

BEFORE THE BOARD OF NURSING
STATE OF MONTANA

IN THE MATTER OF DOCKET NO. CC-09-0027-NUR REGARDING:

THE PROPOSED DISCIPLINARY)	Case No. 349-2009
TREATMENT OF THE LICENSE OF)	
JOAN BROWN, LPN,)	
License No. 3795.)	
)	

**PROPOSED FINDINGS OF FACT; CONCLUSIONS OF LAW;
AND RECOMMENDED ORDER**

I. INTRODUCTION

On July 12, 2007, Denise Clark, a Montana licensed registered nurse (RN) and the Director of Nursing at the Rosebud Health Care Center filed a complaint with the Montana Board of Nursing against the nursing license of Joan Brown, a Montana licensed practical nurse (LPN). On October 3, 2008, the screening panel of the Board of Nursing (BON) found reasonable cause to believe that Brown had violated Mont. Code Ann. § 37-1-316(18) (conduct that does not meet the generally accepted standards of practice), Admin. R. Mont. 24.159.2301(2)(e) (verbally abusing patients), and Admin. R. Mont. 24.159.2301(2)(k) (intentionally committing any act that adversely affects the physical or psychosocial welfare of the patient).

Brown requested a hearing to resist the screening panel's proposed action against her license. Hearing Examiner Gregory L. Hanchett held a contested case hearing in this matter on December 16, 2008. Anjeanette Lindle, agency legal counsel, appeared on behalf of the Business Standards Division (BSD). Brown represented herself. The parties agreed to permit all witnesses to appear by telephone.

BSD's Exhibits 1 and 4 were admitted into evidence. Brown, Clark, Dustin Johnson, compliance specialist for the Board of Nursing, and Debbie Reiger, former dietary aide at Rosebud Health Care Center, all testified under oath. Based on the evidence adduced at the hearing, the following findings of fact, conclusions of law, and recommended order are made.

II. FINDINGS OF FACT

1. At all times pertinent to this matter, Brown has been a Montana licensed practical nurse holding License No. 3795. Brown worked as an LPN at Rosebud Health Care Center, a nursing home located in Forsyth, Montana.

2. On July 10, 2007, Brown was on duty working in the dining room of the health care center. Brown had responsibility for seeing that the residents' personal needs such as toileting were met while the residents were in the dining room. Also present at that time was Debbie Reiger, a dietary aide, who was serving the residents their meals.

3. One of the residents, who was wheelchair bound, told Brown several times that she needed to use the toilet very badly. Eventually, Brown came over and told the resident that someone would be with her in a little while. Reiger stated to Brown that "a little while might be too late." Brown, who was just eight to ten feet away from the resident, responded to Reiger in a loud voice that it did not matter because the lady was "wearing a diaper." The resident clearly could have overheard Brown's remark.

4. At least 20 minutes elapsed between the time the resident first asked to go to the bathroom and the time Reiger left the dining room area. During this time, Brown made no attempt to take the resident to the bathroom nor did she take any action to summon assistance to take the resident to the bathroom. It was not an unusually busy time for Brown and there was no basis for her not seeing to the resident's toileting needs.

5. At all times pertinent to this case, Rosebud Nursing Care maintained a written policy applicable to all employees that prohibited employees from abusing or neglecting the residents. Under that policy, "abuse" is defined as "the deprivation . . . of . . . services that are necessary to attain physical, mental and psychosocial well being." Exhibit 4, Rosebud Health Care Center Policy, Page 1. "Neglect" is defined as a "failure . . . to provide timely, consistent and safe services, treatment and care to a resident." Exhibit 4, Page 2. Brown's conduct violated the health care center's policy against abuse and neglect.

6. Brown's conduct was reported to the assistant director of nursing at the health care center. The assistant director then reported the conduct to the director of nursing at the facility, Denise Clark. Clark spoke to Brown about her conduct. Clark advised Brown that her conduct violated the health care employee policy discussed above. In response, Brown told Clark that she did not agree with the policy and thought it was too strict.

7. Clark placed Brown on administrative leave pending Clark's investigation of Brown's conduct. While on leave, Brown quit her job at the health care center.

8. Clark then filed a complaint with the BON. Investigator Dustin Johnson investigated the complaint for BON. As part of his investigation, Johnson contacted Brown. In response to his inquiry, Brown told Johnson that BON could do whatever it wanted to do with her license since she was no longer interested in practicing as an LPN.

9. Brown's response to both Clark during the investigation at Rosebud Health Care Center and to Johnson during BON's investigation evidences an unwillingness to recognize that her conduct toward the resident was inappropriate and violated professional standards. Her conduct in this case, as well as her inability to acknowledge that her conduct violated standards, necessitates imposition of a period of probation which must include remedial education and

imposition of a requirement that she not hold a LPN position that is unsupervised. These requirements are necessary in order to ensure the protection of the public and to permit Brown to continue practicing as an LPN.

III. CONCLUSIONS OF LAW

A. *Brown Has Violated Professional Standards.*

1. The Department bears the burden of proof to show by a preponderance of the evidence that the licensee committed an act of unprofessional conduct. Mont. Code Ann. § 37-3-311; *Ulrich v. State ex rel. Board of Funeral Service*, 1998 MT 196, 289 Mont. 407, 961 P.2d 126. The Department must also show that any sanction which it seeks is appropriate under the circumstances of the case. In addition, common law and statutory rules of evidence (including Mont. Code Ann. § 26, Chapter 10) apply to this proceeding and control the admission of evidence. Mont. Code Ann. § 37-1-310, Mont. Code Ann. § 2-4-612(2).

2. Mont. Code Ann. § 37-1-316 provides in pertinent part:

The following is unprofessional conduct for a licensee . . . governed by this chapter:

* * *

(18) conduct that does not meet generally accepted standards of practice.

* * *

3. Admin. R. Mont. 24.159.2301(2)(d) prohibits a Montana licensed LPN from failing to safeguard a patient's dignity and right to privacy. Admin. R. Mont. 24.159.2301(2)(e) prohibits a Montana licensed LPN from verbally or physically abusing a patient. Admin. R. Mont. 24.159.2301(2)(k) prohibits a Montana licensed LPN from intentionally committing any act that adversely affects the physical or psychosocial welfare of the patient.

4. The evidence presented in this matter shows that Brown has committed unprofessional conduct under Mont. Code Ann. § 37-1-316(18). The evidence also shows that she failed to safeguard the dignity of a resident, that she abused a patient, and that she intentionally committed an act that adversely affected the physical or psychosocial welfare of a patient. Brown committed an act of abuse in not seeing to the patient's toileting needs within a reasonable amount of time. Despite the patient's repeated requests to be taken to the bathroom, Brown ignored the request even though she was charged with responding to the request. Things were not so busy that Brown could not have responded to the request in a much more timely fashion.

In addition, Brown failed to safeguard the patient's dignity by telling the dietary aide within earshot of the patient and in a room with other patients present that the patient was "wearing a diaper." As the evidence and testimony of both the dietary aide and the former director of nursing showed, this conduct fell below the standard of care to be expected from an

LPN in Brown's situation. Her license is thus vulnerable to the imposition of the sanctions provided in Mont. Code Ann. § 37-1-312.

B. The Appropriate Sanctions In This Case Include A Term Of License Probation, On The Job Supervision, And Remedial Education.

5. A regulatory board may impose any sanction provided for by Montana Code Annotated Title 37, Chapter 1, upon a finding of unprofessional conduct. Mont. Code Ann. § 37-1-307(f). Among other things, Montana Code Annotated § 37-1-312 provides that a regulatory board may impose probation, appropriate terms of probation, and a license suspension.

6. To determine which sanctions are appropriate, the regulatory board must first consider the sanctions necessary to protect the public. Only after this determination has been made can the Board then consider and include in the order requirements designed to rehabilitate the licensee. Mont. Code Ann. § 37-1-312(2).

7. Brown's conduct in this matter was highly inappropriate. Her conduct toward the resident was abusive and wholly unwarranted under the circumstances. Her intentional and indifferent affront to the dignity of the patient and her refusal to participate in the investigation of this matter are also of great concern to the hearing examiner. These things demonstrate that the protection of the public can only be ensured if Brown's license is placed on a term of probation with the provisos that she attend some remedial education in proper patient care, that she work only in a supervised position, and that she submit quarterly reports to the BON so that her work can be appropriately monitored.

IV. RECOMMENDED ORDER

Based upon the foregoing, it is recommended that the Board of Nursing enter its order placing Brown's license on probation for a period of one year from the date of the Board's entry of its final order in this matter with the terms:

(1) That Brown will enroll in, pay for, and successfully complete remedial education dealing with proper care for patients within the time period to be prescribed by the Board of Nursing and under such terms and conditions as deemed appropriate by the Board of Nursing;

(2) That Brown shall not work in any unsupervised position during the term of her probation;

(3) That Brown shall submit quarterly or more frequent reports as directed by the Board of Nursing;

(4) That Brown shall obey

(a) all provisions of Title 37, Chapters 1 and 8, Montana Code Annotated,

(b) all provisions of Title 24, Chapter 159, and

(c) all requirements or directives imposed by the Board;

(5) That in the event Brown fails to comport with any facet of the Board's final order, that her license be suspended until such time as she complies with the terms of the final order.

DATED this 2nd day of February, 2009.

DEPARTMENT OF LABOR & INDUSTRY
HEARINGS BUREAU

By: /s/ GREGORY L. HANCHETT
GREGORY L. HANCHETT
Hearing Examiner

NOTICE

Mont. Code Ann. § 2-4-621 provides that the proposed order in this matter, being adverse to the licensee, may not be made final by the regulatory board until this proposed order is served upon each of the parties and the party adversely affected by the proposed order is given an opportunity to file exceptions and present briefs and oral argument to the regulatory board.