

**BEFORE THE
RESPIRATORY CARE BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA**

In the Matter of the First Amended Accusation
Against:

MAURICIO CHAVEZ
2525 Coventry
Clovis CA 93611

Case No.: 1H 2008 729

OAH No.: 2011030862

DECISION AND ORDER

The attached proposed Decision of the Administrative Law Judge is hereby adopted by the Respiratory Care Board of California, Department of Consumer Affairs, as its Decision in the above entitled matter.

This Decision shall become effective on October 26, 2011.

It is so ORDERED October 19, 2011.

Original Signed By:

LARRY L. RENNER, BS, RRT, RCP, RPFT
PRESIDENT, RESPIRATORY CARE BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

BEFORE THE
RESPIRATORY CARE BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

MAURICIO CHAVEZ

Respiratory Care Practitioner License
No. 23601

Respondent.

Case No. 1H 2008 729

OAH No. 2011030862

CORRECTED PROPOSED DECISION

Administrative Law Judge Perry O. Johnson, State of California, Office of Administrative Hearings, heard this matter on July 21, 2011, at Oakland, California.

Senior Legal Analyst Catherine E. Santillian, Department of Justice, represented Stephanie Nunez, Executive Officer, Respiratory Care Board, Department of Consumer Affairs, State of California.

Respondent Mauricio Chavez appeared at the proceeding, but he was not otherwise represented.

On July 21, 2011, the parties submitted the matter and the record closed.

FACTUAL FINDINGS

1. On November 4, 2010, complainant Stephanie Nunez (complainant), in her official capacity as the Executive Officer, Respiratory Care Board (Board), Department of Consumer Affairs (Department), State of California, made the accusation against respondent Mauricio Chavez (respondent).

2. On May 18, 2004, the Board issued Respiratory Care Practitioner License number 23601 to respondent. The license will expire on October 31, 2012.

3. From July 2007 through November 2008, Mercy Medical Center (the hospital) in Merced, California, employed respondent as a respiratory care practitioner.

4. At the hearing of this matter, Sunit P. Patel, M.D., offered compelling testimony. By his demeanor while testifying, his deliberate, conscientious manner, his attitude towards the proceedings, and the consistency in providing a compelling account of the grave conclusions he reached regarding respondent's acts and omissions, Dr. Patel demonstrated that he was a credible¹ and persuasive witness at the hearing

5. Between September 6, and September 9, 2008, Dr. Patel encountered serious neglect by respondent while the latter was obligated to dutifully perform the functions, duties and responsibilities of a respiratory care practitioner. During that period in September 2008, Dr. Patel was the treating physician for two patients, namely patient A and patient L.B. at the hospital.

Patient A

6. On September 6, 2008, patient A was a 73-year-old woman whose medical history included a diagnosis of severe obstructive sleep apnea syndrome. Her admission to the hospital was because of a pulmonary embolism.

7. On September 6, 2008, pertinent to the care of patient A, Dr. Patel wrote an order that set forth, "CPAP² at 8 cm via nasal mask while sleeping."

On September 6, 2008, respondent did not provide the treatment ordered by Dr. Patel for patient A. And with regard to the fact that he neither provided the prescribed treatment nor recorded a reason for having failed to provide the ordered treatment, respondent did not make any entry in the hospital's medical record chart for patient A.

8. On September 7, 2008, Dr. Patel wrote a second order regarding patient A that prescribed, "CPAP at night while sleeping."

On September 7, 2008, respondent did not provide the treatment ordered by Dr. Patel for patient A. And with regard to the fact that he neither provided the prescribed treatment nor recorded a reason for having failed to provide the ordered treatment, respondent did not make any entry in the hospital's medical record chart for patient A.

¹ California Government Code section 11425.50, subdivision (b), third sentence.

² "CPAP" stands for continuous positive airway pressure.

9. The medical records for patient A include a registered nurse's chart note that indicates the nurse communicated with respondent regarding the treating physician's outstanding order for CPAP. Respondent was described as having said to the nurse, "[t]he patient is not going to have CPAP and Dr. Patel is aware."

10. Respondent's statement to the registered nurse on September 8, 2009, that Dr. Patel was aware that patient A had refused CPAP treatment was a dishonest and misleading statement. Respondent had not made aware Dr. Patel regarding the patient's supposed refusal to accept CPAP.

11. Dr. Patel learned on September 9, 2008, that respondent had not provided CPAP therapy to patient A on September 6, 7, and 8, 2008. Upon learning of respondent's failure to comply with the treating physician's orders, Dr. Patel instructed a registered nurse assigned to patient A to file with the hospital an incident report to document respondent's omissions.

Patient L.B.

12. On approximately September 8, 2008, patient L.B., an 88 year-old male, arrived at the hospital in an ambulance. On his arrival, patient L.B. complained of extreme shortness of breath. He had a history of chronic obstructive pulmonary disorder (COPD). Before the date of his arrival, patient L.B. had used an oxygen delivery system at home on an as-needed basis. In addition, on an as-needed basis, patient L.B. had used BiPAP³ at night for obstructive sleep apnea. He arrived at the emergency room of the hospital in severe respiratory distress.

13. On September 8, 2008, at approximately 9:30 p.m., respondent provided respiratory treatment to L.B. Respondent, however, failed to make complete chart notes regarding the respiratory practitioner's assessment information regarding patient L.B. Respondent failed to record notes regarding patient L.B.'s breath sounds and he failed to otherwise make a comment regarding the condition of patient L.B. at the time of providing the respiratory treatment.

14. At 11:30 p.m. on September 8, 2008, Dr. Patel prescribed, "BiPAP at a setting of 12/6" for patient L.B. A monitor technician placed the order and he telephoned respondent to transmit the order.

Although he placed the BiPAP equipment in the hospital room for patient L.B., respondent failed to initiate the therapy for the subject patient. Notes by a registered nurse indicate that respondent was informed on more than one occasion that Patient L.B. was to receive BiPAP therapy; however, respondent failed to provide the treatment.

³ BiPAP means bilevel positive airway pressure.

15. At 3:30 a.m. on September 9, 2008, respondent wrote in the chart for L.B. that he presented the patient with a hand-held nebulizer treatment device. Respondent, however, did not chart that he had administered the prescribed BiPAP therapy.

At 3:35 a.m. on September 9, 2008, respondent performed an arterial blood gas (ABG) test for patient L.B. The results of the ABG showed critical values that indicated patient L.B.'s suffered with impending respiratory failure.

At 6:50 a.m. on September 9, 2008, an assigned registered nurse for patient L.B. wrote a chart note that she had paged Dr. Patel to inform him about the ABG results. After his receipt of the nurse's message, Dr. Patel asked whether patient L.B. was receiving BiPAP therapy; but, the nurse told Dr. Patel that despite having informed respondent "three times" to start BiPAP, the subject respiratory practitioner had not initiated the therapy. The registered nurse wrote a chart note that Dr. Patel directed her to file with the hospital an incident report regarding respondent's failure to comply with the treating physician's orders.

16. On September 9, 2008, the condition of patient L.B. deteriorated to the point that his transfer to the hospital's critical care unit was required. The failure by respondent to follow the treating physician's order to provide the patient with BiPAP therapy and respondent's failure to closely monitor patient L.B. were contributing factors to the patient's placement in the critical care unit. (Following a few hours in the intensive care unit, patient L.B.'s condition stabilized.)

Pattern of Substandard Care regarding Medication Administration Records (MAR)

17. On September 8, 2008, respondent received assignments to provide respiratory treatment to 15 patients of the hospital. But respondent failed to sign and complete Medication Administration Records (MARs) for the 15 patients. Without completed MARs, the hospital lacked accurate documentary proof of the medications administered to the patients by respondent.

Industry Expert

18. Ms. Coletta Boone offered compelling and persuasive testimonial evidence at the hearing of this matter.

Ms. Boone is employed by Sharp Healthcare at San Diego in the capacity of Clinical Lead for Pulmonary Services. She has been licensed as a respiratory care practitioner since June 1987. By her education, training and experience, Ms. Boone was shown to be competent to render expert witness opinions in this matter.

19. Ms. Boone credibly expressed persuasive opinions regarding the standard of practice for the provision of services by a respiratory care practitioner and

the level or extent of respondent's departure from standards of practice as to the three matters upon which the accusation against respondent are grounded.

a. Patient A

20. Ms. Boone credibly stated that the standard of practice regarding the treatment to patient A holds that a respiratory care practitioner is responsible for the transcription and implementation of the written and verbal orders by a treating physician pertaining to the provision of respiratory care to a patient.

In failing to comply with Dr. Patel's orders regarding the initiation of CPAP therapy for patient A, respondent's conduct constituted an extreme departure from the standard of practice of respiratory care. In this matter, no documentary proof that respondent ever attempted to implement the therapy prescribed by Dr. Patel, the treating doctor for patient A. Also had the patient actually refused to accept the CPAP therapy, respondent had a duty to prepare a written note in the patient's permanent medical record and to promptly inform the treating physician about the patient's refusal. And respondent's assertion that the treating physician was aware of patient A's refusal is contradicted by the written order made by Dr. Patel that an incident report be filed with regard to the fact that therapy had not been initiated on approximately three dates.

b. Patient L. B.

21. Ms. Boone persuasively stated that the standard of practice regarding the treatment to patient L.B. requires that a respiratory care practitioner must observe and monitor signs and symptoms, general behavior, general physical response to respiratory care treatment and diagnostic testing, and to determine whether such signs and symptoms, reactions, behavior or general response of a patient exhibits abnormal characteristics.

In failing to provide the required care for patient L.B., respondent's conduct constituted an extreme departure from the standard of practice of a respiratory care practitioner. Other medical care professionals at the hospital contacted respondent at least three times to prompt him to commence BiPAP therapy for patient L.B., who had come onto the ward from the hospital's Emergency Room. Even though he placed equipment in the room where patient L.B. was located, respondent did not promptly act. Because of his delay, patient's L.B.'s condition deteriorated so that the patient had to be moved to a critical care unit, which provided a higher level of care. Although respondent asserted that certain hospital directives prevented him from initiating BiPAP therapy, the subject hospital had no policy or procedure that prevented respondent from completing the treating doctor's orders. In this matter a respiratory care practitioner had a duty to monitor the patient closely and to collaborate with other medical care professionals to provide appropriate care for

patient L.B. Respondent was determined to have spent a minimal amount of time with patient L.B., and, thus, he failed to administer prescribed treatment.

c. *Medication Administration Records*

22. Ms. Boone believably stated that the standard of practice regarding a respiratory care practitioner for medication administration records imposes a responsibility upon a licensee for the transcription and implementation of the written and verbal orders of a physician pertaining to the practice of respiratory care.

By his failure to document the medication administered on the Medication Administrative Record for 15 patients, respondent's omissions constituted a simple departure from the standard of practice. Respondent's conduct is not an extreme departure because he did document some treatment acts in the Respiratory Care Record. But no record was accurately or completely filled out to show that doctors' orders were carried out regarding medications. Hence respondent's omissions may lead to confusion regarding the medications that are actually due for a patient.

Matter in Aggravation

23. At the hearing of this matter, respondent proclaimed that he had completed entries in a hospital document pertaining to patient A's insurance billing claim even though he did not record any entry on the medical services chart in the room for patient A. But respondent's statements were false and not corroborated by any other evidence.

As part of complainant's rebuttal case, Mr. David Perezselsky was called to offer testimony at the hearing of this matter. Mr. Perezselsky is the Mercy Medical Center Supervisor for Respiratory Care Services. Mr. Perezselsky was respondent's supervisor on the dates mentioned above, that is September 6 through 8, 2008, when respondent was employed at the subject hospital.

Contrary to respondent's assertions, Mr. Perezselsky established that Mercy Medical Center had method of recording on an insurance-oriented form for either the delivery of respiratory care services to a patient, or a patient's refusal to accept respiratory care service, such as initiation of CPAP therapy. The subject hospital required a respiratory care practitioner to make entries regarding therapy provided, or a declination of therapy, on either the computerized program screen or on progress notes for handwritten entries.

Mr. Perezselsky reviewed respondent's acts and omissions regarding patient A after an incident report was filed regarding Dr. Patel's complaints. Mr. Perezselsky determined that respondent had failed to make an entry regarding a supposed refusal by patient A to accept CPAP therapy between September 6 and September 8, 2008.

Mr. Perezselsky established that respondent had been instructed by more senior respiratory care therapist about the proper method of making chart entries.

Other Matters

24. Respondent offered no proof that he has completed, or sustained enrollment in, recent continuing education courses that improved or enhanced his skills as a respiratory care practitioner, especially a course on preparing written medical entries for patient care.

25. He produced no witness at the hearing of this matter to give evidence regarding respondent's changed behavior, his attitude towards the past unprofessional conduct or his current reputation for honesty, integrity and trustworthiness.

With regard to a demonstration of skills in his chosen occupation, respondent did not provide any letter from his current supervisor, fellow respiratory care practitioners, registered nurses or medical doctors at Saint Agnes in Fresno, where he has continuously worked since March 2009.

26. Although he claims that he has acquired recent certifications at the place of his current employment, namely Saint Agnes Medical Center, and that he has gained promotions because of his supposed competent work, respondent did not present documents to corroborate his assertions.

27. Respondent has not engaged in significant and conscientious involvement in community, church or privately-sponsored programs designed to provide social benefits or to ameliorate social problems.

Complainant's Request for Recovery of Costs of Investigation and Prosecution and Respondent's Objection to the Same

28. Complainant requests that respondent be ordered to pay the board its costs of investigation and prosecution under Business and Professions Code section 3753.5, subdivision (a). In support of her request for cost recovery, complainant offered a declaration. The declaration states that as of July 18, 2011, the board had incurred the following costs in connection with the investigation and prosecution of this accusation:

Department of Justice-Costs of Prosecution

Paralegal

<i>Fiscal Year</i>	<i>Number of Hours</i>	<i>Hourly Rate</i>	<i>Total</i>
2010-2011	46.25	\$120	\$5,550
2011-2012	22.25	\$120	\$2,670

Investigative Costs

Expert Consultant

<i>Fiscal year</i>	<i>Number of Hours</i>	<i>Hourly Rate</i>	<i>Total</i>
2009-2010	5	\$75	\$375
2010-2011	5	\$75	\$375

Grand Total Costs \$8,970

29. Respondent offered compelling evidence that suggests the board's recovery of its costs of investigation and prosecution cannot immediately be extracted from respondent. Respondent claimed that currently his income is limited because over the past year his hours at work were reduced. He has a delinquent income tax debt for the 2008 tax year. Even though he has been separated from his wife since 2007, respondent has custody of two children every other week for an entire week at a time. When he is not caring for his two children, he lives alone. And he is aiding his wife to finalize her adoption of another child. He claims that he has very limited personal property or assets, including his lack of any motor vehicle.

Despite the array of supposed financial obligations that he confronts in the wake of reduced earnings, respondent failed to offer documentary proof of either his income or his obligations. Moreover respondent voiced no discernible objection to the reasonableness of the costs of investigation and prosecution as presented in complainant's certificate of costs.

30. The total cost of investigation and prosecution in this matter is \$8,970. The board, however, has an obligation to consider the institution of an installment payment plan for respondent whereby he may pay the full measure of the costs over the coming few years.

LEGAL CONCLUSIONS

The Standard of Proof

1. The standard of proof in an administrative disciplinary action that seeks the suspension or revocation of a respiratory care practitioner is “clear and convincing evidence to a reasonable certainty.” (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 583.)

“Clear and convincing evidence” means evidence of such convincing force that it demonstrates, in contrast to the opposing evidence, a high probability of the truth of the facts for which it is offered. “Clear and convincing evidence” is a higher standard of proof than proof by “a preponderance of the evidence.” (*CACI*⁴ 201.) “Clear and convincing evidence” requires a finding of high probability for the propositions advanced in an accusation against a targeted respondent licensee. It must be so clear as to leave no substantial doubt and to command the unhesitating assent of every reasonable mind. (*In re Michael G.* (1998) 63 Cal.App.4th 700.) And, the standard of proof known as clear and convincing evidence is required where particularly important individual interests or rights are at stake. (*Weiner v. Fleischman* (1991) 54 Cal.3d 476, 487.)

Statutory Authority and Cause for Discipline

2. Business and Professions Code⁵ section 3718 prescribes, in part, that the Board “shall . . . suspend [or] revoke licenses to practice respiratory care”

Code section 3750, subdivision (f), prescribes that the board may suspend, place on probation, or revoke the license of a license holder who has been “[n]egligence in his or her practice as a respiratory care practitioner.”

Cause for discipline against the license issued to respondent exists under Business and Professions Code section 3718 as it interacts with Code section 3750, subdivision (f), by reason of the matters set forth in Factual Findings 7 to 17 and 19 to 22.

3. Business and Professions Code section 3750, subdivision (j), sets out that that the board may suspend, place on probation, or revoke the license of a license holder who is culpable of “[t]he commission of any fraudulent, dishonest, or corrupt

⁴ Judicial Council of California, Civil Jury Instructions.

⁵ Hereafter “Code” signifies the Business and Professions Code, unless otherwise stated.

act which is substantially related to the qualifications, functions, or duties of a respiratory care practitioner.”

Cause for discipline against the license issued to respondent exists under Business and Professions Code section 3718 as it interacts with Code section 3750, subdivision (j), by reason of the matters set forth in Factual Findings 10 and 23.

4. Business and Professions Code section 3750, subdivision (p), establishes that the board may suspend, place on probation, or revoke the license of a license holder who has been shown “[a] pattern of substandard care.”

Cause for discipline against the license issued to respondent exists under Business and Professions Code section 3718 as it interacts with Code section 3750, subdivision (p), by reason of the matters set forth in Factual Findings 7 to 17.

5. Business and Professions Code section 3755 establishes that “unprofessional conduct” constitutes cause of discipline. The statute sets forth:

The board may take action against any respiratory care practitioner who is charged with unprofessional conduct in administering, or attempting to administer, direct or indirect respiratory care. Unprofessional conduct includes, but is not limited to, repeated acts of clearly administering directly or indirectly inappropriate or unsafe respiratory care procedures, protocols, therapeutic regimens, or diagnostic testing or monitoring techniques, and violation of any provision of Section 3750. The board may determine unprofessional conduct involving any and all aspects of respiratory care performed by anyone licensed as a respiratory care practitioner

....

Cause for discipline against the license issued to respondent exists under Business and Professions Code section 3718 as it interacts with Code section 3755, by reason of the matters set forth in Factual Findings 7 to 17 and 19 to 23.

Ultimate Determinations

6. The weight of the evidence demonstrated by clear and convincing proof that respondent failed to provide respiratory care therapy to two patients despite the existence of clearly written orders by a treating physician. For the first patient, orders were written by the treating doctor on two consecutive nights; yet, respondent failed to comply with the doctor’s instruction. Respondent’s explanation for not providing

the therapy was that the patient refused the therapy; but respondent made no written record of the patient's refusal and the subject respiratory care practitioner did not attempt to notify the treating doctor about the patient's supposed refusal to accept therapy. Complainant's expert witness opined that respondent's departure for the standard of care was twofold: first, that respondent acted negligently in his substandard provision of care for two patients, and second, that it is insufficient and below the standard of care merely for a respiratory care practitioner to state after the fact that a patient refused care because it is essential that such occurrence of patient refusal must be documented in writing. In addition, respondent failed to sign the MARs documents regarding the administration of medication to 15 patients.

The order, below, results for the most part because of respondent's refusal at the hearing of this matter to accept responsibility for his grave unprofessional conduct and also his continuing assertions of false and misleading testimonial evidence.

Cost Recovery

7. Business and Professions Code section 3753.5, subdivision (a), establishes that any practitioner "found to have committed a violation or violations of law [may be ordered] to pay to the board a sum not to exceed the costs of the investigation and prosecution of the case."

By reason of Factual Findings 28 through 30, the reasonable costs of investigation and prosecution as set forth in the Factual Findings amount to \$8,970.

ORDER

1. Respiratory Care Practitioner License number 23601 as issued to respondent Mauricio Chavez is revoked.

2. Respondent shall pay to the board a sum not to exceed the costs of the investigation and prosecution of this case. That reasonable cost is \$8,970 and shall be paid by respondent in full directly to the board. Respondent may pay the costs in equal quarterly payments, within 24 months from the effective date of this decision. Cost recovery will not be tolled. If respondent is unable to submit costs timely, he shall be required, instead to submit an explanation of why he is unable to submit these costs in part or in entirety, and the date(s) he will be able to submit the costs including payment amount(s). Supporting documentation and evidence for the reason(s) respondent is unable to make such payment(s) must accompany any submission. Full payment of the costs in this matter must occur before respondent files a petition for reinstatement.

September 12, 2011



PERRY O. JOHNSON
Administrative Law Judge