

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

IN RE:

JUDITH BLISS

License No. 025.0007196

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Docket No. 2010-458(NU)

STIPULATION AND CONSENT ORDER

STIPULATION

NOW COME the State of Vermont, by and through State Prosecuting Attorney S. Lauren Hibbert, and the Respondent, Judith Bliss, LPN, who stipulate and agree as follows:

Board Authority

1. The Vermont State Board of Nursing (the "Board") has authority to issue warnings or reprimands; suspend, revoke, limit, or condition current licenses; or prevent the renewal of lapsed licenses if, after disciplinary hearing, the Board finds that the Respondent has engaged in unprofessional conduct. 3 V.S.A. § 129(a); 3 V.S.A. § 129a; 3 V.S.A. § 814(d); 26 V.S.A. § 1582; the Administrative Rules of the Board of Nursing (the "ARBN"); and the Rules of the Office of Professional Regulation.

Stipulated Facts

2. Judith Bliss (the "Respondent") of Whiting, Vermont is licensed by the State of Vermont as a Licenses Practical Nurse ("LPN") under license number 025.0007196. This license was originally issued on or about February 22, 1995 and expired on or about January 31, 2012.
3. At all times relevant, Respondent was employed as an LPN at Porter Healthcare and Rehabilitation Center in Middlebury, Vermont.
4. On or about August 5, 2010 the Office of Public Regulation received a Report of Unprofessional Conduct from H.Q., Director of Nursing at the Facility, alleging that Respondent provided inappropriate nursing care on four separate occasions and that she was terminated for that conduct on or around July 28, 2010.
5. On or about August 5, 2010, within her Report, H.Q. stated that on or around May 10, 2010, N.S., Memory Care Unit Director, received a call from the son of a resident after he had received eleven (11) messages on his answering machine from his mother in which she berated him for leaving her at the Facility. At that time the Respondent told N.S. that she helped the patient make these calls.

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6. On or about October 28, 2010, in an email to State Investigator Karl Packer, the Respondent stated that she attempted to keep the resident from the phone; however, she was not successful and she did leave the son messages several times stating that his mother wanted to talk to him.

7. On or about August 5, 2010, within her Report, H.Q. stated that on or around May 11, 2010, N.S. received a call from the daughter whose mother is a resident. The daughter advised that she had received a call from her father stating that he had made his daily call to ask how the patient, his wife, was doing and Respondent told the father that the patient was being "a real bitch." When the daughter called to confront Respondent over the comment, Respondent told the daughter that she said "witchy."

8. On or about October 28, 2010, in an email to Investigator Packer, the Respondent stated that she was "too close" to the father and at the time thought they had an informal relationship where her comments would be appropriate; however, she admitted that she crossed a professional line.

9. On or about August 5, 2010, within her Report, H.Q. stated that on or around July 11, 2010 Respondent failed to assist another LNA dealing with an agitated patient because she was already helping a patient who had fallen and did not want to ask for help so that she could leave to assist the LNA. The patient became so agitated that he had to be injected with Haldol. The Report indicated that this could have been avoided if Respondent had prioritized appropriately and asked for assistance.

10. On or about October 28, 2010, in an email to Investigator Packer, the Respondent stated that the agitated patient's behavior was routine and that she did ask for help from B.F, another LPN. She describes the fallen patient's condition as severe and requiring assistance from two doctors and warranting family notification. The Respondent stated that she feels that the situation was handled appropriately.

11. On or about August 5, 2010, within her Report, H.Q. stated that on or around July 25, 2010, the Respondent was providing care to a patient with a fractured arm. The patient was reporting pain of "7 out of 10" and the patient's records indicated that the Respondent did not give the patient appropriate pain management care because she did not document that she repositioned the patient and the amount of Acetaminophen she gave the patient. Additionally, according to H.Q., given the patient's pain level the Respondent should have communicated with a doctor so that adequate pain relief could be administered.

12. On or about October 28, 2010, in an email to Investigator Packer the Respondent stated that when the patient arrived she did express her discomfort as a "7" so the Respondent gave the patient Tylenol after repositioning her. She stated she administered two Tylenol; however, this is not documented in the medical records. Additionally, the Respondent stated that when she checked on the patient later in the evening the patient

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was sleeping and therefore, the Respondent felt that the pain has subsided. Respondent stated that the patient died four days after the incident.

13. On or around May 5, 2011, in an interview with Investigator Packer, Licensed Practical Nurse B.F. stated that on or about July 11, 2010, the only assistance she gave the Respondent was retrieving injectable Haldol for the resident that was agitated.

14. Respondent has committed unprofessional conduct because she performed unsafe patient care when she allowed a resident to make outgoing calls that were in contradiction to that resident's care plan, when she failed to adequately prioritize patients, when she did not properly give pain management care and by engaging in harmful behavior, not conforming to the essential standards of suitable care, and failing to comply with the rules governing the practice of the profession.

Violations

15. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because the Respondent has committed unprofessional conduct in violation of:

- a. 3 V.S.A. § 129a(a)(3) (Failing to comply with provisions of federal or state statutes or rules governing the practice of the profession); and,
- b. 3 V.S.A. § 129a(b)(1) and (2) (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: (1) performance of unsafe or unacceptable patient or client care; or (2) failure to conform to the essential standards of acceptable and prevailing practice).

Understandings

16. Respondent admits the facts above are true and that the conditions below are necessary to protect the public.
17. Respondent understands that the Nursing Board must review and accept the terms of the Consent Order. If the Board rejects any portion, the entire Stipulation and Consent Order shall be null and void.
18. Respondent specifically waives any claims that any disclosures made to the full Board during its review of this agreement have prejudiced her rights to a fair and impartial hearing in future hearings if this agreement is not accepted by the Board.
19. Respondent has read and reviewed this entire document and agrees that it contains the entire agreement between the parties.

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20. Respondent is not under the influence of any drugs or alcohol at the time she signs this Stipulation and Consent Order.
21. Respondent voluntarily enters into this agreement after the opportunity to consult with legal counsel and is not being coerced by anyone into signing this Stipulation and Consent Order.
22. Respondent voluntarily waives her right to a contested hearing before the Board of Nursing and waives any right to appeal from this Stipulation and Consent Order.
23. Respondent agrees that the Order set forth below may be entered by the Board.

ORDER

Based on the Stipulation above, it is **ORDERED AND ADJUDGED** as follows:

- A. The Board of Nursing hereby **WARNS** the Respondent's license to practice nursing. Within ninety (90) days of the entry of this order the Respondent must complete the following:
 - (1) Professional Boundaries Course.
Respondent must successfully complete (i.e., receive a passing grade, if applicable) a professional boundaries course with prior approval by the Board or its designee, and then submit written documentation of completion (certificate of completion, etc.) to verify the same to the satisfaction of the Board or its designee.
 - (2) Documentation Course.
Respondent must successfully complete (i.e., receive a passing grade, if applicable) a documentation course with prior approval by the Board or its designee, and then submit written documentation of completion (certificate of completion, etc.) to verify the same to the satisfaction of the Board or its designee.
- B. The Respondent must continue to meet all Nursing Board requirements for maintaining a license, license renewal and license reinstatement.
- C. This Stipulation and Consent Order is a matter of public record and may be reported to other licensing authorities as provided in 3 V.S.A. § 129(a).
- D. This Stipulation and Consent Order will remain part of Respondent's licensing file and may be used for purposes of determining sanctions in any future disciplinary matter.

AGREED TO:

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SECRETARY OF STATE

Dated: 11/3/11

By: S. Lauren Hibbert
S. Lauren Hibbert
State Prosecuting Attorney

JUDITH BLISS
RESPONDENT

Dated: 10/17/11

By: Judith Bliss
Judith Bliss
ATTORNEY FOR RESPONDENT

APPROVED AS TO FORM:

Dated: 11/1/11

By: Judy Barone, Esq.
Judy Barone, Esq.

APPROVED AND SO ORDERED:

VERMONT BOARD OF NURSING

Dated: 11/14/11

By: Janine Cain
Chairperson

Date of Entry: 11/16/11

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