STATE OF VERMONT
BOARD OF NURSING

In re: Lenny Lee Loizeaux Bennett License No. 026-12090	}	Docket No. 2009-64 NU88-0109

Decision on
UNPROFESSIONAL CONDUCT CHARGE

Participating Board Members:
Alan Weiss
Sandra Norton, LNA
Donarae Metcalf, LPN
William G. White Jr.
Deborah Robinson, RN
John Todd, APRN
De-Ann Welch, LPN[1]

Decision on Unprofessional Conduct Charges

Appearances:
for Petitioner, State of Vermont: Betsy Ann Wrask
for Respondent: Cynthia L. Broadfoot

Presiding Officer: Larry S. Novins

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

The Vermont Board of Nursing held a hearing in the above matter on April 12, 2010 at the National Life Building in Montpelier, Vermont.

The prosecution has the burden of proof in this matter. To prevail on any unprofessional conduct charge, it must prove the charge by a preponderance of the evidence.

Background

The prosecution alleges in its Specification of Charges that in violation of Vermont unprofessional conduct statutes Ms. Bennett failed to return telephone calls in a timely manner, and was untimely in the documentation of patient care, visits, or their absence. Before any

[1] Board member Welch had to leave the hearing before the evidence concluded. She did not participate in the deliberations leading to this Decision.

evidence was offered, the State dismissed its allegation that Ms. Bennett violated 26 V.S.A. § 1582(a)(3).

Findings of Fact

Based on the evidence presented, the Board finds as follows:

1. Ms. Bennett is licensed as a registered nurse and is therefore subject to the regulatory authority of this Board. 3 V.S.A. §§ 129, 129a, 26 V.S.A. § 1582(a), the Administrative Rules of the Board of Nursing, and the Rules of the Office of Professional Regulation.
2. At all times relevant to the allegations of unprofessional conduct Ms. Bennett was employed as a registered nurse by the Visiting Nurse Association (V.N.A.) in Colchester, Vermont. Her job was as a CFC nurse supervisor.
3. Ms. Bennett has been a nurse for thirty seven years. She has no prior disciplinary record.
4. Ms. Bennett was described as a skilled clinical nurse, the "go to"person for clinical questions at the V.N.A..
5. As part of her 2005 annual review Ms. Bennett admitted that she had been behind in her evaluations, renewing care plans and returning phone calls. Phone calls should be returned at the end of a shift or as soon as possible thereafter. It is important to return calls so know if things are safe in a patient's home. Ms. Bennet said that being behind didn't necessarily mean not being timely.
6. Ms. Bennett did make an effort and showed improvement in "customer service." She continued to struggle with "calling others" with updates.
7. In her annual review covering the period between December 2005 and November 2006 three or four of her twenty-four patient plans were out of date. Exhibit 5. Care plans were not always completed. Some were missing PCA signatures. Ms. Bennett denied that getting the PCA signatures was one of her responsibilities. It was.
8. When a patient visit did not occur (the patient's family did not want it), Ms. Bennett did not document the reasons. The same audit showed that her care plans were not always completed with some lacking the PCA signatures. Ex. 5.
9. In the review of Ms. Bennett's 2007 job performance on December 19, 2007, Ex. 6, Ms. Bennett admitted that she continued to struggle with calling others with updates "as opposed to continuing to work on an issue and just call when the issue is resolved." Ex. 6. We note that at this time Ms. Bennett was described as being a "very supportive co-worker often thinking of others." In 2007 some of Ms. Bennett's case load was transferred to others make it "more manageable" for her. Goals and issues for her to address in the coming year included "complete telephony care plans for all clients." In 2007 record keeping was being transitioned from paper to computer kept records.
10. On December 19, 2007, two days after her annual review, Ms. Bennett was seriously injured in an automobile accident. Her work schedule was changed to help accommodate her limitations during her recovery.
11. In 2008 about the time a new supervisor assumed supervision of Ms. Bennet, her evaluations began to decline. Ms. Bennett contended that the evaluations were the result of conflicts between her and the supervisor. Ms. Bennett had complained about the new supervisor. While some conflict may have contributed to the supervisor's complaints

against Ms. Bennett, the conduct Ms. Bennett admitted shows that she did not meet all her responsibilities at her V.N.A. job.

12. The supervisor L.R. testified and her testimony was credible.

13. By August 2008 Ms. Bennett's problems with returning phone calls were again addressed, this time before the yearly evaluation. Exhibit 7. Several people reported to Ms. Bennett's supervisor that she was not returning telephone calls promptly. These calls included ones from PCA's about patients and one relayed from a patient's family member who said he was unable to get a return call from Ms. Bennett. Ms. Bennet thought others were more concerned about the "perception" of her not returning calls than the reality. She felt the calls were returned in a reasonable manner which she said she documented.

14. Care plans created by the nurse are central to client care and PCA services performed. Inaccurate care plans inhibit the ability of PCA's to perform safe care. The evaluation stated that Ms. Bennett's care plans were "chronically deficient," which was considered "unacceptable." Care plans must be reviewed yearly and changed with the facts warrant.

15. Through 2008 Ms. Bennett continued to have inaccurate care plans in the home. The evaluation stated that Ms. Bennett's care plans were "chronically deficient," which was considered "unacceptable." It was noted that in auditing four random charts, two of these had missed visits, which was stated to be unacceptable. Ms. Bennet pointed out that "missed visits" means visits that did not occur, often because the patient did not wish the visit to happen at the time selected. Ms. Bennett did forget sometimes to document when visits were made or explanations for why visits were not made. She was not adequately documenting all activities in a timely manner. She did not feel that her plans were "chronically deficient." Her supervisor felt that they were. We find that enough were late or deficient record entries to show that Ms. Bennet was not keeping the records in a consistently competent manner.

16. Ms. Bennett pointed out that PCA's were sometimes changed without her knowledge. There had been a new scheduling procedure at the V.N.A.. However, the communication problems remain attributable, to some extent to Ms. Bennet.

17. The evaluation stated that Ms. Bennett "failed to work constructively with the scheduling team to efficiently staff her clients [sic] care needs." Schedulers were noted to have had little communication with Ms. Bennett regarding her client's care needs.

18. During 2008 Ms. Bennett showed dramatic improvement in returning phone calls.

19. Ms. Bennett admitted that some of her care plans were not updated daily. She admitted also that there had been a few instances where she had forgotten to document that she made a visit and/or the client and/or the client refused a visit. Ms. Bennett admitted that she was not always timely with documentation if a client refused a visit.

20. Documentation is an essential part of Ms. Bennett's work as a V.N.A. nurse. Returning phone calls is also an essential nursing responsibility for Ms. Bennett's nursing duties. It is necessary for state funding purposes and tracks whether the care givers were there and provide the appropriate care.

21. Conducting timely visits to verify that patients obtain the correct treatment is essential to patient safety. Performing these activities in a timely manner is an essential standard of practice.

22. When it appeared to Ms. Bennett's supervisor that Ms. Bennett's documentation and other problems had persisted longer than the V.N.A. could tolerate, Ms. Bennett was

asked to resign her position. She refused to do so. The V.N.A. discharged her. Under 3 V.S.A. § 128 that termination triggered a V.N.A. obligation to file a report with this Board. But for that legal obligation, the V.N.A. would not have reported Ms. Bennett.

23. Ms. Bennett's problems with her duties at the V.N.A. appear to have been unique to that position. As noted before, Ms. Bennett's individual patient clinical skills were never questioned.

Conclusions of Law

Based on the evidence presented and Facts found above we conclude as follows:

1. **Re: Alleged Violation of 3 V.S.A. § 129a(b)(1) and (2)**: The State has proved by a preponderance of the evidence that Ms. Bennett failed to practice competently. We find that Ms. Bennett's conduct as found above constitutes a failure to conform to the essential standards of acceptable and prevailing practice. This is unprofessional conduct.

2. **Re: Alleged Violation of 26 V.S.A. § 129a(a)(3)**: 3 V.S.A. § 129a(a)(3) defines unprofessional conduct to include failing to comply with provisions of federal or state statutes or rules governing the practice of the profession. Any allegation of failure to comply with statutes or rules has been addressed above. This statute does not provide an independent grounds for discipline. There is no violation of this statute. This charge is dismissed.

Discussion

As we found above, Ms. Bennett's problems led to her termination and the resulting notification to the Board. But for the V.N.A.'s legal obligation to report, the Board would have been unaware of the V.N.A. complaints of Ms. Bennett's conduct while she worked there. This Board is obligated to address cases brought before it and to respond when the evidence shows that essential or prevailing standards of practice have not been achieved. This decision and the sanction we impose reflects our response to the unique facts of this case.

Order

For the violations above, to protect the public, health, safety and welfare, the following sanction is necessary.

Ms. Bennett's license is **warned.**

APPEAL RIGHTS

This is a final administrative determination by the Vermont Board of Nursing. A party aggrieved by a final decision of a board may appeal this decision by filing a written Notice of Appeal with the Director of the Office of Professional Regulation, Vermont Secretary of State, Office of Professional Regulation, National Life Bldg., North, FL2, Montpelier, Vermont

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.

To request a stay of the Board's decision, please refer to the attached stay instructions.

Vermont Board of Nursing

By: _____
John Todd, APRN

Date April 16, 2010

OFFICE OF PROFESSIONAL REGULATION

DATE OF ENTRY: 4/21/10