

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

IN THE MATTER OF:) **FINAL ORDER**
)
CHANTARA HIM, CNA/CMA) OAH Case No.: 1403542
) Agency Case No.: 14-00070
Certificate Nos. 000038432CNA,)
000038432CMA)

HISTORY OF THE CASE

On December 24, 2013, the Oregon State Board of Nursing (Board) issued Chantara Him a Notice of Proposed 30 Day Suspension of Certificate with Conditions (Notice), seeking to suspend her certificates for 30 days and require her to complete two courses on professional boundaries and medication administration. On January 10, 2014, Ms. Him requested a hearing.

On January 15, 2014, the Board referred the matter to the Office of Administrative Hearings (OAH). The OAH assigned Administrative Law Judge (ALJ) Samantha Fair to preside at hearing. On February 12, 2014, ALJ Fair convened a telephone prehearing conference and scheduled the hearing for August 27, 2014 and set deadlines for submission of witness lists and exhibits.

On August 25, 2014, Ms. Him requested a postponement of the hearing. ALJ Monica Whitaker granted the request. On August 27, 2014, ALJ Fair convened a telephone prehearing conference and scheduled the hearing for October 22, 2014 and set deadlines for submission of witness lists and exhibits.

A hearing was held on October 22, 2014, in Portland, Oregon. Ms. Him appeared, testified, and was represented by attorney Scott Cliff. The Board appeared and was represented by Senior Assistant Attorney General Thomas Cowan. Michelle Standridge also appeared on behalf of the Board. Testifying on behalf of the Board were Stephanie Brandt, registered nurse at Robison Jewish Health Center (Robison); Lesley Sacks, Robison's administrator; and Jane Duck, Robison's director of nursing.

On November 5, 2014, ALJ Fair issued a Proposed Order concluding that Ms. Him engaged in multiple instances of "conduct unbecoming a nursing assistant and medication aide" pursuant to ORS 678.442, OAR 851-063-0100 and OAR 851-063-0090. ALJ FAIR recommended the Board suspend Ms. Him's Certified Nursing Assistant and Medication Aide certificates and complete certain courses. ALJ Fair also allowed Ms. Him 10 days from the date of the Proposed Order to submit exceptions. Ms. Him, through her attorney, submitted exceptions to the Proposed Order on November 17, 2014.

At the Board meeting of November 19, 2014, the Board deliberated regarding the Proposed Order and the exceptions submitted by Ms. Him. The Board voted to accept the Proposed Order as written and to accept the recommendation of ALJ Fair to Affirm the Board's Notice of Proposed Suspension of Certified Nurse Assistant and Certified Medication Aide certificates and the ALJ's proposed sanction to Suspend Ms. Him's Certified Nurse Assistant Certificate and Certified Medication Aide Certificate. The Board voted to issue this Final Order. The Board now issues the Final Order in this matter. In accordance with ORS 183.650(2) and (3) and OAR 137-003-0665(3) and (4), an agency must identify and explain those modifications to proposed findings of historical fact that change the outcome or basis for this Final Order from those in the Proposed Order. The Board has not made any changes that substantially modify the ALJ's proposed findings of historical fact or change the ALJ's recommended outcome. The Board has made changes to correct spelling, grammar, and/or textual placement.

ISSUES

1. Whether Chantara Him engaged in conduct unbecoming a nursing assistant and conduct unbecoming a medication aide. OAR 851-063-0090 and OAR 851-063-0100.
2. Whether Chantara Him's nursing assistant and medication aide certificates should be suspended and should she be required to complete coursework on professional boundaries and medication administration. ORS 678.442 and OAR 851-063-0080.

EVIDENTIARY RULINGS

Exhibits A1 through A16, offered by the Board, were admitted into the record without objection. Exhibits R1 through R4 were admitted into the record without objection. The Board objected to testimony from Ms. Him's proposed witness, Esperanza Ureno, a licensed practical nurse at Ms. Him's current place of employment, on the grounds that her testimony was not relevant. ALJ Fair sustained the objection.

FINDINGS OF FACT

1. Ms. Him is 56 years old with two adult children, one of whom resides with her because of his disability. She immigrated to the United States from Cambodia in 1990. After her arrival in the United States, she secured work as a seamstress. Seeking better quality and more fulfilling work, Ms. Him sought work as a nursing assistant. (Test. of Ms. Him.)
2. The Board has certified Ms. Him as a nursing assistant since 1997 and a medication aide since 1999. (Ex. A16 at 1.) She has continuously been employed in those fields since obtaining her certifications. (Ex. A15 at 2; test. of Ms. Him.)
3. On November 19, 2006, Ms. Him accepted a position as a medication aide at Robison, a skilled nursing facility that houses long-term care adults. (Ex. R1 at 348; test. of Ms. Brandt.) She worked continuously at Robison until July 18, 2013. She performed hard and exacting work

for Robison, found that Robison was frequently short staffed, regularly assisted her co-workers in the performance of their work, and covered other job duties than her medication aide duties. She had perfect attendance at Robison. She enjoyed the work as she liked the residents and wanted to serve people. She found the medication aide work challenging because of the number of residents and number of medications for each resident that had to be distributed in a limited time period. (Exs. A13 at 2, 4; A15 at 2; test. of Ms. Him.)

4. Robison trained its medication aides to first administer the medication then document its administration in the electronic medication administration record (eMAR). It was not appropriate to document the administration of the medication at the time of collecting the medications because there was no guarantee that a resident would take all the medications. Robison expected the eMAR to be corrected if its information was not accurate. In July 2013, Robison authorized medication aides to make corrections in the eMAR. (Test. of Ms. Duck.)

5. On February 15, 2013, Robison instructed Ms. Him that she must administer all ordered medications to the residents. (Ex. A11 at 1.) On April 4, 2013, Robison instructed Ms. Him to administer nutritional supplements as ordered, even if resident requested more than ordered. (Ex. A12 at 1-2.) On June 26, 2013, Robison advised Ms. Him that “discussing work grievances with residents is prohibited and places an undue burden on residents.” (Ex. A14 at 1.)

6. In July 2013, RW was a 77-year-old male, residing at Robison.¹ (Ex. A1 at 1.) He had a medical condition which caused him severe pain, requiring the need for regular administration of medication to control his pain. (Ex. A5 at 1.) On July 10, 2013, his physician discontinued RW’s prescription for Oxycontin and prescribed him the pain medication MS Contin, 15 milligrams to be administered twice daily. (Exs. A1 at 1-2; R1 at 1.)

7. Medication deliveries to Robison occurred once per day, usually arriving by 4 a.m. (Test. of Ms. Duck.) The nurses were required to check that newly ordered medications for residents were in the medication cart. Thereafter, medication aides performed the checks and counted medications at the end of shifts. The charge nurse was expected to note any issues with the medications at the end of shifts. (Test. of Ms. Sacks.) If a medication was not on the medication cart, the charge nurse would have to call the pharmacy to obtain an authorization number. With that authorization number, the charge nurse could access the eKit² to obtain a dose of the missing medication. (Test. of Ms. Brandt.)

8. Robison scheduled the daily administration of RW’s MS Contin for 8 a.m. and 8 p.m. (Ex. A1 at 6.) Robison provided for a two-hour window, one hour before and one hour after the scheduled administration times, for the administration of the medication. (Test. of Ms. Brandt.) On July 11, 2013, the pharmacy had not delivered RW’s MS Contin to Robison. (Test. of Ms. Sacks.)

¹ In order to respect the confidentiality of the residents’ identities, they are identified only by their initials.

² An eKit is an electronic medication dispensing cabinet management system to provide for the dispensing of medications in an emergency.

9. At 8 a.m. on July 11, 2013, the certified medication aide (CMA) Mendoza discovered that there was no MS Contin for RW in the medication cart. After a dose of MS Contin was retrieved from Robison's eKit, Mendoza administered it to RW by 10:01 a.m. Mendoza noted in the eMAR the unavailability of the MS Contin and lack of its administration to RW at 8 a.m. He later noted in the eMAR that the medication had been administered to RW by 10:01 a.m. (Ex. A1 at 7; test. of Ms. Duck.)

10. Ms. Him, the CMA for RW, and Ms. Brandt, the charge nurse for RW, began their shifts at 3 p.m. on July 11, 2013. Neither the charge nurse nor the CMA from the earlier shift advised them of the lack of MS Contin for RW in the medication cart. (Test. of Ms. Brandt and Ms. Him.)

11. On July 11, 2013, approximately 7:35 p.m., Ms. Him prepared RW's evening medications. She obtained each medication from the medication cart and placed them in his dispensing cup, checking off each medication in the eMAR as she prepared them. She was unable to locate RW's MS Contin dose. She searched the medication cart and found another MS Contin dose but it was for a different resident. To conserve time because she was busy, rather than canceling the eMAR order she had started, Ms. Him completed the order and documented that all of RW's evening medications, including the MS Contin, were administered to him. (Test. of Ms. Him.) Ms. Him documented in the eMAR that she administered MS Contin to RW at 7:38 p.m. (Ex. A1 at 7.)

12. Sometime after 8 p.m., Ms. Brandt checked on RW. She found him to be visibly upset, questioning why he had not yet received his medication, and in pain. He asked Ms. Brandt for his pain medication because his pain was worsening. (Exs. A2 at 1; A5 at 1; A6 at 1.) Ms. Brandt asked Ms. Him if she had given RW his evening medications, including the MS Contin. Ms. Him showed Ms. Brandt RW's dispensing cup filled with the previously-prepared evening medications. When Ms. Brandt asked for RW's MS Contin, Ms. Him indicated that she did not have it as it was not in the medication cart. (Ex. A2 at 1; test. of Ms. Brandt.) After confirming that RW's MS Contin was not anywhere in the medication cart, Ms. Brandt contacted the pharmacy, waited for the pharmacy to call back with an authorization number, used the authorization number to extract a dose of MS Contin from the eKit by which time it was 9:30 p.m., and administered it to RW. (Ex. A3 at 4; A6 at 2; test. of Ms. Brandt.) When Ms. Brandt administered the MS Contin to RW, she explained to him about the delay in his receipt of the medication and that it had to be retrieved from the eKit. (Ex. A5 at 2; test. of Ms. Him.) Ms. Him overheard Ms. Brandt's discussion with RW. (Test. of Ms. Him.)

13. Ms. Brandt failed to document in the eMAR her administration of the MS Contin to RW. (Test. of Ms. Brandt.) The entry regarding the administration of MS Contin to RW at 7:38 p.m. was never corrected. (Ex. A1 at 7.)

14. On July 12, 2013, Ms. Him informed RW that she had been disciplined because of the prior evening's delay in the administration of his MS Contin and thought she would lose her job. She asked RW to speak with Ms. Brandt on her behalf because she did not want to lose her job. (Exs. A4 at 1; A6 at 3; test. of Ms. Him.)

15. On July 16, 2013, Robison determined that Ms. Him had violated Robison's policies by not administering a medication as scheduled, by failing to notify the charge nurse that the medication was unavailable, and by documenting the administration of the MS Contin when it had not been given to RW. Robison discharged Ms. Him based upon her having documented that she had administered a medication when she had not done so. (Ex. A3 at 1.) On July 18, 2013, Robison notified Ms. Him of her termination from employment. (Ex. A3 at 3.) As she left Robison's premises after her discharge, Ms. Him informed RW that she had been fired because of the July 11, 2013 incident involving his MS Contin medication. RW indicated that he felt bad for her firing, and Ms. Him suggested he talk to either Robison's chief executive officer or chief operating officer on her behalf. (Test. of Ms. Him.)

16. Approximately July 30, 2013, Ms. Him again contacted RW about her termination and indicated that her license was being suspended. She asked him to contact Robison on her behalf. (Exs. A4 at 1; A6 at 2-3.) Ms. Him also contacted at least two additional Robison residents, MF and BT.³ Ms. Him informed MF, a medically fragile woman, of her termination and requested that MF write a letter on her behalf to Robison. MF found the conversation with Ms. Him distressing. Ms. Him informed BT of her termination and requested that BT talk to, or write to, Robison's chief operating officer or chief executive officer to urge Robison to reinstate Ms. Him to her job. BT was not distressed by her discussion with Ms. Him but she felt sorry for Ms. Him because she knew Ms. Him needed a job. (Exs. A4 at 1-2; A7 at 1.)

17. On July 31, 2013, RW wrote a letter to Robison "to aid [Ms. Him] in getting her job back as well as having the State of Oregon reversing the decision to have her license suspended." (Ex. A5 at 1.) During his prior conversation with Ms. Him, he had agreed to help her so he wrote the letter to Robison even though he felt "odd being asked to intervene in company business." (*Id.* at 2.) RW "felt terrible and very guilty" because he believed he had caused Ms. Him's discharge. (Ex. A4 at 1; test. of Ms. Sacks.) He was also concerned for Ms. Him because she was a widow and had two children. (Ex. A6 at 3.)

18. On July 31, 2013, Robison left messages on Ms. Him's voice mail, informing her that she was not to contact residents and was not allowed on Robison's premises. (Ex. A4 at 1.) Robison was concerned about the psychological well-being of its residents following Ms. Him's contacts with them. (Test. of Ms. Duck.)

19. On September 18, 2013, the Board interviewed Ms. Him. (Ex. A16 at 1.) During the course of the interview, when the Board first asked if she had contacted residents after she was discharged to encourage them to speak to Robison, Ms. Him denied such contacts. (*Id.* at 7.) When she was asked again if she had contacted residents, she then admitted to contacting RW and, later in the interview, admitted to contacting BT about her discharge. (*Id.* at 8, 16, 18.) When the Board asked Ms. Him if she had asked RW to intervene on her behalf with Robison to get her job back, she denied asking for his assistance. (*Id.* at 8.) Later in the interview, Ms. Him also acknowledged encouraging BT to talk to Robison on her behalf. (*Id.* at 18.) Ms. Him informed the Board that she never spoke of her problems in front of residents. Subsequently, she

³ Ms. Him also contacted resident MC. Because MC had a memory impairment, she could not recall the details of her conversation with Ms. Him. Ms. Him made no specific statements about any conversation with MC. (Exs A4 at 1; A16; test. of Ms. Him.)

acknowledged talking to RW about her termination and possible loss of her licensure. She excused her conduct by indicating that RW initiated the contact. She repeatedly told the Board that she did not ask the residents for help until after the residents offered to help her. (*Id.* at 8, 16, 18, 19, 20, 24, 29.) She also noted during the interview that other co-workers discussed personal matters in front of residents. (*Id.* at 24, 29.) In regards to the eMAR entry of MS Contin administered to RW at 7:38 p.m. on July 11, 2013, at one point during the interview, Ms. Him informed the Board that Ms. Brandt was the individual who entered that information in the eMAR using Ms. Him's computer profile. (*Id.* at 14.) Shortly afterwards, Ms. Him acknowledged that she was actually the one who completed that eMAR entry. (*Id.*) Almost immediately after that acknowledgment, she told the Board that she made the entry accidentally by clicking on the wrong part of the computer screen. (*Id.* at 15.) Ms. Him also advised the Board that she had called Ms. Brandt when she first discovered the absence of RW's MS Contin, even though no such call was made.⁴ (*Id.* at 9.)

20. Ms. Him has received numerous commendations from prior supervisors and co-workers. (Ex. R1 at 347-355.) The commendations include the following descriptions:

- Tara is a person totally devoted to her job, who loves the residents like her own family. She is very sensitive to the needs of the residents. She extends help to co-workers whenever and wherever it is needed; (*Id.* at 347.)
- Ms. Him is a kind and hard-working person. Ms. Him exhibits those traits essential to success as a nurse: superb work ethic and a caring and compassionate nature; (*Id.* at 348.)
- As you met this challenge your commitment to providing not only adequate but quality care was most evident; (*Id.* at 349.)
- Thank you for the heart and spirit with which you approach the sacred work of caring for the Residents of Robison Jewish Health Center; (*Id.* at 350.)
- She is an exceptional, hard-working and caring employee. She gets along well with her fellow workers; (*Id.* at 352.)
- She is extremely hard working and sets goals for herself that are commendable. She is forever learning and trying to improve herself. (*Id.* at 353.)
- She is a dedicated worker. I appreciate her skills * * * and in caring for our patients; (*Id.* at 354.)
- These [CMA] assignments are done in a timely, accurate manner. She has a warm, empathetic style that allows her to build a trusting relationship with

⁴ There was considerable testimony presented regarding whether Ms. Him called Ms. Brandt upon her discovery of the missing medication. Based upon the preponderance of the evidence presented during the hearing, the Board concludes that no such call was made.

patients * * *. Her professional demeanor, ethics, and moral content are beyond reproach. (*Id.* at 355.)

21. Currently, Ms. Him continues to work as a medication aide. She began school in the fall of 2014 to obtain the degree necessary for a licensed practical nurse. Her coursework included a review of professional boundaries between medical practitioners and patients. Ms. Him will no longer ask residents for any help and will not discuss her personal matters with them. (Test. of Ms. Him.)

CONCLUSIONS OF LAW

1. Chantara Him engaged in conduct unbecoming a nursing assistant and conduct unbecoming a medication aide.

2. Chantara Him's CNA and CMA certificates should be suspended and she should complete coursework in medication administration and professional boundaries.

OPINION

The Board proposes to suspend Ms. Him's medication aide and nursing assistant certificates and require her to complete professional courses based on allegations of conduct unbecoming a medication aide and nursing assistant. As the proponent of the allegations, the Board has the burden to establish, by a preponderance of the evidence, that the allegations are correct and that it is entitled to assess the proposed sanction. 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). 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).

Conduct Unbecoming a Nursing Assistant and a Medication Aide

ORS 678.442(1) grants the Board the authority to establish standards for the certification of nursing assistants. OAR 851-063-0090 defines conduct unbecoming a nursing assistant. It provides, in part:

A CNA, regardless of job location, responsibilities, or use of the title "CNA," who, in the performance of nursing related duties, may adversely affect the health, safety or welfare of the public, may be found guilty of conduct unbecoming a nursing assistant. Conduct unbecoming a nursing assistant includes but is not limited to:

(1) Conduct related to the client's safety and integrity:

* * * * *

(c) Failing to respect client rights and dignity regardless of social or economic status, personal attributes or nature of health problems or disability;

* * * * *

(2) Conduct related to other federal or state statutes/rule violations:

* * * * *

(g) Using the client relationship to exploit the client by gaining property or other items of value from the client either for personal gain or sale, beyond the compensation for services;

(3) Conduct related to communication:

(a) Inaccurate recordkeeping in client or agency records;

* * * * *

(g) Failing to communicate information regarding the client's status to the supervising nurse or other appropriate person in a timely manner.

* * * * *

(9) Conduct related to the certificate holder's relationship with the Board:

(a) Failing to cooperate with the Board during the course of an investigation. The duty to cooperate does not include waiver of confidentiality privileges, except if a client is harmed. This waiver of confidentiality privileges does not apply to client-attorney privilege[.]

OAR 851-063-0100 defines conduct unbecoming a medication aide.⁵ It provides, in part:

Certified Medication Aides are subject to discipline as CNAs as described in these rules. In addition, CMAs are subject to discipline for conduct unbecoming a medication aide. Conduct unbecoming a medication aide includes but is not limited to:

* * * * *

⁵ A certified medication aide is a certified nursing assistant with additional medication training. OAR 851-063-0020(3).

(2) Failing to document medications as administered, medications withheld or refused and the reason a medication was withheld or refused.

* * * * *

(11) Failing to conform to the standards and authorized duties in these rules.

On July 11, 2013, Ms. Him documented in the eMAR that she had administered RW's MS Contin at 7:38 p.m., when she, in fact, had not administered it. Her failure to accurately document the administration of this medication violates OAR 851-063-0090(3)(a) and OAR 851-063-0100(2).

By 7:38 p.m. on July 11, 2013, Ms. Him was aware that RW's new pain medication MS Contin was not in the medication cart. She failed to communicate that information to Ms. Brandt, the charge nurse, until after Ms. Brandt heard from RW that he had not received his pain medication. It was only when Ms. Brandt subsequently asked Ms. Him if she had given RW his pain medication that she advised the charge nurse of the medication's absence. The evidence demonstrated that RW received his morning MS Contin approximately 10 a.m. When he received it in the evening after its retrieval from the eKit shortly after 9:30 p.m., it was approximately 12 hours after the morning dosage. Therefore, he actually received his evening dose of MS Contin within the time parameters of the physician's order. However, even though RW ultimately received the medication within these time parameters, Ms. Him was obligated to inform the charge nurse of the absence of the medication when she first prepared his evening medications. In the medication's absence, Ms. Him no longer had the ability to insure that she would be able to timely administer RW's medication. Therefore, she needed to immediately communicate this problem about RW's status to the charge nurse, the individual who was capable of obtaining replacement medication from the eKit. Ms. Him's failure to timely advise the charge nurse of the lack of RW's pain medication was a violation of OAR 851-063-0090(3)(g).

On July 12, 2013, Ms. Him informed RW that she had been disciplined for the incident involving his pain medication. On July 18, 2013, she informed RW that she had been fired from her job because of this same incident. Approximately July 30, 2013, she again contacted RW about her discharge from employment and also informed him of the potential loss of her CNA and CMA certificates. About that same time, Ms. Him informed at least two other residents of her termination. In all of her discussions with these residents, she encouraged the residents to contact Robison on her behalf in an attempt to be reinstated to her job. Her discussions with these residents adversely affected the residents' emotions because they all felt badly for Ms. Him losing her job. In particular, RW also felt guilty because, as Ms. Him explained to him, it was the incident involving his pain medication that led to her discharge. Ms. Him failed to respect the residents' rights and dignity by discussing her personal employment troubles with the residents, which harmed the emotional integrity of the residents.⁶ Ms. Him's decision to share her employment troubles with these residents violated OAR 851-063-0090(1)(c).

⁶ Integrity is defined as "an unimpaired or unmarred condition." *Webster's Third New Int'l Dictionary* 1174 (unabridged ed 2002).

In its Notice, the Board also alleged that Ms. Him's conduct violated OAR 851-063-0090(2)(g). This administrative rule concerns the exploitation of a resident by obtaining "property or other items of value" from the resident. *Webster's* defines value as:

The amount of a commodity, service, or medium of exchange that is the equivalent of something else * * * the monetary worth of something * * * relative worth, utility, or importance[.]

Webster's at 2530. These definitions indicate that the "property or other items of value" would need some kind of marketable worth to qualify as exploitation of a resident. In this case, Ms. Him did not obtain property or other items of value from the residents. Ms. Him encouraged BT and MF to speak with Robison's executives on her behalf. Although the potential endorsements from the residents would be for Ms. Him's personal gain, she did not obtain anything of marketable worth from either of these residents. RW did write a letter to Robison on Ms. Him's behalf, but there is no monetary worth associated with the actual letter. Therefore, she did not obtain property or other item of value from RW. Although Ms. Him's conduct in discussing her employment troubles with the residents violated OAR 851-063-0090(1)(c) as explained above, this conduct did not violate OAR 851-063-0090(2)(g).

During the course of her interview with the Board, Ms. Him repeatedly denied engaging in specific conduct, such as contacting residents after her discharge, discussing her discharge and loss of licensure with residents, and encouraging residents to speak with Robison about her discharge. Later in the interview, she admitted to the conduct. In discussions regarding the eMAR, she offered an alternative theory that Ms. Brandt made the 7:38 p.m. administration entry and then acknowledged that she made the administration entry but that she did so accidentally. However, the evidence clearly established that she deliberately made the administration entry in an effort to save her time during her shift. By initially denying conduct she actually committed and by offering alternative theories knowing they were false, Ms. Him failed to cooperate with the Board in violation of OAR 851-063-0090(9)(a).

Suspension of License and Imposition of Conditions

ORS 678.442(2) further provides, in part:

In the manner prescribed in ORS chapter 183, the board may revoke or suspend a certificate issued under this section or may reprimand a nursing assistant for the following reasons:

* * * * *

(f) Conduct unbecoming a nursing assistant in the performance of duties.

OAR 851-063-0080 provides, in part:

Under the contested case procedure in ORS 183.310 to 183.550 the

Board may deny, reprimand, suspend, place on probation or revoke the certificate to perform duties as a CNA for the following causes:

* * * * *

(4) Violation of any provision of ORS 678.010 to 678.445 or rules adopted thereunder; ORS 678.442(2)(d).

* * * * *

(6) Conduct unbecoming a nursing assistant in the performance of duties ORS 678.442(2)(f).

As determined above, Ms. Him engaged in conduct unbecoming a nursing assistant when she failed to respect the residents' rights by discussing her personal employment issues with them, failed to communicate RW's lack of pain medication to the charge nurse in a timely manner, and failed to cooperate with the Board. Ms. Him also engaged in conduct that was both unbecoming a nursing assistant and a medication aide when she inaccurately recorded the administration of RW's MS Contin. In its Notice, the Board seeks to suspend Ms. Him's CNA and CMA certificates and require her to complete professional courses on medication administration and professional boundaries, disciplinary actions authorized by ORS 678.442(2)(f) and OAR 851-063-0080(6).⁷

Ms. Him's conduct involved inaccurate medication administration and the violation of professional boundaries between a medical professional and the residents when she discussed her personal employment matters with the residents. Because she demonstrated a lack of understanding of these subjects, it is appropriate for the Board to require Ms. Him to complete professional coursework in medication administration and professional boundaries.

Ms. Him is a dedicated nursing assistant and medication aide with years of experience in these fields. She strives to complete all assigned work and to provide assistance to co-workers when needed. She demonstrates an active interest and liking for the residents that she serves in this challenging field. However, despite her commendable achievements, her conduct in this matter is egregious enough to justify the 30-day suspension sought by the Board. Prior to the July 11, 2013 incident, Robison had warned Ms. Him about the necessity of following medication orders and to not discuss work grievances with residents. These warnings were all issued within the first half of 2013, so Ms. Him knew that her inaccurate recording of the administration of the MS Contin and her discussion of her discharge with the residents were inappropriate conduct. The discussions of her discharge caused emotional distress to the residents, in particular, RW who felt that her discharge was his fault because it arose from the incident involving his medication.

Rather than accept responsibility for her actions, Ms. Him sought to lay blame for her conduct on co-workers. She falsely accused Ms. Brandt of the inaccurate eMAR entry. She also

⁷ Probation involves the establishment of conditions for continued licensure. A requirement to take professional courses would be such a condition.

focused on other co-workers' errors, such as the charge nurse and medication aide from the earlier shifts who failed to notify her or Ms. Brandt of the absence of RW's MS Contin. Even though these workers did err in not conveying that information, these errors do not excuse Ms. Him's subsequent conduct. Likewise, Ms. Brandt's error in not updating the eMAR to reflect her administration of RW's MS Contin does not excuse Ms. Him's identical failure. Ms. Him repeatedly asserted that she did not ask the residents to contact Robison until after the residents asked how they could help her. Such assertions demonstrate Ms. Him's lack of understanding of her breach of professional boundaries with the residents. Ms. Him fails to recognize that the residents should never have been placed in a position of offering to help her with her employment issues. Finally, Ms. Him's lack of cooperation with the Board, including providing false answers to some of its questions, further support the Board's decision to suspend her certificates for 30 days.

Therefore, the Board is entitled to suspend Ms. Him's nursing assistant and medication aide certificates for 30 days and to require her to complete coursework on medication administration and professional boundaries.

ORDER

The Oregon State Board of Nursing hereby issues the following Final Order:

Chantara Him's certificates as a nursing assistant and medication aide, certificate numbers 000038432CNA and 000038432CMA, are suspended for 30 days from the date of this Final Order.

Chantara Him shall complete two courses, approved by the Board of Nursing, on medication administration and professional boundaries and provide proof of such completion of the coursework to the Board of Nursing.

Kay Carnegie, RN
President,
Oregon State 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 November ____, 2014, I mailed the foregoing Final Order issued on this date in OAH Case No. 1403542.

By: First Class Mail

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