

**STATE OF CONNECTICUT  
BOARD OF EXAMINERS FOR NURSING**

Denise LaBonte, R.N.  
License No. E57236

Petition No. 2009-20091374

**MEMORANDUM OF DECISION**

*Procedural Background*

On June 16, 2011, the Department of Public Health ("the Department") filed a Statement of Charges ("the Charges") with the Board of Examiners for Nursing ("the Board"). Bd. Exh. 1. The Charges allege violations of certain provisions of Chapter 378 of the General Statutes ("the Statutes") by Denise LaBonte ("respondent") which would subject respondent's registered nurse ("R.N.") license to disciplinary action pursuant to §§ 19a-17 and 20-99(b) of the Statutes.

On July 20, 2011, the Charges and a Notice of Hearing were sent to respondent by certified and first class mail. Bd. Exh. 2. The hearing was held on September 7, 2011; respondent orally answered the Charges on the record of the hearing. Tr. pp. 11-15. At the hearing, respondent appeared *pro se*; Attorney Joelle Newton represented the Department. Following the close of the record on September 7, 2011, the Board conducted fact-finding.

Each member of the Board involved in this decision attests that he/she was present at the hearing or has reviewed the record, and that this decision is based entirely on the record, the law, and the Board's specialized professional knowledge in evaluating the evidence.

*Allegations*

1. In paragraph one of the Charges, the Department alleges that respondent of Oakville, Connecticut is, and has been at all times referenced in the Charges, the holder of Connecticut RN license number E57236.
2. In paragraph two of the Charges, the Department alleges that at all relevant times, respondent was employed at Meridian Manor ("the facility") in Waterbury, Connecticut.
3. In paragraph three of the Charges, the Department alleges that from approximately April to August 2009, while working as a R.N. at the facility, respondent:
  - a) failed to properly administer and/or apply fentanyl patches;
  - b) failed to properly follow facility policies and/or procedures for medication administration;
  - c) failed to completely, properly and/or accurately document patient records;
  - d) failed to properly store and secure controlled substances prior to patient administration; and/or,
  - e) failed to properly waste medications.

4. In paragraph four of the Charges, the Department alleges that on or about December 23, 2009, respondent inappropriately copied and/or maintained patient records.
5. In paragraph five of the Charges, the Department alleges that the above facts constitute grounds for disciplinary action pursuant to §20-99(b)(2) and/or §20-99(b)(7) of the Statutes.

### *Findings of Fact*

1. Respondent of Oakville, Connecticut is, and has been at all times referenced in the Charges, the holder of Connecticut RN license number E57236. Tr. pp. 10-11.
2. At all relevant times, respondent was employed as a R.N. at the facility. Tr. p. 129.
3. From approximately April to August 2009, while working as a R.N. at the facility, respondent:
  - a) failed to properly administer and/or apply fentanyl patches; Dept. Exh. 1, pp. 2-11, 16; Tr. pp. 22-25, 27-37, 39-40, 134, 163-167;
  - b) failed to completely, properly and/or accurately document patient records; Dept. Exh. 1, pp. 7, 9-10; Tr. pp. 32, 36, 40, 43, 48, 135-136, 162-163;
  - c) failed to properly store and secure controlled substances prior to patient administration; Dept. Exh. 1, pp. 4-6; Tr. pp. 25-26, 28-30, 33-34, 36-40, 122-123, 134, 163-165; and
  - d) failed to properly waste medications. Dept. Exh. 1, pp. 7, 9-10; Tr. pp. 36, 39-40, 48, 66-67, 79-80, 84, 91, 122.
4. The evidence is insufficient to establish that respondent failed to properly follow facility policies and/or procedures for medication administration. Tr. pp. 32-33, 37, 53-54, 56-58, 62-63, 75, 125.
5. The evidence is insufficient to establish that respondent inappropriately copied and/or maintained patient records. Bd. Exh. 3 (under seal); Tr. pp. 14-15, 44-47, 58-62, 126-129, 167-168.

### *Discussion and Conclusions of Law*

The Department bears the burden of proof by a preponderance of the evidence in this matter. *Goldstar Medical Services, Inc., et al. v. Department of Social Services*, 288 Conn. 790 (2008); *Swiller v. Comm'r of Public Health*, CV-950705601, Superior Court, J.D. Hartford/New Britain at Hartford, October 10, 1995; *Steadman v. SEC*, 450 U.S. 91, 101 S. Ct. 999, *reh'g den.*, 451 U.S. 933 (1981). The Department sustained its burden of proof with regard to four of the six allegations set forth in the Charges.

Section 20-99 of the Statutes provides, in pertinent part, that:

- (a) The Board . . . shall have jurisdiction to hear all charges of conduct which fails to conform to the accepted standards of the nursing profession brought against persons licensed to practice nursing. After holding a hearing . . . said board, if it finds such person to be guilty, may revoke or suspend his or her license or take any of the actions set forth in section 19a-17 . . . .
- (b) conduct which fails to conform to the accepted standards of the nursing profession includes, but is not limited to, the following: . . . (2) illegal conduct, incompetence or negligence in carrying out usual nursing functions;. . . (7) wilful falsification of entries in any hospital, patient or other record pertaining to drugs, the results of which are detrimental to the health of a patient; . . . .

With respect to the allegations contained in paragraph 3(a) of the Charges that respondent failed to properly administer and/or apply fentanyl patches, the Department has met its burden of proof. Respondent discarded almost 50 fentanyl patches due to their improper administration and/or application. Dept. Exh. 1,<sup>1</sup> pp. 4-6, 10-11; Tr. pp. 164, 166-167. Patches were replaced and not used in accordance with the scheduled dates and times. Dept. Exh. 1, pp. 4-6, 10-11; Tr. pp. 22-25, 27, 29, 31-36, 39-40. Many patches were also needlessly destroyed prior to use when they got “stuck or caught” in the medicine cart’s narcotics drawer as she attempted to remove them from the drawer. Dept. Exh. 1, pp. 5-8; Tr. pp. 25, 28, 30, 36. On at least eight occasions, respondent opened patches and then subsequently discarded them because her improper handling of the same would cause the patch to stick to itself, rendering it useless. Dept. Exh. 1, pp. 4-6, 10; Tr. pp. 25-26, 29, 134, 164-165. Similarly, on at least six occasions, respondent opened patches to administer to the patients and then discarded them when they would not adhere to the patients’ skin. Subsequently, she opened new patches to replace the ones she had just discarded. With proper preparation of the patients’ skin, the adhesive would adhere to the patients’ skin. Dept. Exh. 1, pp. 6, 8-10; Tr. pp. 33-34, 163-165. Several patches were also wasted when she spilled water on them or otherwise handled them improperly so that they stuck to themselves. Dept. Exh. 1, pp. 8, 10; Tr. pp. 35, 37, 39. Respondent opened patches with the wrong dosage for a particular patient and had to waste them when respondent discovered that the dosage was incorrect. Dept. Exh. 1, pp. 5-7, 9-10; Tr. pp. 36, 39. The record is replete with evidence to

---

<sup>1</sup> Dept. Exh. 1 is a 79-page exhibit, which consists of the following documents: (1) a drug control report from the Department of Consumer Protection; (2) an investigative report from the Department of Public Health; (3) a one page document from the facility’s policy and procedures on medication administration of patches; (4) copies of controlled substance disposition records; (5) copies of medical records; and, (6) respondent’s disciplinary records.

substantiate the allegations set forth in paragraph 3(a) of the Charges. Therefore, the Department has met its burden of proof regarding these allegations.

With respect to the allegations contained in paragraph 3(b) of the Charges that respondent failed to properly follow facility policies and/or procedures for medication administration, the Department has not met its burden of proof. While respondent's medication administration was substandard, the Board does not find that respondent failed to properly follow the facility's policies and/or procedures for medication administration. While on several occasions respondent "borrowed" medication from patient "A" for use for patient "B," this appeared to be a common practice at the facility. Although it is not proper to do so and is not a practice the Board condones, the facility was aware of such practices as evidenced by the August 17, 2009 "in-service education" memo that stated that "all narcotics need to be cosigned if you are *borrowing* or discarding." Emphasis added. Dept. Exh. 1, p. 74; Tr. pp. 32-33, 37, 53, 56-58, 62-63. Maryellen Royka, the Director of Nurses at the facility during respondent's employment, also admitted that the nurses were not supposed to borrow medication from other patients, but she knew that they did; and, that nurses were not reprimanded for borrowing medications until after the Department investigated respondent's record for wasted medications. Tr. p. 53. Similarly, Ms. Royka testified that while respondent did not properly document her medication administration consistently, this was also not an uncommon practice amongst the nurses at the facility. Tr. p. 54.

Ms. Jenny Giannini, L.P.N, also testified for the Department. Ms. Giannini worked the same shift at the facility as respondent worked, from 11pm to 7am, and has worked at the facility since 2004. Ms. Giannini testified that since she and respondent worked together on the night shift, she served as a witness when respondent wasted medications. According to facility policy, Ms. Giannini co-signed for the procedures she witnessed. Tr. pp. 66-68. She further testified that she generally could tell that the patches that respondent had wasted were fentanyl patches, but sometimes they were difficult to identify if they were crumpled or the writing in black magic marker had rubbed off. Under cross examination, Ms. Giannini testified that when other nurses also discarded fentanyl patches for the same reasons, she could not always recognize that the material being discarded were fentanyl patches. Tr. pp. 75, 77-78. Another witness, Mr. Arnel DeLeon, R. N., a per diem staff nurse at the facility, testified that respondent also asked him to serve as a witness when she discarded fentanyl patches, and it was usually in the morning when

he was busy with patients. Mr. DeLeon recalled that only approximately 10 to 20 percent of the time he could actually identify the discarded material for which he co-signed. Tr. pp. 89-91. Again, while this conduct does not meet the standard of care and the Board does not find it acceptable, the Board also finds that respondent was not violating facility policies and/or procedures because this practice was commonplace amongst the nurses at this facility. Thus, the Department has failed to sustain its burden of proof with respect to these allegations.

With respect to the allegations contained in paragraph 3(c) of the Charges that respondent failed to completely, properly and/or accurately document patient records, the Department has met its burden of proof. On at least three occasions, when respondent borrowed medication from patient "A" for patient "B," she did not obtain the requisite co-signature from a fellow nurse. Tr. pp. 32, 40, 48. Respondent also did not properly secure the requisite witness for the process of discarding a patch. Tr. pp. 36, 43, 54. If respondent changed a medication procedure or the time when she administered the medication, she did not consistently update the patient chart to reflect such changes. Tr. pp. 135-136, 162-163. Although the Department has met its burden of proof with respect to the allegations contained in paragraph 3(c) of the Charges, the Board finds that such conduct was more demonstrative of respondent's negligence in carrying out her nursing duties, and not any wilful falsification of the patient records pertaining to drugs. Moreover, there is no evidence in the record that respondent's inaccurate or incomplete entries in the patients' records caused any detrimental results to the health of the patients. Dept. Exh. 1, pp. 1-16, 27-68 (under seal).

With respect to the allegations contained in paragraph 3(d) of the Charges that respondent failed to properly store and secure controlled substances prior to patient administration, the Department has sustained its burden of proof. The preponderance of the evidence establishes that respondent failed to properly store and secure controlled substances, such as fentanyl patches, prior to patient administration. Although Ms. Royka testified that the patches were individually wrapped and contained in a box that was stored in a drawer beneath the medicine cart, respondent claimed that sometimes the patches were "caught in a faulty and overcrowded narcotics drawer," and were torn and were wasted. Tr. pp. 25-26, 28, 30, 38, 122-123, 134, 164-165. Respondent wasted patches when she spilled water on them or they would stick to themselves due to her improper handling, causing further waste. Tr. pp. 36-40. Therefore, the Department has met its burden of proof with respect to these allegations.

With respect to the allegation contained in paragraph 3(e) of the Charges that respondent failed to properly waste medications, the Department has met its burden of proof. Respondent failed to properly waste medication on more than 20 occasions. Dept. Exh. 1, pp. 20-21. Respondent did not always have a witness to the actual discarding of a patch, as required, and would request a witness's signature on a patient's Controlled Substance Disposition Record form attesting to the waste, after the fact. Sometimes the co-signer was busy with paperwork or otherwise preoccupied with medication pass and could not unequivocally state that respondent wasted a fentanyl patch. Tr. pp. 36, 39-40, 48, 122. Ms. Giannini testified that even when she witnessed respondent wasting medication, she could not always positively identify the material that was being discarded. Tr. pp. 66-67, 79-80, 84, 91, 122. Moreover, respondent did not consistently write the date and time in marker on the patch as required. Tr. pp. 67, 81. Thus, the Department sustained its burden of proof.

With respect to the allegations contained in paragraph 4 of the Charges that on or about December 23, 2009, respondent inappropriately copied and/or maintained patient records, the Department failed to sustain its burden of proof. The evidence is insufficient to establish that respondent inappropriately copied and/or maintained patient records because the record contains conflicting testimony regarding these allegations. Respondent testified that copying documents was within her scope of practice, was a common practice at the facility, and that she had made copies to discuss transcription errors with Ms. Royka. She denies that the copies ever left the facility or were disclosed in violation of any confidentiality or privacy laws. Respondent contends that her only purpose for making the photocopies was to use them in a discussion with her supervisor. Bd. Exh. 3, p. 2 (under seal); Tr. pp. 14-15, 126-129, 167-168. To the contrary, Ms. Royka testified that respondent spent an inordinate amount of time making photocopies, and that she had indeed removed them from the building and left them in the front seat of her car where others could see them. Ms. Royka's testimony also asserted that making photocopies of patient records was unnecessary and inappropriate. Tr. pp. 44-47, 58-62.

After respondent was terminated for purportedly violating the facility's confidentiality policy, respondent requested an investigation of her employment termination by the Department of Labor ("DOL"); the findings of which were entered into the record as Bd. Exh. 3 (under seal). DOL's investigation concluded that respondent: (1) in carrying out of her job duties, made photocopies of the patient records for an authorized purpose; (2) left the photocopies in the

medical records room which was locked; (3) did not remove the photocopies from the facility; and, (4) did not violate the facility's confidentiality policy. Bd. Exh. 3, p. 5 (under seal). To the extent that respondent's testimony was bolstered by DOL's findings, and Ms. Royka's testimony was uncorroborated by any other direct or testimonial evidence, the Department failed to satisfy its burden of proof with respect to these allegations.

First, the Board concludes that respondent's conduct as alleged in paragraphs 3(a), 3(c), 3(d), and 3(e) of the Charges is proven by a preponderance of the evidence presented. Second, the Board concludes that said conduct constitutes grounds for disciplinary action pursuant to §20-99(b)(2) of the Statutes. Third, the Board concludes that the Department has failed to meet its burden of proof with respect to the allegations set forth in paragraphs 3(b) and 4 of the Charges; therefore, respondent's conduct with respect to those allegations does not warrant disciplinary action pursuant to §20-99(b)(7) of the Statutes. Based on the totality of the evidence presented, the Board finds that respondent can practice nursing with reasonable skill and safety under the terms of this Order.

#### ***Order***

Based on the record in this case, the above findings of fact and conclusions of law, the Board hereby orders, with respect to license number E57236 held by Denise LaBonte, as follows:

1. Respondent's license shall be placed on probation for a period of six months under the following terms and conditions. If any of the conditions of probation are not met, respondent's registered nurse license may be subject to disciplinary action pursuant to §19a-17 of the Statutes.
  - A. During the period of probation, the Board shall pre-approve respondent's employment and/or change of employment within the nursing profession.
  - B. Respondent shall not be employed as a nurse for a personnel provider service, assisted living services agency, homemaker-home health aide agency, or home health care agency, and shall not be self-employed as a nurse for the period of probation.
  - C. Respondent shall provide a copy of this Memorandum of Decision to any and all employers if employed as a nurse during the probationary period. The Board shall be notified in writing by any employer(s), within 30 days of the

commencement of employment, as to receipt of a copy of this Memorandum of Decision.

- D. During the first three months of the probationary period respondent, at her expense, shall successfully complete a course in medication administration and documentation pre-approved by the Board. Respondent shall provide proof to the satisfaction of the Board of her successful completion of the course within 30 days of completion.
- E. If employed as a nurse, respondent shall cause employer reports to be submitted to the Board, by her immediate supervisor during the entire probationary period. Employer reports shall be submitted commencing with the report due on the first business day of month following employment as a nurse. Employer reports shall be submitted monthly during the probationary period.
- F. The employer reports cited in Paragraph E above shall include documentation of respondent's ability to safely and competently practice nursing. Employer reports shall be submitted directly to the Board at the address cited in Paragraph J below.
- G. Should respondent's employment as a nurse be involuntarily terminated or suspended, respondent and her employer shall notify the Board within 72 hours of such termination or suspension.
- H. If respondent pursues further training in any subject area that is regulated by the Department, respondent shall provide a copy of this Memorandum of Decision to the educational institution or, if not an institution, to respondent's instructor. Such institution or instructor shall notify the Department in writing as to receipt of a copy of this Memorandum of Decision within 15 days of receipt. Said notification shall be submitted directly to the Department at the address cited in Paragraph J below.
- I. The Board must be informed in writing prior to any change of address.
- J. All communications, payments if required, correspondence, and reports are to be addressed to:

Bonnie Pinkerton, RN, Nurse Consultant  
Department of Public Health  
Division of Health Systems Regulation

Board of Examiners for Nursing  
410 Capitol Avenue, MS #12HSR  
P. O. Box 340308  
Hartford CT 06134-0308

2. Any deviation from the terms of probation, without prior written approval by the Board, shall constitute a violation of probation, which will be cause for an immediate hearing on charges of violating this Order. Any finding that respondent has violated this Order will subject respondent to sanctions under §19a-17(a) and (c) of the Statutes, including but not limited to, the revocation of her license. Any extension of time or grace period for reporting granted by the Board shall not be a waiver or preclude the Board's right to take subsequent action. The Board shall not be required to grant future extensions of time or grace periods. Notice of revocation or other disciplinary action shall be sent to respondent's address of record (most current address reported to the Office of Practitioner Licensing and Certification of the Department of Public Health or the Board).
3. This Memorandum of Decision becomes effective, and the six month probation of RN license no. E57236 shall commence, on **January 1, 2012**.

The Board hereby informs respondent, Denise LaBonte, and the Department of this decision.

Dated at Hartford, Connecticut this 7<sup>th</sup> day of **December, 2011**.

BOARD OF EXAMINERS FOR NURSING

By Patricia C. Bouffard, RN  
Patricia C. Bouffard, RN  
Chairperson

**CERTIFICATION**

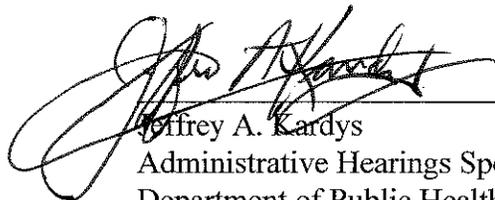
I hereby certify that, pursuant to Connecticut General Statutes § 4-180(c), a copy of the foregoing Memorandum of Decision was sent this 7th day of December 2011, by certified mail, return receipt requested and first class mail to:

Denise LaBonte  
18 Skipper Avenue  
Oakville, CT 06779

Certified Mail 91-7108-2133-3936-6805-9903

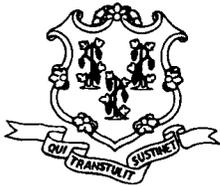
and via email to:

Matthew Antonetti, Principal Attorney  
Legal Office  
Department of Public Health  
410 Capitol Avenue, MS #12LEG  
Hartford, CT 06134-0308



---

Jeffrey A. Kardys  
Administrative Hearings Specialist/Board Liaison  
Department of Public Health  
Public Health Hearing Office



# STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

July 13, 2012

Denise LaBonte, RN  
339 Straits Turnpike  
Watertown, CT 06795

Re: Memorandum of Decision  
Petition No. 2009-20091374  
License No. E57236

Dear Ms. LaBonte:

Please accept this letter as notice that you have satisfied the terms of your license probation, effective July 1, 2012.

Notice will be sent to the Department's Licensure and Registration section to remove all restrictions from your license related to the above-referenced Memorandum of Decision.

Please be certain to retain a copy of this letter as documented proof that you have completed your license probation.

Thank you for your cooperation during this process, and good luck to you in the future.

Very truly yours,

Bonnie Pinkerton, RN, Nurse Consultant  
Practitioner Licensing and Investigations Section

cc: J. Filippone  
J. Wojick



Phone: (860) 509-7400  
Telephone Device for the Deaf (860) 509-7191  
410 Capitol Avenue - MS # 12HSR  
P.O. Box 340308 Hartford, CT 06134  
An Equal Opportunity Employer