STATE OF VERMONT
BOARD OF NURSING

IN RE:	)	
Jessica N. Lennon	)	Case File No. NU37-1203
License No. 25-8295		

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

Introduction

The Vermont Board of Nursing ("the Board") held a hearing in this case on Monday, December 13, 2004, at 81 River Street in Montpelier, Vermont. Board members Susan Farrell, Sandra Norton, Alan Weiss, Elayne Clift, Dee-Ann Welch, Donarae Metcalf and Linda Rice participated in the decision. Edward Adrian, Prosecuting Attorney, appeared for the State. Jessica Lennon ("the Respondent") was present. The presiding officer for the Board was Christopher Winters.

The Respondent largely did not contest the documentation errors set forth in the State's Specification of Charges dated June 16, 2004, as indicated by her testimony at the hearing. During the hearing, the State dismissed paragraphs 12 and 13 of the Charges, and amended the charge at paragraph 9 from failing to catheterize to failure to document catheterization.

Findings of Fact

1. At all times relevant to these charges, the Respondent, Jessica Lennon, was a Licensed Practical Nurse holding license number 025-0008295, issued by the State of Vermont.

2. The Respondent's license was originally issued on October 18, 2002 and the Respondent's license lapsed on January 31, 2004.

3. At all times relevant, the Respondent was employed by Eden Park Nursing Home ("the Facility") in Rutland, Vermont.

4. The Respondent admits that on or about September 22, 2003, the she failed to change a resident's duragesic patch as required. Respondent adds that she was distracted at the time and only recently oriented.

9. The Respondent admits that on or about October 2, 2003, after performing a catheterization on resident E.B., she failed to document the amounts on the flow sheets.

10. The Respondent admits that on or about October 12, 2003, the Respondent checked off resident E.L.'s med chart as having administered Hytrin 2 mg when it had not been given. She adds that this medication had been borrowed for another resident and that she had been trained to do it this way.

11. The Respondent admits that on or about October 13, 2003, she failed to administer the prescribed Hytrin 2 mg to resident E.L.

12. The Respondent admits that on or about October 21, 2003, she guessed the length of a surgical incision when doing an admission assessment of a new resident because the Respondent didn't want to remove the dressing on the resident's lower back for fear of infection. The Respondent wrote this guess on an intake form.

13. The Respondent admits that on or about October 26, 2003, she failed to remove resident A.W.'s nitroglycerin patch at bedtime as required. As a result, the patch was left on for twenty-four hours instead of twelve hours. The Respondent believed that because the patch was not in its normal place, that an LNA must have removed it. She did not inquire of any of the LNAs on that shift as to the patch.

14. The Respondent admits that on or about October 30, 2003, she failed to document resident M.R.'s oxygen level following weaning M.R. off of the ventilator.

15. The Respondent admits that she has failed to document properly on several occasions and has had a problem with attention to detail.

Conclusions of Law

By making the charting errors set forth in the above facts, the Respondent has committed unprofessional conduct in that she has:

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

b) demonstrated an inability to practice nursing competently in violation of 26 V.S.A. §1582(a)(3), including the performance of unsafe or unacceptable patient care pursuant to the Administrative Rules of the Board of Nursing ("ARBN") 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 ("ARBN") Chapter 4, Rule IV(II)(B)(2).

Order

A. Based on the above findings and conclusions as stipulated to by the parties, the Board of Nursing 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 two (2) years 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) Medication Administration / Pharmacology Course and Documentation Course.

Respondent must complete (i.e.: receive a passing grade, if applicable) a course on (1) medication administration / pharmacology and a course on (2) documentation with prior approval by the Board or its designee, and then submit written documentation (certificate of completion, etc.) to verify same to the satisfaction of the Board or its designee. These courses must be completed within one year of the date of entry of this Order. It is possible that both subjects may be covered in one course, subject to Board approval.

(3) 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.

In the event the Respondent is attending a nursing program, Respondent shall cause the Program Director to write to the Board, on school letterhead, acknowledging receipt of the Order and ability of the program to comply with the conditions in the Order during clinical experience.

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 Supervi

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.

(6) Types of Employment

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.

(7) 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.

(8) Costs.

Respondent shall bear all costs of complying with this Order.

(9) Violation of the 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.

Completion of Conditional License Period.

Upon completion of the conditional license period, Respondent may petition the Board to remove any and all conditions on her license 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 of her 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 the 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 State 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.

By: Susan Farrell Date: 12.24.04

Susan Farrell
Chair

OFFICE OF PROFESSIONAL REGULATION

Date of entry: 1/6/05

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

IN RE:	)	
JESSICA N. LENNON	)	**Docket No: NU 37-1203**
License No. 025-0008295	)	

SPECIFICATION OF CHARGES

NOW COMES the State of Vermont and makes the following Charges against the Respondent, Jessica N. Lennon, L.P.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); the Administrative Rules of the Board of Nursing; and the Rules of the Office of Professional Regulation.

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 a Licensed Practical Nurse holding license number 025-0008295, issued by the State of Vermont.

6. The Respondent's license was originally issued on October 18, 2002 and the Respondent's license lapsed on January 31, 2004.

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
Montpelier, VT 05602

7. At all times relevant, the Respondent was employed as an L.P.N. by Eden Park Nursing Home ("the Facility") in Rutland, Vermont.

8. On or about September 22, 2003, the Respondent failed to change a resident's duragesic patch as required.

9. On or about October 2, 2003, the Respondent failed to catheterize resident E.B. and when questioned about it, the Respondent stated that she had performed the catheterization. The Respondent also signed off on E.B.'s chart as if it had been done, though no amounts were recorded on the flow sheets.

10. On or about October 12, 2003, the Respondent checked off resident E.L.'s med chart as having administered Hytrin 2 mg when it had not been given.

11. On or about October 13, 2003, the Respondent failed to administer the prescribed Hytrin 2 mg to resident E.L.

12. On or about October 15, 2003, the Respondent failed to perform or assign LNAs to tasks of completing residents' vital signs, showers and blood pressures.

13. On or about October 17, 2003, the Respondent failed to respond to a resident's chair sensor. The resident was found by staff on the floor in front of the wheelchair calling for help.

14. On or about October 21, 2003, the Respondent "guessed" at the length of a surgical incision when doing an admission assessment of a new resident because the Respondent didn't want to remove the dressing on the resident's lower back.

15. On or about October 26, 2003, the Respondent failed to remove resident A.W.'s nitroglycerin patch at bedtime as required. As a result, the patch was left on for twenty-four hours instead of twelve hours.

16. On or about October 30, 2003, the Respondent failed to document resident M.R.'s oxygen level following weaning M.R. off of the ventilator.

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 Jessica N. Lennon should be revoked, suspended, reprimanded, conditioned or otherwise disciplined.

Dated at Montpelier, Vermont this 16th day of June 2004.

STATE OF VERMONT
SECRETARY OF STATE

By: _____
Edward G. Adrian
State Prosecuting Attorney

nu.lennon.soc

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
Montpelier, VT 05602