

IN THE MATTER OF:)
)
Elvira A. Cornelius, RCP)
License Number – 3982)

CONSENT ORDER

i. Jurisdiction

The North Carolina Respiratory Care Board (the Board) is an occupational licensing board of the State of North Carolina, organized under The Respiratory Care Practice Act, codified at N.C. Gen. Stat. § 90-646, *et seq.* The Board has jurisdiction over this matter pursuant to N.C. Gen. Stat. § 90-652, § 90-659; and 21 N.C. Admin. Code 61.0307.

2. Identification of RCP

The Respiratory Care Practitioner whose license is at issue in this matter is Elvira A. Cornelius (the “RCP”). Her mailing address is 710 Gates Mill Dr. Apt. 302, Fort Mill, SC 29708. The RCP holds North Carolina Respiratory Care License number 3982 (the “License”), first issued on July 12, 2004, with an expiration date of July 31, 2015.

3. Waiver of Rights

I, Elvira A. Cornelius, the RCP, understand that I have each of the following rights, and as noted by my initials below, I, Elvira A. Cornelius, the RCP, hereby freely and knowingly waive each of these rights without further process and agree to the terms of this Consent Order regarding my License:

- EC The right to a hearing before the Board;
- EC The right to present evidence to disprove all or some of the charges against me;
- EC The right to present evidence to limit or reduce any sanction that could be imposed for a violation;
- EC The right to confront and cross-examine witnesses and to challenge evidence presented by the Board against me;
- EC The right to present legal arguments in a brief; and
- EC The right to appeal from any final decision adverse to my License to practice respiratory care.

4. Stipulation to Facts

The Respiratory Care Practitioner and the Board stipulate to the following facts:

A. The RCP was engaged in the practice of respiratory care in North Carolina during the events described in these factual stipulations.

B. On July 15, 2014, the Board received a complaint from Carmita Edison at Carolina Specialty Hospital (CSH) located in Pineville, NC alleging that Ms. Elvira Cornelius, RCP failed to properly document, properly report, and or initiate the ventilator changes after a patient failed a spontaneous breathing trial (SBT) on a 40% tracheostomy collar (T-Collar) the previous day. According to the complaint, the patient was on continuous positive airway pressure (CPAP) +5 cmH₂O and pressure support (PS) + 5 cmH₂O on 65% oxygen instead of the charted settings of assist control (A/C), respiratory rate (RR)-15, tidal volume (VT) of 410 milliliters (ml) and a positive end expiratory pressure (PEEP) of +5 cmH₂O at 65% oxygen as given in report to Ms. Edison. Ventilator settings prior to SBT were A/C RR 15, VT 410 and Peep +5 at 35%. Ventilator flow sheets show that the patient was placed back on A/C without assessment documented by Ms. Cornelius, RCP, the shift the supervisor at 1710H the previous evening after failing spontaneous breathing trial (SBT). Documentation was not provided for the increase in oxygen requirements after failing the SBT.

C. On September 09, 2014, the RCP attended the Board's Investigation and Informal Settlement Committee meeting at which time she stated she followed the policies of hospital in regards to the ventilator checks and the spontaneous breathing trials. Subpoenaed documentation from CSH showed the RCP charting high pressure limits (HPL) at 60 cmH₂O and low pressure alarm (LPA) at 10 cmH₂O on all patients under her care. She stated that she did not have concerns regarding patient safety related to high pressure alarms. She stated that she did not remember the national standard for settings alarms but they always set HPL at 60 cmH₂O and LPA at 10 cmH₂O at CSH. She stated that she was unaware of the actual wording of the ventilator management policy at CSH regarding pressure limits and alarms. Thelma Riley, RCP, who was her manager and also was interviewed by the Committee on that date, stated Ms. Cornelius's actions in regard to high and low pressure alarms on ventilators were consistent with CSH policy.

D. At its regular quarterly meeting on October 9, 2014, the Board voted to defer action on the complaint concerning the RCP and to have the Board's Investigation and Informal Settlement Committee conduct an additional interview with the RCP regarding the information obtained during the September 9 interview that involved ventilator policies and protocols for high and low pressure settings on patients at CSH.

E. On November 19, 2014, Board investigators traveled to CSH and reviewed the documentation concerning Ms. Cornelius with the department manager, Thelma Riley, RCP. The documentation reviewed showed that Ms. Cornelius: 1) omitted or used the inappropriate licensed credential designation in her documentation; 2) set high pressure limits at 60 cmH₂O and low pressure alarms at 10 cmH₂O on all patients under her care; and 3) failed to assess patient status per the stated protocol, and 4) failed chart treatment modalities consistently.

F. On November 20, 2014, the RCP attended the Board's Investigation and Informal Settlement Committee meeting held at a local hotel in Pineville. During the interview, she stated that she did not have concerns regarding patient safety related to high pressure alarms, but was unaware of the actual wording of the CSH policy. The RCP admitted that she: 1) failed to use the appropriate licensed credential designation; 2) set high pressure limits at 60 cmH₂O and

low pressure alarms at 10 cmH2O on all patients under her care but stated that "it was department policy to set alarm settings this way".

G. The Policy # RT-602 submitted to the Board by Carolina Specialty Hospital was last revised in May 2013 and it describes the procedure for setting high and low pressure alarms, and monitoring breath sounds and vital signs on ventilator patients. The Policy procedure provides following procedures for setting high and low pressure alarms on ventilators: 1) high-pressure alarm ideally is set at 15 cmH2) pressure above peak inspiratory pressure (PIP). The pressure alarm can be set higher due to the patient's disease state; and 2) low-pressure alarm ideally is set at 15 cmH2) pressure below peak inspiratory pressure (PIP). In addition, the policy also states that "the routine ventilator assessments are to be performed Q4 hours and include: Breath sounds-verify ET tube position.

H. The subpoenaed documentation received from Carolina Specialty Hospital on November 12, 2014 was reviewed with the RCP during the interview on November 20, 2014. The documentation shows that on February 8-9, 2014, the RCP did not chart vital signs or breath sounds for her assigned ventilator patients, thus violating the department policy.

I. The Policy # RT-802 submitted to the Board by Carolina Specialty Hospital last reviewed in May 2013 describes the aerosolized medication therapy protocol. The protocol states the guidelines and warnings of the procedure to include monitoring patents vital signs and evaluate patient's clinical status with each treatment. The need to change medication and/or therapy modality may be indicated by: 1) a pulse rate of 20 bpm occurring with bronchodilator medications; 2) significant worsening of dyspnea or wheezing occurring during or within 30 minutes of discontinuing therapy; and 3) If the patient's condition does not improve within 72 hours, reevaluate patient's therapy and modify as necessary or consult with the patient's physician. The policy also states that RCP's must consult with the physician if abnormal vital signs are sustained for more than 15 minutes.

J. The RCP stated that she did document treatments and ventilator checks but the location of documentation was inconsistent since her documentation was inconsistently charted on the flow sheet or the RT notes and she acknowledged that she could see why might be an issue.

K. Ventilator flow sheet shows that on 2/28/14, the patient in Room 309 was placed back on A/C after failing the SBT without an assessment of vital signs or breath sounds documented by the RCP. The documentation shows that the RCP did document that the patient was on A/C, RR 20, VT 500, and Peep +5 at 30%.

L. The ventilator flow sheet shows that on 2/28/14, the patient in Room 311 did not have vital signs or breath sounds documented by the RCP.

M. The ventilator flow sheet shows that on 2/28/14, the patient in Room 314 was placed back on A/C after failing the SBT without an assessment of vital signs or breath sounds documented by the RCP.

N. The ventilator flow sheet shows that on 2/28/14, the patient in Room 315 did not show vital signs or breath sounds documented by the RCP.

O. The ventilator flow sheet shows that on 7/12/14 at 1710H, the RCP placed the patient in Room 301 on A/C RR 15, VT 410 and Peep +5 at 35% after the patient failed a spontaneous breathing trial (SBT) and did not document vital signs or breath sounds. RCP documentation indicated the patient distress level required an increase of FIO2 to 70% to stabilize the patient. The ventilator flow sheet does not show any changes in FIO2 or any reassessment following the SBT failure until 1921H that evening. At 1921H, the patient was on 70% according to the ventilator written by Donnazetta Murray, RCP. After reviewing the sequence of events for the patient in Room 301 during the interview, the RCP stated that she could not explain why action was not taken to address the issue on her shift when the documentation showed deteriorating vital signs and oxygenation on the patient. The RCP stated that she was helping Ms. Murray as lead and she did not place the patient in question on CPAP as alleged in the complaint despite the patient deteriorating during the shift.

5. Stipulated Order

Under N.C. Gen. Stat. § 90-652, in lieu of proceeding to a hearing, the RCP and the Board hereby enter into this Consent Order and agree to the following specific terms:

A. RCP's Stipulation as to Pertinent Sections of the Statute and Rules:

I, Elvira A. Cornelius, the RCP, admit that the Stipulated Facts set forth above in this Consent Order constitute violations of N.C. Gen. Stat. § 90-659 (a)(1) (b) and (d), N.C. Gen. Stat. § 90-659 (4); and 21 N.C. Admin. Code 61 .0307 (10) and 61 .0307(15) of the Board's Rules.

B. RCP's Stipulation to Sanctions and Future Performance Obligations:

1) The RCP acknowledges that in light of the Stipulated Facts set forth above, a reprimand of her License is an appropriate sanction for the Board to impose under N.C. Gen. Stat. § 90-659 (1) (b) and (d) and N.C. Gen. Stat. § 90-659 (4). Therefore, the RCP accepts and agrees to receiving a Reprimand from the Board and to comply with and complete each of the specific requirements set forth below within the time period specified for compliance with each.

2) The RCP accepts and agrees to pay a civil penalty of two hundred and fifty dollars (\$250.00) pursuant to N.C. Gen. Stat. § 90-666 and 21 N.C. Admin. Code 61.0309. The RCP shall remit this sum to the Board no later than ninety (90) days after execution of this order.

3) The RCP accepts and agrees to the assessment of two hundred and fifty dollars (\$250.00) in costs pursuant to N.C. Gen. Stat. § 90-666(d) and to remit this sum to the Board no later than ninety (90) days following the execution of this Consent Order. The RCP also assumes financial responsibility for any costs associated with fulfilling the terms of this Consent Order.

4) The RCP accepts and agrees to complete 12 additional continuing education credits on ventilator management and submit the course credits to the Board at least 30 days before the next renewal of the License.

5) The RCP accepts and agrees to complete a two page essay on the Standard of Care for Ventilator Alarms according to Board writing guidelines and submit it electronically no later than 30 days after signing this Consent Order.

6) The RCP agrees to continue to comply with the Respiratory Care Practice Act, the Board's Rules, and the Board's published interpretation of those rules.

7) The RCP acknowledges that this disciplinary action will be reported to appropriate entities as outlined in Board policy and as required by state and/or federal law or guidelines. Those entities include, but are not limited to, the National Databank maintained by the National Board for Respiratory Care and the Healthcare Integrity and Protection Data Bank (HIPDB).

8) The RCP acknowledges and agrees that if she fails to comply with the terms of this Consent Order, either by completely failing to carry out one of her obligations, or failing to complete it within the time specified, that will constitute a violation of 21 N.C. Admin. Code 61 .0307(3); the Board may suspend or revoke the License, or impose additional disciplinary sanctions or performance obligations on the RCP.

9) The RCP acknowledges and agrees that this Consent Order and the materials compiled by the Board are matters of public record under the North Carolina Public Records Law, N.C. Gen. Stat. § 132-1 *et seq.*; and that the contents of this Consent Order will be reported to the appropriate entities as outlined in Board policy and as required by state and/or federal law or guidelines, including but not limited to the National Databank maintained by the National Board for Respiratory Care and the Healthcare Integrity and Protection Data Bank (HIPDB).

10) The RCP agrees that if circumstances arise which affect the RCP's ability to remain in compliance with any of the terms of this Consent Order, the RCP shall immediately notify the Board in writing by return receipt mail, fully describing the situation and providing a specific request to modify its terms for Board consideration. However, no modification of this Consent Order shall be in effect until the Board confirms such a modification in writing to the RCP.

6. Effective Date/Modification

All provisions of this Consent Order are effective upon the date that the Executive Director of the Board signs it, and it shall remain in effect for the time period or periods specified, or until amended in writing by the Board.

The terms of this Consent Order shall remain in effect for one year from its effective date and expire at that point. However, the Licensee must continue to comply with the Respiratory Care Practice Act and the Board's Rules; and if other evidence of the RCP's non-compliance with the Act or the Rules that is not presented in the Stipulated Facts above should arise, then the Board may invoke other disciplinary measures against the RCP, based on that other evidence; and in determining the appropriate action to take, the Board also may consider the conduct of the RCP which is presented in the Stipulated Facts in this Consent Order.

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CONSENT TO ISSUANCE OF ORDER BY RESPIRATORY CARE PRACTITIONER

I, Elvira A. Cornelius, state that I have read the foregoing Consent Order; that I know and fully understand its contents; that I agree freely and without threat or coercion of any kind to comply with the terms and conditions stated herein; and that I consent to the entry of this Consent Order as a condition of maintaining my license from the North Carolina Respiratory Care Board.

Elvira A. Cornelius
Elvira A. Cornelius

STATE OF NORTH CAROLINA
COUNTY OF Union

There personally appeared before me, a Notary Public in and for the County of Union, State of North Carolina, Elvira Cornelius, who, after having presented documentation of her identity that was satisfactory to me, did acknowledge that she executed the foregoing Consent Order as her free and voluntary act.

This 6 day of march, 2015.

Patsy Beuzelle Sawmstr
Notary Public

(SEAL)

My Commission Expires: _____
Expires 12/15/2019

ENTRY OF CONSENT ORDER ON BEHALF OF THE NORTH CAROLINA RESPIRATORY CARE BOARD

The foregoing Consent Order is entered at Cary, North Carolina, this 13th day of MARCH, 2015.

William L. Croft PhD, RRT, RCP
William L. Croft, PhD, RRT, RCP
Executive Director, North Carolina Respiratory Care Board