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

IN RE:	)	
DONNA G. JOHNSON	)	**Docket No: NU 59-0599**
License No. 026-0012334	)	

STIPULATION AND CONSENT ORDER

STIPULATION

NOW COME the State of Vermont, through Attorney General William H. Sorrell, and Respondent Donna G. Johnson, R.N. who stipulate and agree as follows:

Board Authority

1. The Board of Nursing jurisdiction includes investigation of complaints of unprofessional conduct and approval of consent orders pursuant to 3 V.S.A. §§129 and 129a, and 26 V.S.A. §§1574 and 1582.

2. The Board may base disciplinary action for any failure to comply with provisions of federal or state statutes or rules governing the practice of the profession. 3 V.S.A. §129a(a)(3).

3. The Board may base disciplinary action upon any failure to conform to the essential standards of acceptable and prevailing nursing practice. Administrative Rules of the Board of Nursing ("ARBN") Chapter 4, Rule IV(B)(2).

4. The Board may base disciplinary action upon any falsification or altering clinical records or making inaccurate or misleading entries. Administrative Rules of the Board of Nursing ("ARBN") Chapter IV, Rule IV(B)(4)(c).

Facts

5. The Respondent is a Registered Nurse under License Number 026-0012334.

6. Respondent, currently on "inactive status," was originally licensed on November 4, 1977 by endorsement through Connecticut. With the exception of this matter, Respondent has never been subject to any disciplinary proceeding in any of the jurisdictions in which she has held nursing licenses since first licensed as a registered nurse in 1966.

7. At all times relevant to these Charges, the Respondent was the owner/operator, and employed by, the Berlin Hospitality Home in Berlin, Vermont, a level four residential care home.

8. Level IV residential care homes provide care to persons unable to live wholly independently but not in need of the kind of care and services provided in a nursing home. Level IV homes provide room and board, assistance with personal care, general supervision and medication management.

9. By way of history, the Berlin Hospitality Home was established by Respondent in 1979 but is no longer in operation.

10. On or around February 22, 1999, M.B., an 89-year-old resident at the Berlin Hospitality Home was seen in the Emergency Room at the Central Vermont Medical Center with a chief complaint of "change in mental status" and subsequent diagnosis of pneumonia.

11. CVMC discharged M.B. from the Emergency room that same day and returned her to the residential care home in "stable condition" with verbal diagnosis of pneumonia. ER discharge forms did not originally identify a diagnosis of pneumonia.

12. Certain of M.B.'s medical records were not completed until the day after M.B. returned from the hospital Emergency Room and as a result some of the contemporaneous entries were lacking for the following:

a. M.B.'s diagnosis of pneumonia from the hospital;
b. M.B.'s prescribed medication and when they shall be administered;
c. Reason to decide to hold Docusate on morning of February 24, 2001.

13. Between February 22, 1999 and February 24, 1999, M.B. exhibited some diarrhea, weakness, unsteady gait and mental confusion, along with signs of gradual improvement.

14. Respondent contacted M.B.'s physician on February 23, 1999 to discuss medication and blood pressure, and adjusted medication accordingly.

15. M.B.'s caregiver notified Respondent of the increased diarrhea.

16. Respondent was not present and did not personally assess the condition of M.B. at the time of M.B.'s return to the residential care home. Respondent did confirm hospital report of "stable condition" with staff and reassessed M.B. on 2/23/99 and again on 2/24/99.

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15. M.B.'s caregiver notified Respondent of the increased diarrhea.

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17. Respondent, consistent with past practice, contacted the pharmacy and discussed the possible impact of Respondent's medication, including M.B.'s reported loose stool(s).

18. Respondent did not leave orders for the caregiver to check M.B.'s stool(s) for color, but left verbal instructions to check the stool(s) for frequency.

19. During the evening of February 24, 1999, M.B.'s diarrhea did not cease completely and the caregiver had to respond to M.B.'s frequent requests for assistance in "keeping clean," checking on M.B. every 30 minutes to one (1) hour through the night.

20. As of 3:00 a.m. the diarrhea abated and the caregiver returned to her room once M.B. returned to bed. The facility intercom remained in use between M.B.'s room and staff quarters.

21. M.B.'s care plan included blood pressure instructions for staff. Respondent checked M.B.'s blood pressure on February 24 at 5:30, believing it within her normal range at 98/58. The Respondent did not specifically request that the caregiver monitor M.B.'s blood pressure as a result of the increased diarrhea

22. M.B.'s blood pressure was checked by both respondent Central Vermont Home Health Agency and regular physician visits from 12/6/97 through 2/23/99, with readings at times in the range between 110/64 and 98/38.

23. Observing no unusual change, the caregiver did not contact the Respondent or M.B.'s physician or take any further steps that night to have M.B.'s condition assessed.

24. On February 24, 1999, Respondent observed M.B. climbing stairs (twice), eating supper, drinking fluids, and ambulating to the bathroom without assistance in addition to engaging in conversation. Respondent did not closely examine M.B.'s stools and was not aware if there had been any unusual color. Respondent took no steps to attempt to determine if M.B. was experiencing bleeding beyond briefly observing that the color was not unusually dark despite the fact that M.B. had shown intermittent signs of being hypotensive, weak and confused. Based on her observations, Respondent was confident in her assessment.

25. Level four residential care is designed to allow for continued resident independence and mobility. In the early morning hours of February 25, 1999, M.B. left the residential care home on her own and was shortly thereafter discovered in the parking lot of the Berlin Health and Rehabilitation Center in Berlin, Vermont at 5:45 a.m. Respondent subsequently died after transport to CVMC.

26. Around March 11, 1999, and subsequent to the discovery of M.B., Respondent completed M.B.'s medical records in an improper manner for the

period of time from February 24, 1999 to February 25, 1999, including but not limited to:

a. adding specific times to the chart;
b. noting instructions given to the caregiver; and
c. noting caregiver reports that symptoms had ceased.

27. These entries may not have been wholly accurate as written.

Charges

A. The State alleges that Respondent failed to properly assess the resident, failed to assure that the resident was under the care of a qualified person, failed to properly note M.B.'s condition in the medical records; and created false entries in the medical records, such that it is the State's position that Respondent violated:

(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);

(b) Chapter IV, Rule IV(B)(2) of the Administrative Rules of the Board of Nursing ("ARBN") (Failure to conform to the essential standards of acceptable and prevailing nursing practice); and

(c) Chapter IV, Rule IV(B)(4)(c) of the Administrative Rules of the Board of Nursing ("ARBN") (falsifying or altering clinical records or making inaccurate or misleading entries).

B. Respondent neither admits nor denies the truth of the "facts" alleged by the State in the Specification of Charges, and accepts them solely for the limited purpose of this settlement stipulation.

Understandings

28. The Respondent understands that the Board of Nursing must review and accept the terms of the Order set forth below and that if the Board rejects all or any portion of the Order, then this entire document shall be null and void.

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

30. The Respondent is not under the influence of any drugs or alcohol at the time this document is being signed.

31. The Respondent agrees that she has had sufficient opportunity to consult with legal counsel before signing this document.

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31. The Respondent agrees that she has had sufficient opportunity to consult with legal counsel before signing this document.

32. The Respondent is voluntarily waiving her right to a contested hearing before the Board of Nursing.

33. The Respondent agrees that the Order set forth immediately below may be entered by the Board of Nursing.

Consent Order

34. Based on the above stipulations, it is **ADJUDGED** as follows:

(1) The "Facts" listed above are true; and

(2) The Respondent has engaged in unprofessional conduct in that the Respondent has:

i Failed to comply with provisions of federal or state statutes or rules governing the practice of the profession in violation of 3 V.S.A. §129a(a)(3);

ii Failed to conform to the essential standards of acceptable and prevailing nursing practice in violation of Chapter IV, Rule IV(B)(2) of the Administrative Rules of the Board of Nursing ("ARBN"); and

iii Falsified or altered clinical records or made inaccurate or misleading entries in violation of Chapter IV, Rule IV(B)(4)(c) of the Administrative Rules of the Board of Nursing ("ARBN").

35. Based on the above stipulation and on the above findings and conclusions of this Board, it is **ORDERED** follows:

i. The Board hereby **INDEFINITELY PREVENTS THE RENEWAL OF RESPONDENT'S LICENSE.**

ii. Prior to renewal, Respondent shall be required to prove to the Board, at a minimum and to the satisfaction of the Nursing Board, that she poses no danger to the practice of nursing and that she can safely and competently perform the duties of a nurse.

iii. Respondent shall also be required to complete the following education in addition to those conditions which may be imposed:

a. nursing management course; and

b. physical assessment course.

c. The courses above must be approved by the Board in advance.

37. Notwithstanding any provision above, Respondent must meet all Nursing Board requirements for license renewal and license reinstatement.

38. 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). This Stipulation and Consent Order will remain part of the Respondent's licensing file and may be used in determining sanctions in future disciplinary matters.

AGREED TO:

BY: DONNA G. JOHNSON
RESPONDENT

Date: 7/7/01

Donna G. Johnson

approved as to form:

Peter F. Young
Eggleston & Cramer, Ltd.

AND BY: STATE OF VERMONT
WILLIAM H. SORRELL
ATTORNEY GENERAL

Date: 9/10/01

George C. Haegele IV
Assistant Attorney General

ACCEPTED AND SO ORDERED:

BOARD OF NURSING

Date: 9-10-01

Susan O. Farrell
Chairperson

Dated entered: 9/17/01

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