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STATE OF CONNECTICUT  
BOARD OF EXAMINERS FOR NURSING

In re: Department of Health Services  
v. Sharon McNamara, LPN  
License No. 017250  
1103 Totoket Woods  
Northford, CT 06472

Petition No. 870901-11-018

NOTICE OF FINAL DECISION

Notice is hereby given that the Board of Examiners for Nursing, having reviewed the proposed final decision and having reviewed the briefs and listened to the oral arguments presented on March 25, 1992, pursuant to Conn. Gen. Stat. § 4-179, unanimously voted to adopt the attached proposed final decision thereby also denying the respondent's motion to dismiss. A copy of the proposed final decision is attached hereto and incorporated herein.

WHEREFORE, the attached proposed final decision constitutes the final decision of the Board of Examiners for Nursing in this case.

Board of Examiners for Nursing

March 31, 1992  
Date

By:

Janice Thibodeau, R.N.  
Janice Thibodeau,  
Chairperson

STATE OF CONNECTICUT  
BOARD OF EXAMINERS FOR NURSING

Department of Health Services v.  
Sharon McNamara, LPN, License No. 017250  
1103 Totoket Woods  
Northford, Connecticut 06472  
CASE PETITION NO. 870901-11-018

PROPOSED 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 September 21, 1990. (State Exhibit 1) The Statement of Charges alleged violations of certain provisions of Chapter 378 of the General Statutes of Connecticut by Sharon McNamara (fka Sweeney) (hereinafter the "Respondent").

The Board issued a Notice of Hearing dated October 30, 1990. The hearing was scheduled for November 29, 1990 in Room 112, National Guard Armory, Maxim Room, Hartford, Connecticut.

During the hearing on November 29, 1990 the Respondent presented a Supplemental Motion to Dismiss (Respondent Exhibit A) and requests for a More Detailed Statement. (Respondent Exhibits B, C and D). The Department presented an Objection to the Respondent's Request for a More Detailed Statement (State Exhibit 2) and an Objection to

Respondent's Motion to Dismiss. (State Exhibit 3) The hearing was rescheduled to February 27, 1991.

The hearing rescheduled for February 27, 1991 was continued by the Board until March 20, 1991. During the hearing on March 20, 1991 the Board denied the Respondent's Motion to Dismiss. (Hearing Transcript March 20, 1991, pp. 11-12) The hearing was continued until May 22, 1991, rather than April 16, 1991, at the Respondent's request. (Hearing Transcript March 20, 1991, p. 13)

The hearing rescheduled for May 22, 1991 was continued at the Respondent's request. The hearing was rescheduled and heard on June 19, 1991 in Room 122, National Guard Armory, Maxim Road, Hartford, Connecticut.

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. The Respondent, Sharon McNamara, is and was at all times referenced in the Statement of Charges the holder of Connecticut practical nurse license number 017250. (Hearing Transcript June 19, 1991, p. 7)

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 full compliance with all the terms for the retention of her license. (Department Exhibits 4 and 5)
3. The Respondent was aware of the time and location of the hearing. State Exhibit 1 indicates that notice of the location and time of this hearing was mailed by certified mail to the Respondent and the Respondent's attorney.
4. The Respondent was present on all dates of this hearing and was represented by counsel.
5. Since on or about 1979 the Respondent has been employed as a licensed practical nurse at the Hospital of Saint Raphael, New Haven, Connecticut. (Hearing Transcript June 19, 1991, p. 77)
6. On July 11, 1987, while employed as a licensed practical nurse at the Hospital of Saint Raphael, the Respondent signed out a 50 mg. injectable dose of the controlled substance Demerol on line 15 of proof of use sheet 263802 at 8:30 a.m. for patient Richard Shaw but did not document said dose of Demerol on the patient's medication administration record. (State Exhibit 6 pp. 1, 6-7)
7. On July 11, 1987, while employed as a licensed practical nurse at the Hospital of Saint Raphael, the Respondent signed out a dose of the controlled substance Percocet on line 13 of the proof of use sheet 263788 at 10:15 a.m. for patient Richard Shaw

but did not document said dose of Percocet on the patient's medication administration record. (State Exhibit 6, pp. 1, 4-5)

8. On July 11, 1987, while employed as a licensed practical nurse at the Hospital of Saint Raphael, the Respondent signed out a dose of the controlled substance Percocet on line 0 of proof of use sheet 263788 at 5:45 p.m. for patient Kathryn O'Connor but did not document said dose of Percocet on the patient's medication administration record. (State Exhibit 6, pp. 3, 5) (Hearing Transcript June 19, 1991, pp. 26-27)
  
9. On July 15, 1987, while employed as a licensed practical nurse at the Hospital of Saint Raphael, the Respondent signed out two (2) doses of the controlled substance Percocet on lines 4 and 3 of proof of use sheet 263906 at 5:45 p.m. for patient Joseph Basitka but subsequently put a line through the entries to indicate the two (2) doses of Percocet were not given to the patient, however the medication count was reduced by one (1). The Respondent did not document on proof of use sheet 263906 a dose of Percocet being destroyed. (State Exhibit 6, pp. 2, 8) (Hearing Transcript June 19, 1991, p. 28)
  
10. On July 15, 1987, while employed as a licensed practical nurse at the Hospital of Saint Raphael, the Respondent signed out 100 mg. of the controlled substance Demerol on line 4 of proof of use sheet 264302 at 9:00 p.m. for patient Raymond Carrington, then documented wasting 25 mg. of the Demerol. The Respondent documented in the patient's medication administration record that the remaining 75 mg. dose of Demerol ordered for the

patient was refused. The Respondent did not document on proof of use sheet 264302 the 75 mg. dose of Demerol, which was refused, as being destroyed. (State Exhibit 6, pp. 2, 9-11) (Hearing Transcript June 19, 1991, pp. 29-30, 67)

11. On November 18, 1988, while employed as a licensed practical nurse at the Hospital of Saint Raphael, the Respondent signed out two (2) doses of the controlled substance Percocet on line 6 of proof of use sheet 280298 at 4:45 p.m. for patient Hyman Green, Room 511, without determining if the patient was in need of the pain medication. (State Exhibit 7, pp. 1, 7, 12, 35) Patient Hyman Green was not in his room at 4:45 p.m. on November 18, 1988 and had not requested the two (2) doses of Percocet. (State Exhibit 7, pp. 1-4, 6, 9, 11) (Hearing Transcript June 19, 1991, pp. 50, 60, 98-99)

12. On November 18, 1988, while employed as a licensed practical nurse at the Hospital of Saint Raphael, the Respondent failed to properly waste the controlled substance Percocet which she signed out for patient Hyman Green at 4:45 p.m. but which she did not administer to Patient Green. (State Exhibit 7, p. 21, 35) (Hearing Transcript June 19, 1991, p. 106-107)

13. On November 18, 1988, while employed as a licensed practical nurse at the Hospital of Saint Raphael, the Respondent administered one (1) of the Percocet tablets she had signed out for Hyman Green at 4:45 p.m. to patient Stephen Conti, also of Room 511, who at that time requested pain medication from the Respondent. (State Exhibit 7, pp. 2-4, 7, 13) (Hearing Transcript June 19, 1991, pp. 50-51, 60-61)

The Respondent administered the Percocet tablet to patient Stephen Conti without checking his medication record. (State Exhibit 7, pp. 2, 13) (Hearing Transcript June 19, 1991, p. 61)

14. On November 18, 1988, while employed as a licensed practical nurse at the Hospital of Saint Raphael, the Respondent signed out one (1) dose of the controlled substance Percocet on line 22 of the Proof of Use Sheet 280353 indicating the administration of the medication to patient Stephen Conti at 5:45 p.m. (State Exhibit 7, pp. 2, 4, 37) despite having administered Percocet to the patient at 4:45 p.m. (Fact Number 13).
15. On November 18, 1988 at or about 6:00 p.m. the Respondent was questioned by Assistant Head Nurse Bonnie Rademacher, R.N. (fka Rogers) (Hearing Transcript, June 19, 1991, p. 59) concerning why she had signed out two (2) Percocets (Fact Number 11) for a patient who was not in his room and who had not requested pain medication. (State Exhibit 7, pp. 3, 12) (Hearing Transcript June 19, 1991, p. 61)
16. On November 18, 1988 after being questioned by Bonnie Rademacher the Respondent asked unit secretary Paula Brown (aka Maria P. Brown) to give her two (2) Percocets from Brown's personal prescription and to bring the Percocets to her in Room 511. (State Exhibit 7, pp. 3, 5, 14-15) Ms. Brown did not give any Percocets to Respondent on November 18, 1988 and told Bonnie Rademacher about the Respondent's request. Id.

17. On November 17, 1988 Paula Brown had given Respondent two (2) Percocets from Brown's personal prescription, after Respondent had asked for Motrin for her personal use. (State Exhibit 7, p. 5)
18. On November 18, 1988 at or about 11:25 p.m. two (2) Percocets were found in a medication cup, under a sweater in the report room of the nurses station of the Hospital of Saint Raphael unit to which the Respondent was assigned. (State Exhibit 7, pp. 2, 8, 20)
19. On November 18, 1988, while employed as a licensed practical nurse at the Hospital of Saint Raphael, the Respondent documented in the medication administration record of patient Jane Fulton, an administration of a one (1) tablet dose of the controlled substance Percocet at 4:40 p.m. (State Exhibit 7, p. 23) The Respondent, however, did not record the 4:40 p.m. administration on the Percocet proof of use sheet 280353, line 21 (State Exhibit 7, p. 37), until 6:00 p.m. (State Exhibit 7, p. 3)
20. On November 18, 1988, while employed as a licensed practical nurse at the Hospital of Saint Raphael, the Respondent failed to document a 4:40 p.m. administration of the controlled substance Percocet to patient Jane Fulton in the nursing progress notes of the patient's medical records. (State Exhibit 7, pp. 3, 22, 37)

## DISCUSSION AND CONCLUSIONS

The FIRST COUNT, SUBSECTION 2a alleges that during July 1987 and at subsequent times, while working as a licensed practical nurse at the Hospital of Saint Raphael, the Respondent "diverted one or more of the controlled substance(s) demerol or percocet...."

The Respondent denies this charge. (Hearing Transcript June 16, 1991, pp. 7-8, 95-96)

The Board concludes that the Department presented insufficient evidence to prove this charge. Therefore, the First Count, Subsection 2a is dismissed.

The FIRST COUNT, SUBSECTION 2b alleges that during July 1987 and at subsequent times, while working as a licensed practical nurse at the Hospital of Saint Raphael, the Respondent "failed to completely or properly or accurately make documentations in the medical or hospital records...."

The Respondent admits this charge. (Hearing Transcript June 19, 1991, p. 95)

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

Based on the Respondent's admission and Fact Numbers 6, 7, 8, 9 and 10 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 2b.

The FIRST COUNT SUBSECTION 2c alleges that during July 1987 and at subsequent times, while working as a licensed practical nurse at the Hospital of Saint Raphael, the Respondent "falsified one or more Controlled Substance Receipt Records."

The Respondent denies this charge. (Hearing Transcript June 19, 1991, pp. 7-8, 96)

The Board concludes that the Department presented insufficient evidence to prove this charge. Therefore, the First Count, Subsection 2c is dismissed.

The SECOND COUNT SUBSECTION 3a alleges that on November 17, 1988 and November 18, 1988 while working as a licensed practical nurse at the Hospital of Saint Raphael, the Respondent "diverted the controlled substance percocet."

The Respondent denies this charge. (Hearing Transcript June 19, 1991, pp. 7-8, 97)

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

Diversion of a controlled substance occurs when a controlled substance is utilized for purposes other than administration to a patient as ordered by a physician. Percocet is a controlled substance.

On November 18, 1988 the Respondent signed out two (2) Percocets for patient Hyman Green of Room 511 at 4:45 p.m. although the patient was not in his room at that time and had not requested pain medication (Fact Number 11). The Respondent then improperly administered one (1) of the Percocets she had signed out for patient Green to patient Stephen Conti, also of room 511, who at that time (4:45 p.m.) requested pain medication (Fact Number 13).

At the hearing, the Respondent testified that she did not administer one (1) of Green's Percocets to patient Conti. (Hearing Transcript, June 19, 1991, pp. 98-99) This testimony, which the Board did not find credible, conflicts with previous statements the Respondent had made to Bonnie Rademacher, R.N. (fka Rogers) and Martha Smith, R.N., on November 18, 1988.

At the hearing, Bonnie Rademacher, who was the assistant head nurse that had questioned Respondent on November 18, 1988 at approximately 6:00 p.m., testified that the Respondent had told her that the Respondent gave one (1) of Green's Percocets to Conti. (Hearing Transcript June 19, 1991, pp. 50-51, 60-61) The Board found Ms. Rademacher's testimony credible, and consistent with a statement Ms. Rademacher previously gave, and a statement that Martha Smith, R.N., gave, both of which are in evidence. (State Exhibit 7, p. 7 and 11)

Giving one patient's Percocet to another patient constitutes a form of diversion. The Board concludes that the Respondent, by giving one (1) of patient Green's Percocet tablets to patient Conti diverted the controlled substance Percocet. Therefore, the Respondent violated the General Statutes of Connecticut Section 20-99(b)(2).

Regarding the two (2) Percocets that were found at the end of the shift. In fact 16, the Board found that Respondent had asked Paula Brown (aka Marie P. Brown) for two (2) Percocets from Brown's personal prescription, after Respondent was questioned by Bonnie Rademacher about why two (2) Percocets had been signed out for patient Green, when he was not even on the wing. Paula Brown did not give the two (2) Percocets to Respondent, and told Bonnie Rademacher about the Respondent's request (Fact Number 16). Bonnie Rademacher testified that the Respondent told her the following about the request she had made to Paula Brown:

She (the Respondent) said that she was nervous because she had been involved in a previous incident, and with this narcotic being missing, she had been so upset. She had known Paula had Percocet and figured she could ask Paula for the Percocet and replace it when the other one was found...the other two were found. (Hearing Transcript June 19, 1991, p. 62, lines 19-24) See also State Exhibit 7, p. 15.

The Board found the above testimony credible and concludes that Respondent was motivated to and did replace the missing Percocet, on November 18, 1988.

The Respondent signed out a Percocet indicating administration of Percocet to patient Conti at 5:45 p.m. (Fact Number 14). The Board concludes that the Respondent signed out this Percocet sometime

before 8:00 p.m. (See State Exhibit 7, p. 37) for the purpose of providing documentation that she had administered a Percocet to patient Conti; and to replace one (1) of the Percocet tablets which she had signed out for patient Green, but in fact had administered to patient Conti. Further the Board concludes that the two (2) Percocets which were found in a medication cup under a sweater in the nursing station (Fact Number 18) consisted of one (1) of the Percocets which the Respondent signed out at 4:45 p.m. and the Percocet which the Respondent signed out indicating a 5:45 p.m. administration to Patient Conti.

The Board concludes that the Respondent, by signing out a Percocet tablet for the purpose of replacing a Percocet tablet which she improperly administered to a patient, diverted the controlled substance Percocet. Therefore, the Respondent violated the General Statutes of Connecticut Section 20-99(b)(2).

Thus, the Board concludes that two diversions occurred on November 18, 1988. The first, when Green's Percocet was given to Conti. The second, when a Percocet that was signed out for Conti was used to replace the one that should not have been administered to Conti in the first place. Either diversion, in and of itself, is sufficient to support the conclusion that Respondent violated the General Statutes of Connecticut Sections 20-99(b)(2) as alleged in the Second Count, Subsection 3a.

The SECOND COUNT SUBSECTION 3b alleges that on November 17, 1988 and November 18, 1988 while working as a licensed practical nurse at the Hospital of Saint Raphael, the Respondent "failed to properly waste a narcotic...."

The Respondent stated that she did not intentionally fail to properly waste a narcotic. (Hearing Transcript June 19, 1991, p. 97) The Board concludes that the Respondent admitted to the unintentional failure to properly waste a narcotic. The intention of the Respondent is irrelevant to the allegation.

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

Based on the Respondent's admission and Fact Number 12, the Board concludes the Respondent violated the General Statutes of Connecticut, Section 20-99(b)(2) by failing to properly waste a narcotic as specified in the Second Count, Subsection 3b.

The SECOND COUNT SUBSECTION 3c alleges that on November 17, 1988 and November 18, 1988 while working as a licensed practical nurse at the Hospital of Saint Raphael, the Respondent "failed to properly document waste of a narcotic...."

The Respondent denies this charge. (Hearing Transcript June 19, 1991, pp. 7-8, 98)

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

A review of proof of use sheet 280298 (State Exhibit 7, p. 35) indicates the Respondent did not document the waste of a narcotic (Percocet) which was signed out for patient Hyman Green but not administered.

The Board found that the Respondent failed to properly waste a narcotic. (Fact Number 12) Therefore, the lack of documentation accurately reflects the Respondent's failure to properly waste a narcotic. Having previously concluded that the Respondent violated the General Statutes of Connecticut Section 20-99(b)(2) for failing to properly waste a narcotic, the Board cannot conclude that the Respondent merely failed to document the waste of a narcotic.

Therefore, the Second Count, Subsection 3c is dismissed.

The SECOND COUNT SUBSECTION 3d alleges that on November 17, 1988 and November 18, 1988 while working as a licensed practical nurse at the Hospital of Saint Raphael, the Respondent "failed to completely or properly or accurately make documentations in the medical or hospital records...."

The Respondent denies this charge. (Hearing Transcript June 19, 1991, pp. 7-8)

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

Based on Fact Number 20 the Board concludes that the Respondent, by failing to document the administration of a controlled substance in the nursing progress notes of a patient's medical record, failed to make documentations as specified in the Second Count, Subsection 3d and therefore violated the General Statutes of Connecticut Section 20-99(b)(2).

The SECOND COUNT SUBSECTION 3e alleges that on November 17, 1988 and November 18, 1988 while working as a licensed practical nurse at the Hospital of Saint Raphael, the Respondent "failed to appropriately assess one or more patient's need for pain medication...."

The Respondent denies this charge. (Hearing Transcript June 19, 1991, pp. 7-8, 98)

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

Properly assessing a patient's need for pain medication includes checking the patient's medication administration record prior to administering medication.

Based on Facts Number 11 and 13, 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, Subsection 3e.

The SECOND COUNT SUBSECTION 3f alleges that on November 17, 1988 and November 18, 1988 while working as a licensed practical nurse at the Hospital of Saint Raphael, the Respondent "failed to check medication administration records prior to administering medication...."

The Respondent admits this charge regarding Patient Green. (Hearing Transcript June 19, 1991, p. 98)

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

Based on the Respondent's admission and Fact Number 13 regarding Patient Conti, 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, Subsection 3f.

The SECOND COUNT SUBSECTION 3g alleges that on November 17, 1988 and November 18, 1988 while working as a licensed practical nurse at the Hospital of Saint Raphael, the Respondent "failed to timely complete proof of use sheets...."

The Respondent denies this charge. (Hearing Transcript June 19, 1991, pp. 7-8)

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

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

Based on Fact Number 19, 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, Subsection 3g.

The SECOND COUNT SUBSECTION 3h alleges that on November 17, 1988 and November 18, 1988 while working as a licensed practical nurse at the Hospital of Saint Raphael, the Respondent "administered percocet against a physicians order...."

The Respondent denies this charge. (Hearing Transcript June 19, 1991, pp. 7-8, 98)

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

#### ORDER

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

1. That the license of the Respondent be suspended for six (6) months with concurrent probation for six (6) months followed by eighteen (18) months probation after completion of the suspension, as follows:

- A. as to the First Count, Subsection 2b, six (6) months suspension and two (2) years probation;
  - B. as to the Second Count, Subsection 3a, six (6) months suspension and two (2) years probation;
  - C. as to the Second Count, Subsection 3b, six (6) months suspension and two (2) years probation;
  - D. as to the Second Count, Subsection 3d, six (6) months suspension and two (2) years probation;
  - E. as to the Second Count, Subsection 3e, six (6) months suspension and two (2) years probation.
  - F. as to the Second Count, Subsection 3f, six (6) months suspension and two (2) years probation.
  - G. As to the Second Count, Subsection 3g, six (6) months suspension and two (2) years probation.
2. The six (6) months suspension and two (2) years probationary period referenced in A, B, C, D, E, F and G above are to run concurrently for an effective six (6) months suspension with concurrent six (6) months probation followed by an additional eighteen (18) months probationary period.
3. 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 of this decision, as to receipt of a copy of this Memorandum of Decision.
- B. She shall not work as a nurse during the six months suspension with concurrent six months probation.
- C. Should the Respondent change employment at any time during the probationary period which follows the suspension, 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 the Memorandum of Decision.
- D. 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.
- E. She shall be responsible for the submission of monthly employer reports from her nursing supervisor (i.e. Director of Nursing) for the entire probationary period which follows the suspension. Monthly employer reports are due on the first business day of the month. Monthly reports shall commence with the report due October 1, 1992.
- F. Said reports cited in 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 I below.

G. The Connecticut Board of Examiners for Nursing must be informed in writing prior to any change of employment.

H. The Connecticut Board of Examiners for Nursing must be informed in writing prior to any change of address.

I. 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

4. 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 19a-17(a) and (c) including but not limited to the revocation of her license. Any extension of time or grace period for reporting granted by the Connecticut Board of Examiners for Nursing shall not be a waiver or preclude the Board's right to take action at a later time. The Connecticut Board of Examiners for Nursing shall not be required to grant future extensions of time or grace periods. Notice of revocation or other disciplinary action shall be sent to her address of record (most current address reported to the Licensure and Renewal Section of the Division of Medical Quality Assurance of the Department of Health Services or the Connecticut Board of Examiners for Nursing).

5. The date of suspension and concurrent six (6) months probation, followed by an additional eighteen (18) months probation shall commence on May 15, 1992.

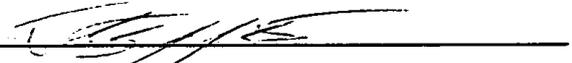
The Respondent, Sharon McNamara, is hereby directed to surrender her Licensed Practical Nurse License No. 017250 and current registration to the Board of Examiners for Nursing, 150 Washington Street, Hartford, Connecticut 06106 on or before May 15, 1992.

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

Dated at *Hartford* Connecticut, this *25<sup>th</sup>* day of *March* 1992.

BOARD OF EXAMINERS FOR NURSING

BY

  
\_\_\_\_\_  
*Timothy J. Johnson*

6631Q



# STATE OF CONNECTICUT

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

May 13, 1994

Sharon McNamara  
1103 Totoket Woods  
P. O. Box 561  
Northford CT 06472

RE: Connecticut LPN License No. 017250

Dear Ms. McNamara:

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

Renewal of your practical 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  
4290/68

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

Phone: TDD: 203-566-1279  
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