

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

**IN RE: HELEN G. SHORT
LICENSE NO. 026-0009280**

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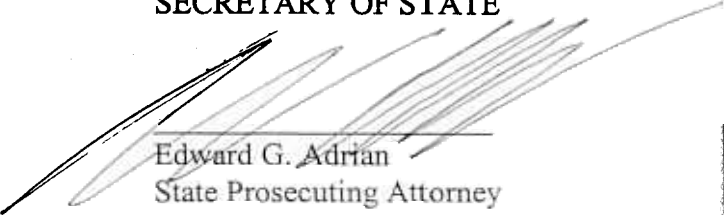
Docket No. NU07-0704

NOTICE OF DISMISSAL

NOW COMES the State of Vermont by and through its State Prosecuting Attorney,
Edward G. Adrian and hereby **DISMISSES WITHOUT PREJUDICE** the Specification of
Charges in the above referenced matter pursuant to newly disclosed evidence.

DATED at Montpelier, Vermont this 4th day of February, 2005.

**STATE OF VERMONT
SECRETARY OF STATE**



Edward G. Adrian
State Prosecuting Attorney

STATE OF VERMONT

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Prosecuting Attorney
Office of
Professional Regulation
Montpelier, VT 05602

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

IN RE:)
HELEN G. SHORT) **Docket No. NU 07-0704**
License No. 026-0009280)

SPECIFICATION OF CHARGES

NOW COMES the State of Vermont and makes the following Charges against the Respondent, Helen G. Short, R.N.:

Board Authority

1. The Vermont State Board of Nursing ("Board") has authority to approve consent orders, issue warnings or reprimands, suspend, revoke, limit, condition or prevent the renewal of current or 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 competently 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 performing unsafe or unacceptable patient care 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)(1) and (2).

Statement of Facts

STATE OF VERMONT



Prosecuting Attorney
Office of
Professional Regulation
Montpelier, VT 05602

5. The Respondent is licensed in the State of Vermont as a Registered Nurse under license number 026-0009280, issued by the State of Vermont. The Respondent's license is currently set to expire on March 31, 2005.
6. At all times relevant, the Respondent was employed by Burlington Health and Rehabilitation ("Facility") in Burlington, Vermont. The Respondent became employed as the Director of Nursing at the Facility on or about May 16, 2004.

Prior to that date, the Respondent was employed as the Assistant Director of Nursing at the Facility.

7. From June 28, 2004 through July 1, 2004, surveyors from the Department of Aging and Disabilities conducted a survey at the Facility. Several deficiencies were found, consisting of the following:
- a. An Immediate Jeopardy situation was identified when residents of the Facility were served hamburger that was raw.
 - b. Based on five of twenty-six records, the Facility failed to notify the physician and/or family of a significant change in status in a resident's condition.
 - c. The Facility failed to provide accommodation of need regarding call bell accessibility for three of twenty-six residents in the targeted sample.
 - d. The Facility failed to ensure a safe resident environment on two of four resident units in the Facility.
 - e. The Facility did not provide adequate housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior.
 - f. The Facility failed to provide a sufficient supply of clean towels, face cloths and clothing protectors for residents.
 - g. The Facility failed to meet professional standards of nursing practice regarding the implementation of physician orders for five of twenty-six applicable residents.
 - h. The Facility failed to provide the necessary care and services for six of twenty-six residents in the total sample to maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.
 - i. The Facility failed to assure that two of thirteen residents identified as being high risk for skin breakdown received the necessary care and services to prevent skin breakdown. In addition, the Facility did not conduct an assessment and notify the physician in a timely manner of one of the resident's skin breakdown in an effort to promote healing.
 - j. The Facility failed to assure that one of ten residents identified as being at risk for falls received adequate supervision and assistive devices to prevent accidents.
 - k. The Facility failed to ensure that one of five residents in the targeted sample identified for weight loss received the prescribed nutritional supplement.
 - l. The Facility failed to assure each resident received sufficient fluids to maintain proper hydration for one of one applicable residents in the targeted sample.
 - m. The Facility failed to provide adequate bowel function monitoring for one of twenty-six residents in the total sample who received an unnecessary bowel medication.
 - n. The Facility failed to ensure that one of twenty-six residents in the total sample was free of a significant medication error.

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Prosecuting Attorney
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Montpelier, VT 05602

- o. The Facility failed to assure sufficient nursing staff were available to provide care and services to residents who experienced weight loss, dehydration, pressure ulcers and medication errors. In addition, nursing staff failed to consistently assess and monitor residents' conditions, failed to notify and follow-up with the residents' physicians as needed, failed to provide adequate pain management to one resident and failed to accommodate individual resident needs.
- p. The Facility failed to assure that potentially hazardous meat was fully cooked prior to serving. In addition, the Facility did not assure that the kitchen was maintained under sanitary conditions.
- q. The Facility failed to assure that all staff carried out infection control practices with the management of resident equipment.
- r. The Facility did not have an effective pest control program to assure that the environment was free of pests.
- s. Based upon complaint investigations conducted on May 13, 2004, May 25, 2004 and June 4, 2004, in addition to complaint investigations conducted during survey and the serious nature of current survey deficiencies resulting in harm, the administration failed to assure compliance with the regulations and implementation of corrective action to address deficient practices.
- t. The Facility failed to maintain complete, accurately documented clinical records for two of twenty-six residents in the total sample.

Charges

8. By engaging in the conduct described above, Respondent has exhibited unprofessional conduct in the performance of her professional duties as the Director of Nursing. Specifically, the Respondent has violated:

- (i) 26 V.S.A. §1582(a)(3) (is unable to practice nursing competently by reason of any cause) which includes performing unsafe or unacceptable patient care 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)(1) and (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 Helen G. Short should be revoked, suspended, reprimanded, conditioned or otherwise disciplined.

Dated at Montpelier, Vermont this 5th day of November 2004.

STATE OF VERMONT



Prosecuting Attorney
Office of
Professional Regulation
Montpelier, VT 05602

STATE OF VERMONT
SECRETARY OF STATE

By: _____

Edward G. Adrian
State Prosecuting Attorney

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