



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

PUBLIC HEALTH HEARING OFFICE

May 20, 2010

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Via Email

RE: Helena Spencer, LPN - Petition No. 2008-0226-011-013

Dear Attorneys Murray and Antonetti:

Enclosed please find a copy of the Memorandum of Decision issued by the Board of Examiners for Nursing in the above-referenced matter.

Sincerely,

Jeffrey A. Kardys
Administrative Hearings specialist/Board Liaison
Public Health Hearing Office

c: Michael J. Purcaro, Chief of Administration
Wendy Furniss, Branch Chief, Healthcare Systems
Jennifer Filippone, Section Chief, Practitioner Licensing and Investigations
Bonnie Pinkerton, RN, Nurse Consultant, Department of Public Health
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**STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH**

Helena Spencer, LPN
License No. 025514

Petition No. 2008-0226-011-013

MEMORANDUM OF DECISION

Procedural Background

On October 23, 2008, the Department of Public Health ("the Department") filed a Statement of Charges ("the Charges") with the Board of Examiners for Nursing ("the Board"). Dept. Exh. 1. The Charges allege violations of certain provisions of Chapter 378 of the General Statutes ("the Statutes") by Helena Spencer ("respondent") which would subject respondent's licensed practical nurse license to disciplinary action pursuant to §§ 19a-17 and 20-99(b) of the Statutes.

On November 5, 2008, the Charges and a Notice of Hearing were sent to respondent by certified and first class mail. Dept. Exh. 1.

The hearing was conducted on February 4, April 1st, August 19th, and September 16, 2009. At the hearing, respondent was represented by Attorney Martha Murray; Attorney Roberta Swafford represented the Department during the first two days of hearing, and Attorney Diane Wilan represented the Department on the last two days of hearing.

Following the close of the record on September 16, 2009, the Board conducted fact-finding.

Each member of the Board involved in this decision attests that he/she was present at the hearing or has reviewed the record, and that this decision is based entirely on the record, the law, and the Board's specialized professional knowledge in evaluating the evidence.

Allegations

1. In paragraphs one and six of the Charges, the Department alleges that Helena Spencer of Vernon, Connecticut is, and has been at all times referenced in this Charges, the holder of Connecticut licensed practical nursing ("LPN") license number 025514.
2. In paragraph two of the Charges, the Department alleges that at all relevant times, respondent was employed as an 11 p.m. to 7 a.m. charge nurse at Kettle Brook Care Center, a skilled nursing facility located in East Windsor, Connecticut ("Kettle Brook").

3. In paragraph three of the Charges, the Department alleges that at all relevant times, RL¹ was a resident of Kettle Brook who:
 - a. was alert and oriented;
 - b. had diagnoses including, but not limited to, pneumonia, renal and respiratory failure, dysphagia, MRSA (methicillin-resistant Staphylococcus aureus in the sputum), and/or, VRE (Vancomycin-resistant Enterococcus in PEG tube);
 - c. was in a private room to prevent the potential to spread infection;
 - d. had a physician's order for tube feed of Novasource Renal, a nutritionally complete formula for renal-impaired patients, at 60 cc/hour continuous for a total of 1440 cc in 24 hours as he was not able to take either foods or liquids by mouth; and/or,
 - e. was a full code.
4. In paragraph four of the Charges, the Department alleges that on or about November 10, 2007, respondent was told at report by the 3 p.m. to 11 p.m. charge nurse that he had hung a new 1000 cc bottle of Novasource Renal for RL at 9 p.m. Shortly thereafter, respondent did first rounds of her residents including RL.
5. In paragraph five of the Charges, the Department alleges that at approximately 1 a.m. on November 11, 2007, RL's tube feeding pump alarm rang. At that time, respondent hung a new 1000 cc bottle of Novasource Renal for RL.
6. In paragraph six of the Charges, the Department alleges that at approximately 4 a.m. on November 11, 2007, RL's tube feeding pump alarm rang. At that time, respondent noted that approximately 700 cc of the Novasource Renal had infused in three hours.
7. In paragraph seven of the Charges, the Department alleges that on or about November 11, 2007, respondent:
 - a. hung a new 1000 cc bottle of Novasource Renal at 1 a.m.;
 - b. failed to investigate when the tube feeding pump for resident RL infused at a rate faster than was consistent with:
 - i. the information she received at shift report,
 - ii. her own observations at the beginning of the shift, and/or,
 - iii. the physician's order.
 - c. failed to perform and/or document a residual check of the contents of RL's stomach as ordered by RL's physician before she hung a new bag of Novasource Renal on the resident's tube feeding pump;
 - d. failed to notify the nursing supervisor when the tube feeding pump for resident RL infused at a rate faster than was consistent with:
 - i. the information she received at shift report,
 - ii. her own observations at the beginning of the shift, and/or,
 - iii. the physician's order; and/or,
 - e. failed to notify the nursing supervisor that she had hung a new 1000 cc bottle of Novasource Renal at 1 a.m.
8. In paragraph eight of the Charges, the Department alleges that the above facts constitute grounds for disciplinary action pursuant to §20-99(b)(2) of the Statutes.

¹ On February 4, 2009, the Department corrected a typographical error in which the Department substituted the initials JL for RL. See, Tr. 02/04/09. p. 6.

Findings of Fact

1. Respondent of Vernon, Connecticut is, and has been at all times referenced in this Charges, the holder of Connecticut LPN license number 025514. Resp. Exh. A.
2. At all relevant times, respondent was employed as an 11 p.m. to 7 a.m. charge nurse at Kettle Brook. Resp. Exh. A.
3. At all relevant times, RL was a resident of Kettle Brook who was alert and oriented, and had diagnoses including, but not limited to, pneumonia, renal and respiratory failure, dysphagia (difficulty in swallowing), MRSA in the sputum, and VRE in his PEG. He was in a private room to prevent the potential to spread infection, and had a physician's order for tube feed of Novasource Renal, a nutritionally complete formula for renal-impaired patients, at 60 cc/hour continuous for a total of 1440 cc in 24 hours. He was not able to take either foods or liquids by mouth, and was a full code. Resp. Exh. A.
4. The evidence is insufficient to establish that on or about November 10, 2007, respondent was told at report by the 3 p.m. to 11 p.m. charge nurse that he had hung a new 1000 cc bottle of Novasource Renal for RL at 9 p.m. Tr. 08/19/09, pp. 37, 41; Tr. 9/16/09, p. 18.
5. At approximately 1:00 a.m. on November 11, 2007, RL's tube feeding pump alarm rang. At that time, respondent hung a new 1000 cc bottle of Novasource Renal for RL. Resp. Exh. A; Dept. Exh. 1, Tab 2, p. 13; Tr. 08/19/09, pp. 18-19.
6. At approximately 4:00 a.m. on November 11, 2007, RL's tube feeding pump alarm rang. At that time, respondent noted that approximately 733 cc of the Novasource Renal had infused in three hours. Dept. Exh. 1, Tab 2, pp. 13-16; Resp. Exh. H; Tr. 08/19/09, p. 55.
7. On November 11, 2007, respondent failed to investigate when the tube feeding pump for resident RL infused at a rate faster than was consistent with the information she received at shift report, her own observations at the beginning of the shift, and the physician's order. Dept. Exh. 2, Tab 2, pp. 14-16, 19-20.
8. On November 11, 2007, respondent failed to perform and/or document a residual check of the contents of RL's stomach as ordered by RL's physician before she hung a new bottle of Novasource Renal on the resident's tube feeding pump. Dept. Exh. 2, Tab 2, pp. 14-16.
9. An abdominal assessment involves listening for bowel sounds in all four quadrants of the abdomen and checking the abdomen for tenderness and possible distention. An abdominal check and a residual check are not the same. Tr. 2/4/09, p. 74; Tr. 8/19/09, pp. 48, 51-52.
10. On November 11, 2007, respondent failed to notify the nursing supervisor when the tube feeding pump for resident RL infused at a rate faster than was consistent with the information she received at shift report, her own observations, and the physician's order. Dept. Exh. 1, Tab 2, pp. 17-19; Tr. 02/04/09, pp. 31-33; Tr. 08/19/09, pp. 23, 47-49, 52.

11. On November 11, 2007, respondent failed to notify the nursing supervisor that she had hung a new 1000 cc bottle of Novasource Renal at 1:00 a.m. Dept. Exh. 1, Tab 2, pp. 17-19; Tr. 02/04/09, pp. 31-33; Tr. 08/19/09, pp. 23, 47-49, 52.
12. At 60 cc/hour, normal infusion time for a 1000 cc Novasource Renal bottle is approximately 16 hours. Tr. 8/19/09, pp. 24-25; Tr. 9/16/09, p. 13.

Discussion and Conclusions of Law

The Department bears the burden of proof by a preponderance of the evidence in this matter. *Goldstar Medical Services, Inc., et al. v. Department of Social Services*, 288 Conn. 790 (2008); *Swiller v. Comm'r of Public Health*, CV-950705601, Superior Court, J.D. Hartford/New Britain at Hartford, October 10, 1995; *Steadman v. SEC*, 450 U.S. 91, 101 S. Ct. 999, *reh'g den.*, 451 U.S. 933 (1981). The Department sustained its burden of proof with regard to all the allegations contained in the Charges except the allegations in paragraph 4.

Section 20-99 of the Statutes provides, in pertinent part, that:

- (a) The Board . . . shall have jurisdiction to hear all charges of conduct which fails to conform to the accepted standards of the nursing profession brought against persons licensed to practice nursing. After holding a hearing . . . said board, if it finds such person to be guilty, may revoke or suspend his or her license or take any of the actions set forth in section 19a-17
- (b) conduct, which fails to conform to the accepted standards of the nursing, profession includes, but is not limited to, . . . (2) . . . incompetence or negligence in carrying out usual nursing functions;

Specifically, in paragraph 2 of the Charges the Department alleges that at all relevant times, respondent was employed as an 11 p.m. charge nurse at the Kettle Brook, a skilled nursing facility located in East Windsor, Connecticut. Respondent admits this allegation.

The Department sustained its burden of proof concerning the allegation in paragraph 3 of the Charges, that RL was a resident of Kettle Brook who was alert and oriented; had diagnoses including, but not limited to, pneumonia, renal and respiratory failure, dysphagia, MRSA, and VRE; was in a private room to minimize the potential to spread infection; had a physician's order for tube feeding of Novasource Renal, a nutritionally complete formula for renal-impaired patients, at 60 cc/hour continuous for a total of 1440 cc in 24 hours because he was not able to take either foods or liquids by mouth; and, was a full code. Respondent admits these allegations. FF 3.

The Department failed to sustain its burden of proof concerning the allegation in paragraph 4 of the Charges, that on or about November 10, 2007, respondent was told at report

by the 3 p.m. to 11 p.m. charge nurse that he had hung a new 1000 cc bottle of Novasource Renal for RL at 9 p.m. Shortly thereafter, respondent did first rounds of her residents including RL. The 3 p.m. to 11 p.m. charge nurse only told respondent that he had hung all new Novasource Renal bottles for the three patients that required it and respondent knew that RL was one of the three patients that required Novasource Renal. FF 4.

The Department sustained its burden of proof concerning the allegation in paragraph 5 of the Charges, that at approximately 1:00 a.m., on November 11, 2007, RL's tube feeding pump alarm rang. At that time, respondent hung a new 1000 cc bottle of Novasource Renal for RL. Respondent admits this allegation. FF 5.

The Department sustained its burden of proof concerning the allegation in paragraph 6 of the Charges that at approximately 4:00 a.m. on November 11, 2007, RL's tube feeding pump alarm rang again. At that time, respondent noted that approximately 733 cc of the Novasource Renal had infused in three hours. FF 6. Respondent denied this allegation in her Answer, but during the hearing on August 19, 2009, she admitted to these facts. Tr. 08/19/2009, p. 55.

The Department sustained its burden of proof concerning the allegations in paragraph 7 of the Charges, that respondent hung a new 1000 cc bottle of Novasource Renal at 1:00 a.m.; failed to investigate when the tube feeding pump for resident RL infused at a rate faster than was consistent with the information she received at shift report, her own personal observations at the beginning of the shift, and, the physician's order; failed to perform and/or document a residual check of the contents of RL's stomach as ordered by RL's physician before she hung a new bottle of Novasource Renal on the resident's tube feeding pump; failed to notify the nursing supervisor when the tube feeding pump for RL infused at a rate faster than was consistent with the information she received at report, her own observations at the beginning of the shift, or the physician's order; and, failed to notify the nursing supervisor that she had hung a new 1000 cc bottle of Novasource Renal at 1 a.m. FF 7-10.

Respondent claims that she did not notify supervisor that she changed the bottle at 1:00 a.m. because it was an ongoing order, not a change in condition. Tr. 08/19/2009, p. 24. However, respondent knew that the Novasource Renal bottle had been placed in the pump sometime during the 3 p.m. to 11 p.m. shift, and that the infusion time required approximately 16 hours. FF 11. Under normal circumstances, the bottle should not have been empty by 1:00 a.m. Even if the bottle had been replaced at 3:00 p.m., which is at the beginning of the previous shift, the bottle should not have been empty until 7:00 a.m. However the Respondent changed the empty bottle at 1:00 a.m. (FF 5) Therefore, the Board finds that there was a change in condition

and respondent should have notified the supervisor of this change, and investigated why the bottle infused faster than expected. Respondent only notified her supervisor after RL had vomited at approximately 4:00 a.m. *See*, Dept. 1, Tab 2, pp. 17-19. Therefore, the Board finds that in this incident, respondent's conduct was negligent and/or incompetent.

Order

Based on the record in this case, the above findings of fact and conclusions of law, the Board hereby orders with respect to license number 025514 held by Helena Spencer, as follows:

1. Respondent's license shall be placed on probation for a period of one year under the following terms and conditions. If any of the conditions of probation are not met, respondent's licensed practical nurse license may be subject to disciplinary action pursuant to § 19a-17 of the Statutes.
 - A. During the period of probation the Board shall pre-approve respondent's employment and/or change of employment within the nursing profession.
 - B. Respondent shall not be employed as a nurse for a personnel provider service, assisted living services agency, homemaker-home health aide agency, or home health care agency, and shall not be self-employed as a nurse for the period of probation.
 - C. If employed as a nurse, respondent shall cause employer reports to be submitted to the Board, by her immediate supervisor during the entire probationary period. Employer reports shall be submitted commencing with the report due on the first business day of month following employment as a nurse. Employer reports shall be submitted every two months during the probationary period.
 - D. The employer reports cited in Paragraph C above shall include documentation of respondent's ability to safely and competently practice nursing. Employer reports shall be submitted directly to the Board at the address cited in Paragraph J below.
 - E. Should respondent's employment as a nurse be involuntarily terminated or suspended, respondent and her employer shall notify the Board within 72 hours of such termination or suspension.

- F. If respondent pursues further training in any subject area that is regulated by the Department, respondent shall provide a copy of this Memorandum of Decision to the educational institution or, if not an institution, to respondent's instructor. Such institution or instructor shall notify the Department in writing as to receipt of a copy of this Memorandum of Decision within 15 days of receipt. Said notification shall be submitted directly to the Department at the address cited in Paragraph J below.
- G. Within the probationary period, respondent shall attend and successfully complete courses pre-approved by the Board in scope of practice, problem solving and critical thinking, enteric feeding and complications. Within one month of the completion of each such course, respondent shall provide the Department with proof, to the Department's satisfaction, of the successful completion of such course.
- H. Respondent shall not perform enteric feeding until she has provided proof to the satisfaction of the Department of completion of such coursework as required in Paragraph G above.
- I. The Board must be informed in writing prior to any change of address.
- J. All communications, payments if required, correspondence, and reports are to be addressed to:

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

- 2. Any deviation from the terms of probation, without prior written approval by the Board, shall constitute a violation of probation, which will be cause for an immediate hearing on charges of violating this Order. Any finding that respondent has violated this Order will subject respondent to sanctions under § 19a-17(a) and (c) of the Statutes, including but not limited to, the revocation of her license. Any extension of time or grace period for reporting granted by the Board shall not be a waiver or preclude the Board's right to take subsequent action. The Board shall not be required to grant future extensions of time or grace periods. Notice of revocation or other disciplinary action shall be sent to

respondent's address of record (most current address reported to the Office of Practitioner Licensing and Certification of the Department of Public Health or the Board).

3. This Memorandum of Decision becomes effective, and the one-year probation of licensed practical nurse license no. 025514 shall commence, on June 1, 2010.

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

Dated at Hartford, Connecticut this 19th day of May, 2010.

BOARD OF EXAMINERS FOR NURSING

By Patricia C. Bouffard
Patricia Bouffard, R.N., Chairperson

CERTIFICATION

I hereby certify that, pursuant to Connecticut General Statutes § 4-180(c), a copy of the foregoing Memorandum of Decision was sent this 20th day of May 2010, by certified mail, return receipt requested to:

Martha Murray, Esq.
383 Orange Street
New Haven, CT 06511

Certified Mail RRR #91 7108 2133 3932 0555 2461

and by E-Mail to:

Matthew Antonetti, Principal Attorney
Legal Office
Department of Public Health
410 Capitol Avenue, MS #12LEG
Hartford, CT 06134-0308



Jeffrey A. Kardys
Administrative Hearings Specialist/Board Liaison
Department of Public Health
Public Health Hearing Office



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

June 1, 2011

Helena Spencer, LPN
325 Kelly Road
#V-10
Vernon, CT 06066

Re: Memorandum of Decision
Petition No. 2008-0226-011-013
License No. 025514

Dear Ms. Spencer:

Please accept this letter as notice that you have satisfied the terms of your license probation, effective June 1, 2011.

Notice will be sent to the Department's Licensure and Registration section to remove all restrictions from your license related to the above-referenced Memorandum of Decision.

Please be certain to retain a copy of this letter as documented proof that you have completed your license probation.

Very truly yours,

Bonnie Pinkerton, RN, Nurse Consultant
Practitioner Licensing and Investigations Section

cc: J. Filippone
J. Wojick



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