

STATE OF CONNECTICUT  
BOARD OF EXAMINERS FOR NURSING

Department of Health Services v.  
Bethann Baer, RN, License No. R39542  
418 Farmington Avenue, Apt. E-4  
New Britain, CT 06053  
CASE PETITION NO. 891018-10-044

MODIFIED 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 15, 1990. (State's Exhibit 2) (Hearing Transcript March 20, 1991 p. 3) The Statement of Charges alleged violations of certain provisions of Chapter 378 of the General Statutes of Connecticut by Bethann Baer (hereinafter the "Respondent").

The Board issued a Notice of Hearing dated October 31, 1990 (State's Exhibit 2). The hearing, scheduled for November 29, 1990 was rescheduled and heard on March 20, 1991 and April 16, 1991 in Room 112 of the National Guard Armory, Maxim Road, Hartford, Connecticut.

- \* This Memorandum of Decision represents the identical Memorandum of Decision, as signed on September 24, 1991, with the exception of a correction in the license number which appears on pages 1 and 2.

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. Bethann Baer, hereinafter referred to as the Respondent, is and was at all times referenced in the Statement of Charges the holder of Register Nurse License Number R39542. (Hearing Transcript March 20, 1991, p. 5) (Respondent's Exhibit B)
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. (State's Exhibit 1)
3. The Respondent was aware of the time and location of the hearing. State's Exhibit 2 indicates that notice of this hearing was mailed to the Respondent and the Respondent's attorney.
4. The Respondent was present at both hearing dates and was represented by counsel. The Respondent filed an answer to the Statement of Charges. (Respondent's Exhibit B)

5. In June, 1989 and subsequent thereto, the Respondent was employed as a registered nurse at Hughes Convalescent Home in West Hartford, Connecticut. (Hearing Transcript March 20, 1991, p. 5) (Respondent's Exhibit B) The Respondent stopped working at Hughes Convalescent Home on or about July 31, 1989. (Hearing Transcript March 20, 1991, p.p. 61, 64-65)
6. On July 18, 1989, while working at the Hughes Convalescent Home, the Respondent drew up Demerol into a syringe and failed to label said syringe. (State's Exhibit 3) (Hearing Transcript March 20, 1991, p.p.5, 65-69) (Respondent's Exhibit B)
7. On July 18, 1989, while working at the Hughes Convalescent Home, the Respondent failed to timely or accurately document the administration of Dilaudid to patient Mary Parry. (State's Exhibit 3) (Hearing Transcript March 20, 1991, p. 5) (Respondent's Exhibit B)
8. On July 21, 1989, while working at the Hughes Convalescent Home, the Respondent administered Dilaudid to patient Mary Parry at 9:00 a.m. and 12 noon, despite physician orders that said medication was to be administered at 8 hour intervals, and the Respondent failed to accurately, completely or properly document said administration in the patient record. (State's Exhibit 3) (Hearing Transcript March 20, 1991, p.5) (Respondent's Exhibit B)

9. On June 14, 1989, while working at the Hughes Convalescent Home, Respondent wasted a dose of the controlled substance Tylox (Rx #1736-085 for patient Walter Mankus) without a witness and failed to properly document said waste. (State's Exhibit 3) (Hearing Transcript March 20, 1991, p.p. 5-6, 78-79) (Respondent Exhibit B)
  
10. On June 20, 1989, while working at the Hughes Convalescent Home, the Respondent did not document a 10:45 p.m. dose of Tylox (Rx #1735-085) in the medication administration record for patient Walter Mankus. (State's Exhibit 3, p.p. 10-11) (Respondent's Exhibit B) (Hearing Transcript March 20, 1991, p.6)
  
11. On June 26, 1989, while working at the Hughes Convalescent Home, the Respondent failed to completely or accurately document an 8:35 p.m. administration of Demerol (Rx #1739-991) to patient Dorothy McConkey in the patient's medication administration record. (State's Exhibit 3) (Hearing Transcript March 20, 1991, p.6) (Hearing Transcript April 16, 1991, p.p. 14-15) (Respondent's Exhibit B)
  
12. On July 9, 1989, while working at the Hughes Convalescent Home, the Respondent did not document an 8:15 p.m. administration of Demerol (Rx #1744-874) to patient Dorothy McConkey in the patient's medication administration record. (State's Exhibit 3) (Hearing Transcript March 20, 1991, p.6) (Respondent's Exhibit B)

13. On July 10, 1989, while working at the Hughes Convalescent Home, the Respondent did not document a 9:00 p.m. administration of Demerol (Rx #1744-874) to patient Dorothy McConkey in the patient's medication administration record. (State's Exhibit 3) (Hearing Transcript March 20, 1991, p.6) (Hearing Transcript April 16, 1991, p.p. 16-17) (Respondent's Exhibit B)
  
14. On July 13, 1989, while working at the Hughes Convalescent Home, the Respondent did not document a 3:30 p.m. and 8:30 p.m. administration of Demerol (Rx #1744-874) to patient Dorothy McConkey in the patient's medication administration record. (State's Exhibit 3) (Hearing Transcript March 20, 1991, p. 6) (Respondent's Exhibit B)
  
15. On July 14, 1989, while working at the Hughes Convalescent Home, the Respondent did not document a 1:00 p.m. administration of Demerol (Rx #1744-874) to patient Dorothy McConkey in the patient's medication administration record. (State's Exhibit 3) (Hearing Transcript March 20, 1991, p.6) (Hearing Transcript April 16, 1991, p.p. 19, 26) (Respondent's Exhibit B)
  
16. On June 20, 1989, while working at the Hughes Convalescent Home, the Respondent did not document a 3:15 p.m. administration of Propoxyphene (Darvocet) (Rx #1735-650) to patient Claire Gustafson in the patient's medication administration record. (State's Exhibit 3) (Hearing Transcript April 16, 1991, p. 37) (Respondent's Exhibit B)

17. On June 20, 1989, while working at the Hughes Convalescent Home, the Respondent failed to properly record an error on the controlled substance administration record of Propoxyphene (Rx No. 1735-650) for patient Claire Gustafson by marking over times listed. (State's Exhibit 3, p. 27) (Respondent's Exhibit B)
18. On July 4, 1989, while working at the Hughes Convalescent Home, the Respondent did not document an 11:00 p.m. administration of Demerol (Rx #1743-078) to patient Alfred Boyd in the patient's medication administration record. (State's Exhibit 3) (Hearing Transcript March 20, 1991, p. 7) (Hearing Transcript April 16, 1991, p. 37) (Respondent's Exhibit B)
19. On July 6, 1989, while working at the Hughes Convalescent Home, the Respondent did not document a 4:00 p.m. administration of Demerol (Rx #1743-078) to patient Alfred Boyd in the patient's medication administration record. (State's Exhibit 3) (Hearing Transcript March 20, 1991, p. 7) (Hearing Transcript April 16, 1991, p. 38) (Respondent's Exhibit B)

#### DISCUSSION AND CONCLUSION

The FIRST COUNT, SUBSECTION 3a, alleges the Respondent, while employed as a registered nurse at Hughes Convalescent Home, West Hartford, Connecticut, on or about July 18, 1989, drew up Demerol into a syringe and failed to label said syringe.

The Respondent admits this charge. (Respondent's Exhibit B)

The above referenced conduct is prohibited by the General Statutes of Connecticut, Section 20-99(b), which prohibits "... (2) illegal conduct, incompetence or negligence in carrying out usual nursing functions...."

Based on the Respondent's admission and Fact No. 6 the Board concludes that the Respondent violated The General Statutes of Connecticut, Section 20-99(b)(2), by the conduct specified in the First Count, Subsection 3a.

The FIRST COUNT, SUBSECTIONS 3b and 3c allege that the Respondent, while employed as a registered nurse at Hughes Convalescent Home, West Hartford, Connecticut on or about July 18, 1989, drew up Demerol into a syringe and "b. failed to properly waste said Demerol; and/or c. failed to secure said Demerol in a locked narcotics cabinet."

The Respondent denies this charge. (Respondent's Exhibit B)

The Board concludes that the Department presented insufficient evidence to prove these charges. Therefore, the First Count Subsections 3b and 3c are dismissed.

The SECOND COUNT, SUBSECTIONS 3a, 3b and 3c allege that the Respondent, while employed as a registered nurse at Hughes Convalescent Home, West Hartford, Connecticut on or about July 18, 1989, "a. diverted the controlled substance Dilaudid; (Rx #1735-573) and/or b. falsified controlled substance administration record; and/or c. failed to administer said Dilaudid to patient Mary Parry..."

The Respondent denies these charges. (Respondent's Exhibit B)

The Board concludes that the Department presented insufficient evidence to prove these charges. Therefore, the Second Count, Subsections 3a, 3b and 3c are dismissed.

The SECOND COUNT, SUBSECTION 3d, alleges that the Respondent, while employed as a registered nurse at Hughes Convalescent Home, West Hartford, Connecticut on or about July 18, 1989, "failed to timely or accurately document the administration of said Dilaudid."

The Respondent admits this charge. (Respondent's Exhibit B)

The above referenced conduct is prohibited by the General Statutes of Connecticut, Section 20-99(b), which prohibits "... (2) illegal conduct, incompetence or negligence in carrying out usual nursing functions...."

Based on the Respondent's admission and Fact No. 7, the Board concludes that the Respondent violated the General Statutes of Connecticut, Section 20-99(b)(2) by the conduct specified in the Section Count, Subsection 3d.

The SECOND COUNT, SUBSECTIONS 4a and 4b allege that the Respondent, while employed as a registered nurse at Hughes Convalescent Home, West Hartford, Connecticut on or about July 21, 1989, "a. diverted the controlled substance Dilaudid; and/or b. falsified the controlled substance administration record..."

The Respondent denies these charges. (Respondent's Exhibit B)

The Board concludes that the Department presented insufficient evidence to prove these charges. Therefore, the Second Count, Subsections 4a and 4b are dismissed.

The SECOND COUNT, SUBSECTIONS 4c and 4d allege that the Respondent, while employed as a registered nurse at Hughes Convalescent Home, West Hartford, Connecticut on or about July 21, 1989, "c. administered Dilaudid to patient Mary Parry against a physician's order; and/or d. failed to accurately completely or properly document inpatient or hospital record."

The Respondent admits these charges. (Respondent's Exhibit B)

The above referenced conduct is prohibited by the General Statutes of Connecticut, Section 20-99(b), which includes "... (2) illegal conduct, incompetence or negligence in carrying out usual nursing functions...."

Based on the Respondent's admission and Fact No. 8, the Board concludes that the Respondent violated the General Statutes of Connecticut, Section 20-99(b)(2) by the conduct specified in the Second Count, Subsections 4c and 4d.

The THIRD COUNT, SUBSECTIONS 3a and 3b allege that the Respondent, while employed as a registered nurse at Hughes Convalescent Home, West Hartford, Connecticut on or about June 14, 1989, "a. failed to properly waste the controlled substance Tylox (Rx #1736-085); and/or b. failed to properly document said waste...."

The Respondent admits these charges. (Respondent's Exhibit B)

The above referenced conduct is prohibited by the General Statutes of Connecticut, Section 20-99(b), which prohibits "... (2) illegal conduct, incompetence or negligence in carrying out usual nursing functions...."

Based on the Respondent's admission and Fact No. 9, the Board concludes that the Respondent violated the General Statutes of Connecticut, Section 20-99(b)(2) by the conduct specified in the Third Count, Subsections 3a and 3b.

The THIRD COUNT, SUBSECTION 3c alleges that the Respondent, while employed as a registered nurse at Hughes Convalescent Home, West Hartford, Connecticut on or about June 14, 1989, "falsified patient Walter Mankus' medication administration record or the controlled substance administration record."

The Respondent denies this charge. (Respondent's Exhibit B)

The Board concludes that the Department presented insufficient evidence to prove this charge. Therefore, the Third Count, Subsection 3c is dismissed.

The THIRD COUNT, SUBSECTION 4a alleges that the Respondent, while employed as a registered nurse at Hughes Convalescent Home, West Hartford, Connecticut on or about June 20, 1989, "failed to record two doses of Tylox on medication administration record...."

The Respondent admits this charge to the extent that "she failed to record one dose." (Respondent's Exhibit B)

The admitted conduct is prohibited by the General Statutes of Connecticut, Section 20-99(b), which prohibits "... (2) illegal conduct, incompetence or negligence in carrying out usual nursing functions...." Failing to record any dose of medication constitutes a violation of Section 20-99(b)(2).

Based on the Respondent's admission and Fact No. 10 the Board concludes that the Respondent violated the General Statutes of Connecticut Section 20-99(b)(2) by failing to record one dose of Tylox on the medication administration record of Walter Mankus on June 20, 1989.

The THIRD COUNT, SUBSECTIONS 4b, 4c and 4d alleges that the Respondent, while employed as a registered nurse at Hughes Convalescent Home, West Hartford, Connecticut on or about June 20, 1989, "b. administered two doses of Tylox against the physician's order; and/or c. diverted said Tylox; and/or d. falsified the controlled substance administration record."

The Respondent denies these charges. (Respondent's Exhibit B)

The Board concludes that the Department presented insufficient evidence to prove these charges. Therefore, the Third Count, Subsections 4b, 4c and 4d are dismissed.

The FOURTH COUNT, SUBSECTION 3 alleges that the Respondent, while employed as a registered nurse at Hughes Convalescent Home, West Hartford, Connecticut on or about June 8, 1989, "administered Demerol (Rx#1734-111) to Dorothy McConkey against a physician's order."

The Respondent denies this charge. (Respondent's Exhibit B)

The Board concludes that the Department presented insufficient evidence to prove this charge. Therefore, the Fourth Count, Subsection 3 is dismissed.

The FOURTH COUNT, SUBSECTION 4 alleges that the Respondent, while employed as a registered nurse at Hughes Convalescent Home, West Hartford, Connecticut on or about June 21, 1989, "a. failed to record administration of Demerol (Rx #1734-826) on the medication administration record; and/or b. diverted the controlled substance Demerol; and/or c. falsified the controlled substance administration record."

The Respondent denies these charges. (Respondent's Exhibit D)

The Board concludes that the Department presented insufficient evidence to prove these charges. Therefore, the Fourth Count, Subsection 4 is dismissed.

The FOURTH COUNT, SUBSECTIONS 5a, 6a, 7a, 8a and 9a allege that the Respondent, while employed as a registered nurse at Hughes Convalescent Home, West Hartford, Connecticut on or about June 26,

1989, July 9, 1989, July 10, 1989, July 13, 1989 and July 14, 1989, failed to completely or accurately document administration of Demerol to patient Dorothy McConkey and/or failed to record Demerol administrations on the medication administration record.

The Respondent admits these charges. (Respondent's Exhibit B)

The above referenced conduct is prohibited by the General Statutes of Connecticut, Section 20-99(b), which includes "... (2) illegal conduct, incompetence or negligence in carrying out usual nursing functions...."

Based on the Respondent's admission and Facts No. 11-15, the Board concludes that the Respondent violated the General Statutes of Connecticut, Section 20-99(b)(2) by the conduct specified in the Fourth Count, Subsections 5a, 6a, 7a, 8a and 9a.

The FOURTH COUNT, SUBSECTIONS 5b, 5c, 6b, 6c, 6d, 7b, 7c, 8b, 8c, 9b and 9c allege that the Respondent, while employed as a registered nurse at Hughes Convalescent Home, West Hartford, Connecticut on or about June 26, 1989, July 9, 1989, July 10, 1989, July 13, 1989 and July 14, 1989, diverted the controlled substance Demerol; administered Demerol to patient, Dorothy McConkey against a physician's order; and falsified controlled substance administration records.

The Respondent denies these charges. (Respondent's Exhibit B)

The Board concludes that the Department presented insufficient evidence to prove these charges. Therefore, the Fourth Count, Subsections 5b, 5c, 6b, 6c, 6d, 7b, 7c, 8b, 8c, 9b and 9c are dismissed.

The FIFTH COUNT, SUBSECTION 3a alleges the Respondent, while employed as a registered nurse at Hughes Convalescent Home, West Hartford, Connecticut on or about June 20, 1989, "failed to record one or more doses of Propoxyphene (Rx #1735-650) on the medication administration record...."

The Respondent denies this charge except that she admits she failed to record "one dose". (Respondent's Exhibit B)

The above referenced conduct is prohibited by the General Statutes of Connecticut, Section 20-99(b), which prohibits "... (2) illegal conduct, incompetence or negligence in carrying out usual nursing functions...."

Based on the Respondent's admission and Fact No. 16 the Board concludes that the Respondent violated the General Statutes of Connecticut, Section 20-99(b)(2) by her conduct of failing to record a dose of Propoxyphene on the medication administration record of Claire Gustafson on June 20, 1989.

The FIFTH COUNT, SUBSECTION 3b alleges the Respondent, while employed as a registered nurse at Hughes Convalescent Home, West Hartford, Connecticut on or about June 20, 1989, "failed to properly record an error on the controlled substance administration record by marking over times listed...."

The Respondent admits this charge. (Respondent's Exhibit B)

The above referenced conduct is prohibited by the General Statutes of Connecticut, Section 20-99(b), which prohibits "... (2) illegal conduct, incompetence or negligence in carrying out usual nursing functions...."

Based on the Respondent's admission and Fact No. 17 the Board concludes that the Respondent violated the General Statutes of Connecticut, Section 20-99(b)(2) by her conduct of marking over times listed on the controlled substance administration record of Claire Gustafson.

The FIFTH COUNT, SUBSECTIONS 3c and 3d allege the Respondent, while employed as a registered nurse at Hughes Convalescent Home, West Hartford, Connecticut on or about June 20, 1989, "c. diverted the controlled substance Propoxyphene; and/or d. falsified the controlled substance administration record."

The Respondent denies these charges. (Respondent's Exhibit B)

The Board concludes that the Department presented insufficient evidence to prove these charges. Therefore, the Fifth Count, Subsections 3c and 3d are dismissed.

The FIFTH COUNT, SUBSECTIONS 4a, 4b and 4c allege the Respondent, while employed as a registered nurse at Hughes Convalescent Home, West Hartford, Connecticut on or about July 3, 1989, July 4, 1989, July 5, 1989 and/or July 6, 1989, "a. failed to record one or more

doses of Propoxyphene; and/or b. diverted on one or more occasions the controlled substance Propoxyphene; and/or c. falsified one or more entries on the controlled substance administration record."

The Respondent claims she does not have sufficient knowledge to admit or deny Subsection 4a. The Respondent denies Subsections 4b and 4c. (Respondent's Exhibit B)

The Board concludes that the Department presented insufficient evidence to prove these charges. Therefore, the Fifth Count, Subsections 4a, 4b and 4c are dismissed.

The SIXTH COUNT, SUBSECTION 3a alleges the Respondent, while employed as a registered nurse at Hughes Convalescent Home, West Hartford, Connecticut on or about July 4, 1989 and/or July 6, 1989, "failed to record one or more doses of Demerol (Rx #1743-078) on the medication administration record...."

The Respondent admits this charge. (Respondent's Exhibit B)

The above referenced conduct is prohibited by the General Statutes of Connecticut, Section 20-99(b), which prohibits "... (2) illegal conduct, incompetence or negligence in carrying out usual nursing functions...."

Based on the Respondent's admission and Facts No. 18 and 19, the Board concludes that the Respondent violated the General Statutes of Connecticut, Section 20-99(b)(2) by the conduct specified in the Sixth Count, Subsection 3a.

The SIXTH COUNT, SUBSECTIONS 3b and 3c allege the Respondent, while employed as a registered nurse at Hughes Convalescent Home, West Hartford, Connecticut on or about July 4, 1989 and/or July 6, 1989, "b. diverted one or more doses of the controlled substance Demerol; and/or c. falsified one or more entries in the controlled substance record."

The Respondent denies this charge. (Respondent's Exhibit B)

The Board concludes that the Department presented insufficient evidence to prove these charges. Therefore, the Sixth Count, Subsections 3b and 3c are dismissed.

The Respondent offered testimony (Hearing Transcript, March 20, 1991, p.p. 57-64) and presented evidence (Respondent's Exhibits C, D, E, F and I) which indicates that prior, during and subsequent to the times when the Respondent's conduct violated the General Statutes of Connecticut, the Respondent was suffering from and being treated for an emotional disorder and mental illness. Specifically, the Respondent's diagnosis and history includes major depression, borderline personality disorder and alcohol abuse.

Pursuant to the General Statutes of Connecticut, Section 20-99(a) the Board may take any of the action set forth in Section 19a-17 if it determines that a nurse's conduct fails to conform to the accepted standards of the nursing profession, including "...emotional disorder and mental illness...." (Section 20-99(b)(4)) In Counts 1 through 6, the Department alleged that the Respondent's conduct violated Section 20-99(b)(4).

Based upon the Respondent's testimony and examination of the evidence, the Board concludes that the Respondent's emotional disorder and mental illness contributed to her conduct which the Board found to be in violation of the General Statutes of Connecticut.

ORDER

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

1. That the license of the Respondent be placed on probation for a minimum of three (3) years, as follows:
  - A. as to the First Count, Subsection 3a, minimum three (3) years probation;
  - B. as to the Second Count, Subsection 3d, minimum three (3) years probation;
  - C. as to the Second Count, Subsections 4c and 4d, minimum three (3) years probation;
  - D. as to the Third Count, Subsections 3a and 3b, minimum three (3) years probation;
  - E. as to the Third Count, Subsection 4a, minimum three (3) years probation;
  - F. as to the Fourth Count, Subsection 5a, minimum three (3) years probation;

G. as to the Fourth Count, Subsection 6a, minimum three (3) years probation;

H. as to the Fourth Count, Subsection 7a, minimum three (3) years probation;

I. as to the Fourth Count, Subsection 8a, minimum three (3) years probation;

J. as to the Fourth Count, Subsection 9a, minimum three (3) years probation;

K. as to the Fifth Count, Subsection 3a, minimum three (3) years probation;

L. as to the Fifth Count, Subsection 3b, minimum three (3) years probation;

M. as to the Sixth Count, Subsection 3a, minimum three (3) years probation;

N. the minimum three (3) year probation period referenced in A, B, C, D, E, F, G, H, I, J, K, L and M, above, are to run concurrently for an effective minimum probationary period of three (3) years.

2. If any of the following conditions of probation are not met, the Respondent's license may be immediately revoked.

- A. She shall provide a copy of this Memorandum of Decision to any and all employers. The Board shall be notified in writing by her employer(s), within thirty (30) days of the effective date, as to receipt of a copy of this Memorandum of Decision.
  
- B. Should the Respondent change employment at any time during the probationary period, she shall 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. She shall not accept employment as a nurse for a personnel provider service, Visiting Nurse Association or home health care agency for the period of her probation.
  
- D. She shall be responsible for the provision of bi-monthly employer reports from her nursing supervisor (i.e. Director of Nursing) at her primary place of employment, during the first and second years of probation. Bi-monthly employer reports are due by the first business day of January, March, May, July, September and November. Bi-monthly reports shall commence with the report due January 1, 1992.
  
- E. She shall be responsible for the provision of quarterly employer reports from her nursing supervisor at her primary place of employment, during the third year of probation. Quarterly reports are due by the first business day January, April, July and October. Quarterly reports shall commence with the report due January 1, 1994.

- F. Said reports cited in D and E above, shall include documentation of her ability to safely and competently practice nursing. Said reports shall be issued to the Board at the address listed in paragraph P below.
- G. She shall engage in counselling with a licensed or certified therapist at her own expense.
- H. She shall provide a copy of this Memorandum of Decision to her therapist. The Board will be notified in writing by her therapist within thirty (30) days of the effective date, as to receipt of a copy of this Memorandum of Decision.
- I. She shall be responsible for bi-monthly reports from her therapist for the first and second years of probation. Bi-monthly reports are due by the first business day of January, March, May, July, September and November. Bi-monthly reports shall commence with the report due January 1, 1992.
- J. She shall be responsible for quarterly reports from her therapist for the third year of probation. Quarterly reports are due by the first business day of January, April, July and October. Quarterly reports shall commence with the report due January 1, 1994.

- K. She shall be responsible for submitting to random urine and/or blood screens for alcohol and drugs at the discretion of her therapist. Said screens shall be legally defensible in that the specimen donor and chain of custody must be identified throughout the screening. She shall be responsible for notifying the laboratory and her therapist of any drug(s) she is taking. There must be at least one such alcohol and drug screen bi-monthly for the first and second years of probation and quarterly for the third year of probation. Said screens shall be negative for alcohol and drugs. All positive results shall be confirmed by a second independent testing method. Reports of bi-monthly random alcohol and drug screens are due by the first business day of January, March, May, July, September and November. Reports of quarterly random alcohol and drug screens are due by the first business day of January, April, July and October. Bi-monthly reports shall commence with the report due January 1, 1992. Quarterly reports shall commence with the report due January 1, 1994.
- L. Said reports cited in I, J and K above, shall include documentation of dates of treatment, an evaluation of her progress and alcohol and drug free status, and copies of all laboratory reports. Said reports shall be issued to the Board at the address cited in paragraph P below.
- M. She shall not obtain for personal use and/or use alcohol or any drug that has not been prescribed for her for a legitimate purpose by a licensed health care practitioner.

- N. The Connecticut Board of Examiners for Nursing must be informed in writing prior to any change of employment.
- O. The Connecticut Board of Examiners for Nursing must be informed in writing prior to any change of address.
- P. 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. Any deviation from the terms of probation without prior written approval by the Board of Examiners for Nursing will constitute a violation of probation and will subject the Respondent to sanctions under the General Statutes of Connecticut, Section 19-17(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 or 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. The date of this period of probation shall commence on November 15, 1991.

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 West Hartford, Connecticut, this 1<sup>st</sup> day of October, 1991.

BOARD OF EXAMINERS FOR NURSING

By Sarah M. [Signature]

6453Q



# STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH AND ADDICTION SERVICES  
BUREAU OF HEALTH SYSTEM REGULATION

*Rec'd  
11/15/94  
J  
Processed  
11-15-94*

November 15, 1994

Bethann Baer  
5 Crystal Avenue 2R  
Springfield MA 01108

RE: Connecticut RN License No. R39542

Dear Ms. Baer:

Your eligibility for reinstatement from probation of your registered nurse license has been reviewed, and the Board of Examiners for Nursing recommends that your license be reinstated with an effective date of November 15, 1994.

Your original license number has been reassigned to you, and will be issued following routine processing by the Department of Public Health and Addiction Services.

Renewal of your registered nurse license is required, by law, annually during the month of your birth following the date of this letter. If the license is not renewed within ninety (90) days of the due date, it will become automatically void. This means that future reinstatement will require re-application.

State law requires you to notify this office within thirty (30) days of ANY change of address whether in or out of this state. Should you have any questions concerning this process contact this Department at 566-4979.

Sincerely,

Marie T. Hilliard, Ph.D., R.N.  
Executive Officer  
Board of Examiners for Nursing

MTH:jew  
4290/44

cc: Richard J. Lynch, Assistant Attorney General  
Donna Buntaine Brewer, Chief, Public Health Hearing Office  
✓ John N. Boccaccio, Chief, Licensure & Registration  
Joseph J. Gillen, Chief, Applications, Examinations and Licensure  
Nurse Licensure, Applications, Examinations and Licensure