

STATE OF CONNECTICUT
BOARD OF EXAMINERS FOR NURSING

Department of Health Services v.

Bonni Venit, L.P.N.

License No. 021099

185 Daniel Road

Hamden CT 06517

CASE PETITION NO. 910716-11-019

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 March 2, 1993. (Department Exhibit 3) The Statement of Charges alleged, in three counts, violations of certain provisions of Chapter 378 of the General Statutes of Connecticut by Bonni Venit (hereinafter the "Respondent").

The Board issued a Notice of Hearing dated March 15, 1993 scheduling a hearing for April 15, 1993. (Department Exhibit 2) The hearing scheduled for April 15, 1993 was continued and took place on May 13, 1993 in Room B-120, Department of Health Services, 150 Washington Street, 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. Bonni Venit, hereinafter referred to as Respondent, was issued Licensed Practical Nurse License Number 021099 on June 12, 1985 and was at all times referenced in the Statement of Charges the holder of said license. (Department Exhibit 1)
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. (Hearing Transcript, May 13, 1993, pp. 7-8)
3. The Respondent was aware of the time and location of the hearing. Department Exhibits 2 and 4 indicates that Notice of Hearing, Notice of Continuance of Formal Hearing and Notice of Change in Location of Formal Hearing were mailed to the Respondent and/or the Respondent's attorney.
4. The Respondent was present during the hearing and was represented by counsel. (Hearing Transcript, May 13, 1993, p. 3)

5. The Respondent submitted an Answer to the Statement of Charges.
(Respondent Exhibit 1)
6. That on November 7, 1988 the Respondent became employed at the Jewish Home for the Aged, New Haven, Connecticut. (Department Exhibit 9) (Respondent Exhibit 1)
7. That during February and April 1991 the Respondent was employed as a licensed practical nurse at the Jewish Home for Aged, New Haven, Connecticut. (Respondent Exhibit 1)
8. That on or about February 12, 1991 and at subsequent times while working as a licensed practical nurse at the Jewish Home for the Aged, the Respondent provided nursing care to patient Matilda Margolis. (Department Exhibit 7) (Respondent Exhibit 1)
9. That patient Matilda Margolis had physician orders effective February 1, 1991, to be administered Lasix 20 mg. and Micro-K 10 mEq. on Mondays and Fridays. That said order was renewed on March 4, 1991. (Department Exhibit 7)
10. That on Thursday February 14, 1991 the Respondent, while working as a licensed practical nurse at the Jewish Home for the Aged, administered Lasix 20 mg. and Micro-K 10 mEq to patient Matilda Margolis. (Department Exhibit 7) (Hearing Transcript, May 13, 1993, pp. 21-24)
11. That while employed as a licensed practical nurse at the Jewish Home for the Aged during February 1991 the Respondent provided nursing care to patient Harry Mendlestein. (Respondent Exhibit 1)

12. That patient Harry Mendlestein had physician orders, effective February 13, 1991, to be administered Prozac 10 mg. each day at 9:00 AM. (Department Exhibit 8)

13. That on February 19, 1991, while working as a licensed practical nurse at the Jewish Home for the Aged, the Respondent administered Prozac to patient Harry Mendlestein. That the Respondent initialed the Cardex indicating that Prozac 10 mg. was administered to patient Harry Mendlestein. (Department Exhibit 8) (Hearing Transcript, May 13, 1993, pp. 17, 48)

14. That on February 20, 1991 a medication error occurred in that the Prozac administered to patient Harry Mendlestein was a 20 mg. dose instead of a 10 mg. dose which was ordered. That the pharmacy for the Jewish Home for the Aged supplied the wrong dosage of Prozac. (Department Exhibit 8)

15. That the Respondent did not work on February 20, 1991. (Hearing Transcript, May 13, 1993, pp. 16-17)

16. That on or about April 19, 1991, while employed as a licensed practical nurse at the Jewish Home for the Aged, the Respondent provided nursing care to patient Polly Kalin. (Department Exhibit 10) (Respondent Exhibit 1)

17. That patient Polly Kalin had physician orders, effective April 18, 1991, to be administered 3 mg. (milligrams) Morphine Sulfate subcutaneously every four (4) hours as needed for pain or restlessness. (Department Exhibit 10)

18. That on April 19, 1991, while employed as a licensed practical nurse at the Jewish Home for the Aged, the Respondent administered 3 ml. (milliliters) Morphine Sulfate subcutaneously to patient Polly Kalin at 7:45 AM. (Department Exhibit 10) (Respondent Exhibit 1) (Hearing Transcript, May 13, 1993, pp. 30-33, 38)

19. That the Respondent did not check the physician order sheet or nursing notes prior to administering the 3 milliliters of Morphine Sulfate to patient Polly Kalin. (Hearing Transcript, May 13, 1993, pp. 49-51)

20. That the Respondent documented in the nursing notes for patient Polly Kalin that 3 milliliters of Morphine Sulfate were administered to the patient at 7:45 AM on April 19, 1991. However, the Respondent subsequently documented on the Cardex, for the patient, that the Morphine Sulfate was administered at 9:15 AM. (Department Exhibit 10) (Respondent Exhibit 1) (Hearing Transcript, May 13, 1993, pp. 34-35)

21. That the Respondent documented patient Polly Kalin's vital signs in the patient's nursing notes on April 19, 1991 at 8:00 AM. (Department Exhibit 10) (Hearing Transcript, May 13, 1993, p. 13)

22. That patient Polly Kalin died on April 19, 1991 at approximately 11:40 AM. (Department Exhibit 10) (Respondent Exhibit 1)

DISCUSSION AND CONCLUSIONS

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

Bonni Venit held a valid licensed practical nurse license in the State of Connecticut at all times referenced in the Statement of Charges.

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

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

The FIRST COUNT, PARAGRAPH 5 of the Statement of Charges alleges the Respondent while employed as a licensed practical nurse at the Jewish Home for the Aged provided nursing care to patient Polly Kalin which was below the accepted standards of the nursing profession in one or more of the following ways:

- "a. she failed to appropriately and/or properly administer medication in that, while it was ordered that the patient receive 3 milligrams of morphine sulfate, she administered 3 milliliters of morphine sulfate: and/or

- b. she failed to adequately and/or properly assess, monitor and recognize the significance of the decedent's deteriorating condition following the administration of said medication; and/or
- c. she failed to accurately, completely and/or properly document the administration of medication."

The Respondent denies these charges. (Respondent Exhibit 1)

Upon review of the evidence presented as well as the credible testimony of the Respondent the Board found (FACTS 16-18) that on April 19, 1991 the Respondent, while working as a licensed practical nurse at the Jewish Home for the Aged, administered three (3) milliliters of Morphine Sulfate to patient Polly Kalin when it was ordered that the patient receive three (3) milligrams of Morphine Sulfate.

Nursing standards require that prior to administering a medication to a patient, a nurse must verify the medication order by checking the physician orders and records of prior medication administration. The Respondent did not do this (FACT 19).

The Board further found (FACT 20) that the Respondent documented, in the nursing notes, the time of administration of the Morphine Sulfate to the patient but subsequently documented an incorrect time of administration in the Cardex portion of the patient's medical record.

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

Based on its findings the Board concludes the Respondent's conduct as specified in the First Count Paragraphs 5a and 5c are proven and are a violation of the General Statutes of Connecticut Section 20-99(b)(2). Therefore, the Respondent is subject to disciplinary action pursuant to the General Statutes of Connecticut.

The Board further concludes, based on the lack of sufficient evidence and FACT 21, that the conduct specified in the First Count Paragraph 5b is not proven. Therefore, the First Count Paragraph 5b is dismissed.

Although it is alleged and admitted that patient Polly Kalin died on April 19, 1991 subsequent to the medication administration error made by the Respondent, the Board makes no finding or conclusion as to whether the conduct of the Respondent contributed to the patient's death. Furthermore, the fact of the patient's death is irrelevant in determining the appropriate disciplinary action in this case.

The SECOND COUNT of the Statement of Charges alleges the Respondent, while employed as a licensed practical nurse at the Jewish Home for the Aged, provided nursing care to patient Matilda Margolis on or about February 12, 1991 which was below the accepted standards of the nursing profession in the following way:

"a. she failed to appropriately and/or properly administer medication, in that she continued to admister Lasix and Micro-K 10 M Eq after they had been discontinued by her physician."

The Respondent denies this charge. (Respondent Exhibit 1)

Based on its findings (FACTS 9-10) the Board concludes that although the Respondent medicated the patient not in conformity with medication orders, there is no evidence that the medication orders were discontinued as alleged. The Board concludes that this charge is not proven. Therefore, the Second Count Paragraph 4 is dismissed.

The THIRD COUNT, PARAGRAPH 4 of the Statement of Charges alleges the Respondent, while employed as a licensed practical nurse at the Jewish Home for the Aged, provided nursing care to patient Harry Mendlestein on or about February 20, 1991 which was below the accepted standards of the nursing profession in one or more of the following ways:

- "a. she failed to appropriately and/or properly administer medication in that while it was ordered that the patient receive 10 milligrams of prozac, she administered 20 milligrams of prozac; and/or
- b. she failed to accurately, completely and/or properly document the administration of medication."

The Respondent denies these charges. (Respondent Exhibit 1)

Based on its findings (FACTS 11-13) the Board concludes that the Respondent medicated patient Harry Mendlestein with Prozac on February 19, 1991, however, no evidence was presented that the Prozac available and actually administered to the patient by the Respondent was the wrong dosage. The Board further concludes the Respondent could not have been responsible for the medication error of February 20, 1991, because she did not work on this date (FACTS 14-15).

The Board concludes that the conduct specified in the Third Count Paragraph 4 is not proven. Therefore, the Third Count Paragraph 4 is dismissed.

ORDER

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

1. That for the First Count, Paragraphs 5a and 5c the licensed practical nurse license of the Respondent be placed on probation for a period of one (1) year.
2. If any of the following conditions or 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. Should the Respondent change employment at any time during the probationary period, she shall immediately provide a copy of this Memorandum of Decision to her employer and said employer shall notify the Board in writing, within thirty (30) days, as to receipt of a copy of this Memorandum of Decision.

- C. She shall cause to be submitted by her nursing supervisor (i.e. Director of Nursing) monthly employer reports for the entire period of probation. Employer reports are due on the first business day of every month. Monthly reports shall commence with the report due August 1, 1993.

- D. The reports cited in C above, shall include documentation of the Respondent's ability to safely and competently practice nursing and an evaluation of her ability to safely and accurately administer medications. Said reports shall be issued to the Board at the address listed in paragraph J below.

- E. During the period of probation the Respondent must successfully complete a Board approved pharmacology course which shall include a clinical and theoretical component.

- F. The course cited in (E) above must be approved by the Board prior to commencement.

- G. An official transcript certifying the Respondent's successful completion of the course cited in (E) above shall be submitted to the Board, at the address cited in (J) below, directly from the educational institution at which the course was taken.
- H. The Connecticut Board of Examiners for Nursing must be informed in writing prior to any change of employment.
- I. The Connecticut Board of Examiners for Nursing must be informed in writing prior to any change of Respondent's address.
- J. All correspondence and reports are to be addressed to:

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

- 3. If the conditions of probation are not met or if there is any deviation from the terms of probation without prior written approval by the Board of Examiners for Nursing it will constitute a violation of probation and will subject the Respondent to sanctions under the General Statutes of Connecticut Section 19a-17(a) and (c) including but not limited to the revocation of her license. Any extension of time or grace period for reporting granted by the Connecticut Board of Examiners for Nursing shall not be a waiver or preclude the Board's right to take action at a later time. The Connecticut Board of Examiners for Nursing shall not be required to grant future extensions of time or grace periods. Notice of

revocation or other disciplinary action shall be sent to her address of record (most current address reported to the Licensure and Renewal Section of the Division of Medical Quality Assurance of the Department of Health Services or the Connecticut Board of Examiners for Nursing).

4. This Memorandum of Decision becomes effective and the one (1) year probation period of the Respondent's license shall commence on July 1, 1993.

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

Dated at Hartford, Connecticut, this 30th day of June, 1993.

BOARD OF EXAMINERS FOR NURSING

By Janice A. Thibodeau

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STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH AND ADDICTION SERVICES

BUREAU OF HEALTH SYSTEM REGULATION

RECEIVED
DEPT. OF PUB. HEALTH & ADDICTION SVCS.

JUL 01 1994

PUBLIC HEALTH HEARING OFFICE
DIVISION OF MEDICAL
QUALITY ASSURANCE

Res'd
7-13-94
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June 30, 1994

Bonni Venit
185 Daniel Road
Hamden CT 06517

RE: Connecticut LPN License No. 021099

Dear Ms. Venit:

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 July 1, 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
4290/38

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

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