STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF NURSING,

Petitioner,

vs. Case No. 15-1868PL

DESHON A. DAVIS, C.N.A.,

Respondent.
_____/

RECOMMENDED ORDER

An administrative hearing in this case was held by video teleconference on July 15, 2015, in Sebastian and Tallahassee, Florida, before William F. Quattlebaum, Administrative Law Judge, Division of Administrative Hearings.

APPEARANCES

For Petitioner: Lucas May, Esquire
Judson Searcy, Esquire
Ann Lewis Prescott, Esquire
Department of Health
Prosecution Services Unit
Bin C-65
4052 Bald Cypress Way
Tallahassee, Florida 32399

For Respondent: Jamison Jessup, Qualified Representative
557 Noremac Avenue
Deltona, Florida 32738

STATEMENT OF THE ISSUE

The issue in this case is whether the allegations set forth in the First Corrected Amended Administrative Complaint filed by

the Department of Health (Petitioner) against Deshon A. Davis, CNA (Respondent), are correct, and, if so, what penalty should be imposed.

PRELIMINARY STATEMENT

By First Corrected Amended Administrative Complaint dated April 6, 2015, the Petitioner alleged that the Respondent, a certified nursing assistant (CNA), engaged in sexual misconduct and otherwise practiced outside the scope of his CNA license. The Respondent disputed the allegations and requested an administrative hearing. The Petitioner forwarded the request to the Division of Administrative Hearings, which scheduled and conducted the proceeding.

At the hearing, the Petitioner presented the testimony of five witnesses, and had Exhibits numbered 1 through 3, 4 (except pages 20 through 22, 24, and 25), and 5 admitted into evidence. The Respondent testified on his own behalf, presented the testimony of two witnesses, and had Exhibit numbered 3 admitted into evidence.

A Transcript of the hearing was filed on August 4, 2015. Both parties filed proposed recommended orders that have been considered in the preparation of this Recommended Order.

FINDINGS OF FACT

1. The Petitioner is the state agency charged by statute with regulating the practice of nursing assistance.

2. At all times material to this case, the Respondent was licensed as a CNA in the State of Florida, holding license no. CNA 274735.

3. At all times material to this case, the Respondent was employed as a CNA by Health First Cape Canaveral Hospital (hereinafter "Hospital") in Cocoa Beach, Florida.

4. On April 23, 2014, Patient K.H. (hereinafter "patient") was admitted to the Hospital. The patient was discharged from the Hospital on May 1, 2014.

5. During the time the patient was admitted to the Hospital, he was able to speak; able to get out of his bed and exit the room; and able to use the bathroom without assistance.

6. On April 25, 2014, the patient contacted Hospital authorities and reported that on the two previous days, the Respondent had committed sexual misconduct.

7. At the hearing, the patient testified that on April 23, 2014, the Respondent entered the room and stated that he needed to bathe the patient.

8. The Respondent testified that the patient had soiled his clothing, and that he entered the room to remove the clothing, clean the patient, and provide fresh clothing to the patient.

9. At the time, the patient was in a semi-private room, with another patient in the other bed. The Respondent pulled the

privacy curtain around the patient's bed to separate the beds and to shield the patient from view.

10. The patient testified that the Respondent removed the patient's clothing, applied an unidentified lotion to the patient's penis, and roughly manipulated the patient's penis in a masturbatory manner for at least five minutes until the patient ejaculated. The patient testified that the Respondent then exited the room, leaving the patient to wipe off the ejaculate.

11. Although the patient testified that he requested that the Respondent cease the manipulation, the patient made no apparent effort to get out of the bed or to contact anyone for assistance during the alleged event.

12. The Respondent denied that he applied a lotion to the patient's penis or that any sexual contact occurred on April 23, 2014.

13. The Respondent testified that while he was cleaning the patient, he observed a "rash" on the patient's thigh, and that he applied a "barrier cream" to the rash.

14. Although the Respondent testified that he informed the Hospital nursing staff about the rash on April 23, 2014, the registered nurses assigned to care for the patient testified that they had no recollection that the Respondent advised them that the patient had a rash.

15. The patient's medical records contain no documentation of a rash or of the application of any medication related to a rash.

16. No nurse approved or directed the application of any substance to the patient for a rash.

17. The patient testified that the second incident occurred on or about April 24, 2014. Although the patient had been moved to another semi-private room, only the Respondent and the patient were present in the room at the time of the alleged event.

18. The patient testified that the Respondent entered the room, made a comment about the patient "bringing in rashes," exposed the patient's genital area, and then again, after applying a lotion to his penis, roughly manipulated the patient's penis in a masturbatory manner for approximately ten minutes until the patient ejaculated. The patient testified that the Respondent left the room, and the patient had to again clean himself.

19. Again, although the patient testified that he asked the Respondent to cease the sexual manipulation, the patient made no apparent effort to get out of the bed or to contact anyone for assistance.

20. The Respondent denied the alleged sexual contact. The Respondent testified that he entered the patient's room because the patient's "call light" was on.

21. The Respondent testified he heard the patient say "ouch" while using a plastic urinal. The Respondent testified that he thereafter observed a "cut" on the patient's penis. He also testified that the thigh rash was still visible.

22. The Respondent suggested that abrasions caused by plastic urinals are not uncommon. There is no credible evidence that the patient's penis was injured on April 24, 2014, whether by a plastic urinal or otherwise.

23. The Respondent testified that after he obtained the patient's consent, he applied the "barrier cream" to the patient's penis and thigh.

24. There is no evidence that the Respondent advised the Hospital nursing staff about any injury to the patient's penis. The patient's medical records contain no documentation of a wound or abrasion on the patient's penis or of a rash on his thigh. No nurse approved or directed the application of any substance to the patient for a wound or a rash.

25. On April 25, 2014, the patient contacted Hospital authorities and reported the alleged sexual improprieties.

26. The patient's medical records indicate that from the time of the patient's Hospital admission on April 23, 2014, until April 25, 2014, the patient had been resting and calm.

27. According to the Hospital's representatives who spoke to the patient on April 25, 2014, he was emotional and "very distraught" while describing the alleged activities.

28. A physical examination of the patient was conducted on April 25, 2014, during which no visible rash on the thigh or injury to the penis was observed.

29. According to the expert testimony of Lynda Tiefel, R.N., a CNA must report the presence of a wound or a rash on a patient to a registered nurse. It is the responsibility of the registered nurse to assess the condition and determine whether a physician referral should occur. Other than reporting the condition to the nurse, a CNA should take no action unless directed to do so by the nurse. Ms. Tiefel's testimony was persuasive and has been credited.

30. According to the expert testimony of Victor Mendez, C.N.A., a CNA is not qualified to diagnose a medical condition. A CNA is required to document the presence of a rash or wound, and advise the appropriate registered nurse of the condition. The CNA may apply medication to a rash or wound only after receiving direction to do so from the registered nurse, and such application should take no more than 15 seconds. Mr. Mendez's testimony was persuasive and has been credited.

31. The Hospital conducted an internal investigation regarding the allegations, and subsequently terminated the Respondent's employment.

CONCLUSIONS OF LAW

32. The Division of Administrative Hearings has jurisdiction over the parties to and subject matter of this proceeding. §§ 120.569 and 120.57(1), Fla. Stat. (2014).

33. In this case, the Petitioner is seeking to impose discipline against the Respondent's license. In order to prevail, the Petitioner must demonstrate the truthfulness of the allegations in the Corrected Amended Administrative Complaint by clear and convincing evidence. Dep't of Banking & Fin. v. Osborne Stern & Co., 670 So. 2d 932 (Fla. 1996); Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987).

34. In order to be "clear and convincing," the evidence must be "of such weight that it produces in the mind of the trier of fact a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established." See Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983).

35. Because the discipline imposed for the violations addressed herein are penal in nature, the statutes alleged to have been violated must be strictly construed in favor of the licensee. See Breesmen v. Dep't of Prof'l Reg., Bd. of Med., 567 So. 2d 469 (Fla. 1st DCA 1990); Farzad v. Dep't of Prof'l

Reg., 443 So. 2d 373 (Fla. 1st DCA 1983); Bowling v. Dep't of Ins., 394 So. 2d 165 (Fla. 1st DCA 1981).

36. Where the licensee is charged with a violation of professional conduct and the specific acts or conduct required of the professional are explicitly set forth in the statute, or valid rule promulgated pursuant thereto, the burden on the agency is to show a deviation from the statutorily-required acts; but where the agency charges negligent violation of general standards of professional conduct, i.e., the negligent failure to exercise the degree of care reasonably expected of a professional, the agency must present expert testimony that proves the required professional conduct, as well as the deviation therefrom. Purvis v. Dep't of Prof'l Reg., 461 So. 2d 134 (Fla. 1st DCA 1984).

37. Count I of the First Corrected Amended Administrative Complaint charges the Respondent with sexual misconduct. In relevant part, section 464.204(1)(b), Florida Statutes (2014), provides that the Petitioner may impose disciplinary sanctions for intentionally violating any provision of chapter 456, Florida Statutes. Section 456.072(1)(v), Florida Statutes, provides that engaging or attempting to engage in sexual misconduct as defined and prohibited in section 456.063(1), constitutes grounds for disciplinary action.

38. Section 456.063(1) provides as follows:

> Sexual misconduct in the practice of a health care profession means violation of the professional relationship through which the health care practitioner uses such relationship to engage or attempt to engage the patient or client, or an immediate family member, guardian, or representative of the patient or client in, or to induce or attempt to induce such person to engage in, verbal or physical sexual activity outside the scope of the professional practice of such health care profession. Sexual misconduct in the practice of a health care profession is prohibited.

39. According to the patient, the first alleged sexual contact occurred on April 23, 2014, while another person occupied the other bed located in the room. Although the patient was capable of getting out of bed and exiting the room or calling for assistance to stop the alleged sexual contact, the patient made no genuine attempt to resist or terminate the event, which, by his testimony, allegedly continued for approximately five minutes until he ejaculated. The patient testified that the Respondent left the patient without cleaning the ejaculate.

40. According to the patient, the second alleged sexual contact occurred on the next day, when, presumably, the patient would have been familiar with the Respondent and aware of the previous day's offensive contact. Again, the patient was capable of getting out of bed and exiting the room or calling for assistance, but he did neither. The alleged sexual contact

continued for a period of ten minutes, again by his testimony, until he ejaculated at the conclusion of the event. The patient testified that the Respondent again left the patient without cleaning the ejaculate. A day later, the patient reported the allegations of sexual misconduct to Hospital officials.

41. The patient's testimony regarding the Respondent's alleged sexual misconduct was somewhat confusing and various details were unclear. However, nothing in the patient's behavior, as documented by the medical records or testimony of witnesses, suggested that anything was amiss until, appearing to be emotional and distraught on April 25, 2014, he reported the two instances of sexual misconduct to the Hospital.

42. It is reasonable to expect that an adult with the ability to resist or terminate uninvited sexual contact from another adult would do so. It is reasonable to presume that such an adult would act to prevent a previous perpetrator from further uninvited sexual contact. It is reasonable to expect such an adult to appropriately report the sexual contact without delay.

43. The fact that the patient in this case made no genuine effort to resist or prevent the alleged contact and delayed in reporting the allegations, does not mean that the contact did not occur. Neither does the fact that, by all reports, the patient's demeanor was unremarkable until the day he reported his complaint to the Hospital. But considered in its entirety, the patient's

testimony is insufficient to produce "in the mind of the trier of fact a firm belief or conviction, without hesitancy" that the Respondent committed the alleged sexual misconduct. As to Count I of the First Corrected Amended Administrative Complaint, the Petitioner has not met the burden of proof.

44. Count II charges the Respondent with practicing outside the scope of his license. In relevant part, section 464.204(1)(b) provides that the Petitioner may impose disciplinary sanctions for intentionally violating any provision of chapter 456. In relevant part, section 456.072(1)(o) provides that "practicing or offering to practice beyond the scope permitted by law or accepting and performing professional responsibilities the licensee knows, or has reason to know, the licensee is not competent to perform" constitutes grounds for disciplinary action. As to Count II, the Petitioner has met the burden of proof.

45. The Respondent's application of medication in this case was outside the scope of his CNA license. Florida Administrative Code Rule 64B9-15.002 provides that a CNA may provide assistance in tasks associated with personal care, including skin care, "only under the general supervision of a registered nurse or licensed practical nurse." Specifically, rule 64B9-15.002(5) states: "[A] certified nursing assistant shall not work

independently without the supervision of a registered nurse or a licensed practical nurse."

46. The Respondent has acknowledged applying a "barrier cream" to the patient's thigh and penis.

47. The Respondent testified that the patient had a rash on his thigh, but he did not report the rash to a nurse, no other witness observed a rash on the patient's thigh, and no rash is documented in the medical records.

48. The Respondent testified that the patient had a "cut" on his penis, but he did not report it to a nurse. No other witness observed the purported wound, and none is documented in the medical records.

49. According to expert testimony presented at the hearing, a CNA must report a rash or wound to a registered nurse and must provide only such treatment as is directed by said nurse. There is no credible evidence that the Respondent advised a nurse that the patient had a rash on his thigh or a wound on his penis. There is no evidence that any nurse directed or approved the Respondent's application of "barrier cream" to the Respondent's thigh or penis.

50. Rule 64B9-15.009 sets forth the disciplinary applicable to this case. The following recommended penalty is within the referenced guidelines for the violations established in this proceeding.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is recommended that the Department of Health, Board of Nursing, enter a final order: finding the Respondent guilty of violating sections 464.204(1)(b) and 456.072(1)(o); placing the Respondent on probation for a period of one year, during which the Respondent shall complete such continuing education courses as specified by the Petitioner; and imposing an administrative fine of $125.00.

DONE AND ENTERED this 11th day of September, 2015, in Tallahassee, Leon County, Florida.

William F. Quattlebaum

WILLIAM F. QUATTLEBAUM
Administrative Law Judge
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
(850) 488-9675
Fax Filing (850) 921-6847
www.doah.state.fl.us

Filed with the Clerk of the
Division of Administrative Hearings
this 11th day of September, 2015.

COPIES FURNISHED:

Deshon A. Davis, C.N.A.
3620 East Powder Horn Road
Titusville, Florida 32796

Lucas Lawrence May, Esquire
Department of Health
Prosecution Services Unit
Bin C-65
4052 Bald Cypress Way
Tallahassee, Florida 32399
(eServed)

Judson Searcy, Esquire
Department of Health
Prosecution Services Unit
Bin C-65
4052 Bald Cypress Way
Tallahassee, Florida 32399
(eServed)

Ann L. Prescott, Esquire
Department of Health
Bin C-65
4052 Bald Cypress Way
Tallahassee, Florida 32399
(eServed)

Jamison Jessup, Qualified Representative
557 Noremac Avenue
Deltona, Florida 32738
(eServed)

Joe Baker, Jr., Executive Director
Board of Nursing
Department of Health
Bin C-02
4052 Bald Cypress Way
Tallahassee, Florida 32399
(eServed)

Ann-Lynn Denker, PhD, ARNP, Chair
Board of Nursing
Department of Health
Bin C-02
4052 Bald Cypress Way
Tallahassee, Florida 32399

NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the Final Order in this case.