STATE OF VERMONT
BOARD OF NURSING

IN RE:	)	
Cathleen Kwiecinski	)	Case File No. NU25-0903
License No. 26-24004	)	

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

Introduction

The Vermont Board of Nursing ("the Board") held a hearing in this case on Monday, May 23, 2005 at 81 River Street in Montpelier, Vermont. Board members Linda Rice, Alan Weiss, Sandra Norton and *ad hoc* board members Lorraine Welch and Marilyn Rinker participated in the decision. Edward Adrian, Prosecuting Attorney, appeared for the State. Cathleen Kwiecinski ("the Respondent") was present and was represented by attorney Norman Watts. Christopher Winters presided for the Board.

Respondent's Exhibits A-I were admitted during the course of the hearing, as were State's Exhibits 1-6. The Board takes official notice of its own licensing and disciplinary files.

Findings of Fact

1. The Respondent is a licensed registered nurse who holds license number 26-24004 issued by the State of Vermont.

2. The Respondent, at all times relevant, was employed by Mount Ascutney Hospital located in Windsor, Vermont.

3. On or about November 16, 2001, the Respondent was caring for resident B.B.. The Respondent made various statements to the resident which made her uncomfortable and the resident felt did not show her the proper respect. The resident felt the Respondent was "intimidating" and "dreaded" having to deal with the Respondent as her caregiver. (See State's Exhibit 1):

A. In response to B.B.'s request for pain medication, the Respondent said "Why don't you wait an hour?"

B. In response to a resident request to answer her room phone, the Respondent said "I don't get paid to answer the phone."

C. The Respondent, when looking at a photograph of a resident, stated, "You look much better with teeth," the resident had lost teeth in a motor vehicle accident.

D. When the resident requested medication, the Respondent stated "I want you to realized the doctor is not going to give you that at home."

4. The Respondent denies making any of these statements or anything that could have been misinterpreted as such. She was issued a "counseling statement" from her employer, which she signed, indicating she agreed to comply with the statement, including improving her attitude and sensitivity toward patients.

5. On or about September 14, 2002, the Respondent was assisting resident M.K. in walking down a hallway. Resident M.K.'s care plan called for assistance in ambulating. The Respondent left M.K. to ambulate alone.

6. The Respondent received a "warning notice" from her employer dated September 26, 2002 as the result of this and other incidents. The Respondent made notes on the warning notice at the time she met with Judy Audette. Her notes indicate that she did not recall the incident but would comply with the care plan.

7. When testifying before the Board, the Respondent did later recall the incident and stated that she left resident M.K. alone to assist a more urgent fall risk, and that M.K. had a secure grip on a railing when she left that resident to assist the other resident, who, by standing, had set off an alarm.

8. Also on or about September 14, 2002, the Respondent did not supervise resident F.B. when F.B. was eating a meal. F.B.'s care plan calls reads "TO BE SUPERVISED" calls for supervision and verbal cues to complete a meal.

9. The Respondent did not set F.B. up for the meal and came on shift with F.B. already prepared to eat. There was a therapist in the room at the time and the Respondent felt this was adequate "supervision." The Respondent was unsure of the care plan for this resident.

10. On or about September 21, 2002, resident H.F. passed away. The resident's family was present. Her daughter believed the resident had stopped breathing and rang the call bell. The Respondent did not answer the call bell right away. A therapist had time to complete several tasks in an adjacent room before going to answer the call bell in H.F.'s room. She then sent for the Respondent.

11. When the Respondent entered the room, she was very matter-of-fact, which was perceived as being cold and uncaring by the decedent's family.

12. On or about April 23, 2003, the Respondent entered resident V.H.'s room.

V.H.'s spouse was placing a pillow between V.H.'s legs. The Respondent said "Sorry for interrupting the cohabitation." The Respondent also said to V.H., "You know what you need is to get out of bed and give your wife a back rub."

13. The Respondent denies making these statements and also denied that she made any statement which could have been misinterpreted as to the above. She did admit that she said something like, "Sorry for interrupting the cuddling" because it looked to her like they were "cuddling." She stated that they also did discuss therapeutic massage for the husband.

14. The Respondent was presented with warning notice number three for this incident, which she signed on May 19, 2003.

15. On or about May 9, 2003, the Respondent discussed "mooning" with resident M.C. and in the presence of resident E.S. M.C. was an 88 year old amputee who was not familiar with "mooning." The Respondent explained what mooning was.

16. On or about August 23, 2003, following a request to the Respondent by resident J.O. for help in going to the bathroom, the Respondent told resident J.O. "We are too busy go ahead and go in your diaper" or something to that effect.

17. The Respondent initially claimed she heard someone else say this, but could not identify who said it.

18. The Respondent received a termination notice dated August 23, 2003. She did not respond to the termination notice immediately. She did respond by letter approximately four months later, dated December 18, 2003, in which she denied anyone made a statement directing a patient to be incontinent. See State's Exhibit 6.

19. The Board took testimony that the Respondent was at times "rude," "socially clumsy," or "socially inept."

20. The Respondent received three written warnings and then was terminated by her employer.

Conclusions of Law

A. The Board of Nursing may revoke, suspend, discipline or otherwise condition the license of a nurse who engages in unprofessional conduct as defined by 26 V.S.A. §1582.

B. Respondent, by engaging in the conduct described above, has committed unprofessional conduct as alleged in the State's Specification of Charges. The Respondent has:

(1) committed unprofessional conduct by failing 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); and

(2) committed unprofessional conduct in violation of 26 V.S.A. §1582(a)(3) (is unable to practice nursing competently by reason of any cause) which includes the performance of unsafe or unacceptable patient care pursuant to the Administrative Rules of the Board of Nursing, Chapter 4, Rule IV(II)(B)(1), and failing to conform to the essential standards of acceptable and prevailing nursing practice pursuant to the Administrative Rules of the Board of Nursing, Chapter 4, Rule IV(II)(B)(2).

C. More specifically, based on the evidence and the facts as found by the Board, the Board determines that each of the State's charges in paragraphs 8-14 were proved.

Opinion

The Respondent, as set forth above, has exhibited insensitive and intimidating behavior toward a vulnerable population. Each incident taken alone may not seem so serious. However, taken as a whole, the pattern becomes obvious and impossible for a Board charged with protecting the public to ignore. While her actions were probably not intentionally harmful, they were harmful nonetheless in that they inflicted psychological damage upon the residents and may have discouraged them from seeking the care they may have needed.

Being "socially inept," as argued by Respondent's counsel, is certainly not grounds for unprofessional conduct. However, it is harmful to the nurse and patient relationship and may ultimately affect the care provided by the nurse. More importantly, each resident deserves respect and consideration, no matter what the circumstance the nurse finds him or herself in.

Order

A. In light of the above findings and conclusions, the Board hereby CONDITIONS the Respondent's license for A MINIMUM OF ONE (1) YEAR from the date of entry of this Order. The CONDITIONS are as follows:

(1) Length of Time 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 one (1) year of supervised nursing practice in which Respondent works at least forty (40) hours every two (2) weeks as a nurse. Part time hours of less than forty (40) hours every two (2) weeks shall be credited on a prorated basis.

(2) Course Work.

Respondent must complete (i.e.: receive a passing grade, if applicable) a course on: (1) establishing therapeutic relationships with patients; (2) communication skills; and (3) stress management. All courses shall have prior approval by the Board or its designee. The Respondent shall submit written documentation (certificate of completion, etc.) to verify

completion to the satisfaction of the Board or its designee.

Notification to Employers.

Respondent shall provide a copy of this Order to all employers in any current or future setting in which Respondent practices as a nurse and inform them of Respondent's conditional license status. Within ten (10) days of the date of entry of this Order or of any subsequent employment, Respondent shall cause Respondent's immediate supervisor to write to the Board, on the employer's letterhead, acknowledging receipt of the Order and the ability to comply with the conditions in the Order.

(4) Reports from Employers.

Within one (1) month of the date of entry of this Order and monthly thereafter, Respondent shall cause every employer Respondent has worked for during the relevant time period to submit to the Board an evaluation of Respondent's performance and attendance during that time period. This report shall be submitted in writing on forms issued by the Board.

Respondent shall sign a consent, upon request of the Board, to authorize Respondent's employer to provide all information requested by the Nursing Board, or its designee, either orally or in writing, at any time during the period the Order is in effect.

Practice Under Supervision.

Respondent shall practice only in a setting where Respondent has on-site supervision for the entire shift by a registered nurse that is licensed and in good standing.

Types of Employment Prohibited.

Respondent shall not work for a nurse registry, traveling nurse agency, float-pool, home health care agency, temporary nursing employment agency, or as a personal care provider during the effective period of this Order. The Respondent shall work no more than forty (40) hours per week.

License Renewal.

In the event Respondent's license is scheduled to expire during the period this Order is in effect, Respondent shall apply for renewal of the license, pay the applicable fee, and otherwise maintain qualifications to practice as a nurse in the State of Vermont.

Costs.

Respondent shall bear all costs of complying with this Order.

Violation of Order.

If Respondent violates the terms of this Order in any respect, the Board, after giving Respondent notice and an opportunity to be heard, may revoke the terms of the conditional license and take further disciplinary action. If a complaint or charges are filed against Respondent during the term of this Order, the conditional license period shall be extended until the matter is final.

(10) Completion of Conditional License Period.

Upon completion of the conditional license period, Respondent may petition the Board to remove any and all conditions and after formal review by the Board, Respondent's nursing license may be formally restored by appropriate Board action. Respondent shall demonstrate, to the Board's satisfaction that Respondent fully complied with all the terms of this Order. If the Respondent demonstrates to the Board's satisfaction compliance with all conditions, then any and all conditions shall be removed.

B. 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).

C. This Order will remain part of Respondent's licensing file and may be used for purposes of determining sanctions in any future disciplinary matter.

Appeal Rights

This is a final administrative determination by the Vermont Board of Nursing. You may appeal by sending a notice of appeal in writing to the Director of the Office of Professional Regulation within 30 days of the date of entry of this order. If you wish to request a stay of the Board's decision, please refer to the attached stay instructions.

Linda Rice Date: 6-24-05

Linda Rice
Acting Board Chair

OFFICE OF PROFESSIONAL REGULATION

Date of entry: 6/29/05

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

IN RE:	)	
CATHLEEN M. KWIECINSKI	)	**Docket No: NU 25-0903**
License No. 026-0024004	)	

SPECIFICATION OF CHARGES

NOW COMES the State of Vermont and makes the following Charges against the Respondent, Cathleen M. Kwiecinski, R.N.:

Board Authority

1. The Vermont State Board of Nursing ("the Board") has authority to issue warnings or reprimands, suspend, revoke, limit, 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)(5); 3 V.S.A. §814(d); 26 V.S.A. §1582(a); Administrative Rules of the Board of Nursing.

2. Failure to comply with the provisions of state statutes or rules governing the practice of the profession is unprofessional conduct upon which the Board can base disciplinary action. 3 V.S.A. §129a(a)(3).

3. The inability to practice nursing by reason of any cause is unprofessional conduct upon which the Board can base disciplinary action. 26 V.S.A. §1582(a)(3).

4. The inability to practice nursing competently includes the performance of unsafe or unacceptable patient care pursuant to the Administrative Rules of the Board of Nursing, Chapter 4, Rule IV(II)(B)(1), and failing to conform to the essential standards of acceptable and prevailing nursing practice pursuant to the Administrative Rules of the Board of Nursing, Chapter 4, Rule IV(II)(B)(2).

Facts

5. The Respondent is licensed in the State of Vermont as a Registered Nurse under license number 026-0024004.

6. The Respondent's was originally licensed on May 28, 1998 and Respondent's license is currently set to expire on March 31, 2005.

7. At all times relevant, the Respondent was employed as an R.N. by Mt. Ascutney Hospital in Windsor, Vermont.

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
Montpelier, VT 05602

8. On or about November 16, 2001, the Respondent responded rudely and inappropriately to resident B.B. when B.B. asked the Respondent questions regarding B.B.'s medications, answering the phone and a late dressing change.

9. On or about September 14, 2002, the Respondent failed to follow the care plan of resident M.K by leaving M.K. in the hallway to ambulate herself although the care plan called for assistance because of a condition with M.K.'s knee.

10. On or about September 14, 2002, the Respondent failed to follow the care plan for resident F.B. by leaving F.B. unsupervised although F.B.'s care plan called for supervision.

11. On or about September 21, 2002, the Respondent was insensitive and rude to the daughter of resident H.F. following H.F.'s death.

12. On or about April 23, 2003, the Respondent made a highly inappropriate comment to resident V.H. and V.H.'s wife. When the Respondent entered V.H.'s room, the Respondent commented "sorry for interrupting the cohabitation" while the wife was placing a pillow between V.H.'s legs. The Respondent also stated "you know what you need is to get out of bed and give your wife a back rub".

13. On or about May 9, 2003, the Respondent made an inappropriate comment about mooning to resident M.C. and in the presence of resident E.S.

14. On or about August 23, 2003, following a request to the Respondent by resident J.O. for help in going to the bathroom, the Respondent told resident J.O. that she was "too busy to do it" and to "go in your diaper".

Charges

A. The above acts, omissions and/or circumstances described above, constitute grounds for discipline because Respondent violated:

(i) 26 V.S.A. §1582(a)(3) (is unable to practice nursing competently by reason of any cause) which includes the performance of unsafe or unacceptable patient care pursuant to the Administrative Rules of the Board of Nursing, Chapter 4, Rule IV(II)(B)(1), and failing to conform to the essential standards of acceptable and prevailing nursing practice pursuant to the Administrative Rules of the Board of Nursing, Chapter 4, Rule IV(II)(B)(2); and

(ii) 3 V.S.A. §129a(a)(3) (failing to comply with the provisions of state statutes or rules governing the practice of the profession).

Relief Requested

WHEREFORE, the license of Cathleen M. Kwiecinski should be revoked, suspended, reprimanded, conditioned or otherwise disciplined.

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
Montpelier, VT 05602

Dated at Montpelier, Vermont this 15th day of April 2004.

STATE OF VERMONT
SECRETARY OF STATE

By: _____
Edward G. Adrian
State Prosecuting Attorney

nu.kwiecinski.soc

STATE OF VERMONT

Prosecuting Attorney
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Professional Regulation
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