IN THE SUPERIOR COURT OF THE STATE OF DELAWARE

IN AND FOR KENT COUNTY

WILLIAM L. HOLDEN, III,	:	
	:	**C.A. No: 05A-05-004 RBY**
Appellant,	:	
	:	
v.	:	
	:	
STATE OF DELAWARE,	:	
DEPARTMENT OF HEALTH AND	:	
SOCIAL SERVICES THE DIVISION	:	
OF LONG TERM CARE	:	
RESIDENTS PROTECTION,	:	
	:	
Appellee.	:	

Submitted: September 7, 2005
Decided: October 12, 2005

James E. Ligouri, Esq., Liguori, Morris & Yiengst, Dover, Delaware, Attorney for Appellant.

James T. Wakley, Esquire, Deputy Attorney General, Wilmington, Delaware, Attorney for Appellee.

OPINION

Upon Consideration of Appellant's Appeal From
Decision of Division of Long Term Care Residents Protection,
Department of Health & Social Services

AFFIRMED

Young, Judge

OPINION

Appellant, William L. Holden, III, appeals the May 9, 2005 decision of the Delaware Department of Health and Social Services, Division of Long Term Care Residents Protection. Appellant was determined to have neglected a nursing home patient pursuant to 16 Del. C. § 1131, and was placed on the Adult Abuse Registry for four (4) years. For the following reasons, the decision of the Department of Health and Social Services is AFFIRMED.

STATEMENT OF FACTS

On April 25, 2004, Appellant, William L. Holden, III (hereinafter "Appellant"), a registered nurse, was working as the D-wing supervisor at the Courtland Manor Nursing Home.[1] One of the patients under Appellant's care on that day was Lucille Allen, age seventy-nine.[2] Ms. Allen (who was diagnosed with chronic obstructive pulmonary disease, aortic stenosis, asthma, bronchitis, anemia, mild congenital hepatic fibrosis, hyperkalemia, and diabetes) was identified as "full-code" patient.[3] The nursing standard of care for a full-code patient in respiratory arrest requires the nurse to perform CPR, if possible, and to contact 911 for further assistance.[4]

On the day in question, Christina Shambler, a certified nursing assistant,

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[1] Appellant's Br. at 2.

[2] Appellant's App. at A-84.

[3] *Id.*

[4] Tr. Smith, DHSS Hearing, at A-40:10-13; A-46:15-17.

entered Ms. Allen's room bringing her a lunch tray.[5] Ms. Shambler testified that when she entered the room, Ms. Allen's breathing was audible.[6] Ms. Shambler stated that Ms. Allen sounded congested.[7] When Ms. Shambler returned a short time later to retrieve the tray, she noticed that Ms. Allen had not eaten her lunch and seemed to be asleep.[8] Ms. Shambler attempted to rouse Ms. Allen; she tried to feed her; but Ms. Allen did not respond.[9] Ms. Shambler then left the room to remove the tray.[10] Upon her return to Ms. Allen's room, Ms. Shambler noticed thick, white discharge coming from Ms. Allen's mouth, so she called Appellant two times to evaluate Ms. Allen.[11] When Appellant responded after the second call, he elevated Ms. Allen's bed and took her pulse.[12] As Appellant raised Ms. Allen to a sitting position, blood began to flow from Ms. Allen's nose.[13] Ms. Shambler wiped the white discharge and blood from Ms. Allen's mouth and nose.[14] Appellant checked Ms. Allen for a pulse, but did

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5 Tr. Shambler at A-10:10-11.

6 *Id.* at A-12:17-20; A-29:11-29.

7 *Id.*

8 *Id.* at A-10:12-14.

9 *Id.*

10 *Id.*

11 *Id.* at A-10:16-21.

12 *Id.* at A-10:21; A-11:1-8.

13 *Id.*

14 Tr. Shambler at A-12:7-14.

not attempt to perform CPR or call 911.[15] Instead, Appellant called Deborah Smith, the C-Wing charge nurse, asking her to bring her stethoscope and meet him on D-Wing.[16] Appellant did not express a sense of urgency or provide an explanation for his request.[17] When Ms. Smith arrived on D-Wing, she was motioned towards Ms. Allen's room, where she observed Ms. Allen, who appeared to be dead.[18] Appellant did not call 911. Instead, he called Ms. Allen's treating physician, Dr. Mohammed A. Malek, who arrived within approximately twenty minutes. Dr. Malek declared Ms. Allen dead.[19]

PROCEDURAL POSTURE

On January 10, 2005, Appellant was notified that he was being placed on the Adult Abuse Registry by the Department of Health and Social Services ("DHSS") for his neglect of Lucille Allen on April 25, 2004.[20] Appellant was accused of neglecting Ms. Allen for his failure to clear her airway and administer CPR, and his failure to contact 911.[21] Appellant was placed on the Adult Abuse Registry for five years pending the outcome of an administrative hearing, which was held on April 26,

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15 Tr. Holden at A-55:3; A-60:12; Tr. Smith at A-46:16-19.

16 Tr. Smith at A-40:17-21.

17 *Id.* at A-41:8-20.

18 *Id.* at A-41:3-7.

19 Tr. Holden at A-55:15-19.

20 *In re: William L. Holden, III*, DHSS Hearing (May 9, 2005).

21 *Id.*

2005.[22]

In his decision, dated May 9, 2005, the Hearing Officer for DHSS determined that the State established a finding of neglect pursuant to 16 Del.C. § 1131(9)(a) by proving that Appellant failed to attend to the physical needs of Ms. Allen. The Hearing Officer emphasized the fact that Ms. Allen's full-code status was her decision, in the face of which Appellant's failure to follow the protocol for a full-code patient in respiratory arrest effectively nullified Ms. Allen's healthcare choice. The Hearing Officer also did not believe Appellant's contention that Ms. Allen's airway could not be cleared to perform CPR. Rather, he relied on the testimony of Ms. Shambler, who testified that only one rag was required to clean up the discharge coming from Ms. Allen's mouth. The Hearing Officer, in his evidentiary analysis, determined that CPR could have been started within the recommended four to six-minute window. Regardless of whether CPR could have been performed, the Hearing Officer found that at a minimum, Appellant should have called 911.

The Hearing Officer also disagreed with Appellant's argument that his failure to perform CPR and/or call 911 merely constituted an infraction of an internal facility policy, and did not rise to the level of neglect. The Hearing Officer held that failure to comply with an internal facility policy could rise to the level of neglect, if there are procedures established to enforce those policies. As such, Appellant committed neglect when he ignored the full-code procedures for a patient in respiratory arrest.

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[22] *Id.*

STANDARD OF REVIEW

This Court will not reverse the decision of an administrative agency if the agency's decision was "free from legal error and supported by substantial evidence in the record."[23] Substantial evidence is "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion."[24] In addition, this Court's role is not to make factual findings, weigh the evidence, or decide the credibility of the witnesses. Rather this Court will determine if the agency's decision is based on legally adequate evidence.[25]

DISCUSSION

In Delaware, DHSS investigates allegations of abuse or neglect of nursing facility residents.[26] If the claims of abuse or neglect are substantiated following DHSS's investigation, then the accused person is placed on the Adult Abuse Registry.[27] The health and safety of nursing facility residents is regulated by Chapter 11 of Title 16, and Subchapter III specifically addresses the abuse, neglect, mistreatment or financial exploitation of those residents. Under the statute, neglect

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[23] *Methodist Country House v. Wright*, 2005 Del. Super. LEXIS 167, at *5 (citing *Unemployment Insurance Appeal Board v. Martin*, 431 A.2d 1265 (Del. 1981)).

[24] *Id.* (citing *Oceanport Ind. v. Wilmington Stevedores*, 636 A.2d 892, 899 (Del. 1994)).

[25] *Munyori v. Div. of Long Term Residents Protection*, 2005 WL 2158508, at *2 (quoting *McManus v. Christiana Serv. Co.*, Del. Super., C.A. No. 96A-06-013, Silverman, J. (Jan. 31, 1997) (Op. And Order), at 4).

[26] 16 Del.C. § 1134(d)(4).

[27] 11 Del.C. § 8564(b).

of a nursing facility resident is defined as a "[l]ack of attention to physical needs of the patient or resident including, but not limited to toileting, bathing, meals and safety."[28] In the case at issue, the focus of Appellant's neglect of Ms. Allen, a nursing home resident, was his lack of attention to the safety of Ms. Allen, a full-code patient, by failing to call 911 or perform CPR after she went into respiratory arrest.

The incidents that could rise to the level of neglect for failing to attend to the safety of a nursing facility resident are varied. In *Lynch v. Ellis*, the Court affirmed the decision of the Division of Long Term Care Residents Protection ("Division") to place an adult foster care provider on the Adult Abuse Registry for three years based on a finding of neglect pursuant to 16 Del.C. §1131(3).[29] The Court found that the provider neglected a sixty year-old, mentally retarded resident, when she briefly left the resident alone in the bathroom with the bathtub spigot running to answer the telephone.[30] While the provider was out of the room, the resident got into the bathtub and suffered second and third degree burns on her feet from the hot water.[31] In addition, the provider waited two days after the incident to seek appropriate medical treatment.[32] The Court agreed with the opinion of the Hearing Officer for the Division that the provider neglected the resident by failing to supervise the resident

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[28] 16 Del.C. § 1131(9)(a).

[29] 2003 WL 22087629.

[30] *Id.* at *1.

[31] *Id.* at *2.

[32] *Id.*

in the bath, failing to report the resident's health problem in a timely fashion, and by treating the resident's injuries with over-the-counter medication in violation of the Division policies.[33]

The standard for proving neglect, as defined by the statute, is not a bright-line test. Instead, neglect is established by a course of conduct that rises to a level of substantial evidence. Such evidence can be demonstrated by a breach of a standard of care, violation of a policy, or any act or course of conduct that a fact-finder determines to be a lack of attention to a nursing facility resident's physical needs.

Here Appellant maintains that his failure to call 911 or administer CPR to a full-code patient in respiratory arrest did not constitute neglect in violation of §1131(9)(a). Appellant contends that his actions were reasonable under the circumstances, as Ms. Allen was "obviously" dead when Appellant entered the room. Appellant maintains that there is insufficient evidence to support a finding of neglect. In addition, citing this Court's decision in *Ayika v. State*[34], Appellant argues that the protocol for a full-code patient was an internal facility policy, and his failure to follow that internal policy cannot be a basis for neglect as defined by §1131(9)(a).

Appellant's argument is not persuasive. Appellant's conduct in this matter was not guided by an internal facility policy, but rather by a nursing standard of care. Marsha Crossland, a registered nurse and Compliance Nurse Surveyor for the State of Delaware, testified as to the nursing standard of care for responding to a full-code

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[33] *Id.*

[34] Del. Super., C.A. 04A-10-005, Young, J. (April 11, 2005)(Mem. Op.).

patient in respiratory arrest.[35] Ms. Crossland testified that, if a nurse finds a patient who is not breathing or whose heart is not beating, then the nurse should initiate CPR and call 911.[36] If a patient has an obstructed airway, then the nurse should attempt to swipe away the obstruction with his finger or suction the airway.[37] Ms. Crossland also emphasized that time is of the essence for a patient in respiratory arrest.[38] CPR must be started within four to six minutes to restore brain function.[39] The nurse's first priority, however, is to call 911.[40] If the nurse cannot call 911, then he should direct someone else to do so.[41] Deborah Smith, Appellant's co-worker, also testified that the procedure for responding to a full-code patient in respiratory arrest is to perform CPR and call 911.[42]

Although Appellant admits that he did not perform CPR or call 911, a breach of the standard of care, he argues that his actions were reasonable and did not constitute neglect. The record is supported by substantial evidence that Appellant's actions were not reasonable under the circumstances. Appellant's claim that Ms.

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35 Tr. Crossland at A-68:5-12.

36 *Id.*

37 *Id.* at A-68:13-18.

38 *Id.* at A-70:3-7.

39 *Id.*

40 *Id.* at A-71:3-7.

41 Tr. Crossland at A-71:3-7.

42 Tr. Smith at A-40:10-13; A-46:15-21.

Allen was "obviously dead"[43] when he entered the room was rejected by the Hearing Officer, and is contradicted by the testimony of Ms. Shambler, who testified that Ms. Allen was breathing and making audible sounds.[44] Appellant also states that there was a "huge" amount of foam coming from Ms. Allen's mouth, which prevented him from performing CPR.[45] However Ms. Shambler testified that she was able to clean Ms. Allen's mouth, inside and out, with one rag.[46] In addition, Appellant testified that the volume of foam coming from Ms. Allen's mouth was so great that it could not be suctioned. This was not otherwise supported. Further, Appellant testified that he did not even know if there was a suctioning machine in the room.[47] Although Appellant claimed to have witnessed seven to eight prior deaths, he admitted that he had never observed a dead patient with foam coming out of the mouth.[48]

Appellant also testified that Ms. Allen had no pulse and her eyes were fixed and dilated[49], however Appellant did not try to perform CPR or call 911 or do anything within the four to six-minute window of opportunity to revive Ms. Allen. Instead, Appellant merely called Ms. Smith, asking her come to D-Wing and bring

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[43] Tr. Holden at A-53:4.

[44] Tr. Shambler at A-12:17-20; A-29:11-29.

[45] Tr. Holden at A-54-55.

[46] Tr. Shambler at A-16:11-15.

[47] Tr. Holden at A-55:5-8.

[48] *Id.* at A-54:3-7.

[49] *Id.* at A-54:2.

her stethoscope when she "got a chance."[50] Regardless of Appellant's claim that Ms. Allen was "obviously dead" when he entered the room, which position was certainly not undisputed, the testimony of Ms. Crossland and Ms. Smith makes it clear that Appellant should acted in one or more of the ways (CPR, dialing 911...) they described. Appellant was aware of Ms. Allen's full-code status; yet, as the record indicates, Appellant did nothing of any consequence. By failing to attempt CPR or, at a minimum, to call 911, not only did Appellant deny Ms. Allen the chance to be revived, he disregarded Ms. Allen's expressed wishes.

CONCLUSION

After reviewing the record, this Court is satisfied that the decision of DHSS to place Appellant on the Adult Abuse Registry for four years after a finding of neglect is supported by substantial evidence, and is free from legal error. Accordingly, the decision of DHSS is AFFIRMED.

/s/ ROBERT B. YOUNG
Judge

oc: Prothonotary
cc: Counsel
Opinion Distribution

[50] Tr. Smith at A-40:19-21; Tr. Shambler at A-13:13-14.