STATE OF VERMONT
BOARD OF NURSING

In re: Maureen Mucha	}	
License No. 075-81048	}	Docket No. 2013-296(LNA)
	}	

Decision on
UNPROFESSIONAL CONDUCT CHARGE

Participating Board Members:
Jeanine Carr, RN, Chair
Ellen Watson, APRN, Vice Chair
Alan Weiss, Public Member
William G. White, Jr., Public Member
Deborah Swartz, RN
Douglas Sutton, RN
Sheila Davis, LPN
Virginia Hudson, RN
Stephen Morse, LNA
Sheri Brown, APRN

Appearances:
Prosecuting the case: S. Lauren Hibbert
for Respondent: Edwin L. Hobson

Presiding Officer: Larry S. Novins

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

The Vermont Board of Nursing held a hearing in the above matter on March 3, 2014 at the Capitol Plaza in Montpelier, Vermont.

The prosecution has the burden of proof in this matter. To prevail on any unprofessional conduct charge, it must prove the charge by a preponderance of the evidence.

Background

The Specification of Charges alleges that Ms. Mucha, in violation of Vermont Statutes, improperly dealt with a dementia patient, Patient A.

Findings of Fact

Based on the evidence presented, the Board finds as follows:

1. At the beginning of the hearing neither party presented an opening statement. Testimony at the hearing came from seven witnesses. Only two of the witnesses had first hand knowledge of what happened between Ms. Mucha and Patient A. The other five testified either about Patient A's documented aggressive tendencies or testified favorably about the care Ms. Mucha provided in general. The evidence presented at the hearing varied from what was charged in the Amended Specification of Charges. Ms. Mucha and her attorney were, however, prepared for the evidence presented. They completely responded to the evidence presented by the Prosecution.
2. Ms. Mucha is a licensed nursing assistant and is therefore subject to the regulatory authority of this Board. 3 V.S.A. §§ 129, 129a, 26 V.S.A. §§ 1595 and 1598, the Administrative Rules of the Board of Nursing, and the Rules of the Office of Professional Regulation.
3. At all times relevant Ms. Mucha worked as a nursing assistant at The Manor in Morrisville, Vermont.
4. On May 24, 2013 Ms. Mucha cared for Patient A at the Manor. Patient A was a dementia patient. She had a well-documented history of aggressive behavior toward those who provided her care. The documentation provided at the hearing showed frequent scratching, pushing, grabbing and spitting. Ms. Mucha had cared for Patient A for several months and was well aware of her aggressive behavior.
5. On May 24, 2013 Ms. Mucha and another LNA were assisting Patient A to a sit stand so that she could be readied for bed. The other LNA testified at the hearing. Her memory of the events that evening was incomplete. During the process Patient A hit Ms. Mucha on the side of her face. It caused Ms. Mucha pain. She expressed her concern that Patient A could easily have broken her glasses.
6. When a patient is behaving aggressively Manor policy is for the LNA to back off, stand back and let the patient calm down before resuming patient care. Ms. Mucha did not follow that procedure. She continued to work in close proximity to Patient A. Within a minute of hitting Ms. Mucha, Patient A attempted to hit Ms. Mucha again. Ms. Mucha reacted by extending her arm making actual physical contact with Patient A. The essential standards of acceptable and prevailing practice require an LNA to take necessary steps to avoid physical contact with a patient. Ms. Mucha failed to comply with the facility policy. By having physical contact with Patient A, even if reflexive and unintentional, Ms. Mucha did not meet the essential standards of acceptable and prevailing LNA practice.
7. Shortly after her physical contact with Patient A, Ms. Mucha reported her physical contact to the nurse who was overseeing that portion of the facility at the time.
8. There was mention of Ms. Mucha's participation in an Employee Assistance Program before this event. We make no finding that Ms. Mucha engaged in any improper conduct with patients before May 24, 2013. Ms. Mucha's prior participation in the program is irrelevant to our Findings of Fact and Conclusions of Law in this Decision.
9. One question which arose at several times during the hearing was whether or not Patient A's care plan contained any provisions for dealing with Patient A's combative behavior. From the evidence presented it was clear that if there was such a plan, Ms. Mucha and her coworkers were unaware of it.
10. Testimony at the hearing portrayed Ms. Mucha as a very caring and conscientious LNA.

She was described as passionate about her work and being a most caring LNA who did all the extras and took extra time with patients when needed. Her practical skills were described as very good.

11. After this event with Patient A, Ms. Mucha successfully completed an on line course in "Dementia Care: Approaches and Communication Techniques" and "Patient Safety: Increasing Awareness," and "Abuse Prevention in Long Term Care."
12. There was no persuasive evidence that Ms. Mucha made any false reports or obstructed the making of any reports.
13. There is no indication that Ms. Mucha is unable to practice as an LNA.

Conclusions of Law

Based on the evidence presented and Facts found above we conclude as follows:

1. **Re: Alleged Violation of 3 V.S.A. § 129a(b)(1) and (2)**: The Prosecution has proved by a preponderance of the evidence that Ms. Mucha failed to practice competently. We find that Ms. Mucha's conduct as found above constituted unacceptable patient care and failure to conform to the essential standards of acceptable and prevailing practice. This is unprofessional conduct.

2. **Re: Alleged Violation of 26 V.S.A. § 1595(5):** The Prosecution has not proved by a preponderance of the evidence that Ms. Mucha's conduct renders her unfit or incompetent to function as a nursing assistant by reason of any cause. 26 V.S.A. § 1595(5). This charge is dismissed.

3. **Re: Alleged Violation of 3 V.S.A. § 129a(a)(7)**: The Prosecution has not proved by a preponderance of the evidence that Ms. Mucha willfully made or filed false reports or records in the practice of the profession; or willfully impeded or obstructed the proper making or filing of reports or records or willfully failed to file the proper reports or records. This charge is dismissed.

Order

For the violations above, to protect the public, health, safety and welfare, the following sanction is necessary.

Ms. Mucha's license is **warned,** effective the date of this decision. Because Ms. Mucha has already taken steps to address the conduct found above, it is not necessary to impose any conditions for her continued practice.

APPEAL RIGHTS

This is a final administrative determination by the Vermont Board of Nursing. A party aggrieved by a final decision of a board may appeal this decision by filing a written Notice of Appeal with the Director of the Office of Professional Regulation, Vermont Secretary of State,

Office of Professional Regulation, 89 Main Street, Fl. 3, Montpelier, Vermont 05620-3402 within 30 days of the entry of this Order.

If an appeal is filed, the Director of the Office of Professional Regulation shall assign the case to an appellate officer. The review shall be conducted on the basis of the record created before the board. In cases of alleged irregularities in procedure before the board, not shown in the record, proof on that issue may be taken by the appellate officer. 3 V.S.A. §§ 129(d) and 130a.

To request a stay of the Board's decision, please refer to the attached stay instructions.

Vermont Board of Nursing

By: Jeanine Carr
Jeanine Carr, RN, Chair

Date: March 5, 2014

OFFICE OF PROFESSIONAL REGULATION

DATE OF ENTRY: 3-10-14