

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

Department of Public Health

Petition No. 2001-0716-010-047

v.

Vashti Skyers, R.N., Lic. No. R28330  
Respondent

**MEMORANDUM OF DECISION**

***Procedural Background***

The Board of Examiners for Nursing (hereinafter the "Board") was presented by the Department of Public Health (hereinafter the "Department") with a Statement of Charges dated April 10, 2002. The Statement of Charges alleged violations of certain provisions of Chapter 378 of the General Statutes of Connecticut by Vashti Skyers (hereinafter "respondent") which would subject respondent's registered nurse license to disciplinary action pursuant to *Conn. Gen. Stat.* §§ 19a-17 and 20-99(b).

The Board issued a Notice of Hearing dated April 26, 2002, scheduling a hearing for August 21, 2002. Bd. Exh. 1. Respondent was provided notice of the hearing and charges against her. The Notice of Hearing and Statement of Charges were delivered by certified mail to respondent on May 4, 2002. Bd. Exh. 1.

The hearing scheduled for August 21, 2002 was continued until December 4, 2002. Tr., 12/4/02, p. 4.

On August 2, 2002 the Department filed a Motion to Amend Statement of Charges along with a First Amended Statement of Charges (the "Charges"). The Board granted the Department's motion on December 4, 2002. Dept. Exh. 2; Tr., 12/4/02, pp. 7-10.

The hearing took place on December 4, 2002, and January 29, 2003, at the Legislative Office Building, Capitol Avenue, Hartford, Connecticut, and on June 18, 2003 at Hartford Hospital-Newington Campus, Curtis Building, 181 Patricia M. Genova Drive, Newington, Connecticut.

Respondent was not present on any of the hearing dates; however, respondent was represented by counsel at the December 4, 2002 and January 29, 2003 hearings. Although respondent's counsel was aware of the hearing on June 18, 2003, respondent's counsel communicated to the Board that she would not be attending the hearing and had no further evidence to present, and she did not appear. Bd. Exh. 4; Tr., 6/18/03, pp. 3-6, 45, 161.

Respondent submitted a written Answer to each Count of the Charges except for Count Nine which she orally answered on January 29, 2003. Resp. Exh. A; Tr., 12/4/02, pp. 5-6; Tr., 1/29/03, pp. 4-6.

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, the law, and the Board's specialized professional knowledge in evaluating the evidence.

### *Findings of Fact*

Based on the testimony given and the exhibits offered into evidence, the Board makes the following Findings of Fact:

1. Vashti Skyers of Bridgeport, Connecticut (hereinafter "respondent"), is and has been at all times referenced in this Statement of Charges, the holder of Connecticut registered nurse license number R28330. Bd. Exh. 2; Dept. Exh. 3; Tr., 12/4/02, p. 11.
2. At all times referenced in the First Amended Statement of Charges, Superior Home Care Group, Inc, d/b/a, EVS Home Health Care in Bridgeport, Connecticut (hereinafter "EVS"), held a license as a home health care agency which was valid until September 18, 2001. At that time, EVS entered into a Consent Order (hereinafter "Consent Order") with the Department in which it voluntarily agreed to surrender its license. Dept. Exh. 5; Dept. Exh. 13 (F); Tr., 12/4/02, p. 12.
3. At all relevant times, respondent served as the administrator and/or supervisor of clinical services for EVS. As the administrator, respondent was responsible for planning, staffing, directing and implementing the programs as well as managing the affairs of the agency. As the supervisor of clinical services, respondent held primary authority and responsibility for maintaining the quality of clinical services. Dept. Exh. 7, p. 5; Tr., 12/4/02, p. 24.

### *Count One*

4. From approximately June 20, 2000 to October 30, 2000, D.T. was a patient of EVS. Dept. Exh. 8 (Under Seal), p. 1, 7; Tr., 12/4/02, pp. 44-45.
5. At all relevant times, D.T. was diagnosed with insulin-dependent diabetes mellitus (brittle-type diabetes) with an onset date of June 19, 2000, hypertension, and coronary artery disease. In addition, she was legally blind. Dept. Exh. 8 (Under Seal), p. 1; Tr., 12/4/02, p. 46.
6. On or about June 20, 2000, EVS established a plan of care (hereinafter "care plan") for D.T. for the period June 20, 2000 to August 20, 2000. EVS recertified D.T.'s care plan for the period of August 20, 2000 to October 20, 2000. The care plan required:
  - a. skilled nursing services; and/or,
  - b. home health aide services.
 Dept. Exh. 8 (Under Seal), pp. 1-2; Tr., 12/4/02, pp. 44-45, 48-49; Tr., 12/29/03, pp. 20-23.

7. On or after October 20, 2000, EVS provided home health care services to D.T. without a care plan. Tr., 1/29/03, pp. 40-41.
8. D.T.'s physician signed the initial care plan dated June 20, 2000. However, D.T.'s physician did not sign the care plan dated August 20, 2000. Dept. Exh. 8 (Under Seal), pp. 1-2; Tr., 12/4/02, pp. 49-50; Tr., 1/29/03, p. 24.
9. D.T., who was legally blind, required skilled nursing services to teach her about diabetes, instruct her about self-injection and self-testing for glucose levels, and, if necessary, administer insulin injections. Dept. Exh. 8 (Under Seal), p. 1; Tr., 1/29/03, p. 21.
10. On or about August 30, 2000, EVS changed D.T.'s physician's order for twice daily skilled nursing services to one visit every other day without notification to or approval by D.T. and her physician. Dept. Exh. 8 (Under Seal), p. 4; Tr., 1/29/03, p. 25.
11. On one or more occasions between June 20, 2000 and October 30, 2000, D.T. did not receive skilled nursing services and/or the services of a home health aide. Dept. Exh. 8A; Tr., 1/29/03, pp. 33-34.
12. On or about June 24, 2000, EVS discontinued D.T.'s home health aide services without notification to or approval by D.T. and her physician. Dept. Exh. 8 (Under Seal), p. 4; Tr., 1/29/03, p. 35.
13. On or after October 15, 2000, respondent, as administrator and/or supervisor of clinical services for EVS, abandoned D.T. as she failed to ensure that skilled nursing services were appropriately provided. Tr., 1/29/03, pp. 42-43
14. On or before October 20, 2000, EVS failed to ensure that a registered nurse who had provided direct clinical care to D.T., conducted a follow-up assessment to establish D.T.'s need for continuing home health care services. Tr., 1/29/03, p. 40.
15. On or about October 30, 2000, EVS discharged D.T. from home health care services without notification to or approval by D.T. and her physician. Dept. Exh. 8 (Under Seal), p. 7; Tr., 1/29/03, pp. 29-30.

***Count Two***

16. From approximately August 4, 2000 to November 15, 2000, A.F. was a patient of EVS. Dept. Exh. 10 (Under Seal), p. 1-2; Tr., 1/29/03, pp. 76, 87.
17. At all relevant times, A.F. was diagnosed with sinus "arthritis", gastroesophageal reflux disease, depression, and hypertension with an additional diagnosis as of October 13, 2000 of non-insulin dependent diabetes mellitus. Dept. Exh. 10 (Under Seal), p. 1; Tr., 1/29/03, p. 77.
18. On or about August 4, 2000, EVS established a care plan for the period of August 4, 2000 to October 4, 2000, and recertified the care plan for the period October 4, 2000 to December 4, 2000. The care plan required:
  - a. skilled nursing services; and/or,
  - b. home health aide services.Dept. Exh. 10 (Under Seal), p. 1-2; Tr., 1/29/03, pp. 77-78.

19. The signature appearing on the care plan for the period August 4, 2000 to October 4, 2000, and on the recertification for the period October 4, 2000 to December 4, 2000, was not A.F.'s physician's signature. Further, the recertification care plan for the period October 4, 2000 to December 4, 2000, was a photocopy of the preceding care plan with the exception that the dates had been altered to reflect the new recertification period. Dept. Exh. 10 (Under Seal), pp. 1-2; Tr., 1/29/03, pp. 79, 81-82.
20. On one or more occasions between August 4, 2000 and November 15, 2000, without notification to or approval by A.F. and his physician, EVS:
  - a. failed to provide A.F. with skilled nursing services; and/or,
  - b. changed the provision of home health aide services.Dept. Exh. 10A, p. 3; Tr., 1/29/03, pp. 84-87.
21. On or after September 21, 2000, respondent, as administrator and/or supervisor of clinical services for EVS, abandoned A.F. as skilled nursing services were not appropriately provided. Dept. Exh. 10A; Tr., 1/29/03, pp. 87-88.
22. Beginning approximately October 16, 2000, EVS failed to deliver home health aide services that were required by A.F.'s care plan in that EVS changed the frequency of home health aide services without A.F.'s physician's authorization. Dept. Exh. 10A; Tr., 1/29/03, pp. 86-87.
23. On or before October 4, 2000, EVS failed to ensure that a registered nurse conducted a follow-up assessment to establish A.F.'s need for continuing home health care services. Tr., 1/29/03, pp. 88-89.

### ***Count Three***

24. On or about October 6, 1999, V.S. became a patient of EVS. Dept. Exh. 11 (Under Seal), p. 1; Tr., 1/29/03, pp. 99-100.
25. V.S. was diagnosed with bilateral open heel wounds, peripheral vascular disease, hypothyroidism, osteoarthritis, congestive heart failure, and hypertension. V.S. was nonambulatory. On or about August 6, 2000 and October 6, 2000, EVS recertified V.S.'s care plans. Both care plans contained the same diagnosis and orders for discipline and treatment as the care plan dated April 6, 2000. Dept. Exh. 11 (Under Seal), pp. 1-3; Tr., 1/29/03, pp. 100-101, 105-107.
26. On or before August 6, 2000, EVS failed to ensure that a registered nurse who had provided direct clinical care to V.S., conduct a follow-up assessment to establish V.S.'s need for continuing home health care services. Tr., 1/29/03, pp. 114-115.
27. The nursing component of the care plans for the periods August 6, 2000 to October 6, 2000 and October 6, 2000 to December 6, 2000, was not consistent with V.S.'s changed medical status. V.S.'s heel wounds had healed, and she had developed open wounds on her shins that required different nursing interventions. Dept. Exh. 11 (Under Seal), pp. 2-3; Tr., 1/29/03, pp. 109-111.

28. The recertification care plan for the period October 6, 2000 to December 6, 2000, was a photocopy of the preceding recertification for the period August 6, 2000 to October 6, 2000. The signatures of V.S.'s physician as well as V.S.'s primary care nurse were carried over on the photocopy and therefore, neither V.S.'s physician nor nurse signed or authorized the recertified care plan. Further, the dates had been altered to reflect the new recertification period. Dept. Exh. 11 (Under Seal), pp. 3-4; Tr., 1/29/03, pp. 110-113.
29. On or after October 6, 2000, respondent, as administrator and/or supervisor of clinical services for EVS, abandoned V.S. as skilled nursing services were not appropriately provided. Dept. Exh. 11 (Under Seal), pp. 2-3; Tr., 1/29/03, pp. 109-111, 114-115.

#### ***Count Four***

30. On or about February 14, 2000, M.G. became a patient of EVS. There was an interruption of services provided to M.G. commencing on September 25, 2000, when M.G. was admitted to a skilled nursing facility. On or about November 22, 2000, EVS recommenced providing services to M.G. Dept. Exh. 16 (Under Seal), p. 1; Tr., 6/18/03, pp. 51, 55-56.
31. At all relevant times M.G. was diagnosed with cerebellum atrophy, hypothyroidism, and urinary incontinence. Dept. Exh. 16 (Under Seal), pp. 1-4; Tr., 6/18/03, pp. 51-52.
32. On or about August 14, 2000 and October 14, 2000, EVS recertified M.G.'s care plan. The care plan required:
  - a. skilled nursing services one time per month; and/or,
  - b. home health aide services.Dept. Exh 16 (Under Seal), pp. 3-4; Tr., 6/18/03, pp. 52-53.
33. From approximately June 14, 2000 to September 21, 2000, M.G.'s care plan required home health aide services. During that period of time, EVS made changes in the home health aide services provided to M.G., which failed to conform to the requirements of her care plan. Such changes were made without notification to or approval by M.G. and her physician. Dept. Exh. 16A; Tr., 6/18/03, pp. 61-62.
34. Between approximately August 14, 2000 and September 24, 2000, EVS failed to provide home health aide services to M.G. in that insufficient visits were made and/or no visits were made at all. Dept. Exh. 16A; Tr., 6/18/03, p. 61.
35. On or after September 25, 2000, when M.G. was admitted to a skilled nursing facility, EVS failed to notify M.G.'s physician of the interruption of home health care services. Tr., 6/18/03, p. 62.
36. EVS recertified M.G.'s care plan for the period October 14, 2000 to December 14, 2000 despite the fact that EVS had not provided skilled nursing services to M.G. since August 30, 2000, and/or home health aide services since September 21, 2000. Dept. Exh. 16 (Under Seal), p. 4; Tr., 6/18/03, pp. 67-68.

37. The recertification care plan for the period October 14, 2000 to December 14, 2000 was a photocopy of the preceding recertification. The signatures of M.G.'s physician as well as M.G.'s primary care nurse were carried over on the photocopy and, therefore, neither M.G.'s physician nor nurse signed or authorized the recertified care plan. Further, the dates had been altered to reflect the new recertification period. Dept. Exh. 16 (Under Seal), p. 4; Tr., 6/18/03, pp. 54-55.
38. On or about November 22, 2000, M.G. returned to EVS. Her care plan required skilled nursing, home health aide, physical therapy and speech therapy services. Dept. Exh. 16 (Under Seal), p. 5; Tr., 6/18/03, pp. 56-57.
39. On or after November 22, 2000, respondent, as administrator and/or supervisor of clinical services for EVS, abandoned M.G. as skilled nursing services were not appropriately provided. Dept. Exh. 16 (Under Seal), p. 4; Tr., 6/18/03, pp. 54-55, 61-62.
40. From November 22, 2000 to at least January 24, 2001, EVS failed to ensure that M.G. received the services of a physical therapist and/or a speech therapist as required by her care plan. Dept. Exh. 16 (Under Seal), p. 6; Tr., 6/18/03, pp. 57, 63-64.

#### ***Count Five***

41. From approximately July 6, 2000 to November 21, 2000, E.M. was a patient of EVS. Dept. Exh. 17 (Under Seal), pp. 1-2; Tr., 6/18/03, pp. 69, 75.
42. At all relevant times E.M. was diagnosed with hypertension. Dep. Exh. 17 (Under Seal), p. 1; Tr., 6/18/03, p. 69.
43. On or about July 6, 2000, EVS established a care plan for E.M. Such care plan required skilled nursing services. Dept. Exh. 17 (Under Seal), p. 1; Tr., 6/18/03, pp. 69-70.
44. EVS prepared a recertification of E.M.'s care plan for the period of September 6, 2000 to November 6, 2000. The recertified care plan had a physician's signature dated September 13, 2000, and was date stamped as received on September 15, 2000. E.M.'s physician did not sign the recertification care plan until November 13, 2000. Dept. Exh. 17 (Under Seal), pp. 4,7; Tr., 6/18/03, pp. 71-73.
45. On one or more occasions between July 6, 2000 and November 21, 2000, E.M. did not receive skilled nursing services as required by her care plan. Dept. Exh. 17A; Tr., 6/18/03, pp. 73-76.
46. On or before September 6, 2000, EVS failed to ensure that a registered nurse who had provided direct clinical care to E.M., conduct a follow-up assessment to establish her need for continuing home health care services. Tr., 6/18/03, p. 77.
47. On or after September 29, 2000, respondent, as administrator and/or supervisor of clinical services for EVS, abandoned E.M. in that skilled nursing services were not provided to E.M. as required. Tr., 6/18/03, pp. 75-76.
48. On or about November 21, 2000, EVS provided skilled nursing services to E.M. despite the fact that there was no care plan in place authorizing home health care services. Tr., 6/18/03, p. 78.

**Count Six**

49. From approximately June 8, 2000 to November 25, 2000, C.F. was a patient of EVS. Dept. Exh. 18 (Under Seal), p. 2; Dept. Exh. 18A; Tr., 6/18/03, p. 83.
50. At all relevant times C.F. was diagnosed with non-insulin dependent diabetes mellitus, hypertension, severe cerebral white matter disease, end stage renal disease, and cerebral ataxia. In addition, he was legally blind. Dept. Exh. 18 (Under Seal), pp. 2-3; Tr., 6/18/03, pp. 83-85.
51. On or about June 8, 2000, EVS established a care plan for C.F. for the period of June 8, 2000 to August 8, 2000. EVS recertified C.F.'s care plan for the period August 8, 2000 to October 8, 2000, and October 8, 2000 to December 8, 2000. The care plans required:
- a. skilled nursing services; and/or,
  - b. home health aide services.
- Dept. Exh. 18 (Under Seal), p. 2-4; Tr., 6/18/03, pp. 85-88.
52. On or before October 8, 2000, EVS failed to ensure that a registered nurse who had provided direct clinical care to C.F., conduct a follow-up assessment to establish his need for continuing home health care services. Tr., 6/18/03, p. 88.
53. The recertification care plan for the period October 8, 2000 to December 8, 2000 was a photocopy of the preceding recertification. The signatures of C.F.'s physician as well as C.F.'s primary care nurse were carried over on the photocopy and, therefore, neither C.F.'s physician nor nurse signed or authorized the recertified care plan. Further, the dates had been altered to reflect the new recertification period. Dept. Exh. 18 (Under Seal), pp. 3-4; Tr., 6/18/03, pp. 88-90.
54. On one or more occasions between June 8, 2000 and November 25, 2000, EVS failed to provide C.F. with skilled nursing services and/or home health aide services. Dept. Exh. 18A; Tr., 6/18/03, pp. 94-98.
55. On or after October 13, 2000, respondent, as administrator and/or supervisor of clinical services for EVS, abandoned C.F. in that skilled nursing services were not provided as required. Tr., 6/18/03, pp. 95-96.
56. A copy of an unsigned physician's verbal order dated October 20, 2000 that authorized "interruption of services," was not ordered by C.F.'s physician. Respondent wrote the entry on November 28, 2000. Dept. Exh. 18 (Under Seal), p. 5; Tr., 6/18/03, p. 91.

**Count Seven**

57. From approximately December 3, 1999 to November 16, 2000, W.M. was a patient of EVS. Dept. Exh. 19, pp. 1-3; Dept. Exh. 19A; Tr., 6/18/03, p. 104.
58. At all relevant times W.M. was diagnosed with laryngeal cancer, hypertension, diabetes mellitus, and atrial fibrillation. Dept. Exh. 19 (Under Seal), p. 1; Tr., 6/18/03, p. 104.

59. On and after June 3, 2000, EVS recertified W.M.'s care plan for the periods June 3, 2000 to August 3, 2000, August 3, 2000 to October 3, 2000, and October 3, 2000 to December 3, 2000. These care plans required:
- skilled nursing services; and/or,
  - homemaker home health aide services.
- Dept. Exh. 19 (Under Seal), pp. 1-3; Tr., 6/18/03, pp. 104, 107-108.
60. The recertification care plans for the period August 3, 2000 to October 3, 2000, and October 3, 2000 to December 3, 2000, were photocopies of the June 3, 2000 to August 3, 2000 care plan. The signatures of W.M.'s physician as well as W.M.'s primary care nurse were carried over on the photocopy and, therefore, neither W.M.'s physician nor nurse signed or authorized the recertified care plan. Further, the dates had been altered to reflect the new recertification period. Dept. Exh. 19 (Under Seal), pp. 1-3; Tr., 6/18/03, pp. 107-109.
61. The nursing notes for W.M. dated October 27, 2000 are photocopies of the nursing notes dated October 20, 2000 with the exception of the blood pressure and capillary blood sugar values after eating, both of which had been altered. Tr., 6/18/03, p. 111.
62. On one or more occasions from June 3, 2000 to November 16, 2000, EVS failed to provide skilled nursing services and/or home health aide services to W.M. Dept. Exh. 19A; Tr., 6/18/03, pp. 112-115.
63. On or before October 3, 2000, EVS failed to ensure that a RN who had provided direct clinical care to W.M. conducted a follow-up assessment to establish his need for continuing home health care services. Tr., 6/18/03, pp. 108-109.
64. On or after October 28, 2000, respondent, as administrator and/or supervisor of clinical required. Tr., 6/18/03, pp. 118-121.

### ***Count Eight***

65. From approximately September 9, 2000 to November 10, 2000, J.M. was a patient of EVS. Dept. Exh. 20 (Under Seal), p. 1; Tr., 6/18/03, p. 123.
66. At all relevant times J.M. was diagnosed with chronic obstructive pulmonary disease, congestive heart failure, renal failure and coronary artery disease. Dept. Exh. 20 (Under Seal), p. 1; Tr., 6/18/03, p. 124.
67. On or about September 9, 2000, EVS established a care plan for J.M. for the period of September 9, 2000 to November 9, 2000, which required:
- skilled nursing services; and/or,
  - home health aide services.
- Dept. Exh. 20 (Under Seal), p. 1; Tr., 6/18/03, pp. 124-128.
68. J.M.'s care plan required Epogen injections three times a week. Dept. Exh. 20 (Under Seal), p. 1; Tr., 6/18/03, p. 124.
69. On one or more occasions between September 9, 2000 and November 9, 2000, EVS failed to ensure that J.M. received Epogen injections. Dept. Exh. 20A; Tr., 6/18/03, pp. 127-129.

70. On or after September 23, 2000, respondent, as administrator and/or supervisor of clinical services for EVS, abandoned J.M. as nursing services were not provided as required. Dept. Exh. 20A; Tr., 6/18/03, pp. 129-130.
71. On or before November 9, 2000, EVS failed to ensure that a registered nurse who had provided direct clinical care to J.M., conduct a follow-up assessment to establish his need for continuing home health care services. Tr., 6/18/03, pp. 130, 138
72. On or about November 10, 2000, EVS provided skilled nursing services to J.M. despite the fact that there was no care plan in place at that time authorizing home health care services. Dept. Exh. 20A, Tr., 6/18/03, p. 130.

### ***Count Nine***

73. Paragraph 3 of the Consent Order, dated September 19, 2001, precluded respondent from acting in a supervisory capacity in a skilled nursing facility with which she had a relationship as an independent contractor. Dept. Exh. 13 (E, F); Tr., 6/18/03, pp. 26-27.
74. From approximately November 2001 through February 2002, respondent served as the primary training instructor for Global Training Center (hereinafter Global) in Bridgeport, Connecticut, which provided courses to train students as nurse aides. Dept. Exh. 13 (J, K, L, M); Tr., 6/18/03, pp. 40-41.
75. As primary instructor for Global, respondent conducted clinical training for and supervised nurse aide trainees at Northbridge Healthcare Center, a skilled nursing facility located in Bridgeport, Connecticut. Dept. Exh. 15; Tr., 6/18/03, p. 38.

### ***Conclusions of Law and Discussion***

In consideration of the above Findings of Fact, the following conclusions are rendered: Vashti Skyers held a valid registered nurse license in the State of Connecticut at all times referenced in the Amended Statement of Charges.

The Notice of Hearing and Statement of Charges provided sufficient legal notice as mandated by *Conn. Gen. Stat.* § 4-177(a) and (b), and § 4-182(c). The hearing was held in accordance with *Conn. Gen. Stat.* Chapters 54 and 368a as well as § 19a-9-1 through § 19a-9-29 of the Regulations of Connecticut State Agencies.

The Notice of Hearing, Amended Statement of Charges, and the hearing process provided respondent with the opportunity to demonstrate compliance with all lawful requirements for the retention of her license as required by *Conn. Gen. Stat.* § 4-182(c).

The Department bears the burden of proof by a preponderance of the evidence in this matter.

**COUNT ONE, PARAGRAPH 16** of the Charges alleges that respondent's conduct fell below an acceptable standard of care for registered nurses in violation of *Conn. Gen. Stat.* §§ 20-99(b)(2) and (6), in that she:

- a. knew or should have known that portions of D.T.'s medical records were falsified or inaccurate;
- b. failed to deliver home health care services to D.T. without notification to or approval by D.T. and her physician;
- c. revised D.T.'s care plan without authorization by her physician;
- d. failed to ensure that a registered nurse who had provided direct clinical care to D.T., conduct periodic reassessments of D.T.'s current status; and/or,
- e. aided or abetted the unauthorized practice of medicine in that she authorized the delivery of home health care services without a physician's order or authorization

Respondent denies the allegations contained in the First Count of the Charges. Resp. Exh. A, p.1.

**COUNT TWO, PARAGRAPH 27** of the Charges alleges that respondent's conduct fell below an acceptable standard of care for registered nurses in violation of *Conn. Gen. Stat.* §§ 20-99 (b)(2) and (6), in that she:

- a. knew or should have known that portions of A.F.'s medical record were falsified or inaccurate;
- b. having initiated skilled nursing and home health aide services to A.F., failed to deliver those services to him without notification to or approval by A.F. and his physician;
- c. revised A.F.'s care plan without authorization by his physician;
- d. failed to ensure that a registered nurse who had provided direct clinical care to A.F., conduct periodic reassessments of A.F.'s current status; and/or
- e. aided or abetted the unauthorized practice of medicine in that she authorized the delivery of home health care services without a physician's order or authorization.

Respondent denies the allegations contained in the Second Count of the Charges. Resp. Exh. A, p. 1.

**COUNT THREE, PARAGRAPH 35** of the Charges alleges that respondent's conduct fell below the acceptable standard of care for registered nurses in violation of *Conn. Gen. Stat.* §§ 20-99 (b)(2) and (6), in that she:

- a. knew or should have know that portions of V.S.'s medical record were falsified or inaccurate;
- b. failed to ensure that V.S.'s physician received and/or signed the recertifications for the periods of August 6, 2000 to October 6, 2000, and October 6, 2000 to December 6, 2000;

- c. failed to ensure that V.S.'s physician received a recertified care plan that accurately reflected her current medical status thereby depriving V.S. of appropriate medical treatment;
- d. failed to ensure that a registered nurse who provided direct clinical care to V.S., conduct periodic reassessments of her current status; and/or,
- e. aided or abetted the unauthorized practice of medicine in that she authorized the delivery of home health care services without a physician's order or authorization.

Respondent denies the allegations contained in the Third Count of the Charges. Resp. Exh. A, p. 1.

**COUNT FOUR, PARAGRAPH 48** of the Charges alleges that respondent's conduct fell below an acceptable standard of care for registered nurses in violation of *Conn. Gen. Stat.* §§ 20-99(b)(2) and (6), in that she:

- a. knew or should have known that portions of M.G.'s medical records were falsified or inaccurate; and/or,
- b. failed to deliver skilled nursing services, home health aide services, physical therapy, and/or speech therapy services to M.G. without notification to or approval by M.G. and her physician.

Respondent denies the allegations contained in the Fourth Count of the Charges. Resp. Exh. A, p. 1.

**COUNT FIVE, PARAGRAPH 59** of the Charges alleges that respondent's conduct fell below an acceptable standard of care for registered nurses in violation of *Conn. Gen. Stat.* §§ 20-99(b)(2) and (6), in that she:

- a. knew or should have known that one or more portions of E.M.'s medical record were altered or falsified;
- b. failed to deliver skilled nursing services to E.M. without notification to or approval by E.M. and her physician;
- c. failed to ensure that a registered nurse who provided direct clinical care to E.M., conduct a periodic reassessment of E.M.'s current status; and/or,
- d. aided or abetted the unauthorized practice of medicine in that she authorized the delivery of home health care services without a physician's order or authorization.

Respondent denies the allegations contained in the Fifth Count of the Charges. Resp. Exh. A, p. 1.

**COUNT SIX, PARAGRAPH 70** of the Charges alleges that respondent's conduct fell below an acceptable standard of care for registered nurses in violation of *Conn. Gen. Stat.* §§ 20-99 (b)(2) and (6), in that she:

- a. knew or should have known that portions of C.F.'s record were altered or falsified;
- b. failed to deliver home health care services to C.F. without notification to or approval by C.F. and his physician;

- c. failed to ensure that a registered nurse who provided direct clinical care to C.F., conduct periodic reassessments of his current status; and/or,
- d. aided or abetted the unauthorized practice of medicine in that she authorized the delivery of home health care services without a physician's order or authorization.

Respondent denies the allegations contained in the Sixth Count of the Charges. Resp. Exh. A, p. 1.

**COUNT SEVEN, PARAGRAPH 81** of the Charges alleges that respondent's conduct fell below an acceptable standard of care for registered nurses in violation of *Conn. Gen. Stat.* §§ 20-99 (b)(2) and (6), in that she:

- a. knew or should have known that portions of W.M.'s medical record were falsified or inaccurate;
- b. failed to deliver home health care services to W.M. without notification to or approval by him and his physician;
- c. failed to ensure that a registered nurse who provided direct clinical care to W.M., conduct periodic assessments of W.M.'s current status; and/or,
- d. aided or abetted the unauthorized practice of medicine in that she authorized the delivery of home health care services without a physician's order or authorization.

Respondent denies the allegations contained in the Seventh Count of the Charges. Resp. Exh. A, p. 1.

**COUNT EIGHT, PARAGRAPH 92** of the Charges alleges that respondent's conduct fell below an acceptable standard of care for registered nurses in violation of *Conn. Gen. Stat.* §§ 20-99 (b)(2), (6), and (7), in that she:

- a. failed to ensure that Epogen injections were administered to J.M. as ordered;
- b. failed to deliver home health care services to J.M. without notification to or approval by J.M. and her physician;
- c. failed to ensure that a registered nurse who provided direct clinical care to J.M., conduct periodic reassessments of her current status; and/or,
- d. aided or abetted the unauthorized practice of medicine in that she authorized the delivery of home health care services without a physician's order or authorization.

Respondent denies the allegations contained in the Eighth Count of the Charges. Resp. Exh. A, p. 2.

**COUNT NINE, PARAGRAPH 98** of the Charges alleges that respondent's conduct as described in Paragraphs 95, 96, and 97 of the Amended Statement of Charges constitutes a violation of the terms of the Consent Order and subjects respondent's license to disciplinary action authorized by the *Conn. Gen. Stat.* §§ 19a-17 and 20-99(b).

Respondent denies the allegations contained in the Ninth Count of the Charges. Tr., 1/29/03, pp. 4-6.

The General Statutes of Connecticut § 20-99 provides in relevant part:

(a) The Board of Examiners for Nursing 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 performing usual nursing functions; . . . (6) fraud or material deception in the course of professional services or activities; (7) willful 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; . . . .

The Board finds that substantial and credible evidence was presented by the Department. The Board also finds credible the testimony of Department witnesses Marsha Mehmel, R.N., Marsha Balat, R.N., Angeline Komarow, R.N., and Victoria Carlson, R.N.

Based on its findings, the Board concludes that respondent's conduct as alleged in Counts 1, 2, 3, 4, 5, 6, 7, 8, and 9 of the Amended Statement of Charges is proven by a preponderance of the evidence presented. The Board further concludes that said conduct constitutes grounds for disciplinary action pursuant to *Conn. Gen. Stat.* §§ 20-99(b)(2), (6), and 19a-17.

### **Order**

Pursuant to its authority under *Conn. Gen. Stat.* § 19a-17 and § 20-99, the Board of Examiners for Nursing hereby orders the following:

1. Respondent's registered nurse license number R28330, is revoked.
2. The Respondent is assessed a civil penalty of ten thousand dollars (\$10,000.00) for each count, resulting in a total civil penalty of ninety thousand dollars (\$90,000.00)

Payment of the civil penalty shall be made by certified or cashier's check, made payable to "Treasurer, State of Connecticut." The check shall reference Petition Number 2001-0716-010-047 on the face of the check and shall be sent to:

Bonnie Pinkerton  
Department of Public Health  
Division of Health Systems Regulation  
410 Capitol Avenue, MS #12HSR  
P.O. Box 340308  
Hartford, CT 06134-0308

The Board of Examiners for Nursing hereby informs respondent, Vashti Skyers, and the Department of Public Health of the State of Connecticut of this decision.

Dated at Hartford, Connecticut this 1<sup>st</sup> day of October, 2003.

BOARD OF EXAMINERS FOR NURSING

By 

**CERTIFICATION**

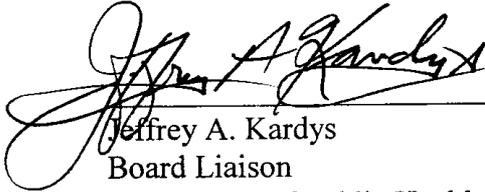
I hereby certify that, pursuant to Connecticut General Statutes §4-180(c), a copy of the foregoing Memorandum of Decision was sent this 2nd day of October 2003, by certified mail, return receipt requested, and first class mail to:

Cynthia R. Jennings, Esq  
Barrister Law Group  
211 State Street  
Bridgeport, CT 06604

Certified Mail RRR #70022410000675062291

and by Inter-Departmental Mail to:

Stanley K. Peck, Director  
Legal Office  
Department of Public Health  
410 Capitol Avenue, MS #12LEG  
Hartford, CT 06134-0308



---

Jeffrey A. Kardys  
Board Liaison  
Department of Public Health  
Public Health Hearing Office