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STATE OF RHODE ISLAND

DEPARTMENT OF HEALTH
DIVISION OF HEALTHCARE QUALITY AND SAFETYCENTER FOR PROFESSIONAL BOARDS AND LICENSING

In the matter of:
AMELINDA DUBOIS
LICENSE NUMBERS: RN38934
COMPLAINT NO: C24-1317

SUMMARY SUSPENSION OF NURSING LICENSE AND HEARING NOTICE/ SPECIFICATION OF CHARGES

I. Summary Suspension

Amelinda Dubois (hereinafter "Respondent") is licensed as a registered nurses pursuant to R.I Gen. Laws § 5-34-1 et seq. and their license is currently on probation. Complaint ID C24-1317 (the "Complaint") recently came before the Rhode Island Department of Health, Division of Healthcare Quality and Safety, Center for Professional Boards and Licensing ("RIDOH").
This Summary Suspension is issued related to the Complaint and pursuant to R. I. Gen. Laws § 5-34-26. After careful consideration and further investigation by RIDOH, the Director has determined that evidence exists indicating Respondent's continuation in practice would constitute an immediate danger to the public. In particular, the Department has evidence of Respondent engaging in unprofessional conduct involving improper and false documentation regarding medication orders.

Based on the foregoing and pursuant to R. I. Gen. Laws §5-34-26, the License is hereby SUSPENDED until a final decision is issued by the Board of Nurse Registration and Nursing Education after hearing.

II. Specification of Charges

A. STATEMENT OF FACTS

1. That Respondent is a registered nurse licensed to practice in the State of Rhode Island under License Number RN38934 ("License").

2. On or about May 13, 2024, the Board of Nursing placed the Respondent on probation with monitoring for three (3) separate allegations, including failing to comply with proper pain assessment protocol for the administration of an as needed narcotic, signing out a dose of a narcotic for a resident who was not at the facility resulting in the medication administration and pain scale being documented without the resident in the building, failing to follow proper waste procedure for a narcotic, and failing to make corresponding electronic medical record entries for several entries in the narcotic log book.

3. On November 19, 2024, the Respondent was responsible for readmitting a resident to the facility. Another nurse (Nurse A) offered to assist the Respondent by calling the nurse practitioner (NP) to review the hospital's Continuity of Care form and medication orders. The medication order on the Continuity of Care form, "Insulin Lispro to be administered three (3) times per day with meals, using a sliding scale zero (0) to fifteen (15) units," was discontinued by the NP during the call with Nurse A. Nurse A transcribed the verbal telephone orders from the NP on the carbon copy sheets used by the facility.

4. On November 19, 2024, the Respondent transcribed an order for Insulin Lispro fifteen (15) units to be administered three (3) times per day with meals into the electronic medication system.

5. On November 19, 2024, the evening nurse (Nurse B) who took over care of the resident from the Respondent administered a dose of insulin Lispro fifteen (15) units to the resident, as per the Respondent's transcribed order.

6. The medication transcription error and subsequent administration error was identified by Nurse A when they were on the unit assisting Nurse B with the resident.

7. On November 20, 2024, the Respondent crossed out two copies of the verbal orders that Nurse A recorded the previous day on the carbon copy order sheets; one of the orders stated that the Insulin Lispro was to be discontinued. The Respondent admitted to the Director of Nursing that they then destroyed the two carbon copy order sheets of the verbal orders by shredding them, stating the orders were all wrong.

8. The Respondent transcribed a verbal order on the carbon copy order sheet for Insulin Lispro 15 units to be administered three (3) times per day; this order was backdated to November 19, 2024, and did not indicate a time that the order was received. This verbal order further states that it was received and ordered by the NP.

9. On November 21, 2024, RIDOH received a complaint alleging that the Respondent falsely transcribed an order and falsified documentation in the medical record.

10. The NP was interviewed and confirmed that the orders transcribed by the Respondent on November 19, 2024, were not authorized, as the Respondent did not contact the NP, as they stated, to review the orders.

11. On duty nurses have a responsibility to properly document medication orders in accordance with prescriber instructions.

12. The relationship between nursing and other health professionals needs to be clearly articulated, represented, and preserved.

13. Nurses must ensure that all relevant persons participate in patient care decisions.

14. Nurses bear primary responsibility for the nursing care that their patients receive and are accountable for their own practice.

15. Nursing practice includes care as ordered by an authorized healthcare provider.

16. Nurses are accountable and responsible for the quality of their practice.

17. Nurses are accountable for their decisions made and actions taken in the course of nursing practice.

18. The registered nurse is responsible for conveying accurate information.

19. The registered nurse maintains communication with the interpersonal team and others to facilitate safe transitions and continuity in the delivery of care.

20. The registered nurse ensures that their nursing practice is safe.

B. ALLEGATIONS OF VIOLATIONS OF REGULATIONS AND STATUTES

21. The RIDOH Board of Nursing has the authority to impose discipline on this licensee in accordance with R.I. Gen. Laws §5-34-24 and Regulations for Licensing of Nurses and Standards for the Approval of Basic Nursing Education Programs at 216-RICR-40-05-3.

Count I

22. RIDOH hereby incorporates the foregoing paragraphs as if fully set forth herein.

23. This Respondent violated the R.I. Gen. Laws §5-34-24(6)(ii) by taking part in unprofessional conduct as they willfully documented false records in the practice of nursing.

Count II

24. RIDOH hereby incorporates the foregoing paragraphs as if fully set forth herein.

25. This Respondent violated the R.I. Gen. Laws §5-34-24(6)(v) by taking part in unprofessional conduct as they displayed willful disregard of standards of nursing practice and failure to maintain standards established by the nursing profession. Specifically, the standards as provided in the American Nurses Association (ANA) Scope and Standards of Practice, 3rd Edition and by reference to ANA Code of Ethics for Nurses.

Count III

26. RIDOH hereby incorporates the foregoing paragraphs as if fully set forth herein.

27. That the conduct described in paragraphs (1)-(9), (11), and (12) herein constitutes unprofessional conduct pursuant to Provision 2.3 (Collaboration) of the ANA Code of Ethics for Nurses.

Count IV

28. RIDOH hereby incorporates the foregoing paragraphs as if fully set forth herein.

29. That the conduct described in paragraphs (1)-(9), (13)-(15) herein constitutes unprofessional conduct pursuant to Provision 4.1 (Authority, Accountability, and Responsibility) of the ANA Code of Ethics for Nurses.

Count V

30. RIDOH hereby incorporates the foregoing paragraphs as if fully set forth herein.

31. That the conduct described in paragraphs (1)-(9), and (16) herein constitutes unprofessional conduct pursuant to Provision 4.2 (Accountability for Nursing Judgments, Decisions, and Actions) of the ANA Code of Ethics for Nurses.

Count VI

32. RIDOH hereby incorporates the foregoing paragraphs as if fully set forth herein.

33. That the conduct described in paragraphs (1)-(9), (17), and (18) herein constitutes unprofessional conduct pursuant to Standard 9 (Communication) of American Nurses Association (ANA) Scope and Standards of Practice, 3rd Edition.

Count VII

34. RIDOH hereby incorporates the foregoing paragraphs as if fully set forth herein.

35. That the conduct described in paragraphs (1)-(9), and (19) herein constitutes unprofessional conduct pursuant to Standard 14 (Quality of Practice).

III. <u>Procedure And Notice of Hearing</u>

Pursuant to R. I. Gen. Laws §5-34-26, a hearing must be held within ten (10) days after the summary suspension has occurred. A hearing will be held in accordance with the provisions of R.I. Gen. Laws § 42-35-1 et seq., and the "Rules and Regulations Governing the Practices and

Procedures before the RI Department of Health,"216-RICR-10-05-4, §4.13 which are available at the RIDOH website (www.health.ri.gov) or by request from the RIDOH Board of Nurse Registration and Nursing Education. This is a contested hearing in which you have the right to appear personally or by your counsel, or both, to produce witnesses and present evidence on your behalf and to cross-examine witnesses, as well as appeal any outcome directly to the RI Superior Court. If you fail to appear at said hearing, the Administrative Hearing Officer and Board of Nurse Registration and Nursing Education will hear evidence regarding the alleged conduct and may impose disciplinary sanctions and fines, and enter an Administrative Order based thereon.

The date of this hearing will be on January 27, 2025 at 9:00 AM, after the optional prehearing conference, which has been scheduled for January 21, 2025, at 2:00 PM, both at the Department of Administration Powers Building, Floor 4, Legal Conference Room, located at One Capitol Hill, Providence, RI 02908. If you or your counsel fail to appear at this hearing the hearing will proceed on the evidence and testimony.

At this hearing the Board will make a determination as to whether Respondent has violated the law and may take action including, but is not limited to, suspension or revocation of license pursuant to R.I. Gen. Laws§§ 5-34-1 et seq.

For questions on this matter please contact Lynda D'Alessio, Director for the RI Board of Board of Nurse Registration and Nursing Education at Lynda.dalessio@health.ri.gov or at (401) 222-1741 or Department of Health Attorney David Marzilli @ david.marzilli@ohhs.ri.gov..

Entered this 17th day of January 2025

Jerome Larkin, MD

Jerome Larkin, M.D.,

Director
Rhode Island Department of Health
3 Capitol Hill, Room 401
Providence, RI 02908

CERTIFICATION OF SERVICE

I hereby certify that on this 17th day, in the month of January 2025 I have mailed this Summary Suspension by**, hand delivery, by certified mail, and by email** to Amelinda Dubois at the address on file at RIDOH.

I further hereby certify that I have mailed a true and accurate copy of this Summary Suspension, by email on this 17th day of January 2025 to:

Catherine Warren

RI Department of Administration Division of Legal Services

One Capitol Hill, Providence, RI 02908 catherine.warren@doa.ri.gov

Date:1/17/2025 _/s/ David Marzilli

David Marzilli, Esq.
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RI Bar Number No. 8798