STATE OF VERMONT
SECRETARY OF STATE
OFFICE OF PROFESSIONAL REGULATION
BOARD OF NURSING

In re: Jason Barnhart **Docket No. 2019-144**
License No. 025.0134196

DECISION AND ORDER ON ALLEGATIONS OF UNPROFESSIONAL CONDUCT

Board of Nursing

Ellen Watson, APRN, Chair
Krystal Bernier, LPN
Daniel Coane, public member
Jennifer Laurent, APRN
Kelly Sinclair, LNA
Deborah Swartz, RN
Wendy Thurston, RN
William White, Jr., public member

Appearances:

Jennifer B. Colin, Esq., Prosecuting Attorney
Douglas Sutton, RN, Investigative Team
Respondent Jason Barnhart did not appear

Presiding Officer:

Michael S. Kupersmith, Esq., Administrative Law Officer

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

Introduction

This matter came before the Board of Nursing on Specification of Charges filed by the State on September 23, 2019. The hearing was held on October 12, 2020 and was conducted remotely pursuant to the Emergency Rules for Remote Hearings adopted by the Office of Professional Regulation (OPR). Jennifer B. Colin, Esq. Prosecuting Attorney, appeared for the State. Respondent Jason Barnhart did not appear.

Findings of Fact

After hearing, the Board finds that the following facts have been proved by a preponderance of the evidence.

1. Jason Barnhart (Respondent) is licensed by the State of Vermont as a Licensed Practical Nurse (LPN) under license number 025.0134196. The license was first issued on April 4, 2018.

2. Respondent was employed as an LPN at The Meadows at East Mountain Assisted Living Community ("Facility") in Rutland, Vermont starting on or about March 4, 2019.

3. During a certain week in March 2019, Respondent was assigned to work as a charge nurse in a dementia unit at the Facility. At this time, another employee, D.M., a medical technician, was also assigned to work on the same unit. As such, Respondent was a supervisor of D.M. D.M. had worked at the Facility for almost three years. She did not know Respondent prior to his employment by the Facility. Respondent was involved in three incidents involving D.M.

4. The first incident occurred at about 6:00 one morning when D.M. was seated at the unit's nurses' station. Respondent was seated when Respondent came up behind her and put his hand down the back of shirt, "almost to [her] bra strap." He made a comment to the effect of, "My hands are cold, aren't they?" D.M. was uncomfortable with this gesture, but laughed it off. The gesture appeared to be intentional; Respondent did not apologize.

5. The second incident occurred just after breakfast on another morning. The residents had finished eating and there were some link sausages left over. D.M. was standing near the nurses' station when J.B. approached and said something like, "I have enough sausage for [D.M.] to go around," and laughed. D.M. thought this was particularly inappropriate because there were residents as well as co-workers within earshot. The remark made D.M. feel very uncomfortable.

6. The third incident occurred on another day at the end of a double shift worked by D.M. (Respondent had also worked a double shift.) D.M. was standing at the nurses' station when Respondent came up behind her and "grazed" her backside with his hand. He made a statement like, "I can't get any work done with [D.M.] around with her ass." Respondent treated his touching and remark as a joke. He did not apologize or indicate that it had been an accidental touching. The incident occurred in the presence of two other employees. D.M. felt demeaned to the extent that she did not want to come back to work.

7. A day or two after the last incident, D.M. reported Respondent's conduct to the director of nursing at the Facility. Respondent's employment was terminated by the Facility that day.

Conclusions of Law

The State has alleged three charges of unprofessional conduct. Based upon the pleadings and the evidence presented, The Board concludes that the State established the three violations alleged.

On three occasions within a single week—and in the early stages of Respondent's employment by the Facility—the Respondent engaged in sexual harassment of a co-worker who was his subordinate. In the first incident, he placed his hand down the back of his subordinate's shirt, almost to her bra strap. In the second, he made a degrading sexualized remark aimed at her in her presence and in the presence of others. In the third, he rubbed her buttocks with his hand. Each of these acts was uninvited, unwarranted, inappropriate, and demeaning.[1]

> **Violation One:** 3 V.S.A. § 129a(b): Failure to practice competently by reason of any cause on a single occasion or on multiple occasions may constitute unprofessional conduct, whether actual injury to a client, patient, or customer has occurred. Failure to practice competently includes: . . . (2) failure to conform to the essential standards of acceptable and prevailing practice.

The essential standards of acceptable and prevailing practice require that a professional refrain from unwarranted and uninvited touching of a co-worker—especially of a subordinate. This is particularly true of any kind of sexualized touching. Inserting one's hand down the back of another's shirt and grazing another's buttocks involves intimate areas of another's body and is unacceptable conduct for any individual, let alone a professional. Similarly, the essential standards of acceptable and prevailing practice require that a professional refrain from making sexually suggestive remarks to a co-worker (as well as anyone else while on duty). The Board concludes that the conduct established by the evidence constitutes a clear failure to practice nursing competently.

> **Violation Two:** 3 V.S.A. § 129a(a)(15): Failing to exercise independent professional judgment in the performance of licensed activities when that judgment is necessary to avoid action repugnant to the obligations of the profession.

The obligations of the nursing profession require that nurses observe the dignity and integrity of all persons with whom they interact, whether they be patients, co-workers, staff, or the public at large. The Respondent's conduct during the course of his professional duties violated both the dignity and bodily integrity of a subordinate and constituted a gross failure to appropriately exercise independent professional judgment. As a consequence of his poor

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[1] Though not in issue here, the Board notes that Respondent's conduct could, in another forum, be the basis of a determination that D.M. had been subjected to a hostile work environment. See generally, *In re Grievance of Butler*, 166 Vt. 423 (1997).

> This is not a case of outright and blatant discrimination based on gender; hostile environment cases seldom are. They are based, as this case demonstrates, upon the accretion of seemingly small incidents—of being criticized more harshly, scrutinized more closely, ridiculed for lack of aggression, or diminished for one's appearance, that in the aggregate create an environment of hostility and discrimination. . . .

Id. at 430.

judgment, he engaged in conduct which was clearly repugnant to the obligations of the nursing profession.

Violation Three: 26 V.S.S. § 1582(a)(3): Engaging in conduct of a character likely to deceive, defraud, or harm the public.

D.M. testified that Respondent's conduct made her feel uncomfortable. The third incident made her feel demeaned to the extent that she did not want to return to work. D.M.'s reactions to Respondent's conduct was objectively reasonable under any standard. Respondent's conduct was not only likely to cause harm to the public, but actually caused harm to D.M.'s psyche.

ORDER

I. Respondent's license is hereby ***reprimanded.***

II. Respondent's license is hereby ***suspended indefinitely.***

III. Respondent may apply for reinstatement of his license when he meets the following conditions.

A. Within ninety (90) days of his application for reinstatement, Respondent must obtain an independent evaluation with a written report from a forensic psychologist who is preapproved by the Case Manager of the Board of Nursing. The evaluation and report must a statement of Respondent's fitness to practice nursing supported by a detailed written synopsis of gathered history, reviewed documents and information, assessment tools utilized, diagnosis, treatment recommendations and practice conditions. The evaluator must also verify receipt and review of this Order in the report.

B. Respondent must provide proof of satisfactory completion of the following continuing education courses preapproved by the Board of Nursing Case Manager: (1) professional boundaries; (2) professional ethics; (3) sexual harassment.

C. The Board of Nursing reserves the right to ***condition*** Respondent's license on whatever terms the Board finds reasonable at the time of Respondent's reinstatement request, taking into account the independent evaluation, the facts set forth above, and any other information the Board deems relevant.

D. This Order is a matter of public record and may be reported to other licensing authorities as provided in 3 V.S.A. § 129(a)(6).

It is SO ORDERED:

E-SIGNED by Ellen Watson
on 2020-10-19 14:03:28 EDT

Board of Nursing
By: Ellen Watson, APRN, Chair

Date of Entry: 10/19/2020

APPEAL RIGHTS

This is a final administrative determination by the Vermont Board of Nursing. A party aggrieved by a final decision by the Board may appeal this decision by filing a written Notice of Appeal with the Director of the Office of Professional Regulation, Office of Professional Regulation, 89 Main St., 3rd floor, Montpelier, VT 05620-3402, within 30 days of the entry of this Order. If an appeal is filed, the Director of the Office of Professional Regulation shall assign the case to an Appellate Officer. The review shall be conducted on the basis of the record created before the Board. In cases of alleged irregularities in procedure before the Board, not shown in the record, proof on that issue may be taken by the Appellate Officer. 3 V.S.A. §§ 129(d) and 130a. A stay may also be requested.