

STATE OF CONNECTICUT
CONNECTICUT BOARD OF EXAMINERS FOR NURSING

Jennifer Gaudino, L.P.N.
License No. 029316

Petition No. 2012-1242

MEMORANDUM OF DECISION

I

Procedural Background

On February 3, 2013, the Department of Public Health ("Department") filed a Motion for Summary Suspension ("Motion") and a Statement of Charges ("Charges") with the Board of Examiners for Nursing ("Board"). Board ("Bd.") Exhibit ("Ex.") 2. The Charges allege violations of certain provisions of Chapter 378 of the General Statutes ("Statutes") by Jennifer Gaudino ("Respondent") which would subject Respondent's licensed practical nurse license to disciplinary action pursuant to Conn. Gen. Stat. §§ 19a-17 and 20-99(b).

Based on the allegations in the Charges and the affidavits and reports accompanying the Motion, the Board found that Respondent's continued nursing practice presented a clear and immediate danger to the public health and safety and ordered, on February 20, 2013, pursuant to Conn. Gen. Stat. §§ 4-182(c) and 19a-17(c), that Respondent's licensed practical nurse license be summarily suspended pending a final determination by the Board of the allegations contained in the Charges ("Order"). Bd. Ex. 1.

On February 20, 2013, the Charges, the Order, and a Notice of Hearing were served on Respondent in person. Bd. Ex. 1, 2, 3.

The hearing was held on March 6, 2013. Respondent appeared *pro se*. Attorney Linda Fazzina represented the Department. At the hearing, Respondent orally answered the Charges on the record, in addition to the written narrative she had filed. Bd. Ex. 4; Transcript ("Tr.") pp. 6-9. Following the close of the record on March 6, 2013, the Board conducted fact finding.

Each member of the Board involved in this decision attests that 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. *Pet v. Department of Health Services*, 228 Conn. 651 (1994).

II

Allegations

1. In paragraph 1 of the Charges, the Department alleges that Jennifer Gaudino of Andover, Connecticut is, and has been at all times, as referenced in the Charges, the holder of Connecticut licensed practical nurse license number 029316.
2. In paragraph 2 of the Charges, the Department alleges that at all relevant times, Respondent was employed as a licensed practical nurse by Advanced Staffing Associates, L.L.C. ("Advanced Staffing") of Plainville, Connecticut.
3. In paragraph 3 of the Charges, the Department alleges that on or about December 9, 2012, Respondent was working as a nurse, through Advanced Staffing, at a group home in Hebron, Connecticut. On said date, while providing nursing services to one or more residents of the group home she was assigned to, Respondent:
 - a. Abused one or more residents and/or exhibited aggressive and/or unprofessional behavior toward one or more residents, in one or more of the following ways:
 - i. Engaged in inappropriate physical contact with resident M.R., including, but not limited to, one or more of the following:
 1. slapping, swatting and/or smacking resident M.R. in her face with a strap;
 2. using a spoon and/or her hand to slap, swat and/or smack resident M.R.; and/or
 3. grabbing resident M.R. by the forehead and/or by the hair;
 - ii. Engaged in inappropriate physical contact with resident F.S., including, but not limited to, swatting and/or smacking resident F.S.'s stomach; and/or
 - iii. Engaged in inappropriate physical contact with resident A.D., including, but not limited to, pinching A.D.'s nose;
 - b. Failed to deliver nursing services to one or more residents in a manner to ensure well-being and/or safety at all times;
 - c. Performed personal care for one or more residents in an aggressive or unprofessional manner, including forcefully feeding one or more residents in a manner that caused choking, gagging and/or spitting up;
 - d. Used profanities and/or made inappropriate remarks to resident M.R., resident A.D. and/or resident M.U.;
 - e. Pre-poured medications for one or more residents and signed the medication administration record for said medication(s); and/or
 - f. Documented that a therapy and/or treatment program was conducted for resident M.R. and/or resident A.D., when in fact, said program(s) were not conducted.

4. In paragraph 4 of the Charges, the Department alleges that the above facts constitute grounds for disciplinary action pursuant to Conn. Gen. Stat. § 20-99(b)(2).

III

Findings of Fact

1. Respondent of Andover, Connecticut is, and has been at all times, as referenced in the Charges, the holder of Connecticut licensed practical nurse license number 029316. Tr. p. 6.
2. Respondent, at all relevant times, was employed as a "pool" licensed practical nurse by Advanced Staffing of Plainville, Connecticut. Tr. p. 6.
3. On December 9, 2012, Respondent was scheduled to work a double shift, from 7:00 a.m. until 11:00 p.m. at the residential group home. Dept. Ex. 1, p. 2; Dept. Ex. 3; Tr. p. 81.
4. The group home residents are primarily nonverbal and profoundly disabled adults, ranging in ages from 26 to 46. Some of the residents are blind and most are non-ambulatory. Bd. Ex. 4, pp. 1-3; Tr. p. 83.
5. On December 9, 2012, Respondent worked with Victoria Prince, Residential Program Worker ("RPW") and a recent graduate of a certified nursing assistant program. Tr. p. 21; Dept. Ex. 3, p. 1; Dept. Ex. 4, p. 4; Dept. Ex. 5.
6. December 9, 2012, was Ms. Prince's sixth day of employment at the group home, on the first shift from 7:00 a.m. to 3:00 p.m. As of the date of the alleged incidents, Respondent had worked at the group home for more than three years. Dept. Ex. 3, p. 1; Tr. pp. 23, 33.
7. On December 9, 2012, Respondent and Ms. Prince provided care to the residents by showering, bathing, dressing and giving them their meals (breakfast and lunch). Respondent administered medication to the residents. Dept. Ex. 1, pp. 3-4; Dept. Ex. 3, pp. 3-6, 8; Dept. Ex. 4, pp. 4-8; Dept. Ex. 5.
8. Resident M.R. is female, in her mid-40's. She is blind, non-verbal, and non-ambulatory. She makes spastic arm and leg movements, flails her arms, and unintentionally hits or bites her care givers. She requires total care of her activities of daily living ("ADLs"). She requires a shower sling and a shower chair because of her seizures and spastic movements. She is scheduled to spend 2 hours of therapy per day on a sidelyer (tilt table). Bd. Ex. 4, p. 1; Tr. pp. 23, 28.
9. Resident M.U. is male, non-ambulatory. He flails his arms, bites and throws temper tantrums. Music calms him down. Bd. Ex. 4, pp. 2-3; Tr. p. 30.

10. Resident A.D. is male, non-ambulatory, is scheduled to be in hand splints twice a day for a total of two hours per day, and on a sidelyer (tilt table) for two hours per day. He can feed himself with some assistance. Bd. Ex. 4, p. 3; Dept. Ex. 6, p. 2; Tr. pp. 28, 48-49.
11. Resident F.S. is male, in his mid-40's, non-verbal and non-ambulatory, He requires total care of most of his ADLs, except he can feed himself with some assistance and can drink out of a cup. He uses a high sided plate, elongated plastic spoon and a nose cup. Bd. Ex. 4, p. 2; Tr. pp. 25, 45-46.
12. Resident C.R. is male, in his early 30's, blind, verbal, non-ambulatory, and has the functional use of his left arm and hand. He requires total care of most of his ADLs, except he can feed himself with some assistance. He uses a toddler spoon, high sided plate and a cup with a built-in straw. Bd. Ex. 4, p. 2; Dept. Ex. 1, p. 4.
13. On December 9, 2012, Respondent and Ms. Prince prepared resident M.R. for a shower. M.R. made noises and Respondent told her "to shut up." Respondent smacked M.R. in the face with the shower sling strap. Tr. pp. 23-24; Dept. Ex. 1, p. 3; Dept. Ex. 4, p. 5; Dept. Ex. 5, p. 3.
14. Respondent slammed M.R.'s head against the back of her wheelchair and told her that "[she] is not putting up with [M.R.'s] diva shit; that she was not special or even cute." Tr. pp. 26-27; Dept. Ex. 1, p. 3, 5; Dept. Ex. 4, p. 6-7; Dept. Ex. 5, p. 3.
15. During breakfast, Respondent forcefully fed M.R. with a spoon, causing M.R. to gag, choke and spit up her food. Respondent took M.R.'s spoon and smacked her on her cheek with the spoon. Tr. pp. 26-27; Dept. Ex. 1, p. 3; Dept. Ex. 4, p. 7; Dept. Ex. 5, p. 3.
16. When M.R. started to flail her arms, Respondent took her right arm and tucked it between Respondent's legs, and remarked [to M.R.] that "you don't like it when you can't hit people." Dept. Ex. 1, p. 3; Dept. Ex. 4, p. 7; Dept. Ex. 5, p. 4. .
17. During lunch, M.R. started to make noises because she does not like to wait to eat. Respondent told M.R. that "she wasn't putting up with her shit." Tr. pp. 28-29. Respondent kicked M.R.'s wheelchair twice; wheeled her out of the dining room into the living room and told that she would have to wait to be fed. A different Residential Program Worker, Jamie Mitchell, started her second shift early and fed M.R. Dept. Ex. 1, p. 3; Dept. Ex. 4, p. 8; Dept. Ex. 5, p. 4.
18. On December 9, 2012, Respondent and Ms. Prince gave F.S. a tub bath before breakfast. While he was being dressed on the changing table, his legs tightened and Respondent could not put his underwear on him. Respondent pried his legs open and told him "to loosen up." Dept. Ex. 1, p. 4; Dept. Ex. 4, p. 5; Dept. Ex. 5, p. 5; Tr. p. 24.
19. The evidence is insufficient to establish that Respondent swatted or smacked F.S. on the stomach or engaged in any other inappropriate physical contact with F.S. Tr. pp. 59-60.

20. Contrary to the group home instructions that stated that F.S. could feed himself with some assistance, Respondent forcefully fed F.S. "because he was too slow." Dept. Ex. 1, p. 6; Tr. pp. 25-26. Respondent also pinched his nose to make him open his mouth and forced liquid down in his mouth. Respondent told F. S. to take "man drinks" (meaning larger sips.) Dept. Ex. 1, p. 4; Dept. Ex. 5, p. 3.
21. According to the group home instructions, A.D. could feed himself with some assistance. However, during breakfast, Respondent forcefully fed A.D. "because he was too slow." Dept. Ex. 1, p. 6; Tr. pp. 25-26, 30. When A.D. pursed his lips and refused to open his mouth, Respondent pinched his nose to make him open his mouth and forced food into his mouth. Respondent "told him that she was not playing his game." Dept. Ex. 1, p. 4; Dept. Ex. 4, p. 6; Dept. Ex. 5, p. 3; Tr. pp. 26, 29.
22. During lunch, A.D. shifted in his chair to one side and would not sit up straight. When Ms. Prince could not get him to sit up straighter, Respondent came over, placed his hands in his lap, picked him up by his wrists and positioned him in his chair. Respondent told Ms. Prince that she "was not playing his fucking games." Dept. Ex. 1, pp. 3-4; Dept. Ex. 5, p. 5.
23. On December 9, 2012, Ms. Prince tried to calm M.U. down because he was flailing his arms, biting his arms and making noise. When Ms. Prince was not able to get him to calm down, Respondent intervened. She grabbed his arms, leaned into his chest with her body and told him that [she] "was not Claire and [she] was not Gloria, that [she] was Jen, and that [she] was not putting up with [his] tantrums and feeding into [his] shit." Dept. Ex. 1, p. 4; Dept. Ex. 5, pp. 7-8; Dept. Ex. 5, p. 4; Tr. p. 30.
24. During breakfast and lunch, Respondent force fed C.R. because he was taking too long to feed himself. C.R. could feed himself with some assistance. Dept. Ex. 1, p. 4; Dept. Ex. 4, p. 6; Dept. Ex. 5, p. 4.
25. On December 9, 2012, at approximately 5:00 p.m., Ms. Prince contacted the group home manager, Priscilla Prior, L.P.N., about the incidents she had witnessed involving Respondent. Ms. Prior returned to the group home, told Respondent about the allegations, and sent Respondent home at 7:00 p.m., pending an investigation of abuse and neglect charges. Bd. Ex. 4, p. 3; Tr. pp. 44-47.
26. On December 9, 2012, in violation of the group home's policies, Respondent had pre-poured medications, including controlled substances, which were to be administered to various residents at 7:00 p.m., 7:30 p.m., 8:00 p.m., and 10:00 p.m. Tr. pp. 48, 65-66; Dept. Ex. 1, p. 5.
27. The evidence is insufficient to establish that on December 9, 2012, Respondent falsely documented in M.R.'s and A.D.'s medical records that they had received their prescribed rehabilitative therapies. Tr. pp. 28, 63-65.

IV

Discussion and Conclusions of Law

The Department bears the burden of proof by a preponderance of the evidence in this matter. *Charles Ray Jones, M.D. v. Connecticut Medical Examining Board*, S.C. 18843 (2013); *Goldstar Medical Services, Inc., et al. v. Department of Social Services*, 288 Conn. 790, 821 (2008). The Department sustained its burden of proof with regard to all of the allegations contained in the Charges, except the allegations contained in paragraphs 3a(ii) and 3f.

Conn. Gen. Stat. § 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, the following: . . . (2) illegal conduct, incompetence or negligence in carrying out usual nursing functions; . . .

In presenting its case, the Department relied on the following witnesses to prove its case: Victoria Prince, RPW and a recent graduate of a certified nursing assistant program; and Priscilla Prior, L.P.N., the group home manager. Respondent testified for the defense. The Department also relied on its investigative reports which included witness statements and excerpts from the group home's data collection records. The investigative reports were entered into the record as business record exceptions to the hearsay rule and were found to have sufficient indicia of reliability to be given substantial weight. *Dolgner v. Jon M. Alander, Commissioner of Human Resources*, 237 Conn. 272, 676 A.2d 865 (1996).

With respect to the allegations in the Charges, Respondent admits the allegations contained in paragraphs 1, 2 and 3e of the Charges. Respondent denies the remaining Charges.

With respect to the allegations contained in paragraph 3 of the Charges, the Department sustained its burden of proof with regard to all of the allegations contained in the Charges, except the allegations contained in paragraphs 3a(ii) and 3f.

With respect to the allegations concerning resident M.R., the Department established by a preponderance of the evidence that Respondent abused and exhibited aggressive and

unprofessional behavior towards M.R. on December 9, 2012. Ms. Prince credibly testified that she witnessed Respondent do the following to M.R.: smacked M.R. in the face with a shower sling strap; slammed M.R.'s head against the back of her wheelchair and spoke to M.R. inappropriately; on several occasions, told M.R. "to shut up" and used profanity when speaking to or about M.R.; restrained M.R.'s right arm and tucked it between Respondent's legs; kicked M.R.'s wheelchair at least twice that day; forcefully fed M. R. and caused her to gag, choke and spit up her food; and, withheld her lunch because of the noises and spastic movements M.R. made. FF 13-17.

With respect to the allegations concerning resident F.S., the Department established by a preponderance of the evidence that Respondent also abused and exhibited aggressive and unprofessional behavior toward F.S. on December 9, 2012. The record evidences that Ms. Prince credibly testified and her testimony is corroborated by Ms. Prior's testimony that Respondent pried F.S.'s legs apart so she could put his underwear on and forcefully fed F.S. although he could feed himself with some assistance. Respondent also pinched his nose to make him open his mouth and forced liquid down his throat. FF 18, 20.

With respect to the Charges concerning resident A.D., the Department sustained its burden of proof that Respondent also abused A.D. on December 9, 2012. The record establishes that Respondent forcefully fed A.D. by pinching his nose to make him open his mouth, although he could feed himself with some assistance. Additionally, Respondent used profanity when she spoke to A.D. and picked him up by his wrists when he refused to sit up straight in his chair. FF 21-22.

With regard to the Charges concerning resident M.U., the Department met its burden of proof that Respondent also abused and exhibited aggressive and unprofessional behavior toward M.U. on December 9, 2012. Ms. Prince testified that on that day, she had difficulty calming M.U. down as he flailed his arms, bit his arms and made disruptive noises. Respondent intervened, grabbed M.U.'s arms and leaned into his chest with her body. Respondent spoke to M.U. aggressively and used profanity. FF 23.

The evidence also establishes that Respondent force fed resident C.R. because he was taking too long to eat, although he could feed himself with some staff assistance. FF 24. Thus, the Department met its burden of proof with respect the allegations concerning C.R.

Based on the documentary and testimonial evidence in the record, the Department established that Respondent's behavior toward M.R., F.S., A.D., M.U., and C.R. was verbally and physically abusive, aggressive, intimidating, and unprofessional. Contrary to Respondent's suggestion that her intentions and behavior may have been misinterpreted, the evidence is clear, Respondent's conduct constituted abuse. Such abusive behavior towards a defenseless and vulnerable population cannot be tolerated. There is "zero" tolerance for abuse.

With respect to the allegations contained in paragraph 3e, Respondent admitted in her testimony that, on December 9, 2012, she had prepoured some of the residents' medications, which included controlled substances. Ms. Prior's testimony and written documentation also corroborates this evidence. FF 26. Therefore, the Board finds that the Department sustained its burden of proof with regard to all of the allegations contained in paragraphs 3a(i)(1), (2), and (3), 3a(iii), 3b, 3c, 3d, and 3e.

With respect to the allegations contained in paragraph 3a(ii), the Department did not establish by a preponderance of the evidence that Respondent swatted or smacked F.S.'s stomach. Rather, the Board found Respondent's testimony to be credible when she testified that when she rubbed F.S.'s stomach, she cupped her hand like she would do in chest percussion and, in doing so, the motion makes a loud, hollow sound that may sound like a "smack," but the technique is not hard enough to harm or injure the resident. Tr. pp. 59-60.

With respect to the allegations contained in paragraph 3f that Respondent falsely documented the residents' records that she provided therapy or treatment programs to M.R. and A.D., Ms. Prince testified that she did not observe Respondent provide the prescribed therapies (time in splints and on the sidelyer equipment) to M.R. and A.D. on December 9, 2012. Tr. p. 28. Respondent testified that she did. Tr. pp. 63-65. Ms. Prior testified that the times Respondent entered on the ISP data collection forms for M.R.'s and A.D.'s therapy sessions would have been at the times they were taking their naps in the afternoon, and that those times were not accurate. Dept. Ex. 7; Tr. pp. 49-50. Inasmuch as the Department did not produce the residents' medical records to establish how the therapy sessions were usually charted, the Board finds that there is no reliable way to determine whether the prescribed therapies were administered to M.R. and A.D. on December 9, 2012.

Therefore, the Board finds that with respect to the allegations contained in paragraphs 3a(ii) and 3f, the Department did not sustain its burden of proof.

Order

Based on the record in this case, the above findings of fact and conclusions of law, the Board hereby orders, that Respondent's license number 029316 to practice as a licensed practical nurse in the State of Connecticut is hereby **REVOKED**.

The Board informs Respondent, Jennifer Gaudino, and the Department of this decision.

Dated at Hartford, Connecticut this 21st day of August, 2013.

BOARD OF EXAMINERS FOR NURSING

By Patricia C. Bouffard, D.N.Sc.
Patricia C. Bouffard, D.N.Sc., Chair

CERTIFICATION

I hereby certify that, pursuant to Connecticut General Statutes Section 4-180(c), a copy of the foregoing Memorandum of Decision was sent this 22nd day of August 2013, certified mail return receipt requested mail to:

Jennifer M. Gaudino
35B Center Street
Andover CT 06232

and E-Mail to:

Matthew Antonetti, Principal Attorney
Licensure Regulation and Compliance
Department of Public Health – MS#12LEG
410 Capitol Avenue
P. O. Box 340308
Hartford CT 061343-0308


Janice E. Wojick, Hearings Liaison