BASIC INVESTIGATIVE REMINDER **HANDOUT 1**

Adapted from C. Woodard's Police Academy Criminal Investigation Notes - 1977

1. *WHO* questions

   Who discovered the violation?
   Who reported it?
   Who saw or heard anything of importance?
   Who had a motive for committing the violation?
   Who committed the violation?
   Who helped the respondent commit the violation?
   With whom did the respondent associate?
   With whom are the witnesses associated?

2. *WHAT* questions

   What happened?
   What violation was committed?
   What are the elements of the violation?
   What were the actions of the respondent?
   What do the witnesses know about the case?
   What evidence was obtained?
   What was done with the evidence?
   What tools were employed?
   What knowledge or skill was necessary to commit the violation?
   What was the motive?
   What was the modus operandi?

3. *WHERE* questions

   Where was the violations discovered?
   Where was the violation committed?
   Where was the respondent seen?
   Where were the witnesses during the time of the violation?
   Where was the victim found?
   What were the tools obtained?
   Where does the respondent live and work?
   Where was the respondent confronted?

4. *WHEN* questions

   When was the violation committed?
   When was the violation discovered?
   When was the violation reported?

5. *HOW* questions

   How was the violation committed?
   How did the respondent have access to the area where the violation occurred?
   How did the respondent get the information necessary to enable him to commit the violation?
   How was the violation discovered?
   How much damage was done?
   How much injury occurred?
   How much property was stolen?
   How much knowledge or skill was necessary to commit the violation?

6. *WHY* questions

   Why was the violation committed?
   Why were the particular tools used?
   What was the particular method employed?
   Why are the witnesses reluctant to talk?
   Why was the violation reported?

HANDOUT 2

WASHINGTON STATE
DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE DIVISION

CONFIDENTIAL INVESTIGATION REPORT

****

Case #2015-1111RN

RESPONDENT: Nurse Nancy, RN
****

TABLE OF CONTENTS

Investigator: Dirty Harry
Health Care Investigator
Phone number: (360) 555-1234

APPROVED BY _____ DATE _____

HANDOUT 2

APPENDIX A

PRINCIPAL PARTICIPANTS

Respondent

Name:	Nurse Nancy
Address:	
	Ocean Shores, WA 98391
Telephone/email	Unknown
DOB:	02/07/1961
License number:	RN.RN.0000000
First issue date:	09/14/1992
Expiration date	03/05/2017
Method of Licensure:	Examination
Current place of employment:	Unknown

Additional Credentials: None

Out of State License (s): None

Respondent Attorney None

Complainant: Helen Headstrong

Patient (s): None

HANDOUT 2

APPENDIX B

GENERAL SUMMARY

Complaint Summary

The respondent was arrested for DUI on 10/10/2015. She told the Complainant (an Emergency Department Nurse) that she took Xanax prior to going to work and while at work. **Page 2**

Summary

Helen Headstrong, ARNP FNP filed this complaint with the Nursing Commission against the Respondent. On October 10, 2016, the respondent was treated in an Emergency Department following her arrest for DUI.

- The Complainant reported that while treating the Respondent in the ED the Respondent told her she had taken Xanax prior to going to work. She additionally wrote that the Respondent additionally told her she takes Xanax while at work as well. **Page 2**

In the initial complaint the Complainant provided very little information. On December 16, 2015 I e-mailed her requesting further information. I specifically requested her to,

- Identify where she was working at the time of her contact with the Respondent.
- In what jurisdiction did the Respondent's arrest occur.
- Who is the arresting agency?
- Current contact information for the Respondent. **Page 10**

The Complainant responded with a short reply. She wrote she was working at the Memorial Hospital ED at the time she treated the Respondent and she believed the arresting agency to be the Dodge County Sheriff's department. **Page 10**

I sent a letter to the PD requesting a copy of the Respondent's arrest report for DUI on 10/10/2015. I later received a response from the PD informing that the arresting agency was not them but the Colfax police Department. **Pages11-14**

On December 16, 2015 I sent the Respondent an allegation letter requesting a response by December 30, 2015. I did not receive a response and the letter was not returned as being unable to deliver.

On January 8, 2016 I sent the Respondent a Final Demand Letter with a response due date of January 18, 2016. The Respondent did not respond and again the letter was not returned as being unable to deliver.

I will additionally note that I attempted to contact the Respondent via telephone but her phone number listed in licensing data is no longer a working phone number.

HANDOUT 2

On 5/20/2016 I took a request letter to the records office of the Colfax police department requesting a copy of the Respondent's October 10, 2015 DUI arrest report. **Page 15**

On May 25, 2016 I received copy of the request arrest report via e-mail.

- The arrest report shows the Respondent was arrested on October 10, 2015 in Dodge County at the scene of a two car collision where she was determined to be the at fault driver. Report # 15-223355. **Pages 16-35**
- The Respondent failed field sobriety tests and was arrested. **Page 22**
- A search warrant was obtained for a sample of the Respondent's blood.
- The blood was obtained and tested by the state Toxicology Laboratory on October 23, 2015. **Page 18**
- The respondent's blood tested positive.
- The arrest report noted that the Respondent has three prior DUI convictions. **Page 22**

I will note that the Respondent's address listed on the DUI report is the same address listed in the Nursing data system and is the same address that both the Allegation letter and Final Demand letter were sent to.

On June 7, 2016 I phoned the Dodge County District Court to inquire the status of the Respondent's DUI trial results. I spoke with a records clerk who advised the Respondent's case is yet to be adjudicated with her next pre-trial date being July 27, 2016.

HANDOUT 2

APPENDIX C

EVIDENSCE/EXHIBITS

Page #'s	Description
1	RCW 43.70.075
2	Complaint to NCQAC, Helen Headstrong ARNP FNP
3	Investigative Notice to Complainant
4	Investigative Notice to Complainant
4-5	Notification Letter, Respondent
6-7	Allegation Letter, Respondent
8	Declaration of Service by Mail
9	Final Demand Letter, Respondent
10	E-mail exchange with Complainant
11-12	Fax with request for Police Report, Dodge County Sheriff's Department
13-14	DCSD reply advising Colfax PD as the arresting Agency
15	Request Letter to CPD for Respondent's DUI Arrest Report
16-35	CPD Arrest Report of Respondent for DUI

HANDOUT 2

APPENDIX D

CONTACT LIST
(OTHER THAN PRINCIPALS)

Dirty Harry
Health Care Investigator
NCQAC
PO Box 47864
Olympia, WA 98504

Helen Headstrong, ARNP FNP
1234 Maple Tree Lane
Eaton, WA 98354
312-160-9874
helhead@rocketmail.com

CPD Officer Top Gun
Badge #767

HANDOUT 2

APPENDIX E

PREVIOUS CASES

1995-39905	Unprofessional Drug Diversion	Signed WHPS contract January 1996 Completed WHPS Program 10/26/1998

HANDOUT 3

WASHINGTON STATE
DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION

CONFIDENTIAL INVESTIGATION REPORT

****

CASE # 2017-0055RN

RESPONDENT: Jane Doe, RN

****

TABLE OF CONTENTS

Columbo
Health Care Investigator
360-236-4757

APPROVED BY _____ DATE _____

HANDOUT 3

APPENDIX A

PRINCIPAL PARTICIPANTS

Respondent

Name: Jane Doe
Address: 123 Main Street, Mytown, WA 98000
Telephone/email: Janey@nursesrus.com
DOB: 01-01-1961
License number: RN.RN.0070015
First issue date: 07-11-1985
Expiration date: 10-25-2017
Method of Licensure: Exam
Current place of employment: Freeway View Hospital

Additional Credentials: none

Out of State License(s): none

Respondent Attorney: none

Complainant: Florence Nightingale
Director of Nursing Services
Freeway View Hospital
555 Eye Five Corridor
Speedtrack, WA 99955

Patient(s): Average Joe

HANDOUT 3

APPENDIX B

GENERAL SUMMARY

Complaint Summary

The complainant, the Director of Nursing Services at Freeway View Hospital, alleged the respondent practiced beyond scope when she applied a tourniquet to a bleeding patient with no physician order. ***(pages 2-3)***

Summary

1. The respondent allegedly failed to follow the provider order for dressing changes. ***(pages 2-3)***
   - The physician ordered a standard dressing, changed every two hours, to treat the patient's wound sustained in a recent fall in the bathroom. ***(pages 28-29)***
   - The respondent charted in her nursing notes on January 1, 2017, that she applied a standard dressing to the wound as ordered at 0630. ***(page 30)***
2. The respondent allegedly practiced beyond scope when she applied a tourniquet to the patient's arm instead of completing dressing changes as ordered. ***(pages 2-3)***
   - Occupational Therapist Body Builder came to work with the patient at 0900 on January 1, 2017, and found a tourniquet around the patient's upper left arm and no dressing on the wound. Mr. Builder called for help when he found the patient to be diaphoretic and his lower arm cold and blue. ***(pages 17-20)***
   - The respondent came to the patient's assistance and told Mr. Builder she had applied the tourniquet hours ago because she was busy and didn't want to be bothered with changing the hemophiliac patient's dressing multiple times during her shift. (pages 17-20)
3. Freeway View Hospital conducted an internal investigation and found:
   - The patient took blood thinner medication and bled easily, requiring a frequent dressing change per physician order. ***(pages 21-23, 28-29)***
   - The respondent recently had an agitated conversation with her charge nurse, complaining that this was the second time this week she was required to stay and work a double shift. ***(pages 32-25)***
   - On the day of the reported incident, the respondent's patient load was five during her shift. ***(page 26)***
   - The patient suffered tissue damage from the loss of blood flow to the lower arm as a result of the tourniquet. ***(pages 33-35)***

The respondent failed to submit her statement by the requested date. After two follow-up phone calls and a final demand letter, the respondent submitted her statement. She stated she was tired of her facility being short-staffed, tired of being told what to do, and felt her nursing judgment

was beyond reproach. She admitted to applying the tourniquet and stated she would do the same thing again under similar circumstances. She charted that she changed the dressing as ordered to avoid conflict with her supervisor. She is sorry for the patient's pain and suffering. ***(pages 8-15)***

HANDOUT 3

APPENDIX C

EVIDENCE/EXHIBITS

Page #'s	Description
1	RCW Confidentiality Notice.
2-3	January 2, 2012 Complaint from Freeway View Hospital.
4-5	January 10, 2012 Letter of Notification to complainant.
6-7	January 10, 2012 Letter of Notification to respondent.
8-9	January 11, 2012 Letter of Allegation to respondent.
10-11	January 27, 2012 Final Demand Letter to respondent.
12-15	February 1, 2012 Respondent's statement.
16	Respondent telephone memo.
17-20	January 11, 2012 Letter of Cooperation to Occupational Therapist Body Builder and statement.
21-27	Facility internal investigation.
28-35	Average Joe patient records.
36-44	Facility policies on wound care and documentation.

APPENDIX D

CONTACT LIST
(Other than principals)

Columbo
Healthcare Investigator
Department of Health
PO Box 47864
Olympia, WA 98504-7864
Phone 360-236-4757

Body Builder
222 Apple Lane
Beatenpath, WA 99321

APPENDIX E

PREVIOUS CASES

None.

HANDOUT 4

WASHINGTON STATE
DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION

CONFIDENTIAL INVESTIGATION REPORT

****

CASE # 2016-0012

RESPONDENT: Jerry, RN

****

Companion Cases:
2016-0013/ Lisa, RN
2016-0014/ Rebecca, RN

TABLE OF CONTENTS

Super Star
Health Care Investigator
Phone number: 360-236-4757

APPROVED BY _____ DATE _____

APPENDIX A

PRINCIPAL PARTICIPANTS

Respondent

Name: Jerry, RN
Address:
Telephone/email:
DOB:
License number:
First issue date: 09-12-1995
Expiration date: 04-10-2017
Method of Licensure: Exam
Current place of employment: Bald Eagle Home

Additional Credentials: LPN, expired (Lic #-------)

Out of State License(s): Oregon RN, expired 2012 (Lic #----------)

Respondent Attorney: None

Complainant: Krista, RN, Investigator, Residential Care Services
Department of Social and Health Services

Patient(s): Mary

APPENDIX B

GENERAL SUMMARY

Complaint Summary

The Complainant, a Department of Social and Health Services, Residential Care Services Complaint Investigator, alleged that three nurses at the Bald Eagle Home in Seattle provided substandard nursing care to a resident, which likely resulted in the resident's death. ***(pages 3-12)***

Also see Companion Cases #2016-0013RN/Lisa, RN and 2016-0014RN/ Rebeca, RN.
Note: All evidence is located in this case file and page numbering on all three complaints is consistent with the evidence in this case file.

On October 6, 2016, the resident fell and hit her head. She was on daily blood thinning medication (Coumadin). The Complainant alleged:

- Nurses failed to properly document and report significant information regarding the fall and the Resident's condition.
- The night shift nurse failed to properly notify the physician or the Resident's family of the Resident's fall.
- Nurses failed to recognize the Resident's change in condition and altered mental status in a timely manner which likely resulted in the Resident's death. ***(pages 3-12)***

Summary

Mary, a 91 year old female, was a resident in the Assisted Living section of the Bald Eagle Home in Seattle.

- She had lived at the Bald Eagle Home since 2001.
- She had medical diagnoses of dementia, A-Fib, hypertension and other comorbidities.
- She took Coumadin and Digoxin daily for her chronic heart issues. ***(pages 11 and 13)***

The Complainant, an investigator with the Department of Social and Health Services, Residential Care Services, alleged that three nurses who had worked on October 6 and 7, 2016 provided substandard care to the Resident after she sustained a head injury from a fall. She alleged:

- Three staff nurses failed to properly document and report significant information about the fall,
- Failed to recognize a change in the Resident's condition and mental status, and
- Failed to send the Patient to the emergency department in a timely manner to get treatment for a large subdural hematoma.
    - The Patient died on October 11, 2016. ***(pages 3-12)***

On October 6, 2016, at approximately 7:45 pm, the Resident fell in her room and hit her head against a dresser.

The evening shift nurse (Respondent in Case file #2016-00123RN and hereinafter referred to as "Nurse JW") came to the Resident's room after an aide notified him that the Resident had fallen.

- Nurse JW wrote a progress note stating that the Resident "…felt fain(t) and lost her balance and fell backward to the floor." He indicated that he had cleaned the puncture wound on the back of the Resident's head and put the Resident back to bed.
- JW also sent a fax to the Resident's Primary Care Provider and documented calling the Resident's granddaughter. ***(pages 135-137)***

Shannon, RN, BSN, was the Resident's Power of Attorney, Guardian and granddaughter. She provided a written statement and pictures of the Resident:

- No one in her family received a phone call advising them that her grandmother had fallen and hit her head.
- She is a nurse and knows that her grandmother is at high risk for a brain injury if she hits her head because she is on a daily regime of Coumadin.
    - She would have advised Nurse JW to send her grandmother to the emergency room.
- She believes that Nurse JW should have called the Primary Care Provider instead of faxing him the information so that he would have known sooner.
- Shannon said that she received a call from the day shift nurse (Respondent in Companion Case # 2016-0014RN and hereinafter referred to as "Nurse RS") on October 7, 2016, advising her that her grandmother had fallen and she was non-responsive.
- Nurse RS advised that they were sending the Resident to the hospital's emergency department.
    - Shannon went to the emergency department, but the Resident was not there yet.
    - Several minutes later, the Resident arrived at the emergency department via the facility's van.
    - Shannon said that she had to wait in the waiting room for almost an hour before the emergency department doctor saw the Resident because the Nurse RS had not sent the Resident by ambulance.
- Shannon said that the Resident remained unconscious the entire time she and her sister were with her.
- Test results showed that the Resident had a large subdural hematoma which caused a brain shift.
- The doctor advised that the Resident should be placed on comfort care only. ***(pages 32-48)***

Rosa, CAN, participated in a phone interview:

- She heard a loud thump and went to the Resident's room.
    - The Resident was sitting on her bottom on the floor.

  - She said that her bottom hurt.
- Rosa notified Nurse JW that the Resident had fallen.
  - Nurse JW went to the Resident's room and assessed her.
  - He checked her eyes and asked her questions. (He asked her name and if she knew where she was, etc.)
  - She does not recall if or what other testing Nurse JW did.
- Rosa took the Resident's vital signs.
  - She believes that they were all normal, but could not recall specifically what they were.
  - The Resident told her and Nurse JW that she was fine, that she just wanted to go to bed.
- Rosa said that Nurse JW placed the Resident's name on a white board in the nurses' station.
  - Staff use this board to notify staff that the patients have had a change of condition and need monitoring.
  - The names on this board are discussed during a change of shift report.
- Rosa notified the oncoming aide (Silvina) that the Resident had fallen and asked her to check on her during her shift.
- Rosa got off shift at approximately 10:30 pm. ***(pages 57-58)***

Silvina participated in a phone interview:

- She confirmed that the aide, Rosa, had notified her that the Resident had fallen and asked her to keep an eye on her during her shift.
- She left the Resident's door open (standard procedure for this resident in case she fell while trying to go to the bathroom or needed help during the night) and she stuck her head in to listen to her breathing several times during the night.
  - The Resident slept well and did not appear to be in any distress.
- The Resident woke at approximately 5 am and got herself dressed.
- Silvina took her vital signs and noted a slightly elevated temperature.
  - She could not give Tylenol yet, because it was too soon (according to the provider's order).
- She told the on-coming aide, Edna, that the Resident had fallen and had an elevated temperature.
  - She asked her to give her some Tylenol.
- Silvina got off shift at approximately 6:30 am. ***(pages 59-60)***

Edna participated in a phone interview:

- She confirmed that Silvina reported to her at shift change that the Resident had fallen the evening before.
- She said that Silvina asked her to give the Resident Tylenol.
  - She does not recall what specifically she gave as a reason to give the Tylenol.

- She said that she assisted the Resident with getting dressed and gave her Tylenol.
    - She does not recall asking if the Resident complained of any pain.
    - She does not recall if the Resident told her she had fallen.
- Edna said that the Resident came to the nurses' station (she used her walker) and was talking to the nurses and people going by.
    - This was a normal part of her daily routine. ***(pages 61-62)***

Respondent Nurse JW provided a written statement:

- An aide notified him that the Resident had fallen.
    - He immediately went to her room and assessed her.
- His first concern was that she might have injured her hips or legs. The Resident told him she felt faint and fell.
    - She hit her head on the dresser.
- There was a small laceration to the back of the head that he cleaned. It was not bleeding anymore.
- He said that he did a neuro check and the results were normal. He determined that it was best to monitor the Resident for 72 hours for a change in condition.
- Nurse JW said that he followed the policies that were in place at the time of the Resident's fall and acknowledged that those policies have changed and all caregiving staff have received training regarding the new policies. ***(pages 18-21)***

Respondent Lisa, RN, (hereinafter referred to as "Nurse LM") provided a written statement:

- She confirmed that Nurse JW had reported at shift change that the Resident had fallen and hit her head.
    - He said that the neuro check and vital signs were at baseline and that he had placed the Resident on the "Alert Charting Board."
- She knew that there was a small puncture wound on her head because she read the "Alert Charting Progress Note" that Nurse JW had written.
- There were no abnormalities or changes in the Resident's condition during her shift.
    - She checked the Resident throughout the night and did a neuro check in the morning, which was still at baseline for the Resident.
- The Resident got up and got herself dressed and came to the nurses' station early in the morning.
    - She was chatting with staff and other residents. This is a normal routine for her.
- The Resident complained of a headache at approximately 6:30 am.
    - Nurse LM was with Nurse RS at this time. It was shift change and they were going to count narcotics.
    - Nurse RS requested that the aide give the Resident Tylenol for her headache.
- Nurse LM went off shift at 7:00 am. ***(pages 24-27)***

Respondent Rebeca, RN, (hereinafter referred to as Nurse RS) provided a written statement:

-

- When she came to work on the morning of October 7, 2016, the Resident was seated at the nurses' station visiting with staff and other residents.
- The Resident's name was on the Alert Charting Board and Nurse LM advised her that the Resident had fallen the evening before.
    - Nurse RS believed that it was a non-injury fall. Nurse LM did not relay any concerns.
- At approximately 6:30 am the Resident complained of a headache.
    - She requested that the medication aide give the Resident Tylenol.
- The Resident asked what she should do and Nurse RS told the Resident to go back to her room to rest.
- After completing other tasks at about 8:30 am, Nurse RS went into the Resident's room to check on her. She was asleep in her recliner and she was not able to arouse her.
    - This was not unusual for the Resident.
- Nurse RS asked the aide to check the Resident's vital signs.
    - At approximately 10:00 am she learned that the Resident's temperature was 99. something.
    - All other vital signs were within normal limits.
- After report, she pulled up Nurse JW's Alert Charting Progress Note and saw that the Resident had hit her head in the fall.
    - She went back to the Resident's room to do a more thorough assessment.
    - The Resident's temperature was over 100 F° and she was still not responsive.
- Nurse RS determined that the Resident needed to go to the emergency room for a more thorough work up.
- She called the Resident's POA (Shannon) and found out that she knew nothing about the fall.
    - She advised the POA that she was sending her grandmother to the emergency department. ***(page 31)***

John, Executive Director at the Bald Eagle Home, participated in an interview:

- He confirmed that DSHS had cited the facility for policies that were not adequate.
    - The facility has since updated those policies.
- He said that management has provided training to all caregiving staff regarding the new policies.
- These policies include direction to send a resident who takes blood thinning medication that falls and hits their head out to the emergency department for further evaluation. ***(page 63)***

The Bald Eagle Home provided copies of the following documentation:

- Phone records from October 6, 2016, and contact information for Resident's family.
    - Staff (presumably Nurse JW) made a one minute phone call at 8:28 pm to a Portland area code. The area code is correct for one granddaughter and the telephone number correct for the other. It appears he misdialed. ***(pages 118-119)***

- Resident Care Records:
  - Progress Notes
    - October 6, 2016 at 9:57 pm, Nurse JW documented Resident's fall and small puncture wound. Family and Dr. notified. Placed Resident on 72 hr. monitoring and Vital Sign checks.
    - October 7, 2015 at 06:39 am, Med-Aide Edna gave the Resident two Tylenol tablets- "res req for pain."
    - October 7, 2016 at 07:03 am, Nurse LM documented that the Resident rested well during the night. Resident was up and in the clinic lobby, complaining of a headache. Nuero check and vital signs at baseline.
    - At 11:00 am, Medication Aide, Edna noted that the PRN administration of Tylenol was "effective."
    - On October 7, 2016 at 12:24 pm, Nurse RS documented that the Resident complained of a "raging headache." Staff gave Tylenol and the Resident went back to her room and fell asleep. Staff were not able to rouse the Resident for breakfast or morning medications. Temp was 99.1 up to 100.5 after rechecking an hour later. Other vital signs were stable. Pupil check was non-reactive to light. Sent to the hospital ER for evaluation. POA and MD updated. ***(pages 120-126)***
  - Nurse JW filled out a facility incident report regarding the Resident's fall. ***(pages 135-137)***
- Bald Eagle Home - Old and New Facility Policies:
  - Old Fall Prevention Policy (April 2001) ***(page 165)***
  - New Fall Prevention Policy (November 17, 2016) ***(page 166)***
  - New Policy Change of Resident Condition (November 16, 2016) ***(page 167)***
  - Old Policy Change of Resident Condition (January 2001) ***(page 168)***
  - Old Policy Reporting Abuse Neglect or Exploitation (July 1999) ***(page 169)***
  - New Policy Abuse Prohibition and Reporting (November 4, 2016) ***(pages 170-174)***

Providence St Agnes Medical Center provided copies of the Resident's Patient Records:

- The Resident admitted to the hospital on comfort care only after a CT scan of her brain showed a large subdural hematoma with a brain shift.
- The Resident discharged to a skilled nursing facility on October 10, 2016 and died on October 11, 2016. ***(pages 76-112)***

The Sedro Woolley County Coroner provided a copy of the Resident's death certificate:

- The Resident died on October 11, 2016.
- Cause of Death was a subdural hemorrhage, blunt force trauma to the head, and a fall.
  - Other contributing conditions listed: bronchopneumonia. • The Manner of Death was "Accidental." ***(pages 64-65)***
-

- The Sedro Woolley County Coroner autopsy report is consistent with the finding listed on the death certificate. ***(pages 49-56)***

Residential Care Services (RCS) provided a copy of their Investigation Summary and Statement of Deficiency reports. RCS cited the Bald Eagle Home for several violations.

- The Bald Eagle Home policies and procedures did not direct staff on what steps to take after a resident fell and incurred a head injury.
    - The policy did not contain post fall interventions or protocols on when to send a resident to the hospital for further assessment/evaluation.
- DSHS required that the Bald Eagle Home change their policy regarding reporting a resident's change in condition.
    - When the Resident fell and hit her head at approximately 7:45 pm, Nurse JW notified the provider via fax.
    - He also misdialed a telephone number for the Resident's granddaughter and left a voicemail message when no one picked up the call. Staff at the Bald Eagle Home did not actually notify the Resident's family until the next day when Nurse RS sent the Resident to the emergency department. ***(pages 151-164)***

HANDOUT 4

APPENDIX C

EVIDENCE/EXHIBITS

Page #'s	Description
1	RCW Confidentiality Notice.
2-11	Complaint against Respondent and Two Companion Cases
12	November 29, 2016 - Complaint Phone Interview
13	November 4, 2016 – Respondent Notification Letter File # 2016-000123/Jerry, RN
14-19	January 3, 2017 – Letter of Allegations and Submitted Written Statements
20	January 10, 2017 – Respondent Phone Contact Memo
21	November 8, 2016 – Additional Statements
22-27	January 3, 2017 – Letter of Allegations Respondent File # 2016-00124 RN/ Lisa, and Written Response.
28-31	January 3, 2017 – Letter of Allegations Respondent File #2016-00125RN/Rebeca, and Written Response.
32-56	January 3, 2017 – Phone Interview for Shannon and Submitted Documents. 34-44 Pictures of Resident's head wound, October 7th, 2016. 46-47 Shannon Submitted Statement to APS. 49-56 Seattle County Coroner Autopsy Report.
57-58	January 13, 2017 - Phone Interview Memo, Rosa, CNA.
59-60	January 13, 2017 – Phone Interview Memo, Silvina, CNA.
61-62	January 13, 2017 – Phone Interview Memo, Edna, CNA.
63	November 30, 2016 – Phone Interview Memo, John, ED.
64-65	Certified Copy of Death Certificate.

HANDOUT 4

66-112 January 10, 2017 - Letter of Cooperation to Providence St Joseph Medical Center and Submitted Patient Records.

113-149 November 30, 2017 – Letter of Cooperation to Bald Eagle Home and Submitted Documents.

150-164 Email Request to Complainant for DSHS Records and Submitted Reports.

165-174 Bald Eagle Home Policy and Procedures.

- Old Fall Prevention Policy (April 2001)
- New Fall Prevention Policy (November 17th, 2016)
- New Policy Change of Resident Condition (November 16th, 2016)
- Old Policy Change of Resident Condition (January 2001)
- Old Policy Reporting Abuse Neglect or Exploitation (July 1999)

170-174 New Policy Abuse Prohibition and Reporting (November 4, 2016

HANDOUT 4

APPENDIX D

CONTACT LIST
(Other than principals)

Super Star
Healthcare Investigator
Department of Health
PO Box 47864
Olympia, WA 98504-7864
Phone 360-236-4757

(List all witnesses here)

APPENDIX E

PREVIOUS CASES

None.

HANDOUT 5

File Format for Evidence *June 2018*
WA State Nursing Care Quality Assurance Commission

Evidence to appear in this order in the investigative file, placed on the right side:

1. Confidentiality (RCW) notice
2. Complaint
    a) Complaint information
    b) Complainant notification letter
    c) Whistleblower (confidentiality) waiver, if applicable
    d) Note: Impact statement placed on left side of the file; not considered evidence
    e) Letter of cooperation to complainant
    f) Additional statement from complainant
    g) Any additional information or correspondence received from complainant that doesn't fit into the categories of medical records, internal investigation, or policies and procedures
    h) Telephone contact memo
3. Respondent
    a) Respondent notification letter
    b) Letter of representation, if applicable
    c) Letter of allegation
    d) Final demand letter, if applicable
    e) Statement and/or interview notes
    f) Additional information submitted by respondent
    g) Telephone contact memo
    h) All commission orders related to the respondent
4. Investigative contacts (grouped by individual contacts)
    a) Telephone memo
    b) Letter of cooperation requesting statement, records
    c) Final demand letter to licensed witness, if applicable
    d) Statement and/or interview notes
5. Facility internal investigation
6. Medical records
    a) Usually grouped by patient
7. Facility policies and procedures
8. Miscellaneous documents not relevant to the case
    a) Identified and preceded by pre-printed hot pink sheet of paper
9. Duplicates (including correspondence, records, etc.)
    a) Identified and preceded by pre-printed blue sheet of paper

HANDOUT 6

DEPARTMENT OF HEALTH
HEALTH PROFESSIONS QUALITY ASSURANCE DIVISION

CONFIDENTIAL INVESTIGATION REPORT
PREPARED FOR THE
NURSING CARE QUALITY ASSURANCE COMMISSION

****

Case # 2017-123456RN

RESPONDENT: Jean Luc Picard, RN

****

TABLE OF CONTENTS

Catherine Woodard
Health Care Investigator
360-236-4757

APPROVED BY _____ DATE _____

HANDOUT 6

APPENDIX A

GENERAL SUMMARY

Principal Participants

Respondent: Jean Luc Picard, RN
Complainant: self reported
Patient(s): none

Complaint Summary

The respondent filled prescriptions for oral pain medication that a colleague wrote for him. In return, the colleague requested that the respondent share the narcotic medications with her, which the respondent did. The respondent and colleague worked in the Med-Surg Unit together at Stitchemup Hospital and Medical Center. ***(pages 2-3)***

Summary

The respondent accepted and filled prescriptions for narcotic pain medication, without an evaluation, written by a colleague/friend in exchange for giving a portion of his prescription medications back to the provider. ***(pages 2-3)***

- In August 2015, Avon Calling, ARNP, evaluated the respondent when the respondent hurt his back lifting an obese patient in her presence. The respondent also complained of an ear infection. Ms. Calling prescribed Oxycodone for the respondent's back pain and Diazepam and Diclofenac for the ear infection. ***(pages 8, 13)***
- In April 2016, Ms. Calling offered to write the respondent a prescription for Oxycodone for the respondent's hip pain without an evaluation. ***(pages 8, 13)***
- Ms. Calling told him she would continue to write prescriptions for narcotic pain mediation if the respondent would give her back some of the drugs for her own knee pain. The respondent agreed to the arrangement. ***(pages 8-13)***
- The respondent never denied filling the prescriptions or giving a portion of his prescription to Ms. Calling. ***(pages 14, 51)***
- Ms. Calling stated that the respondent requested that she write the prescriptions for pain medications. She asked the respondent to return part of the Oxycodone prescription to her on one occasion, and on two other occasions she received prescription opiates from the respondent but could not be certain that they were from prescriptions she wrote. ***(page 47)***

The facility's internal investigation revealed:

- The pharmacy manager at Easy Street Drugs noticed multiple Oxycodone prescriptions written to the same patient by Ms. Calling. ***(page 48)***
- Ms. Calling wrote a total of ten prescriptions to the respondent for Oxycodone and Percocet from April to September 2016. (***pages 57-58, 60-67, 71-72)***
- The respondent filled eight prescriptions at Easy Street Drugs in Metro City, and the other two at the hospital pharmacy in the same city. ***(pages 57-58, 70-72)***
- Ms. Calling wrote two prescriptions for the same narcotic on the same day, which the respondent filled at two different pharmacies. ***(page 69)***
- The pharmacy manager learned the patient was a nurse employee of the hospital when he called the charge nurse of the Med-Surg Unit of the hospital to inquire about the prescriptions. The respondent was present when the charge nurse took the call. He knew there would be an internal investigation as a result and immediately went to his supervisor and said he would cooperate fully with the investigation. (***pages 9, 49-50)***
- Stitchemup Hospital and Medical Center terminated the respondent in October 2016 as a result of his actions. ***(pages 4-6)***

The respondent's employer:

- The employer regards the respondent as a highly skilled nurse who has acted in leadership positions in the Med-Surg Unit. She said she never saw him impaired at work. ***(pages 30-31, 34-35)***
- Others contacted in the course of the investigation made the same observations, which is that they never saw the respondent impaired at work and they regarded him as a capable nurse. ***(pages 36-37, 49)***

The respondent:

- The respondent self-reported to NCQAC the same day of his termination. ***(pages 4-6)***
- The respondent has been under the care of his surgeon for his pain and is not currently taking any medications. (***pages 14-17)***
- The respondent submitted letters of recommendation and character references from coworkers and supervisors. ***(pages 18-27)***

Washington Health Professional Services (WHPS):

- The respondent contacted WHPS for an evaluation. The evaluator informed the WHPS caseworker that the respondent did not have a substance abuse or chemical dependency problem.
- WHPS said they would offer the respondent a minimized contract for monthly monitoring and he would be encouraged to attend a drug/alcohol class.
- A subsequent communication from WHPS noted that the respondent refused to participate in the program. ***(pages 10, 28-29)***

HANDOUT 6

APPENDIX B

EVIDENCE/EXHIBITS

Page #'s	Description
1	Confidentiality notice.
2-3	Self-reported complaint from respondent.
4	Follow-up letter from Stitchemup Hospital and Medical Center.
5-6	Discharge from Employment letter to respondent.
7	Respondent notification letter.
8-10	Respondent telephone memo.
11-12	Respondent letter of allegations.
13-14	Respondent written statement.
15-17	Respondent FMLA information.
18-27	Letters of recommendation and character reference.
28-29	WHPS telephone memo and memo regarding refusal to participate.
30-35	Employer X, RN, Director of Nursing Services, telephone memo, letter of cooperation, statement.
36-43	Hereto Help, HR Director, telephone memo, e-mails, letter of cooperation, statement.
44-47	Avon Calling, ARNP, letter of cooperation and statement.
48	Pill Provider, Easy Street Drugs Pharmacy Manager, telephone memo.
49	Morticia Adams, RN, BSN, Clinical Manager, telephone memo.
50	Wilma Flintstone, RN, Charge Nurse, telephone memo.
51-72	Stitchemup Hospital and Medical Center internal investigation, including prescription profiles and copies of written scripts.
73-85	Facility policies on Corrective Action and Substance Abuse/ Drug Testing.

APPENDIX C

CONTACT LIST

Respondent

Jean Luc Picard
NCC-1701 Starship Enterprise
Metro City, WA 99922
111-222-5555
Date of Birth: 07-07-1967
License Number: RN00171717
First Issuance Date: 08-07-1991
Expiration Date: 07-07-2012

Respondent Attorney

None.

Complainant

Respondent

Others

Employer X, RN
Director of Nursing
Stitchemup Hospital and Medical Center
Metro City, WA 99922
222-333-4444

Hereto Help
Director, Human Resources
Stitchemup Hospital and Medical Center
Metro City, WA 99922
444-333-6666

Pill Provider, Pharmacy Manager
Easy Street Drugs
Metro City, WA 99933
555-666-7777

HANDOUT 6

Wilma Flintstone, RN
Stitchemup Hospital and Medical Center
Metro Suburb, WA 99934
888-222-7777

Morticia Adams, RN, BSN
Stitchemup Hospital and Medical Center
Metro City, WA 99934
444-888-5555

Avon Calling, ARNP
Small Town, WA 99934
777-555-8888

HANDOUT 6

APPENDIX D

PREVIOUS CASES

None noted.

HANDOUT 7

WORD USAGE

Wordiness is often caused by the bad habit of resorting to ready-made phrases and sentence patterns. Very often a single word will do the work of a whole mouth-full of words, and do it better. A single little word, for example, may take the place of a group of words, like these:

of the order of magnitude of	about
for the purpose of	for
in the nature of	like
along the lines of	like
prior to	before
subsequent to	after
in connection with	by, in, etc.
with respect to	about, in etc.
with regard to	about
in the amount of	for
In accordance with	by
on the occasion of	when, on
in the event that	if
in the case of	if
in view of the fact that	since, because
for the reason that	since
with a view to	to
despite the fact that	though
give consideration to	encourage
have need for	need
give encouragement to	courage
make inquiry regarding	inquire
comes into conflict with	conflicts
give information to	inform
make note of	noted
is of the opinion	believes

Sometimes you can make a word or two do the work of a whole clause, like this:

Information which is of a confidential nature….. Confidential information

HANDOUT 8

Homonyms are simple words having the same or nearly the same pronunciation. They differ from each other in origin, meaning, and spelling. Misuse of these words is common in investigative reports.

accede	to express approval or give consent
exceed	to surpass
accept	to take, receive
except	to exclude
access	admittance, admission
excess	surplus
altar	a place of worship
alter	to change
ascent	act of rising; motion upward
assent	consent
bale	a bundle or package of goods; to make into bale or bales
bail	to set free to liberate from arrest on security
bare	naked; unconcealed; simple; unfurnished
bear	plantigrade carnivorous mammal
basis	a groundwork or fundamental principle of anything
bases	the plural of base; the parts of things on which they rest
berth	a sleeping place on a ship or railway car; situation
birth	the act of coming into life; lineage; descent; origin
born	inmate; inherited
borne	past participle of verb "to bear"
brake	a mechanical device for checking the motion of a vehicle
break	to separate; interrupt; fracture; violate
calendar	record of time
calender	finishing machine used in the manufacture of paper, cloth
cite	summon to appear in court; to quote
sight	the set of seeing; perception
site	local position; ground plot

HANDOUT 8

coarse	rough, large
course	direction; part of a dinner, action taken, subject in school
council	an assembly of men or women summoned for deliberation
counsel	an attorney; advice
desert	to forsake; abandon
dessert	a course of fruit, sweets, etc
dye	to change the color
die	to cease to live; finish
dyeing	the act of changing color
dying	at the point of death; about to die
forth	onward in time, place, or order; forward
fourth	one of four equal parts
hole	a cavity; hollow places; a difficulty or dilemma
whole	all of anything
incite	to cause trouble, uprising
insight	an inner knowledge; understanding
indict	to charge with an offense
indite	to compose and write (a document)
instance	example; case; illustration
instants	particular moments of time
its	a possessive pronoun
it's	contraction of "it is"
lead	a metal
led	guided, past tense of the verb "to lead"
leased	past tense of vert "to lease"
least	the smallest of two or more things
pain	physical or mental suffering
pane	a window glass
passed	past tense of the verb "to pass;" went by
past	having been; gone by; completed

HANDOUT 8

patience	the quality of being patient
patients	those who suffer pain; persons under medical treatment
pore	a minute hole in the skin
pour	to empy; send forth; give vent to ; utter
precedence	priority; superior rank
precedents	previous acts used as guides
presence	the state or quality of being present
presents	gifts
principal	chief; the original sum; the head of a school
principle	a fundamental truth; a settled rule of action
residence	place of abode
residents	those who dwell in a place
role	a part in a play; a function assumed by anyone
roll	to cause to revolve by turning over and over
serge	a twilled woolen cloth
surge	a large wave or billow; great roll or pull
stationary	staying in one place
stationery	writing supplies
taut	tight; stretched; snug
taught	past tense or verb "to teach"
their	a possessive pronoun
there	a particular place
they're	contraction of "they are"
thew	past tense of verb "to throw"
through	from end to end of
to	propostion
too	more than enough; also
two	one and one
whose	a possessive pronoun
who's	a contraction of "who is"
your	possessive pronoun
you're	you are