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

IN RE:	)	
Basilio Romaguera	)	**Docket No. 2020-52**
License No. 025.0124347	)	

STIPULATION AND CONSENT ORDER

STIPULATION

NOW COME the State of Vermont, by and through Prosecuting Attorney Jennifer B. Colin, and Respondent Basilio Romaguera, 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").

Alleged Facts

2. Basilio Romaguera ("Respondent") of Newport, Vermont is licensed by the State of Vermont as a Licensed Practical Nurse ("LPN") under license number 025.0124347. This license was originally issued on September 26, 2016 and expires on January 31, 2022.

3. Respondent was employed as an LPN at Newport Health Care Center located in Newport, Vermont ("Facility") from June 2018 to August 15, 2018.

4. On August 4, 2018, Respondent was on duty at the Facility.

5. At approximately 7:00 a.m., Respondent was notified by an LNA that an eighty-nine year old male resident of the Facility, R.L. ("Patient"), was found lying on the floor of his room after a fall.

6. Respondent told the LNA's he did not have time to assist in moving Patient. Respondent instructed the LNA to get Patient up and said that Respondent would assess Patient later.

7. Two LNA's were unable to use a hoyer lift to move Patient and instead used a gait belt to get Patient up and move him to the side of the bed.

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05620-3402

8. Patient reported to the LNA's that he had no pain and showed no signs of pain.

9. At approximately 10:00 a.m., Respondent approached one of the LNA's who assisted Patient after his fall and asked what they were going to do about situation. Respondent stated if they documented the fall, they would have to do "neuros" every ten to fifteen minutes, that Patient was fine and had no bruises, pain or lacerations, and that they all had to get their stories straight.

10. Respondent did not assess Patient after his fall and before he was moved by the LNA's.

11. Respondent did not notify the RN on duty who was in the building at the time of Patient's fall, nor did he notify the Director of Nursing of Patient's fall.

12. Respondent did not notify Patient's provider of Patient's fall.

13. Respondent did not notify Patient's family of his fall.

14. Respondent did not report Patient's fall to the oncoming nursing staff for the next shift from 3:00 p.m. to 11:00 p.m., so Patient did not receive any follow-up care or ongoing assessment after the fall.

15. Respondent did not document Patient's fall in Patient's medical record on August 4, 2018.

16. An LPN on the 3:00 p.m.-11:00 p.m. shift, S.D., gave Patient his scheduled Tylenol and documented 4 out of 10 on the pain scale; however, because she did not know of Patient's fall, she did not understand that a change in Patient's condition may have occurred or provide any follow-up care or assessment.

17. On August 5, 2018, at approximately 1:00 a.m., Patient reported to the night nurse on duty, E.R., that he had a ten out of ten on the pain scale in his right leg.

18. When examined, Patient had no bruising, swelling, or rotation to the leg.

19. E.R. contacted Patient's provider, and per provider orders, transferred Patient to the hospital, where he was diagnosed with a hip fracture.

20. Respondent reported to the Facility that he did not assess Patient until approximately 10:00 a.m. on August 4, 2018, attributing the delay to the day being busy and forgetting to do the assessment.

21. Respondent admitted to the Facility that he failed to inform the RN on duty, the Director of Nursing ("DON") or the oncoming staff about Patient's fall.

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22. Respondent documented Patient's fall in his medical record after Patient was transferred to the hospital and Respondent reported to work on August 5, 2018, approximately 24 hours after Patient's fall.

23. On August 5, 2018, Respondent completed a SBAR Fax Sheet to communicate with Patient's physician about the fall.

24. On August 5, 2018, Respondent filled out a Head Injury Flow Sheet, which purportedly documented Respondent's assessments of Patient every thirty minutes from the time of the fall at 7:20 a.m. until 12:50 p.m., including blood pressure readings, pulse, respiration, temperature, level of consciousness, hand grasp, pupil check, and comments about Patient's condition.

25. On August 5, 2018, Respondent filled out an Incident/Accident Report documenting details and conditions surrounding the circumstances of Patient's fall. In this Report, Respondent included Patient's purported vital signs while initially supine immediately following the fall, one minute after initially standing following the fall, and three minutes after standing following the fall.

26. After investigating the response to Patient's fall, the Facility terminated Respondent's employment on August 15, 2018.

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.

27. Paragraphs 2 through 26 above are incorporated herein.

28. As an LPN, Respondent is required to perform safe and acceptable patient care.

29. Paragraphs 2 through 26 above demonstrate that Respondent failed to perform safe and acceptable patient care in responding to Patient's fall, including when he failed to assist with helping Patient immediately after his fall, failed to assess Patient in a timely manner after his fall, failed to document Patient's fall in a timely manner, failed to report the fall to the RN on duty or the DON, failed to report the fall to nursing staff for the oncoming shift, failed to inform Patient's provider about the fall in a timely manner, failed to report the fall to Patient's family, and falsely documented care provided to and assessments of Patient after his fall.

30. 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).

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Violation Two: 26 V.S.A. §1582(a)(4) Willfully failing to file or record, or willfully impeding or obstructing filing or recording, or inducing another person to omit to file or record medical records.

31. Paragraphs 2 through 26 above are incorporated herein.

32. As an LPN, Respondent is required to accurately file and record information in patients' medical records.

33. Paragraphs 2 through 26 above demonstrate that Respondent willfully failed to file or record and willfully impeded or obstructed the filing or recording of accurate information in Patient's medical records regarding Patient's fall on August 4, 2018.

34. 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 26 V.S.A. §11582(a)(4).

Violation Three: 26 V.S.A. §1582(a)(3) Engaging in conduct of a character likely to deceive, defraud or harm the public.

35. Paragraphs 2 through 26 above are incorporated herein.

36. As an LPN, Respondent is prohibited from engaging in conduct of a character likely to deceive, defraud, or harm the public.

37. Paragraphs 2 through 26 above demonstrate that Respondent engaged in conduct of a character likely to deceive, defraud, or harm the public when he intentionally falsified Patient's medical records regarding the care to and assessments provided for Patient in the hours after Patient's fall.

38. 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 26 V.S.A. §1582(a)(3).

Violation Four: 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.

39. Paragraphs 2 through 26 above are incorporated herein.

40. The essential standards of acceptable and prevailing practice require that an LPN provide appropriate care to and assessment of a patient in a timely manner after a patient has fallen.

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41. Paragraphs 2 through 26 above demonstrate that Respondent failed to conform to the essential standards of acceptable and prevailing practice when he failed to assist with Patient when he fell and failed to assess Patient in a timely manner after he fell.

42. The essential standards of acceptable and prevailing practice require that an LPN report a patient fall to the RN on duty or the Director of Nursing as soon as practicable.

43. Paragraphs 2 through 26 above demonstrate that Respondent failed to conform to the essential standards of acceptable and prevailing practice when he failed to inform the RN on duty or the Director of Nursing of Patient's fall on August 4, 2018.

44. The essential standards of acceptable and prevailing practice require an LPN to accurately document patient care and assessments.

45. Paragraphs 2 through 26 above demonstrate that Respondent failed to accurately document the care provided to Patient and the assessments of Patient after Patient's fall on August 4, 2018.

46. 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 Five: 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.

47. Paragraphs 2 through 26 above are incorporated herein.

48. As an LPN, Respondent is required to exercise his 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.

49. Paragraphs 2 through 26 above demonstrate that Respondent failed to exercise independent professional judgment on multiple occasions following Patient's fall on August 4, 2018 by engaging in the conduct described above.

50. 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).

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Understandings

51. This Stipulation is neither an admission of liability by Respondent nor a concession by the State of Vermont that its charges are not well-founded. To avoid delay, uncertainty, inconvenience, and the expense of protracted litigation, the Parties enter this full and final Stipulation pursuant to these Understandings and the Order below. Respondent does not dispute that the State may be able to prove these charges by a preponderance of the evidence if this matter proceeds to a merits hearing.

52. 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.

53. Respondent specifically waives any claims that any disclosures made to the full Board during its review of this agreement have prejudiced his rights to a fair and impartial hearing in future hearings if this agreement is not accepted by the Board.

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

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

56. 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.

57. Respondent voluntarily waives the right to a contested hearing before the Board of Nursing and waives any right to appeal from this Stipulation and Consent Order.

58. 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

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supervised practice in which Respondent works at least eighty (80) hours every calendar month as a nurse. Part time hours of fewer than eighty (80) hours every calendar month 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 his 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. Documentation: A Critical Aspect of Client Care (4.8 hours)

   b. Righting a Wrong: Ethics & Professionalism in Nursing (3.0 hours).

   Failure to satisfactorily complete the coursework 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

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satisfactory performance (i.e. consistently meeting all standards of nursing practice) and attendance.

6. Practice Under Supervision. Respondent shall practice as a licensed practical nurse only in a setting where Respondent has on-site 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, home health care agency, temporary nursing employment agency, or as a private duty nurse or personal care provider requiring a nursing or nursing assistant license during the effective period of this Consent Order.

8. Interview with the Board or its Designee. Respondent shall appear in person for interviews with the Board or its designee upon request.

9. Out-of-State Practice. Before any out-of-state practice can be credited toward fulfillment of these terms and conditions, Respondent shall first obtain approval from the Board. The Board will approve out-of-state nursing practice so long as Respondent can still comply with the provisions of this Consent Order. If Respondent receives discipline on a nursing license held in another state during the conditioned period, Respondent must inform the Board of such, in writing, within ten (10) days of receiving such discipline.

10. Notification of Place of Employment/Personal Address/Telephone Number. Within ten (10) days of the date of entry of this Consent Order, Respondent shall notify the Board, in writing, of Respondent's current place of employment, personal address, and telephone number. Respondent shall further notify the Board, in writing, within forty-eight (48) hours of any change in employment (including resignation or termination), personal address, or telephone number.

11. Notification to Other States. In the event that Respondent is licensed in nursing in any other state(s), Respondent must inform the nursing licensing board of the state(s) in which Respondent is licensed of the conditional status of Respondent's Vermont nursing license within thirty (30) days of the date of entry of this Order.

12. License Renewal. This Order does not automatically extend the license and Respondent must comply with the Board of Nursing requirements for license renewal and/or reinstatement.

13. Costs. Respondent shall bear all costs of complying with this Consent Order.

14. Violation of this Order. If Respondent violates this Order the Board, after giving Respondent notice and an opportunity to be heard, may rescind or modify this Order and impose additional appropriate disciplinary actions. If a complaint of unprofessional conduct is made against Respondent during the term of this Order, this Order shall be automatically extended until the unprofessional conduct matter is concluded.

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15. 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:

Dated: September 20, 2021

By: STATE OF VERMONT
SECRETARY OF STATE
E-SIGNED by Jennifer Colin
on 2021-09-20 17:07:41 EDT
Jennifer B. Colin
Prosecuting Attorney

Dated: September 20, 2021

By: RESPONDENT
E-SIGNED by Basilio Romaguera
on 2021-09-20 16:37:12 EDT
Basilio Romaguera

APPROVED AND SO ORDERED:

Dated: 10/11/2021

By: VERMONT BOARD OF NURSING
DocuSigned by:
Jennifer Laurent
EB1741915719477
Chairperson

Date of Entry: 10/11/21

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