

**BEFORE THE OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF OREGON
for the
OREGON STATE BOARD OF NURSING**

In the Matter of Licensee) **FINAL ORDER**
)
STACEY SCRUGGS) OAH Case No. 1202914
) Agency Case No. 12-01600

HISTORY OF THE CASE

On August 8, 2012, the Oregon Board of Nursing (Board) issued a “Notice of Proposed 60 Day Suspension of Registered Nurse License” to Stacey Scruggs. On August 14, 2012, Ms. Scruggs requested an administrative hearing. On August 21, 2012, the Board referred the matter to the Office of Administrative Hearings (OAH). The OAH assigned the matter to Senior Administrative Law Judge (ALJ) Jennifer H. Rackstraw.

On September 5, 2012, Presiding ALJ John M. Mann held a telephone prehearing conference. Senior Assistant Attorney General Tom Cowan represented the Board. Attorney Tom Doyle represented Ms. Scruggs. A hearing was scheduled for April 3 and 4, 2013.

On March 13, 2013, the parties jointly requested that the hearing be postponed.¹ On March 13, 2013, ALJ Rackstraw granted the postponement request, and the hearing was rescheduled.

On June 5 and 6, 2013, ALJ Rackstraw convened a hearing in Portland, Oregon. Senior Assistant Attorney General Lori Lindley represented the Board. Mr. Doyle represented Ms. Scruggs. The following persons testified: Ms. Scruggs; Mary Lee, R.N.; Joshua Brown, R.N.; Wendy Ackley, R.N.; Kathy Wilson; Hilary (formerly Turner) Chambers; Ret. Reverend Jana Hall; Anita Schacher; and Nisha Sexton, R.N. The record closed at the conclusion of the hearing on June 6, 2013. The Proposed Order was issued on August 8, 2013 and instructed Exceptions to be filed by August 18, 2013. No exceptions were filed by Licensee.

ISSUES

1. Whether Ms. Scruggs violated ORS 678.111(1)(f) by engaging in conduct derogatory to the standards of nursing under OAR 851-045-0070(1)(c), (3)(h), (3)(i), and (4)(b).

¹ By this time, Senior Assistant Attorney General Lori Lindley had become the Board’s assigned counsel in this matter.

2. If so, whether a 60-day suspension of Ms. Scruggs' registered nurse license is the appropriate sanction. ORS 678.111(1)(f).

EVIDENTIARY RULINGS

The Board's Exhibits A1, A2 and A4 through A7 were admitted into the record without objection. Exhibit A3 was admitted over Ms. Scruggs' hearsay objection. Ms. Scruggs' Exhibits R1 through R4 and R6 and R7 were admitted into the record without objection. Ms. Scruggs' Exhibit R5 was admitted over the Board's objection that it was not timely provided to the Board.

CREDIBILITY DETERMINATION

To reconcile any conflicts in the record and determine which evidence is more likely than not correct, it is necessary in this case to assess the credibility and reliability of the various witnesses offering testimony. ORS 44.370 provides, in part:

A witness is presumed to speak the truth. This presumption, however, may be overcome by the manner in which the witness testifies, by the character of the testimony of the witness, or by evidence affecting the character or motives of the witness, or by contradictory evidence.

A determination of witness credibility can be based on a number of factors, other than the manner of testifying. These factors include the inherent probability of the evidence, whether the evidence is corroborated, whether the evidence is contradicted by other testimony or evidence, whether there are internal inconsistencies, and "whether human experience demonstrates that the evidence is logically incredible." *Tew v. DMV*, 179 Or App 443, 449 (2002), citing *Lewis and Clark College v. Bureau of Labor*, 43 Or App 245, 256 (1979) *rev den* 288 Or 667 (1980) (Richardson, J., concurring in part, dissenting in part).

For the reasons explained below, the ALJ concluded that Ms. Scruggs' hearing testimony and various statements she made to Board Investigator Nisha Sexton during a May 4, 2012 Board interview are of questionable reliability.

First, certain statements Ms. Scruggs made to Ms. Sexton during the Board interview conflict with other, more reliable evidence in the record. For example, after Ms. Sexton asked Ms. Scruggs whether she had received any written or verbal warnings while working in the Extended Care Unit (ECU) at Providence Seaside Hospital (Providence Seaside), Ms. Scruggs stated that she "never had a written warning" and that she "didn't have any verbal warnings about [her] patient care." Exhibit A5 at 5. Similarly, after Ms. Sexton asked whether the employer noted any practice concerns or issues in Ms. Scruggs' performance evaluations, Ms. Scruggs replied in the negative. *Id.* at 17. And, after Ms. Sexton asked Ms. Scruggs whether she had any issues with coworkers, Ms. Scruggs replied, "Nothing really out of the ordinary. Just *** normal." *Id.* The record, however, does not support Ms. Scruggs' statements.

Based on documentary evidence, hearing testimony from ECU manager Mary Lee, and testimony from Ms. Scruggs herself, the record establishes that Ms. Scruggs received at least one

verbal warning for conduct related to resident care;² that Ms. Lee placed Ms. Scruggs on a written “work plan” for conduct related to her poor communication with coworkers³ and her unilateral decision-making regarding resident care; that Ms. Scruggs met weekly with Ms. Lee in November 2011 as a follow-up to the work-plan; and that Ms. Scruggs received at least one performance evaluation that noted all of these issues. *See* Exhibit A3 at 4-6, 12, 15, 21-24, 42-43; testimony of Lee and Scruggs. Given these facts, Ms. Scruggs’ statements to Ms. Sexton, discussed above, were not accurate.

Second, certain statements Ms. Scruggs made to Ms. Sexton on May 4, 2012 conflict with statements Ms. Scruggs previously made to Ms. Lee on December 27, 2011. When discussing resident RJ’s POLST with Ms. Sexton on May 4, 2012, Ms. Scruggs twice claimed that she was not aware that RJ’s POLST had a handwritten note on it that stated “If feeding tube is displaced, do not replace.” *See* Exhibit A5 at 11, 18. However, during a telephone conversation with Ms. Lee on December 27, 2011, Ms. Scruggs told Ms. Lee that she was aware of the handwritten note on RJ’s POLST, but that she could not tell if the person who wrote the note had added it before or after RJ’s physician signed the document. Exhibit A3 at 32. Given this discrepancy, and the incorrect statements Ms. Scruggs made to Ms. Sexton with regard to work issues and coworker relationships, it appears that Ms. Scruggs may have been trying to minimize her work-related problems to Ms. Sexton and paint herself in the most positive light possible, even at the risk of providing inaccurate, untruthful information to the Board. In the alternative, Ms. Scruggs may be an inadvertently unreliable historian. Either scenario casts doubt on her reliability and credibility in this proceeding.

Third, Ms. Scruggs’ hearing testimony conflicts with the hearing testimony and written statements of several individuals. With respect to whether Ms. Scruggs told Ms. Wilson that she was “useless” during a meeting, Ms. Scruggs’ hearing testimony conflicts with the hearing testimony of Ms. Lee and Ms. Wilson, as well as with documentation drafted by Ms. Lee in 2011. *See* Exhibit A3 at 4-5. With respect to whether Ms. Scruggs previously stated to coworkers that she would replace RJ’s G-tube if it came out during her shift, her testimony conflicts with the testimony and written statements of ECU administrative assistant Kathy Wilson, nurse Joshua Brown, and certified nursing assistant (CNA) Paige McManus. Ms. Wilson and Mr. Brown each provided a written statement to Ms. Lee in January 2012 asserting that prior to December 24, 2011, Ms. Scruggs had personally declared to them that she would replace the G-tube if it came out during her shift. Ms. McManus provided a written statement to Ms. Lee asserting that she had overheard Ms. Scruggs make a similar comment on more than one occasion. *See id.* at 39, 45, 47. Ms. Wilson’s hearing testimony supports her written statement.

² The warning involved Ms. Scruggs impermissibly requesting changes to her father-in-law’s medications while he was a resident in the ECU. (*See Ex. A3* at 43.)

³ For example, the record establishes that some ECU staff members complained that Ms. Scruggs was discourteous, sarcastic, condescending, and unapproachable. Ms. Lee noted these complaints in Ms. Scruggs’ October 21, 2011 performance evaluation. Some staff members reported to Ms. Lee that they did not like working with Ms. Scruggs and that they chose to report work issues to other nurses instead of to Ms. Scruggs. Ms. Lee and Ms. Scruggs discussed this matter on November 11, 2011. Sometime prior to October 21, 2011, Ms. Lee convened a meeting between Ms. Scruggs and the ECU’s administrative assistant in an attempt to improve their communication and strained working relationship. (*See Ex. A3* at 4-6, 21, 23.)

Although at hearing Mr. Brown could not specifically recall Ms. Scruggs making the G-tube assertion to him, he testified that he considered his written statement accurate and that if he wrote such a thing in January 2012, he stands by his statement. Ms. Scruggs, on the other hand, denied at hearing that she ever made the alleged statements to Ms. Wilson and Mr. Brown.

To accept Ms. Scruggs's hearing testimony as truthful and accurate with regard to whether she called Ms. Wilson "useless" and with regard to whether she told people that she would replace RJ's G-tube if it came out during her shift, it would be necessary to conclude that Ms. Lee and Ms. Wilson lied at hearing. It would also be necessary to conclude that Ms. Lee, Ms. Wilson, Mr. Brown, and Ms. McManus all lied in their written statements.

At hearing, Ms. Lee appeared forthright, and her testimony was consistent with her comprehensive documentation regarding both the G-tube incident and Ms. Scruggs' work performance issues. There is no evidence to suggest that Ms. Lee had any ill intent towards Ms. Scruggs. Indeed, the record establishes that Ms. Lee considered Ms. Scruggs a skilled R.N., and that Ms. Lee tried earnestly to improve Ms. Scruggs' working relationship with ECU staff, other nurses, and CNAs. Overall, the ALJ found that Ms. Lee was a credible witness.

Counsel for Ms. Scruggs contends that coworkers did not like Ms. Scruggs because they disliked her communication style and found her to be sarcastic. The record supports that contention, as well as a finding that Ms. Scruggs did not get along with Ms. Wilson and Ms. McManus. However, even given those facts, the ALJ was not persuaded that Ms. Wilson, Ms. McManus, or Mr. Brown conspired against Ms. Scruggs or that they fabricated their written statements or hearing testimony due to any animosity towards Ms. Scruggs. At hearing, Mr. Brown appeared forthright; his testimony was internally consistent; and he indicated when he could not remember something, or he did not know the answer to a question. Overall, the ALJ found him to be a credible witness. Ms. Wilson's hearing testimony appeared similarly reliable.

In weighing the competing evidence, the ALJ concluded that with respect to the matters discussed above, the written and verbal statements of Mr. Brown, Ms. Lee, Ms. Wilson, and Ms. McManus are more reliable than the testimony of Ms. Scruggs. Thus, where Ms. Scruggs' testimony conflicts with other, more reliable evidence, the ALJ accorded greater weight to the other evidence. The Board agrees with the ALJ's assessment.

FINDINGS OF FACT

1. Ms. Scruggs has been a registered nurse (R.N.) in Oregon since 1977. (Test. of Scruggs; Ex. A5 at 3.) She has no previous disciplinary history with the Board. (Ex. A5 at 15.)
2. From October 1999 to January 18, 2002, Ms. Scruggs worked as an RN charge nurse in the Extended Care Unit (ECU) of Providence Seaside Hospital (Providence Seaside). (Test. of Scruggs; Exs. A4 at 2, A5 at 5.) The ECU is an intermediate-level care nursing home attached to the hospital where approximately 22 elderly residents reside. (Ex. A5 at 7-8; test. of Lee.) Ms. Scruggs typically worked the day shift, which was 6:30 a.m. to 3:00 p.m. She worked with certified nursing assistants (CNAs) during her shift. (Test. of Scruggs.)

3. Claimant's father-in-law was a patient in the ECU for several years. There were "ill feelings" between Ms. Scruggs and the resident care manager (RCM), Tuula Reinoso, and the ECU manager, Mary Lee, with regard to the father-in-law's pain management. (Ex. A5 at 16-17; test. of Scruggs.)

4. In January 2011, a physician questioned Ms. Scruggs' conduct in requesting a change to her father-in-law's medications through the hospital system via her role as the charge nurse. On January 20, 2011, Ms. Lee discussed the issue with Ms. Scruggs and informed her that she was not allowed to request medication changes for a relative in her role as a charge nurse. They discussed other methods by which the father-in-law's medications could be changed, including referring such requests through the RCM or communicating with the physician directly, as a relative and not as a charge nurse. (Ex. A3 at 43.)

5. On March 26, 2011, Ms. Scruggs again requested a change to her father-in-law's medications through the hospital system via her role as the charge nurse. The physician refused the request and reported the incident to Ms. Reinoso, who was unaware of the request. (Ex. A3 at 43.) On October 21, 2011, Ms. Scruggs and Ms. Lee each signed a written statement detailing corrective action taken with regard to this issue. (*Id.* at 42.)

6. On October 21, 2011, Ms. Scruggs received an employee performance appraisal which stated, in part:

[H]er response to co-workers is often less than courteous[.]

[W]hen Stacey is approached about a concern or a question her response is often sarcastic[.]

[O]n several occasions Stacey has made decisions to request a discontinuation of medications without consulting the Care Team. Generally these decisions are reviewed before the request is made in an effort to make the best decision for the resident. Stacey has continued to avoid bringing these proposals to the morning meeting for team review and proceeded with what appears to be her own agenda. This has had a negative impact on her relationship with the team.

[I] convened a meeting with Stacey and the Administrative Assistant because there appeared to be some communication issue between the two team members. The Administrative Assistant asked Stacey, how can I better support you, I am trying and I don't know what you want? Stacey responded ["You can't, you are useless to me, you are in the way and I don't need your help." * * * [The Administrative Assistant] was so hurt she avoids Stacey and works around her.

* * * * *

[A] few of the [CNAs] have reported that they feel you are condescending towards them and they do not like working with you[.]

* * * * *

Stacey[']s clinical skills are good, she has good assessment skills, however, Stacey tends to go beyond her role as charge nurse and make decisions for residents that should be made by the Interdisciplinary team. She does not communicate through our unit systems her concerns and her plans to approach a change, however minor, for the resident. * * *. Stacey recently requested a change in a resident[']s vitamin order and did not discuss or even mention the change to the RCM, who caught the order while looking through the chart for another issue.

* * * * *

Stacey requested a discontinuation of a medication from a physician. There were concerns she had that le[[]d her to believe this would be a benefit for the resident. Again, this order was found and the Unit team could have provided input that might have been advantage[ou]s to the resident. This medication had been discontinued a few years ago and it had resulted in the resident getting sick. It was decided at that time to continue the medication in order to avoid a resident decline.

* * * * *

[T]he team is becoming more and more alienated by what appears to be a self[-]serving agenda on Stacey[']s part.

(Ex. A3 at 4-6, 12, 15.)

7. On November 4, 2011, Ms. Lee issued a “Work Plan for Improvement” to Ms. Scruggs.⁴ (Ex. A3 at 21-22.) The work plan primarily focused on improving Ms. Scruggs’ communications with ECU team members. The work plan directed Ms. Scruggs to recognize that she was part of a team and also directed her to use clear and respectful communication with her peers. (*Id.* at 21; test. of Lee.) Ms. Lee and Ms. Scruggs had weekly follow-up meetings in November 2011. After those meetings, Ms. Lee noted improvement in Ms. Scruggs’ communications with staff. (Ex. A3 at 23-24.)

8. At the ECU, when a nurse begins a shift, he or she is expected to review a “Daily Report,” which contains medication pages and treatment sheets for each resident. (Test. of Lee.)

⁴ At hearing, Ms. Scruggs testified that she was put on a work plan after CNA Paige McManus became upset that Ms. Scruggs made a comment that Ms. McManus “thinks she’s in charge here.” (Test. of Scruggs.) It is unclear whether the work plan that Ms. Scruggs referenced at hearing was this November 4, 2011 work plan, or some other work plan.

The medication pages are part of a Medication Administration Record (MAR). Any new changes to medications appear in the front of the “Daily Report.” (*Id.*) The treatment sheets are part of a Treatment Administration Record (TAR), which contains physician orders for each resident. Every month, the RCM reviews the orders and sends them to the appropriate physicians so that the physicians can review and resign them. (*Id.*) If a nurse believes that an order is unclear or confusing, the nurse is expected to seek clarification from a supervisor or from the resident’s physician. (*Id.*; test. of Brown.)

9. At the ECU, when an order for a medication or treatment is discontinued (also known as “D/C”), it gets “yellowed out” on that month’s MAR or TAR. (Test. of Lee.) The following month it will be deleted from the MAR or TAR. On the MAR and TAR, if an order has not been “D/C’d,” then the order is still considered to be in effect. (*Id.*) If two seemingly contradictory orders appear on a treatment sheet, the newest order takes precedence over the older order. (Test. of Sexton.)

10. A POLST is an order that communicates a person’s preferences with regard to life-sustaining procedures such as CPR resuscitation, antibiotics, and feeding tubes.⁵ (Ex. A1 at 1; test. of Scruggs.) At the ECU, a POLST is printed on bright fuchsia paper and is typically kept in the front of a resident’s chart. (Test. of Scruggs, Lee; *see* Ex. A7.) A resident’s chart is comprised of a MAR and a TAR, and the chart is kept in a cart in the nurse’s station. (Test. of Lee.)

11. Resident RJ was born on July 15, 1921. On February 2, 2004, she was admitted to the ECU at Providence Seaside after having multiple cerebrovascular accidents (*i.e.* strokes). (Ex. A2 at 1-2, 17.) She was incontinent of bowel and bladder; she experienced frequent respiratory problems; and she was dependent on G-tube feeding.⁶ (Exs. A2 at 17, A5 at 9.) She had two guardians, Mr. and Ms. Abrams,⁷ who made medical decisions on her behalf. Mr. and Ms. Abrams had difficulty making decisions with regard to RJ’s end-of-life orders. As a result, they sought the assistance of a Catholic priest. (Test. of Lee; Ex. A5 at 16.)

12. On August 23, 2011, RJ’s POLST was amended. Under Section D of RJ’s POLST, there was an “x” in the box next to “Long-term artificial nutrition by tube.” (Ex. A1 at 1.) Directly below that was a space for “Additional Orders,” and the following handwriting appeared: “If feeding tube is displaced, do not replace.” (*Id.*) RJ’s physician, Ben Cockcroft, M.D., signed the POLST. (*Id.*) Richard Berg also signed the POLST as RJ’s health care representative. (*Id.* at 2.)

13. RJ’s TAR for the month of December 2011 contained, in part, the following under a section titled “ORDER”:

⁵ POLST stands for “Physician Orders for Life-Sustaining Treatment.” (Ex. A1 at 1.)

⁶ The terms “G-tube,” “feeding tube” and “PEG tube” are used interchangeably in this Order.

⁷ Although it is unclear whether RJ was related to Mr. and Mrs. Abrams, the record contains multiple references to RJ’s “family” and the record supports an inference that those references are to Mr. and Mrs. Abrams.

Start Date: 5/22/2007

INFO

PRN

If PEG tube is unintentionally pulled out LN may
reinsert a new feeding tube usin[g] Xylocaine 2%[.]
20 french Magna-Port gastronomy tube.

*** PER REVISED POLST AS OF 8/23/2011.

NEW TUBE IS NOT TO BE INSERTED****

Notify guardian if tube comes out.

Start Date: 4/7/2010

APPLY PRN Topical (TP) Nystatin powder[.]

(Ex. A2 at 26; emphasis and asterisks in original.)

14. RJ's Resident Care Plan, which was in effect in December 2011, had a cover sheet that included advanced directives. A box was checked for "Feeding Restrictions" with a date of "8/23/11" written next to it. (Ex. A2 at 30.) Just below that section was a handwritten note that stated "8/23/11 – POLST revised[.] PEG tube not to be replaced." (*Id.*) On page six of the Resident Care Plan, it stated, in part:

If PEG tube is unintentionally pulled out, LN may insert a new feeding
tube using Xylocaine 2% jelly. Approach Start Date: 02/02/2008

(*Id.* at 36.) The following handwritten note appeared next to and below that section: "D/C 8/23/11 Refer to POLST. PEG tube not to be replaced." (*Id.*)

15. In October 2011, Ms. Scruggs had a conversation with Joshua Brown, who was a licensed practical nurse (LPN) at the time.⁸ Mr. Brown worked the shift after Ms. Scruggs, which began at 3:00 p.m. During their conversation, Ms. Scruggs mentioned that she thought the orders regarding RJ's G-tube were confusing, and that she would probably replace the G-tube if it came out during her shift. (Test. of Brown, Scruggs; Ex. A3 at 39.) This statement piqued Mr. Brown's interest, so he checked RJ's POLST and TAR. In the TAR, because the second order was dated after the first order, he concluded that it was appropriate to follow the second (*i.e.* newest) order. He did not find the matter confusing and he concluded that if the G-tube came out during his shift, he would not replace it. (Test. of Brown; Ex. A3 at 39.)

16. On December 24, 2011, the ECU was minimally staffed. Ms. Scruggs worked the day shift, along with three CNAs. (Ex. A5 at 6, 8.) Ms. Scruggs was the only nurse on duty that day. (Test. of Scruggs.)

17. At approximately 9:00 a.m. on December 24, 2011, Ms. Scruggs went into RJ's room to administer morning medications (Tylenol and Baclofen). At the time, Ms. Scruggs was working off of RJ's MAR. (Test. of Scruggs; Ex. A5 at 8-9; *see* Ex. A2 at 18-25.) The MAR

⁸ At the time of the hearing, Mr. Brown was an R.N.

does not contain POLST information on it. (Test. of Scruggs.) Ms. Scruggs picked up the G-tube and noticed that it appeared to be malfunctioning because fluid was leaking out of the port. She tried to wiggle the port, but it did not resolve the problem. (*Id.*; Ex. A5 at 8-9.) She did not contact, or attempt to contact, Ms. Lee, Dr. Cockcroft, another physician, or anyone else to seek clarification of RJ's orders or guidance with respect to how to handle the leaking G-tube. She also did not check RJ's POLST or her Resident Care Plan for guidance. She removed the malfunctioning G-tube and replaced it with a new G-tube. She thereafter administered RJ's medications and a liquid feeding. (Test. of Scruggs; Ex. A5 at 9-10.) She wrote the following note in RJ's TAR on December 24, 2011:

BALLOON PART OF MAGNA PORT TUBE COMES APART * * *
REPLACED [WITH] NEW MAGNA PORT[.]

(Ex. A2 at 28; emphasis in original.) She wrote the same note in RJ's Interdisciplinary Progress Record. (*Id.* at 5.)

18. There was no urgent or immediate need for action with respect to RJ's leaking G-tube. Even once Ms. Scruggs removed the leaking G-tube, there was no emergent reason to immediately replace it because, although RJ may have missed some medications and a feeding, the opening would not have closed up right away. (Test. of Lee, Brown, Ackley.) If a resident's G-tube comes out and a nurse does not replace it, the nurse should notify the physician so that the physician can provide new orders with regard to feeding and administration of medication. (Test. of Lee.)

19. Ms. Scruggs could have contacted Ms. Lee, whose number she had, for guidance on what to do with regard to RJ's leaking G-tube. (Test. of Scruggs, Lee.) If Ms. Scruggs had contacted Ms. Lee, Ms. Lee would have called RJ's family and asked how they wished to proceed. Ms. Lee would have also notified RJ's physician, Dr. Cockcroft (or, presumably, whichever physician was covering for Dr. Cockcroft at that time)⁹ for guidance with regard to subsequent feedings and administration of medication for RJ. (Test. of Lee.)

20. At approximately 9:30 a.m. on December 24, 2011, Ms. Scruggs called RJ's family and spoke to a family member. She informed the family member that RJ's feeding tube had come out and been replaced. (Test. of Scruggs; Ex. A5 at 16.) At the end of her shift, Ms. Scruggs informed the incoming nurse, Mr. Brown, that she had replaced RJ's G-tube. (Test. of Scruggs, Brown; Ex. A3 at 39.) Ms. Scruggs did not work on December 25, 26, and 27, 2011. (Ex. A5 at 10.)

21. On Monday, December 26, 2011, RJ's family contacted the RCM, Ms. Reinoso, and expressed concern about RJ's G-tube being replaced. (Ex. A3 at 41.) Also on December 26, 2011, Ms. Lee received a phone call from the ECU's administrative assistant, Kathy Wilson. Ms. Wilson informed Ms. Lee of an email from Daniel J. Caulder, LPN, to Ms. Lee and Ms. Reinoso that stated, in part:

⁹ Dr. Cockcroft was on vacation at the time. (*See* Ex. R4 at 1.)

I thought you should know that on 12-24-2011 the G-tube for [RJ] * * * was replaced by another nurse due to an issue with the tubing end that allows you to check the amount of fluid in the balloon that holds the G-tube system in place. Apparently it malfunctioned/broke and the RN on duty thought it necessary to replace the entire system. I cannot find a doctor's order or anything that confirms family consent to allow this to be done. If this is the case, then we directly violated the family's request to not reinsert a new G-tube without first obtaining permission to do so from them and/or Dr. Cockcroft. I hate to "tattle" but I see this as a huge offense on the part of the nurse to take such action knowing that she was so openly disregarding the wishes of the family[.]

(Ex. A3 at 41.) In response, Ms. Lee called Mr. Caulder. He informed Ms. Lee that "every nurse" knew that RJ's G-tube was not to be replaced. (*Id.* at 31.) He further informed Ms. Lee that Ms. Scruggs had previously stated to some staff members that if the tube came out during her shift she would replace it. Also on December 26, 2011, Ms. Lee left a voicemail message instructing Ms. Scruggs to call her, no matter how late. Ms. Scruggs did not return Ms. Lee's call. (*Id.*)

22. On the morning of December 27, 2011, CNA Paige McManus and Ms. Wilson both told Ms. Lee that Ms. Scruggs had previously stated that if RJ's G-tube came out on her shift she would put it back in. (Ex. A3 at 31.) At approximately 8:30 a.m. on December 27, 2011, Ms. Lee again tried to contact Ms. Scruggs via telephone, with no success. She called Ms. Scruggs two more times that morning, and at approximately 9:15 a.m., Ms. Scruggs answered the phone. Ms. Lee's notes of that conversation state, in part:

Mary: [I] have a concern about R's tube, [the] family is very upset that it was replaced, why did you do that?

Stacey: Well the bulb malfunctioned and the orders were not clear. (see below)

Mary: What do you mean?

Stacey: Well the order said to replace the tube if it pulled out and I did.

Mary: The POLST stated that "if displaced it was not to be replaced," did you not see that?

Stacey: Yes, someone had written that on the POLST, but I could not tell if it was before or after the Dr[.] signed it. (See above POLST)

Mary: Stacey, it was also on the Treatment sheet.

Stacey: Well that I found a little confusing, it said to replace, but also not to replace and the POLST, I couldn't tell if the person had added that after the Dr[.] signed it.

Mary: Did you call anyone to ask?

Stacey: No, I guess I upset the family, but I didn't argue, I just let them know they could call you on Monday and you could handle it. They wanted to argue with me and I just referred the[m] to you. I'm sorry Mary, I just didn't feel it was ethical. I like R.

Mary: We should have had this discussion before this became an issue. The family really toiled over this decision, this decision was made with the involvement of two priests and the person who signed the POLST as Health Representative was a [p]riest[.]

(*Id.* at 31-32; parentheses in original.)

23. At approximately 9:30 a.m. on December 27, 2011, Ms. Lee spoke with a member of RJ's family. The family member stated that she was upset to learn that RJ's G-tube had been replaced. She also informed Ms. Lee that Ms. Scruggs had been argumentative with her when Ms. Scruggs called her on December 24, 2011 to report the tube incident. (Ex. A3 at 34.)

24. At approximately 10:30 a.m. on December 27, 2011, Ms. Lee had a telephone conference with the hospital's spiritual mission director, Mary Trudell, and a Providence ethicist, Reverend John F. Tuohey, Ph.D. Rev. Tuohey expressed that it was important not to put RJ's family through another end-of-life decision process, and he recommended that ECU staff remove RJ's tube to comply with the wishes expressed in the POLST. (Exs. A3 at 34, A6 at 2; test. of Lee.) In his personal notes regarding that conversation, Rev. Tuohey opined that it "[s]ounds like [Ms. Scruggs'] personal moral beliefs trumped professional judgment." (Ex. A6 at 2.)

25. At approximately 11:00 a.m. on December 27, 2011, Ms. Lee and Ms. Reinoso met with members of RJ's family. The family was noticeably distraught about the situation. Ms. Lee informed the family that because ECU staff had erred in replacing the tube, the ECU would "make it right" by removing the tube, and therefore honoring the wishes expressed in RJ's POLST. (Ex. A3 at 34.) The family agreed with this course of action. (*Id.*)

26. Following the meeting with RJ's family on December 27, 2011, ECU staff stopped RJ's tube feedings and planned for removal of the G-tube the following morning, on December 28, 2011. An on-call physician provided the necessary order for removal of the G-tube. (Exs. A2 at 5, 12; A3 at 34-35.)

27. On the morning of December 28, 2011, Ms. Scruggs was the charge nurse on duty. As the nurse on duty, she was responsible for removing RJ's G-tube. At approximately 10:30 a.m., Ms. Scruggs removed RJ's tube. (Exs. A3 at 35, A5 at 10; test. of Lee, Scruggs.)

28. At the end of Ms. Scruggs' shift on December 28, 2011, Ms. Lee informed her that she was being placed on administrative leave. Ms. Scruggs remained on administrative leave until January 18, 2012, at which time the employer terminated her employment. (Exs. A5 at 16, A3 at 1.)

29. On January 3, 2012, RJ passed away. (Ex. A2 at 2, 7.)

30. In a January 4, 2012 email to Ms. Lee, Mr. Brown stated, in part:

During my first month or so (Oct) I discussed with Stacey the orders regarding the placement of the PEG tube during a shift report. At the time, she mentioned that the orders were confusing and that she would probably replace the tube if it came out during her shift. After that discussion I remember going to the resident's treatment book to look up the orders myself. At the time, I remember thinking that the orders were clear enough to me not to replace the PEG tube if it came out and I decided that is what I would do if I ran into that situation, but I did not discuss it further with Stacey until the hand[-]off from day to evening shift on Dec 24th. During the shift report she mentioned that she was trying to fix the inflatable bladder of the PEG tube when she accidentally pulled it out, she then said that she had replaced it and that she had notified the caregiver. She mentioned that the caregiver was upset with her decision. When I asked her why she did this, she stated that the orders were confusing. I remember thinking that this was questionable but I did not pursue the matter because I wanted to double check the orders and be certain what was going on, as it had been a few months since I last checked on this. After this shift report was over I went to the treatment book and again confirmed my impression that the orders were clearly stated to my satisfaction.

In my opinion, there was no emergent reason for this decision to be made quickly, and that even if the orders were confusing there was an opportunity to verify with the PCP or the nurse manager before any action was taken[.]

(Ex. A3 at 39.)

31. In a January 4, 2012 email to Ms. Lee, CNA McManus wrote, in part:

[O]n several occasions I heard Stacey Scruggs state that if [RJ's] feeding tube was to ever come out on her shift that she would put it back in. Stacey made that perfectly clear and didn't seem to be bothered by the fact that it was against what the family and [RJ] wanted.

(Ex. A3 at 45.)

32. In a January 4, 2012 email to Ms. Lee, Ms. Wilson wrote, in part:

I do not recall the date; however I have heard Stacey Scruggs make a comment regarding [RJ's] peg tube. I had asked her if she was aware of the change made to this resident's POLST [be]cause she had been off and she stated "yes, but if it comes out on my shift I'm putting it back in." I was very taken aback by that comment and felt very uneasy, however, Stacey often makes sarcastic and not appropriate comments. You do not always know what to believe with her statements.

(Ex. A3 at 47.)

33. In a written statement dated January 8, 2012, Dr. Cockcroft stated, in part:

I have cared for * * * [RJ] since March 2006. She has been on tube feedings since prior to my becoming her doctor. Over these many years she has had many occasions where the feeding tube was replaced for malfunction or falling out, etc. In August 2011 there was a change in the POLST for this patient which essentially said that the patient should be allowed to die a natural death the next time that the feeding tube became displaced. I took over 24 hours to implement this because this was something that I did not want to do without clearly having the legality of the power of attorney clearly delineated. * * *. Apparently, the written monthly orders for this patient did not completely reflect the change in the care plan because they still contained the order stating to replace malfunctioning feeding tubes. While I was unavailable (out of the country), the feeding tube malfunctioned on 12/24/11. The nurse on duty followed the order on the written orders to replace the malfunctioning tube. She did contact the family. Subsequently, on 12/27/11, while I was still out of the country, the physician that was covering me that day signed an order to discontinue the tube. Natural death ensued 1/3/12. I do not think that the patient was harmed by having her Christmas dinner and her subsequent feeding on 12/26/11. I do not believe that removal of the replacement tube was unreasonable, since the POLST as signed by me was based on the directive of a catholic priest. * * * * *.

[I] have known Stacey Scruggs as an RN on the Providence ECU since she started working there many years ago. I have never had a negative experience. I have had countless positive experiences, and her help in providing good care to the ECU patients has been invaluable. In addition to vouching for her excellence as a nurse, I would like to also state that her bright personality and wit make the entire unit a more pleasant environment.

(Ex. R4 at 1.)

34. On May 4, 2012, Ms. Scruggs participated in an interview with Board Investigator Nisha Sexton, RN. (Ex. A5.) During the interview, Ms. Sexton asked Ms. Scruggs whether she had ever received any written or verbal warnings while working at Providence Seaside. In response, Ms. Scruggs stated that she “never had a written warning” and that she “didn’t have any verbal warnings about [her] patient care.” (*Id.* at 5.) After Ms. Sexton asked Ms. Scruggs whether Ms. Scruggs had any issues with coworkers, Ms. Scruggs replied, “Nothing really out of the ordinary. Just, I, normal.” (*Id.* at 17.) After Ms. Sexton asked whether there were “any practice concerns in [Ms. Scruggs’] performance evaluations, any, any issues at all,” Ms. Scruggs replied in the negative. (*Id.*) When discussing RJ’s POLST with Ms. Sexton, Ms. Scruggs stated, in part:

This is the first patient that someone has written a little note on. You know, it’s either you want a feeding tube or you don’t want a feeding tube.

* * * * *

[I]f you quit using a feeding tube, you just quit using it. Generally. You don’t have to remove it, leaving an opening. [I] had other patients that when they don’t want their feeding tubes anymore, the tube is removed in surgery and the patient[] [is] stitched-up, stitched closed. Or you just leave the tube and quit using it. It doesn’t need maintenance[.]

* * * * *

I have in the thirty years I’ve been practicing, I’ve never had a tube removed * * * and let the gastric juices run as they wish. It’s always been stitch them up. If they don’t or leave the tube in place. So, I, I wasn’t aware that someone had written a hand written note to the uh on the POLST.¹⁰ “If the tube” and I’m not sure what that note says now, something about, “If the tube falls out, don’t replace it.”

* * * * *

Was also on the treatment sheet though. “If the tube fell out” or was “came out” or something, “don’t put a new one back in.”

(*Id.* at 11-12.) Ms. Scruggs further stated, in part:

There were two orders on the same treatment sheet and they’ve been carried out month after month after month[.]

* * * * *

¹⁰ Later on in the interview, Ms. Scruggs again stated “I wasn’t aware that there was a little note on the POLST that said that.” (Ex. A5 at 18.)

[O]ne says “Replace malfunctioning tubes.”

* * * * *

The other one said I’m paraphrasing[,] “If the tube falls out, don’t put it back.”

[Ms. Sexton then asked Ms. Scruggs why she chose to follow one order and not the other]

Just that was the first order and there was no morphine ordered; there was no other method of pain medication for this lady. How is she gonna get her medication? So it really hadn’t been planned out very well and hadn’t been communicated very well[.]

* * * * *

[I] had MARs that only said give everything by tube[.]

* * * * *

[T]he problem is if you don’t order another route for medications, if the medications are all ordered by the PEG * * * where’s the planning there? All of her medications were ordered by PEG tubes.

(*Id.* at 12-13.)

35. In a letter to the Board dated July 9, 2012, retired Reverend Jana Hall stated, in part:

Sometime around the middle of last January Stacey shared with me a bit of information about a patient she had cared for some time earlier. * * *. [I] was taken aback to learn that she had been punished – basically for trying to help that person life [*sic*].

Stacey Scruggs is one of the most conscientious and responsible women I’ve ever known. Taking any punitive action(s) against her seems unjust, unfounded, AND irresponsible!! I surely do hope the Board of Nursing will re-think their recent decision.

(Ex. R6; emphasis in original.)

CONCLUSIONS OF LAW

1. Ms. Scruggs violated ORS 678.111(1)(f) by engaging in conduct derogatory to the standards of nursing under OAR 851-045-0070(1)(c) and (4)(b).

2. A 60-day suspension of Ms. Scruggs's registered nurse license is the appropriate sanction.

OPINION

The Board alleges that Ms. Scruggs engaged in conduct derogatory to the standards of nursing and seeks to impose a 60-day suspension of her RN license. The Board must prove its allegations by a preponderance of the evidence, and it must also establish that the proposed sanction is appropriate. *See* ORS 183.450(2) ("The burden of presenting evidence to support a fact or position in a contested case rests on the proponent of the fact or position"); *Harris v. SAIF*, 292 Or 683, 690 (1982) (general rule regarding allocation of burden of proof is that the burden is on the proponent of the fact or position); *Metcalf v. AFSD*, 65 Or App 761, 765 (1983) (in the absence of legislation specifying a different standard, the standard of proof in an administrative hearing is preponderance of the evidence). Proof by a preponderance of the evidence means that the fact finder is persuaded that the facts asserted are more likely than not true. *Riley Hill General Contractor v. Tandy Corp.*, 303 Or 390, 402 (1987).

1. Conduct derogatory to standards of nursing

ORS 678.111 provides, in relevant part:

(1) Issuance of the license to practice nursing, whether by examination or by indorsement, of any person may be refused or the license may be revoked or suspended or the licensee may be placed on probation for a period specified by the Oregon State Board of Nursing and subject to such condition as the board may impose or may be issued a limited license or may be reprimanded or censured by the board, for any of the following causes:

* * * * *

(f) Conduct derogatory to the standards of nursing.

OAR 851-045-0070 defines conduct derogatory to the standards of nursing, in part, as follows:

Nurses, regardless of role, whose behavior fails to conform to the legal standard and accepted standards of the nursing profession, or who may adversely affect the health, safety, and welfare of the public, may be found guilty of conduct derogatory to the standards of nursing. Such conduct shall include, but is not limited to, the following:

(1)(c) Failing to * * * follow through with the plan of care.¹¹

* * * * *

¹¹ OAR 851-045-0030(p) defines a "plan of care" as "the written guidelines developed to identify specific needs of the client and intervention/regimen to assist clients to achieve optimal health potential."

(4)(b) Failing to conform to the essential standards of acceptable and prevailing nursing practice. Actual injury need not be established.

The Board contends that Ms. Scruggs failed to follow through with RJ's plan of care and failed to conform to acceptable and prevailing nursing standards on December 24, 2011, when she removed RJ's leaking G-tube and replaced it with a new G-tube. The Board asserts that the order not to replace the G-tube was clear; that there was no emergent need to replace the G-tube when Ms. Scruggs noticed that the port was leaking; and that if Ms. Scruggs found the physician orders confusing she should have sought clarification before acting on December 24.

Prior to and at hearing, Ms. Scruggs offered numerous, and sometimes contradictory, reasons for why she replaced RJ's G-tube on December 24. Ultimately, she contends that her conduct in replacing the tube was reasonable, justified, and not contrary to a clearly expressed physician's order.

During a telephone conversation with Ms. Lee on December 27, 2011, Ms. Scruggs asserted that "the orders were not clear;" that "the order said to replace the tube if it pulled out;" that she knew there was a handwritten note on the POLST stating that if the tube was displaced not replace it, but she was uncertain when the note was written; and that she "just didn't feel it was ethical" not to replace the tube because she "like[d]" RJ. Exhibit A3 at 31-32.

During a Board interview with Ms. Sexton on May 4, 2012, Ms. Scruggs stated that she was not aware that RJ's POLST had a handwritten note on it (not to replace the tube if it became displaced); that she felt she needed to give RJ her morning medications and those medications all had to be administered via the G-tube; and that she followed an order on the TAR to reinsert the G-tube if it came out. Exhibit A5 at 9, 11, 18. During the Board interview, Ms. Scruggs stressed the fact that without a functioning G-tube, RJ would not have been able to receive her medications the morning of December 24, and that it was poor planning not to have an order in place setting forth an alternate method for administering her medications. *Id.* at 12-13.

At the June 2013 hearing, Ms. Scruggs testified that it was her understanding that the POLST order not to replace the G-tube only applied if the tube fell out accidentally (*i.e.* through an "act of God"). Testimony of Scruggs.¹² She testified that once she noticed that the G-tube was malfunctioning on December 24, her primary thought was that she needed to "fix" it so that she could medicate RJ. *Id.* She further testified that she believed the need to medicate RJ gave her (Ms. Scruggs) "a leg to stand on" and that she wanted to "give the family an option." *Id.* She stated that her actions with respect to replacing the G-tube were "proactive" and not reactive. *Id.* She also testified that she knew that RJ's physician, Dr. Cockcroft, was out of town and that she did not try to contact him or anyone else before replacing the tube because she did not think anyone would be available on Christmas Eve.

¹² Ms. Scruggs seems to suggest that because she took out the G-tube (and it did not fall out on its own), she believed the August 23, 2011 POLST order did not apply, and she in good faith replaced the tube.

From May 22, 2007 to on or about August 22, 2011, RJ's TAR stated, in part, "If PEG tube is unintentionally pulled out LN may reinsert a new feeding tube[.]" [May 22, 2007 order]. Exhibit A2 at 26. On August 23, 2011, RJ's POLST was amended to include the instruction "If feeding tube is displaced, do not replace." See Exhibit A1 at 1. RJ's TAR for the month of December 2011 continued to include the May 22, 2007 order, but directly below that order, it stated: "**** PER REVISED POLST AS OF 8/23/2011. NEW TUBE IS NOT TO BE INSERTED**** Notify guardian if tube comes out." Exhibit A2 at 26; emphasis and asterisks in original. RJ's December 2011 Resident Care Plan noted in two places that RJ's POLST had been revised on August 23, 2011, and that her PEG tube was not to be replaced. *Id.* at 30, 36.

The record establishes that Ms. Scruggs was aware of the August 23, 2011 POLST instruction regarding RJ's feeding tube. In approximately October 2011, she told another nurse, Mr. Brown, that she found the G-tube orders confusing and that if RJ's G-tube came out during her shift, she would probably replace it. Sometime between August 23, 2011 and December 24, 2011, she also told at least one other coworker, Ms. Wilson, that if RJ's G-tube came out during her shift, she would replace it.

In the opinions of Board Investigator Nisha Sexton, R.N.; Providence Seaside Chief Nurse Officer Wendy Ackley, R.N.; ECU Manager Mary Lee, R.N.; Daniel Caulder, L.P.N.; and Joshua Brown, R.N., as of August 23, 2011, there was an order in effect that clearly directed a nurse *not* to replace RJ's G-tube if it came out.

Even assuming that Ms. Scruggs was genuinely confused about the orders pertaining to RJ's G-tube, there is no evidence that she ever asked for clarification with respect to those orders from RJ's physician, the RCM, the ECU manager, another nurse, or any other physician. As a matter of common sense, and as established through the reliable testimony of Mary Lee and Joshua Brown, if orders are unclear or confusing to a nurse, the nurse has a duty to seek clarification. If, as Ms. Scruggs has asserted, the G-tube orders were confusing to her, it seems inconsistent with the nursing standard of care for Ms. Scruggs to have provided care to RJ for *four months* while lacking an adequate understanding of the orders (which she was supposed to be following), and without making any attempt to clarify her obligations pursuant to those orders.¹³ Thus, to the extent that Ms. Scruggs did not fully understand the G-tube orders and chose to replace the G-tube on December 24, without seeking clarification of the orders, her conduct was contrary to the essential standards of acceptable nursing practice. This constitutes conduct derogatory to the standards of nursing under OAR 851-045-0070(4)(b).

The preponderance of the evidence establishes that Ms. Scruggs replaced RJ's G-tube on December 24, not because she was confused by the orders, but because she *wanted* to replace the tube, regardless of whether the April 23, 2011 POLST directed otherwise. In fact, as demonstrated by her comments to coworkers, she had decided prior to December 24 that she would replace the tube if it came out during her shift. Moreover, Ms. Scruggs told Ms. Lee on

¹³ Similarly, if an order regarding the dosage of a narcotic medication for a resident was unclear or confusing, as a matter of common sense, a nurse would be expected to seek clarification regarding the dosage. Failing to do so, while continuing to provide care to the resident for four months, would pose a risk of harm to the resident and be contrary to the nursing standard of care.

December 27 that she liked RJ and that she replaced RJ's tube because ethically she felt she had to do so. Ms. Scruggs' hearing testimony establishes that her primary concerns on December 24 were making sure that RJ could continue to receive her medications, as scheduled,¹⁴ and giving RJ's family the "option" of allowing RJ to continue living in her current state with G-tube feedings and medications. There is no evidence that Ms. Scruggs' primary concern (or intent) was to follow, or attempt to follow, the end-of-life wishes of RJ and her family, as expressed in the August 23, 2011 POLST.

The ALJ concluded that, more likely than not, on December 24, 2011, Ms. Scruggs purposefully chose to disregard the order directing that RJ's G-tube not be replaced once it was displaced. In so doing, Ms. Scruggs failed to follow RJ's plan of care. This constitutes conduct derogatory to the standards of nursing under OAR 851-045-0070(1)(c). The Board agrees.

In the August 8, 2012 notice, the Board also alleged that Ms. Scruggs engaged in conduct derogatory to the standards of nursing pursuant to OAR 851-045-0070(3)(h) and (i), which pertain to communication and provide:

(3)(h) Failing to communicate information regarding the client's status to members of the health care team (physician, nurse practitioner, nursing supervisor, nurse co-worker) in an ongoing and timely manner; and

(i) Failing to communicate information regarding the client's status to other individuals who need to know; for example, family, and facility administrator.

The Board's notice did not explain how the facts alleged in the notice relate to OAR 851-045-0070(3)(h) and (i), and the Board's counsel did not articulate how Ms. Scruggs' conduct, as established at hearing, constitutes conduct derogatory to the standards of nursing under subsections (3)(h) and (i). With regard to communicating information regarding the client's status, counsel for Ms. Scruggs pointed out at hearing that Ms. Scruggs contacted RJ's family after replacing the G-tube and that she noted her actions in RJ's TAR and Interdisciplinary Progress Report. In addition, Ms. Scruggs informed the incoming shift nurse, Mr. Brown, of what had occurred. The ALJ concluded that the Board failed to prove that Ms. Scruggs engaged in conduct derogatory to the standards of nursing pursuant to OAR 851-045-0070(3)(h) and (i). However, the Board has proven by a preponderance of the evidence that Ms. Scruggs engaged in conduct derogatory to the standards of nursing pursuant to OAR 851-045-0070(1)(c) and (4)(b). Thus, she is subject to Board discipline under ORS 678.111(1)(f).

2. Sanction

¹⁴ Indeed, at hearing, counsel for Ms. Scruggs argued that, in replacing RJ's malfunctioning G-tube, Ms. Scruggs used her best judgment to ensure that RJ received her "Christmas dinner" and medications. While Ms. Scruggs' concern with RJ receiving her scheduled medications and liquid meal on the morning of December 24 is laudable, it does not negate Ms. Scruggs' duty to follow the POLST order.

Under ORS 678.111(1)(f), the Board may sanction Ms. Scruggs for the conduct established herein, and the possible sanctions include license revocation, license suspension, license conditions, probation, and reprimand.

The Board has proposed suspension of Ms. Scruggs' nursing license for 60 days. Such a sanction is within the Board's discretion and, on this record, the Board has provided sufficient justification for the suspension. The ALJ concluded that the proposed sanction is consistent with the Board's interest in protecting the health, safety, and welfare of nursing residents and patients and that it is the appropriate under the circumstances. The Board agrees.

ORDER

The Board of Nursing issues the following order:

Stacey Scruggs' registered nurse license is suspended for 60 days to begin when this order becomes final.

Dated:

Kay Carnegie R.N. President, Oregon Board of
Nursing

APPEAL

If you wish to appeal the final order, you must file a petition for review with the Oregon Court of Appeals within 60 days after the final order is served upon you. *See* ORS 183.480 *et seq.*

CERTIFICATE OF MAILING

On , I mailed the foregoing Final Order issued on this date in OAH Case No. 1202914.

By: First Class Mail

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