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

IN RE:	)	
Melissa S. Chenier	)	**Docket No. 2020-38**
License No. 026.0067409	)	

STIPULATION AND CONSENT ORDER

STIPULATION

NOW COME the State of Vermont, by and through Prosecuting Attorney Jennifer B. Colin, and Respondent Melissa S. Chenier, by and through her counsel Paul D. Jarvis, Esq., who hereby 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; 3 V.S.A. §129a; 3 V.S.A. §814(d); 26 V.S.A. Chapter 28; the Administrative Rules of the Board of Nursing (the "ARBN"); and the Rules of the Office of Professional Regulation ("OPR").

Stipulated Facts

2. Melissa S. Chenier ("Respondent") of Williston, Vermont is licensed by the State of Vermont as a Registered Nurse ("RN") under license number 026.0067409. This license was originally issued on June 17, 2010 and expires on March 31, 2021.

3. During the relevant time, Respondent was employed as an RN at University of Vermont Medical Center in Burlington, Vermont ("Facility").

4. Respondent worked at the Facility from June 2016 to June 2018.

5. The Facility terminated Respondent's employment in June 2018 after Respondent displayed a pattern of conduct that included denying patient care, being confrontational with patients, not listening and responding appropriately to patient requests and concerns, and in at least one documented instance physically hurting a patient by forcing movement in the patient's arm in an attempt to prove a point.

6. In August 2017, Respondent received discipline from the Facility as the result of her first and only interaction with a patient ("Patient 1").

7. Patient 1 was a female patient with a history of pulmonary embolism.

8. In late July 2017, Respondent went to Patient 1's room in order to administer Patient 1's morning medications, which included a scheduled pain medication.

9. Respondent desired to perform a lung assessment using a stethoscope to listen to Patient 1's breathing prior to administering Patient 1's medications.

10. Patient 1 was not in any respiratory distress.

11. The lung assessment was not required as a prerequisite to the administration of Patient 1's medications.

12. When Respondent asked Patient 1 to take deep breaths, Patient 1 was trying to speak with Respondent, but Respondent claimed she could not hear what Patient 1 was saying due to the use of the stethoscope.

13. However, Respondent also understood that Patient 1 was indicating during the assessment that she was unable to take the deep breaths due to pain.

14. Patient 1 attempted to speak with Respondent multiple times during the assessment and Respondent indicated to Patient 1 each time that Respondent was not able to hear due to the use of the stethoscope, rather than removing the stethoscope from her ears.

15. As Respondent continued with the exam, Patient 1 leaned back in bed and Respondent applied pressure to Patient 1's left shoulder to prevent Patient 1 from leaning back.

16. When Patient 1 raised her tone in response, Respondent removed the stethoscope from her ears. Patient 1 instructed Respondent not to touch her again and stated that she was in pain and Respondent had grabbed her arm.

17. Respondent told Patient 1 that she had Patient 1's morning medications, which included pain medications and, if Patient 1 did not allow the assessment, then Respondent would not be able to administer the medications. Respondent also insisted that she [Respondent] did not grab Patient 1's arm.

18. Patient 1 stated she would leave the Facility if she did not get her morning medications, to which Respondent told the patient that she had the right to leave.

19. Respondent left Patient 1's room without administering the ordered medications when Patient 1 continued in her refusal to let Respondent do the exam.

20. Respondent returned a short time later to find out if Patient 1 was ready for the assessment. Patient 1 again refused, yelling that she did not want Respondent as her nurse.

21. Respondent did not administer Patient 1's medications as ordered.

22. The Facility issued written discipline to Respondent for the above-described patient interaction and required her to engage in additional training.

23. In December 2017, Respondent provided care to a patient, R.B. ("Patient 2").

24. On December 1, 2017, an LNA reported to Respondent that Patient 2 was in pain and that the family was requesting Automatic Positive Airway Pressure (APAP).

25. Patient 2 was audibly heard at the nurse's station moaning and calling out in pain.

26. Respondent stated to the LNA that she did not have time for attending to the patient, the family could wait, and "they're annoying me."

27. Respondent did not ask for assistance with providing care to Patient 2.

28. Another nurse stepped in and assisted with medication administration for Patient 2's comfort.

29. In March 2018, Respondent provided care to a female patient who was in a bariatric bed and had no use of her left arm ("Patient 3").

30. Patient 3 requested that Respondent change the TV channel.

31. Respondent insisted that Patient 3 try to push the button for the TV for herself.

32. Patient 3 tried to push the button for the TV, was unable to do so, and told Respondent.

33. Respondent did not change the channel and instead turned Patient 3's TV off, moved the TV and left Patient 3's room after instructing another staff member to not turn on Patient 3's TV.

34. Respondent returned to Patient 3's room a few minute later and said, "can we try again and can you say please," which was upsetting to Patient 3, who stated she felt like Respondent treated her like a child.

35. When Respondent was counseled about her interaction with Patient 3, Respondent stated that the patient never said please and that she [Respondent] is a nurse and not a servant.

36. The Facility gave Respondent a Final Written Warning on March 26, 2018 due to the situation with Patient 3 described above, as well as various other instances of inappropriate interactions with patients and their families and/or colleagues.

37. In the Final Written Warning, Respondent was disciplined by the Facility, was offered guidance from her supervisors about the situations described above and was required to take Emotional Intelligence Training and Crucial Conversations training.

38. In April 2018, Respondent provided care to Patient 4, a male patient with Huntington's Disease, which is a progressive brain disorder, and paraplegia resulting in Patient 4 only having the ability to move his left upper extremity enough to use a tap call bell.

39. Patient 4 required frequent repositioning and had orders for turns every two hours.

40. Due to the Huntington's Disease, Patient 4 displayed inappropriate anger, verbal aggression and lashing out over which Patient 4 had no control.

41. Patient 4's admission notes included strategies for preventing angry outbursts such as: "avoid direct confrontation and adopt a helpful stance," "make sure basic needs are met," "TV on," "Call bell within reach," and "drinks offered regularly."

42. On April 6, 2018, Respondent improperly refused to provide care to Patient 4 and removed his call bell to punish Patient 4 for an angry outburst.

43. Respondent's notes indicate when Respondent asked Patient 4 if he wanted to be turned, Patient 4 lashed out, did not permit the turn, but did allow a boost up in bed.

44. Respondent's note's continued: "Pt has rang [sic] call bell numerous times each hour, at least 4-6 times per hour for last 2-3 hours, often for minor things like changing channel 5 times while in room and turning different fans on/off or up/down. Pt rang before change of shift, this RN was going through the five P's to ensure all needs are met and to limit # of calls when pt became demanding re: drink (we had finished all in his room) and activated emergency staff light as RN left the room. Call bell removed by this RN when went back in to cancel call bell as pt kept pushing when RN was trying to cancel. As it was given back to pt, he called this writer 'a stupid fucking cunt', [sic] as I left the room, pt advised we will not be coming back until after change of shift or during report due to this outburst."

45. In May 2018, Respondent provided care to Patient 5, a female patient who had an infection that caused her pain in her neck and left arm and poor range of motion in her left arm.

46. While Respondent was providing care to Patient 5, Patient 5 requested help from Respondent to roll her head up by pushing a button to adjust the bed.

47. Respondent told Patient 5 to try to reach the buttons to adjust the bed for herself.

48. When Patient 5 responded that she was not able to reach the buttons due to her poor range of motion in her left arm, Respondent grabbed Patient 5's left arm and pulled it to the location of the buttons to adjust the bed.

49. The movement caused pain to Patient 5, who yelled "Ouch!" and told Respondent to go away.

50. Respondent then said to Patient 5 words to the effect of, "you can't tell me you can't do that."

51. The Facility terminated Respondent on June 8, 2018.

52. Soon after Respondent was terminated from the Facility, she was hired by Bayada Hospice, which is part of the Bayada Home Health Care network.

53. Respondent's current position with Bayada is a home health care position.

54. Respondent's patient load is much lower than when she worked at the Facility. She generally has between 10 and 20 patients on her caseload at a given time.

55. Presently Respondent sees sixteen patients, most of whom reside in a facility. Only about 1/3 of Respondent's patients live in a private residence.

56. Respondent's supervisor accompanies her on home visits once every six months to monitor and evaluate her performance.

57. Respondent's supervisor is supportive of Respondent's continued work in home health for Bayada, stating that families and facilities have praised Respondent's work and that Respondent has been awarded the Bayada Hero Award, which is the highest award for nurses employed by Bayada.

58. Respondent states her current position is much less stressful and pressured than working at the Facility, due in large part to the lower caseload.

Violation One: 3 V.S.A. §129a(b)(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 care.

59. Paragraphs 2 through 51 above are incorporated herein.

60. As an RN, Respondent is required to perform safe and acceptable patient care.

61. Paragraphs 5 through 51 above demonstrate that Respondent failed to perform safe and acceptable patient care on multiple occasions when she: failed to administer medications to Patient 1, failed to listen to Patient 1, and physically handled Patient 1 in a manner that caused her unnecessary pain; failed to provide care to Patient 2; treated Patient 3 in a disrespectful manner; refused to provide care for Patient 4 and moved his

call bell so that he was unable to request care; and refused to move Patient 5's bed and pulled her arm unnecessarily causing pain.

62. 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 3 V.S.A. §129a(b)(1).

Violation Two: 3 V.S.A. §129a(b)(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: (2) failure to conform to the essential standards of acceptable and prevailing practice.

63. Paragraphs 2 through 51 above are incorporated herein.

64. The essential standards of acceptable and prevailing practice require that an RN treat patients with respect and dignity.

65. Paragraphs 5 through 51 above demonstrate that Respondent failed to conform to the essential standards of acceptable and prevailing practice when she failed to treat Patients 1, 3, 4, and 5 with respect and dignity in her interactions with them.

66. The essential standards of acceptable and prevailing practice require an RN to administer medications as ordered.

67. Paragraphs 5 through 21 above demonstrate that Respondent failed to adhere to essential standards of acceptable and prevailing practice when she failed to administer medications to Patient 1.

68. The essential standards of acceptable and prevailing practice require an RN to physically handle patients in a careful and prudent manner, taking into account patients' medical conditions.

69. Paragraphs 5 through 21 and 45 through 50 demonstrate that Respondent did not physically handle Patients 1 and 5 in a careful and prudent manner taking into account their medical conditions and thereby causing them unnecessary pain.

70. The essential standards of acceptable and prevailing practice require an RN to provide patient-centered care.

71. Paragraphs 5 through 51 above demonstrate that Respondent engaged in a pattern and practice of failing to provide patient-centered care, as demonstrated by her interactions with Patients 1, 2, 3, 4, and 5.

72. 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 3 V.S.A. §129a(b)(2).

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

73. Paragraphs 2 through 51 above are incorporated herein.

74. As an RN, Respondent is required to refrain from engaging in conduct of a character likely to deceive, defraud, or harm the public.

75. Paragraphs 5 through 51 demonstrate that Respondent engaged in conduct of a character likely to deceive, defraud, or harm the public on multiple occasions with numerous patients by physically handling patients in a careless manner, by failing to provide appropriate care for patients, by removing a patient's call bell, by failing to administer medications as ordered, and by treating patients with disrespect.

76. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent committed unprofessional conduct of a character likely to deceive, defraud, or harm the public in violation of 26 V.S.A. §1582(a)(3).

Violation Four: 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.

77. Paragraphs 2 through 51 above are incorporated herein.

78. As an RN, Respondent is required to exercise her own independent professional judgment in the performance of licensed activities when that judgment is necessary to avoid action repugnant to the obligations of the profession.

79. Paragraphs 5 through 51 demonstrate that with multiple patients over time Respondent failed to exercise independent professional judgment on multiple occasions by engaging in the conduct described above.

80. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent committed unprofessional conduct in violation of 3 V.S.A. §129a(a)(15).

Understandings JBC

81. Respondent admits that the facts above are substantially true and that the conditions below are necessary to protect the public.

82. 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.

83. 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.

84. Respondent has read and reviewed this entire document and agrees that it contains the entire agreement between the parties.

85. Respondent is not under the influence of any drugs or alcohol at the time she signs this Stipulation and Consent Order.

86. 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.

87. 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.

88. 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 **REPRIMANDS** Respondent's license.

B. The Board of Nursing hereby **CONDITIONS** Respondent's license **FOR A MINIMUM OF ONE (1) YEAR**. The conditions will be as follows:

1. Re-issuance of License. Upon the commencement of these conditions, Respondent shall be issued a license labeled "conditioned."

2. Length of Time of Conditions Imposed. The conditions shall remain in place until Respondent has completed all conditions ordered. Respondent shall be subject to the conditions until Respondent completes **a minimum of one (1) year** of supervised practice in which Respondent works at least forty (40) hours every two (2) weeks as a registered nurse. Part time hours of fewer than forty (40) hours every two (2) weeks shall be credited on a prorated basis. Respondent shall be prohibited from working more than forty (40) hours per week.

3. Required Coursework. Respondent shall, at her own expense and within ninety (90) days of the date of entry of this Stipulation and Consent Order, successfully complete (i.e., receive a passing score, if applicable) the following pre-approved online courses

from the National Council of States Boards of Nursing (NCSBN) (or equivalent that are pre-approved by the Enforcement Case Manager) and submit test results, completed workbooks and certificates of completion to the Office of Professional Regulation:
a. Ethics of Nursing Practice (4.8 hours)
b. Sharpening Critical Thinking Skills (3.6 hours).

Failure to complete the course within the prescribed timeframe shall constitute a violation of this Order. The coursework may not be counted toward any continuing education requirement of licensure.

4. Notification to Employers/Nursing School. Respondent shall provide a copy of this Stipulation and Consent Order to all employers in any current or future setting in which Respondent practices as a licensed nursing assistant or nurse and inform them of Respondent's conditional license status. Within ten (10) days of the date of entry of this Consent Order or of any subsequent nursing employment, Respondent shall cause Respondent's immediate supervisor to submit to the Board an employer agreement form approved by the Board, acknowledging receipt of the Stipulation and Consent Order and the ability to comply with the conditions in the Consent Order.

   In the event Respondent is attending a nursing program which has a clinical portion that involves actual patient care, Respondent shall provide a copy of the Stipulation and Consent Order to the Program Director. Respondent shall cause the Program Director to submit to the Board a nursing program agreement form approved by the Board, acknowledging receipt of the Stipulation and Consent Order and the ability of the program to comply with the conditions in the Consent Order during clinical experience.

5. Reports from Employers/Program Director. Within one (1) month of the date of this order or within one (1) month of the commencement of nursing employment and **monthly** thereafter, Respondent shall cause every nursing employer Respondent has worked for during the month to submit to the Board an evaluation of Respondent's work performance and attendance during that month. In the event Respondent is attending a nursing program, Respondent shall cause the Program Director to submit to the Board, on a monthly basis, a written evaluation of Respondent's performance and attendance. These reports shall be submitted in writing on forms issued by the Board. All employer reports shall indicate satisfactory performance (i.e. consistently meeting all standards of nursing practice) and attendance.
   While Respondent is employed by Bayada Hospice, Respondent shall also cause her employer to also submit to the Board evaluations that occur every six months whereby Respondent's supervisor accompanies Respondent on home visits and monitors/assesses Respondent's performance.

6. Practice Under Supervision. In the event Respondent leaves her current position with Bayada Hospice during the conditional license period, Respondent shall practice as a registered nurse only in a setting where Respondent has direct supervision for the entire shift by a licensed registered nurse that is in good standing with the Board.

7. Types of Employment Prohibited. Respondent shall not work in a supervisory role. Respondent shall not work for a nurse registry, traveling nurse agency, float-pool, temporary nursing employment agency, or as a private duty. In the event Respondent leaves her current position at Bayada Hospice while this Order is in effect, Respondent shall not be permitted to work in home health until her license is restored to unencumbered status.

8. Completion of Conditioned License Period. After the conditioned license period, the Respondent may petition the Board to remove any and all conditions on her license. Respondent shall have the burden of proof to demonstrate successful completion of the above-stated conditions.

C. Notwithstanding any provision above, the Respondent must continue to meet all Nursing Board requirements for maintaining a license, license renewal and license reinstatement.

D. 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).

E. 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:

STATE OF VERMONT
SECRETARY OF STATE

Dated: 11/17/2020 By: /s/ Jennifer B. Colin

Jennifer B. Colin
Prosecuting Attorney

RESPONDENT

Dated: 11/9/2020 By: Melissa S. Chenier

APPROVED AS TO FORM:

COUNSEL FOR RESPONDENT

Dated: 11/10/2020 By:

Paul D. Jarvis, Esq.
Jarvis, McArthur & Williams
Attorney for Respondent

APPROVED AND SO ORDERED:

VERMONT BOARD OF NURSING

Dated: January 12, 2021

By: E-SIGNED by Ellen Watson on 2021-01-12 12:37:44 EST

Chairperson

Date of Entry: 1/11/2021