BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

WILLIAM MICHAEL CLAWSON
705 Sixteenth Street
Eureka, CA 95501
Registered Nurse License No. 355796
Public Health Nurse Certificate No. 83445

Respondent.

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about February 24, 1983, the Board of Registered Nursing issued Registered Nurse License Number 355796 to William Michael Clawson (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2016, unless renewed.

3. On or about June 18, 2012, the Board of Registered Nursing issued Public Health Nurse Certificate Number 83445 to Respondent. The Public Health Nurse Certificate was in full
force and effect at all times relevant to the charges brought herein and will expire on September 30, 2016, unless renewed.

**JURISDICTIONAL, STATUTORY, AND REGULATORY PROVISIONS**

4. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

5. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

6. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

7. Section 2761 of the Code states:

   "The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

   "(a) Unprofessional conduct, which includes, but is not limited to, the following:

   "(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

   ""

8. California Code of Regulations, title 16, section 1442, states:

   "As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

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9. California Code of Regulations, title 16, section 1443, states:
   "As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the
   failure to exercise that degree of learning, skill, care and experience ordinarily possessed and
   exercised by a competent registered nurse as described in Section 1443.5."

10. California Code of Regulations, title 16, section 1443.5 states:
   "A registered nurse shall be considered to be competent when he/she consistently
demonstrates the ability to transfer scientific knowledge from social, biological and physical
sciences in applying the nursing process, as follows:

   "(1) Formulates a nursing diagnosis through observation of the client's physical condition
   and behavior, and through interpretation of information obtained from the client and others,
   including the health team.

   "(2) Formulates a care plan, in collaboration with the client, which ensures that direct and
   indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and
   for disease prevention and restorative measures.

   "(3) Performs skills essential to the kind of nursing action to be taken, explains the health
treatment to the client and family and teaches the client and family how to care for the client's
health needs.

   "(4) Delegates tasks to subordinates based on the legal scopes of practice of the
   subordinates and on the preparation and capability needed in the tasks to be delegated, and
effectively supervises nursing care being given by subordinates.

   "(5) Evaluates the effectiveness of the care plan through observation of the client's physical
   condition and behavior, signs and symptoms of illness, and reactions to treatment and through
   communication with the client and health team members, and modifies the plan as needed.

   "(6) Acts as the client's advocate, as circumstances require, by initiating action to improve
   health care or to change decisions or activities which are against the interests or wishes of the
   client, and by giving the client the opportunity to make informed decisions about health care
   before it is provided."
COSTS

11. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licentiate to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

BACKGROUND

12. In 2013, Nina's Care Home (Nina's) operated in Eureka, California as a residential care facility for the elderly. Nina's was licensed by the Community Care Licensing Division (CCL) within the California Department of Social Services.

13. In late April or early May 2013, N.W., the named licensee of Nina's, died unexpectedly. Following N.W.'s death, N.W.'s children hired an attorney, L.R., to assist them with the estate. The children then obtained administrative authority over Nina's and decided to close the facility.

14. On or about May 9, 2013, L.R. hired Respondent as a consultant to help with the closing process. Respondent operated a consultancy business at the time, offering his assistance as a registered nurse with specialization in elder care within community care licensed facilities. Respondent's role in closing the facility was to guide M.B., the principal caretaker at Nina's who had been acting as a temporary administrator, in completing M.B.'s obligations, to assess the patients for transfer to other facilities, and to work with CCL to comply with all rules and regulations governing the closure.

A. The Patient Placement Evaluations

15. There were five residents at Nina's at that time. As part of the CCL requirements for closing the facility, CCL required that each resident at the facility be assessed and a determination

1 Full names will be provided in discovery.
be made about the level of care appropriate for the patient. Respondent was hired to perform the
assessments as part of his work for the estate.

was 83 years-old. She had severe dementia and was unable to communicate. She was severely
emaciated and had no ability to move or turn herself. Respondent was aware that patient J.N. had
a history of skin breakdown and urinary tract infections. Respondent also knew that skin
breakdown and emaciation are tightly interconnected.

17. Respondent did not actually perform a physical assessment. Respondent stood behind
M.B. while M.B. dealt with the patient. M.B. controlled what would be shown to Respondent,
lifting up or pulling down areas of patient J.N.'s clothing. Respondent had not practiced clinically
for some time and took the position that he was an expert and not hired to perform patient care
services. Respondent did not touch patient J.N. during the evaluation. M.B. told Respondent
information about patient J.N., and Respondent paraphrased that information onto the appraisal
forms. Once completed, Respondent asked M.B. to sign the assessments. M.B. refused.

18. Respondent saw that patient J.N.'s perirectal area was red and did not blanch when
touched. Respondent also saw that patient J.N. had the beginnings of a groin rash. Respondent
was concerned that the skin covering patient J.N.'s coccyx was red and non-blanching, and he was
cconcerned with patient J.N.'s level of emaciation. Respondent notified L.R. about the non-
blanching nature of the redness on the coccyx, but did not make note of it on the appraisal forms.
Respondent similarly did not mention his concerns to patient J.N.'s public guardian.

19. Although Respondent initially had the intention of viewing patient J.N.'s bony
prominences, some were covered. Patient J.N. had dressings over her elbows. Respondent did
not have them removed or inspect those areas. Patient J.N. had dressings on her feet from her
ankle to her toes that Respondent did not have removed. M.B. told Respondent that the bandages
on the feet had been applied by the podiatrist. Respondent accepted that explanation.

20. Respondent indicated on the Resident Appraisal form that patient J.N. "weakly
repositions" herself in bed. Respondent indicated on the form that patient J.N. did not need a
skilled nursing facility, in large part because he believed patient J.N. could reposition herself in bed. Patient J.N., in fact, could not reposition herself and had to be turned by staff.

21. CCL generally requests that a doctor perform the resident evaluations under such circumstances, but if a facility cannot obtain an appraisal from a doctor, CCL will send their own RN Consultant to assess the residents. Here, on each of the Resident Appraisal forms, Respondent signed "William Clawson, RN Relocation Evaluation." Respondent also signed each of the accompanying Appraisal/Needs and Services Plan forms, "William Clawson, RN." Given that Respondent, an RN, had performed the patient assessments, CCL accepted them.

B. The Skin Tears

22. In the thirteen days between Respondent's evaluation of patient J.N. on May 11, 2013, and patient J.N.'s transfer to Frye's Care Home (Frye's) on May 23, 2013, Respondent conducted between six and nine visits at Nina's. At some point during that time, M.B. informed Respondent that patient J.N. had skin tears on her arm and beneath her knee.

23. Having been so informed, Respondent declined to look at or examine the skin tears, or to check on patient J.N. at all. Respondent took the position that it was not his job to check on any patients after the initial assessment.

C. The Patient Transfer

24. Patient J.N. was transferred to Frye's on May 23, 2013. When staff from Frye's arrived, patient J.N.'s legs were covered in wrappings and her feet were covered by socks. Patient J.N.'s daughter was present and suggested patient J.N. wear jeans for the transfer, but M.B. responded "No, she's all glued up." At the time, it was unclear to Frye's staff what M.B. meant by that. Frye's staff had the Resident Appraisal form from Respondent that indicated patient J.N. had no wounds.

25. When the Frye's staff began to move patient J.N., she yelled out in pain, and she cried while they moved her to the vehicle. Frye's staff also noted a smell of urine and feces, which they assumed was from the facility. After the short drive to Frye's, staff noted that patient J.N. still smelled like urine and feces, so Frye's staff prepared patient J.N. for a shower and body check.
26. Removing patient J.N.'s clothing was a team effort; patient J.N. was in obvious pain. The staff discovered wounds, all of which had been covered up by a shirt, diaper, bandages, or socks. The top of patient J.N.'s knee had a large, open sore with gauze stuck to it. It appeared that the whole knee cap was missing several layers of skin; in its place was dead, yellowy, smelly skin. Looking behind patient J.N.'s knee, Frye's staff understood what M.B. likely meant by "all glued up": The knee was contracted and unable to straighten, with an open wound at least four inches in length exposing white tendon and/or bone. Patient J.N. further had an open sore on the coccyx. A skin tear on the upper arm measured approximately 4" by 3" and appeared meaty; the bandages covering it were soiled and smelled badly. Throughout the process, patient J.N. was in great pain and crying out "Oh Lord help me," and "Ow it hurts."

27. As staff removed the dressing on patient J.N.'s foot, they discovered a black toe with a bad odor. In fact, patient J.N. had been diagnosed with gangrene by her podiatrist 25 days before then, on April 29, 2013. Patient J.N.'s plan of care upon leaving the podiatrist on April 29, 2013, had been to change patient J.N.'s foot bandages daily. When Respondent performed patient J.N.'s assessment on May 11, 2013, the dressings applied by the podiatrist had already gone unchanged for 12 days.

28. Patient J.N., moreover, was wearing multiple soiled diapers that were much too large for her, and under those, approximately 4 "poise" pads that were soaked in urine and feces. The feces was sticky and thick, with some areas more dried than others. The diapers and pads were soaked through.

29. Frye's staff called 911. Patient J.N. was taken to the hospital and later transferred to hospice. Patient J.N. died on June 8, 2013.

FIRST CAUSE FOR DISCIPLINE
(Gross Negligence)

30. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1), in that Respondent failed to exercise ordinary precaution in a situation that Respondent knew or should have known could have jeopardized a patient's health or life. Respondent's failure under
such circumstances constituted gross negligence under California Code of Regulations, title 16, section 1442. The circumstances are described above in Background. More specifically:

A. Respondent failed to perform a complete assessment of patient J.N.

B. Respondent failed to notify the physician and responsible party of the physical condition of patient J.N.

C. Respondent failed to ensure that patient J.N.'s service plan accurately reflected the needs and status of the patient. The plan did not identify the stage 1 ulcer on the coccyx, the treatment recommended by the podiatrist, or that the patient required assistance to reposition and turn. The plan also did not mention all of the patient's gauze bandages and coverings.

D. Respondent failed to ensure the treatment plan prescribed by the podiatrist was followed by the direct care staff.

E. Respondent failed to recommend a higher level of care.

F. Respondent did not act as an advocate by initiating action to improve healthcare for the patient.

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

31. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1), in that Respondent failed to exercise the degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in section 1443.5. The failure to do so constituted incompetence under California Code of Regulations, title 16, section 1443. The circumstances are described above in Background. More specifically:

A. Respondent failed to perform a complete assessment of patient J.N.

B. Respondent failed to notify the physician and responsible party of the physical condition of patient J.N.

C. Respondent failed to ensure that patient J.N.'s service plan accurately reflected the needs and status of the patient. The plan did not identify the stage 1 ulcer on the coccyx, the treatment recommended by the podiatrist, or that the patient required assistance to reposition and turn. The plan also did not mention all of the patient's gauze bandages and coverings.
required assistance to reposition and turn. The plan also did not mention all of
the patient's gauze bandages and coverings.

D. Respondent failed to ensure the treatment plan prescribed by the podiatrist was
followed by the direct care staff.

E. Respondent failed to recommend a higher level of care.

F. Respondent did not act as an advocate by initiating action to improve healthcare
for the patient.

THIRD CAUSE FOR DISCIPLINE
(Unprofessional Conduct)

32. Respondent is subject to disciplinary action under section 2761, subdivision (a), in
that Respondent engaged in unprofessional conduct. The circumstances are described above in
the First and Second Causes for Discipline.

FOURTH CAUSE FOR DISCIPLINE
(Unprofessional Conduct - Deceit)

33. Respondent is subject to disciplinary action under section 2761, subdivision (a), in
that Respondent engaged in unprofessional conduct. Respondent was dishonest and/or deceitful
in answering questions during the investigation conducted by the Department of Social Services
and/or the investigation conducted by the Board. Specifically:

34. Respondent informed the investigator from the Department of Social Services that he
had directed M.B. what to do during his assessment of patient J.N. Respondent stated that he had
M.B. move patient J.N. onto her side; that he had M.B. touch a red area so he could judge how
long it took to return to normal color; and that he had M.B. pull patient J.N.'s depends down to
check patient J.N.'s coccyx. Later, Respondent informed the Board's investigator that M.B. was in
charge of what would be shown during patient J.N.'s assessment; that M.B. actually had
performed the physical assessment, not Respondent; that M.B. had pressed on the coccyx (to
show it did not blanch) without being instructed; and that Respondent had not needed to instruct
or prompt M.B. regarding what she was doing during the examination.
35. Respondent informed the investigator from the Department of Social Services that he did not have M.B. roll patient J.N. over to check her front, because Respondent had only been concerned with those bony prominences that were in constant contact with the surface. Later, Respondent informed the Board's investigator that M.B. had rolled patient J.N. over, that he and M.B. had examined both sides of patient J.N., and that Respondent had checked patient J.N.'s knees and saw nothing that concerned him.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 355796, issued to William Michael Clawson;
2. Revoking or suspending Public Health Nurse Certificate Number 83445, issued to William Michael Clawson;
3. Ordering William Michael Clawson to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;
4. Taking such other and further action as deemed necessary and proper.

DATED: June 24, 2015

LROISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant