

**BEFORE THE
BOARD OF NURSING
STATE OF OREGON**

IN THE MATTER OF:) **FINAL ORDER**
)
MERLE MCBRYANT) OAH Case No.: 1403930
) Agency Case No.: 14-01235
Certificate No. 200112185CNA)

HISTORY OF THE CASE

On September 24, 2014, the Oregon State Board of Nursing (Board) issued a Notice of Proposed Revocation of Certificate (Notice) to Merle McBryant (Licensee). The Notice alleges that Ms. McBryant engaged in conduct unbecoming a nursing assistant in the performance of duties. Specifically, the Notice alleges that Ms. McBryant failed to assist residents in a timely manner with incontinence care and failed to honor residents' requests for care. For this, the Board proposes to revoke Ms. McBryant's Certified Nursing Assistant (CNA) certificate. On October 11, 2014, Ms. McBryant timely requested a contested case hearing. The Board referred the matter to the Office of Administrative Hearings (OAH) on October 22, 2014. The OAH assigned the case to Senior Administrative Law Judge (ALJ) Jennifer H. Rackstraw.

ALJ Rackstraw convened a telephone prehearing conference on December 5, 2014. Senior Assistant Attorney General Thomas Cowan represented the Board. Attorney Joe B. Richards represented Ms. McBryant.

On May 27, 2015, the OAH reassigned the case to Senior ALJ Monica A. Whitaker. ALJ Whitaker convened a hearing at the Board of Nursing in Portland, Oregon, on June 3, 2015. Mr. Cowan represented the Board and Mr. Richards represented Ms. McBryant. At the commencement of the hearing, Mr. Cowan moved for a protective order to be issued in this matter. Mr. Richards did not oppose the motion. ALJ Whitaker granted the motion for a protective order.¹

The following witnesses testified on the Board's behalf: Board Investigator Shanon Rahimi; CNA Aaron Green; Adult Protective Services Abuse Investigator Frank Moro; Patsy Paulus, R.N.; and Teri Mabie, R.N. Ms. McBryant testified on her own behalf. The record closed at the conclusion of the hearing.

¹ All parties to this proceeding are prohibited from using or disclosing protected health information released by any covered entity for any purpose other than in conjunction with this contested case proceeding or judicial review of this contested case proceeding. In addition, all parties to this proceeding are required to return all protected health information (including all copies) to the person who provided the protected health information or to destroy all such protected health information (including copies) at the conclusion of this contested case proceeding, or judicial review of this contested case proceeding, whichever is later, and provide such certification to the person of the destruction.

ALJ Whitaker issued a Proposed Order on June 11, 2015. Licensee was notified of her right to file exceptions with the Board within 10 days following the date of service of the Proposed Order. The Board did not receive any exceptions from Licensee within those 10 days.

At its Board meeting on July 15, 2015, the Board deliberated regarding the Proposed Order and voted to accept the Proposed Order. The Board now issues this Final Order. The Board has not made any changes to the Proposed Order that substantially modifies the ALJ's proposed findings of historical fact or changes the ALJ's recommended outcome or basis therefore. The Board has made changes to the Proposed Order to correct spelling, grammar, and/or textual placement.

ISSUES

1. Whether, while working as a CNA, Ms. McBryant repeatedly failed to assist residents in a timely manner with incontinence care and failed to honor residents' requests for care, thereby engaging in conduct unbecoming a nursing assistant in the performance of duties. *Former* OAR 851-063-0090(1)(c) and (2)(d).²
2. If so, whether the Board may revoke Ms. McBryant's Certified Nursing Assistant certificate. ORS 678.442(2)(f) and *former* OAR 851-063-0080(6).³

EVIDENTIARY RULING

The Board's Exhibits A1 through A10 were admitted into the record without objection.

FINDINGS OF FACT

Background Information

1. The Board first licensed Ms. McBryant as a CNA on September 27, 2001. Her license is set to expire on July 14, 2015.⁴ (Ex. A10 at 7.)
2. Good Samaritan Society, Eugene Village (the employer) employed Ms. McBryant as a CNA in a skilled nursing facility (the facility) beginning in April 2013. (Test. of Paulus and Mabie.) Ms. McBryant typically worked the midnight shift, which ended at 6:00 a.m. When Ms. McBryant worked the midnight shift, she worked alone. (Test. of Mabie.) The employer expected her to check on its residents at least every two hours. (Test. of Green; Ex. A8 at 11.)

² The Board amended this administrative rule effective January 1, 2015. The version of the rule cited herein was in effect at the time the alleged conduct occurred.

³ The Board amended this administrative rule effective January 1, 2015. The version of the rule cited herein was in effect at the time the alleged conduct occurred.

⁴ Ms. McBryant is currently licensed as a CNA2. (Ex. A10 at 7.)

3. Ms. McBryant's job description included, in part, the following requirements:

A. Resident Personal Care:

Provides personal care for residents without rushing them and with a respectful attitude according to the plan of care. Explains procedures to residents before and during cares; promotes highest level of self-care. Maintains resident-centered conversations while caring for residents. Included bathing, grooming, dressing/undressing, vital signs and other personal cares. Provides post mortem care in a caring and sensitive manner.

* * * * *

C. Promotes the highest level of resident mobility and continence functioning through restorative care techniques:

* * *. Assists residents with toileting needs reinforcing bowel and bladder training.

* * * * *

E. Resident Rights:

Maintains residents' self esteem[.]

(Ex. A1 at 1.)

4. At the employer's facility, residents have the right to direct their care. Some residents prefer to use a toilet rather than a commode. If a resident elects to use the toilet, the employer expects its CNAs to honor that resident's request. (Test. of Mabie.)

5. The employer implemented a progressive discipline policy, whereby it would coach and counsel employees before providing the employee with a formal written warning, suspension, and, eventually, termination. (Test. of Mabie.)

6. Ms. Paulus, the employer's resident care manager in the long-term unit, supervised Ms. McBryant. Ms. Paulus received reports from CNAs whose shifts started after Ms. McBryant's shift ended that Ms. McBryant had failed to complete her work before completing her shift, including changing wet bedding and placing call lights for residents. On one occasion, Ms. Paulus found a resident, who was not incontinent but needed assistance walking to the bathroom, sitting in a urine soaked bed. The resident was very cold and when questioned by Ms. Paulus about what occurred, the resident reported that she had turned on her call light and waited a long time, but no one responded and the resident urinated in her bed. Ms. McBryant would have been the CNA expected to respond to the resident's call light. When Ms. Paulus tried to

coach Ms. McBryant regarding the incident, Ms. McBryant responded that the resident was dry when she checked on the resident. (Test. of Paulus.)

7. In or about August 2013, the employer received a complaint that a resident had asked Ms. McBryant to take off his splint, which she refused to do. In addition, the resident alleged that he asked Ms. McBryant to assist him with using his urinal, that she did not give him enough time to finish using it, and that Ms. McBryant acted as though she did not care what the resident was requesting. (Ex. A2 at 4.) When the employer interviewed the resident, he was very tearful when describing the incident. (Test. of Paulus.)

8. On or about August 9, 2013, the employer met with Ms. McBryant and provided her with counseling and coaching regarding the resident's complaint. In a coaching and counseling note, the employer wrote, in part:

It is important to acknowledge what the resident says and to give the resident time to explain his wants and needs. It is also important not to hurry the residents but to make them feel like they have your undivided attention. This resident did not want to file a formal complaint but he has requested to not have you in his room again.

(Ex. A2 at 4.)

9. On or about August 15, 2013, the employer received a complaint/concern from CNA Aaron Green. Mr. Green, who generally worked the shift immediately following Ms. McBryant's shift, wrote in the complaint:

When Megan and I checked on [resident 1]⁵ in 709 there was dr[ie]d urin[e] stains from the night befor[e] and we were told by Mer[le] that she had changed and checked on her. [Resident 2] told us she didn't have her call light all night and she had[n't] been checked on all night.

(Ex. A2 at 5.)

10. On December 4, 2013, the employer placed Ms. McBryant on a Performance Improvement Plan (PIP). The PIP noted that Ms. McBryant should not wear headphones while on duty because it "is hard for you to hear call li[ghts] or a resident calling out for help." (Ex. A2 at 6.) After placing Ms. McBryant on the PIP, the employer met with her weekly for coaching and counseling. Despite giving Ms. McBryant positive written feedback regarding her work performance, Ms. McBryant refused to sign any of the written coaching and counseling statements. (*Id.* at 7; test. of Paulus.)

11. On or about January 2, 2014, the employer received a written complaint that Ms. McBryant had hurt a resident while putting the resident in her bed. (Ex. A2 at 8.)

⁵ To protect the identity of the residents, their names are not used in this order.

12. The employer investigated the complaint by interviewing the resident who alleged the injury. (Ex. A2 at 10.) The resident reported that Ms. McBryant had refused to allow her to use the toilet and instead insisted that the resident use a commode. Eventually, at the resident's insistence, Ms. McBryant assisted the resident to the toilet. When assisting the resident from the toilet to the resident's bed, the resident requested that she climb into bed in a specific manner. The resident, who had significant back issues and attended physical therapy, wanted to get in the bed in the manner in which her physical therapist had recommended. Ms. McBryant ignored the resident's request and had the resident get back in the bed in a manner that caused the resident "so much pain." (Ex. A2 at 10.) The resident reported that she "began to cry and begged her to put the head of the bed up because I was in so much pain. * * *. Was crying and having a hard time breathing and told her I needed help. * * *. I just la[i]d there and cried. She did not try to help me[.]" (*Id.*)

13. On January 2, 2014, the employer provided Ms. McBryant with a Corrective Action Notice – Written Warning. (Ex. A2 at 9.) The notice stated that Ms. McBryant had been inconsiderate in her treatment of others and that "[e]ach resident/patient has the right to considerate treatment, assisting with their own care, and directing their own care regarding ADL's." (*Id.*)

Adult Protective Services Investigation

14. On February 25, 2014, Adult Protective Services (APS), Senior & Disabled Services, received a complaint that the employer had failed to provide appropriate care at the facility. (Ex. A5 at 2.) The complaint alleged that Ms. McBryant would consume alcohol before arriving to work; that she did not change residents who were incontinent; that she told a resident to urinate in his or her bed; that she left a resident in feces all night; and that she had been disciplined numerous times by the employer. (*Id.* at 4.)

15. As a result of the complaint, on February 25, 2014, APS Abuse Investigator Frank Moro opened an investigation. (Ex. A5 at 1-2.) As part of the investigation, Mr. Moro interviewed the reported victims (RV1 and RV2), Mr. Green, Mr. Phillips, a CNA at the employer's facility, Ms. Mabie, and the facility's director, Mr. Chadick. (*Id.* at 4-8; test. of Moro.)

16. During Mr. Moro's investigation, RV1 reported that despite asking Ms. McBryant for a urinal, he did not receive one and was instructed by Ms. McBryant to urinate in his bed. RV1 also reported that he had to "lay in pee" and felt "neglected." (Ex. A5 at 4.)

17. During Mr. Moro's investigation, RV2 reported that her incontinence care was delayed and that she did not know if anyone was checking on her during the night. (Ex. A5 at 4.)

18. During Mr. Moro's investigation, Mr. Phillips reported that there were several occasions when Ms. McBryant said she had changed a patient's brief, but he would find the patient in a brief that was soaked with urine or that contained dried feces. Mr. Phillips also reported that he would find dried stool "on a patient's bottom." (Ex. A5 at 5.) Mr. Phillips also reported that there were several times when he came on shift after Ms. McBryant and found that

patients had not been checked by Ms. McBryant during the night. In Mr. Phillips' opinion, the volume of urine in the briefs and the amount of dried feces he would find were inconsistent with Ms. McBryant's claims that she had just changed a patient. (*Id.*)

19. During Mr. Moro's investigation, Mr. Green reported that when started his work shift, he could tell that Ms. McBryant had not checked on patients for hours because of the amount of urine he would find in their briefs or on their bedding. (Ex. A5 at 5-6.)

20. When Mr. Moro interviewed Ms. McBryant regarding the allegations, she denied any wrongdoing. Ms. McBryant reported that she would "[s]tick around after my shift has ended and help them [other staff] change the residents." (Ex. A5 at 7.) Ms. McBryant also reported that other staff members "don't want to do their job." (*Id.*)

21. After completing his investigation, Mr. Moro concluded that RV1 was alert and oriented, could easily track the conversation, and was able to articulate a coherent and detailed account of the incident in question. Mr. Moro also concluded that RV2 was very articulate, alert and oriented (but would occasionally lose her train of thought), and had difficulty remembering the event in question, but could track the conversation and responded to questions with appropriate answers. Finally, Mr. Moro concluded that Ms. McBryant deflected all allegations of neglect and shifted any blame to other staff and denied any wrongdoing on her part. (Ex. A5 at 7.)

22. Mr. Moro prepared a report with his investigative findings in which he concluded the following:

- Ms. McBryant failed to check or change incontinent residents during her shift;
- Ms. McBryant failed to provide urinals or other means to residents who request assistance;
- Ms. McBryant subjected multiple residents to laying in their own urine and feces for hours;
- Ms. McBryant directed residents to relieve themselves in their beds.

(Ex. A5 at 8.)

The Employer's Investigation

23. On February 26, 2014, the employer suspended Ms. McBryant after learning that APS was investigating a complaint involving the facility and Ms. McBryant. (Ex. A2 at 17.) Thereafter, the employer began an investigation into Ms. McBryant's treatment of patients. The employer interviewed a number of facility residents and employees. (*Id.* at 18-78.)

24. When interviewing resident MF, MF reported that on one occasion, she did not have her call light so she called out for help, but no one responded. MF became upset, felt stranded, and was worried no one would respond if she needed help. MF reported that she had asked Ms. McBryant to clip the call light on MF's nightgown, but Ms. McBryant had refused. MF also reported that Ms. McBryant referred to her as a "silly old woman." (Ex. A2 at 25.)

25. In an interview with Nathan Alpers, a CNA whose shift generally started after Ms. McBryant's ended, he reported that in the week prior to the interview, he had found a resident in room 711 "covered in poop, dried on the sheet as well as her legs." (Ex. A2 at 30.)

26. In an interview with Mr. Green, he reported that at approximately 6:30 a.m. on February 21, 2014, after Ms. McBryant's shift had ended, he found a resident, AZ, in a urine soaked brief and under pad. (Ex. A2 at 35.) Also on February 21, 2014, Mr. Green found another resident, JS, with "dried stool on her bottom and she had stool in her brief and her bed pad was soaked and her bed had dried urine stains[.]" (*Id.*) Ms. McBryant had reported changing JS at about 5:00 a.m., but based on the amount of urine in JS's brief, Mr. Green did not believe JS had been changed for several hours. (*Id.*; test. of Green.) Mr. Green also reported finding another resident, H, in a urine soaked brief that morning. (Ex. A2 at 35.)

27. Mr. Green reported that on or about February 14, 2014, at approximately 7:00 a.m., he found a resident in a "dirty bed." (Ex. A2 at 35.) He described her sheets as "really nasty looking" and that her "pull[-] up was needing to be changed badly." (*Id.*) Mr. Green described the pull-up as containing a moderate amount of blood and feces. (*Id.*)

28. Mr. Green also reported that on February 16, 2014, Ms. McBryant stated that she had changed a resident in room 707. Approximately five minutes after Ms. McBryant made this statement, the resident called and stated that she was soaking wet and that her brief had not recently been changed. (Ex. A2 at 36.)

29. In an interview with Charge Nurse Julia McKeough, Ms. McKeough reported that during one evening shift Ms. McBryant was working, Ms. McBryant did not answer call lights for rooms to which she was assigned. Ms. McKeough tried three times, unsuccessfully, to page Ms. McBryant in an attempt to locate her. (Ex. A2 at 51.)

30. The employer interviewed CNA Alice Owens, who reported that Ms. McBryant was "real bad about answering call lights to the extent that by the time I get in the patient[']s room they are sometimes upset." (Ex. A2 at 61.) Ms. Owens described one incident where she responded to a call light belonging to a resident assigned to Ms. McBryant and found the resident sitting on a bedside commode. The resident was angry and agitated because she had been sitting on the commode for a long period of time. (*Id.*)

31. The employer interviewed CNA Darrell Phillips, who reported that in the week prior to the interview, a resident was upset because she had been laying in a urine soaked bed. The resident had taken off her brief because it was so full of urine. The resident's bedding had to be changed and her mattress had to be disinfected because it was urine soaked. (Ex. A2 at 71.)

32. When the employer interviewed Ms. McBryant regarding the allegations, Ms. McBryant contended that she regularly checked on residents and changed them. (See Ex. A2 at 79-83.)

33. On March 7, 2014, the employer terminated Ms. McBryant after concluding that she had engaged in a pattern of behavior which was inconsistent with residents' care plans and/or resident wishes regarding care. (Ex. A2 at 84.)

Other information

34. By letter dated March 11, 2014, the Board notified Ms. McBryant that it had received a complaint related to her performance as a CNA.⁶ The letter informed Ms. McBryant that it would be investigating the allegations raised in the complaint and requested Ms. McBryant contact the Board.

35. On April 29, 2014 Board Investigator Shanon Rahimi interviewed Ms. McBryant. During the interview, Ms. McBryant contended that she did not have any problems with the facility's residents, but rather with CNAs at the facility because they did not like that she corrected their errors. (Ex. A8 at 7-8.) Ms. McBryant also asserted that she had reported other CNAs to the employer for failing to provide appropriate care to residents and that those CNAs had essentially retaliated against her by filing their own complaints about her job performance. Ms. McBryant also asserted that her final rounds on her shift were at 4:30 a.m. and that she would do her best to check on the residents again at 6:00 a.m., when her shift ended. In Ms. McBryant's opinion, residents would be wet by the time the other CNAs started their shifts because approximately two hours had gone by since she completed her rounds. (*Id.* at 9.)

36. On May 6, 2014, the Oregon Department of Human Services (DHS), Office of Licensing and Regulatory Oversight, issued a Letter of Determination (Determination) to the employer and the Board. (Ex. A9.) The Determination found that the facility failed to provide appropriate peri care and that the residents experienced a loss of dignity. The Determination found that Ms. McBryant failed to assist RV1 and RV2 with timely incontinence care. This, the Determination found, resulted in neglect of resident care and a great loss of resident dignity, both of which constitute abuse under DHS's administrative rules. (*Id.* at 1.)

37. On or about May 16, 2014, DHS's Office of Licensing and Regulatory Oversight issued a Notice of Intent to Place Finding of Abuse on Certified Nurse Assistant Registry – Final Order By Default (Default Order), to Ms. McBryant. (Ex. A10 at 4-6.) The Default contained, in part, the following facts and conclusions:

⁶ The complaint alleged that Ms. McBryant consumed alcohol prior to her shift and neglected soiled residents while working for the employer. (Ex. A6 at 1.)

Merle L. Mc[B]ryant, a Certified Nurse Assistant, has been found responsible for neglect.

RP2⁷ failed to assist RV1 or RV2 in a timely manner with incontinence care. RV1 reported asking RP2 for a urinal, did not receive the urinal, “was told to pee in my bed and laid in the pee[.]” RV1 reported feeling neglected by RP2. RV2 reported incontinence care is delayed. W1 and W2 reported coming on shift after RP2 on multiple occasions to find residents with dried feces on their body and urine soaked. W3, administrative staff, knew of RP2’s poor performance and resident complaints from July 2013 through January 2014 and provided warning, but kept RP2 on night shift[,] which has less supervision. W4, administrative staff, directed the investigator to speak with W3, but would also be aware of RP2’s poor performance and resident complaints. RP2 failed to honor resident requests for care; and failed to provide incontinence care resulting in neglect of care and great loss of resident dignity which constitutes abuse[.]

A finding of abuse shall be placed against his/her certification 200112185CNA on the Nurse Assistant Registry maintained by the Oregon State Board of Nursing.

(*Id.* at 4-5; emphasis in original.) If Ms. McBryant disagreed with the findings contained in the Default Order, she could have appealed it to the Oregon Court of Appeals, but did not do so. (*See id.* at 6; test. of McBryant.)

38. After receiving a copy of the Default Order, the Board placed a finding of abuse against Ms. McBryant’s CNA certificate. (*See Ex. A10 at 7.*)

CONCLUSIONS OF LAW

1. While working as a CNA, Ms. McBryant failed to assist residents in a timely manner with incontinence care and failed to honor residents’ requests for care, thereby engaging in conduct unbecoming a nursing assistant in the performance of duties.
2. It is appropriate that the Board revoke Ms. McBryant’s Certified Nursing Assistant certificate.

OPINION

In its Notice, the Board alleged that Ms. McBryant repeatedly failed to assist residents in a timely manner with incontinence care and failed to honor residents’ requests for care. The Board alleges this constitutes conduct unbecoming a nursing assistant in the performance of duties. For this alleged violation, the Board proposed to revoke Ms. McBryant’s CNA certification. The Board bears the burden of proving its allegations by a preponderance of the

⁷ RP2 refers to Ms. McBryant. (Test. of Moro.)

evidence. ORS 183.450(2) and (5); *Reguero v. Teachers Standards and Practices Commission*, 312 Or 402, 418 (1991) (burden is on Commission in disciplinary action); *Cook v. Employment Div.*, 47 Or App 437 (1980) (in the absence of legislation adopting a different standard, the standard of proof in administrative hearings is preponderance of the evidence). Proof by a preponderance of the evidence means that the fact finder is convinced that the facts asserted are more likely true than false. *Riley Hill General Contractor v. Tandy Corp.*, 303 Or 390, 402 (1987).

1. Conduct unbecoming

Former OAR 851-063-0090 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:

* * * * *

(e) Neglecting a client. The definition of neglect includes but it is not limited to unreasonably allowing a client to be in physical discomfort or be injured[.]

In her interviews with Mr. Moro and the Board, Ms. McBryant denied neglecting residents and insisted that she routinely checked on patients, provided them with the care they needed, and that she never left them in dirty briefs or bedding. However, the overwhelming evidence establishes otherwise.

On one occasion, Ms. McBryant refused to assist a resident with using a urinal and instead instructed the resident to urinate in his bed. The resident was thereafter left in his own urine and felt neglected. On another occasion, Ms. McBryant initially refused to assist a resident with using the toilet and instead insisted that the resident use a commode. It was only after the resident insisted that she be allowed to use the toilet that Ms. McBryant provided the resident

with the assistance necessary to walk to the toilet. When she placed the resident back in bed, Ms. McBryant caused the resident pain, to the point where the resident cried and experienced difficulty breathing.

Another resident reported that her incontinence care was delayed and that she did not know if anyone checked on her during the night. On several occasions, other CNAs coming on shift after Ms. McBryant's shift ended found residents in urine soaked briefs, found dried feces in the briefs or on the resident, and found residents' bedding soiled or stained. On one occasion, a resident had been left to sit in her urine soaked brief and bedding for such an extended period of time that her mattress was also urine soaked.

In addition, the evidence establishes that on more than one occasion, Ms. McBryant did not respond to resident call lights in a timely manner or at all. Charge Nurse McKeough reported that on one occasion, Ms. McBryant did not answer call lights for rooms to which she was assigned. Ms. McKeough tried, without success, to page Ms. McBryant three times in an attempt to locate her. On another occasion, Ms. McBryant failed to respond to a resident's call light. CNA Owens responded to that resident's call light and found the resident sitting on a bedside commode. The resident was angry and agitated because she had been sitting on the commode for a long period of time and did not receive the assistance she needed.

Ms. McBryant's contentions that she always provided adequate care to residents and that she routinely checked on them at the end of her shift are self-serving and implausible. If, as Ms. McBryant contends, she regularly checked on residents and changed them prior to ending her shift, the residents would not have had urine stained or soaked bedding or briefs and the residents would not have been found with dried feces in their briefs or on their person. Moreover, the complaints the employer received, the residents' statements during numerous interviews, and the statements provided by the CNAs are consistent and similar. They all involve detailed descriptions that establish Ms. McBryant failed to assist residents in a timely manner with incontinence care and that she failed to honor residents' requests for care.

The Board defines "conduct unbecoming a nursing assistant" to include conduct related to the client's safety and integrity, including failing to respect client rights and dignity. It is undisputed that allowing a resident to sit in urine or feces poses significant health and hygiene concerns. Failing to provide residents with the care they both request and require demonstrates a lack of respect and an unwillingness to maintain residents' dignity. The preponderance of the evidence demonstrates that Ms. McBryant neglected the residents entrusted in her care, and that she engaged in conduct unbecoming a nursing assistant.

2. Revocation of CNA certificate

ORS 678.442 provides, in part:

- (2) 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.

Former 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:

* * * * *

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

The Board has established by a preponderance of the evidence that Ms. McBryant engaged in conduct unbecoming a nursing assistant. Under the above statute and rule, the Board may sanction Ms. McBryant for this conduct. In this matter, the Board proposed to revoke Ms. McBryant's CNA certificate, the most severe sanction it can impose. Here, Ms. McBryant's behavior was serious and posed a significant risk to the health and well-being of the facility's residents. In addition, Ms. McBryant demonstrated a lack of regard for the dignity of the residents affected by her behavior. Ms. McBryant has not acknowledged any of her behavior or shown an understanding for the impact of her behavior. Considering all of these factors, revocation of Ms. McBryant's CNA certificate is appropriate.

ORDER

The Oregon State Board of Nursing issues the following Order:

Merle McBryant's Certified Nursing Assistant certificate numbered 200112185CNA is hereby REVOKED.

DATED this _____ day of July 2015.

FOR THE OREGON STATE BOARD OF NURSING

Gary Hickmann, R.N.

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.*