IN THE MATTER OF	*	**BEFORE THE MARYLAND**
	*	
KHADIDIA DIAW	*	**BOARD OF NURSING**
	*	
License Number: LP53063	*	**OAG CASE No. 22-BP-024**
	*	

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ORDER FOR SUMMARY SUSPENSION OF LICENSED PRACTICAL NURSE LICENSE PURSUANT TO SECTION 10-226(c)(2) OF THE ADMINISTRATIVE PROCEDURE ACT

The Maryland Board of Nursing (the "Board") hereby orders the **SUMMARY SUSPENSION** of the license of **KHADIDIA DIAW**, (the "Respondent"), Licensed Practical Nurse - License Number **LP53063**, in the State of Maryland. The Board takes this action pursuant to the authority of Maryland Code Ann., State Gov't Article § 10-226(c)(2) (2021 Repl. Vol.), which provides:

> (2) A unit may order summarily the suspension of a license if the unit:
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> (i) finds that the public, health, safety, or welfare imperatively requires emergency action; and
>
> (ii) promptly gives the licensee:
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> 1. Written notice of the suspension, the finding and the reasons that support the finding; and
> 2. An opportunity to be heard.

On July 27, 2022, a pre-deprivation show cause hearing was held before the Board to give the Respondent an opportunity to present oral argument as to why the Board should not summarily suspend the Respondent's license. The Respondent was present at the Show Cause Hearing. The Assistant Attorney General – Administrative Prosecutor, was present at the Show Cause hearing on behalf of the State.

ORDER FOR SUMMARY SUSPENSION PURSUANT TO § 10-226(c)(2) OF THE STATE GOVERNMENT ARTICLE
Khadidia Diaw, LP53063

INVESTIGATIVE FINDINGS AND REASONS IN SUPPORT OF SUMMARY SUSPENSION

Based on investigatory information obtained by, received by and made known to and available to the Board, the Board has reason to believe that the following facts are true:[1]

1. On November 19, 2004, the Board issued a CNA certificate to the Respondent. The Respondent received GNA designation on April 27, 2005, and certification as a CMA on May 3, 2007. The Respondent's CNA/GNA/CMA certificate is currently nonrenewed, having expired on October 28, 2008.

2. On or about October 3, 2016, the Respondent was issued a license to practice as a licensed practical nurse ("LPN") in the State of Maryland, license number LP53063. The Respondent's LPN license is currently active and is scheduled to expire on October 28, 2022. The Compact[2] status of the Respondent's Maryland LPN license is "Multistate." According to the Maryland Board's MyLicense Office ("MYLO") database, the Respondent's current address is in Maryland.

3. At all relevant times the Respondent was employed as an LPN at a long-term care facility (the "Facility").[3]

4. As part of her job description, the Respondent was required to maintain current BLS/CPR certification. According to the Respondent's employment records, the Respondent was certified as a Basic Life Support ("BLS") Provider by the American Heart Association on March 7, 2018

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[1] The allegations set forth in this document are intended to provide the Respondent with reasonable notice of the Board's action. They are not intended as, and do not necessarily represent a complete description of the evidence, either documentary or testimonial, to be offered against the Respondent in connection with this action.

[2] The Nurse Licensure Compact (NLC) is an agreement between Boards of Nursing of party states that allows nurses to have one Multistate nursing license with the ability to practice nursing in both their home state and other party states. In accordance with the Nurse Licensure Compact, Md. Code Ann., Health Occ. § 8-7A-01.3(h) and § 8-7A-01.3(m) respectively, "Home state" means the party state that is the nurse's primary state of residence and, "Party state" means any state that has adopted this Compact.

[3] For purposes of ensuring confidentiality, proper names have been omitted and replaced with generic placeholders. Upon written request, the Administrative Prosecutor will provide the information to the Respondent.

and her BLS certificate was recommended to be renewed in March 2020. The Respondent was also certified in basic IV Therapy on December 6, 2017.

COMPLAINT

5. On or about April 30, 2020, the Board received a complaint ("Complaint") from the Facility's Nurse Executive (the "Complainant") regarding the Respondent's practice as an LPN alleging that the Respondent failed to call a STAT code and failed to initiate and perform cardiopulmonary resuscitation (CPR) on a patient (the "Patient") who was a full code and had no pulse and no respirations.

6. The Patient was a 59-year-old male with the following diagnoses: multiple sclerosis, paraplegia, contractures of the right and left hands, Type II Diabetes Mellitus, anemia, and hypertension. On or about April 14, 2020, the Patient was diagnosed with novel coronavirus SARS-CoV-2[4] ("COVID-19").

7. According to the Patient's Maryland Medical Orders for Life-Sustaining Treatment (MOLST) dated March 21, 2019, the Patient wanted medical providers to provide cardiopulmonary resuscitation (CPR), "intubation and artificial ventilation as a limited therapeutic trial," blood transfusions, "transfer to a hospital for severe pain or severe symptoms that cannot be controlled otherwise," diagnostic testing, intravenous and/or oral antibiotics, "artificially administered nutrition and fluids if medically indicated, as a trial" and "dialysis for a limited period."[5]

8. After the Patient's COVID-19 diagnosis, the Patient met with a Nurse Practitioner on April 17, 2020 via telemedicine. According to the Nurse Practitioner's April 17, 2020 Progress Note,

[4] SARS is the acronym for severe acute respiratory syndrome caused by a SARS-associated coronavirus.
[5] The Patient's "Full Code" status is not only listed on his MOLST form, but is listed at the top of each page of the Patient's Medication Administration Record (MAR).

the Patient was alert and oriented at that time and was experiencing intermittent fevers, poor appetite, nausea, vomiting and said he felt "like he has the Flu." The Patient had no complaints of shortness of breath. The Nurse Practitioner documented that the Patient "continues to want full code as seen below in GOC (Goals of Care) discussion." Under the Goals of Care, the Nurse Practitioner documented that the Patient wanted to "focus on aggressive care at all costs," to be "moved to ICU if clinically worsens," "a breathing tube (intubation) if breathing worsens," "vasopressors in the event of very low blood pressure (shock)," and "CPR if [his] heart stopped working."

9. The Respondent was assigned to provide nursing care to the Patient from 7 a.m. to 11 p.m. on Sunday, April 19, 2020.

10. In the April 20, 2020 written statement the Respondent provided to the Facility, she wrote the following regarding her care of the Patient on April 19, 2020:

a. At 8:00 a.m. she gave the Patient ginger ale and then at 9:00 a.m. she assisted the GNA in turning the Patient.

b. At 9:30a.m. she asked the Nurse Educator to come to the Patient's room and look at him.[6] The Nurse Educator told her to call the on-call agency ("Agency"). The Agency called her back and stated that the Patient's family did not want the Patient to be transferred to an emergency room and to treat the Patient at the Facility.[7]

c. At 10:00 a.m., she asked the Nurse Educator if she would initiate an IV or call the IV Agency because the Respondent was not IV certified. The Nurse Educator texted the Respondent back and told her that she (the Respondent) had been IV certified on December 5 and 6 in 2017.

d. At 10:17 a.m., she texted the Nurse Educator asking if she should call the IV Agency.

[6] The reason the Respondent requested that the Nurse Educator assess the Patient at 9:30 a.m. is unclear. There is no documentation made by the Respondent regarding the Patient's medical condition or a change in the Patient's status at approximately 9:30 that morning.
[7] There is no documentation of this call in the Patient's medical records received by the Board.

e. At 10:40 a.m., a nurse ("RN 1") came to the floor and attempted to start an IV on the Patient, but failed to get IV access.

f. Around lunch time, the Nurse Educator advised her to call the IV Agency.

g. At approximately 12 p.m., she checked the Patient's blood glucose which was 87 mg/dl.[8]

h. At approximately 1:00 p.m., she obtained the Patient's vital signs.[9]

i. At approximately 2:00 p.m., she checked on the Patient when she was in his room providing medications to the Patient's roommate.

j. At approximately 3:00 p.m., the IV Agency obtained IV access on the Patient and she initiated IV fluids (normal saline) at that time.[10]

k. At approximately 4:00 p.m., the GNA notified her that the Patient's blood pressure was low "at 87 over something" so she went to recheck the Patient's blood pressure and "it was normal." "All his vitals were normal."[11]

l. At 5:00 p.m., she went to do her dinner fingerstick (blood glucose check) on the patient and the Patient "appeared to be sleeping from earlier."

m. The Respondent wrote, "I attempted to wake him up so he could eat but I couldn't wake him. He was breathing but wasn't responding. I got cold water and put it on. I rubbed his chest with ice cubes but still no response. I called [the Nurse Educator] and asked her to please come and look at [the Patient.] She stated she was on her way out and to call the [on-call agency.] I called [the on-call agency] and they said they were experiencing high call volume. When I finally spoke with the nurse she asked me to check his fingerstick again and call her back. Around 5:25 I reentered [Patient's room] to recheck his fingerstick but he appeared to be gone already. I went to go get my stethoscope and while I was walking I called [Nurse Educator's]

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[8] There is no documentation in the Patient's medical records that indicate the Respondent obtained a blood glucose level on the Patient at 12:00 p.m. on April 19, 2020. The only blood glucose levels documented in the Patient's medical records for April 19, 2020 were 137 mg/dL at 6:10 a.m. (documented by night nurse); and 175 mg/dL at 4:00 p.m. documented by the Respondent.

[9] There are no 1:00 p.m. vital signs documented in the Patient's medical records by the Respondent or any other care provider. However, the Respondent placed a "check mark" on the Patient's Orders chart indicating that she obtained the Patient's vital signs at 1:00 p.m. and 5:00 p.m. on April 19, 2020. The only vital signs that the Respondent documented in the Patient's medical records on April 19, 2020 were obtained at 5:01 p.m.

[10] According to the Nurse Educator's nursing note on April 19, 2020, the IV agency initiated IV access and the Patient began receiving IV fluids at 1:17 p.m. However, the Respondent documented that she administered IV fluids to the Patient at 3:00 p.m.

[11] There is no documentation in the Patient' medical records that indicates a blood pressure was obtained by the GNA or the Respondent at 4:00 p.m. on April 19, 2020. There is only one blood pressure documented for the Patient for the date of April 19, 2020 - the Respondent documented that she obtained the Patient's blood pressure manually at 5:01 p.m. on April 19, 2020 and it was 90/55 mmHg.

> cell, [the Complainant's] cell, and [the Complainant's] home to get directions on what to do because I truly did not know…I text [*sic*] [Nurse Educator], "I think he passed" I also alerted the nurses I needed their assistance in [Patient's room]. [At] 5:33 I reentered the room with my stethoscope but I could not get a good listen…I checked his pulse and felt absolutely nothing. I went outside and met [RN 2] at the door, she came and verified [the Patient] had no pulse…I did everything I could for him….I may not have acted with my best judgment but it was not out of self-preservation but out of pure ignorance…When we attempted to use the AED machine we did not even have pads and had to wait to get another one from another unit.

11. The GNA wrote in her April 19, 2020 statement that "around 5 p.m." she went to the Patient's room and saw that the Patient was "breathing slowly" and she ran to get the Respondent who then went into the Patient's room.[12]

12. According to the Facility's staffing sheet, RN 2 was the assigned registered nurse for the evening and night shift beginning on April 19, 2020. In the April 19, 2020 written statement RN 2 provided to the Facility, RN 2 wrote that at 5:30 p.m. the Respondent asked her to confirm the absence of a pulse and respirations in the Patient. RN 2 stated that she confirmed that the Patient had no pulse and respirations and attempted to start CPR. RN 2 wrote that when she asked about the Patient's code status, the Respondent stated "there is no code" and the Respondent asked RN 2 to assist her in notifying the physician and the family about the Patient's death.

13. In the written statement the Nurse Educator provided to the Facility on April 23 2020, the Nurse Educator wrote that the Respondent contacted her at approximately 10 a.m. on April 19, 2020 to ask if she could initiate an IV or call the Facility's IV company to initiate the IV on the Patient. The Nurse Educator sent RN 3 to the room but RN 3 was unable to initiate an IV on the patient. The Nurse Educator also attempted to draw blood on the Patient but was unsuccessful. She

[12]The GNA did not follow the Respondent back into the Patient's room, but went to break up an argument between two residents in a different room.

told the Respondent to call the Facility's IV Agency who subsequently arrived and initiated IV access and drew blood from the Patient. The Nurse Educator stated that she left the Facility at 5:00 p.m. and that the Respondent notified her at approximately 5:30 p.m. that "I think he passed." She stated that she asked the Respondent twice if the Respondent had initiated CPR and the Respondent did not answer her question. The Respondent did tell her that RN 2 verified that the Patient did not have a heartbeat or respirations.

14. According to the Emergency Medical Services report, a 911 call was received for cardiac arrest at the Facility at 6:25 p.m. and the medics arrived at the Patient's bedside at 6:35 p.m. The paramedic ("Paramedic") noted upon arrival the Patient had "dependent lividity"[13] and documented the following:

> Upon arrival donned PPE…-+COVID19 patient. Staff standing in room with pt. Pt laying supine in bed. No CPR in progress. AED NOT on pt. Staff notes pt is confirmed COVID19 pt. Pt has been having respiratory issues recently staff noted. Staff notes he was like this since 1700. Placed pt on cardiac monitor. Pt not breathing no pulse. Pt. asystole. Priority 4 called at 18:38.

15. According to the Facility's policy on Cardiac and/or Respiratory Arrest, upon discovery of a patient in cardiopulmonary arrest, "staff will immediately (1) call for assistance; (2) alert the licensed nurse and CPR/ automated external defibrillator (AED) certified staff; and (3) prepare the patient for CPR/AED while determining the presence of a Do Not Resuscitate order (DNR)." The policy further states, that "[the Facility] will perform CPR on all patients, except in certain limited circumstances, unless there is a written physician's order, agreed to by the patient or healthcare decision maker, not to resuscitate (DNR), in accordance with state regulation/law" and "an automated external defibrillator (AED) will be used , if available, to treat persons who experience

[13] Dependent lividity is a reddish blue discoloration of the skin resulting from the gravitational pooling of blood in blood vessels evident in the lower lying parts of the body in the position of death. Also called livor mortis. During initial phases, patches of discoloration start appearing in the dependent regions in 1 to 3 hours after death. NIH National Library of Medicine, Postmortem Changes Rutwik Shedge, KewaiKrishan, Varsha Warier Tanuj Kanchan. www.ncbi.nlm.nih.gov/books/NBK539741

sudden cardiac arrest." "If a patient does not have a DNR order, CPR/AED certified staff will initiate CPR/AED and emergency medical services (EMS) will be activated. CPR is to be provided in the location where the patient is discovered as long as the location is safe for the responder and patient."

16. The Respondent was terminated from her employment for gross negligence at the Facility for failing to follow the Facility's policy related to cardiac and/or respiratory arrest and failing to follow the Patient's MOLST orders, thereby violating the Patient's wishes.

PATIENT'S MEDICAL RECORDS

17. According to the Patient's medical records, at 9:39 a.m. on April 19, 2020, the Respondent documented her assessment of the Patient indicating that the Patient had new orders for a chest x-ray and IV fluids[14] and that his status was a "Full Code." The Respondent documented that the Patient was alert to person, place and time, and there had been no change in mental status of the Patient. The Respondent also documented that the Patient did not have a cough, any shortness of breath, chest discomfort and that lung sounds were clear in all lobes. In addition, the Respondent documented that the Patient's most recent blood glucose was 137.0 mg/dL at 6:10 a.m. However, the Respondent did not obtain or document any vital signs for the Patient on April 19, 2020 until 5:01 p.m.[15]

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[14] There was no documentation in the Respondent's 9:39 a.m. assessment to indicate the reason for the new physician's orders for a chest x-ray and IV fluids. However, the physician's order itself indicated that the orders were for a change in the Patient's mental status.

[15] Under the Vitals section of her 9:39 a.m. assessment, the Respondent documented the Patient's vital signs that were obtained at 5:01 p.m. that afternoon (Pulse 82; Respirations 22, temperature 97.5°F, and blood pressure 90/55 mm Hg). The Vitals section of the assessment directs the healthcare provider when documenting to "Clear vitals that were not taken as part of this note (if vitals were taken and entered after note was initiated View ALL and choose current vitals.)" Prior to 5:01 p.m. on April 19, 2020, the most recent pulse (89 bpm), respirations (18), and temperature (97.7°) were obtained by the night shift nurse at 6:08 a.m. on April 19, 2020. Prior to 5:01 p.m. on April 19, 2020, the most recent blood pressure obtained for the Patient before 5:01 p.m. on April 19, 2020 was obtained the day before at 4:44 p.m. on April 18, 2020 (106/99 mmHg).

18. At approximately 9:45 a.m., the Patient's physician ordered that peripheral IV access be obtained (one time) on the Patient "for change in mental status until 04/19/2020 23:59" and that the Patient receive 100 ml/hr. of 0.9% normal saline solution intravenously every shift "for change in mental status" for 3 days x 2 liters via peripheral line continuously. [16]

19. According to the Physician's Orders, beginning at 1:00 p.m. on April 19, 2020, the Patient's vital signs were to be obtained "every 4 hours for change in mental status for 1 day, Start Date 04/19/2020 1300." The Respondent initialed and placed a "check mark" on the physician's order at 1 p.m. and 5 p.m. indicating that she obtained the Patient's vital signs at 1:00 p.m. and 5:00 p.m. However, there are no vital signs documented in the Patient's records for 1:00 p.m. on April 19, 2020.

20. The Nurse Educator documented on April 19, 2020 that at 1:13 p.m. an IV was initiated on the Patient and a blood draw was obtained for diagnostic testing.[17]

21. The Respondent documented that the Patient's blood glucose level was 175 mg/dL at 4:00 p.m. on April 19, 2020.

22. The Respondent documented that the Patient's vital signs at 5:01 p.m. on April 19, 2020 were: pulse 82 bpm, respirations 22, temperature 97.5°F, O_2 saturations 96% on room air, and blood pressure was 90/55 mmHg. The Respondent did not document any "new onset indicators" of cough, chest congestion, or increase of shortness of breath as of 5:01 p.m.

23. In her Nursing Note, after the Patient had died, the Respondent documented that "Resident observed with absence of breath and pulse. EMT arrived and pronounced resident expired at 6:30 p.m. [On Call Agency] nurse made aware. Family made aware."

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[16] The Respondent did not document anywhere in the Patient's medical records any changes in the Patient's mental status or the Patient's condition that occurred on April 19, 2020 that prompted the physician's new order for IV access and the administration of IV fluids on the morning of April 19, 2020.
[17] The physician had ordered a basic metabolic panel and complete blood count with differential.

Respondent's Written Statement to the Board

24. In the written statement the Respondent provided to the Board dated October 18, 2021, the Respondent wrote the following:

> …What happened on the eve of April 19, 2020 was an unfortunate incident for all parts [*sic*] involved. I will not say that the cause in my delay to perform CPR was due to a mistake or ignorance. I know my patient very well, I knew his code status, I had a copy of it, I know how to perform CPR efficiently and I did perform CPR on him…
> ….
> Around 4 pm [GNA] told me that [the Patient's] blood pressure was low at 87 over something so went in to recheck it and it was normal. All of his vitals were normal…
>
> Around 5:25 I reentered room 58 to recheck his finger stick but he appeared to have deteriorated. I went to get help and I grabbed a pair of stethoscopes which I believe may have been on my nursing cart, I also called [Nurse Educator] and the [Complainant]…Around 5:30 p.m. [Nurse Educator] who lives right next to the [F]acility came and we performed CPR together. I don't know if [Nurse Educator] mentioned that I performed CPR but yes, I Khadidia Diaw did perform CPR on [the Patient] on the evening of August 19, 20202 [*sic*]. In my statement I write that the EKG wasn't working because it shows how unorganized the [F]acility was…
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> …I will admit that when I returned to [the Patient's] room and he appeared to be not breathing, I did get stuck for a moment…He didn't look like he was asleep how most bodies look when they passed not long ago but he looked like he passed hours ago. Even the paramedic said "He passed hours ago."

Interviews by Board Investigator

25. In her interview with the Board's Investigator on March 29, 2022, RN 2 stated that approximately 30 to 40 minutes after she arrived for her 3 p.m. – 11 p.m. shift at the Facility, the Respondent asked her to confirm that the Patient had no pulse and no respirations which she did. She asked the Respondent if the Patient was a full code, and the Respondent told her the Patient had COVID and was a "no code." RN 2 stated that to her knowledge, no CPR was performed on the Patient.

26. The Board Investigator interviewed the Nurse Educator on March 28, 2022 who stated that she had already left the facility at 5 p.m. and was not present when the Patient died. The Nurse Educator said she did not perform CPR on the Patient with the Respondent.

27. The Complainant told the Board's Investigator that that during the Facility's internal investigation, the Respondent admitted to her and the Assistant Director of Nursing that she (the Respondent) did not initiate CPR on the Patient.

28. On November 12, 2021, the Respondent was interviewed by the Board Investigator. During the interview, the Respondent stated the following:

a. The Nurse Educator was the supervisor for the day shift on April 19, 2020.

b. She was very familiar with the Patient and had been providing care for him for years.

c. On April 19, 2020, the Patient was in his second week of having COVID-19 and she had taken care of the Patient on April 18th the day before he died, and knew he had been deteriorating.

d. On April 18, 2020, the day before he died, the Patient was drinking fluids and was alert.

e. On April 19, 2020, the Patient could be heard wheezing without auscultation[18] but he was not on oxygen because his "oxygen wasn't low." The Patient was "weak," "lethargic,"[19] and "he could barely speak" but he was still his "polite self."

f. The Patient wouldn't drink fluids for her on the 19th like he had been doing the day before on April 18th.

g. She called the Nurse Educator on the morning of April 19th between 8 a.m. and 9 a.m. to tell her about the Patient's declining condition. She called the family and the family did not want the Patient transferred out so the on-call physician ordered IV fluids and additional tests.

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[18] In both her assessments of the Patient on April 18th and April 19th, 2020, the Respondent documented that the Patient's lungs were clear in all lobes and she did not document any crackles, rales, rhonchi, wheezes, or diminished breath sounds. In her nursing note on April 19, 2020, the Respondent also documented "lung sounds: all lobes clear. No cough present."

[19] In her April 19, 2020 assessment, under the Mental Status section, the Respondent indicated that the Patient was "alert." The Respondent did not indicate that the Patient was drowsy or lethargic. The Respondent indicated that there had been no decline in the Patient's mental status.

h. As the day went on, she monitored the Patient "all the time" and "as much as she could." The Patient had two roommates at the time.

i. The times listed in the timeline that she provided to the Facility regarding the events of April 19, 2020 were not accurate.

j. She and the GNA were in the Patient's room around 4:00 p.m. to do vital signs because the COVID-19 patients required vital signs every shift. The GNA told her the Patient's blood pressure was "a little low"- "like around 87 over something." She obtained the Patient's blood pressure with a manual cuff and "got like 92 over 60" mmHg and she documented it in the computer. She did not call the doctor about the Patient's blood pressure because "he runs a little low" and "that wasn't too low for him."[20]

k. When she went into the Patient's room to do his fingerstick at 5:00 p.m., the Patient "wasn't responsive at all." His "eyes were closed" and he didn't respond to her calling his name. She obtained the Patient's vital signs and his "vital signs were good." The Patient's "oxygen was good" – "it might have been 92 or something, but it wasn't too bad." She tried to get the Patient up and "got some cold water and was throwing it on him" and did a "sternal rub."

l. She called the Nurse Educator because she did not want her to leave and told the Nurse Educator that the Patient was "looking really bad" and asked her to come upstairs. The Nurse Educator told her she was leaving and the Respondent was to "take care of it."

m. There was another RN on the floor but she did not do an overhead page (call a code) for assistance because the Patient was initially still breathing.

n. When she called the on-call Agency, they were experiencing high call volume and she remembered sitting at the nurse's station waiting on the phone for approximately 15 minutes. The on-call physician wanted her to recheck the Patient's blood glucose level. She remembers it was low and thought it may have been around 80 or "under 100" [mg/dL].

o. When she went back into the Patient's room, she "saw [the Patient] and could tell he was not breathing." She got "stuck in the beginning" because she "wasn't expecting to see him passed away." The Patient's "cheeks were sunken in" and he "looked like someone who had passed away 6 hours ago."

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[20] According to the Patient's medical records, the Respondent documented that the Patient's blood pressure was 90/55 mmHg at 5:01 p.m. on April 19, 2020. Leading up to April 19, 2020, the Patient's blood pressure was 139/70 mmHg at 5:56 a.m.; 123/67 mmHg at 4:34 p.m.; and 110/74 at 6:07 p.m. on April 12, 2020; 109/71 mmHg at 6:24 a.m. and 119/67 mmHg at 10:20 a.m. on April 13, 2020; 126/71 at 6:20 a.m.; 105/63 at 9:18 a.m.; and 105/63 at 9:18 p.m. on April 14; 109/74 mmHg at 6:17 a.m. on April 15, 2020; 130/70 mmHg at 6:13 a.m.; 113/68 mmHg at 12:37 p.m.; and 117/66 mmHg at 5:38 p.m. on April 16, 2020; 128/80 mmHg at 6:25 a.m. on April 17, 2020; and, 106/69 mmHg at 4:44 p.m. on April 18, 2020.

p. At that time, she "did an assessment on him," she "checked his carotid artery," she "listened to his apical pulse," and she "did his radial pulse."

q. She did not do an overhead page (call a code) at that time because she thought that the nurses that worked downstairs would not have come upstairs because the Respondent's floor had COVID patients on it.

r. She did not start CPR until the Nurse Educator and other people came into the room with her. The "EKG machine" (AED) did not have pads, so they had to get pads.[21] She was doing compressions when EMS arrived and that is when she stopped doing compressions.[22]

s. She does not know who called 911.

29. The Respondent's failure to call a STAT code and failure to perform CPR on the Patient when he was found without a pulse or respirations poses a serious risk and danger to the public health, safety, and welfare.

CONCLUSION OF LAW

Based on the foregoing investigative findings and reasons, the Board finds that the public health, safety or welfare imperatively requires emergency action in this case pursuant to Md. Code Ann., State Govt. § 10-226(c)(2) (20121 Repl. Vol.).

ORDER

It is hereby:

ORDERED that pursuant to the authority vested in the Board of Nursing by Maryland Code Ann., State Govt. § 10-226(c)(2) (2021 Repl. Vol.) the license of **KHADIDIA DIAW** to practice as a licensed practical nurse, **License Number LP53063**, in the State of Maryland is hereby **SUMMARILY SUSPENDED**; and be it further

[21] She admitted that she was responsible for stocking the crash carts and had previously told her supervisors that things were missing on the crash carts.
[22] According to the Paramedic's report, when the medics arrived no one was doing CPR on the Patient and the AED (Automated External Defibrillator) was NOT on the Patient.

ORDER FOR SUMMARY SUSPENSION PURSUANT TO § 10-226(c)(2) OF THE STATE GOVERNMENT ARTICLE
Khadidia Diaw, LP53063

ORDERED that if the Respondent's license is suspended following a Show Cause Hearing, the Respondent has the right to an evidentiary hearing before the Board on the merits of the summary suspension and an evidentiary hearing will be scheduled before the Board, if the Respondent submits a written request for an evidentiary hearing to the Board **NO LATER THAN THIRTY (30) DAYS from the date of this Order for Summary Suspension**; and be it further

ORDERED that if the Respondent does not submit a timely written request to the Board for an evidentiary hearing within 30 days of the date of this Order, the Respondent shall have waived all rights now and in the future to any hearing on the merits of the summary suspension of the Respondent's license and the factual allegations contained in the Order for Summary Suspension; and it is further

ORDERED that this Order for Summary Suspension shall remain in effect and the summary suspension of the Respondent's license shall continue until further Order of the Board; and it is further

ORDERED that this, "Order for Summary Suspension of Licensed Practical Nurse License" is a **PUBLIC RECORD** pursuant to Md. Code Ann., General Provisions § 4-101 *et seq.* & § 4-333 (2019).

July 27, 2022
Date

Gary N. Hicks, MS, RN, CEN, CNE
The Board President's Signature
Appears on the Original Document
Maryland Board of Nursing