BEFORE THE
BOARD OF VOCATIONAL NURSING
AND PSYCHIATRIC TECHNICIANS
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: Benedicta Onoshoagbe Aguele 8227 Lyton Way Elk Grove, CA 95624 Vocational Nurse License No. VN 248442 Respondent.	Case No. 4302021000336 OAH No. 2022080432 Precedential Decision No: 2024-01

DESIGNATION OF DECISION AS PRECEDENTIAL

Pursuant to Government Code section 11425.60, subdivision (b), the Board of Vocational Nursing and Psychiatric Technicians hereby designates the attached decision, in its entirety, as precedential.

This precedential designation shall be effective immediately.

IT IS SO ORDERED this 17th day of May 2024.

SIGNATURE ON FILE
Dr. Carel Mountain
President

BEFORE THE
BOARD OF VOCATIONAL NURSING
AND PSYCHIATRIC TECHNICIANS
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: BENEDICTA ONOSHOAGBE AGUELE, Vocational Nurse License No. VN 248442, Petitioner.	OAH Case No.: 2022080432 Agency Case No.: 4302021000336

DECISION AFTER REJECTION OF PROPOSED DECISION

Administrative Law Judge Sean Gavin, Office of Administrative Hearings (OAH), State of California, heard this matter by videoconference on May 3 and 4, 2023, from Sacramento, California. This matter was consolidated for hearing with OAH Case No. 2022080432/Agency Case No. 4302021000336.

Deputy Attorney General Patricia Heim represented Elaine Yamaguchi (complainant), Executive Officer of the Board of Vocational Nursing and Psychiatric Technicians (Board). Attorney Ian Scharg represented Patrick E. Aguele (respondent), who was present throughout the hearing before the Administrative Law Judge.

Testimony and documents were admitted into evidence at the hearing. The record was closed and the matter was submitted for proposed decision at the conclusion of the hearing on May 4, 2023.

On June 5, 2023, the Administrative Law Judge issued a Proposed Decision in which he made factual findings and legal conclusions and issued a proposed Order in which he found cause for discipline and fixed the level of discipline at public reproval.

On August 23, 2023, the Board issued an Order of Non-Adoption of Proposed Decision rejecting the Proposed Decision of the Administrative Law Judge. The Board ordered and received the transcript of the hearing before the Administrative Law Judge in due course.

By Order Fixing Dates issued September 28, 2023, the Board notified the parties that the transcript was available and fixed the date for the submission of written arguments. The Board received timely written argument from the parties.

Having considered the entire administrative record, including the transcript of hearing and the documents admitted into evidence at the hearing, and the written arguments of the parties, the Board makes factual findings and conclusions of law and orders the Accusation be sustained and respondent be given the discipline of revocation, revocation stayed and three years probation with standard terms and conditions as follows:

FACTUAL FINDINGS

Jurisdictional Matters

1. On March 10, 2010, the Board issued respondent vocational nurse license number VN 248442. The license was active at all relevant times and is scheduled to expire on March 31, 2024, unless renewed.

2. Respondent and her husband, Patrick Aguele (the respondent in the consolidated matter) formerly owned and operated Benny's Care Home, a residential care facility for the elderly (RCFE) located in Sacramento, California. Respondent was a caregiver with her husband and other caregivers. Benny's Care Home was a non-medical RCFE and did not require respondent to act in her capacity as a licensed vocational nurse (LVN).

3. On November 30, 2021, complainant, acting solely in her official capacity, signed and filed an Accusation seeking to discipline respondent's license based on her conduct toward L.W., a resident of respondent's RCFE. Specifically, the Accusation alleged that in August 2020, respondent roughly pushed L.W., grabbed L.W. by the upper arms and threw her into a chair, and slapped L.W.'s head and forcefully grabbed her hair. The Accusation alleged causes to discipline respondent's license for using excessive force against a patient and for unprofessional conduct consisting of gross negligence, incompetence, and general unprofessional conduct.

4. After receiving due and legal notice of the Accusation, respondent filed a timely Notice of Defense in which she raised three affirmative defenses. Respondent waived the three affirmative defenses at the conclusion of the hearing. The Administrative Law Judge accepted the waiver of these defenses on the record at the hearing.

5. The Administrative Law Judge had jurisdiction to issue a Proposed Decision on the Accusation. Having rejected the Proposed Decision, the Board has retained jurisdiction to issue a final decision on the Accusation.

Respondent’s Interactions with L.W.

6. On August 11, 2020, L.W.'s caregiver found her unresponsive at Benny's Care Home. L.W. was deceased. The Sacramento County Sheriff's Department and the Department

of Social Services (DSS), which licenses and regulates RCFEs, investigated the facts and circumstances surrounding L.W.'s death.

DSS Investigation

7. During their investigation, DSS investigators viewed video surveillance footage of the interior of Benny's Care Home from early August 2020 and documented their findings. DSS investigator Sonia Boyal incorporated these findings into an Investigation Case Report. This case report was admitted into evidence without objection.

8. According to the DSS Investigation Case Report, video surveillance footage showed that on August 3, 2020, there were "two incidents of [respondent] roughly shoving [L.W.] forward while she ([L.W.]) is sitting in her wheelchair so that [L.W.] is leaning forward." The footage also showed, on August 4, 2020, "one incident of [respondent] aggressively transferring [L.W.] from her wheelchair to a sofa in the living room." Additionally, the footage showed, on August 10, 2020, "[L.W.] is sitting in her wheelchair facing a dining table. [Respondent] grabs [L.W.]'s hair on the back of her head and yanks her back and forth." Finally, the footage showed, also on August 10, 2020, "[respondent] grabs [L.W.]'s neck from the back and forcefully pushes her forward so that she can lean towards the table."

9. Based on the investigation, Ms. Boyal found the allegation that respondent physically abused L.W. to be substantiated. Ms. Boyal testified at hearing consistently with the Investigation Case Report. Based on the findings in the case report, DSS referred the matter to the Board for possible license discipline.

Board Investigation

10. The Board assigned Special Investigator Darin Hieb to investigate the complaint about respondent's actions. Among other things, Mr. Hieb reviewed the portions of the video surveillance footage identified by Ms. Boyal and interviewed respondent. During respondent's interview, Mr. Hieb played the video clips for her. Respondent admitted she was frustrated and stressed about the COVID-19 pandemic and an argument with her husband. She acknowledged she was more aggressive than she had to be and expressed regret for her behavior. Based on his investigation, Mr. Hieb prepared a written investigative report which was admitted into evidence at the hearing without objection. Mr. Hieb referred the matter back to the Board to determine the appropriate action. He testified at hearing consistent with his report.

Board Expert

11. Complainant retained Christina Curry, LVN, to evaluate the facts and offer an opinion regarding the nursing standard of care and whether respondent violated the same. Ms. Curry received her degree in Vocational Nursing from Sacramento City College in an unspecified year. She has been an LVN in California since May 2000. Since 2008, she has worked for the Charles A. Jones Career & Education Center of the Sacramento City Unified School District as a vocational nursing/certified nursing assistant/home health aide instructor. She has been an

expert consultant for the Board approximately eight times since 2017. She was qualified to offer expert opinion testimony on the nursing standard of care and on whether respondent violated the same.

12. Ms. Curry reviewed Ms. Boyal's and Mr. Hieb's reports and their supporting documentation and observed the security camera footage. Based thereon, she prepared a written report of her expert opinion. Her written report was admitted into evidence without objection. Ms. Curry testified at the hearing consistent with her report. Ms. Curry provided an expert opinion that respondent's mistreatment of L.W. violated the nursing standard of care. At hearing, Ms. Curry acknowledged RCFEs provide custodial, non-medical care and, typically, an RCFE is not permitted to provide nursing care. Ms. Curry understands neither respondent nor her husband were acting as LVNs during their interactions with L.W., but that does not change her expert opinion that respondent violated the nursing standard of care. Respondent offered no expert witness testimony in rebuttal.

Respondent's Evidence

13. Respondent testified at hearing. She has worked in healthcare since she moved to the United States in approximately 2003. She began her career as a certified nursing assistant (CNA) in a post-acute rehabilitation facility. She worked as a CNA for six years until 2010, when she became an LVN. She has worked for the State of California in a prison healthcare facility since 2013. Presently, she works in the mailroom while her employer investigates an allegation that she has been harassed at work. She is currently in a registered nursing (RN) program and scheduled to begin her clinical rotation in June 2023. She has no previous license or employment discipline.

14. Respondent testified that she and her husband opened the RCFE in 2018 because they love taking care of people. In early 2020, many staff members quit due to the COVID-19 pandemic. Respondent worked full-time in her regular employment and also full-time at the RCFE. Before the events of August 2020, she sought psychological counseling because she felt "burned out and stressed." She continues to go to counseling.

15. L.W. entered the RCFE in 2019. She was wheelchair bound and needed help with many of her activities of daily living, such as eating, bathing, laundry, and making her bed. Respondent and other staff members helped L.W. with those activities. He did not provide nursing care to L.W. or any other resident of the RCFE.

16. Respondent acknowledged she used one hand behind L.W.'s neck to adjust L.W.'s position in her wheelchair. She typically used her other hand to stabilize herself or the wheelchair. She also transferred L.W. from her wheelchair into other seats by lifting L.W. from the upper arms. She claimed that was not trying to be too rough and did not believe she was hurting L.W. by using these techniques. After watching the surveillance videos, she recognized that her conduct appears rough, and she would use different techniques in the future.

17. On August 10, 2020, respondent was arguing with her husband and feeling stressed. She thinks she "snapped" when she slapped L.W.'s head. Respondent claims that she did not intend to hurt L.W. but that she was frustrated L.W. was tilting her head back while she ate because she risked aspirating her food. Respondent claims that she was trying to convince L.W. to help herself more and that she regrets her conduct every day and believes it was out of character for her. She denied ever having behaved that way toward a resident before or after that day.

18. Respondent no longer operates the RCFE. As part of a settlement with DSS, she and her husband surrendered their licenses and agreed never to seek re-licensure.

Character Witnesses

19. Sonny Eboigbe testified at hearing and submitted a letter of support on respondent's behalf. Mr. Eboigbe is the chief pastor at the church respondent attends. He has known respondent for 10 years and considers her a friend. He described respondent as cordial, warm, and respectful. Mr. Eboigbe does not know the details about this matter but knows respondent is sad and remorseful. He has counseled respondent about her conduct and believes she understands it "cannot happen again."

20. Crystal Davis testified at hearing and submitted a letter of support on respondent's behalf. She has worked with respondent for approximately two years and supervised respondent in the prison facility's mailroom for approximately one year. In her experience, respondent is hard-working, positive, happy, and upbeat. She is not aware of the nature of the Accusation but finds any allegation of wrongdoing surprising given her high opinion of respondent's work ethic and character.

21. Respondent also submitted six letters of support from friends and coworkers. Collectively, the authors described respondent as conscientious, compassionate, dependable, friendly, cheerful, and honest. None of the authors described in any detail their knowledge of the basis for the Accusation or respondent's rehabilitation from any misconduct.

Analysis

22. Complainant alleged that between August 3 and 10, 2020, respondent pushed L.W. forward roughly twice while L.W. was seated in her wheelchair, grabbed L.W. by her upper arms and roughly threw her from the wheelchair to a reclining chair, readjusted L.W. by grabbing her upper arms and dropping her back down, slapped L.W.'s head and grabbed her hair to forcefully push her toward the dining table, and shoved L.W. toward the dining table by the back of her neck.

23. The record provides clear and convincing evidence that respondent slapped L.W.'s head and grabbed her hair on August 10, 2020. Respondent acknowledged adjusting L.W.'s body position by using one hand behind her neck. She also acknowledged gripping L.W. by her upper arms to transition her from her wheelchair and repositioning her in a different

seat. She denied using excessive force in those circumstances but her denial is not credible in light of the other evidence.

24. The Board can discipline a licensee for unprofessional conduct. (Bus. & Prof. Code, § 2878, subd. (a).) Complainant alleged respondent demonstrated general unprofessional conduct when she "failed to comply with the Personal Rights in Privately Operated Residential Care Facilities for the Elder policy." Specifically, complainant alleged respondent: (1) "failed to ensure that resident L.W. was accorded dignity in her personal relationships with staff, residents, and other persons, in violation of Policy number one"; (2) "failed to ensure that resident L.W. was to be accorded safe, healthful treatment, and had comfortable accommodations, furnishings and equipment, in violation of Policy number two"; and (3) "failed to ensure that resident L.W. was free from corporal or unusual punishment, humiliation, intimidation, mental, or physical abuse, in violation of Policy number three." These rights are found in the regulations that govern RCFEs. (Cal. Code Regs., tit. 22, § 87468.1, subd. (a)(1)-(3).)

25. The record provides clear and convincing evidence that this misconduct occurred and that it relates to the practice of vocational nursing. Ms. Curry opined that respondent's violation of the DSS regulation relates to her work as an LVN because LVNs must be aware of and comply with their facility's policies and procedures, state and county policies and procedures relating to the operation of a RCFE. On that basis, she concluded respondent's violation of the DSS regulation constituted unprofessional conduct for an LVN. Respondent offered no expert opinion testimony to rebut this conclusion.

26. Nursing is a highly regulated field and LVNs must be able to follow applicable statutes and regulations. Respondent's ability to follow the RCFE regulation, though not in the course of her work as an LVN, is therefore related to her practice as a nurse. Although respondent was not providing nursing care to L.W., she was responsible for the safety and wellbeing of a vulnerable person. Her failure to comply with a legal regulation designed to ensure the safety and dignity of such an individual demonstrates an unfitness to practice nursing. On that basis, complainant proved by clear and convincing evidence that respondent engaged in general unprofessional conduct when she violated the DSS regulation governing treatment of RCFE residents.

<u>Costs</u>

27. Pursuant to Business and Professions Code section 125.3, complainant requested respondent be ordered to reimburse the Board its costs for the investigation and prosecution of this matter, which total $20,526. Complainant submitted a Declaration of Investigative Costs, signed by Mr. Hieb, seeking $4,686 for 22.75 hours of his time investigating the matter. Included in the declaration is a summary of the investigative tasks Mr. Hieb performed and the time he spent on those tasks. Complainant also submitted a Certification of Prosecution Costs signed by Ms. Heim. This certification indicates Ms. Heim and four of her colleagues billed the Board $1 5,320 in costs for 71 hours of time enforcing this matter and includes a daily itemization of the tasks performed and time consumed. Complainant also submitted an Expert Consultant Itemized Invoice, signed by Ms. Curry, seeking $520 for eight hours of her time spent on this matter.

28. Respondent objected to complainant's investigation costs as too high in general. Respondent also objected that the scope of Mr. Hieb's investigation was excessive and that his investigation included double billing with the case against respondent's husband. Finally, respondent testified that repaying Board costs would create a hardship given her financial circumstances. Specifically, in addition to her student loan and credit card debt, she pays tuition for her RN program, contributes to one son's college tuition, and will contribute for a second son's tuition next year. Additionally, she and her husband owe approximately $60,000 for a business loan related to their RCFE, but because they have closed the facility, they are unable to use it to generate income to repay that loan.

LEGAL CONCLUSIONS

1. The standard of proof to be used in these proceedings is "clear and convincing evidence." (*Ettinger v. Bd. of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) This means the burden rests on complainant to establish the charging allegations by proof that is clear, explicit and unequivocal, as to leave no substantial doubt, and sufficiently strong to command the unhesitating assent of every reasonable mind. (*In re Marriage of Weaver* (1990) 224 Cal.App.3d 478, 487.)

Causes for Discipline

2. The Board may discipline an LVN's license if the LVN has engaged in unprofessional conduct. (Bus. & Prof. Code, § 2878, subd. (a).) Unprofessional conduct includes, among other things, "gross negligence in carrying out usual nursing functions." (*Id*. at subd. (a)(1).) Gross negligence means "a substantial departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent licensed vocational nurse, and which has or could have resulted in harm to the consumer." (Cal. Code Regs., tit. 16, § 2519.)

3. In the first cause for discipline, complainant alleged respondent was grossly negligent when she slapped L.W.'s head and grabbed her by the hair to forcefully push her toward the dining table. Complainant failed to prove by clear and convincing evidence that respondent was carrying out usual nursing functions for L.W. when the misconduct occurred. As a result, cause does not exist to discipline respondent’s license for gross negligence under Business and Professions Code section 2878, subdivision (a)(1). The first cause for discipline of gross negligence is not sustained.

4. Unprofessional conduct also includes, among other things, "incompetence . . . in carrying out usual nursing functions." (Bus. & Prof. Code, § 2878, subd. (a)(1).) Incompetence means "the lack of possession of and the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by responsible licensed vocational nurses." (Cal. Code Regs., tit. 16, § 2519.)

5. In the second cause for discipline, complainant alleged that respondent demonstrated incompetence when she failed to ensure that L.W. was properly positioned in her wheelchair to avoid slouching or to allow L.W.'s head to fall back and used force on the back of L.W.'s neck to move her forward in an upright position. Complainant failed to prove by clear and convincing evidence that respondent was carrying out usual nursing functions for L.W. when the misconduct occurred. As a result, cause does not exist to discipline respondent's license for incompetence under Business and Professions Code section 2878, subdivision (a)(1). The second cause for discipline of incompetence is not sustained.

6. Unprofessional conduct also includes, among other things, "the use of excessive force upon or the mistreatment or abuse of any patient." (Bus. & Prof. Code, § 2878, subd. (a)(4).) "Excessive force" means "force clearly in excess of that which would normally be applied in similar clinical circumstances." (Cal. Code Regs., tit. 16, § 2519.)

7. In the third cause for discipline, complainant alleged respondent used excessive force against L.W. during their several interactions between August 3 and 10, 2020. Complainant failed to prove by clear and convincing evidence that L.W. was a "patient" of respondent when the misconduct occurred. As a result, cause does not exist to discipline respondent's license for use of excessive force against a patient under Business and Professions Code section 2878, subdivision (a)(1). The third cause for discipline of incompetence is not sustained.

8. In the fourth cause for discipline, complainant further alleged respondent engaged in general unprofessional conduct by failing to comply with the Personal Rights in Privately Operated Residential Care Facilities for the Elder policy, found at California Code of Regulations, title 22, section 87468.1, subdivision (a)(1)-(3). The policy entitles RCFE residents to dignity, safety, and freedom from abuse. Respondent's conduct toward L.W. violated her rights under that policy. Her failure to comply with a legal regulation designed to protect vulnerable individuals in her care demonstrates an unfitness to practice nursing. On that basis, cause exists to discipline respondent's license for general unprofessional conduct based on her violation of a regulation that governs RCFEs, pursuant to Business and Professions Code section 2878, subdivision (a). The fourth cause for discipline is sustained.

<u>Level of Discipline</u>

9. Having sustained the fourth cause for discipline, the Board now turns to the appropriate level of discipline in this case. The Board's Disciplinary Guidelines and Uniform Standards Relating to Substance Abuse recommend a maximum of revocation and a minimum of revocation, revocation stayed and two years probation for unprofessional conduct. Applying the relevant factors in this case, the Board determines that the intermediate level of discipline a is warranted in this case based on respondent's lack of prior discipline, warnings or remediation and the evidence of mitigation. The Board finds that the appropriate level of discipline is

revocation, revocation stayed and three years probation and this level of discipline adequately protects the public. (Bus. & Prof. Code, § 2841.1.)

Costs

10. Complainant requested respondent be ordered to reimburse the Board its costs for the investigation and prosecution of this matter in the amount of $20,526. As the Administrative Law Judge noted in the Proposed Decision, the California Supreme Court set forth factors in *Zuckerman V. Board of Chiropractic Examiners* (2002) 29 Cal.4th 32 that must be considered in determining the reasonableness of the costs sought pursuant to statutory provisions like section 125.3. These factors include whether the licensee has been successful at hearing in getting charges dismissed or reduced, the licensee's subjective good faith belief in the merits of her position, whether the licensee has raised a colorable challenge to the proposed discipline, the financial ability of the licensee to pay, and whether the scope of the investigation and prosecution was appropriate in light of the alleged misconduct.

11. Applying the *Zuckerman* factors, the Administrative Law Judge found that the complainant's requested costs for Mr. Hieb's investigation ($4,686), Ms. Curry's work as an expert ($520), and the work of the attorney general are adequately supported and reasonable and rejected respondent's arguments that Mr. Hieb's invoice was excessive and included double billing. The Administrative Law Judge found that the cost award should be reduced because assessing the full costs to respondent would unfairly penalize her for using the hearing process to defend herself and seek a reduction of the discipline sought and she not only maintained a subjective good faith belief in the merits of her position she also was successful in reducing the level of potential license discipline. Finally, the Administrative Law Judge found respondent credibly explained that a cost award would cause financial hardship for her. Based on these factors, the Administrative Law Judge concluded it is appropriate to reduce the costs to $10,000. The Board adopts the findings and conclusions of the Administrative Law Judge regarding the award of costs.

ORDER

Based on the foregoing factual findings and legal conclusions, the Board orders that Vocational Nurse License number VN 248442, issued to respondent Benedicta Onoshoagbe Aguele, be and hereby is revoked, that the revocation be immediately stayed and the license placed on three-years probation with Standard Terms of Probation numbers 1-14 (attached to this decision and incorporated by reference), and that respondent pay costs in the amount of $10,000. This decision is effective immediately.

IT IS SO ORDERED this 25th day of January 2024.

SIGNATURE ON FILE
Dr. Carel Mountain
President