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Court of Appeals Div II No. 45834-9-II

SUPREME COURT
OF THE STATE OF WASHINGTON

FAIRUZA STEVENSON,

Appellant
v.

STATE OF WASHINGTON, DEPARTMENT OF HEALTH, NURSING CARE QUALITY ASSURANCE COMMISSION,

Respondent

APPELLANT'S PETITION FOR DISCRETIONARY REVIEW

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1. Identity of Petitioner

Fairuza Stevenson

II. Citation to Court of Appeals Decision

The Court of Appeals Decision from which Ms. Stevenson seeks review was filed in the Court of Appeals on May 27, 2015 and there are no further orders concerning a Motion for Reconsideration. A copy of the Decision and the Trial Court Memorandum Opinion are attached in Appendix 'A'.

III. Issues Presented for Review

1. Did the COA err in concluding that the Commission's Findings were supported by substantial evidence that Ms. Stevenson breached the relevant standard of conduct and acted outside her scope of practice?
2. Did the Commission err in concluding Ms. Stevenson violated the UDA?
3. Did the Commission err in concluding that because Ms. Stevenson was incorporated the legal doctrines of Collateral Estoppel and / or Res Judicata do not apply to her settlement

with DSHS and therefore did not bar DOH from proceeding with a separate proceeding on identical facts with identical parties?

IV. Statement of the Case

1. Facts

a. Preclusion

Ms. Stevenson is a registered nurse with a four-year degree in nursing and some advanced nursing education beyond her four-year degree. (ROP 488 L 13 -18)

She operates what is known in Washington as an Adult Family Home which is incorporated under the corporate name, Stevenson Group Inc. But Ms. Stevenson is the only principal that was involved in a settlement agreement with DSHS as there were no other individuals involved in negotiating the settlement and Correction Plan with DSHS. Ms. Stevenson was personally charged with committing acts as a provider that

DSHS alleged were personal deficiencies and required her to personally submit a Plan of Correction. (ROP 148 – 151).

The settlement agreement with DSHS, contrary to the COA's Finding, did not designate the settlement being with Stevenson Group Inc., but rather required Ms. Stevenson as a provider to personally pay a fine and complete a Correction Plan. Therefore Ms. Stevenson should have available to her the preclusion doctrines of Collateral Estoppel and Res Judicata, particularly Res Judicata.

b. Burden of Proof and Standard of Care

The COA holding that the administrative board whose members possess training and expertise significantly less than the professional being subject to potential discipline sets a standard which diminishes the burden of proof by the administrative agency in question absent testimony that the professional being disciplined conducted themselves in a manner that fell below the standard of care for that

professional. The concept that nurses, doctors, lawyers, CPAs or other professionals subject to a disciplinary proceeding can be exposed to having a disciplinary board (which in this case could have been comprised solely of lay persons) should be rejected by this Court.

c. Weight Given to Various Witnesses' Testimony

The argument that the fact finder is best suited to pass on the credibility and demeanor of the witnesses during a hearing, while correct under the law, was incorrectly applied by the COA in this case in that there was no opportunity for the Board to observe the typical types of conduct a fact finder usually has the opportunity to observe in a trial setting. Ms. Stevenson's experts all testified live in front of the Board and had impeccable credentials, the State's witness testified by phone and the Board had no opportunity to observe her demeanor, mannerisms, etc. It should be noted Dr. Hu, the State's only witness, prescribed a dose of Enoxaparin for 30 days on

discharge. However while hospitalized only 2 daily shots were given. (ROP 061 and 084).

The conclusion that withholding delivery of the anti-coagulant placed patient A at greater risk of harm to stroke than going blind through its administration is not supported by the record in light of the testimony that the only witness for the State was inexperienced (3 plus years) (ROP 326) and failed to even read the patient's chart (ROP 338).

The record supports the medical conclusion by Ms. Stevenson that giving of the anti-coagulant would pose a greater risk of harm to patient A than withholding it was correct and was supported by highly confident professionals who testified on her behalf.

V. Argument

a. Why Review Should be Accepted

Considerations favoring acceptance of review are that the issue of the burden of proof necessary to establish whether or not the

standard of care has been breached by a health care professional affects a substantial public interest that should be determined by the Supreme Court, not the Court of Appeals.

The Court of Appeals went outside the record briefly by noting at Footnote 4 the Commission's make up allows for two advanced registered nurse practitioners, seven registered nurses, three licensed practical nurses and three members of the public.

The Appellant certainly does not question that is the statutory language presently in place. The Appellant's position is that only one of the Board Members in this case had at least the equivalent level of training and experience as the Appellant.

This raises the question of whether someone such as a four-year nursing graduate with some Masters qualifications should not be judged by a panel of their peers, the same argument might be made by an MD who could arguably be confronted by a panel that had lay people with little or no medical knowledge. This is not to say that medical knowledge could not be provided by an expert who

testified as to a strong working knowledge of patient's care when substandard care is alleged. But in Ms. Stevenson's case we note that was not true by reviewing the Exhibits submitted by the State where it appears Dr. Hu provided only minimal care to this patient during her nine-day hospitalization. This of course should be taken into consideration with the fact that Dr. Hu had never taken time to review the patient's chart for a very recent prior admission. These facts are relevant when looking at the State's exhibits.

In fact, Dr. Hu only saw Patient A three times during her nine-day stay being November 24, 2007 (ROP 060), November 18th (ROP 080) and November 17th (ROP 084).

Interestingly Ms. Stevenson was accused of placing Patient A at great risk for harm by withholding the medication for 7 days. The patient had a shot at the hospital on November 24th which is a Saturday evening, the date of her discharge (ROP 061). While at the hospital She went without a shot between November 17th and November 23rd, seven full days, meaning she was only given the

drug in question on the date she entered the hospital on November 16, 2007 (ROP 084) and November 24, 2007 (ROP 061).

The discharge summary is factually important as well and was apparently overlooked or at least ignored by the Board. It is unclear who wrote the Discharge Summary (ROP 111, 112, 113) but it is clear from comments on ROP 112 that lab studies were apparently done including an ultrasound which showed no deep vein thrombosis as a noted problem.

It was also clear to the discharge physician that Patient A was non-mobile for several months prior to her admission based on a conversation with a case worker or notes from a case worker on November 23, 2007 (ROP 113).

Therefore the conclusion that withholding what Ms. Stevenson felt was a dangerous dosage for seven days while she was attempting to verify what the primary care physician's orders would be, placed patient A in no greater danger than she was placed in during her hospital stay.

Another question concerning the credibility of witnesses is that Dr. Hu, it must be inferred, did not review Patient A's chart at all during her hospital stay up until the time there was a discharge summary written or more likely until she was provided with documents to review in preparation for hearing.

VI. Conclusion

The primary defect in the COA's decision is the failure to impose upon the Board at least the duty to present competent expert evidence through an opinion that the standard of care was breached by Ms. Stevenson under these complicated circumstances. The record bears out the fact that Ms. Stevenson made a normal choice to do everything possible to contact the primary care physician who simply ignored her for several days. Even Dr. Hu testified they normally defer to the primary care physician concerning questions of care after discharge. (ROP 341 L 11-15).

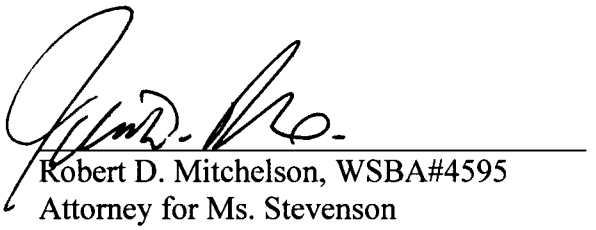
Dr. Hu's instruction that huge doses of Enoxaparin over 30 days was contra indicated by her other's doctor's use of the drug while Patient A was hospitalized and therefore a holding by the Supreme Court that the burden of proof in this case requires more substantial evidence by at least an opinion of conduct that fell below the standard of care should be adopted.

Probably Ms. Stevenson should be granted a new hearing. The Board should be comprised of no less than three RN's with equivalent education or the Supreme Court should simply order reversal of the Order of COA based on inadequate proof of substandard care in violation of nursing standards. The Supreme Court should also reverse the COA's Order and Order the fines be rescinded and Ms. Stevenson's derogatory remarks on her nursing registry be removed.

The conclusion that Res Judicata should not apply because Ms. Stevenson operated in a corporate capacity is also without merit.

The finding was that she was personally placed a patient at undue risk. The entry into the registry of her conduct is personal not a corporate notation.

Respectfully submitted this 24th day of June, 2015



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Attorney for Ms. Stevenson

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WASHINGTON STATE COURT OF APPEALS

DIVISION TWO

In the Matter of FAIRUZA M. STEVENSON Appellant, v. STATE OF WASHINGTON, DEPARTMENT OF HEALTH, NURSING CARE QUALITY ASSURANCE COMMISSION, Respondents.	**CASE NO. 45834-9-II** **DECLARATION OF SERVICE**

I declare under penalty of perjury under the laws of the State of Washington that on June 24, 2015, that I served a true and correct copy of the Appellant's Motion for Discretionary Review, Notice of Discretionary Review and this Proof of Service to the following attorneys / parties:

By UPS deliver to:

Washington State Court of Appeals
Division Two
950 Broadway Ste 300
Tacoma, WA 98402-4454

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P.O. BOX 87096
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By first class postage prepaid to Respondent's Attorney:

Daniel R. Baker, WSBA #43034
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DATED this 24th day of June, 2015.

Sherri Farr, legal assistant to
ROBERT D. MITCHELSON, WSBA#4595
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COURT OF APPEALS DIVISION II

OF THE STATE OF WASHINGTON

In the Matter of Fairuza Stevenson Petitioner/Appellant, and State of Washington, Department of Health, Nursing Care Quality Assurance Commission, Respondent	**Court of Appeals Div. II no. 45834-9-II** **Superior Ct Cause No. 11-2-00119-2** **Master Case No. M2008-118333** **NOTICE OF DISCRETIONARY REVIEW TO SUPREME COURT FOR THE STATE OF WASHINGTON**

Fairuza Stevenson, Petitioner/Appellant seeks review by the Supreme Court of the State of Washington of the Court of Appeal for the State of Washington Division II Decision entered on May 27, 2015.

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A copy of the Decision is attached to this Notice.

Dated this 24th day of June 2015.

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IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON

DIVISION II

FAIRUZA STEVENSON, Appellant, v. STATE OF WASHINGTON, DEPARTMENT OF HEALTH, NURSING CARE QUALITY ASSURANCE COMMISSION, Respondent.	No. 45834-9-II UNPUBLISHED OPINION

BJORGEN, A.C.J. — Fairuza Stevenson appeals a superior court order affirming a decision by the Washington State Department of Health's Nursing Care Quality Assurance Commission (Commission). The Commission found that Stevenson, by refusing over several days to obey a physician's order to provide doses of a medication to Patient A, had breached the standard of conduct for nurses and acted outside the scope of practice allowed by Stevenson's registered nurse's license. Based on these findings, the Commission concluded that Stevenson was subject to discipline under the Uniform Disciplinary Act (UDA), chapter 18.130 RCW, and sanctioned her.

On appeal, Stevenson claims that (1) the Commission's findings that she breached the relevant standard of conduct and acted outside the scope of practice are not supported by

substantial evidence, (2) the Commission's conclusions that she violated provisions of the UDA are erroneous, and (3) collateral estoppel, res judicata, and an earlier stipulation agreement made pursuant to CR 2A with the Department of Social and Health Services (DSHS) to settle a related matter bar the Commission's order. We hold that (1) substantial evidence supports the Commission's findings, (2) the Commission correctly concluded that Stevenson violated several provisions of the UDA, and (3) nothing precluded the Commission's order. Consequently, we affirm the superior court.

FACTS

Stevenson is a registered nurse and operates an adult family home through a corporation called Stevenson Group Inc. Stevenson provides nursing services through her work at the home.

Patient A first came to the adult family home operated by Stevenson Group Inc. in 2005.[1] By 2007, one of Patient A's physicians had prescribed a blood thinning medication to treat some of her health problems. Another physician had prescribed antibiotics. The combination of these drugs produced bleeding in one of Patient A's eyes, requiring her admission to a local hospital for treatment. Patient A's discharge orders discontinued the doses of the blood thinner.

In November 2007, Patient A again was hospitalized, this time for fever and abdominal pain. Dr. Meituck Hu, Patient A's treating physician, diagnosed an infection in her leg related to a prosthetic implant and prescribed antibiotics to remedy it. Because she believed the problem with the prosthetic implant would limit Patient A's mobility, Hu also prescribed prophylactic doses of enoxaparin, another blood thinner, to prevent deep vein thrombosis, the potentially fatal

[1] To protect her privacy, the agency record refers to the patient at issue as Patient A. We follow that nomenclature.

formation of blot clots in Patient A's legs. Hu's discharge orders continued Patient A's daily doses of enoxaparin for one month.

After discharge on November 24, 2007, Patient A returned to the adult family home operated by Stevenson Group Inc. Stevenson, aware of Patient A's history, made attempts to contact Patient A's primary care physician to ask him to discontinue the enoxaparin based on fears it could lead to eye bleeding and vision loss. While waiting for this order, Stevenson refrained from giving Patient A the daily enoxaparin dose Hu had prescribed. Stevenson had great difficulty in getting the order to discontinue enoxaparin from the primary care physician, but made no attempts to contact Hu, physicians covering for Hu at the hospital, or Patient A's other physicians. Eventually, feeling that she could not wait any longer, Stevenson gave Patient A an enoxaparin dose on December 3, 2007, hours before the primary care physician faxed an order to discontinue the drug.

Stevenson's refusal to give Patient A the enoxaparin spawned two state administrative actions. In the first, DSHS took action against Stevenson Group Inc., the entity licensed to operate the adult family home. Specifically, DSHS alleged that the failure to give the enoxaparin violated WAC 388-76-620, a provision requiring the adult family home to "ensure that the resident receives necessary [medical] services."[2] Administrative Record (AR) at 149-50 (citing WAC 388-76-620). Stevenson, as the representative of the home, signed a corrective action plan and Stevenson Group Inc. settled the matter by paying an $800 fine to DSHS from its corporate checking account.

[2] The DSHS complaint against the adult family home also alleged a second violation unrelated to this appeal.

The second administrative action concerned Stevenson's license to practice as a registered nurse. The Commission alleged that Stevenson violated various subsections of RCW 18.13.180 and WAC 246-240-710(2) when she refused to give Patient A the enoxaparin.[3] Stevenson's motion to dismiss the matter, based on her theory that the settlement with DSHS precluded any action by the Commission, was denied and the matter proceeded to an administrative hearing before a panel of the Commission.

At the hearing, the Department of Health, which prosecuted the complaint, presented two witnesses: Hu and Stevenson. Hu testified about her diagnosis and treatment of Patient A, including her decision to prescribe prophylactic doses of enoxaparin. Hu admitted that she had not known about Patient A's recent eye bleeding episode when she ordered the enoxaparin, but

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[3] RCW 18.130.180 provides, in relevant part:

> The following conduct, acts, or conditions constitute unprofessional conduct for any license holder under the jurisdiction of this chapter:
>
> . . .
>
> (4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed;
>
> . . .
>
> (7) Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice;
>
> . . .
>
> (12) Practice beyond the scope of practice as defined by law or rule.

WAC 246-840-710 provides that:

> The following conduct may subject a nurse to disciplinary action under the Uniform Disciplinary Act, chapter 18.130 RCW:
>
> . . .
>
> (2) Failure to adhere to the standards enumerated in WAC 246-840-700 which may include, but are not limited to:
>
> . . .
>
> (d) Willfully or repeatedly failing to administer medications and/or treatments in accordance with nursing standards.

stated that knowing about the incident would not have changed her order: she believed that Patient A's problems with her implant limited her mobility and placed her at a risk of fatal deep vein thrombosis, requiring prophylactic doses of enoxaparin. On questioning from one of the commission members, Hu testified that the benefits of prophylactic enoxaparin outweighed any potential risks of bleeding given the extreme dangers of developing deep vein thrombosis. Hu also testified that she expected her orders "to be followed," AR at 340, unless the nurse implementing the order had questions and brought those questions to either her or another doctor covering for her. Hu specifically stated that the reason she expected any nurse questioning a medication order to contact her or a covering physician was because of possible problems getting in contact with a primary care doctor. Finally, Hu testified that registered nurses had no authority to "unilaterally write a prescription order or change a prescription order." AR at 340.

Stevenson admitted that, as a nurse, she had to follow a physician's prescription order and that she had no authority to unilaterally alter a prescription. Stevenson also admitted that she did not attempt to contact Hu, the hospital, or any of Patient A's other doctors when having difficulty communicating with Patient's A's primary care doctor.

Stevenson presented testimony from three expert witnesses in her defense. Each opined that Stevenson had not breached the standard of conduct for registered nurses because she had a duty to question the order to give enoxaparin, which she and the expert witnesses believed was inappropriate for Patient A. On cross-examination, one of Stevenson's experts stated that, when refusing to comply with a physician order, a nurse had a duty to present his or her concerns to the physician. Also on cross-examination, one of the other experts agreed that Patient A was at risk of developing deep vein thrombosis.

The Commission found that

> 1.11 Physician medication orders must be carried out as ordered in order to ensure patient safety. The scope of practice . . . of a registered nurse does not include the authority to unilaterally fail to follow physician orders. Nor does the standard of care for a registered nurse permit a nurse to engage in such action. The nursing standard of care requires that in circumstances where a registered nurse has concerns about a physician order, the nurse should attempt to contact the physician as soon as possible to discuss her concerns.
>
> 1.12 As a result of the Respondent's failure to follow the physician medication order and failure to attempt to contact the treating physician about her concerns, Patient A was placed at an unreasonable risk of harm. Although Patient A suffered no apparent harm from the missing medication, Patient A could have suffered significant harm including death as a result of the Respondent's actions.

AR at 292.

Based on these findings, the Commission concluded that Stevenson had committed unprofessional conduct as defined by RCW 18.130.180(4), (7), (12) and WAC 246-840-710(2)(d). The Commission imposed a fine and a requirement that Stevenson complete some continuing education courses, as well as placing Stevenson's nursing license on probation for two years.

Stevenson appealed the Commission's findings of fact, conclusions of law, and order to the superior court, which affirmed. This appeal followed.

ANALYSIS

I. STANDARDS OF REVIEW

Washington's Administrative Procedure Act (APA), chapter 34.05 RCW, governs appeals of discipline imposed under the UDA. RCW 18.130.140. Under the APA, when reviewing an agency action, we sit in the same position as the superior court and apply the APA's standards directly to the agency record. *DaVita, Inc. v. Dep't of Health*, 137 Wn. App. 174, 180, 151 P.3d 1095 (2007). The APA allows relief from an agency order for any of nine enumerated reasons. RCW 34.05.570(3). As relevant here, we may grant relief where the agency's order "is not supported by evidence that is substantial when viewed in light of the

whole record before the court," or where the Commission has "erroneously interpreted or applied the law." RCW 34.05.570(3)(d), (e). Stevenson bears the burden of showing the invalidity of the Commission's order. RCW 34.05.570(1)(a).

We review challenged commission findings for substantial evidence in the record, RCW 34.05.570(3)(e), and consider unchallenged findings verities on appeal. *Fuller v. Dep't of Emp't Sec.*, 52 Wn. App. 603, 606, 762 P.2d 367 (1988). When reviewing the record for substantial evidence to support challenged findings, we view the evidence in the light most favorable to the Commission and accept the Commission's "'views regarding the credibility of witnesses and the weight to be given reasonable but competing inferences.'" *William Dickson Co. v. Puget Sound Air Pollution Control Agency*, 81 Wn. App. 403, 411, 914 P.2d 750 (1996) (quoting *State ex rel. Lige & William B. Dickson Co. v. Pierce County*, 65 Wn. App. 614, 618, 829 P.2d 217 (1992)). Evidence supporting a finding is substantial where it would convince a rational, fair-minded person of the finding's truth. *Lawrence v. Dep't of Health*, 133 Wn. App. 665, 671, 138 P.3d 124 (2006).

We review the Commission's legal conclusions de novo. *DaVita*, 137 Wn. App. at 181. However, we accord great deference to the Commission's interpretation of the UDA and the rules it has promulgated pursuant to its authority under chapter 18.79 RCW. *Verizon Nw, Inc. v. Wash. Emp't Sec. Div.*, 164 Wn.2d 909, 915, 194 P.3d 255 (2008); *DaVita*, 137 Wn. App. at 181. We review Stevenson's preclusion claims de novo. *Christensen v. Grant County Hosp. Dist. No. 1*, 152 Wn.2d 299, 305, 96 P.3d 957 (2004) (collateral estoppel); *Nevers v. Fireside, Inc.*, 133 Wn.2d 804, 809, 947 P.2d 721 (1997) (court rules interpreted de novo); *Lynn v. Dep't of Labor & Indus.*, 130 Wn. App. 829, 837, 125 P.3d 202 (2005) (res judicata).

II. THE FINDINGS OF FACT

Stevenson, although not assigning error to any specific findings of fact, generally argues that substantial evidence did not support findings of fact 1.11 and 1.12, set out above. In these, the Commission found that Stevenson (1) failed to adhere to the relevant standard of conduct, (2) practiced outside the scope of practice, and (3) placed Patient A at an unreasonable risk of harm. Stevenson's arguments largely center on evidence she presented and her claims that the Department of Health did not present expert testimony that she violated the standard of conduct at the hearing before the Commission. The Commission contends that substantial evidence in the record supports its findings. We agree with the Commission.

Turning first to finding of fact 1.11, testimony offered at trial supported the Commission's finding that Stevenson failed to adhere to the standards of conduct required of a registered nurse. Hu testified that she expected Stevenson to implement her discharge orders, although she stated that Stevenson could question that order by speaking with her. Hu also testified that Stevenson, as a registered nurse, lacked the authority to alter the prescriptions that were part of the discharge orders, which Stevenson did by failing to give the enoxaparin. One of Stevenson's own experts testified that any nurse who refused to fulfill a physician order based on concerns about the order had a duty "to convey to the doctor that she is not fulfilling that order and she is not giving that medication because of these concerns." AR at 379. A reasonable inference from this testimony is that nurses have a duty to follow the orders given by a doctor unless they raise concerns about the order with the doctor. Stevenson refused to follow Hu's orders and failed to contact Hu or a covering physician to explain why she was declining to do so. The Commission could readily find that Stevenson failed to comply with nursing standards from those facts.

Testimony at trial also supported the Commission's finding, embodied in finding of fact 1.11, that Stevenson practiced outside the scope of practice granted by her nursing license. Hu, one of Stevenson's experts, and Stevenson herself all testified that registered nurses lack "prescriptive authority and must act at the direction of a physician." AR at 340, 379, 506. This testimony allowed the Commission to find that Stevenson, by refusing to follow the direction of Hu, had practiced outside the scope of authority granted to her by her registered nursing license.

Stevenson, however, contends that substantial evidence does not support finding 1.11 because the Department of Health failed to provide expert testimony that she breached the standard of care at the hearing. She is incorrect. The APA provides that agencies in general may utilize their expertise when evaluating factual matters. RCW 34.05.452(5). The regulations governing proceedings before the Commission specifically authorize it to make use of its expertise when making factual determinations. WAC 246-11-160. Common law precedent also recognizes that medical discipline boards like the Commission do not need expert testimony about any possible breach of the standard of care, because such testimony is not helpful when the fact finder, as here, includes experts. *Ames v. Dep't of Health*, 166 Wn.2d 255, 261-62, 208 P.3d 549 (2009); *Davidson v. Dep't of Licensing*, 33 Wn. App. 783, 785-86, 657 P.2d 810 (1983). As noted above, the State presented evidence that would allow the Commission, based on its expertise, to find that Stevenson breached her standard of care.[4]

[4] Stevenson notes that two members of the panel adjudicating the Department of Health's complaint were licensed practical nurses instead of registered nurses, like Stevenson. This appears to be an argument that we should not allow the Commission's panel to determine the appropriate standard of conduct and scope of practice.

RCW 18.79.070(2) provides for the Commission's make-up and requires that it include two advanced registered nurse practitioners, seven registered nurses, three licensed practical nurses, and three members of the public. RCW 18.79.070(2) does not require that commission panels include only members of the same professional type as the appellant. We read that

Stevenson also contends that substantial evidence does not support finding 1.11 because she presented testimony that she declined to dose Patient A with enoxaparin because of fears that it would cause her to bleed, and her experts testified that, by doing so, she had not breached the standard of conduct. That evidence, though, does not change the result of our review. The Commission acted as the fact finder and accorded what it deemed the appropriate weight to the evidence each side presented and the inferences reasonably drawn from that evidence. In doing so, it gave greater weight to the evidence offered by the Department of Health and the inferences drawn from that evidence. We will not upset that determination on appeal. *Ancier v. Dep't of Health*, 140 Wn. App. 564, 575, 166 P.3d 829 (2007).

We also hold that substantial evidence supports finding of fact 1.12, the Commission's finding that Stevenson's actions placed Patient A at an unreasonable risk of harm. Hu testified that Patient A's condition at the time of her admission to the hospital rendered her immobile and placed her at risk of developing deep vein thrombosis. One of Stevenson's experts agreed. Hu also testified that development of deep vein thrombosis risked a quick death. A reasonable inference from this testimony is that the withholding of prophylactic doses of enoxaparin, which would prevent deep vein thrombosis, put Patient A at risk of dying. The Commission could find from that testimony that Stevenson's actions placed the patient at an unreasonable risk of harm.

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omission as embodying the legislature's belief that, as an institution, the Commission has the relevant experience and knowledge necessary to adjudicate nursing misconduct.

Further, Stevenson does not explain how the panel's composition affects the panel's expertise. WAC 246-840-700(2)(a)(i)(D), discussed below and which governs standards of practice for registered nurses, does not appear to operate differently than WAC 246-840-700(2)(b)(i)(D), also discussed below and which governs the standards of practice for licensed practical nurses. Two other provisions discussed below, WAC 246-840-700(3)(a) and -710(2)(d) apply to both licensed practical nurses and registered nurses. Stevenson fails to show how the panel's composition extinguishes the Commission's expertise recognized by the case law.

Stevenson challenges finding of fact 1.12 by claiming the evidence shows the wisdom of her choice to withhold the enoxaparin. Specifically, Stevenson argues that the evidence shows that Patient A lived two years after the December 3, 2007 injection of enoxaparin without any further prophylactic doses of blood thinner. The fact that Stevenson's choice to withhold enoxaparin did not result in actual harm to Patient A or that the patient continued to live without enoxaparin is irrelevant to our review on appeal. The Commission's findings and the relevant law, RCW 18.130.180(4), concern the risk of harm. As noted above, Hu testified to the risks from Stevenson's failure to follow her orders. On this evidence, the Commission could readily find that Stevenson's choice to withhold enoxaparin was a gamble that placed Patient A at an unreasonable risk of harm.

III. THE CONCLUSIONS OF LAW

Stevenson also appears to challenge in three different ways the Commission's conclusions that she committed unprofessional conduct. For the following reasons, however, the challenged conclusions are correct.

Stevenson challenges conclusion of law 2.4, the conclusion that she committed unprofessional conduct by violating RCW 18.130.180(4), by claiming that no evidence showed her actions placed Patient A at an unreasonable risk of harm. As discussed above, substantial evidence supports finding of fact 1.12 that Stevenson's actions placed Patient A at an unreasonable risk of harm. Conclusion 2.4 flows directly from that finding and finding 1.11 that Stevenson breached the standard of conduct required by nurses. We affirm the conclusion. *Nguyen v. Dep't of Health Med. Quality Assurance Comm'n*, 144 Wn.2d 516, 530, 29 P.3d 689 (2001) (this court reviews conclusions by looking to whether the factual findings support them).

Stevenson challenges conclusion of law 2.5, the conclusion that she committed unprofessional conduct under RCW 18.130.180(12), and conclusion of law 2.6, the conclusion that she committed unprofessional conduct under RCW 18.130.180(7), by claiming that the Department of Health failed to show that she breached the standard of conduct or practiced beyond the scope of acceptable practice. Specifically Stevenson claims that WAC 246-840-700 prescribes the scope of practice and the standard of conduct for nurses and that her conduct violated no part of that provision.

With regard to conclusion of law 2.5, RCW 18.130.180(12) includes practicing beyond the scope of practice as unprofessional conduct. With finding of fact 1.11, the Commission found that Stevenson practiced beyond the scope of practice when she unilaterally changed Patient A's prescription by failing to follow Hu's order. As noted above, substantial evidence supported that finding. Finding of fact 1.11 supports the Commission's conclusion of law 2.5 that Stevenson committed unprofessional practice. RCW 18.130.180(12). Therefore, we affirm the Commission's conclusion. *Nguyen*, 144 Wn.2d at 530.

As concerns conclusion of law 2.6 that Stevenson committed unprofessional conduct under RCW 18.130.180(7), that statute defines unprofessional conduct to include the violation of any state or federal statute or regulation establishing the standard of conduct for the profession. WAC 246-840-700(2)(a)(i)(D) establishes one such standard of conduct. It requires nurses to "*implement*[] the plan of care by initiating nursing interventions through giving direct care and supervising other members of the care team." WAC 246-840-700(2)(a)(i)(D) (emphasis added). WAC 246-840-700(3)(a) establishes another standard of conduct, providing that "[t]he registered nurse . . . shall communicate significant changes in the client's status to appropriate members of the health care team. This communication shall take place in a time period consistent with the

client's need for care." WAC 246-840-710(2)(d) establishes a final, relevant, standard of conduct. That provision forbids any nurse from "[w]illfully or repeatedly failing to administer medications . . . in accordance with nursing standards." WAC 246-840-710(2)(d).

A number of the Commission's findings support the conclusion that Stevenson committed unprofessional conduct under RCW 18.130.180(7). The Commission found in finding of fact 1.9, a finding unchallenged and therefore a verity on appeal, that Stevenson failed to provide Patient A her enoxaparin dose from November 24, 2007 to December 3, 2007. With finding 1.11, a finding supported by substantial evidence, the Commission found that Stevenson breached the standard of conduct by refusing to obey the order to provide enoxaparin. With finding of fact 1.12, a finding supported by substantial evidence, and finding of fact 1.10, a finding unchallenged and therefore a verity on appeal, the Commission found that Stevenson failed to communicate her refusal to follow Hu's order or to any covering physician. Those findings support a conclusion that Stevenson violated WAC 246-840-700(2)(a)(i)(D), -700(3)(a), and -710(2)(d) by repeatedly declining to implement Hu's orders to provide a daily dose of enoxaparin without communicating to Hu that she was not complying with the order and explaining her reasons for her refusal. Each of those WAC violations constituted unprofessional conduct under RCW 18.130.180(7). We affirm conclusion of law 2.6. *Nguyen*, 144 Wn.2d at 530.

IV. PRECLUSION

Stevenson also contends that a number of preclusion doctrines prevented the Commission from entering its order. We disagree..

A. Res judicata

Res judicata bars "[r]esurrecting the same claim in a subsequent action." *Hilltop Terrace Homeowner's Ass'n v. Island County*, 126 Wn.2d 22, 31, 891 P.2d 29 (1995). "The threshold requirement" for applying the doctrine of res judicata "is a final judgment on the merits" in a prior action. *Hisle v. Todd Pac. Shipyards Corp.*, 151 Wn.2d 853, 865, 93 P.3d 108 (2004). Once a party satisfies that threshold, we review whether the current action and the prior one involve the same claim by looking to whether the two involve the same "subject matter, cause of action, people and parties, and . . . 'quality of the persons for or against whom the claim is made.'" *Hisle*, 151 Wn.2d at 865-66 (quoting *Rains v. State*, 100 Wn.2d 660, 663, 674 P.2d 165 (1983)). Stevenson bore the burden of showing each of these elements to preclude the Commission from entering its order. *Hisle*, 151 Wn.2d at 865, 866.

Stevenson's res judicata claim fails on at least one of the elements. Both Stevenson's and the Commission's briefing assume that she was a party to the DSHS proceeding. She was not. The DSHS proceeding involved a complaint against Stevenson Group Inc., and payment for the fine in those proceedings came from the corporation's accounts. The commission proceedings involved a complaint against Stevenson. The corporation has an existence separate and apart from Stevenson's. *W. Wash. Laborers-Emp'rs Health & Sec. Trust Fund v. Harold Jordan Co.*, 52 Wn. App. 387, 392, 760 P.2d 382 (1988). Observing that separate existence means holding that the corporation, not Stevenson, was a party to the DSHS action and Stevenson, not the corporation, was a party to the Commission action. Res judicata does not bar the Commission's order.

B. Collateral Estoppel

Collateral estoppel bars relitigation of an issue decided in a prior proceeding, even where the subsequent proceeding involves different claims or causes of action. *Rains*, 100 Wn.2d at 665 (quoting *Seattle-First Nat'l Bank v. Kawachi*, 91 Wn.2d 223, 225-26, 588 P.2d 725 (1978)). Collateral estoppel only applies where (1) the prior proceeding decided an issue identical to the one presented in the subsequent action, (2) there was a final judgment on the merits, (3) the party to be estopped was a party to the prior proceeding or in privity with a party to the proceeding, and (4) estopping the party will not produce an injustice. *Rains*, 100 Wn.2d at 665 (quoting *Seattle-First Nat'l Bank v. Cannon*, 26 Wn. App. 922, 927, 615 P.2d 1316 (1980)). Stevenson bore the burden of proving the earlier proceeding estopped the Commission. *State Farm Mut. Auto. Ins. Co. v. Avery*, 114 Wn. App. 299, 304, 57 P.3d 300 (2002).

The DSHS proceeding did not result in a final judgment on the merits, but instead ended in settlement with Stevenson agreeing to pay a fine. Settlements are not considered final judgments on the merits for purposes of collateral estoppel, because parties may settle for "myriad reasons not related to the resolution of the issues they are litigating." *Marquardt v. Fed. Old Line Ins. Co. (Mut.)*, 33 Wn. App. 685, 689, 658 P.2d 20 (1983); *Krikava v. Webber*, 43 Wn. App. 217, 222, 716 P.2d 916 (1986). Without a final judgment on the merits, collateral estoppel does not apply.

C. CR 2A Settlement Agreement

Finally, Stevenson contends that the settlement with DSHS constituted a stipulation under CR 2A, releasing all claims that the State may have had against Stevenson for her failure to give

Patient A the enoxaparin doses.[5] We disagree.

The civil rules apply to civil proceedings in Washington's superior courts. Stevenson provides no authority for the proposition that they apply in administrative proceedings, and we therefore assume that none exists. *DeHeer v. Seattle Post-Intelligencer*, 60 Wn.2d 122, 126, 372 P.2d 193 (1962). We therefore are not persuaded by her argument. *DeHeer*, 60 Wn.2d at 126.

CONCLUSION

We find that substantial evidence supports the Commission's findings and that it did not erroneously interpret or apply the law. We affirm the superior court order affirming the Commission's decision and order.

A majority of the panel having determined that this opinion will not be printed in the Washington Appellate Reports, but will be filed for public record in accordance with RCW 2.06.040, it is so ordered.

Bjorgen, A.C.J.

BJORGEN, A.C.J.

We concur:

Worswick, J.

WORSWICK, J.

Sutton, J.

SUTTON, J.

[5] CR 2A provides that

> No agreement or consent between parties or attorneys in respect to the proceedings in a cause, the purport of which is disputed, will be regarded by the court unless the same shall have been made and assented to in open court on the record, or entered in the minutes, or unless the evidence thereof shall be in writing and subscribed by the attorneys denying the same.

APPENDIX "A"

1. Court of Appeals Decision entered May 27, 2015

2. Clark County Superior Court Order Affirming Commissioner's Final Order entered Dec. 30, 2013

3. Dept. of Health for the State of Washington Findings of Fact and Conclusions of Law and Final Order dated December 9, 2010

4. Dept. of Health for the State of Washington Statement of Charges filed April 2, 2010

5. Dept. of Social and Health Services Imposition of Civil Fine dated January 31, 2008

6. Copies of the ROP no.'s 060, 061, 080, 082, 084, 111, 112, 113, 148, 149, 150, 151, 326, 338, 341, and 488.

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DIVISION II

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STATE OF WASHINGTON

BY _____
DEPUTY

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON

DIVISION II

FAIRUZA STEVENSON, Appellant, v. STATE OF WASHINGTON, DEPARTMENT OF HEALTH, NURSING CARE QUALITY ASSURANCE COMMISSION, Respondent.	No. 45834-9-II UNPUBLISHED OPINION

BJORGEN, A.C.J. — Fairuza Stevenson appeals a superior court order affirming a decision by the Washington State Department of Health's Nursing Care Quality Assurance Commission (Commission). The Commission found that Stevenson, by refusing over several days to obey a physician's order to provide doses of a medication to Patient A, had breached the standard of conduct for nurses and acted outside the scope of practice allowed by Stevenson's registered nurse's license. Based on these findings, the Commission concluded that Stevenson was subject to discipline under the Uniform Disciplinary Act (UDA), chapter 18.130 RCW, and sanctioned her.

On appeal, Stevenson claims that (1) the Commission's findings that she breached the relevant standard of conduct and acted outside the scope of practice are not supported by

substantial evidence, (2) the Commission's conclusions that she violated provisions of the UDA are erroneous, and (3) collateral estoppel, res judicata, and an earlier stipulation agreement made pursuant to CR 2A with the Department of Social and Health Services (DSHS) to settle a related matter bar the Commission's order. We hold that (1) substantial evidence supports the Commission's findings, (2) the Commission correctly concluded that Stevenson violated several provisions of the UDA, and (3) nothing precluded the Commission's order. Consequently, we affirm the superior court.

FACTS

Stevenson is a registered nurse and operates an adult family home through a corporation called Stevenson Group Inc. Stevenson provides nursing services through her work at the home.

Patient A first came to the adult family home operated by Stevenson Group Inc. in 2005.[1] By 2007, one of Patient A's physicians had prescribed a blood thinning medication to treat some of her health problems. Another physician had prescribed antibiotics. The combination of these drugs produced bleeding in one of Patient A's eyes, requiring her admission to a local hospital for treatment. Patient A's discharge orders discontinued the doses of the blood thinner.

In November 2007, Patient A again was hospitalized, this time for fever and abdominal pain. Dr. Meituck Hu, Patient A's treating physician, diagnosed an infection in her leg related to a prosthetic implant and prescribed antibiotics to remedy it. Because she believed the problem with the prosthetic implant would limit Patient A's mobility, Hu also prescribed prophylactic doses of enoxaparin, another blood thinner, to prevent deep vein thrombosis, the potentially fatal

[1] To protect her privacy, the agency record refers to the patient at issue as Patient A. We follow that nomenclature.

formation of blot clots in Patient A's legs. Hu's discharge orders continued Patient A's daily doses of enoxaparin for one month.

After discharge on November 24, 2007, Patient A returned to the adult family home operated by Stevenson Group Inc. Stevenson, aware of Patient A's history, made attempts to contact Patient A's primary care physician to ask him to discontinue the enoxaparin based on fears it could lead to eye bleeding and vision loss. While waiting for this order, Stevenson refrained from giving Patient A the daily enoxaparin dose Hu had prescribed. Stevenson had great difficulty in getting the order to discontinue enoxaparin from the primary care physician, but made no attempts to contact Hu, physicians covering for Hu at the hospital, or Patient A's other physicians. Eventually, feeling that she could not wait any longer, Stevenson gave Patient A an enoxaparin dose on December 3, 2007, hours before the primary care physician faxed an order to discontinue the drug.

Stevenson's refusal to give Patient A the enoxaparin spawned two state administrative actions. In the first, DSHS took action against Stevenson Group Inc., the entity licensed to operate the adult family home. Specifically, DSHS alleged that the failure to give the enoxaparin violated WAC 388-76-620, a provision requiring the adult family home to "ensure that the resident receives necessary [medical] services."[2] Administrative Record (AR) at 149-50 (citing WAC 388-76-620). Stevenson, as the representative of the home, signed a corrective action plan and Stevenson Group Inc. settled the matter by paying an $800 fine to DSHS from its corporate checking account.

[2] The DSHS complaint against the adult family home also alleged a second violation unrelated to this appeal.

The second administrative action concerned Stevenson's license to practice as a registered nurse. The Commission alleged that Stevenson violated various subsections of RCW 18.13.180 and WAC 246-240-710(2) when she refused to give Patient A the enoxaparin.[3] Stevenson's motion to dismiss the matter, based on her theory that the settlement with DSHS precluded any action by the Commission, was denied and the matter proceeded to an administrative hearing before a panel of the Commission.

At the hearing, the Department of Health, which prosecuted the complaint, presented two witnesses: Hu and Stevenson. Hu testified about her diagnosis and treatment of Patient A, including her decision to prescribe prophylactic doses of enoxaparin. Hu admitted that she had not known about Patient A's recent eye bleeding episode when she ordered the enoxaparin, but

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[3] RCW 18.130.180 provides, in relevant part:

> The following conduct, acts, or conditions constitute unprofessional conduct for any license holder under the jurisdiction of this chapter:
>
> . . .
>
> (4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed;
>
> . . .
>
> (7) Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice;
>
> . . .
>
> (12) Practice beyond the scope of practice as defined by law or rule.

WAC 246-840-710 provides that:

> The following conduct may subject a nurse to disciplinary action under the Uniform Disciplinary Act, chapter 18.130 RCW:
>
> . . .
>
> (2) Failure to adhere to the standards enumerated in WAC 246-840-700 which may include, but are not limited to:
>
> . . .
>
> (d) Willfully or repeatedly failing to administer medications and/or treatments in accordance with nursing standards.

stated that knowing about the incident would not have changed her order: she believed that Patient A's problems with her implant limited her mobility and placed her at a risk of fatal deep vein thrombosis, requiring prophylactic doses of enoxaparin. On questioning from one of the commission members, Hu testified that the benefits of prophylactic enoxaparin outweighed any potential risks of bleeding given the extreme dangers of developing deep vein thrombosis. Hu also testified that she expected her orders "to be followed," AR at 340, unless the nurse implementing the order had questions and brought those questions to either her or another doctor covering for her. Hu specifically stated that the reason she expected any nurse questioning a medication order to contact her or a covering physician was because of possible problems getting in contact with a primary care doctor. Finally, Hu testified that registered nurses had no authority to "unilaterally write a prescription order or change a prescription order." AR at 340.

Stevenson admitted that, as a nurse, she had to follow a physician's prescription order and that she had no authority to unilaterally alter a prescription. Stevenson also admitted that she did not attempt to contact Hu, the hospital, or any of Patient A's other doctors when having difficulty communicating with Patient's A's primary care doctor.

Stevenson presented testimony from three expert witnesses in her defense. Each opined that Stevenson had not breached the standard of conduct for registered nurses because she had a duty to question the order to give enoxaparin, which she and the expert witnesses believed was inappropriate for Patient A. On cross-examination, one of Stevenson's experts stated that, when refusing to comply with a physician order, a nurse had a duty to present his or her concerns to the physician. Also on cross-examination, one of the other experts agreed that Patient A was at risk of developing deep vein thrombosis.

The Commission found that

> 1.11 Physician medication orders must be carried out as ordered in order to ensure patient safety. The scope of practice . . . of a registered nurse does not include the authority to unilaterally fail to follow physician orders. Nor does the standard of care for a registered nurse permit a nurse to engage in such action. The nursing standard of care requires that in circumstances where a registered nurse has concerns about a physician order, the nurse should attempt to contact the physician as soon as possible to discuss her concerns.
>
> 1.12 As a result of the Respondent's failure to follow the physician medication order and failure to attempt to contact the treating physician about her concerns, Patient A was placed at an unreasonable risk of harm. Although Patient A suffered no apparent harm from the missing medication, Patient A could have suffered significant harm including death as a result of the Respondent's actions.

AR at 292.

Based on these findings, the Commission concluded that Stevenson had committed unprofessional conduct as defined by RCW 18.130.180(4), (7), (12) and WAC 246-840-710(2)(d). The Commission imposed a fine and a requirement that Stevenson complete some continuing education courses, as well as placing Stevenson's nursing license on probation for two years.

Stevenson appealed the Commission's findings of fact, conclusions of law, and order to the superior court, which affirmed. This appeal followed.

ANALYSIS

I. STANDARDS OF REVIEW

Washington's Administrative Procedure Act (APA), chapter 34.05 RCW, governs appeals of discipline imposed under the UDA. RCW 18.130.140. Under the APA, when reviewing an agency action, we sit in the same position as the superior court and apply the APA's standards directly to the agency record. *DaVita, Inc. v. Dep't of Health*, 137 Wn. App. 174, 180, 151 P.3d 1095 (2007). The APA allows relief from an agency order for any of nine enumerated reasons. RCW 34.05.570(3). As relevant here, we may grant relief where the agency's order "is not supported by evidence that is substantial when viewed in light of the

whole record before the court," or where the Commission has "erroneously interpreted or applied the law." RCW 34.05.570(3)(d), (e). Stevenson bears the burden of showing the invalidity of the Commission's order. RCW 34.05.570(1)(a).

We review challenged commission findings for substantial evidence in the record, RCW 34.05.570(3)(e), and consider unchallenged findings verities on appeal. *Fuller v. Dep't of Emp't Sec.*, 52 Wn. App. 603, 606, 762 P.2d 367 (1988). When reviewing the record for substantial evidence to support challenged findings, we view the evidence in the light most favorable to the Commission and accept the Commission's "'views regarding the credibility of witnesses and the weight to be given reasonable but competing inferences.'" *William Dickson Co. v. Puget Sound Air Pollution Control Agency*, 81 Wn. App. 403, 411, 914 P.2d 750 (1996) (quoting *State ex rel. Lige & William B. Dickson Co. v. Pierce County*, 65 Wn. App. 614, 618, 829 P.2d 217 (1992)). Evidence supporting a finding is substantial where it would convince a rational, fair-minded person of the finding's truth. *Lawrence v. Dep't of Health*, 133 Wn. App. 665, 671, 138 P.3d 124 (2006).

We review the Commission's legal conclusions de novo. *DaVita*, 137 Wn. App. at 181. However, we accord great deference to the Commission's interpretation of the UDA and the rules it has promulgated pursuant to its authority under chapter 18.79 RCW. *Verizon Nw, Inc. v. Wash. Emp't Sec. Div.*, 164 Wn.2d 909, 915, 194 P.3d 255 (2008); *DaVita*, 137 Wn. App. at 181. We review Stevenson's preclusion claims de novo. *Christensen v. Grant County Hosp. Dist. No. 1*, 152 Wn.2d 299, 305, 96 P.3d 957 (2004) (collateral estoppel); *Nevers v. Fireside, Inc.*, 133 Wn.2d 804, 809, 947 P.2d 721 (1997) (court rules interpreted de novo); *Lynn v. Dep't of Labor & Indus.*, 130 Wn. App. 829, 837, 125 P.3d 202 (2005) (res judicata).

II. THE FINDINGS OF FACT

Stevenson, although not assigning error to any specific findings of fact, generally argues that substantial evidence did not support findings of fact 1.11 and 1.12, set out above. In these, the Commission found that Stevenson (1) failed to adhere to the relevant standard of conduct, (2) practiced outside the scope of practice, and (3) placed Patient A at an unreasonable risk of harm. Stevenson's arguments largely center on evidence she presented and her claims that the Department of Health did not present expert testimony that she violated the standard of conduct at the hearing before the Commission. The Commission contends that substantial evidence in the record supports its findings. We agree with the Commission.

Turning first to finding of fact 1.11, testimony offered at trial supported the Commission's finding that Stevenson failed to adhere to the standards of conduct required of a registered nurse. Hu testified that she expected Stevenson to implement her discharge orders, although she stated that Stevenson could question that order by speaking with her. Hu also testified that Stevenson, as a registered nurse, lacked the authority to alter the prescriptions that were part of the discharge orders, which Stevenson did by failing to give the enoxaparin. One of Stevenson's own experts testified that any nurse who refused to fulfill a physician order based on concerns about the order had a duty "to convey to the doctor that she is not fulfilling that order and she is not giving that medication because of these concerns." AR at 379. A reasonable inference from this testimony is that nurses have a duty to follow the orders given by a doctor unless they raise concerns about the order with the doctor. Stevenson refused to follow Hu's orders and failed to contact Hu or a covering physician to explain why she was declining to do so. The Commission could readily find that Stevenson failed to comply with nursing standards from those facts.

Testimony at trial also supported the Commission's finding, embodied in finding of fact 1.11, that Stevenson practiced outside the scope of practice granted by her nursing license. Hu, one of Stevenson's experts, and Stevenson herself all testified that registered nurses lack "prescriptive authority and must act at the direction of a physician." AR at 340, 379, 506. This testimony allowed the Commission to find that Stevenson, by refusing to follow the direction of Hu, had practiced outside the scope of authority granted to her by her registered nursing license.

Stevenson, however, contends that substantial evidence does not support finding 1.11 because the Department of Health failed to provide expert testimony that she breached the standard of care at the hearing. She is incorrect. The APA provides that agencies in general may utilize their expertise when evaluating factual matters. RCW 34.05.452(5). The regulations governing proceedings before the Commission specifically authorize it to make use of its expertise when making factual determinations. WAC 246-11-160. Common law precedent also recognizes that medical discipline boards like the Commission do not need expert testimony about any possible breach of the standard of care, because such testimony is not helpful when the fact finder, as here, includes experts. *Ames v. Dep't of Health*, 166 Wn.2d 255, 261-62, 208 P.3d 549 (2009); *Davidson v. Dep't of Licensing*, 33 Wn. App. 783, 785-86, 657 P.2d 810 (1983). As noted above, the State presented evidence that would allow the Commission, based on its expertise, to find that Stevenson breached her standard of care.[4]

[4] Stevenson notes that two members of the panel adjudicating the Department of Health's complaint were licensed practical nurses instead of registered nurses, like Stevenson. This appears to be an argument that we should not allow the Commission's panel to determine the appropriate standard of conduct and scope of practice.

RCW 18.79.070(2) provides for the Commission's make-up and requires that it include two advanced registered nurse practitioners, seven registered nurses, three licensed practical nurses, and three members of the public. RCW 18.79.070(2) does not require that commission panels include only members of the same professional type as the appellant. We read that

Stevenson also contends that substantial evidence does not support finding 1.11 because she presented testimony that she declined to dose Patient A with enoxaparin because of fears that it would cause her to bleed, and her experts testified that, by doing so, she had not breached the standard of conduct. That evidence, though, does not change the result of our review. The Commission acted as the fact finder and accorded what it deemed the appropriate weight to the evidence each side presented and the inferences reasonably drawn from that evidence. In doing so, it gave greater weight to the evidence offered by the Department of Health and the inferences drawn from that evidence. We will not upset that determination on appeal. *Ancier v. Dep't of Health*, 140 Wn. App. 564, 575, 166 P.3d 829 (2007).

We also hold that substantial evidence supports finding of fact 1.12, the Commission's finding that Stevenson's actions placed Patient A at an unreasonable risk of harm. Hu testified that Patient A's condition at the time of her admission to the hospital rendered her immobile and placed her at risk of developing deep vein thrombosis. One of Stevenson's experts agreed. Hu also testified that development of deep vein thrombosis risked a quick death. A reasonable inference from this testimony is that the withholding of prophylactic doses of enoxaparin, which would prevent deep vein thrombosis, put Patient A at risk of dying. The Commission could find from that testimony that Stevenson's actions placed the patient at an unreasonable risk of harm.

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omission as embodying the legislature's belief that, as an institution, the Commission has the relevant experience and knowledge necessary to adjudicate nursing misconduct.

Further, Stevenson does not explain how the panel's composition affects the panel's expertise. WAC 246-840-700(2)(a)(i)(D), discussed below and which governs standards of practice for registered nurses, does not appear to operate differently than WAC 246-840-700(2)(b)(i)(D), also discussed below and which governs the standards of practice for licensed practical nurses. Two other provisions discussed below, WAC 246-840-700(3)(a) and -710(2)(d) apply to both licensed practical nurses and registered nurses. Stevenson fails to show how the panel's composition extinguishes the Commission's expertise recognized by the case law.

Stevenson challenges finding of fact 1.12 by claiming the evidence shows the wisdom of her choice to withhold the enoxaparin. Specifically, Stevenson argues that the evidence shows that Patient A lived two years after the December 3, 2007 injection of enoxaparin without any further prophylactic doses of blood thinner. The fact that Stevenson's choice to withhold enoxaparin did not result in actual harm to Patient A or that the patient continued to live without enoxaparin is irrelevant to our review on appeal. The Commission's findings and the relevant law, RCW 18.130.180(4), concern the risk of harm. As noted above, Hu testified to the risks from Stevenson's failure to follow her orders. On this evidence, the Commission could readily find that Stevenson's choice to withhold enoxaparin was a gamble that placed Patient A at an unreasonable risk of harm.

III. THE CONCLUSIONS OF LAW

Stevenson also appears to challenge in three different ways the Commission's conclusions that she committed unprofessional conduct. For the following reasons, however, the challenged conclusions are correct.

Stevenson challenges conclusion of law 2.4, the conclusion that she committed unprofessional conduct by violating RCW 18.130.180(4), by claiming that no evidence showed her actions placed Patient A at an unreasonable risk of harm. As discussed above, substantial evidence supports finding of fact 1.12 that Stevenson's actions placed Patient A at an unreasonable risk of harm. Conclusion 2.4 flows directly from that finding and finding 1.11 that Stevenson breached the standard of conduct required by nurses. We affirm the conclusion. *Nguyen v. Dep't of Health Med. Quality Assurance Comm'n*, 144 Wn.2d 516, 530, 29 P.3d 689 (2001) (this court reviews conclusions by looking to whether the factual findings support them).

Stevenson challenges conclusion of law 2.5, the conclusion that she committed unprofessional conduct under RCW 18.130.180(12), and conclusion of law 2.6, the conclusion that she committed unprofessional conduct under RCW 18.130.180(7), by claiming that the Department of Health failed to show that she breached the standard of conduct or practiced beyond the scope of acceptable practice. Specifically Stevenson claims that WAC 246-840-700 prescribes the scope of practice and the standard of conduct for nurses and that her conduct violated no part of that provision.

With regard to conclusion of law 2.5, RCW 18.130.180(12) includes practicing beyond the scope of practice as unprofessional conduct. With finding of fact 1.11, the Commission found that Stevenson practiced beyond the scope of practice when she unilaterally changed Patient A's prescription by failing to follow Hu's order. As noted above, substantial evidence supported that finding. Finding of fact 1.11 supports the Commission's conclusion of law 2.5 that Stevenson committed unprofessional practice. RCW 18.130.180(12). Therefore, we affirm the Commission's conclusion. *Nguyen*, 144 Wn.2d at 530.

As concerns conclusion of law 2.6 that Stevenson committed unprofessional conduct under RCW 18.130.180(7), that statute defines unprofessional conduct to include the violation of any state or federal statute or regulation establishing the standard of conduct for the profession. WAC 246-840-700(2)(a)(i)(D) establishes one such standard of conduct. It requires nurses to "*implement*[] the plan of care by initiating nursing interventions through giving direct care and supervising other members of the care team." WAC 246-840-700(2)(a)(i)(D) (emphasis added). WAC 246-840-700(3)(a) establishes another standard of conduct, providing that "[t]he registered nurse . . . shall communicate significant changes in the client's status to appropriate members of the health care team. This communication shall take place in a time period consistent with the

client's need for care." WAC 246-840-710(2)(d) establishes a final, relevant, standard of conduct. That provision forbids any nurse from "[w]illfully or repeatedly failing to administer medications . . . in accordance with nursing standards." WAC 246-840-710(2)(d).

A number of the Commission's findings support the conclusion that Stevenson committed unprofessional conduct under RCW 18.130.180(7). The Commission found in finding of fact 1.9, a finding unchallenged and therefore a verity on appeal, that Stevenson failed to provide Patient A her enoxaparin dose from November 24, 2007 to December 3, 2007. With finding 1.11, a finding supported by substantial evidence, the Commission found that Stevenson breached the standard of conduct by refusing to obey the order to provide enoxaparin. With finding of fact 1.12, a finding supported by substantial evidence, and finding of fact 1.10, a finding unchallenged and therefore a verity on appeal, the Commission found that Stevenson failed to communicate her refusal to follow Hu's order or to any covering physician. Those findings support a conclusion that Stevenson violated WAC 246-840-700(2)(a)(i)(D), -700(3)(a), and -710(2)(d) by repeatedly declining to implement Hu's orders to provide a daily dose of enoxaparin without communicating to Hu that she was not complying with the order and explaining her reasons for her refusal. Each of those WAC violations constituted unprofessional conduct under RCW 18.130.180(7). We affirm conclusion of law 2.6. *Nguyen*, 144 Wn.2d at 530.

IV. PRECLUSION

Stevenson also contends that a number of preclusion doctrines prevented the Commission from entering its order. We disagree..

A. Res judicata

Res judicata bars "[r]esurrecting the same claim in a subsequent action." *Hilltop Terrace Homeowner's Ass'n v. Island County*, 126 Wn.2d 22, 31, 891 P.2d 29 (1995). "The threshold requirement" for applying the doctrine of res judicata "is a final judgment on the merits" in a prior action. *Hisle v. Todd Pac. Shipyards Corp.*, 151 Wn.2d 853, 865, 93 P.3d 108 (2004). Once a party satisfies that threshold, we review whether the current action and the prior one involve the same claim by looking to whether the two involve the same "subject matter, cause of action, people and parties, and . . . 'quality of the persons for or against whom the claim is made.'" *Hisle*, 151 Wn.2d at 865-66 (quoting *Rains v. State*, 100 Wn.2d 660, 663, 674 P.2d 165 (1983)). Stevenson bore the burden of showing each of these elements to preclude the Commission from entering its order. *Hisle*, 151 Wn.2d at 865, 866.

Stevenson's res judicata claim fails on at least one of the elements. Both Stevenson's and the Commission's briefing assume that she was a party to the DSHS proceeding. She was not. The DSHS proceeding involved a complaint against Stevenson Group Inc., and payment for the fine in those proceedings came from the corporation's accounts. The commission proceedings involved a complaint against Stevenson. The corporation has an existence separate and apart from Stevenson's. *W. Wash. Laborers-Emp'rs Health & Sec. Trust Fund v. Harold Jordan Co.*, 52 Wn. App. 387, 392, 760 P.2d 382 (1988). Observing that separate existence means holding that the corporation, not Stevenson, was a party to the DSHS action and Stevenson, not the corporation, was a party to the Commission action. Res judicata does not bar the Commission's order.

B. Collateral Estoppel

Collateral estoppel bars relitigation of an issue decided in a prior proceeding, even where the subsequent proceeding involves different claims or causes of action. *Rains*, 100 Wn.2d at 665 (quoting *Seattle-First Nat'l Bank v. Kawachi*, 91 Wn.2d 223, 225-26, 588 P.2d 725 (1978)). Collateral estoppel only applies where (1) the prior proceeding decided an issue identical to the one presented in the subsequent action, (2) there was a final judgment on the merits, (3) the party to be estopped was a party to the prior proceeding or in privity with a party to the proceeding, and (4) estopping the party will not produce an injustice. *Rains*, 100 Wn.2d at 665 (quoting *Seattle-First Nat'l Bank v. Cannon*, 26 Wn. App. 922, 927, 615 P.2d 1316 (1980)). Stevenson bore the burden of proving the earlier proceeding estopped the Commission. *State Farm Mut. Auto. Ins. Co. v. Avery*, 114 Wn. App. 299, 304, 57 P.3d 300 (2002).

The DSHS proceeding did not result in a final judgment on the merits, but instead ended in settlement with Stevenson agreeing to pay a fine. Settlements are not considered final judgments on the merits for purposes of collateral estoppel, because parties may settle for "myriad reasons not related to the resolution of the issues they are litigating." *Marquardt v. Fed. Old Line Ins. Co. (Mut.)*, 33 Wn. App. 685, 689, 658 P.2d 20 (1983); *Krikava v. Webber*, 43 Wn. App. 217, 222, 716 P.2d 916 (1986). Without a final judgment on the merits, collateral estoppel does not apply.

C. CR 2A Settlement Agreement

Finally, Stevenson contends that the settlement with DSHS constituted a stipulation under CR 2A, releasing all claims that the State may have had against Stevenson for her failure to give

Patient A the enoxaparin doses.[5] We disagree.

The civil rules apply to civil proceedings in Washington's superior courts. Stevenson provides no authority for the proposition that they apply in administrative proceedings, and we therefore assume that none exists. *DeHeer v. Seattle Post-Intelligencer*, 60 Wn.2d 122, 126, 372 P.2d 193 (1962). We therefore are not persuaded by her argument. *DeHeer*, 60 Wn.2d at 126.

CONCLUSION

We find that substantial evidence supports the Commission's findings and that it did not erroneously interpret or apply the law. We affirm the superior court order affirming the Commission's decision and order.

A majority of the panel having determined that this opinion will not be printed in the Washington Appellate Reports, but will be filed for public record in accordance with RCW 2.06.040, it is so ordered.

Bjorgen, A.C.J.

BJORGEN, A.C.J.

We concur:

Worswick, J.

WORSWICK, J.

Sutton, J.

SUTTON, J.

[5] CR 2A provides that

> No agreement or consent between parties or attorneys in respect to the proceedings in a cause, the purport of which is disputed, will be regarded by the court unless the same shall have been made and assented to in open court on the record, or entered in the minutes, or unless the evidence thereof shall be in writing and subscribed by the attorneys denying the same.

COPY

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ORIGINAL FILED
DEC 30 2013
Scott G. Weber, Clerk, Clark Co.

STATE OF WASHINGTON
CLARK COUNTY SUPERIOR COURT

FAIRUZA STEVENSON, Petitioner, STATE OF WASHINGTON, DEPARTMENT OF HEALTH, NURSING CARE QUALITY ASSURANCE COMMISSION, Respondents.	NO. 11-2-00119-2 ORDER AFFIRMING COMMISSION'S FINAL ORDER

This matter came before the Court on November 27, 2013, with the Honorable David E. Gregerson, Clark County Superior Court Judge, presiding. The Court, having considered the pleadings and administrative record in the matter, and having heard the arguments of both parties, now, therefore, IT IS HEREBY ORDERED AS FOLLOWS:

The Nursing Care Quality Assurance Commission's Findings of Fact, Conclusions of Law and Final Order dated December 9, 2010, Master Case No. M2008-118333 is AFFIRMED.

ATTORNEY GENERAL OF WASHINGTON
1125 Washington Street SE
PO Box 40100
Olympia, WA 98504-0100
(360) 664-9006

IT IS HEREBY FURTHER ORDERED:

The Department of Health shall refund Petitioner $700.00 of the $1000.00 sanction previously ordered by this Court and paid to the Department of Health.

DATED this 30th day of December, 2013.

/s/ Thomas Lee Lieberman

The Honorable ~~David E. Gregerson~~
Clark County Superior Court ~~Judge~~

Presented by:

ROBERT W. FERGUSON
Attorney General

DANIEL R. BAKER, WSBA #43034
Assistant Attorney General
Attorneys for Respondents

Approved as to Form:

ROBERT D. MITCHELSON, WSBA #4595
Attorney for Petitioner

ATTORNEY GENERAL OF WASHINGTON
1125 Washington Street SE
PO Box 40100
Olympia, WA 98504-0100
(360) 664-9006

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION

In the Matter of: FAIRUZA M. STEVENSON, Credential No. RN.RN.00139022, Respondent.	Master Case No. M2008-118333 FINDINGS OF FACT, CONCLUSIONS OF LAW, AND FINAL ORDER

APPEARANCES:

Respondent, Fairuza M. Stevenson, by
Law Office of Robert D. Mitchelson, per
Robert D. Mitchelson, Attorney at Law

Department of Health Nursing Program (Department), by
Office of the Attorney General, per
Cassandra Buyserie, Assistant Attorney General

PANEL: Margaret Kelly, L.P.N., Panel Chair
Linda Batch, L.P.N.
Lois Hoell, L.P.N., R.N., A.R.N.P.

PRESIDING OFFICER: Christopher Swanson, Health Law Judge

A hearing was held in this matter on September 24, 2010, regarding allegations of unprofessional conduct. Probation.

ISSUES

Did the Respondent commit unprofessional conduct as defined in RCW 18.130.180(4), (7), and (12) and WAC 246-840-710(2)(d)?

If the Department proves unprofessional conduct, what are the appropriate sanctions under RCW 18.130.160?

SUMMARY OF PROCEEDINGS

At the hearing, the Department presented the testimony of Meituck Hu, M.D. The Respondent testified on her own behalf and presented the testimony of Lee Patton, R.N., Associate Professor of Nursing, Concordia College; Zbigieu Grudzien, M.D.; Judy Tichrob; and Douglas V. Harroun, M.D.

The Presiding Officer admitted the following Department exhibits:

Exhibit D-1: ASI Report, dated December 3, 2007.

Exhibit D-2: Medical Records of Patient A from Legacy Salmon Creek Hospital, November 16-24, 2007.

Exhibit D-3: Fax from Hope Medical Holistic Clinic to Respondent, dated February 13, 2008.

Exhibit D-4: Respondent's Medication Log for Patient A at Better Options Foster Care Home, November 2007.

Exhibit D-5: Statement of Respondent, undated.

Exhibit D-6: Dr. Zbigieu Grudzien's Medical treatment notes of Patient A, dated November 29, 2007.

Exhibit D-7: Letter from Respondent's attorney to Department of Health, dated May 27, 2008.

The Presiding Officer admitted the following Respondent exhibits:

Exhibit R-1: Medication logs for Patient A for August-December 2007.

Exhibit R-2: Final Report and Discharge instructions for Katherine Plowman, August 23-25, 2007.

Exhibit R-3: Final Report and Discharge instructions for Katherine Plowman, November 16-24, 2007, including addendum.

Exhibit R-4: Notes of Jody Tichrob, November 26-December 4, 2008.

Exhibit R-5: Respondent's Narrative letter to the Commission, undated.

Exhibit R-6: Dr. Rasky chart note, September 21, 2007.

Exhibit R-7: Notes from Hope Medical Holistic Clinic, November 29, 2007.

Exhibit R-8: History and Physical, Legacy Salmon Creek Hospital, November 16-24, 2007.

Exhibit R-9: Discharge summary, Legacy Salmon Creek Hospital, November 24, 2007.

I. FINDINGS OF FACT

1.1 The Respondent was granted a license to practice as a registered nurse in the state of Washington on October 30, 2000.

1.2 At relevant times, the Respondent operated an adult family home, and provided nursing services to Patient A, a 94-year-old female suffering from multiple medical conditions, including hypertension, dementia, and mobility issues.

1.3 In August 2007, per physician order, Patient A discontinued the use of Coumadin, a blood thinning medication, following the occurrence of bleeding in her eye.

1.4 There are risks associated with taking all blood thinning medications, including the risk of bleeding and the possibility of stroke. There are also risks associated with not taking blood thinning medications when a patient is immobile for extended periods of time, such as blood clots forming in the legs and then traveling through the cardiovascular system into the lungs and heart causing death.

1.5 On November 16, 2007, Patient A was admitted at Legacy Salmon Creek Hospital in Vancouver, Washington, with complaints of fever and abdominal pain.

1.6 On November 24, 2007, following treatment, Patient A was discharged from the hospital. As part of her discharge instructions, Patient A was given a prescription for Enoxaparin, a different blood thinning medication, 40 mg subcutaneous once a day. The medication was prescribed for the purpose of preventing blood clots. Patient A was at risk for blood clots because upon discharge she would not be mobile.

1.7 In making her determination to prescribe Enoxaparin, the treating physician at the hospital weighed the risks to Patient A and determined that the risks associated with not taking a blood thinning medication were greater than the risks associated with taking the medication.

1.8 When compared with Enoxaparin, Coumadin is a less stable and less predictable blooding thinning medication. Coumadin requires constant monitoring to ensure the patient's blood is not thinning too much. Additionally, Coumadin's effects may be influenced by the patient's diet. Coumadin also takes longer to clear the patient's system once discontinued. The physician determined Enoxaparin was the appropriate blood thinning medication due to Patient A's specific circumstances.

1.9 Upon her discharge from the hospital, Patient A was returned to the adult family home operated by the Respondent. The Respondent believed that the blood thinning medication ordered by the hospital physician was inappropriate due Patient A's history of bleeding, and failed to administer the ordered Enoxaparin from November 24, 2007 until December 3, 2007.

1.10 Despite 24 hour physician consult availability at the hospital, the Respondent did not contact the hospital to consult with a physician about her concerns. On December 4, 2007, the Respondent administered the medication.

1.11 Physician medication orders must be carried out as ordered in order to ensure patient safety. The scope of practice and of a registered nurse does not include the authority to unilaterally fail to follow physician orders. Nor does the standard of care for a registered nurse permit a nurse to engage in such action. The nursing standard of care requires that in circumstances where a registered nurse has concerns about a physician order, the nurse should attempt to contact the physician as soon as possible to discuss her concerns.

1.12 As a result of the Respondent's failure to follow the physician medication order and failure to attempt to contact the treating physician about her concerns, Patient A was placed at an unreasonable risk of harm. Although Patient A suffered no apparent harm from the missing medication, Patient A could have suffered significant harm including death as a result of the Respondent's actions.

1.13 The Respondent did not express remorse for her conduct. The Respondent does not have any past discipline in the state of Washington.

II. CONCLUSIONS OF LAW

2.1 The Commission has jurisdiction over the Respondent and subject of this proceeding. RCW 18.130.040 RCW.

2.2 The standard of proof in a professional disciplinary hearing is clear and convincing evidence. *Ongom v. Dept. of Health,* 159 Wn.2d 132 (2006), cert. denied 127 S. Ct. 2115 (2007).

2.3 The Commission used its experience, competency, and specialized knowledge to evaluate the evidence. RCW 34.05.461(5).

2.4 The Department proved with clear and convincing evidence that the Respondent committed unprofessional conduct as defined in RCW 18.130.180(4), which states:

> Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;

2.5 The Department proved with clear and convincing evidence that the Respondent committed unprofessional conduct as defined in RCW 18.130.180(12), which states:

> Practice beyond the scope of practice as defined by law or rule;

2.6 The Department proved with clear and convincing evidence that the Respondent committed unprofessional conduct as defined in RCW 18.130.180(7) and WAC 246-840-710(2)(d), which state:

> Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice;

RCW 18.130.180(7).

> The following conduct may subject a nurse to disciplinary action under the Uniform Disciplinary Act, chapter 18.130 RCW:
>
> . . . .
>
> (2) Failure to adhere to the standards enumerated in WAC 246-840-700 which may include, but are not limited to:
>
> . . . .
>
> (d) Willfully or repeatedly failing to administer medications and/or treatments in accordance with nursing standards[.]

WAC 246-840-710(2)(d).

2.7 In determining appropriate sanctions, public safety must be considered before the rehabilitation of the Respondent. RCW 18.130.160.

2.8. The sanction rules of the Department of Health, WAC 246-16-800 through 246-16-890 apply. WAC 246-16-810 is the sanction schedule for practice that falls below the standard of care. The sanction schedule adequately addresses the conduct in this case. The Respondent's conduct caused risk of moderate to severe risk of harm.

2.9 The aggravating factors are: 10 The vulnerability of the patient; 2) Lack of remorse; and 3) The risk of injury. The mitigating factor is the lack of past disciplinary record.

III. ORDER

3.1 The Respondent's license to practice as a registered nurse in the state of Washington shall be placed on PROBATION for at least 24 months commencing on the date of entry of this Order. During the course of probation, the Respondent shall follow all of the following terms and conditions.

3.2 The Respondent shall present both portions of her license to the Commission to be stamped "probation" within ten days of receipt of this Order. The Respondent shall also ensure that all subsequent licenses received during the probationary period of this Order are stamped "probation" and shall immediately return any license to the Commission that is not stamped "probation."

3.3 The Respondent shall permit a Department of Health investigator or other Commission approved reviewer, on a quarterly basis, to audit and review the patient records at any adult family home operated by her.

3.4 Within 12 months of the date of entry of this Order, the Respondent shall provide evidence to the Commission that she has successfully completed 24 hours of course-work, pre-approved by the Commission or its designee, in the area of scope of practice and medication administration. The course-work must be taken at an accredited educational institution or through a program otherwise approved by the Commission. The Respondent shall provide the Commission with proof of completion of such course-work within 30 days of such completion.

3.5 The Respondent shall pay a fine to the Commission in the amount $2,000 which must be received by the Commission within 90 days of the date of entry of this Order. The fine shall be paid by certified or cashier's check or money order, made payable to the Department of Health and mailed to the Department of Health, Nursing Commission, at P.O. Box 1099, Olympia, Washington 98507-1099.

3.6 The Respondent may not seek modification or reinstatement of her license for two years from the date of this Order.

3.7 Change of Address. The Respondent shall inform the program manager and the Adjudicative Service Unit, in writing, of changes in her residential and/or business address within 30 days of such change.

3.8 Assume Compliance Costs. The Respondent shall assume all costs of complying with all requirements, terms, and conditions of this Order.

3.9 Failure to Comply. Protecting the public requires practice under the terms and conditions imposed in this Order. Failure to comply with the terms and conditions of this Order may result in suspension and/or revocation of the Respondent's license after a show cause hearing. If the Respondent fails to comply with the terms and conditions of this Order, the Commission may hold a hearing. At that hearing, the Respondent must show cause why her license should not be suspended. Alternatively, the Commission may bring additional charges of unprofessional conduct under RCW 18.130.180(9). In either case, the Respondent will be given notice and an opportunity for a hearing on the issue of non-compliance.

Dated this 9th day of December, 2010.

MARGARET KELLY, L.P.N.
Panel Chair

CLERK'S SUMMARY

Charge	Action
RCW 18.130.180(4)	Violated
RCW 18.130.180(7)	Violated
WAC 246-840-710(2)(d)	Violated
RCW 18.130.180(12)	Violated

NOTICE TO PARTIES

This order is subject to the reporting requirements of RCW 18.130.110, Section 1128E of the Social Security Act, and any other applicable interstate or national reporting requirements. If discipline is taken, it must be reported to the Healthcare Integrity Protection Data Bank.

Either party may file a **petition for reconsideration**. RCW 34.05.461(3); 34.05.470. The petition must be filed within 10 days of service of this order with:

Adjudicative Service Unit
P.O. Box 47879
Olympia, WA 98504-7879

and a copy must be sent to:

Nursing Program
P.O. Box 47864
Olympia, WA 98504-7864

The petition must state the specific grounds for reconsideration and what relief is requested. WAC 246-11-580. The petition is denied if the Commission does not respond in writing within 20 days of the filing of the petition.

A **petition for judicial review** must be filed and served within 30 days after service of this order. RCW 34.05.542. The procedures are identified in chapter 34.05 RCW, Part V, Judicial Review and Civil Enforcement. A petition for reconsideration is not required before seeking judicial review. If a petition for reconsideration is filed, the above 30-day period does not start until the petition is resolved. RCW 34.05.470(3).

The order is in effect while a petition for reconsideration or review is filed. "Filing" means actual receipt of the document by the Adjudicative Service Unit. RCW 34.05.010(6). This order is "served" the day it is deposited in the United States mail. RCW 34.05.010(19).

For more information, visit our website at http://www.doh.wa.gov/hearings.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION

FILED
APR 02 2010
Adjudicative Clerk

In the Matter of	No. M2008-118333
FAIRUZA M. STEVENSON Credential No. RN.RN.00139022 Respondent	**STATEMENT OF CHARGES**

The Health Services Consultant of the Nursing Care Quality Assurance Commission (Commission), on designation by the Commission, makes the allegations below, which are supported by the evidence contained in case no. 2007-60346 (program file no. 2007-12-0001RN). The patient referred to in this Statement of Charges is identified in the attached Confidential Schedule.

1. ALLEGED FACTS

1.1 On October 30, 2000, the state of Washington issued Respondent a credential to practice as a registered nurse. Respondent's credential is currently active.

1.2 At relevant times, Respondent operated an adult family home, and provided nursing services to Patient A.

1.3 On or about November 24, 2007, Patient A was discharged from Legacy Salmon Creek Hospital in Vancouver, Washington. As part of her discharge instructions, Patient A was given a prescription for Enoxaparin, 40 mg subcutaneous once a day.

1.4 Upon her discharge from the hospital, Patient A was returned to the adult family home operated by Respondent. Respondent believed that the medication ordered by the hospital physician was inappropriate, and failed to administer the ordered Enoxaparin from November 24, 2007 until December 3, 2007.

1.5 Patient A suffered no apparent harm from the missing medication. The prescription was ultimately discontinued by Patient A's primary physician in or around December 2007.

//

2. ALLEGED VIOLATIONS

2.1 Based on the Alleged Facts, Respondent has committed unprofessional conduct in violation of RCW 18.130.180(4), (7), (12), and WAC 246-840-710(2)(d), which provide:

> **RCW 18.130.180 Unprofessional conduct.** The following conduct, acts, or conditions constitute unprofessional conduct for any license holder under the jurisdiction of this chapter:
>
> ...
>
> (4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;
>
> ...
>
> (7) Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice;
>
> ...
>
> (12) Practice beyond the scope of practice as defined by law or rule;
>
> ... .
>
> **WAC 246-840-710 Violations of standards of nursing conduct or practice.** The following conduct may subject a nurse to disciplinary action under the Uniform Disciplinary Act, chapter 18.130 RCW:
>
> ...
>
> (2) Failure to adhere to the standards enumerated in WAC 246-840-700 which may include, but are not limited to:
>
> ...
>
> (d) Willfully or repeatedly failing to administer medications and/or treatments in accordance with nursing standards;
>
> ... .

2.2 The above violations provide grounds for imposing sanctions under RCW 18.130.160.

3. NOTICE TO RESPONDENT

The charges in this document affect the public health, safety and welfare. The Health Services Consultant of the Commission directs that a notice be issued and served on Respondent as provided by law, giving Respondent the opportunity to defend

against these charges. If Respondent fails to defend against these charges, Respondent shall be subject to discipline and the imposition of sanctions under Chapter 18.130 RCW.

DATED: April 2, 2010

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE
COMMISSION

Mary Dale
MARY DALE
HEALTH SERVICES CONSULTANT

Cassandra Bousefield
CASSANDRA BOUSEFIELD, WSBA # 40600
ASSISTANT ATTORNEY GENERAL

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND DISABILITY SERVICES ADMINISTRATION
*PO Box 45600 * Olympia, WA 98504-5600*

January 31, 2008

CERTIFIED MAIL
(7004 1160 0002 0550 9776)

Fairuza Stevenson
Better Options for Elder Care
15214 NE 25th Circle
Vancouver, Washington 98684

License #64503

IMPOSITION OF CIVIL FINE

Dear Ms. Stevenson:

This letter constitutes formal notice of the imposition of a civil fine for your adult family home, located at **15214 NE 25th Circle, Vancouver, Washington,** by the State of Washington, Department of Social and Health Services, pursuant to the Revised Code of Washington (RCW) 70.128.160 and Washington Administrative Code 388-76-10940.

The civil fine is based on the following violations of the RCW and/or WAC found by the department in your adult family home. These and other deficiencies are more fully described in the attached Statement of Deficiencies report completed by the department on December 6, 2007.

WAC 388-76-620 (1) Provision of services and care.

$100.00 a day x seven days=$700.00

The licensee failed to ensure one resident received necessary services (an injectable medications) as ordered by her physician. This failure put the resident at high risk for medical complications.

This is a repeat or uncorrected deficiency previously cited on June 21, 2007.

WAC 388-76-76515 (8) What fire safety and emergency requirements must the provider have in the home. **$100.00**

The licensee failed to ensure portable space heaters were not used in the home. This failure put all residents at risk for harm.

This is a repeat or uncorrected deficiency previously cited on June 21, 2007.

You may contest the civil fine by requesting an administrative hearing. The Office of Administrative Hearings must receive your written request for a hearing within twenty-eight (28) calendar days following receipt of this letter. A copy of this letter and a copy of the enclosed Statement of Deficiencies must be included with your request. Send your request to:

Office of Administrative Hearings
PO Box 42489
Olympia, Washington 98504-2489

If no hearing is requested, the fine is due twenty-eight (28) calendar days after receipt of this notice. Please remit a check for **$800.00** payable to the Department of Social and Health Services. The check should be sent to:

DSHS Office of Financial Recovery
PO Box 49501
Olympia, Washington 98504-9501

If payment has not been received within twenty-eight (28) days after receipt of this notice, interest will begin to accrue on the balance at the rate of one percent per month. If you do not submit a hearing request or make payment within twenty-eight (28) days, the balance due the department will be recovered.

As provided in RCW 70.128, you may request an informal dispute resolution review of enforcement actions initiated in response to a Statement of Deficiencies report. During the informal dispute resolution process you also have the right to present written evidence refuting this action. A request for informal dispute resolution review will not change the deadline for you to request an administrative hearing. Informal dispute resolution review by the department is not binding in an administrative hearing.

To request an informal dispute resolution review, send your written request to:

Denny McKee, Informal Dispute Resolution Program Manager
Aging and Disability Services Administration
PO Box 45600
Olympia, Washington 98504-5600
Phone (360) 725-2590 / Fax (360) 438-7903

The written request should:

- Identify the citation and/or enforcement action that is disputed;
- Explain why the home is disputing the action;

- Indicate the type of dispute resolution process you prefer (direct meeting, telephone conference or documentation review); and
- Be sent within 10 working days of your receipt of this notice.

If you have any questions, please contact Suzanne Thompson, Field Manager at (360) 725-2255.

Sincerely,

Lori Melchiori, Ph.D.
Assistant Director
Residential Care Services

Enclosure

cc: Janice Schurman, Adult Family Home Compliance Specialist
Field Manager, Region 6, Unit A
RCS Regional Administrator, Region 6
HCS Regional Administrator, Region 6
DDD Regional Administrator, Region 6
Karen Dinan, Assistant Attorney General
WA LTC Ombudsman
Area Agency on Aging, AAA-SW
Office of Financial Recovery, Vendor Program Unit

COPY

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND ADULT SERVICES ADMINISTRATION
5411 E Mill Plain Blvd, Suite 25, Vancouver, WA 98661

Statement of Deficiencies/ Plan of Correction	License #: 64503 BETTER OPTIONS FOR ELDER CARE	Completion Date December 6, 2007

An unannounced complaint investigation was conducted on 12/3/2007 at BETTER OPTIONS FOR ELDER CARE, an adult family home licensed to STEVENSON GROUP INC, 15214 NE 25TH CIR, VANCOUVER, WA 98684. 0 of 0 current residents and 0 former residents were selected for review.

This document references the following:

Complaint Number 071127107

Licensors / Team members:

Shawn Swanstrom, RN, BSN, Licensor

From:

DSHS, Aging and Disability Services Administration
Residential Care Services, Region 6, Unit A
5411 E Mill Plain Blvd
Vancouver, WA 98661

An acceptable written Plan of Correction (POC) for each deficiency cited must be submitted within 10 calendar days. Enforcement action may be recommended dependent upon the scope and severity of deficiencies cited in this report. The licensee may question cited deficiencies and enforcement actions if initiated through the State's informal dispute resolution process. Further, findings are discloseable to the public.

Suzanne Thorpe Wiring
Residential Care Services

12/13/07
Date

F Stevenson
Licensee (or Representative)

12/23/07
Date

RECEIVED
JAN 07 2008
DSHS AASA
Residential Care Services

FU: 01/18/2008 V1-9-08 SS OK

WAC 388-76-620 Provision of services and care.
(1) The provider shall ensure that the resident receives necessary services and care to promote the most appropriate level of physical, mental, and psychosocial well-being consistent with resident choice.

This requirement was not met as evidenced by:
Based on observation, interview and record review, the provider failed to ensure 1 of 1 resident (#1) received necessary services (an injectable medication) as ordered by her physician. This failure put the resident at a high risk for medical complications.

On 12/3/07, Resident # 1 stated she had just been in the hospital. She was unable to state why she had gone to the hospital, but did state she had been sick.

Resident record review revealed Resident # 1 had been originally admitted to the home on 5/3/05 with a diagnoses of non- insulin dependent diabetes, a history of peripheral vascular disease, and a history of strokes resulting in right sided weakness. Resident history revealed the resident also had a left below the knee amputation related to her diabetes, cellulitis, and peripheral vascular disease.

A recent hospital discharge instruction summary dated 11/24/07 was found in the resident record. Resident #1 had been admitted to the hospital on 11/16/07 for abdominal pain and fever. On 11/24/07, the resident was discharged back to the adult family home. The resident had a past right hip replacement with some hardware (a screw) loose in the hip. New medication orders sent to the adult family home on 11/24/07 included:

1. Enoxaparin (Lovenox) 40 mg subcutaneous daily. An injectable medication used to help blood from clotting as fast. Used at times for residents as a presentation measure to stop deep vein thrombosis (blood clots).

2. Seroquel 12.5 mg every evening for restlessness. An anti-psychotic medication used to help with behaviors or delusions.

Caregiver A stated on 12/3/07 she was the caregiver on duty at the time of Resident #1's readmission to the adult family home on 11/24/07. She stated the provider, a registered nurse, was aware of the residents return and aware of the new medication orders, including daily injections.

Enoxaparin 40 mg SQ daily was placed on the November 2007 medication record as of November 26, 2007. The medication was not signed as administered for November 26 – 30, 2007. The December 2007 medication administration record revealed Enoxaparin 40 mg SQ had been added. The medication had not been signed as administered as given on December 1st & 2nd. The medication had been signed for as given on December 3, 2007 by the Registered Nurse provider.

On 12/3/07, the medication supply for Resident # 1 revealed a box of Enoxaparin 40 mg pre-filled injections dated 11/26/07. Thirty doses were filled on 11/26/07 - 29 dosed were still available on 12/3/07.

The provider was interviewed on 12/3/07 and stated she was aware of the new injectable medication order for Resident #1 on 11/24/07 (late Saturday afternoon). She stated Resident # 1 had been on Coumadin (an oral medication used to help blood from clotting as fast) in the past and wanted to verify with the physician to start the medication Enoxaparin. She stated she had attempted to call the physician multiple times, but was unable to make contact, so she started the medication on December 3, 2007.

Resident record reviewed showed no documentation the provider had attempted to contact the physician or notified the physician she had not administered the medication Enoxaparin. The provider stated she had not contacted that physician to review the Enoxaparin orders.

The provider was re-interviewed on the afternoon of 12/3/07 and stated she had contacted Resident #1's physician and reported she had not given the Enoxaparin injections as ordered.

On 12/6/07, the adult family home was called and the caregiver on duty stated the provider had been in on December 4, 5 & 6th to give the Enoxaparin injection.

This is a repeat citation from 6/21/07

POC Date: 12/23/07
POC:
- I won't won't or tried to contact primary physician
- I will start to fulfill orders from Hospital the same day after residents return from Hospital
- I will make sure to talk to MD or RN while resident in hospital to discuss potential problems instead of waiting for primary doctor. I will be responsible for fixing this problem.

WAC 388-76-76515 What fire safety and emergency requirements must the provider have in the home?
(8) Portable oil, gas, kerosene, and electric space heaters must not be used in the home except in the case of a power outage and the portable space heater is the home's only safe source of heat.

This requirement was not met as evidenced by:
Based on observation and interview, the provider failed to ensure portable space heaters were not used in the home. This failure put all residents at risk for harm.

During the full inspection on 6/21/07, a space heater was observed plugged into an electrical outlet of a resident's bedroom; a citation was written. During the follow-up visit on 9/14/07, the space heated had been removed and the citation corrected.

During a compliant investigation on 12/3/07, two space heaters were observed plugged into electrical outlets in two resident rooms (Resident #1, & #2). Both space heaters were on and blowing warm air.

Resident # 1 was sitting up in her wheelchair on 12/3/07. The resident was noted to have a left below the knee amputation. When interviewed, Caregiver A stated the resident needed to be transferred via a Hoyer lift (mechanical lift) from a bed to the chair and would need extensive

assistance to evacuate from the home.

Resident # 2 was sitting in her room on 12/3/07. She stated she was nearly blind and during an emergency, would need, "A lot of help" to get out of her room.

This is a repeat citation from 6/21/07

POC Date: 12/23/07

POC: We removed portable heater on 12/3/07-same day caregiver placed it w/o provider knowing it. I'll make sure caregiver will be oriented, given instructions. I'll personally check and reevaluate caregiver's knowledge re: portable heaters

Patient:	**PLOWMAN, KATHERINE**	**Location:**	SC 5D 549D 01
RN:	950033-77-21	**Date:**	11/16/2007 - 11/24/2007
Fin Number:	[redacted]	**Pt Type:**	Inpatient
DOB:	12/06/1912 **Age:** 95 years **Sex:** Female		
Attending:	Hu, Meituck		
Primary Care:	Harroun, Douglass V		

ORDERS

Order Date/Time 05/03/2008 20:52:38

Mnemonic	Action	Order Status	Type of Order
cilostazol	Modify	Ordered	Pharmacy
Ordering Physician		Order Placed By	
		SEMENYUK, YELENA S	
Review Information N/A			
Order Details			
100, mg, 1, Tab, PO, qAM & PM, 0, 0, 05/03/08 0:00:00, Substitution Allowed, current medication from another provider, Constant Indicator			

Order Date/Time 05/03/2008 20:52:10

Mnemonic	Action	Order Status	Type of Order
amlodipine	Modify	Discontinued	Pharmacy
Ordering Physician		Order Placed By	
Guenzburger, Todd N		SEMENYUK, YELENA S	
Review Information N/A			
Order Details			
mg, 2, Tab, PO, qAM, 0, 0, 05/03/08 0:00:00, Substitution Allowed, current medication from another provider, 2211 NE 139th St ...ancouver, WA 98686, Constant Indicator			

Order Date/Time 05/03/2008 20:51:39

Mnemonic	Action	Order Status	Type of Order
acetaminophen-hydrocodone	Modify	Ordered	Pharmacy
Ordering Physician		Order Placed By	
		SEMENYUK, YELENA S	
Review Information N/A			
Order Details			
1, Tab, PO, qHS, 0, 0, 05/03/08 0:00:00, Print DEA Number, current medication from another provider, Constant Indicator			

05/03/2008 20:51:39: PRN

Order Date/Time 11/24/2007 14:01:23

Mnemonic	Action	Order Status	Type of Order
Discharge Patient	Order	Discontinued	Nursing Services
Ordering Physician		Order Placed By	
Hu, Meituck		Hu, Meituck	
Review Information			
Nurse Review, Accepted - PERKINS, RAMONE C, 11/24/2007 15:13:51			
Order Details			
11/24/07 14:01:00			

Patient:	PLOWMAN, KATHERINE	**Location:**	SC 5D 549D 01
RN:	950033-77-21	**Date:**	11/16/2007 - 11/24/2007
Fin Number:	[redacted]	**Pt Type:**	Inpatient
DOB:	12/06/1912 **Age:** 95 years **Sex:** Female		
Attending:	Hu, Meituck		
Primary Care:	Harroun, Douglass V		

ORDERS

Order Date/Time 11/24/2007 13:55:26

Mnemonic	Action	Order Status	Type of Order
quetiapine	Order	Discontinued	Pharmacy
Ordering Physician: Hu, Meituck		Order Placed By: Hu, Meituck	
Review Information N/A			
Order Details: 12.5, mg, Oral, qHS, 30, 0, 0, 11/24/07 13:55:06, Substitution Allowed, SC RX Print, 2211 NE 139TH STREET VANCOUVER, WA 98686			

11/24/2007 13:55:26: Please obtain refills from PCP

Order Date/Time 11/24/2007 13:54:54

Mnemonic	Action	Order Status	Type of Order
enoxaparin	Order	Discontinued	Pharmacy
Ordering Physician: Hu, Meituck		Order Placed By: Hu, Meituck	
Review Information N/A			
Order Details: -0, mg, Subcutaneous, qDay, 30, 0, 0, 11/24/07 13:53:44, Substitution Allowed, SC RX Print, 2211 NE 139TH STREET VANCOUVER, WA 98686			

11/24/2007 13:54:54: Please obtain refills from PCP

Order Date/Time 11/24/2007 05:46:00

Mnemonic	Action	Order Status	Type of Order
MD	Order	Completed	Laboratory
Ordering Physician: Goebel, Melissa		Order Placed By: SYSTEM	
Review Information: Nurse Review, Accepted - PERKINS, RAMONE C, 11/24/2007 11:43:02			
Order Details: Early AM Draw, 11/24/07 5:10:00			

Order Date/Time 11/23/2007 15:54:32

Mnemonic	Action	Order Status	Type of Order
Quetiapine Tab 25mg	Modify	Discontinued	Pharmacy
Ordering Physician: Goebel, Melissa		Order Placed By: Ellis, Kimberly A	
Review Information: Nurse Review, Accepted - Garvin, Trina L, 11/23/2007 15:59:29			
Order Details: 12.5 mg, Total Dose = 0.5 Tab, Tab, Oral, qHS, 11/21/07 22:00:00			

Patient:	**PLOWMAN, KATHERINE**	**Location:**	SC 5D 549D 01
RN:	950033-77-21	**Date:**	11/16/2007 - 11/24/2007
Encounter Number:	[redacted]	**Pt Type:**	Inpatient
DOB:	12/06/1912 **Age:** 95 years **Sex:** Female		
Attending:	Hu, Meituck		
Primary Care:	Harroun, Douglass V		

O R D E R S

Order Date/Time 11/18/2007 22:05:03

Mnemonic	Action	Order Status	Type of Order
Fluconazole Tab 150mg UD	Order	Completed	Pharmacy
Ordering Physician Hu, Meituck		Order Placed By Hu, Meituck	
Review Information Nurse Review, Accepted - Peters, Jennifer A, 11/18/2007 23:18:56 Pharmacist Verify, Accepted - FOSTER, BRYAN M, 11/18/2007 22:05:51			
Order Details 150 mg, Total Dose = 1 Tab, Tab, Oral, Once, 11/18/07 23:00:00, Stop date/time 11/18/07 23:00:00			

Order Date/Time 11/18/2007 22:05:02

Mnemonic	Action	Order Status	Type of Order
COMP	Order	Canceled	Laboratory
Ordering Physician Hu, Meituck		Order Placed By Hu, Meituck	
Review Information Nurse Review, Accepted - Peters, Jennifer A, 11/18/2007 22:33:04			
Order Details Routine, 11/18/07 22:04:00, Once			

Order Date/Time 11/18/2007 21:04:19

Mnemonic	Action	Order Status	Type of Order
Nursing Communication Order	Order	Completed	Nursing Services
Ordering Physician Hu, Meituck		Order Placed By Peters, Jennifer A	
Review Information Nurse Review, Accepted - DUNHAM, JANE, 11/19/2007 18:38:06 Doctor Cosign, Accepted - Hu, Meituck, 11/19/2007 12:08:36			
Order Details 11/18/07 21:04:00, order RA Chest 1 view portable after PICC placed			

Legacy Salmon Creek Hospital
2211 NE 139TH ST
VANCOUVER, WA 98686

Patient:	PLOWMAN, KATHERINE	Location:	SC 5D 549D 01
RN:	950033-77-21	Date:	11/16/2007 - 11/24/2007
Fin Number:	[redacted]	Pt Type:	Inpatient
DOB:	12/05/1912 Age: 95 years Sex: Female		
Attending:	Hu, Meituck		
Primary Care:	Harroun, Douglass V		

ORDERS

Order Date/Time 11/18/2007 15:58:06

Mnemonic	Action	Order Status	Type of Order
VAN TR	Order	Completed	Laboratory
Ordering Physician: Guenzburger, Todd N		Order Placed By: NGUYEN, LAM T	
Review Information: Nurse Review, Accepted - Kyhn, Katherine D, 11/18/2007 16:05:32			
Order Details: Timed Draw - Stat Report, 11/18/07 21:30:00, Once			

Order Date/Time 11/17/2007 22:07:12

Mnemonic	Action	Order Status	Type of Order
MD	Order	Completed	Laboratory
Ordering Physician: Hu, Meituck		Order Placed By: SYSTEM	
Review Information: Nurse Review, Accepted - Peters, Jennifer A, 11/17/2007 22:15:38			
Order Details: Routine, 11/17/07 22:00:00, Once			

Order Date/Time 11/17/2007 19:56:50

Mnemonic	Action	Order Status	Type of Order
CBC	Order	Completed	Laboratory
Ordering Physician: Hu, Meituck		Order Placed By: Hu, Meituck	
Review Information: Nurse Review, Accepted - Peters, Jennifer A, 11/17/2007 21:01:21			
Order Details: Routine, 11/17/07 19:56:00, Once			

Order Date/Time 11/17/2007 17:34:23

Mnemonic	Action	Order Status	Type of Order
Nystatin Powder 100,000u/gm 15gm	Order	Discontinued	Pharmacy
Ordering Physician: Hu, Meituck		Order Placed By: Lorphanpaibul, Brandy H	
Review Information: Nurse Review, Accepted - Kyhn, Katherine D, 11/17/2007 18:00:56 Doctor Cosign, Accepted - Hu, Meituck, 11/17/2007 19:04:47 Pharmacist Verify, Accepted - Ellis, Kimberly A, 11/17/2007 17:42:31			
Order Details: 1 application, Powder, Topical, TID, 11/17/07 22:00:00			

Legend: L=Low, H=High, C=Critical, *=Abnormal, #=Footnote, c=corrected, @=Interpretive Data
All tests performed at Legacy Salmon Creek Hospital unless otherwise specified.

000056

STEVENSON, RN
Inv.00078

Legacy Salmon Creek Hospital

2211 NE 139TH ST
VANCOUVER, WA 98686

Patient:	PLOWMAN, KATHERINE	Location:	SC 5D 549D 01
RN:	950033-77-21	Date:	11/16/2007 - 11/24/2007
Fin Number:	[redacted]	Pt Type:	Inpatient
DOB:	12/06/1912 Age: 95 years Sex: Female		
Attending:	Hu, Meiruck		
Primary Care:	Harroun, Douglass V		

ORDERS

Order Date/Time 11/17/2007 00:12:33

Mnemonic	Action	Order Status	Type of Order
VAN TR	Order	Canceled	Laboratory
Ordering Physician: Guenzburger, Todd N		Order Placed By: FOSTER, BRYAN M	
Review Information: Nurse Review, Accepted - Kyhn, Katherine D, 11/17/2007 08:08:48			
Order Details: Timed Draw - Stat Report, 11/18/07 20:30:00, Once			

Order Date/Time 11/17/2007 00:11:32

Mnemonic	Action	Order Status	Type of Order
Vancomycin IVPB Frozen	Order	Discontinued	Pharmacy
Ordering Physician: Guenzburger, Todd N		Order Placed By: FOSTER, BRYAN M	
Review Information: Nurse Review, Accepted - Kyhn, Katherine D, 11/17/2007 08:08:48 Pharmacist Verify, Accepted - FOSTER, BRYAN M, 11/17/2007 00:12:55			
Order Details: 1 Gram, Total Dose = 200 mL, Solution, IV Piggyback, qHS, 11/17/07 0:11:00, 200 mL/hr			

Order Date/Time 11/16/2007 23:50:34

Mnemonic	Action	Order Status	Type of Order
Ramipril Cap 5mg UD	Modify	Discontinued	Pharmacy
Ordering Physician: Guenzburger, Todd N		Order Placed By: FOSTER, BRYAN M	
Review Information: N/A			
Order Details: 10 mg, Total Dose = 2 Cap, Cap, Oral, qDay, 11/17/07 9:00:00			

Order Date/Time 11/16/2007 23:48:56

Mnemonic	Action	Order Status	Type of Order
Enoxaparin Inj 40mg/0.4ml SYR	Modify	Discontinued	Pharmacy
Ordering Physician: Guenzburger, Todd N		Order Placed By: FOSTER, BRYAN M	
Review Information: Nurse Review, Accepted - Peters, Jennifer A, 11/17/2007 00:05:06			
Order Details: 40 mg, Total Dose = 0.4 mL, Syringe, Subcutaneous, qDay, 11/17/07 9:00:00			

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STEVENSON, RN
Inv.00080

Patient:	PLOWMAN, KATHERINE	Location:	SC 5D 549D 01
RN:	950033-77-21	Date:	11/16/2007 - 11/24/2007
Fin Number:	[redacted]	Pt Type:	Inpatient
DOB:	12/06/1912 Age: 95 years Sex: Female		
Attending:	Hu, Meituck		
Primary Care:	Harroun, Douglass V		

DISCHARGE DOCUMENTS

Document Name:	Discharge Summary
Entry Date:	11/24/2007 14:15:00
Verified By:	Hu, Meituck
Verified Date/Time:	12/04/2007 10:11:22
Document Status:	Auth (Verified)
Transcribed By:	Contributor_system, SCW
Transcribed Date/Time:	11/24/2007 15:21:11

Discharge Summary

LEGACY HEALTH SYSTEM
Legacy Salmon Creek Hospital
2211 NE 139th St.
Vancouver, WA 98686

DISCHARGE SUMMARY

PLOWMAN, KATHERINE
9500337721
PT TYPE: SCI
DOB: 12/06/1912
ADM. DATE: 11/16/2007
DISCHARGE DATE: 11/24/2007

ATTENDING PHYSICIAN: MEITUCK HU, MD

PRIMARY DISCHARGE DIAGNOSES
1. Cellulitis.
2. Dermatitis in the groin region.
3. Constipation.

SECONDARY DISCHARGE DIAGNOSES
1. Hypertension.
2. Dementia.
3. Osteoarthritis.
4. Peripheral vascular disease.

CONSULTATIONS
Sally Williams, MD from infectious diseases.
Dane Moseson, MD from general surgery.

PROCEDURES
Fluoroscopic-guided aspiration of the right hip.

Patient:	PLOWMAN, KATHERINE	Location:	SC 5D 549D 01
MRN:	950033-77-21	Date:	11/16/2007 - 11/24/2007
Fin Number:	[redacted]	Pt Type:	Inpatient
DOB:	12/06/1912 Age: 95 years Sex: Female		
Attending:	Hu, Meituck		
Primary Care:	Harroun, Douglass V		

DISCHARGE DOCUMENTS

Document Name:	Discharge Summary
Entry Date:	11/24/2007 14:15:00
Verified By:	Hu, Meituck
Verified Date/Time:	12/04/2007 10:11:22
Document Status:	Auth (Verified)
Transcribed By:	Contributor_system, SCW
Transcribed Date/Time:	11/24/2007 15:21:11

STUDIES
1. Ultrasound of the right hip showing no fluid collection. There was loosening of multiple screws in the acetabular component of the total hip prosthesis.
2. Bilateral lower extremity ultrasound showing no deep vein thrombosis.
3. Right hip x-ray showing bilateral total hip arthroplasties.
4. Abdominal x-ray showing no free air or obstruction.

HOSPITAL COURSE
Mrs. Plowman is a 94-year-old woman who comes from Better Options Adult Foster Home who has had a history of hypertension and dementia. She was admitted on November 16, 2007, with complaints of fever and abdominal pain. Please see the history and physical for full details. The patient was found to be very constipated accounting for the abdominal pain.

She was also found to have cellulitis of her right lower extremity and possible cellulitis in the right groin and pelvic region. She was started on vancomycin. She did have improvement in her right lower extremity cellulitis; however, she developed worsening erythema and swelling in the inguinal region. Because there were concerns for Fournier gangrene because it was in the distribution of Scarpa fascia, general surgery was consulted. They felt that it was cellulitis that required no surgical intervention. However, the erythema worsened and infectious disease was then consulted. It was difficult to determine the cause of this erythema and swelling as it was in the distribution of the incontinence pad. It also could have been a drug reaction to the vancomycin; however, it was only on the right side.

For the lower cellulitis, the vancomycin was then discontinued after 7 days. By the eighth day, her rash in the inguinal region had almost completely resolved.

Initially, there was also a concern that there may be involvement of the right hip given her history of total hip replacement. An x-ray was obtained showing an intact joint. However, it was noted have multiple loose screws in the acetabular portion. The right hip was also aspirated under

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STEVENSON, RN
Inv.00108

Patient:	PLOWMAN, KATHERINE	Location:	SC 5D 549D 01
MRN:	950033-77-21	Date:	11/16/2007 - 11/24/2007
Fin Number:	[redacted]	Pt Type:	Inpatient
DOB:	12/06/1912 Age: 95 years Sex: Female		
Attending:	Hu, Meiluck		
Primary Care:	Harroun, Douglass V		

DISCHARGE DOCUMENTS

Document Name:	Discharge Summary
Entry Date:	11/24/2007 14:15:00
Verified By:	Hu, Meiluck
Verified Date/Time:	12/04/2007 10:11:22
Document Status:	Auth (Verified)
Transcribed By:	Contributor_system, SCW
Transcribed Date/Time:	11/24/2007 15:21:11

fluoroscopy to rule out any infection or hemorrhagic fusion. Orthopedics was also curbsided and they suggested outpatient followup for possible repair of the loose screws.

The patient was visited on November 23, 2007, by her caseworker who stated that the patient had been turned down by physical therapy at their facility several times and that she is unable to walk. She has been wheelchair bound for several months. Her facility is equipped for physical handicaps and she does have a Hoyer lift in her room.

Dementia with delirium. The patient was also noted to be agitated several nights in a row. She was given Haldol as needed and then was started on Seroquel 25 mg; however, this caused increased oversedation. This was then decreased to 12.5 mg. On the day of discharge, she was easily arousable and was no longer oversedated.

DISCHARGE INSTRUCTIONS
The patient is to follow up with her primary care doctor, Dr. Grudzien, some time next week. She should also follow up with her previous orthopedic surgeon for possible repair of the loose screws.

DISCHARGE MEDICATIONS
The 2 new medicines we have put her on are:
1. Seroquel 12.5 mg p.o. nightly.
2. Enoxaparin 40 mg subcutaneously daily.
3. She can resume her outpatient medications which are:
A. Prilosec 20 mg p.o. daily.
B. Ramipril 10 mg p.o. daily.
C. Zyprexa 2.5 mg p.o. nightly p.r.n.
D. Cilostazol 100 mg p.o. b.i.d.
E. Lutein 20 mg p.o. daily.
F. Amlodipine 10 mg p.o. daily.
G. Metoprolol 25 mg p.o. b.i.d.
H. Vicodin at night as needed.
I. Lidex cream as needed.

000087

STEVENSON, RN
Inv.00109

COPY

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND ADULT SERVICES ADMINISTRATION
5411 E Mill Plain Blvd, Suite 25, Vancouver, WA 98661

Statement of Deficiencies/ Plan of Correction	License #: 64503 BETTER OPTIONS FOR ELDER CARE	Completion Date December 6, 2007

An unannounced complaint investigation was conducted on 12/3/2007 at BETTER OPTIONS FOR ELDER CARE, an adult family home licensed to STEVENSON GROUP INC, 15214 NE 25TH CIR, VANCOUVER, WA 98684. 0 of 0 current residents and 0 former residents were selected for review.

This document references the following:

Complaint Number 071127107

Licensors / Team members:

Shawn Swanstrom, RN, BSN, Licensor

From:

DSHS, Aging and Disability Services Administration
Residential Care Services, Region 6, Unit A
5411 E Mill Plain Blvd
Vancouver, WA 98661

An acceptable written Plan of Correction (POC) for each deficiency cited must be submitted within 10 calendar days. Enforcement action may be recommended dependent upon the scope and severity of deficiencies cited in this report. The licensee may question cited deficiencies and enforcement actions if initiated through the State's informal dispute resolution process. Further, findings are discloseable to the public.

Suzanne Harper Wiring
Residential Care Services

12/13/07
Date

F Stevenson
Licensee (or Representative)

12/23/07
Date

RECEIVED
JAN 07 2008
DSHS AASA
Residential Care Services

FU: 01/18/2008 v1-9-08 SS OK

WAC 388-76-620 Provision of services and care.
(1) The provider shall ensure that the resident receives necessary services and care to promote the most appropriate level of physical, mental, and psychosocial well-being consistent with resident choice.

This requirement was not met as evidenced by:
Based on observation, interview and record review, the provider failed to ensure 1 of 1 resident (#1) received necessary services (an injectable medication) as ordered by her physician. This failure put the resident at a high risk for medical complications.

On 12/3/07, Resident # 1 stated she had just been in the hospital. She was unable to state why she had gone to the hospital, but did state she had been sick.

Resident record review revealed Resident # 1 had been originally admitted to the home on 5/3/05 with a diagnoses of non- insulin dependent diabetes, a history of peripheral vascular disease, and a history of strokes resulting in right sided weakness. Resident history revealed the resident also had a left below the knee amputation related to her diabetes, cellulitis, and peripheral vascular disease.

A recent hospital discharge instruction summary dated 11/24/07 was found in the resident record. Resident #1 had been admitted to the hospital on 11/16/07 for abdominal pain and fever. On 11/24/07, the resident was discharged back to the adult family home. The resident had a past right hip replacement with some hardware (a screw) loose in the hip. New medication orders sent to the adult family home on 11/24/07 included:

1. Enoxaparin (Lovenox) 40 mg subcutaneous daily. An injectable medication used to help blood from clotting as fast. Used at times for residents as a presentation measure to stop deep vein thrombosis (blood clots).

2. Seroquel 12.5 mg every evening for restlessness. An anti-psychotic medication used to help with behaviors or delusions.

Caregiver A stated on 12/3/07 she was the caregiver on duty at the time of Resident #1's readmission to the adult family home on 11/24/07. She stated the provider, a registered nurse, was aware of the residents return and aware of the new medication orders, including daily injections.

Enoxaparin 40 mg SQ daily was placed on the November 2007 medication record as of November 26, 2007. The medication was not signed as administered for November 26 – 30, 2007. The December 2007 medication administration record revealed Enoxaparin 40 mg SQ had been added. The medication had not been signed as administered as given on December 1st & 2nd. The medication had been signed for as given on December 3, 2007 by the Registered Nurse provider.

On 12/3/07, the medication supply for Resident # 1 revealed a box of Enoxaparin 40 mg pre-filled injections dated 11/26/07. Thirty doses were filled on 11/26/07 - 29 dosed were still available on 12/3/07.

The provider was interviewed on 12/3/07 and stated she was aware of the new injectable medication order for Resident #1 on 11/24/07 (late Saturday afternoon). She stated Resident # 1 had been on Coumadin (an oral medication used to help blood from clotting as fast) in the past and wanted to verify with the physician to start the medication Enoxaparin. She stated she had attempted to call the physician multiple times, but was unable to make contact, so she started the medication on December 3, 2007.

Resident record reviewed showed no documentation the provider had attempted to contact the physician or notified the physician she had not administered the medication Enoxaparin. The provider stated she had not contacted that physician to review the Enoxaparin orders.

The provider was re-interviewed on the afternoon of 12/3/07 and stated she had contacted Resident #1's physician and reported she had not given the Enoxaparin injections as ordered.

On 12/6/07, the adult family home was called and the caregiver on duty stated the provider had been in on December 4, 5 & 6th to give the Enoxaparin injection.

This is a repeat citation from 6/21/07

POC Date: 12/23/07
POC: • I won't wait or try to contact primary physician
• I will start to fulfill orders from hospital the same day after residents return from hospital
• I will make sure to talk to MD or NP while resident in hospital to discuss potential problems instead of waiting for primary doctor. I will be responsible for fixing this problem.

WAC 388-76-76515 What fire safety and emergency requirements must the provider have in the home?
(8) Portable oil, gas, kerosene, and electric space heaters must not be used in the home except in the case of a power outage and the portable space heater is the home's only safe source of heat.

This requirement was not met as evidenced by:
Based on observation and interview, the provider failed to ensure portable space heaters were not used in the home. This failure put all residents at risk for harm.

During the full inspection on 6/21/07, a space heater was observed plugged into an electrical outlet of a resident's bedroom; a citation was written. During the follow-up visit on 9/14/07, the space heated had been removed and the citation corrected.

During a compliant investigation on 12/3/07, two space heaters were observed plugged into electrical outlets in two resident rooms (Resident #1, & #2). Both space heaters were on and blowing warm air.

Resident # 1 was sitting up in her wheelchair on 12/3/07. The resident was noted to have a left below the knee amputation. When interviewed, Caregiver A stated the resident needed to be transferred via a Hoyer lift (mechanical lift) from a bed to the chair and would need extensive

assistance to evacuate from the home.

Resident # 2 was sitting in her room on 12/3/07. She stated she was nearly blind and during an emergency, would need, "A lot of help" to get out of her room.

This is a repeat citation from 6/21/07

POC Date: 12/23/07

POC: we removed portable heater on 12/3/07-same day Caregiver placed it w/o provision knowing it. I'll make sure caregiver will be counseled, given instructions. I'll personally check and reevaluate caregiver's knowledge re: portable heaters

A. I am a physician. Specifically I am what's called hospitalist.

Q. And where do you work?

A. I work at the Legacy Salmon Creek Hospital, up at the Vancouver, Washington.

Q. And how long have you worked there?

A. This is my third year, going on my fourth.

Q. And for those of us who aren't members of the medical profession, what does a hospitalist do?

A. Well, so I am basically an internal medicine doctor, and I am similar to your primary care physician, who is usually also an intern -- internal medicine doctor. So nowadays the practice of medicine is such that if you get admitted to the hospital, your primary care physician usually does not follow you in the hospital, so I would be the surrogate doctor in the meantime. So I would be in charge of her total care, and then when she's ready to be discharged, I would discharge her back to the care of her primary care physician.

Q. So you take on the role of caring for patients when they're in the hospital?

A. Exactly.

Q. As a preliminary matter, did you receive

Q. And so it looks like we're looking at some more orders.
A. Right.
Q. And the second one down --
A. That's my order.
Q. And is that -- so that's the order you wrote in your discharge instructions?
A. Yes. I wrote for 30-day supply, and I had her obtain refills from the primary care because I wanted the primary care to follow her by that point and reassess whether she still needs this enoxaprin.
Q. When you ordered this medication, were you aware that Patient A had previously been admitted to the hospital in August for bleeding in her eye?
A. Actually, at that time I didn't realize that she had bleed in her eye.
Q. If you had known that, would you have changed your order?
A. I actually would not have changed her order, because if -- and I don't have it to refer to, but if you look back at her previous hospitalization in August for the bleed, she had had a large bleed in the eye, causing visual loss, and when you look back at what had happened, it was actually that at that time she was on Coumadin, and the Coumadin wasn't --

say, "Hey, Dr. Hu, I have a" -- "I have a concern about this medication"?

A. Then we discuss it, we review the chart, and we address it.

Q. And have you ever been contacted by someone who has maybe left the hospital so is no longer in the hospital or under the care of one of your nurses but maybe under the care of a different nurse? Have you ever had anyone contact you about concerns with an order in that situation?

A. Yes, this actually happens all the time, and if we discharge a patient and the patient has already been followed by their primary care, then we defer back to the primary care. However, if the patient is discharged and they have not yet had a chance to see their primary care, we -- we always take the call and we address the issue at that point.

And it's an understanding among all the hospitalists in our group that we do this cross-cover. So it doesn't matter who had discharged the patient and who had seen the patient. The physician that is on would take this call and go up to the chart and address it.

Q. And how many hours a day is there a physician on call at your hospital?

DIRECT EXAMINATION

BY MR. MITCHELSON:

Q. I'm going to address you as Faia, because that's what I know you as, but would you give a full spelling for the court reporter.

A. Yeah, my name is Faia Stevenson.

Q. Your full name, please.

A. Fairuza Stevenson.

Q. Okay. Would you spell it, please.

A. F-a-i-r-u-z-a, S-t-e-v-e-n-s-o-n.

Q. Tell me about your medical training and background.

A. Well, I graduated from Clark College in 2000 -- in year 2000 with A.A. in nursing, and then I started my bachelor degree in Washington State University, I finished it in 2009, was admitted to graduate school in 2009.

Q. Are you going to graduate school now?

A. I'm taking a break now.

Q. Okay.

A. I finished a couple semesters and I'm taking a break.

Q. How much more do you need --

Well, does graduate school confer on you a master's at some point? Is that what you mean?