

STATE OF CONNECTICUT  
BOARD OF EXAMINERS FOR NURSING

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IN RE: Mary M. Powell, R.N. R07533  
278 Main Street  
Apartment G-111  
West Haven, Connecticut 06516

MEMORANDUM OF DECISION

INTRODUCTION

The Board of Examiners for Nursing, (hereafter the "Board"), was presented by the Department of Health Services with a Statement of Charges dated June 25, 1985 and presented with an amended Statement of Charges December 17, 1985.

The Amended Statement of Charges alleged violations of certain provisions of Chapter 378, Connecticut General Statutes. The Board issued a Notice of Hearing. The hearings took place on January 30, 1986, May 28, 1986, July 9, 1986, August 13, 1986, October 23, 1986 in room 308, 360 Broad Street, Connecticut National Guard Armory, Hartford, Connecticut and March 25, 1986, February 25, 1987, and June 25, 1987 in room 112, National Guard Armory, Maxim Road, Hartford, Connecticut.

Each member of the Board involved in this decision attests that he/she has reviewed the record, and that this decision is based entirely on the record and their specialized professional knowledge in evaluating the evidence.

## FACTS

The respondent was present at the abovementioned hearings and represented by counsel. Based on the testimony given and the exhibits offered into evidence at the hearings, the Board made the following findings of fact:

1. Mary M. Powell, respondent, was at all pertinent times licensed to practice nursing as a registered nurse with registration number R07533.

2. Pursuant to Connecticut General Statutes, Section 4-184(c), the respondent was provided full opportunity prior to the institution of agency action to show compliance with all the statutory terms for the retention of her license.

3. From approximately January 1975 through March 27, 1981, Mary Powell was an officer, operator, owner, consultant, food service supervisor, dietician, and resident nurse or employed as a registered nurse of Sherman Avenue Manor, a rest home with nursing supervision, in New Haven, CT.

4. During the time she was associated as a registered nurse with Sherman Avenue Manor, Mary M. Powell engaged in conduct which failed to conform to accepted standards of the nursing profession in one or more of the following ways: During the aforementioned time the respondent physically abused patients. On one occasion the respondent hosed a blind patient, Albert Cease, with a garden hose on the back porch of the facility when he refused to shower. The respondent also force fed, or required others to force feed, a patient, Moses Brooks, with a vaginal speculum.

5. Further, the respondent knew or should have known unlicensed

personnel were administering or dispensing to patients P.R.N. medications and controlled substances. Medications administered by unlicensed personnel included Valium and Phenobarbital. Specifically, on March 24, 1981, medications, including controlled substances, ordered to be administered between 5 P.M. and 10:30 P.M. were administered by Lula Henyard, a nurse's aide. She poured and administered the 8:00 P.M. medications which included controlled drugs on March 26, 1981 as well. Henyard often poured and administered drugs for which the respondent would sign the cardex and controlled drug book.

6. Further, the respondent failed to properly maintain or failed to maintain proper control over the handling, administration, or recording of patient medications. Department of Health Services exhibits HHH and III demonstrate that patient Alexander Williams' Individual Narcotic Record for Phenobarbital contains a gap from 12 noon on February 19, 1977 to 4:00 P.M. on February 20, 1977 in which the form was not signed by a licensed nurse to indicate administration of the medication. An identical gap in record keeping occurred on the Individual Narcotic Record of Alexander Williams exactly one week later, running from 12 noon on February 26, 1977 to 4:00 P.M. on February 27, 1977.

7. Further, the respondent failed to properly maintain or failed to maintain proper control over patient records, including medical records. Results of a facility inspection on August 20, 1980 revealed that four of five records reviewed lacked current physician's orders or had orders which were not dated or signed.

8. Further, the respondent knew or should have known that Sherman Avenue Manor was inadequately staffed or failed to insure

adequate staffing at said facility. During unannounced inspections on October 29, 1978 and August 28, 1980, inspectors found a nurse's aide left in charge of the facility without the required supervision of either a registered nurse or a licensed practical nurse. The aide on duty during the October 29, 1978 inspection had been left alone in the facility three times in the two weeks that she had worked there.

9. Further, the respondent abused or excessively used alcohol. While on duty the respondent was observed on more than one occasion by Rita Sweat to have a glass containing an alcoholic substance in it. Sweat recognized the smell of alcohol on the respondent's breath and saw her walk around the facility with a drink in her hand. Nurse's aide Eva Harrell also often smelled alcohol on the respondent's breath and had seen bottles of liquor in her office.

#### DISCUSSION AND CONCLUSIONS

The First Count Subsection 3a alleged that while employed as a registered nurse at Sherman Avenue Manor, the respondent physically abused patients.

The above described conduct is a violation of the Connecticut General Statutes Section 20-99(b). In pertinent part, Section 20-99(b) includes: (2) illegal conduct, incompetence or negligence in carrying out usual nursing functions. Although respondent did not admit to actually abusing patients, evidence was submitted to prove such occurrences. Sworn testimony by the respondent indicated that hosing of a patient for bathing purposes may have occurred. Sworn testimony by aides Rita Sweat and Eva Harrell indicated that

the hosing did occur. Sweat's testimony also demonstrated that force feeding of Moses Brooks with a speculum did occur.

The Board has determined that during January 1975 through March 27, 1981, while employed as a registered nurse at Sherman Avenue Manor, the respondent physically abused patients. The Board therefore concludes that the respondent has violated Section 20-99(b)(2) as specified in the First Count, Subsection 3a.

The First Count Subsection 3b alleges that while employed as a registered nurse at the Sherman Avenue Manor, the respondent verbally abused patients.

The above described conduct is a violation of the Connecticut General Statutes Section 20-99(b). In pertinent part, Section 20-99(b) includes: (2) illegal conduct, incompetence or negligence in carrying out usual nursing functions.

The Board has determined that there was insufficient evidence to prove such verbal abuse occurred.

The First Count Subsection 3c alleges that while employed as a registered nurse at Sherman Avenue Manor, the respondent knew or should have known that unlicensed personnel were administering or dispensing to patients P.R.N. medications and controlled substances.

The above described conduct is a violation of Connecticut General Statutes Section 20-99(b). In pertinent part, Section 20-99(b) includes: (2) illegal conduct, incompetence or negligence in carrying out usual nursing functions. The respondent admitted to allowing unlicensed personnel to administer or dispense to patients P.R.N. medications and controlled substances. Testimony of Lula Henyard and Rita Sweat, nurse aides at Sherman Manor, corroborate this charge.

The Board has determined that during January 1975 through March 27, 1981, while employed as a registered nurse of Sherman Avenue Manor, the respondent allowed unlicensed personnel to administer or dispense P.R.N. medications and controlled substances. The Board therefore concludes that the respondent has violated Section 20-99(b) as specified in the First Count, Subsection 3c.

The First Count Subsection 3d alleges that during January 1975 through March 27, 1981, while employed as a registered nurse at Sherman Avenue Manor, the respondent failed to properly maintain or failed to maintain proper control over the handling, administration or recording of patient medications.

The above described conduct is a violation of Connecticut General Statutes Section 20-99(b). In pertinent part, Section 20-99(b) includes: (2) illegal conduct, incompetence or negligence in carrying out usual nursing functions; (6) fraud or material deception in the course of professional services or activities. The respondent testified to the fact that she did not always maintain records properly. Department of Health Services Exhibits HHH and III clearly illustrate the improper care of patient medication records.

The Board has determined that during January 1975 through March 27, 1981, while employed as a registered nurse at Sherman Avenue Manor, the respondent failed to properly maintain or failed to maintain proper control over the handling, administration, or recording of patient medications. The Board therefore concludes that the respondent has violated Section 20-99(b) as specified in the First Count, Subsection 3d.

The First Count Subsection 3e alleges that during January 1975

through March 27, 1981, while employed as a registered nurse at Sherman Avenue Manor, the respondent failed to properly maintain or failed to maintain proper control over patient records, including medical records.

The above described conduct is a violation of Connecticut General Statutes Section 20-99(b). In pertinent part, Section 20-99(b) includes: (2) illegal conduct, incompetence or negligence in carrying out usual nursing functions; (6) fraud or material deception in the course of professional services or activities. The respondent testified that medical records were not always maintained in a timely fashion. Department of Health Services Exhibit OO was submitted as evidence providing information about two patients who were admitted to Sherman Avenue Manor on August 1, 1980. Also noted in this exhibit is failure to maintain current and accurate information. This report detailed how four of five medical records reviewed lacked current physician's orders or that orders which were there were not dated and signed.

The Board has determined that during January 1975 through March 27, 1981, while employed as a registered nurse, at Sherman Avenue Manor, the respondent, failed to make accurate, proper, complete documentation of patient records, including medical records. The Board therefore concludes that the respondent has violated Section 20-99(b) as specified in the First Count, subsection 3e.

The First Count Subsection 3f alleges that during January 1975 through March 27, 1981, while employed as a registered nurse, the respondent knew or should have known that Sherman Avenue Manor was inadequately staffed or failed to insure adequate staffing at said facility.

The above described conduct is a violation of Connecticut General Statutes Section 20-99(b). In pertinent part, Section 20-99(b) includes: (2) illegal conduct, incompetence or negligence in carrying out usual nursing functions. The respondent, in her testimony, admitted to leaving the facility on several occasions without a licensed person in the facility. Entered as evidence is Department of Health Services Exhibit XX which states that Mary Powell was not present at the facility and left a nurse's aide in charge of the facility on March 26, 1981. Similar absence of licensed personnel was documented in Department of Health Services Exhibits S, KK, and RR.

The Board has determined that during January 1975 through March 27, 1981, while employed as a registered nurse at Sherman Avenue Manor, the respondent failed to adequately staff said facility. The Board therefore concludes that the respondent has violated Section 20-99(b) as specified in the First Count, Subsection 3f.

The First Count Subsection 3g alleges that during aforementioned time while employed as a registered nurse at Sherman Avenue Manor, the respondent failed to properly prepare or failed to insure proper preparation of the food served to residents in that said food was inadequate in amount or nutrition or prepared under less than sanitary conditions.

The Board has determined that said charge is not within their jurisdiction and not an offense against the respondent's nursing license. Therefore, the Board concludes that they lack the power to adjudicate this charge.

The First Count Subsection 3h alleges that during January 1975 through March 27, 1981, while employed as a registered nurse at

Sherman Avenue Manor, the respondent abused or excessively used alcohol.

The above described conduct is a violation of Connecticut General Statutes Section 20-99(b). In pertinent part, Section 20-99(b) includes: (2) illegal conduct, incompetence or negligence in carrying out usual nursing functions; (5) abuse or excessive use of drugs, including alcohol, narcotics, or chemicals. The respondent denies these allegations but sworn testimony by Rita Sweat, a nurse's aide at Sherman Avenue Manor at time of incident indicated that the respondent did drink alcohol while on duty as a registered nurse. Additionally, aide Eva Harrell also testified that she had seen the respondent drink while on duty and had also seen bottles of liquor in her office.

The Board has determined that during January 1975 through March 27, 1981, while employed as a registered nurse at Sherman Avenue Manor, the respondent abused alcohol by drinking alcohol while on duty as a registered nurse. The Board therefore concludes that the respondent has violated Section 20-99(b) as specified in the First Count 3h.

#### ORDER

It is the unanimous decision of those of the Board of Examiners for Nursing who were present and voting that:

a. The license of the respondent be placed on suspension for a minimum of four years and a six month probation determined as follows:

- i. as to the First Count, Subsection 3a, four year suspension and six months probation;
- ii. as to the First Count, Subsection 3c, two years suspension and six months probation;
- iii. as to the First Count, Subsection 3d, one year suspension and six months probation;
- iv. as to the First Count, Subsection 3e, one year suspension and six months probation;
- v. as to the First Count, Subsection 3f, one year suspension and six months probation;
- vi. as to the First Count, Subsection 3h, one year suspension and six months probation;
- vii. the suspension periods referenced in (i), (ii), (iii), (iv), (v), and (vi) above are to run concurrently for an effective four year suspension;
- viii. the six month probationary periods referenced in (i), (ii), (iii), (iv), (v), and (vi) above are to run concurrently to each other and consecutively to the four year suspension referenced above in (vii).
- ix. as a condition of the probation referenced in (viii) above, the respondent is to successfully complete a theoretical and clinical refresher course approved by the Board. Monthly evaluations are to be submitted to the Board by her supervisor, documenting successful performance within the course. In addition, at the end of the probationary period a final report documenting successful completion of the course must be submitted to the Board.

- c. The said period of suspension shall commence June 1, 1988. The said period of probation shall commence June 1, 1992.
- d. The respondent is hereby directed to surrender her license on or before June 1, 1988 to the Board of Examiners for Nursing, 150 Washington Street, Hartford, Connecticut, 06106.

The Board of Examiners for Nursing herewith advises the Department of Health Services of the State of Connecticut of this decision.

Dated at Hartford, Connecticut, this 12<sup>th</sup> day of May, 1988.

BOARD OF EXAMINERS FOR NURSING

BY Scott James M. Murphy RN MS

6241V