin Cook, LSW, re: Interview with Resident A, November 7, 2011

13. Statement of Mary Ngebeth, November 8, 2011

14. Statement of Fabiola Albertini, November 11, 2011

15. Statement of Catherine Mullinax, November 8, 2011

16. Department of Public Health("DPH"), Division of Health Care Quality ("DHCQ") Investigation Report, November 14, 2011

17. Board's Record of Standing re: Respondent

18. Statement of Respondent, November 7, 2011

FINDINGS OF FACT

1. On July 3, 2009, the Board issued Respondent a license to engage in the practice of nursing as a Licensed Practical Nurse ("LN") in the Commonwealth of Massachusetts ("Commonwealth"). Respondent's license is scheduled to expire on July 9, 2015, unless renewed. Ex. 17

2. In November 2011, Respondent was employed as an LN at ("Eastpointe" or "facility") in Chelsea, Massachusetts ("MA") working the night shift from 11:00 p.m. to 7:00 a.m. ("11P-7A shift"). Respondent testimony

3. Donna Cecchini ("Ms. Cecchini") has been an RN since 1988 and has been employed at the Medford Rehabilitation and Nursing Center since January 1, 2013. In November 2011, Ms. Cecchini was employed at Eastpointe in a dual role as the Assistant Director of Nursing and Acting Director of Nursing. Cecchini testimony

4 Erin Cook ("Ms. Cook") has been an LSW and mental health counselor since 2007. In November 2011, Ms. Cook had been employed at Eastpointe as a social worker for 5 years. Cook testimony

5 On Thursday and Friday, November 3 and 4, 2011[5], Respondent worked the 11P-7A shift at Eastpointe.[6] As part of his duties during that shift, Respondent was assigned to provide care for Resident B. Respondent was familiar with Resident B as she had been on the floor for approximately 18 months and he cared for her whenever he was assigned to her side of the floor. Respondent testimony

6 Resident B, a long-term patient at Eastpointe, was cognitively impaired, and experienced long and short term memory loss. Resident B was also diagnosed as suffering from dementia. Resident B ambulated with a walker and needed assistance with all activities of daily living. Resident B also had a history of

[5] The Board takes administrative notice of the days and dates of the week pursuant to the 2011 calendar.
[6] There was no testimony relative to Respondent's specific assignment during that shift. However, based on a written statement by an LN who worked the same unit on the same shift as Respondent on November 3-4, 2011, Respondent was reportedly assigned to the third floor Arbor side unit and assigned to Team II with responsibilities for patients in Rooms 316-334. Respondent's assigned rooms included the rooms occupied by Residents A and B. Exhts. 4, 13, 14

refusing care and becoming combative. Respondent testimony; Cecchini testimony

7 Resident B shared a room with a roommate and as a result, there were 2 beds in Resident B's room. The roommate's bed was the first bed closest to the door. Resident B's bed was next to the window. Each resident had a side table and a wardrobe. There was a curtain between the beds. Respondent testimony

8 Resident A resided in a room adjacent to Resident B's room and both shared an adjoining bathroom. One bathroom door led to Resident A's room and the second bathroom door led to Resident B's room. Each room also had a door leading from the room to the hallway. There was an Eastpointe policy that required the door from the bathroom to each resident's room to remain closed. Respondent testimony; Ngebeth testimony; Walsh testimony

9 Resident A was a female in her mid-50's who resided in a private room and had no roommate. Resident A had no cognitive deficits, was alert, oriented, and had previously reported information to Eastpointe staff that was truthful. At the time of the November 2011 incident, Resident A had been prescribed the following medications for the following conditions: doxapan for insomnia; neurontin for diabetic nerve pain; omeprazol for heartburn; and morphine and oxycodone for pain.[7] At the time of the November 2011 incident, Resident A had been

[7] Ms. Cecchini testified that she had no knowledge as to whether Resident A was administered any of the above-referenced medications between 11P and 7A on November 3-4, 2011. Cecchini testimony

diagnosed with anxiety, depression, seizure disorder, and alcohol dependence. Cecchini testimony; Exhts. 5 and 6

10 Shortly after Ms. Cook commenced her employment at Eastpointe, Resident A moved to Ms. Cook's unit. At that time, the unit was reserved for cognitively intact residents. When the unit was subsequently designated as a memory-impaired unit, several of the original cognitively-intact residents remained on the unit, including Resident A. Cook testimony

11 By November 2011, Ms. Cook had known Resident A for 5 years and had developed a good relationship with Resident A. Ms. Cook described Resident A as alert and oriented as to person, place, and time, with no cognitive deficits. Ms. Cook also found that Resident A was capable of reporting events accurately and was generally forthcoming and truthful. Cook testimony

12 Prior to the events of November 3-4, 2011, Resident A filed several complaints against various staff members at Eastpointe. The following are the complaints filed and the conclusions reached following each investigation:

a. In July 2011, Resident A alleged that on two occasions Nurse #4 gave her the wrong medications. Conclusion: validity unable to be determined due to conflicting information. Ex. 7

b. In October 2012, Resident A alleged to her social worker that her medications had been misappropriated by two (2) nurses. Conclusion: unsubstantiated; Ex. 8

c. In April 2013, Resident A, while looking after another resident at the request of the resident's family, reported to the charge nurse that the resident had not been fed. The charge nurse stated that he had assigned a CNA to feed the resident and that the resident had been fed. Resident A believed that the charge nurse was accusing her of lying. Resident A was also unhappy with the charge nurse because he set boundaries for her regarding the care and privacy of other residents on the unit. Corrective action: the charge nurse was reassigned to another unit. Conclusion: none. Ex. 9

d. In May 2013, Resident A complained about a physical confrontation initiated by another resident (Resident 1) during which Resident 1 struck Resident A with a chair. Conclusion: None; Corrective action: Resident 1 transferred to another facility Ex. 10

Exhts. 7-10; Cook testimony; Cecchini testimony

13 Ms. Cook was aware of some of Resident A's complaints, including those described in ¶ 12 a and b. After interviewing Resident A as part of an investigation of the complaints set forth in ¶ 12 a and b, Ms. Cook believed that Resident A had accurately reported both incidents. Ms. Cook believes that as a result of the incident described in ¶12 b, a nurse was terminated. Ms. Cook's opinion of Resident A's capacity for truthfulness did not change as a result of these complaints. According to Ms. Cook, unsubstantiated complaints are those in which the evidence is deemed insufficient to prove or disprove the allegations. Cook testimony; Exhts. 7, 8

14 A review of the complaints filed by Resident A demonstrate that in most cases the evidence was insufficient to prove or disprove the allegations. Moreover, 2 of Resident A's complaints were related to Resident A's medications including the misappropriation or incorrectly-administered medications. One of Resident A's complaints involved a physical confrontation with another resident and the fourth complaint was related to Resident A's belief that a staff member had failed to feed a resident. None of Resident A's complaints were baseless complaints related to abusive behavior by staff members toward residents. In addition, Ms. Cook, the LSW who worked closely with Resident A, found at least two of Resident A's complaints were credible. In several instances, although Resident A's complaints were unsubstantiated, corrective action was taken by the facility. The Board, therefore, finds that Resident A's complaints do not suggest a pattern of Resident A's fabrication of complaints against staff members.

Respondent Testimony

15 At approximately 6:00 a.m. on November 4, 2011, Respondent was passing medications and providing treatments to patients. When he arrived at Resident B's room he observed Resident B on the floor with feces on her hands. At that time, Resident B's roommate was in bed with the curtain drawn around her bed. When he saw Resident B on the floor, he called Mary Ngebeth ("Ms. Ngebeth"), a CNA, to come and assist him. As Ms. Ngebeth had towels and linens with her when she arrived, Respondent took a towel from Ms. Ngebeth in order to clean Resident B. Respondent testimony

16 According to Respondent, when Ms. Ngebeth arrived, they both entered Resident B's room together. Respondent then went to the bathroom to wet the towel. Respondent knocked on the bathroom door at which time Resident A permitted him to enter. According to Respondent, Resident A left the bathroom, went to her room, and closed the door leading from the bathroom to Resident A's room. Respondent testified that he entered the bathroom, wet the towel, left the bathroom, and closed the bathroom door that led to Resident's B's room. [8] Pursuant to the facility's policy, the doors to shared bathrooms were to remain closed. According to Respondent, during his 18 months at Eastpointe, he had never seen the doors to a shared bathroom left open. Respondent further asserted that the doors to the bathroom do not close automatically. Respondent testimony

17 According to Respondent, he cleaned Resident B's hands and during that cleaning he explained to Resident B what he was doing. During direct examination, Respondent testified that Resident B remained on the floor as he cleaned her hands. At some point, Resident B took her hands away from Respondent but, according to Respondent, Resident B did not raise her hands and she did not physically resist his efforts to clean her. Respondent also testified that Ms. Ngebeth was in the room assisting him during the cleaning. Respondent testimony.

[8] Based on the evidence presented at these proceedings, the Board can make no determination that Resident A left the bathroom while Respondent wet the towel. In addition, in a subsequent un-witnessed fall report, Respondent asserted that he closed and locked the bathroom after he left the bathroom. The Board does not find that Respondent closed or locked the bathroom door upon his departure, and the Board also questions the appropriateness of locking a bathroom door in a nursing home facility. Ex. 18

18 According to Respondent, when he had completed the cleaning of Resident B, he and Ms. Ngebeth lifted Resident B from the floor, each holding a side of Resident B, and put her on the bed. Respondent testified that at no time did Resident B resist when she was lifted from the floor and placed on the bed. Respondent told Ms. Ngebeth to change Resident B's clothes and left the room to complete his medication passes.[9] During direct examination, Respondent testified that he was not present at the time Ms. Ngebeth dressed Resident B and placed her in a chair in the room. Respondent testimony

19 According to Respondent, he and Ms. Ngebeth were together in Resident B's room the entire time that the cleaning of Resident B's hands occurred and he was never alone with Resident B. Respondent also testified that he had no interaction with Resident A. According to Respondent, 5 minutes after he left Resident B's room, Ms. Ngebeth also left the room. Respondent testimony

20 Respondent's shift ended at 7:00 a.m. on November 4, 2011, at which time Respondent completed an un-witnessed fall report ("UF report") purportedly related to Resident B's un-witnessed fall.[10] In that UF report, Respondent wrote: "a comprehensive assessment [of Resident B] revealed no injuries". Respondent testimony; Ex. 3

[9] Based on the testimony of Ms. Ngebeth on the issue, that has been credited by the Board, the Board concludes that upon the completion of cleaning Resident B, Ms. Ngebeth left the room prior to Respondent, leaving Respondent alone in the room with Resident B.

[10] The Board concludes that there is insufficient evidence to determine that Resident B's location on the floor in a sitting position was the result of a fall as the evidence is equally consistent with Resident B lowering herself to a sitting position on the floor. Ex. 3

21 Respondent testified that he did not strike Resident B on November 4, 2011. Respondent testimony

22 On the evening of November 4, 2011, Respondent spoke by telephone to Ms. Cecchini at which time she informed him that certain allegations had been made against him related to an incident with Resident B. Ms. Cecchini also instructed Respondent that he should not report to work for the next 2 days pending an investigation of the allegations. According to Respondent, he did not learn the nature of the allegations against him until he met with Ms. Cecchini the following Monday. Respondent testimony

23 In his November 7, 2011 statement ("11/7 statement"), Respondent asserted that when he entered Resident B's room he noticed Resident B sitting on the floor with feces on her hands. He returned the supplies that he had with him for G-tube care to the cart and gathered the tools he would need to check vital signs. Respondent then summoned Ms. Ngebeth, the CNA, to bring linen and towels. Respondent testified that he and Ms. Ngebeth entered the room together. According to Respondent's report, while Ms. Ngebeth watched Resident B, Respondent went to the bathroom, knocked on the door, and Resident A told him to come in. According to Respondent, as he entered the bathroom, Resident A left the bathroom. Respondent applied soap and warm water to the towel and left the bathroom locking the door behind him. Respondent further reported that no injuries were observed during his examination of Resident B. Ex. 18

Testimony of Mary Ngebeth[11]

24 Ms. Ngebeth is a CNA who has been licensed in the Commonwealth since 2004. In November 2011, Ms. Ngebeth was employed as a CNA at Eastpointe working from either 3:00 p.m. – 11:00 p.m. ("3-11 shift") or from 11:00 p.m. – 7:00 a.m. ("11-7 shift"). Ngebeth testimony

25 On November 3-4, 2011, Ms. Ngebeth worked the 11-7 shift as a floater and was assigned to Resident B's side of the floor. As Resident B was incontinent, one of Ms. Ngebeth's responsibilities during her shift was to change Resident B's diaper, change her bed, and wash Resident B prior to the next shift. However, when she arrived at Resident B's room, Resident B refused care. Pursuant to her training at Eastpointe, Ms. Ngebeth reported Resident B's refusal to accept care to Respondent. Respondent subsequently called her over to Resident B's room and requested that she bring towels and/or linen with her. At the time she was called Ms. Ngebeth testified that she was at the opposite end of the floor. Ngebeth testimony; Ex. 13

26 During direct examination, Ms. Ngebeth testified as follows: 1) prior to Respondent's call for assistance, Ms. Ngebeth had informed Respondent that Resident B had earlier refused care and refused to be washed or changed; 2) when Respondent called for assistance he instructed Ms. Ngebeth to bring cleaning supplies with her; 3) when Ms. Ngebeth entered the room, Resident B was on the floor with feces on

[11] Portions of Ms. Ngebeth's testimony were confusing and inconsistent. At times Ms. Ngebeth did not appear to understand various questions and on other occasions, Ms. Ngebeth elaborated on points not clearly pertinent to the inquiry. The Board attributes part of the confusion to a language barrier. However, certain inconsistencies in Ms. Ngbeth's testimony appear to be calculated. As a means of clarifying Ms. Ngebeth's testimony related to the events of November 3-4, 2011, her testimony is summarized in order by direct, cross, redirect, and re-cross examinations.

her hands; 4) Respondent took towels and washed Resident B's hands; 5) Respondent and Ms. Ngebeth transferred Resident B from the floor to the bed and Respondent continued to clean her; 6) Respondent went to the bathroom to wet a towel and get soap; 7) the bathroom door was closed as this was an Eastpointe policy to keep it closed and Ms. Ngebeth did not notice if Respondent knocked on the door or whether he was let in by someone; 8) Respondent returned to Resident B and Respondent continued to wash Resident B's hands while Resident B was on the bed; 9) Respondent and Ms. Ngebeth washed Resident B's hands before transferring her to the bed; 10) Resident B was on the bed when Respondent and Ms. Ngebeth washed Resident B's hands and Ms. Ngebeth was standing next to Respondent as he washed Resident B's hands; 11) as soon as Respondent finished cleaning Resident B, Ms. Ngebeth gathered the dirty linen, left the room, and did not return to the room; 12) Ms. Ngebeth left the room first, and left Respondent in the room with Resident B; 13)Respondent did not instruct her to finish cleaning Resident B and Ms. Ngebeth does not know what Respondent was doing as she left; 14) Ms. Ngebeth testified that she did not see Respondent attend to Resident B's roommate, did not see Respondent perform a finger-stick for Resident B, did not see Resident A, and did not see Respondent strike Resident B; and 15) Ms. Ngebeth testified that she and Respondent continued cleaning Resident B, together as a team or as part of team-work, after

Resident B was transferred to the bed.[12] Ngebeth testimony

27 On cross-examination, Ms. Ngebeth testified that: 1) English is not her first language; 2) her shift ended at 7:00 a.m. and she has seen bathroom doors open on occasion although those doors are supposed to be closed; 3) Resident B had earlier refused to allow her to wash her and at this time Resident B was not on the floor and did not have feces on her hands; 4) Ms. Ngebeth went to Respondent and told him that Resident B had refused care; 5) Respondent came to address the situation but did not call her to come to assist immediately; 6) Respondent later called her to assist and told her to bring towels as they needed to clean Resident B; 7) when she arrived they entered the room together; 8) Resident B was on the floor with feces on her hands; 9) Respondent took towels and went to get soap and they transferred Resident B to the bed; 10) while Respondent was in the bathroom, Ms. Ngebeth was standing next to Resident B; 11) when Respondent returned to Resident B with the towels and soap, Respondent cleaned Resident B's hands while Ms. Ngebeth held Resident B to keep her from falling; 12) during the cleaning Resident B was crying; 13) Resident B allowed Respondent to wash her hands; 14) Respondent and Ms. Ngebeth got Resident B to bed; 15) while Resident B was on the bed, Ms. Ngebeth and Respondent continued to clean

[12] As noted above, Ms. Ngebeth, on direct examination, Ms. Ngebeth asserted that some cleaning of Resident B's hands occurred while Resident B was on the floor and continued after Resident B was transferred to the bed. However Ms. Ngebeth was less clear as to whether she entered the room alone and on which occasions, Respondent cleaned Resident B alone and when the cleaning was performed by both Ms. Ngebeth and Respondent: During direct examination, Ms. Ngebeth was inconsistent on the issue of whether Resident B was transferred to the bed prior to or subsequent to Respondent entering the bathroom to wet a towel.

Resident B, jointly, to save time and for safety reasons; 16) Ms. Ngebeth then gathered the dirty linen, took it out in a trash bag and did not return to the room; 17) Respondent remained in the room and Ms. Ngebeth does not know how long he remained in the room; and 18) when Ms. Ngebeth left the room, Resident B was lying in the bed, in a clean johnny. Ms. Ngebeth further testified on cross-examination that she did not see Respondent do an assessment of Resident B; did not see Respondent check Resident B's vital signs; did not see Respondent check Resident B's blood pressure; and did not see Respondent examine Resident B for bruises or perform a skin check. [13] Ngebeth testimony

28 During redirect examination, Ms. Ngebeth testified that when Resident B was transferred to the bed, she was placed in a prone position and remained in that position during the cleaning. Ms. Ngebeth further testified that she could not say that Resident B never sat up during the cleaning. Ms. Ngebeth further asserted that as she left the room, Resident B was still lying in the bed and Ms. Ngebeth then covered Resident B. Ngebeth testimony

29 During re-cross examination, Ms. Ngebeth stated that Respondent did not instruct her to stay in the room while he did an assessment of Resident B. Ngebeth testimony

[13] On cross-examination, Ms. Ngebeth stated specifically that she and Respondent entered the room together, suggested that Resident B was transferred to the bed after Respondent went into the bathroom to wet a towel; and indicated that at times she did not participate in the cleaning of Resident B as she was holding Resident B to keep her from falling. However, Ms. Ngebeth consistently testified that she did not observe Respondent perform an assessment of Resident B; that she did not see Respondent examine Resident B for bruises; did not observe him perform a skin check or check Resident B's vital signs or blood pressure.

30 In her written statement, Ms. Ngebeth reported that Resident B refused to allow Ms. Ngebeth to clean and change her. Ms. Ngebeth reported this refusal to Respondent. Respondent later called Ms. Ngebeth and asked her to bring towels or linen. Ms. Ngebeth followed Respondent to Resident B's room and saw Resident B "sitting on the floor with feces". Respondent asked Ms. Ngebeth to help get Resident B up after which Respondent wet the towel and washed Resident B's hands. Respondent and Ms. Ngebeth put Resident B on the bed to clean her. Resident B was crying because she did not want to be cleaned. Ms. Ngebeth picked up the dirty linen and went out after the cleaning of Resident B was completed. Ex. 13

31. The Board concludes that the testimony of Ms. Ngebeth is consistent and credible on the following material issues:[14] a) Resident B was found on the floor of her room with feces on her hands; b) Respondent began to initially clean Resident B's hands while she remained on the floor; c) Respondent and Ms. Ngebeth transferred Resident B to her bed; d) Respondent went into the bathroom to wet a towel, returned to Resident B, and continued cleaning her hands; and e) at the time the cleaning of Resident B had been completed, Ms. Ngebeth left the room prior to Respondent, leaving Respondent in the room alone with Resident B.

32. The Board also concludes that other aspects of Ms. Ngebeth's testimony were implausible and inconsistent with other credible evidence and the Board does not

[14] The Board credits Ms. Ngebeth's testimony regarding Resident B's refusal to allow Ms. Ngebeth to clean her and the fact that Ms. Ngebeth did not observe Respondent complete any assessments or treatments. However, as those issues are not material to this decision, the Board has made no findings on those issues.

credit that testimony including: 1) Ms. Ngebeth's testimony on redirect that she and Respondent transferred Resident B to the bed, placed her in a prone position, and she remained in that position while Respondent cleaned her hands; and 2) Ms. Ngebeth's testimony on cross-examination to the effect that Resident B allowed Respondent to clean her hands. The Board doubts the feasibility of cleaning Resident B's hands while she remained in a prone position on the bed and Resident A observed Resident B sitting on the bed. In addition, on cross-examination, Ms. Ngebeth indicated that she was holding Resident B to keep her from falling indicating that Resident B was not lying in a prone position on the bed. Lastly, the Board finds Ms. Ngebeth's statement that Resident B allowed Respondent to clean her is inconsistent with Ms. Ngebeth's assertion that Resident B was crying because she did not want to be cleaned and is contrary to Resident B's reputation as a combative patient who was usually resistant to care. Moreover, as Respondent made various statements to Ms. Cecchini and Ms. Walsh that Resident B did, in fact, resist the cleaning, the Board finds Ms. Ngebeth's assertions to the contrary, implausible.

33. The Board finds Ms. Ngebeth's testimony too inconsistent to be considered reliable and probative on any material issue other than those identified in ¶ 31, above.

Testimony of Erin Cook

34. On November 7, 2011, Erin Cook, after meeting with Resident A, summarized Resident A's statement relative to the November 3-4, 2011 incident and provided the following summary of Resident A's statement to Ms. Cecchini: On Friday,

November 4, 2011 between 5:45 a.m. and 6:00 a.m., Resident A was in her bathroom when Respondent knocked on the bathroom door from Resident B's room. Respondent entered the bathroom and wet a towel to clean Resident B. When Respondent left the bathroom, the door from the bathroom to Resident B's room remained open and Resident A observed Resident B sitting up in the bed facing the door to her room.[15] Respondent began cleaning Resident B and Resident B put her arm up to "have him stop". At that time Respondent hit Resident B on the arm with his open hand causing her arm to drop to her side. Resident B began to put her arm up again but Respondent did not strike Resident B again. Respondent looked at Resident A and stated words to the effect that "sometimes you have to do that as it's the only language these people understand".[16] Resident A said nothing to Respondent. Resident A did not recall if the aide was in the bedroom with Resident B during this time but believes the aide may have been beside or behind Resident B.[17] Resident A stated that she reported this incident to "nurse Russell"[18] between 3:30 p.m. and 4:00 p.m. on Friday, November 4, 2011. Cook testimony; Ex. 12

[15] In Ms. Cook's report, there was no indication as to whether Resident A remained in the bathroom while Respondent wet the towel or whether Resident A left the bathroom and returned when Respondent departed. However, on the basis of interviews with Resident A, both Ms. Cook and Ms. Walsh indicated in their testimony that Resident A observed the events that took place in Resident B's room from her location in the bathroom where she observed Respondent strike Resident B. Based the testimony of Ms. Walsh that Resident A showed her the location in the bathroom from which she could observe the incident, the Board concludes that at the time of the incident Resident A was in the bathroom with a clear view of the events.

[16] Neither Ms. Cook nor any other witness testifying about Respondent's comments at this time could assert that their testimony reflected the exact words spoken by Respondent at the time.

[17] When interviewed by Ms. Walsh on or about November 14, 2011, Resident A reported that the CNA was in and out of the room during the cleaning but was not in the room at the time of the incident. Resident A also reported that the door from the bathroom to Resident B's room was open. Ex. 16

[18] Subsequently identified as Russell Pacewicz , a Licensed Practical Nurse ("LPN") at Eastpointe.

35 In accordance with Findings of Fact at ¶ 14, above, the Board, in relying on the Resident A's summary of the events of November 3-4, 2011 as told by Resident A to Ms. Cook, concludes that the unsubstantiated complaints filed by Resident A as described in ¶ 12 above, do not detract from A's description of the incident or her ability to observe the November 3 -4, 2011 incident and report those observations accurately. Ex. 12

Testimony of Ms. Cecchini

36 On November 4, 2011, between 5:00 p.m. and 6:00 p.m., Ms. Cecchini received a call from Russell Pacewicz ("Mr. Pacewicz"), an LPN and supervisor on the 3-11 shift at Eastpointe. Mr. Pacewicz informed Ms. Cecchini that he had received a complaint of abuse from Resident A who had witnessed an incident that had occurred at approximately 6:00 a.m. that morning involving Respondent and Resident B. Mr. Pacewicz described Resident A as alert and oriented and indicated that Resident A had identified Respondent as the staff member involved in the incident. Ms. Cecchini then asked Mr. Pacewicz to replace Respondent if he was on the schedule and told Mr. Pacewicz to initiate a 3-day skin check for Resident B. Cecchini testimony

37 In any cases of alleged abuse or assault, a skin-check is required in order to document any injuries to the victim and in order to determine if there is any basis to the allegation. When Mr. Pacewicz performed a skin check of Resident B on November 4, 2011, he observed a new bruise on Resident B's right upper arm consistent with Resident's A's report of the location of the slap. Skin checks were

performed on November 4, 5, and 6, 2011 and each reporting nurse noted a bruise on Resident B's right inner arm. Cecchini testimony; Ex. 16

38 On Saturday, November 5, 2011, Ms. Cecchini, while checking on Resident B, personally observed the bruise on Resident B's arm. Cecchini testimony; Ex. 16

39 In the UF report and the pain assessment report filed by Respondent on November 4, 2011, Respondent indicated there was no evidence of a bruise, abrasion, scratch, or blister present on Resident B. The UF report also consisted of representations of the back and front of a human body to permit Respondent to mark on those representations, the placement of any body marks, bruises, scars, lacerations or new discolorations on Resident B's body. Respondent failed to mark any discolorations or bruises on the report form. Respondent wrote the following comment on the form: "comprehensive assessment revealed no injuries". Respondent also reported on a pain assessment report that Resident B experienced no pain as a result of the fall. According to Ms. Cecchini, if Respondent had observed a bruise or discoloration, including a pre-existing bruise or discoloration, he was required to indicate that on the form. Cecchini testimony; Exhts. 3 and 4

40 According to Ms. Cecchini, if Resident B had sustained a bruise as a result of a fall, it was possible that the bruise would not have become visible by the time Respondent arrived at Resident B's room, but there should have been redness or a discoloration on Resident B's arm that Respondent did not indicate in his report. Cecchini testimony; Ex. 3

41 Based on the statements of Resident A and Respondent, the skin check, and the presence of a bruise on Resident B, Ms. Cecchini believed that the allegation of abuse was valid. As a result, Ms. Cecchini reported the incident to DPH, DHCQ. Cecchini testimony; Ex 11

42 In her report, Ms. Cecchini asserted that during the November 7, 2011 meeting, Respondent indicated to her that Resident B did resist during the cleaning. During cross-examination, Respondent admitted that during a conversation with Ms. Cecchini he told her that Resident B did resist somewhat. Respondent testimony; Ex. 11

43 On November 5, 2011, Ms. Cecchini called in the staff members that had been on duty at the time of the incident and kept all the interviews of the staff separate as a means of keeping the investigative process fair. Because Resident B could not be interviewed due to her cognitive deficiencies, Ms. Cecchini planned to interview Respondent and she asked Ms. Cook, to interview Resident A.

44 On November 7, 2011, Ms. Cecchini and the Director of Social Services interviewed Respondent.[19] Ms. Cecchini summarized the meeting with Respondent as follows: Respondent asserted that he went to Resident B's room to give her insulin and to address a report that Resident B was refusing care. Upon his arrival, Respondent noticed that Resident B was on the floor and her hands were covered in feces. Respondent stated that he immediately left the room to summon Ms. Ngebeth to assist him in lifting Resident B from the floor.

[19] During the November 7, 2011 meeting, Respondent completed a written statement that is summarized in ¶ 23, above.

Respondent asserted that he then noticed that Resident B's hands were covered in feces so he knocked on the bathroom door, was told to come in by Resident A, and proceeded to wet the towel and obtain soap. Respondent reported to Ms. Cecchini that Resident A walked into her room. Respondent indicated to Ms. Cecchini that he began washing Resident B's hands as he waited for the CNA to come and assist him in removing Resident B from the floor.[20] When the CNA arrived, Respondent and Ms. Ngebeth transferred her from the floor to the bed and Ms. Ngebeth left the room to provide care for another resident. According to Respondent, he continued to care for Resident B who was agitated. Respondent informed Ms. Cecchini that during his interaction with Resident B, he noticed Resident A watching him at which time he reassured Resident A that he was just taking care of Resident B. Respondent also denied striking Resident B. Ex. 11

45. During the meeting Respondent told Ms. Cecchini that at some point when Resident B pulled back a little, he held onto her hand. Respondent then explained to Ms. Cecchini that when Resident B pulls her hands back, he holds onto them and eventually she stops resisting. Respondent then stated that he knows how to get the residents to accept care. When Ms. Cecchini asked Respondent why staff members asked for his assistance in managing patients that resist care, Respondent stated that he makes patients accept care. Respondent then described the means by which he achieves the cooperation of patients, such as Resident B. He informed Ms. Cecchini that when Resident B pulls her hands back, he holds

[20] Respondent's statement is inconsistent with the testimony of Respondent and Ms. Ngebeth to the effect that they entered the room together and remained together during the entire time of the cleaning of Resident B.

onto her hands and after a couple of minutes, she stops resisting. Ms. Cecchini then gave Respondent her hand and asked Respondent to demonstrate this technique. Respondent held onto her hand for an extended period of time and with enough pressure that he left finger marks on her hand.[21] Cecchini testimony

46 During the meeting, Respondent denied striking Resident B and indicated that the CNA was in the room while he got towels and when he had completed cleaning Resident B's hands, the CNA left the room with the dirty linen. Ms. Cecchini also received a statement from Ms. Ngebeth and in that statement Ms. Ngebeth indicated that she picked up the dirty linen and left the room, leaving Respondent in the room with Resident B. Cecchini testimony

47 At the conclusion of the November 7, 2011 meeting with Respondent, Ms. Cecchini removed Respondent from the facility's schedule pending an investigation. Ms. Cecchini also continued to obtain statements from nurses who had been on the unit at the time of the incident. Cecchini testimony

Testimony of Kathleen Walsh

48 Kathleen Walsh ("Ms. Walsh") has been a complaint surveyor for DPH/DHCQ for 14 years. Prior to that position, Ms. Walsh was a social worker in a nursing home for 20 years. As a complaint surveyor, Ms. Walsh investigates complaints at health care facilities including nursing homes. About 25% of the cases she has investigated involve complaints of abuse. She investigates approximately 7 complaints per month. Ms. Walsh has investigated about 200 cases of physical

[21] In her written summary of the interview, Ms. Cecchini failed to elaborate on Respondent's demonstration as described in ¶ 45. Ex. 11

abuse during her career as a surveyor. In cases of allegations of abuse, she visits the facility. At the end of her investigations, she arrives at one of 3 conclusions: the complaint is valid, invalid, or she is unable to make a determination. On those occasions that she finds a complaint valid she finds some evidence to demonstrate the allegation is true. In most of her investigations, Ms. Walsh finds the complaint invalid (reported and recanted) or that she is unable to make a determination. Ms. Walsh tries to be fair and neutral in assessing the complaints she investigates. Walsh testimony

49 A complaint filed in November 2011, alleging an incident of abuse at Eastpointe, was assigned to Ms. Walsh. Ms. Walsh initiated an on-site visit to Eastpointe where she reviewed the internal investigation report, the statements from witnesses, and other relevant documentation. Ms. Walsh interviewed Ms. Cecchini who provided Ms. Walsh with a summary of the interview that Ms. Cecchini had conducted with Respondent as well as a summary of the interview Ms. Cook, the social worker had conducted with Resident A. Ms. Walsh also interviewed Ms. Cook, Mr. Pacewicz, and various nurses. Because of Resident B's cognitive deficiencies, Resident B could not be interviewed. In essence, the complaint alleged that Respondent hit Resident B's inner right arm in the presence of another resident. Walsh testimony

50 During an interview with Respondent conducted by telephone[22] on November 17, 2011 at 8:00 a.m., Respondent informed Ms. Walsh that Resident B's resistance

[22] Although Respondent was offered an in-person interview, he elected to complete his interview by telephone. Walsh testimony

to care was well-documented. Respondent also informed Ms. Walsh that when CNAs had problems providing care to Resident B, they came to him for assistance. Walsh testimony; Ex. 16

51 During the interview, Respondent acknowledged that he went to Resident B's room and found her on the floor with feces on her hands. Respondent called a CNA to assist him and instructed her to bring towels and linen. Respondent then left the room to gather instruments to take vital signs and returned to the room with the CNA. Respondent informed Ms. Walsh that he knocked on the bathroom door, Resident A permitted him to enter and Resident A left the bathroom. Respondent then asserted that he wet the towel, left the bathroom, and closed the bathroom door leading to Resident B's room. Respondent told Ms. Walsh that he began cleaning Resident B and that Resident B was combative and resistant to care. Walsh testimony; Ex. 16

52 Respondent told Ms. Walsh that he wiped Resident B's hands and then he and the CNA transferred Resident B to the bed from the floor at which time he took Resident B's vital signs. Respondent then informed Ms. Walsh that the CNA washed Resident B while Respondent assessed Resident B. According to Respondent, he found no injuries to Resident B during his assessment. Ms. Walsh was informed by Ms. Cecchini that the location of Resident B's bruise was in an area that would have been difficult to bruise in another way. Walsh testimony; Ex. 16.

53 Ms. Walsh interviewed Resident A on January 14, 2011. Resident A reported that Respondent knocked on the bathroom door and came into the bathroom to wet a

towel. At the time Respondent knocked on the door Resident A was brushing her teeth. At that time, Resident A observed Resident B sitting in the middle of the bed with her legs over the side. Resident A informed Ms. Walsh that at no time did she see Resident B sitting on the floor. Resident A also stated to Ms. Walsh that the CNA was in and out of the room over the course of the incident but the CNA was not in the room at the time Respondent struck Resident B. Resident A also stated that the door from the bathroom to Resident B's room remained open and she observed Respondent commence washing Resident B who had feces on her hands. Resident A reported that Resident B raised her right arm at which point Respondent hit Resident B hard with an open hand. When Respondent realized that Resident A saw him slap Resident B, Respondent said words to the effect, "Sometimes it's what you have to do with these people –that's all they understand". Walsh testimony; Ex. 16

54 Ms. Walsh testified that at this point Resident A was reportedly afraid and said nothing. Nor did Resident A report the incident as she did not know the staff on duty at the time well enough to feel comfortable reporting the incident. As a result she waited until the 3-11 nursing supervisor came on duty and reported the incident to him. Ex. 16

55 According to Ms. Walsh, the nursing supervisor observed a purple bruise on Resident B's arm approximately one inch by three inches in size. The nursing supervisor then initiated a 3-day skin check. Walsh testimony; Ex. 16

56 During the interview, Ms. Walsh asked Resident A to show her where she was standing in the bathroom when she observed the incident. Ms. Walsh stood in the

same place in the bathroom where Resident A indicated she was standing when she observed the incident. Ms. Walsh wanted to verify that Resident A could have observed the incident from that location. With the bathroom door leading to Resident B's room open, Ms. Walsh had a clear view of Resident B's bed, where Resident A indicated Resident B was sitting when Respondent struck her. Walsh testimony; Ex. 16.

57 At the conclusion of her investigation, Ms. Walsh determined that the complaint was valid. Walsh testimony; Ex. 16

Board's Findings of Fact re: Events of November 3-4, 2011

58. On November 3, 2011, at approximately 6:00 a.m., Respondent, while working the 11P-7A shift at Eastpointe, entered the room of Resident B and found her sitting on the floor with feces on her hands.

59. Respondent called Ms. Ngebeth, a CNA, for assistance and together, they transferred Resident B from the floor to Resident B's bed, and placed Resident B in a sitting position on the bed.

60. Respondent entered the shared bathroom between the rooms of Resident A and Resident B where Resident A was brushing her teeth. Respondent proceeded to wet a towel and obtain soap. When Respondent left the bathroom to return to Resident B, he left the door between the bathroom and Resident B's room ajar.

61. Respondent began washing Resident B's hands at which time Resident B resisted Respondent's efforts to clean her hands. In order to stop Respondent from cleaning her hands, Resident B raised her right arm away from Respondent.

62. Respondent then slapped Resident B on the upper portion of her inner right arm with his open hand.

63. Resident A observed Respondent slap Resident B.

64. Between 3:30 p.m. and 4:00 p.m. on Friday, November 4, 2011, Resident A reported the incident described in ¶¶ 61-63, above, to Russell Pacewicz ("Mr. Pacewicz"), an LPN and supervisor on the 3-11 shift.

65. Mr. Pacewicz initiated a 3-day skin check for Resident B and personally observed a bruise on Resident B's arm in the location described by Resident A.

66. On November 4, 5, and 6, 2011, nurses who conducted skin checks for Resident B observed a bruise in the location described by Resident A.

67. In his 11/7 statement relative to the events of November 3 -4, 2011, Respondent indicated that he observed no injuries "on examination" [of Resident B].

68. The Board has previously determined that an act that constitutes contact with a patient that harmed or intimidated or was likely to harm or intimidate a patient whether physically, mentally, or emotionally, constitutes patient abuse. *In the Matter of Francis J. Sears, RN 01-187 (Final Decision and Order, December 10, 2004)*

69. The Board has previously found that a nurse who abuses a patient has engaged in conduct that constitutes gross misconduct in the practice of the profession of nursing in violation of G.L. c. 112, § 61. *In the Matter of Bruce Davis, NUR 2011-0117 (Final Decision and Order October 9, 2014); In the Matter of Ellen M. O'Connor, LN 05-129 (Final Decision and Order March 14, 2008); In the Matter of Christine M. Mucci, RN 05-192 (Final Decision Order June 18, 2008); In the*

Matter of Diane C. Concilio, RN 98-048(Final Decision and Order January 18, 2001); In the Matter of Francis J. Sears, RN 01-187 (Final Decision and Order December 10, 2004).

Credibility Determinations

70. Respondent was not a credible witness. Respondent was frequently evasive, failed to give answers that were responsive to questions put forth, and on several occasions provided elaborate explanations that were not pertinent to the inquiries at issue. Much of Respondent's testimony was self-serving, inconsistent with other credible evidence, and frequently varied from his earlier interview statements and written reports. [23]

71. Respondent's testimony to the effect that: 1) Resident B did not resist as Respondent washed her hands is inconsistent with Ms. Cecchini's testimony that Respondent admitted during the November 7, 2011 meeting that Resident B did resist his efforts to clean her and at variance with Respondent's report to Ms. Walsh during a telephone interview that Resident B was combative and resistant to care. Moreover, during cross-examination, Respondent admitted that he did, in fact, inform Ms. Cecchini that Resident B had resisted his efforts to clean her hands; 2) Respondent's testimony that he left the bathroom door closed and

[23] During the proceedings, Respondent proffered testimonial and documentary evidence that purportedly demonstrated that he performed certain procedures or assessments during the events of November 2011 including a comprehensive assessment of Resident B, a pain assessment of Resident B, an insulin treatment, and a check of Resident B's vital signs. Based on credibility determinations relative to the testimony of Respondent and Ms. Ngebeth, the Board is unable to make any determination with respect to the actual performance of the assessments or treatments. As those issues are not material to the primary allegation of abuse, the Board need not make those findings.

locked after he wet the towel was discredited by Resident A's observations and accurate reporting of the incident. Moreover, Resident A showed Ms. Walsh where she was standing during the incident and Ms. Walsh verified that at that location, Resident A had a clear view of Resident B's bed and the events that subsequently occurred; and 3) Respondent's testimony, that he entered Resident B's room with Ms. Ngebeth and that he and Ms. Ngebeth consistently remained in the room together during the entire event, was inconsistent with the following: the testimony of Ms. Cecchini to the effect that Respondent informed her that he entered Resident B's room without the CNA; Respondent's statement to Ms. Cecchini that after he and Ms. Ngebeth transferred Resident B to the bed, Ms. Ngebeth left to complete care for another resident while he continued to care for Resident B; and Ms. Ngebeth's testimony that after the cleaning was complete, Ms. Ngebeth left the room prior to Respondent. Lastly, Respondent's testimony during direct examination that he had no interaction with Resident A was inconsistent with his statement to Ms. Cecchini that he "reassured" Resident A when he noticed that she was watching him and at variance with a statements Resident A made to Ms. Walsh and Ms. Cook to the effect that when Respondent realized that Resident A was watching him and had observed the slap, Respondent made comments similar to those described in ¶¶ 34 and 53 above.

72 As noted above, the Board has found that Ms. Ngebeth's testimony was replete with contradictions, inconsistent with other credible testimony, at times not pertinent to the stated inquiry, and of little probative value on any material issue in this matter.

73 The Board credits the testimony of Ms. Cecchini, Ms. Walsh, and Ms. Cook. The testimony of each of the witnesses was direct, consistent, unambiguous, and candid. In addition, the Board can discern no motive for any of the above-referenced witnesses to testify untruthfully about Respondent.

74. The Board specifically credits the testimony of Ms. Cecchini to the effect that during the November 7, 2011 meeting, Respondent admitted that Resident B resisted Respondent's attempts to clean her hands by pulling her hands away from Respondent. The Board also finds that Ms. Cecchini's testimony that Respondent indicated that he noticed Resident A watching him and "reassured" her was consistent and reliable. The Board also credits Ms. Cecchini's testimony to the effect that in demonstrating his technique in managing resistant patients, he held her hands with sufficient pressure to leave finger marks on her hand. The Board attaches no significance to Ms. Cecchini's failure to include a description of this technique in her written statement and the Board does not find that the omission indicates that Ms. Cecchini's testimony on the issue was untruthful.

75. The Board credits Ms. Cook's testimony that Resident A was truthful, alert, oriented, and capable of observing and reporting observations accurately. Based on Ms. Cook's credible testimony, the Board concludes that after observing Respondent strike Resident B, Resident A was fearful of the staff on the 11-7 shift and failed to report the incident until the arrival of Mr. Pacewicz on the 3-11 shift.

76. The Board credits the testimony of Ms. Walsh to the effect that she interviewed Resident A regarding the November 2011 incident and during the course of that interview Resident A showed Ms. Walsh where she was standing when she

observed the incident. The Board further credits Ms. Walsh's testimony that she was able to see Resident B's room and the bed from that location in the bathroom. Lastly, the Board credits the clear, straight-forward, and credible testimony of Ms. Walsh that during her interview with Respondent, Respondent admitted that Resident B was combative and resistant to care.

Sanction and Mitigation

77. Respondent was born in Nigeria and learned English there before coming to the United States ("U.S.") in 2002. Respondent lives in Lynn, MA, and has been licensed in Massachusetts ("MA") as an LPN since 2009. Respondent has worked in various nursing home facilities in Rockport, MA and in Beverly, MA. Respondent testimony

78. According to Respondent during his nursing career he has never had a complaint filed against him. Respondent testimony

RULINGS OF LAW

1. Based on Finding of Fact in ¶ 1, above, the Board concludes that it has jurisdiction to hear this matter.

2. Based on Findings of Fact in ¶¶ 1-11, 13-14, 24-25, 31, 33-38, 40-45, 48- 57, and credibility determinations at ¶¶ 70-76, above, the Board finds that Respondent failed to engage in the practice of nursing in accordance with accepted standards

of care in the practice of nursing in violation of Board regulations at 244 CMR 9.03(5).

3. Based on Findings of Fact in ¶¶ 1-11, 13-14, 24-25, 31, 33-38, 40-45, 48-57, 58-69, and credibility determinations at ¶¶ 70-76, above, the Board finds that Respondent violated Board regulations at 244 CMR 9.03(15) by abusing, neglecting, mistreating, abandoning or otherwise harming a patient.

4. Based on Findings of Fact in ¶¶ 1-11, 13-14, 24-25, 31, 33-38, 40-45, 48-57, 58-69, and credibility determinations at ¶¶ 70-76, above, the Board finds that Respondent engaged in conduct that was likely to have an adverse effect upon the health, safety, or welfare of the public in violation of 244 CMR 9.03(47).

5. Respondent's conduct as described constitutes gross misconduct in the practice of the profession of nursing and an offense against the laws of the Commonwealth in violation of G.L. c. 112, § 61.

6. Respondent's conduct, as described, constitutes unprofessional conduct and conduct which undermines public confidence in the integrity of the nursing profession. *Kvitka v. Board of Registration in Medicine,* 407 Mass. 140 cert. denied, 498 U.S. 823 (1990); *Raymond v. Board of Registration in Medicine*, 387 Mass. 708, 713 (1982).

DISCUSSION

M.G.L. c. 112, § 61 provides, in part:

> . . .[E]ach board of registration . . .may . . . suspend, revoke or cancel any certificate, registration, license, or authority . . . if it appears . . . that the holder of such certificate, registration, license or authority . . . is guilty of deceit, malpractice, gross misconduct in the practice of the profession, or of any offense against the laws of the commonwealth relating thereto . . .

The Supreme Judicial Court has affirmed that a Board's discipline of licensees for conduct that undermines public confidence in the integrity of the profession is reasonably related to the promotion of the public health, welfare, and safety. *Raymond v. Board of Registration in Medicine*, 387 Mass. 708, 713 (1982). The Board has authority to "protect the image of the profession and is not limited to disciplining conduct involving direct care, criminal activity or deceit". *Raymond,* supra at 713. The boards of registration have broad authority to regulate the conduct of professionals including the ability to sanction professionals for conduct that undermines public confidence in the integrity of the profession. See *Kvitka v. Board of Registration in Medicine*, 387 Mass. 708, 713 (1982).

Evidence before this Board demonstrates that Respondent, while working the 11-7 shift at Eastpointe on November 3-4, 2011, arrived at Resident B's room and found Resident B on the floor near her bed with feces on her hands. Respondent called Ms. Ngebeth to come and assist him and when she arrived, they transferred Resident B from the floor to her bed, placing her in a sitting position on the bed. Respondent then proceeded to the bathroom shared by Resident A and Resident B to wet a towel and obtain soap. At that time, Resident A was in the shared bathroom brushing her teeth. After Respondent knocked on the door, Resident A permitted him to enter. Respondent wet the towel, obtained soap, and left the bathroom. When Respondent left

the bathroom, he left the door from the bathroom to Resident B's room ajar. At the time Respondent returned to Resident B and began washing her hands, Resident A was in the bathroom and the door from the bathroom to Resident B's room was open. From Resident A's position in the bathroom, Resident A could observe Respondent and Resident B's interactions. At some point while Respondent was cleaning Resident B, Resident B began to resist Respondent's efforts to clean her. Resident B raised her right arm away from Respondent at which point Respondent slapped Resident B on the upper portion of her right, inner arm with his open hand. Resident A observed Respondent slap Resident B. When Respondent realized that Resident A was watching him, he said words to the effect, "sometime you have to do that as it's the only language these people understand". Resident A did not reply to this comment.

Before the end of his shift, Respondent filed a UF report with respect to Resident B's "unwitnessed fall". In that report, Respondent indicated that there was no evidence of a bruise, abrasion, scratch, or blister present on Resident B. Moreover, on that part of the UF report that comprised representations of the back and front of a human body, Respondent placed no marks to indicate any abrasions on Resident B's body nor did he document any discoloration or redness present on Resident B's body. According to Ms. Cecchini, the area of the slap would have been discolored or red and Respondent was obligated to note such an observation on his UF report.

Because Resident A was unfamiliar with the staff and was fearful after having just witnessed a nurse physically abuse Resident B, Resident A did not immediately report the incident of abuse. Rather, between 3:30 p.m. and 4:00 p.m. on Friday, November 4, 2011, Resident A reported the incident to Russell Pacewicz, a nurse-supervisor on the 3-11 shift with whom she was familiar. Mr. Pacewicz then called Ms. Cecchini between 5:00 p.m. and 6:00 p.m. to report the incident. Ms. Cecchini removed Respondent from the facility's schedule, and

instructed Mr. Pacewicz to initiate a three-day skin-check for Resident B. Mr. Pacewicz subsequently observed a new bruise on Resident B's right, upper, inner arm on November 4, 2011. On Saturday, November 5, 2011, Ms. Cecchini personally checked Resident B's arm and observed the bruise. Skin checks performed by other nurses between November 4 and November 6 confirmed the presence of a bruise on Resident B's right arm.

On November 7, 2011, Ms Cecchini met with Respondent regarding the incident. During that meeting, Respondent made several statements that varied from his previous statements and written reports. At that meeting Respondent: 1) indicated that he entered Resident B's room without Ms. Ngebeth and began washing Resident B's hands until Ms. Ngebeth arrived to assist him in transferring Resident B to the bed; 2) described Resident B as pulling her hands away from Respondent during the cleaning; 3) indicated that Ms. Ngebeth left the room while Respondent continued caring for Resident B and 4) when he noticed Resident A, he had some interaction with her in terms of "reassuring" Resident A that he was just taking care of Resident B. At that meeting, Respondent also informed Ms. Cecchini that when he entered the bathroom, Resident A left the bathroom and walked into her room. As noted above, the Board is unable to determine whether Resident A left the bathroom and returned or whether she remained in the bathroom while Respondent wet the towel. However, the Board has concluded that at the time Respondent slapped Resident B, Resident A was in the bathroom, in a position to witness Respondent's interactions with Resident B, and that Resident A did, in fact, observe Respondent slap Resident B.

Although there is no evidence to suggest that during his tenure at Eastpointe Respondent engaged in a pattern of abusing patients, there is evidence that Respondent was viewed as a nurse who could manage combative, resistant patients and that Respondent's technique, as

demonstrated to Ms. Cecchini may have included behavior inconsistent with accepted standards of nursing practice.

The Board has previously held that abuse and mistreatment of patients, including pinching a patient, yelling at a patient, or slapping a patient constitutes abuse and mistreatment warranting discipline for gross misconduct in the practice of nursing. *In the Matter of Bruce Davis, NUR 2011-0117 (Final Decision and Order October 9, 2014)*(RN kicking a patient in the foot and lightly kicking/tapping the patient in the abdomen was gross misconduct in the practice of nursing). Moreover, several other decisions address the same or similar issues, as follows: *In the Matter of Diane C. Concilio, RN 98-048* (Final Decision and Order, January 18, 2001)(nurse's conduct in forcibly holding down patient was gross misconduct); *In the Matter of Francis J. Sears, RN 01-187* ("Sears matter")(Final Decision and Order, December 10, 2004) (nurse's conduct in slapping a patient was abuse and gross misconduct); and *In the Matter of David N. Ikanyi, LN 02-209* (Final Decision and Order, May 19, 2005)(nurse's conduct in yelling at patient and pointing finger at patient was abuse and mistreatment). In the Sears matter, the Board stated:

> "Whether a slap is a "hard slap" or a "light slap" . . . does not make Respondent's act in slapping an elderly, confused resident any less a "slap". The act of slapping a resident constitutes patient abuse within the meaning of 244 CMR 9.02, which defines "abuse as "impermissible or unjustifiable contact or communication with a patient". . . [T]he act of slapping the resident constitutes contact with a patient that harmed or intimidated, or was likely to harm or intimidate, the resident—whether physically, mentally, or emotionally—and, as such, constitutes patient abuse in violation of 244 CMR 9.03(15)."

In this case, the Board also concludes that Respondent's conduct was a violation of Board regulations at 244 CMR 9.03 (5), (15), and (47). The Board has concluded that Respondent's treatment of Resident A did not conform to accepted standards of practice in the nursing profession in violation of 244 CMR 9.03(5). The Board has determined that Respondent's

conduct with respect to Resident A constitutes abuse in violation of 244 CMR 9.03(15) and is consequently the type of conduct likely to adversely effect the health, safety, and welfare of patients and the general public in violation of 244 CMR 9.03 (47).

As a result of violating Board regulations at 244 CMR 9.03, Respondent has also failed to adhere to the laws of the Commonwealth relating to his profession in violation of G. L. c. 112, § 61.

In his post-hearing brief, Prosecuting Counsel maintains that the evidence demonstrates that on November 4, 2011 between 6:00 a.m. and 7:00 a.m., Respondent struck Resident B as Resident B resisted Respondent's attempts to clean feces from Resident B's hands. Prosecuting Counsel contends that the evidence before the Board supports the premise that Respondent struck Resident B while providing care to her. Prosecuting Counsel notes that Resident B had a documented history of resisting care and Respondent had previously boasted of his ability to manage combative patients. Lastly, Prosecuting Counsel asserts that based on case law, hearsay alone may be sufficient to support a finding by an administrative body where the hearsay has "indicia of reliability." *Covell v. Dept. of Social Services*, 439 Mass. 766,786 (2003) quoting *Embers of Salisbury, Inc. v. Alcoholic Beverage Control Commission*, 401 Mass. 526, 530 (1988).

In his post-hearing brief, Respondent seeks first to discredit the report provided to Eastpointe by Resident A. In general, Respondent attempts to utilize Resident A's psychological diagnoses and her prescribed medications as a means of discrediting Resident A's statement. As noted in the decision, there was no evidence that Resident A received any medication in or around the time of the incident and as further noted, during the proceedings, Respondent failed to present any expert testimony to suggest that Resident A's ability to observe and accurately report

those observations may have been impacted by her diagnoses of anxiety and depression, or prescribed medications. Respondent then questioned Resident A's truthfulness based on her "unsubstantiated accusations" against staff suggesting that the November 2011 incident as reported by Resident A was fabricated. The Board's conclusions relative to Resident A's complaints are fully addressed in the decision and require no further discussion. Respondent also asserts that the Board should infer from Resident A's delay in reporting the incident as well as her refusal to testify in this matter that her allegations are, therefore, false. The Board concludes that a vulnerable nursing home resident with anxiety and multiple medical issues including diabetes and a seizure disorder, who has witnessed abusive behavior by a care-giver, is likely to be fearful and intimidated by that behavior such that testifying against the care-giver creates an insurmountable challenge. The Board concludes that her reluctance to testify in this matter does not detract from the accuracy of her observations and report. In fact, much of her report was consistent with other credible evidence in this matter, including the bruise evident on Resident B's arm.

Respondent next requests that the Board consider that Respondent had no prior history of any disciplinary actions against him. According to Respondent, the Board should find that Respondent was "calm, forthright and consistent in his testimony". As noted in the decision, based on the credibility determinations, the Board's conclusions relative to Respondent's credibility does not comport with the representations in Respondent's brief.

Lastly, in his post-hearing brief, Respondent suggests that all the evidence presented against Respondent was hearsay or totem-pole hearsay and that as the hearing was based on unsubstantiated hearsay a finding in favor of Respondent is required.

Much of the evidence in this matter upon which the Board has relied was in the form of testimony from credible witnesses such as Ms. Cecchini, Ms. Walsh, and Ms. Cook. Ms. Cecchini and Ms. Walsh reported statements made to them by Respondent in a direct, concise manner. The Board has found that many of Respondent's statements to Ms. Cecchini and Ms. Walsh were inconsistent with other credible evidence and often at variance with Respondent's previous statements and written reports. Ms. Cook, a social worker, who had worked closely with Resident A, described her as truthful and capable of observing events and reporting those events accurately. The witnesses testified in a knowledgable and persuasive manner. In addition to the credible testimony of witnesses, the Board relied on the presence of a bruise on Resident B's arm that was located in the exact place described by Resident A and confirmed by Ms. Cecchini, Mr. Pacewicz, and several other nurses who conducted skin checks on Resident B.

In administrative hearings, including matters before this Board, hearsay is permissible but may be subject to reduced credibility or accorded reduced weight. Hearsay evidence must be the type upon which reasonable people rely. Resident A's reported observations, upon which this Board has relied, were consistent with other credible evidence and supported by significant indicia of reliability. See *Ohio v Roberts*, 448 US 56, 100 S Ct 2531, 65 L Ed 2d 597 (1980); Covell, supra at 786. Respondent's argument, that this matter should be dismissed because Resident A did not testify, has been previously dismissed by the courts. Courts have consistently held that there is no right of confrontation in civil proceedings. See *Frizado v Frizado*, 420 Mass 592, 596-597 n.3 (1995); *Commonwealth v. McGruder*, 348 Mass. 712, 716 (1965), cert denied, 383 U.S. 972 (1966). Therefore, the failure of Resident A to testify in person gave rise to no violation of Respondent's due process rights, and the hearsay evidence presented was reliable and accorded appropriate weight.

The Board finds that Respondent's conduct in this matter denigrates the dignity of patients and denies them the respect they should be accorded. In addition, by inflicting physical and emotional harm on a patient for whom he was obligated to provide care, Respondent has also impugned the integrity of the profession.

The Board, by statutory mandate, is charged with the protection of the public health, safety and welfare. The Board, therefore, has a compelling interest in ensuring that its licensees practice the profession of nursing in a safe, competent, and trustworthy manner. Nursing professionals are not only responsible for the health and well-being of their patients they also have an obligation to fulfill their duties with compassion and professionalism. Respondent violated the trust inherent in his position by treating Patient B in an abusive and otherwise unacceptable manner. Respondent's conduct not only reflects an absence of the professionalism, compassion, and competence required in the nursing profession but it is also the type of unprofessional conduct that would tend to undermine public confidence in the profession.

Accordingly, the Board concludes that Respondent's conduct, as described above, is subject to discipline.[24]

[24] Pursuant to 801 CMR 1.01(11)(c), the parties have thirty (30) days from the filing of this Tentative Decision to file objections.

ORDER

EFFECTIVE DATE OF ORDER

RIGHT TO APPEAL

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