

STATE OF CONNECTICUT  
BOARD OF EXAMINERS FOR NURSING

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Department of Health Services v.

Sari Gottlieb, RN

License No. R24891

60 Miller Road

Preston CT 06365

CASE PETITION NO. 920116-10-006

MEMORANDUM OF DECISION

INTRODUCTION

The Board of Examiners for Nursing (hereinafter the "Board") was presented by the Department of Health Services (hereinafter the "Department") with a Statement of Charges dated August 17, 1992. (Department Exhibit 2) The Statement of Charges alleged in four counts, violations of certain provisions of Chapter 378 of the General Statutes of Connecticut by Sari Gottlieb (hereinafter the "Respondent").

The Board issued a Notice of Hearing dated August 25, 1992. (Department Exhibit 2) The hearing originally scheduled for October 29, 1992 was continued on two (2) occasions. (Hearing Transcript, January 7, 1993, p. 4) The hearing took place on January 7, 1993 in Room 112, National Guard Armory, Maxim Road, Hartford, Connecticut and on January 28, 1993 in Room 127, Department of Transportation, 24 Wolcott Hill Road, Wethersfield, Connecticut.

During the hearing on January 7, 1993 the Department verbally amended the Statement of Charges by withdrawing the First Count Paragraphs 3c and 3d, and the Fourth Count in its entirety. (Hearing Transcript, January 7, 1993, p. 6)

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 and their specialized professional knowledge in evaluating the evidence.

#### FACTS

Based on the testimony given and the exhibits offered into evidence, the Board made the following findings of fact:

1. Sari Gottlieb, hereinafter referred to as Respondent, was issued Registered Nurse License Number R24891 on February 15, 1973 and was at all times referenced in the Statement of Charges the holder of said license. (Department Exhibit 3) (Respondent Exhibit A)
2. Pursuant to the General Statutes of Connecticut, Section 4-182(c), the Respondent was provided full opportunity prior to the institution of agency action to show compliance with all the terms for the retention of her license. (Department Exhibit 1)
3. The Respondent was present on both dates of the hearing and was represented by counsel. (Hearing Transcript, January 7, 1993, p. 3, Hearing Transcript January 28, 1993, p. 3)
4. The Respondent submitted an Answer to the Statement of Charges. (Respondent Exhibit A)

5. That from November 25, 1974 to November 25, 1975 the registered nurse license of the Respondent was suspended, as ordered by the Board of Examiners for Nursing, for diverting and adulterating the controlled substances Demerol and Morphine. (Department Exhibit 4)
  
6. That during August 1991 through October 1991 the Respondent was employed as a registered nurse in the Emergency Room and Trauma Center at William W. Backus Hospital, Norwich, Connecticut. (Answer: Respondent Exhibit A) (Respondent Exhibit L)
  
7. That on August 29, 1991 at approximately 9:53 a.m. Pamela Molcan was admitted to the Emergency Room at William W. Backus Hospital. (Respondent Exhibit F)
  
8. On August 29, 1991, while employed as a registered nurse in the Emergency Room at William W. Backus Hospital the Respondent documented on Controlled Substance Administration Record No. 46821 that she administered a dose of Demerol 50mg. to patient Pamela Molcan at 12:30 p.m. (Department Exhibit 5) However, the Respondent did not document in the nursing notes of the patient's medical record that a 50mg. dose of Demerol was administered at 12:30 p.m. (Respondent Exhibit F)
  
9. The Controlled Substance Administration Record No. 46821 and the medical record of Pamela Molcan indicate that a dose of Demerol 50mg. signed out at 10:00 a.m. was administered to Pamela Molcan at 10:15 a.m. on August 29, 1991. (Department Exhibit 5) (Respondent Exhibit F)

10. That Pamela Molcan testified during the hearing that she received only one (1) injection of Demerol, which was soon after her admission to the Emergency Room on the morning of August 29, 1991. (Hearing Transcript, January 7, 1993, pp. 81-84, 86-87)
11. That on August 20, 1991 at approximately 7:55 p.m. John Delaney was admitted to the Emergency Room at William W. Backus Hospital. (Respondent Exhibit E)
12. On August 20, 1991, while employed as a registered nurse in the Emergency Room at William W. Backus Hospital, the Respondent documented in the patient record of patient John Delaney and on Controlled Substance Administration Record No. 46116 that she administered a dose of Demerol 100mg. to patient John Delaney at 9:30 p.m. (Department Exhibit 5) (Respondent Exhibit E)
13. That patient John Delaney was discharged from the William W. Backus Hospital Emergency Room at approximately 9:30 p.m. on August 20, 1991 after receiving treatment for a dislocated shoulder. (Respondent Exhibit E)
14. John Delaney testified at the hearing that he had no recollection of being administered an injection of Demerol after his shoulder was reduced and immediately prior to his discharge from William W. Backus Hospital. (Hearing Transcript, January 7, 1993, pp. 70-71)
15. Kathleen Delaney, R.N., wife of patient John Delaney, testified during the hearing that there was no indication that John Delaney received an injection of Demerol and that he did not mention receiving any injection of Demerol. (Hearing Transcript, January 7, 1993, pp. 70-71)

16. John Delaney's treating physician, Kenneth J. Paonessa, M.D., wrote in letters signed by him that it was very unlikely that he ordered additional IM pain medication after the patient's shoulder was reduced but it is possible that he did as a telephone order. (Department Exhibit 12) (Respondent Exhibit K)
  
17. That on September 27, 1991 patients Jessica Palmer and Rhonda Johnson were admitted to the Emergency Room at William W. Backus Hospital. (Department Exhibit 10) (Respondent Exhibits C and D)
  
18. On September 27, 1991, while employed as a registered nurse in the Emergency Room at William W. Backus Hospital, the Respondent documented in the patient record of Rhonda Johnson and on Controlled Substance Administration Record No. 47857 that she administered a 50mg. dose of Demerol to patient Johnson at 3:30 p.m. That patient Johnson was no longer in the Emergency Room at 3:30 p.m. in that she had been admitted to the hospital. (Department Exhibits 5 and 10) (Respondent Exhibit C) (Hearing Transcript, January 28, 1993, p. 37)
  
19. That the Respondent corrected the error cited in FACT 18 by crossing out the notation she made in patient's medical records (Department Exhibit 10) (Respondent's Exhibit C) and by crossing out the notation she made on Controlled Substance Administration Record No. 47857 by indicating the dose of Demerol was administered to patient Jessica Palmer at 11:00 a.m. on September 27, 1991. (Department Exhibit 5) (Hearing Transcript, January 28, 1993, pp. 37-38)

20. That the medical record of patient Jessica Palmer indicates she did not have an order to receive a 50mg. dose of Demerol at 11:00 a.m. on September 27, 1991. (Respondent Exhibit D)
21. On August 17, 1991 Virginia Stein was admitted to the Emergency Room at William W. Backus Hospital. (Respondent Exhibit B)
22. On August 17, 1991, while employed as a registered nurse in the Emergency Room at William W. Backus Hospital, the Respondent documented on Controlled Substance Administration Record No. 46402 that she administered a 50mg. dose of Meperidine (Demerol) to patient Virginia Stein at 10:50 p.m. (Department Exhibit 5)
23. That the medical record of patient Virginia Stein indicates she did not have orders to receive a 50mg. dose of Demerol.  
(Respondent Exhibit B)
24. On August 20, 1991 Steven Danis was admitted to the Emergency Room at William W. Backus Hospital. (Department Exhibit 6)
25. On August 20, 1991, while employed as a registered nurse in the Emergency Room at William W. Backus Hospital, the Respondent documented on Controlled Substance Administration Record No. 46573 that she administered a 50mg. dose of Meperidine (Demerol) to patient Steven Danis at 3:40 p.m. That documentation of this administration appears after a Demerol administration documented at 8:20 p.m. (Department Exhibit 5)

26. That the medical record of patient Steven Danis indicates he did not have orders to receive a 50mg. dose of Demerol. (Department Exhibit 6) (Hearing Transcript, January 7, 1993, pp. 19-20)
  
27. On September 9, 1991 Joseph Lucas and Andrew D'Elia were admitted to the Emergency Room at William W. Backus Hospital. (Department Exhibit 7 and 8)
  
28. On September 9, 1991, while employed as a registered nurse in the Emergency Room at William W. Backus Hospital, the Respondent documented on Controlled Substance Administration Record No. 47191 that she administered a 50mg. dose of Meperidine (Demerol) to patient Joseph Lucas at 2:15 p.m. (Department Exhibit 5)
  
29. That the medical record of Joseph Lucas indicates he did not have orders to receive a 50mg. dose of Demerol. (Department Exhibit 7)
  
30. On September 9, 1991, while employed as a registered nurse in the Emergency Room at William W. Backus Hospital, the Respondent documented on Controlled Substance Administration Record No. 46980 that she administered a 100mg. dose of Meperidine (Demerol) to a patient D'Elia at 12:40 p.m. She also documented in the medical record of patient Andrew D'Elia that she administered a 100mg. dose of Demerol at 12:40 p.m. (Department Exhibit 5 and 8)
  
31. That the medical record of patient Andrew D'Elia indicates he did not have orders to receive a 100mg. dose of Demerol. (Department Exhibit 8)

32. On October 8, 1991 Harry Jones was admitted to the Emergency Room at William W. Backus Hospital. (Department Exhibit 9)
33. On October 8, 1991, while employed as a registered nurse in the Emergency Room at William W. Backus Hospital, the Respondent documented on Controlled Substance Administration Record No. 48116 that she administered a 50mg. dose of Meperidine (Demerol) to patient Harry Jones at 3:55 p.m. (Department Exhibit 5)
34. That the medical record of patient Harry Jones indicates he did not have orders to receive a 50mg. dose of Demerol. (Department Exhibit 9)

#### DISCUSSION AND CONCLUSIONS

In consideration of the above Findings of Fact, the following conclusions are rendered:

Sari Gottlieb held a valid registered nurse license in the State of Connecticut at all times referenced in the Statement of Charges.

The Notice of Hearing and Statement of Charges sufficiently provided information as mandated by the General Statutes of Connecticut Sections 4-177, 4-182 and 19a-17.

The hearing was held in accordance with Chapters 54 and 368a of the General Statutes of Connecticut as well as 19-2a-1 through 19-2a-30 of the Regulations of Connecticut State Agencies. The Notice of Hearing, Statement of Charges and the hearing process provided the Respondent with the opportunity to demonstrate compliance with all lawful requirements for the retention of her license as required by the General Statutes of Connecticut Section 4-182(c).

The FIRST COUNT PARAGRAPH 4 of the Statement of Charges alleges the Respondent, while employed as a registered nurse at William W. Backus Hospital, Norwich, Connecticut, and with reference to doses of Demerol she documented as administering to patients Pamela Molcan and John Delaney (FACTS 8, 12), "a. diverted Demerol; and/or b. did not actually administer Demerol; and/or c. failed to completely or properly or accurately make documentations in the medical or hospital records; and or d. falsified one or more controlled substance receipt records."

The Respondent denies the allegations set forth in paragraphs 4a, 4b and 4d and neither admits nor denies paragraph 4c. (Respondent Exhibit A)

The Board concludes the Department presented insufficient evidence to prove that the Respondent diverted Demerol and/or falsified one or more controlled substance receipt records. Therefore, the First Count Paragraph 4a and 4d are dismissed.

Based on the credible testimony of John Delaney and Kathleen Delaney, and FACT No. 16 the Board concludes that the Respondent did not administer Demerol to patient John Delaney at 9:30 p.m. on August 20, 1991. Therefore, the documentations the Respondent made in the hospital and controlled substance administration records (FACT 12) are improper and inaccurate.

The Board concludes the Department presented insufficient evidence to prove that the Respondent did not actually administer Demerol to patient Pamela Molcan, but does conclude that the Respondent failed

to completely make documentations in the medical record of Pamela Molcan by failing to document in the nursing notes of the medical record that a dose of Demerol was administered to the patient (FACT No. 8).

The General Statutes of Connecticut Section 20-99(b) prohibits conduct which fails to conform to the accepted standards of the nursing profession, which includes "... (2) illegal conduct, incompetence or negligence in carrying out usual nursing functions.

The Board concludes that the Respondent's conduct as specified in the First Count Paragraphs 4b and 4c is a violation of the General Statutes of Connecticut Section 20-99(b)(2) and therefore renders the Respondent subject to disciplinary action pursuant to the General Statutes of Connecticut.

The SECOND COUNT PARAGRAPH 3 of the Statement of Charges alleges the Respondent, while employed as a registered nurse at William W. Backus Hospital, Norwich, Connecticut on or about September 27, 1991, "...documented that she had administered a dose of Demerol 50mg. to Rhonda Johnson at 3:30 p.m. when she had not...b. failed to timely document the administration of a dose of Demerol 50mg. to Jessica Palmer...c. failed to properly document the administration of a dose of Demerol 50mg. to Jessica Palmer...d. documented that she had administered a dose of Demerol 50mg. to Jessica Palmer when she had not."

The Respondent neither admits nor denies these allegations.

(Respondent Exhibit A)

Based on FACTS 17-20 the Board concludes that the conduct specified in the Second Count Paragraph 3 is proven.

The SECOND COUNT PARAGRAPH 4 of the Statement of Charges alleges, with reference to the conduct cited in the Second Count Paragraph 3, that the Respondent "a. diverted Demerol; and/or b. did not actually administer Demerol; and/or c. failed to completely or properly or accurately make documentations in the medical or hospital records; and/or d. falsified one or more controlled substance receipt record."

The Respondent denies the allegations set forth in paragraphs 4a, 4b and 4d and neither admits or denies paragraph 4c. (Respondent Exhibit A)

The Board concludes the Department presented insufficient evidence to prove the Respondent diverted Demerol, did not actually administer Demerol, and/or falsified one or more controlled substance receipt records. Therefore, the Second Count Paragraphs 4a, 4b and 4d are dismissed.

Based on its conclusion that the allegations in the Second Count Paragraph 3 are proven, the Board further concludes that the Respondent failed to completely or properly or accurately make documentations in the medical or hospital records pertaining to patients Rhonda Johnson and Jessica Palmer.

The General Statutes of Connecticut Section 20-99(b) prohibits conduct which fails to conform to the accepted standards of the

nursing profession, which includes "... (2) illegal conduct, incompetence or negligence in carrying out usual nursing functions."

The Board concludes that the Respondent's conduct as specified in the Second Count Paragraph 3 and Paragraph 4c is a violation of the General Statutes of Connecticut Section 20-99(b)(2) and therefore renders the Respondent subject to disciplinary action pursuant to the General Statutes of Connecticut.

The THIRD COUNT PARAGRAPH 3 of the Statement of Charges alleges the Respondent, while working as a registered nurse at William W. Backus Hospital, Norwich, Connecticut, administered Demerol without the order of a physician, failed to properly document a physician's order or diverted Demerol.

The Respondent denies that she administered Demerol without the order of a physician, or diverted Demerol and neither admits or denies that she failed to properly document a physician's orders.  
(Respondent Exhibit A)

The Board found (FACTS 21 - 34) that the Respondent administered Demerol in the following instances:

- a. 50mg. to Virginia Stein on August 17, 1991 at 10:50 p.m.
- b. 50mg. to Steven Danis on August 20, 1991 at 3:40 p.m.
- c. 50mg. to Joseph Lucas on September 9, 1991 at 2:15 p.m.
- d. 100mg. to Andrew D'Elia on September 9, 1991 at 12:40 p.m.
- e. 50mg. to Harry Jones on October 8, 1991 at 3:55 p.m.

Upon review of the patient medical records the Board found that the records lacked documentation of physician orders for the administration of Demerol in the instances above. (FACTS 23, 26, 29, 31, 34)

The Lack of documentation of physician orders is in itself evidence that orders to administer Demerol to the patients did not exist.

A registered nurse is prohibited from administering a medication to a patient unless there exists an order from a physician for the administration of the medication to the patient.

Based on its finding that physician orders did not exist in the above instances, the Board cannot conclude that the Respondent merely failed to properly document a physician's order.

The Board further concludes that the Department presented insufficient evidence to prove that the Respondent diverted Demerol.

The General Statutes of Connecticut Section 20-99(b) prohibits conduct which fails to conform to the accepted standards of the nursing profession, which includes "... (2) illegal conduct, incompetence or negligence in carrying out usual nursing functions."

The Board concludes that the Respondent's conduct of administering Demerol to patients without a physician's order, as specified in the Third Count Paragraph 3, is a violation of the General Statutes of

Connecticut Section 20-99(b)(2) and therefore renders the Respondent subject to disciplinary action pursuant to the General Statutes of Connecticut.

The THIRD COUNT PARAGRAPH 4 of the Statement of Charges alleges the Respondent, while working as a registered nurse at William W. Backus Hospital, Norwich, Connecticut, and with reference to the incidents cited in the Third Count Paragraph 3, "a. diverted Demerol; and/or b. failed to completely or properly or accurately make documentations in the medical or hospital records; and/or c. falsified one or more controlled substance receipt record."

The Respondent denies the allegations set forth in paragraphs 4a and 4c and neither admits or denies paragraph 4b. (Respondent Exhibit A)

The Board concludes that the Department presented insufficient evidence that the Respondent diverted Demerol and/or falsified one or more controlled substance receipt records, therefore the Third Count Paragraphs 4a and 4c are dismissed.

Based on the conclusion that the Respondent administered Demerol to patients without a physician's order, the Board concludes that the controlled substance administration records completed by the Respondent (FACTS 22, 25, 28, 30, 33), improperly and inaccurately indicate that the Demerol administered to the patients was ordered by a physician. Therefore, The Board concludes that the Respondent failed to completely or properly or accurately make documentations in the medical or hospital records.

The General Statutes of Connecticut Section 20-99(b) prohibits conduct which fails to conform to the accepted standards of the nursing profession, which includes "... (2) illegal conduct, incompetence or negligence in carrying out usual nursing functions."

The Board concludes that the Respondent's conduct as specified in the Third Count Paragraph 4b is a violation of the General Statutes of Connecticut Section 20-99(b)(2) and therefore renders the Respondent subject to disciplinary action pursuant to the General Statutes of Connecticut.

ORDER

Pursuant to its authority under the General Statutes of Connecticut Sections 19a-17 and 20-99, the Board of Examiners for Nursing hereby orders:

1. That for the First Count Paragraphs 4b and 4c, for the Second Count Paragraph 4c and for the Third Count Paragraphs 3 and 4b, the registered nurse license of the Respondent be suspended for a period of one (1) year followed by two (2) years probation after completion of the suspension.

The Board of Examiners for Nursing finds the misconduct cited in this decision severable and warrants the disciplinary action imposed.

2. If any of the following conditions of probation are not met, the registered nurse license of the Respondent may be revoked.

- A. The Respondent shall provide a copy of this Memorandum of Decision to any and all employers should she be employed in nursing. The Board shall be notified in writing by her employer(s), if employed in nursing, as to receipt of a copy of this Memorandum of Decision.
- B. Should the Respondent change employment in the nursing profession at any time during the probationary period, she shall immediately provide a copy of this Memorandum of Decision to her employer and said employer shall notify the Board in writing, within thirty (30) days, as to receipt of a copy of this Memorandum of Decision.
- C. The Respondent shall not accept employment as a nurse for a personnel provider service, Visiting Nurse's Association or home health care agency for the period of probation.
- D. If employed in the nursing profession, she shall cause to be submitted by her nursing supervisor (e.g. Director of Nursing) quarterly employer reports for the entire period of probation. Employer reports are due on the first business day of January, April, July and October. Quarterly reports shall commence with the report due July 1, 1994.
- E. The reports cited in D above, shall include documentation of the Respondent's ability to safely and competently practice nursing and an evaluation of her ability to completely and accurately document the administration of medications. Said reports shall be issued to the Board at the address listed in paragraph J below.

- F. During the period of probation the Respondent must complete a minimum of sixty (60) hours of continuing education in nursing of which thirty (30) hours must be instruction and review of nursing documentation.
- G. Certification of successful completion of the continuing education cited in (F) above shall be submitted to the Board at the address cited in (J) below.
- H. The Connecticut Board of Examiners for Nursing must be informed in writing prior to any change in the Respondent's employment.
- I. The Connecticut Board of Examiners for Nursing must be informed in writing prior to any change of the Respondent's address.
- J. All correspondence and reports are to be addressed to:

OFFICE OF THE BOARD OF EXAMINERS FOR NURSING  
Department of Health Services  
150 Washington Street  
Hartford CT 06106

- 3. If the conditions of probation are not met or if there is any deviation from the terms of probation without prior written approval by the Board of Examiners for Nursing it will constitute a violation of probation and will subject the Respondent to sanctions under the General Statutes of Connecticut Section 19a-17(a) and (c) including but not limited to the revocation of her license. Any extension of time or

grace period for reporting granted by the Connecticut Board of Examiners for Nursing shall not be a waiver or preclude the Board's right to take action at a later time. The Connecticut Board of Examiners for Nursing shall not be required to grant future extensions of time or grace periods. Notice of revocation or other disciplinary action shall be sent to her address of record (most current address reported to the Licensure and Renewal Section of the Division of Medical Quality Assurance of the Department of Health Services or the Connecticut Board of Examiners for Nursing).

4. This Memorandum of Decision becomes effective and the one (1) year suspension followed by two (2) years probation of the Respondent's license shall commence, on May 1, 1993.

The Respondent, Sari Gottlieb, is hereby directed to surrender her Registered Nurse License No. R24891 and current registration to the Board of Examiners for Nursing, 150 Washington Street, Hartford, Connecticut 06106, on or before May 1, 1993.

The Board of Examiners for Nursing informs the Respondent, Sari Gottlieb, and the Department of Health Services of the State of Connecticut of this decision.

Dated at Hartford, Connecticut, this 15th day of April, 1993.

BOARD OF EXAMINERS FOR NURSING

By Jania Thibodeau