

STATE OF CONNECTICUT  
BOARD OF EXAMINERS FOR NURSING

Department of Health Services v.

Janet M. Krueger

121 Newton Street

Norwich, Connecticut 06360

CT. License No. R.N. R35499

Petition # 860624-10-033

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 13, 1987. The Board issued a notice of Hearing dated May 10, 1988. The hearing was scheduled for June 21, 1988, Ms. Krueger was not present. A continuance was granted to the Department of Health Services due to their uncertainty if Ms. Krueger wished to negotiate a Consent Order and questions concerning the Notice of Hearing. The Consent Order was not negotiated and a Statement of Charges was signed on July 14, 1988 by the Department. The Board was presented by the Department with an amended Statement of Charges dated October 19, 1988.

The Statement of Charges alleged violations of certain provisions of Chapter 378, Connecticut General Statutes. The Board issued a Summary Suspension Order dated July 21, 1988 setting a hearing date of September 28, 1988. The Board issued a Continuance of Formal Hearing dated October 3, 1988 at the request of Ms. Krueger and the Department of Health Services. The hearing took place on October 27, 1988 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

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

1. Janet M. Krueger, hereinafter referred to as Respondent, was issued Connecticut Registered Nurse license number R35499 on May 28, 1982; her license was summarily suspended on July 21, 1988 pending a final determination of the Connecticut Board of Examiners for Nursing .

2. Pursuant to Connecticut General Statutes 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.

3. The Respondent was notified of the time and location of the hearing. Notice of the location and time of this hearing were delivered by certified mail to the Respondent. The Respondent was present at the hearing.

4. In March of 1985, Janet Krueger was associated with Community Health Services in the Voluntown Clinic in her capacity as a family nurse practitioner.

5. On approximately March 1, 1985 and again on March 4, 1985 Betty Mitchell attempted to obtain health care services from Community Health Services in Voluntown, Connecticut for relief from severe lower back pain.

6. During the above-referenced time, Betty Mitchell was seen by Janet Krueger at the Voluntown Medical Clinic.

7. The care rendered to Betty Mitchell by Janet Krueger on the above-referenced date was below acceptable standards of nursing care. In one or more of the following ways, Janet Krueger:

- a) failed to elicit Betty Mitchell's significant past medical history;
- b) performed an inadequate physical examination on Betty Mitchell;
- c) performed insufficient tests to reach the above-referenced diagnosis.

8. In May of 1985, Janet Krueger was associated with Community Health Services in the Voluntown Clinic in her capacity as a family nurse practitioner.

9. Between May 2, 1985 and May 10, 1985, Deborah Peirson went to Community Health Services in Voluntown to receive health care for a variety of symptoms.

10. Blood tests were performed on or about May 3, 1985 as a part of the examination given to Deborah Peirson on that day.

11. On or about May 6, 1985 Janet Krueger prescribed Synthroid for Deborah Peirson; medication was prescribed pending receipt of results of the aforementioned blood tests.

12. On or about May 8, 1985 the blood test results were available, which results indicated that Deborah Peirson suffered from hyperthyroidism.

13. In October of 1985, Janet Krueger was associated with Community Health Services in the Jewett City Clinic in her capacity as a family nurse practitioner.

14. During October 1985 Liana Whitcomb attempted to obtain health care services from Community Health Services in Jewett City for relief of a sore throat.

15. The nursing care rendered to Liana Whitcomb by Janet Krueger was below acceptable standards of nursing care in the following ways:

- a) no vital signs were taken during the visit of October 10, 1985;
- b) serous fluid was noted in the middle ears, but an external preparation was prescribed;
- c) the use of Amoxil was inappropriate, given the age of the patient and the symptoms presented;
- d) there was no laboratory testing done on the visit of October 15, 1985 to establish a diagnosis of mononucleosis;
- e) on or about October 15, 1985 Janet Krueger prescribed Medrol and Decadron for this patient without the supervision or authorization of a physician;
- f) there was no medical reason, based on the information obtained on the visits of October 10, 1985 and October 15, 1985, to prescribe steroids for this patient;
- g) there was no physical exam given to the patient on the visit of October 15, 1985;
- h) there is no record of parental permission to treat a minor and no record of a parent being present during the visit of October 15, 1985; and
- i) there was no consultation with the doctor prior to the undertaking treatment of this patient, nor is there a co-signature from the doctor.

16. In May of 1985 Janet Krueger was associated with Community Health Services in the Voluntown Clinic in her capacity as a family nurse practitioner.

17. In May of 1985 Mary MacComber attempted to obtain health care services from Community Health Services in Voluntown for relief from arthritis pain in all joints, easy fatigue, and other physical complaints.

18. During the above-referenced time, Janet Krueger reached a diagnosis of anemia for Mary MacComber based on inadequate test results.

19. During the above-referenced time, Janet Krueger failed to provide adequate and complete treatment to Mary MacComber based on Mary MacComber's physical symptoms and medical history and rendered care below acceptable standards of nursing care.

20. In January of 1985 Janet Krueger was associated with Community Health Services in the Voluntown Clinic in her capacity as a family nurse practitioner.

21. In January of 1985 Cheryl Miner attempted to obtain health care services from Community Health Services in Voluntown for relief from sinus stuffiness, joint pain and fever.

22. Cheryl Miner was seen by Janet Krueger at the above-mentioned Voluntown Clinic on or about January 22, 1985.

23. The care rendered to Cheryl Miner by Janet Krueger during the above-referenced time was below acceptable standards of nursing care in the following ways:

- a) failed to take vital signs as part of the physical exam;
- b) despite the finding of a positive mononucleosis spot, she failed to check Cheryl Miner's abdomen for splenic and liver enlargement;
- c) she prescribed Tavistand Penicillin, without the supervision or authorization of a physician; and
- d) given the clinical findings made by Janet Krueger, the medication prescribed for Cheryl Miner by Janet Krueger was of questionable efficacy.

24. In March and April of 1985 Janet Krueger was associated with Community Health Care Services in Voluntown in her capacity as a family nurse practitioner.

25. During the above-referenced time, Evelyn Pizzo attempted to obtain health care services from Community Health Care Services in Voluntown for relief from pain in her knee.

26. Janet Krueger falsified the medical records of Evelyn Pizzo.

27. From approximately October 30, 1984 until approximately April of 1985, Janet Krueger was associated with Community Health Care Services in Voluntown in her capacity as a family nurse practitioner.

28. During the above-referenced time Fannie Kangas attempted to obtain health care services from Community Health Care Services in Voluntown, and was seen during those times by Janet Krueger.

29. The care provided to Fannie Kangas by Janet Krueger was below acceptable standards of nursing care in the following ways:

- a) the assessment and plan developed by Janet Krueger focused solely on congestive heart failure, and failed to consider any other diagnosis as a possibility;
- b) Digoxin was prescribed by Janet Krueger prior to a physician reviewing the record or consulting with Janet Krueger about this patient;
- c) Janet Krueger did not take into account other medications being taken by Fannie Kangas at the time Digoxin was prescribed;
- d) on or about March 7, 1985 Janet Krueger treated Fannie Kangas for either serous otitis or otitis media with medication effective only for external infections; and
- e) Janet Krueger failed to maintain adequate medical records for Fannie Kangas.

30. Between January and February of 1986, Janet Krueger was associated with Community Health Services in the Jewett City Clinic in her capacity as a family nurse practitioner.

31. During the above-referenced time, Michael Silver attempted to obtain health care services from Community Health Services in Jewett City for relief from dizziness, sore throat and nasal congestion.

32. During the above-referenced time, Michael Silver was seen by Janet Krueger at the Jewett City Clinic.

33. The care rendered to Michael Silver by Janet Krueger during the above-referenced time was below acceptable standards of nursing care in one or more of the following ways:

- a) Janet Krueger falsified Michael Silver's patient records;
- b) Janet Krueger performed an inadequate physical exam on Michael Silver;
- c) Janet Krueger prescribed Erythromycin for Michael Silver without the supervision or authorization of a physician;
- d) despite the fact that a test for mononucleosis was positive, Michael Silver was continued on Erythromycin by Janet Krueger; and
- e) Michael Silver was prescribed Compazine by Janet Krueger without the supervision or authorization of a physician.

34. On approximately January 5, 1988 Janet Krueger was associated with Primary Care Inc., in Moosup, Connecticut in her capacity as a family nurse practitioner and as president of the corporation.

35. Between approximately January 5, 1988 and approximately June 30, 1988, Janet Krueger provided health care services to one or more of the following patients: William P. Cline, Marion J. Causey, Rosemary E. Sullivan, Eugene J. Arcand, Edward C. Winkler and Phyllis Brodeur.

36. The care provided to the above-referenced patients failed to conform to an acceptable standard of nursing care in one or more of the following ways:

- a) she failed to refer the patients to a physician when they requested to be seen by a physician;
- b) she failed to refer patients to a physician when their medical condition warranted such referral;  
and
- c) she prescribed medications for patients without the supervision or authorization of a physician.

37 On May 28, 1982, Janet Krueger was issued Connecticut nursing license number R-35499 on the basis of reciprocity.

38. On July 21, 1988, Janet Krueger's Connecticut nursing license was summarily suspended by order of the Connecticut Board of Examiners for Nursing.

39. On July 30, 1988, Janet Krueger received notice of the summary suspension order by in-hand service from Deputy Sheriff Woodrow Goirdani.

40. On August 20, 1988, Janet Krueger was interviewed for the position of Durational Practical Nurse Education Instructor of Norwich Regional Vocational Technical School.

41. Janet Krueger did not indicate during that interview that her Connecticut nursing license had been summarily suspended.

42. Janet Krueger began working in the above-referenced position on September 6, 1988.

43. On September 28, 1988, Janet Krueger appeared before the Connecticut Board of Examiners for Nursing and testified that at the time she applied for the above-referenced position at Norwich Regional Vocational Technical School, her Connecticut nursing license was active.

44. Janet Krueger further testified that she informed her supervisors of the fact her Connecticut nursing license was summarily suspended at the time she began her employment in the above-referenced position.

#### DISCUSSION AND CONCLUSIONS

The First Count, Section 5 alleges that the Respondent, while working in her capacity as family nurse practitioner at the Voluntown Clinic, during March, 1985, provided an unacceptable standard of care to patient Betty Mitchell in one or more of the following ways:

- a) failed to elicit Betty Mitchell's significant past medical history;
- b) performed an inadequate physical examination on Betty Mitchell;
- c) prescribed various medications for a diagnosed kidney infection and back pain without the supervision or authorization of a physician; and

- d) performed insufficient tests to reach above-referenced diagnosis.

The above referenced conduct constitutes a violation of Connecticut General Statutes Section 20-90(b). In pertinent part, Section 20-99(b) includes: "... (2) illegal conduct, incompetence or negligence in carrying out usual nursing functions...." In reference to Subsection 5a, the Board refers to Department Exhibit 2, the medical records of Betty Mitchell which indicate, upon review, that the Respondent's medical history taking was inadequate. Expert testimony at the hearing of October 27, 1988, by Dorothy Shearer (hereinafter referred to as Expert) supports this allegation: "On the particular visit of 3/1/85 there is no past medical history elicited for this patient or at least reported for the patient, and there was a very significant past medical history with this particular patient [i.e. ovarian cancer with radium implants to the pelvis, and a myocardial infraction]," (Department Hearing Transcript of October 27, 1988, p. 53, lines 12-15.)

In reference to Subsection 5b, the Board refers to Department Exhibit 2, the medical records of Betty Mitchell, which indicate upon review, that no physical examination was documented except for urinalysis, lumbar spine x-ray and a neurological check. Therefore, the Respondent failed to give a complete physical to the patient.

In reference to Subsection 5d, the Board refers to the information discussed in Subsections 5a and 5b, above. Based on this information the Board has determined that the Respondent performed insufficient tests to enable her to reach her diagnosis.

The Board has determined that during March, 1985 the Respondent rendered care to Betty Mitchell which was below acceptable standards of nursing care as specified in the First Count Subsections 5a, b, and d. In reference to Subsection 5c, the information presented before the Board is insufficient to determine the Respondent guilty and is therefore dismissed. The Board concludes that the Respondent has violated Connecticut General Statutes Section 20-99(b)(2), as specified in the First Count, Subsections 5a, b, and d.

The Second Count, Section 5 alleges that the Respondent, while in her capacity as family nurse practitioner at the Voluntown Clinic, during May, 1985, caring for patient Deborah Peirson, practiced illegally, incompetently, or negligently. The above referenced conduct constitutes a violation of Connecticut General Statutes Section 20-90(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 the Respondent failed to meet a reasonable standard of care for this patient, and thus practiced in a negligent manner, in the following ways:

- a. Blood tests were performed on May 3, 1985, as part of the examination given to Deborah Peirson on that day;
- b. On May 6, 1985, Janet Krueger prescribed Synthroid for Deborah Peirson, which medication was prescribed pending receipt of results of the aforementioned blood tests;

- c. On or about May 8, 1985, the blood test results were available, which results indicated that Deborah Peirson suffered from hyperthyroidism;
- d. The patient was prescribed Synthroid on May 6, 1985 prior to receipt of blood tests (Department Exhibit 3, pp 132-33). Expert testimony indicates such treatment is for a hypoactive thyroid, and that the patient's medical history and physical exam made it clear that the symptoms were more suggestive of a hyperactive thyroid than a hypoactive thyroid (Hearing Transcript of October 27, 1988, p. 56, lines 14-21).

The Board concludes that Respondent has violated Connecticut General Statutes Section 20-99(b)(2), as specified in the Second Count, Sections four through seven.

The Third Count, Section 4, alleges that Respondent, while in her capacity as family nurse practitioner, while associated with Community Health Services, in the Jewett City Clinic, during October, 1985, provided an unacceptable standard of care to patient Liana Whitcomb in the following ways:

- a) no vital signs were recorded during the visit of October 10, 1985;
- b) serous fluid was noted in the middle ears, but an external preparation was prescribed;
- c) the use of Amoxil was inappropriate, given the age of the patient and the symptoms presented;

- d) there was no laboratory testing done on the visit of October 15, 1985 to establish a diagnosis of mononucleosis;
- e) on or about October 15, 1985, Janet Krueger prescribed Medrol and Decadron for this patient without the supervision or authorization of a physician;
- f) there was no medical reason, based on the information obtained on the visits of October 10, 1985 and October 15, 1985, to prescribe steroids for this patient;
- g) there was no physical exam given to the patient on the visit of October 15, 1985;
- h) there is no record of parental permission to treat a minor and no record of a parent being present during the visit of October 15, 1985; and
- i) there was no consultation with the doctor prior to the undertaking treatment of this patient, nor is there a co-signature from the doctor.

The above referenced conduct constitutes 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;" and "... (6) fraud or material deception in the course of professional services or activities...."

The Respondent, in formal testimony, admits to the charges of Count Three, with the exceptions of Subsections c), f) and h). (Hearing Transcript of October 27, 1988, p. 128, lines 20-24 and p. 129, lines 1-14).

The Third Count, Subsection 4c alleges: c) the use of Amoxil was inappropriate, given the age of the patient and the symptoms presented. The Board refers to the testimony of the Expert in which she explains the inappropriate use of Amoxycillin for a patient where mononucleosis is still a possibility. "However the thinking at this point in this record did not begin to consider the possibility of mononucleosis which is a very common disease to 16 year old children and see[n] commonly in children with strep throat. Amoxycillin in that case you would certainly not [want] to use because of its potential to produce rash." (Hearing Transcript p. 62, lines 17-22).

The Third Count, Subsection 4f alleges: f) there was no medical reason, based on the information obtained on the visits of October 10, 1985 and October 15, 1985, to prescribe steroids for this patient. The Board refers again to the testimony of the Expert which indicates that the use of steroids in a strep throat situation would only be used in the case of an emergency. (Hearing Transcript of October 27, 1988, p. 67, lines 4-10). The Board believes that an emergency was clearly not the situation, and this action was inaccurate and below a reasonable standard of care.

The Third Count, Subsection 4h alleges: h) there is no record of parental permission to treat a minor and no record of a parent being present during the visit of October 15, 1985.

The Board has no way of determining whether there was parental permission for Liana Whitcomb on the October 15, 1985 visit because there is no documentation of this fact in the chart presented to the Board. For this reason, the Board must assume that there was not. The Board has determined that the Respondent failed to meet a reasonable standard of care for this patient due to her own admission of the Third Count, Subsections 4a, b, d, e, g. Also, due to the aforementioned Expert testimony and lack of documentation in the record, the Board has determined that the Respondent did not meet a reasonable standard of care as alleged in the Third Count, Subsections 4c, f, and h. The Board concludes that the Respondent has violated Connecticut General Statutes 20-99(b) (2) and (6), as specified in the Third Count.

The Fourth Count, Section 4, alleges that the Respondent, during May of 1985, while associated with Community Health Services in Voluntown Clinic, reached a diagnosis of anemia for Mary MacComber based on inadequate test results.

The above referenced conduct constitutes 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 Board refers to the testimony of the Expert in which she explains that in review of the medical records for Mary MacComber, she had found that the Respondent had, "...made a note that the blood work results confirm iron poor anemia and the patient was

started at that point on iron supplements...." (Hearing Transcript p.69, lines 19-21). However, the Expert concluded that the only laboratory results clearly documented was a record of blood sugar, and that she was unsure as to how the Respondent had reached that decision at that time. It is the Board's belief that a serum iron, a relatively simple test, could have been performed to produce sufficient results in order to reach a qualified diagnosis. Due to the fact that this was not performed, the Board concludes that the Respondent failed to provide an acceptable standard of health care and thus violated Connecticut General Statutes Section 20-99(b)(2) as specified in the Fourth Count, Section 4.

The Fourth Count, Sections 5 and 6, alleges that the Respondent, during the above-referenced time, failed to provide adequate and complete treatment to Mary MacComber based on Mary MacComber's physical symptoms and medical history and rendered care below acceptable standards of nursing care.

The above referenced conduct constitutes 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 Board refers to the testimony of the Expert in which she states that "...in people with chronic disease like rheumatoid arthritis, anemia is a common component. It is not something that is amenable to the treatment with iron. Iron does not help." (Hearing Transcript of October 29, 1988, p. 71, lines 21 - 24). The Board

therefore believes that patient Mary MacComber was not provided with adequate treatment for her symptoms and physical history.

The Board has determined that the care rendered to Mary MacComber by Janet Krueger constitutes inadequate and incompetent treatment and was below acceptable standards of nursing care. The Board therefore concludes that the Respondent has violated Connecticut General Statutes Section 20-99(b)(2) as specified in the Fourth Count Sections 5 and 6.

The Fifth Count, Section 5 alleges that the care rendered to Cheryl Miner by Janet Krueger during January of 1985, was below acceptable standards of nursing care in the following ways:

- a) she failed to take vital signs as part of the physical exam;
- b) despite the finding of a positive mononucleosis spot, she failed to check Cheryl Miner's abdomen for splenic and liver enlargement; and
- c) she prescribed Tavistand penicillin, without the supervision or authorization of a physician.
- d) given the clinical findings made by the Respondent, the aforementioned medication was of questionable efficacy.

The above referenced conduct constitutes 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..."; and "... (6)

fraud or material deception in the course of professional services or activities...."

The Board refers to Department Exhibit 6, the medical record for patient Cheryl Miner, in which documentation of vital signs and notation of examining the abdomen for splenic and liver enlargement are absent. The Board has determined that, to render adequate nursing care to a patient exhibiting symptoms of mononucleosis, documentation of these items should be included. In regard to Subsection c), a registered nurse is not licensed to prescribe medications in the State of Connecticut. In regard to Subsection d), the medical record indicates a positive mono spot test result (Department Exhibit 6). In the presence of mononucleosis the use of Tavistand Penicillin is not indicated.

The Board has determined that the Respondent, during January, 1985, rendered care to Cheryl Miner below acceptable standards of nursing care. The Board therefore concludes that Respondent has violated Connecticut General Statutes Section 20-99(b)(2) and (6), as specified in the Fifth Count, Subsections 5a), b), c) and d).

The Sixth Count, Subsection 4, alleges that the Respondent, while working in her capacity as a family nurse practitioner at Community Health Care Services in Voluntown, during March and April of 1985, falsified the medical records of Evelyn Pizzo. The Respondent denied this charge at the hearing (Hearing Transcript p. 131, lines 4-7).

The Board refers to Department Exhibit 7 pp. 157-163, the medical records of Evelyn Pizzo, which present a discrepancy in record keeping of the Respondent. Department Exhibit 7, p.158 and p. 162 are the identical medical progress notes for Evelyn Pizzo, with the exception of an additional entry on p. 158.

On June 20, 1985 Department Hearing Office received Evelyn Pizzo's medical records as the Patient's subsequent treating physician, Dr. Goslin's (Department Exhibit 7, p. 162), which contained only two entries, accompanied by a physician's signature. The records from the Respondent's place of employment contained a third entry dated 4/5/[85], with no physician's signature (Department Exhibit 7, p. 158).

It is the Board's belief that the Respondent was charting entries into medical records subsequent to the fact and dating the entries to correspond to the original date of treatment, thereby willingly falsifying the medical records of Evelyn Pizzo.

The Board has determined that Respondent, during March and April of 1985, falsified the medical records of Evelyn Pizzo. The Board therefore concludes that Respondent has violated Connecticut General Statutes Section 20-99(b) (2) and (6) as specified in the Sixth Count, Section 4.

The Seventh Count, Section 4, alleges that the Respondent, while working in her capacity as a family nurse practitioner at Community Health Care Services in Voluntown, during the period of October 1984 to April, 1985, failed to provide an acceptable

standard of care to patient Fannie Kangas in the following ways:

- a) the assessment and plan developed by Janet Krueger focused solely on congestive heart failure, and failed to consider any other diagnosis as a possibility;
- b) Digoxin was prescribed by Janet Krueger prior to a physician reviewing the record or consulting with Janet Krueger about this patient;
- c) Janet Krueger did not take into account other medications being taken by Fannie Kangas at the time Digoxin was prescribed;
- d) on or about March 7, 1985 Janet Krueger treated Fannie Kangas for either serous otitis or otitis media with medication effective only for external infections; and
- e) Janet Krueger failed to maintain adequate medical records for Fannie Kangas.

The Respondent denied these charges at the hearing. (Hearing Transcript of October 27, 1988, p. 131, line 22).

The above referenced conduct constitutes 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...; and "... (6) fraud or material deception in the course of professional services or activities...."

Expert testimony demonstrates that complete assessment of the patient's complaints was not made and that notations of the patient's history are "...vague...." (Hearing Transcript of October 27, 1988, p. 78, line 20). Results of a chest x-ray are not

recorded nor is the patient's serum potassium level (the patient was being treated with diuretic). Bilateral chest rattles were not recorded, the bilateral presence of which would be more indicative of congestive heart failure. The record does not indicate that the physician was consulted concerning digitalization of the patient. (Hearing Transcript of October 27, 1988, pp. 75-82). The patient's medical record reflects symptoms of otitis media but treatment was an external preparation (Department Exhibit 7, p. 166). By the Respondent's own admission records of assessment data collected on home visits was not completely recorded (Hearing Transcript of October 27, 1988, p. 85, lines 5-8).

The Board has determines that during the period of October 1984 to April 1985 the Respondent failed to provide an acceptable standard of care to patient Fannie Kargas. The Board therefore concludes that the Respondent has violated Connecticut General Statutes Section 20-99(b)(2) and (6) as specified in the Seventh Count.

The Eighth Count, Section 5, alleges that the Respondent, while working in her capacity as a family nurse practitioner at Community Health Services in Jewett City , during January and February 1986, failed to provide an acceptable standard of care to patient Michael Silver in the following ways:

- a) falsified Michael Silver's patient records;
- b) performed an inadequate physical exam on Michael Silver;
- c) prescribed Erythromycin for Michael Silver without the supervision or authorization of a physician;

- d) despite the fact that a test for mononucleosis was positive, Michael Silver was continued on Erythromycin by Janet Krueger; and
- e) Michael Silver was prescribed Compazine by Janet Krueger without the supervision or authorization of a physician.

The above referenced conduct constitutes a violation of Connecticut General Statutes 20-99(b). In pertinent part Section 20-99(b) includes: "... (2) illegal conduct, incompetence or negligence in carrying out usual nursing functions...; and "... (6) fraud or material deception in the course of professional services or activities...."

The Respondent admits to rewriting part of Michael Silver's medical record, although she does not admit to falsification (Hearing Transcript of October 27, 1988, p. 132, lines 4-8, 17-19). The Respondent admits to prescribing, under protocol for strept throat, Erythromycin on February 26, 1986 (Hearing Transcript of October 27, 1988, p. 142, line 24). The patient's medical record dated February 25, 1986 indicates that the throat culture was negative for streptococcal infection (Department Exhibit 9, p. 177). The medical record indicates further that on February 27, 1986, with a positive diagnosis for mononucleosis the Erythromycin was continued and Compazine was ordered by the Respondent (Department Exhibit 9, p. 178). The Respondent admitted to prescribing Compazine (Hearing Transcript of October 27, 1988, p. 144, lines 4 and 5). Expert testimony indicates that the physical

examination of Michael Silver was incomplete (Hearing Transcript, October 27, 1988, p. 88, line 8); and based on the plan of care developed by the Respondent the Board must concur.

The Board has determined that the Respondent, while working in her capacity as a facility nurse practitioner at Community Health Services in Jewett City, during January and February 1986, failed to provide an acceptable standard of care to Michael Silver. The Board, therefore, concludes that the Respondent has violated Section 20-99(b)(2) and (6) as specified in the Eighth Count.

The Ninth Count, Section 4, alleges that the Respondent, while working in her capacity as a family nurse practitioner at Primary Care Inc. in Moosup, Connecticut, during the period of January 5, 1988 to June 30, 1988, failed to provide an acceptable standard of care to one or more of the following patients: William P. Cline, Marion J. Causey, Rosemary E. Sullivan, Eugene J. Arcand, Edward C. Winkler and Phyllis Brodeur. (Phyllis Brodeur's mother was treated by the Respondent, not Brodeur herself.) The care provided to the above-referenced patients failed to conform to an acceptable standard of nursing care in one or more of the following ways:

- a) she failed to refer the patients to a physician when they requested to be seen by a physician;
- b) she failed to refer patients to a physician when their medical condition warranted such referral;  
and
- c) she prescribed medications for patients without the supervision or authorization of a physician.

The above referenced conduct constitutes 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...; and "... (6) fraud or material deception in the course of professional services or activities...."

The Board refers to Department Exhibit 1, pp. 19-32 documenting patient/family complaints concerning the aforementioned patients. These complaints focus on treatment by Mr. Krueger, including the prescription of medication, without the supervision of a licensed physician, even at times when the patient requested to be seen by a physician.

The Board has determined that the care rendered to the patients listed above by Janet Krueger was below acceptable standards of nursing care. The Board therefore concludes that the Respondent has violated Connecticut General Statutes Section 20-99(b)(2) and (6) as specified in the Ninth Count Section 4.

The Tenth Count alleges that:

1. On July 21, 1988, the Respondent's Connecticut nursing license was summarily suspended by order of the Connecticut Board of Examiners for Nursing.
2. On July 30, 1988, the Respondent received notice of the summary suspension order by in-hand service from Deputy Sheriff Woodrow Giordani.

3. On August 20, 1988, the Respondent was interviewed for the position of Durational Practical Nurse Education Instructor of Norwich Regional Vocational Technical School.
4. The Respondent did not indicate during that interview that her Connecticut nursing license had been summarily suspended.
5. The Respondent began working in the above-referenced position on September 6, 1988.
6. On September 28, 1988, the Respondent appeared before the Connecticut Board of Examiners for Nursing and testified that at the time she applied for the above-referenced position at Norwich Regional Vocational Technical School, her Connecticut nursing license was active.
7. The Respondent further testified that she informed her supervisors of the fact her Connecticut nursing license was summarily suspended at the time she began her employment in the above-referenced position.

The above referenced conduct constitutes 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...; and "... (6) fraud or material deception in the course of professional services or activities...."

The Board refers to the Hearing Transcript of September 28, 1988. The Respondent, on September 28, 1988, appeared before the Connecticut Board of Examiners for Nursing and testified that at the

time she applied for the above-referenced position at Norwich Regional Vocational Technical School, her Connecticut nursing license was active (Hearing Transcript of September 28, 1988, p. 5). The Board takes notice of the Summary Suspension Order dated, July 21, 1988, and recognizes that the interview to which the Respondent referred was conducted on August 20, 1988, one month later. Furthermore, the Respondent accepted the position and began work as a nurse there more than one month subsequent to the effective date on the Summary Suspension (See Department Exhibit 12).

The Board has determined that the Respondent, although in receipt of her Summary Suspension Order, did not indicate during her pre-employment interview that her Connecticut nursing license had been summarily suspended. She began working as a registered nurse on September 6, 1988. On September 28, 1988 The Respondent appeared before the Connecticut Board of Examiners for Nursing and testified that at the time she applied for the above-referenced position at Norwich Regional Vocation Technical School, her Connecticut nursing license was active. The Respondent further testified that she informed her supervisors of the fact her Connecticut nursing license was summarily suspended at the time she began her employment in the above-referenced position. The Board therefore concludes that Respondent has violated Connecticut General Statutes Section 20-99(b) (2) and (6) as specified in the Tenth Count, Section 4.

ORDER

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

1. ~~The license of the Respondent be revoked for each of the Ten Counts.~~
2. ~~The date of this revocation shall commence on July 15, 1989.~~

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

Dated at *Hartford* . Connecticut, this *24<sup>th</sup>* day of *May* , 1989.

BOARD OF EXAMINERS FOR NURSING

By *Ruth Jane M. Murphy RN*