The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
250 Washington Street, Boston, MA 02108-4619

MAURA T. HEALEY
Governor

KIMBERLEY DRISCOLL
Lieutenant Governor

KATHLEEN E. WALSH
Secretary

ROBERT GOLDSTEIN, MD, PhD
Commissioner

Tel: 617-624-6000
www.mass.gov/dph

October 24, 2024

Via First Class and Certified Mail No. : 9589 0710 5270 1788 9296 41
Return Receipt Requested
Thomas Bright, Esq.
Hamel, Marcin, Dunn, Reardon & Shea, PC
1 Merril Industrial Drive, Suite 19
Hampton, NH 03842
tbright@hmdrslaw.com

RE: In the Matter of Chibanda Oswald
Docket No. NUR-2019-0029
License No. LN59115 (active)

Dear Attorney Bright:

Enclosed, please find the *Ruling on Objections to Tentative Decision After Full Adjudicatory Hearing* ("Ruling") and *Final Decision and Order on Tentative Decision After Full Adjudicatory Hearing* ("Order") issued by the Board of Registration in Nursing on October 24, 2024 and **effective November 3, 2024.** This constitutes full and final disposition of the above-referenced Complaint, as well as the final agency actions of the Board. Should Mr. Oswald wish to appeal the enclosed decision, his appeal rights are noted within the Order.

Please note that as of the effective date, Mr. Oswald's license statuses will change to **Probation**. Per the terms of the Order, Mr. Oswald's license will remain on probation for a period of **one (1) year.** Following a satisfactory probation, as deemed by the Board, Mr. Oswald may petition for reinstatement.

You may contact Rebecca Barros, Board Counsel at rebecca.barros@mass.gov with any questions that you may have concerning this matter.

Sincerely,

Heather Cambra BSN, RN, JD

Heather Cambra, BSN, RN, JD
Executive Director
Board of Registration in Nursing

Enclosures
Cc *(via email only)*: Beverly A. Kogut., Esq., Administrative Magistrate
Julie A. Brady, Esq., Prosecuting Counsel

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, COUNTY

BOARD OF REGISTRATION IN NURSING

Board of Registration in Nursing Petitioner, v. **OSWALD CHIBANDA** License No. LN59115 License Expires 03/01/20215 Respondent.	)	Docket No. NUR-2019-0029

FINAL DECISION AND ORDER ON TENTATIVE DECISION AFTER FULL ADJUDICATORY HEARING

I. Background and Procedural History

Pursuant to the above-referenced matter, the Board of Registration in Nursing (the "Board") submits this herein Final Decision and Order after Sanction Hearing. Briefly, the allegations in this case and the stipulated facts are as follows: On or about November 18, 2018, Licensee Peter Gathuka ("Respondent Gathuka") and Oswald Chibanda ("Respondent Chibanda")[1] (collectively, "Respondents"), were employed as Licensed Practical Nurses ("LN" or "LPN") and were on duty at West Side House Long-Term Care Facility ("West Side House"). Both Respondents were working the 3:00 p.m. to 11:00 p.m. shift on opposite sides of the same floor at West Side House. Assigned to Respondent Gathuka's side of the facility was the patient involved in the complaint, Resident A. At some point in the morning, prior to the 3:00 p.m. to 11:00 p.m. shift, Resident A became involved in an altercation with another patient and was struck in the head. The allegations in the complaint concern a practice breakdown by the

[1] A separate Final Decision and Order after Full Adjudicatory Hearing for Respondent Gathuka was voted on by the Board on October 9, 2024, pertaining to NUR-2019-0028. The events underlying the Gathuka and Chibanda complaints are the same, and therefore, this Final Decision and Order addresses the actions taken against both licensees, following the complaints.

Respondents in the aftermath of this event. The two matters were consolidated by agreement in October of 2020, for purposes of the full adjudicatory hearing.

In connection with the Final Decision and Order, the Board reasserts the following procedural history: On February 18, 2020, the Board issued and duly served on Respondent Gathuka an Order to Show Cause ("OTSC") as to why the Board should not take action against his nursing license or right to renew. The OTSC issued on Respondent Gathuka alleges that while employed and on duty at West Side House as an LN, and during the course of his care for Resident A, Respondent Gathuka (1) failed to perform a neurological assessment; (2) failed to respond to and document identifiable changes in Resident A's condition; (3) failed to make accurate entries in the record; (4) failed to call 911 or ensure that another person called 911 in a timely manner; and (5) failed to provide rescue breathing. Respondent Gathuka filed a written request for hearing on March 12, 2020 and answered the OTSC on May 4, 2020.

On February 19, 2020, the Board similarly issued and duly served on Respondent Chibanda an OTSC as to why the Board should not take action against his nursing license or right to renew. The OTSC issued on Respondent Chibanda alleges that while he was employed and on duty at West Side House as an LN, during the course of his care for Resident A, he (1) failed to call 911 or ensure that someone else called 911 in a timely manner; and (2) failed to provide rescue breathing. On March 12, 2020, Respondent Chibanda was sent another OTSC to a new address. Respondent Chibanda responded to the OTSC on May 1, 2020.

A full adjudicatory hearing was held before Administrative Magistrate Beverly Kogut over the course of June 1, 2021, June 2, 2021, and June 3, 202, during which both parties and their counsel were present. Both parties filed post-hearing briefs in December of 2021. Closing arguments were held before Administrative Magistrate Kogut on May 25, 2022.

On May 14, 2024, the Tentative Decision after Full Adjudicatory Hearing ("Tentative Decision") was issued by Administrative Magistrate Kogut. Respondents Gathuka and Chibanda jointly filed objections to the Tentative Decision on June 13, 2024. The objections have been addressed in a separate Ruling on Objections filed in this matter, which came before the Board[2].

II. Analysis of Tentative Decision

The Tentative Decision by Administrative Magistrate Kogut summarized the facts at issue and the positions of the Petitioner and the Respondents, and ultimately found that both Respondent Gathuka and Respondent Chibanda violated nursing practice regulations. Specifically, Administrative Magistrate Kogut found that Respondent Gathuka violated 244 CMR 9.03(5), accepted standards of nursing practice, when he failed to perform frequent neurological checks after Resident A was struck in the head. The Administrative Magistrate accepted and relied upon testimony by petitioner's expert, Dr. Judith Baldwin, APRN, Ph.D., a general practice and psychiatric nurse who had previously worked in a long-term care facility. Dr. Baldwin's testimony supported that both accepted standards of nursing practice and West Side House's policy concerning neurological assessments required frequent neurological assessments over several days following head trauma, regardless of visible injury, in order to ensure that there was no change in the patient's condition. Administrative Magistrate also found that Respondent Gathuka violated 244 CMR 9.03(5) when he delayed calling 911 immediately upon finding Resident A unresponsive, in favor of checking the patient's code status.

Finally, Administrative Magistrate Kogut found that Gathuka violated 244 CMR 9.03(44), regarding inaccurate documentation, when he admitted to inaccurate entries in the patient's medical record. While Administrative Magistrate Kogut recognized that it is difficult to

[2] In an Order dated October 9, 2024, the Board declined to modify the Tentative Decision as written, denying any action on Respondents' Objections to Tentative Decision After Full Adjudicatory Hearing.

document times and patient care contemporaneously, particularly in a code situation, as supported by expert testimony, Magistrate Kogut nonetheless noted that the approximation times recorded by Respondent Gathuka rendered the record incomplete and not as precise as possible.[3]

Likewise, Administrative Magistrate Kogut found that Respondent Chibanda violated 244 CMR 9.03(5) when he delayed calling 911 immediately upon assisting Respondent Gathuka when Resident A was found unresponsive, in order to confirm the patient's code status, and failed to ensure that someone else called 911 immediately.

The Board acknowledges that both Respondents are dedicated, hard-working nurses who have earned a respected reputation in the nursing community. Both Respondents have accepted accountability for their actions and proven themselves willing to learn since this incident, demonstrated by the fact they each completed relevant CEUs in 2021. Neither Respondent was terminated from the facility following their care of Resident A on November 18, 2018, and both have continued to practice nursing since this event, without any further complaints related to nursing practice made against their licenses[4]. The Board is sympathetic to the fact that Respondents oversaw nearly twenty (20) patients on the evening of the incident and cared for Resident A with great effort; however, standard nursing practices were not followed. The Board highlights the fact that the Respondents' training regarding checking patient code status prior to calling 911 starkly contrasted with accepted nursing practice and led to delay in this particular case, which may have contributed to dire consequences for the patient involved.

III. Recommended Discipline

[3] Administrative Magistrate Kogut wrote, "The evidence at the hearing established that the "At around 9:30 PM" and "At around 9:40 PM" times Respondent Gathuka wrote in his Progress Note as to when the events occurred on the evening of November 18, 2018 prior to his calling 911 were inaccurate."

[4] The Board notes that a complaint was opened on Respondent Chibanda in 2023, NUR-2023-0283, resulting in a license suspension from 9/7/2023-10/23/23. This complaint was related to court-ordered child support payments, for which he is now in good standing.

The Board has carefully considered the Tentative Decision and hereby adopts the Tentative Decision, including all findings of fact and conclusions of law. The Tentative Decision is attached hereto and incorporated herein by reference.

Based on the findings and violations noted by the Administrative Magistrate, the Board has determined that the evidence warrants a **ONE (1) YEAR PROBATIONARY PERIOD.** In support of this finding, the Board states that it is charged with protecting the public health, safety, and welfare. *See* Kvitka v. Board of Registration in Medicine, 407 Mass. 140, 143 (190), *citing Levy v. Board of Registration & Discipline in Medicine,* 378 Mass. 519, 524 (1979). The Board has broad authority to regulate the conduct of nursing professionals including the ability to sanction professionals for conduct that undermines public confidence in the integrity of the profession. *See* Kvitka, 407 Mass. at 143; *see also* Raymond v. Board of Registration in Medicine, 387 Mass. 708, 713 (1982).

The evidence supports that Respondent Gathuka did not adhere to West Side House's policy regarding neurological assessments and that following Resident A's injury, regardless of whether the patient exhibited any immediate symptoms, neurological assessments should have been performed on a frequent basis, pursuant to standard nursing practices. The evidence also supports that Respondent Gathuka did not document the patient's medical record accurately, by his own admission, and delayed calling 911, or having someone else call 911, upon finding Resident A unresponsive in his bed. The evidence further supports that Respondent Chibanda delayed calling 911 upon finding Resident A unresponsive, or delayed having someone else call 911. The Board acknowledges all of the mitigating factors described above in rendering its decision.

The Board voted to adopt the within **Final Decision** at its meeting held on October 9, 2024, by the following vote:

In favor:	*A. Alley, K.A. Barnes, A. Joseph, L. Kelly, L. Keough, J. Monagle, D. Nikitas, R. Reynolds, R. Sesay, and H. Underwood*
Opposed:	*None*
Abstained:	*None*
Recused:	*None*
Absent:	*K. Crowley and A. Sprague*

ORDER

Based on its Final Decision, the Board imposes a **ONE-YEAR PROBATIONARY PERIOD** on Respondents' nursing licenses, LN65616 and LN59115. The Board notes that the evidence supports practice breakdowns in violation of 244 CMR 9.03(5) and 244 CMR 9.03(44) as to Respondent Gathuka, and 244 CMR 9.03(5) as to Respondent Chibanda. The Board believes this sanction will sufficiently serve to notify and protect the public and will allow for necessary monitored practice of the Respondents' nursing practice, following a supported breakdown in practice during the events of November 18, 2018. The Board recognizes that Respondents are dedicated to their practices, are remorseful, have engaged in necessary CEUs since the incident, and are well respected by their peers in the nursing community.

The One (1) Year Probationary Period is subject to the following agreement:

1. The Board may choose to reinstate the Licensee's license if the Board determines that reinstatement is in the best interests of the public at large. Any reinstatement of the Licensee's license may be conditioned upon the Licensee entering into a consent agreement for the **PROBATION** of their license for at least **one (1) year** (**"Probationary Period"**) including other requirements that the Board determines at the time of re-licensure to be reasonably necessary in the best interests of the public health, safety and welfare.

2. During the Probationary Period, the Licensee further agrees that they shall comply with all of the following requirements to the Board's satisfaction:

    a. Comply with all laws and regulations governing the practice of nursing, and not engage in any continued or further conduct such as that set forth in Paragraph 2.

    b. Notify the Board in writing within ten (10) days of each change in their name and/or address.

    c. Timely renew their license to practice nursing.

    d. Respond to inquiries from Board staff in a timely manner.

    e. Disclose the terms of this Agreement to the Program Administrator of any Nursing Education Program at which they are enrolled during the Probationary Period.

    f. Maintain active employment (Active Practice Requirements) in a position that requires a nursing license, in a facility setting where the Licensee receives consistent, on-site supervision by a qualified licensed nurse[5] for a minimum average of twenty (20) hours per week throughout the Probationary Period.

        a. The Licensee agrees that a qualified licensed nurse is defined as a nurse who 1) possesses a Massachusetts[6] nursing license in good standing or authority to practice under federal law, or both; 2) is employed in a supervisory role; 3) possesses a minimum of one year of full-time experience in nursing, or its equivalent, within the last five years; 4) is educationally prepared at or above the level of the Licensee; and 5) has no open complaints with the Board and no open criminal matters.

    g. Refrain from the practice of nursing in any of the following employment settings during the Probationary Period:

        a. Settings where structured, consistent on-site supervision is not in place including but not limited to, home care agencies or private home care;

        b. Travel nurse agencies; or

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[5] The Licensee must receive direct supervision from a qualified licensed nurse who is employed in a supervisory role and is physically located at all times in each facility in which the Licensee practices nursing.

[6] Or a license to practice in the jurisdiction in which the Licensee is employed.

c. Temporary staffing agencies.

h. Review this Agreement with each of their nursing supervisors, and arrange for each nursing supervisor to submit directly to the Board:

i. a completed and signed "Supervisor Verification Form" (Form 1), provided with this Agreement, within thirty (30) days of

(1) the Effective Date *and*

(2) any subsequent employment commenced during the Probationary Period

ii. *quarterly* written reports[7], using the "Supervision Report Form" (Form 2) provided with this Agreement attesting to the quality of the Licensee's nursing practice, reliability and attendance and specifically addressing Licensee's administration of medication and documentation, including any errors and incidents. The Board may take action pursuant to paragraph 9 in the event that any quarterly report reveals a practice issue the Board deems significant.

i. Within 30 days of the Effective Date, notify the Board in writing if the Licensee is not employed in accordance with paragraph 2(f).

j. If not employed in accordance with paragraph 2(f) within 30 days of the Effective Date:

a. On a weekly basis: actively search for nursing employment.

b. On a monthly basis: submit to the Board a detailed description of their nursing job search activities and the status of their nursing employment.

k. Complete the Active Practice Requirements within a period up to a maximum of double the length of the Probationary Period.[8]

l. Notify the Board in writing within seven (7) days of any change in the Licensee's employment status, including each change in Employer, each resignation or termination, and the name, address and telephone number of each new Employer.

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[7] The Licensee 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.
[8] The Probationary Period is defined in Paragraph 1.

m. Notify the Board in writing within seven (7) days of any complaint filed against their nursing license in any jurisdiction in which they hold such a license.

3. If the Licensee does not comply with each requirement of this Agreement, or if the Board opens a Subsequent Complaint[9] during the Probationary Period:

a. The Board may upon written notice to the Licensee, as warranted to protect the public health, safety, or welfare:

i. EXTEND the Probationary Period; and/or

ii. MODIFY the Probation requirements; and/or

iii. IMMEDIATELY SUSPEND the Licensee's nursing license.

b. If the Board suspends the Licensee's nursing license pursuant to Paragraph 3(a)(iii), the suspension shall remain in effect until:

i. the Board gives the Licensee written notice that the Probationary Period is to be resumed and under what terms; or

ii. the Board and the Licensee sign a subsequent agreement; or

iii. the Board issues a written final decision and order following adjudication of the allegations (1) of noncompliance with this Order, and/ or (2) contained in the Subsequent Complaint.

The Board voted to adopt the within **Final Order** at its meeting held on October 9, 2024, by the following vote:

In favor: *A. Alley, K.A. Barnes, A. Joseph, L. Kelly, L. Keough, J. Monagle, D. Nikitas, R. Reynolds, R. Sesay, and H. Underwood*

Opposed: *None*

Abstained: *None*

[9] The term "Subsequent Complaint" applies to a complaint opened after the Effective Date, which (1) alleges that the Licensee engaged in conduct that violates Board statutes or regulations, and (2) is substantiated by evidence, as determined following the complaint investigation during which the Licensee shall have an opportunity to respond.

Recused: *None*

Absent: *K. Crowley and A. Sprague*

EFFECTIVE DATE OF ORDER

This Final Decision and Order becomes effective upon the tenth (10th) day from the date issued (see "Date Issued" below).

RIGHT TO APPEAL

Respondent is hereby notified of the right to appeal this Final Decision and Order to the Supreme Judicial Court pursuant to M.G.L. c. 112, § 64. Respondent must file any appeal within thirty (30) days of receipt of this notice of Final Decision and Order.

Board of Registration in Nursing,

Heather Cambra BSN, RN, JD

Heather Cambra, BSN, RN, JD
Executive Director
Board of Registration in Nursing

Date Issued: October 24, 2024

Notified:

By first-class, electronic mail, and certified mail no. : 9589 0710 5270 1788 9296 41
Return receipt requested
Thomas Bright, Esq.
Hamel, Marcin, Dunn, Reardon & Shea, PC
1 Merril Industrial Drive, Suite 19
Hampton, NH 03842
tbright@hmdrslaw.com

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Julie A. Brady, Esq.
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Department of Public Health
Office of General Counsel
250 Washington Street, 2nd Floor
Boston, MA 02108
julie.a.brady@mass.gov

Via electronic mail

Beverly A. Kogut
Administrative Magistrate
Department of Public Health
Office of the General Counsel
250 Washington Street
Boston, MA 02108
beverly.a.kogut@mass.gov