The Commonwealth of Massachusetts
Executive Office of Health and Human Services
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Division of Health Professions Licensure
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Commissioner

June 11, 2015

VIA CERTIFIED MAIL, RETURN RECEIPT REQUESTED NO. **7012 3460 0001 7330 8234**

Laurie G. Cleveland
redact

RE: In the Matter of Laurie Cleveland, Docket No. NUR-2013-0102
License No. RN200966

Dear Ms. Cleveland:

Please find enclosed the Final Decision and Order issued by the Board of Registration in Nursing on June 11. This constitutes full and final disposition of the above-referenced complaint, as well as the final agency action of the Board. Your appeal rights are noted on page 2.

You may contact Vita Berg, Board Counsel at (617) 973 – 0950 with any questions that you may have concerning this matter.

Sincerely

Rula Harb/VPB

Rula Harb, MSN, RN
Executive Director,
Board of Registration in Nursing

Encl.

cc: Beth Oldmixon, Esq., Prosecuting Counsel

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, SS

BOARD OF REGISTRATION IN NURSING

In the Matter of)
LAURIE CLEVELAND)
License No. RN200966)
License expires: 3/23/16)

Docket No. NUR-2013-0102

I do hereby certify the foregoing to be a true and certified copy of the document on file with the Massachusetts Board of Registration in Nursing.

6/15/15

Authorized Signature Date

FINAL DECISION AND ORDER

FINAL DECISION

On April 21, 2015, the Board held a formal hearing on the issue of sanction in this matter before Administrative Hearings Counsel ("AHC") Beverly Kogut. On April 29, 2015, the AHC issued a Tentative Decision that incorporates facts stipulated by the Respondent Laurie Cleveland ("Respondent") and Prosecuting Counsel. The stipulated facts establish that the Respondent engaged in conduct that constitutes violations of the Board's regulations. The Tentative Decision further contains the AHC's summary of facts presented by the Respondent at the April 21, 2015 on the issue of sanctions. Neither the Respondent nor Prosecuting Counsel have filed Objections to the Tentative Decision.

The Board hereby adopts the Tentative Decision, including all findings of fact, credibility determinations, conclusions of law and discussion contained therein, as the Board's Final Decision, with a correction on page 2 to a typographical error, which reads "Exhibits B and C were marked for identification," but should read "Exhibits C and D were marked for identification."

ORDER

Based on its Final Decision, the Board orders a **Reprimand** of the Respondent's license to practice as a Registered Nurse in Massachusetts, License No. RN200966.

The Board voted to adopt the within Final Decision at its meeting held on June 10, 2015, by the following vote:

In favor:	A. Alley, BSN, RN; M. Beal,RN/NM; P. Gales, RN; K. Gehly, RN; S.Kelly, RN/NP; J. Killion, LPN; B. Levin, RN; A. Peckham, RN, MSN; C. Simonian, Pharm.D., R.Ph.; S. Taylor, MSN, RN; C. Tebaldi, RN, MS; C. Urena, LPN
Opposed:	None
Abstained:	None
Recused:	None
Absent:	E. Richard Rothmund

The Board voted to adopt the within Final Order at its meeting held on June 10, 2015, by the following vote:

In favor:	A. Alley, BSN, RN; M. Beal,RN/NM; P. Gales, RN; K. Gehly, RN; S.Kelly, RN/NP; J. Killion, LPN; B. Levin, RN; A. Peckham, RN, MSN; C. Simonian, Pharm.D., R.Ph.; S. Taylor, MSN, RN; C. Tebaldi, RN, MS; C. Urena, LPN
Opposed:	None
Abstained:	None
Recused:	None
Absent:	E. Richard Rothmund

EFFECTIVE DATE OF ORDER

This Final Decision and Order by Default becomes effective upon the tenth (10th) day from the date it is issued (see "Date Issued" below).

RIGHT TO APPEAL

Respondent is hereby notified of the right to appeal this Final Decision and Order to a Superior Court with jurisdiction pursuant to M.G.L. c. 30A §§ 14. Respondent must file his appeal within thirty (30) days of receipt of notice of this Final Decision and Order.

Board of Registration in Nursing,

Date Issued: 6·11·15

Rula Harb/VPB
Rula Harb, MSN, RN
Executive Director

Notified:

VIA FIRST CLASS AND CERTIFIED MAIL RETURN
RECEIPT REQUESTED NO. 7012 3460 0001 7330 8234
Laurie G. Cleveland
redact

BY HAND DELIVERY
Beth Oldmixon, Esq.
Prosecuting Counsel
Department of Public Health
Division of Health Professions Licensure
239 Causeway Street
Boston, MA 02114

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK COUNTY

BOARD OF REGISTRATION IN NURSING

IN THE MATTER OF LAURIE CLEVELAND RN LICENSE NO. 200966 RN LICENSE EXP. DATE 03/23/16	))))))	DOCKET NO. NUR-2013-0102

TENTATIVE DECISION AFTER SANCTION HEARING

I. Introduction

This matter comes before the Board of Registration in Nursing (Board) for a determination of an appropriate sanction and issuance of a Final Decision and Order in this disciplinary action against the license of Respondent, Laurie Cleveland (RN License No, 200966), to practice as registered nurse in the Commonwealth of Massachusetts. Respondent stipulates that from February 2012 through March 2012 she failed to timely document the condition of and care provided to four (4) patients and that her conduct subjects her license to discipline for violations of applicable nursing statutes, laws and regulations, including, but not limited to, G. L. c. 112, § 61 and Board regulations at 244CMR 9.00 et seq. The record also includes testimony and documents presented by Respondent at the April 21, 2015 sanction hearing held at Respondent's request.

II. Procedural Background

On June 17, 2014, the Board issued an Order to Show Cause. Respondent submitted an answer and request for hearing on July 7, 2014. The Administrative Hearings Counsel (AHC) convened a status conference on July 28, 2014, which was attended by the parties. On April 1, 2015, Respondent and Prosecuting

Counsel filed a Stipulation and Request for Hearing. Respondent waived her right to a full adjudicatory hearing on the merits and requested that the matter be set for a sanction hearing. The AHC convened the sanction hearing on April 21, 2015. Respondent appeared *pro se*. She testified and called one witness. Four exhibits were entered into the record. Beth Oldmixon was Prosecuting Counsel on behalf of the Board.

III. Exhibits

Exhibits A and B were admitted into the record. Exhibits B and C were marked for identification only. [1]

A. Thirteen (13) Letters of Reference (14 pages)

B. Eight (8) Certificates of Completion of Continuing Education Units (8 pages)

C. (Marked for Identification Only) Respondent's Examples of Patient Summary Notes Prepared Post-Incident (Redacted) (10 pages)

D. (Marked for Identification Only) Documentation Guidelines for PHH Clinicians, Revised 2/22/12

IV. Stipulations

Respondent and Prosecuting Counsel stipulate to the facts and conclusions of law recited below. The Board adopts these stipulations.

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[1] On March 30, 2015, the AHC notified the parties in writing that the due date for filing documentary evidence to be submitted at the sanction hearing was April 6, 2015 and that failure to timely file may result in an order precluding a party from presenting the documents at the hearing. At the hearing, Respondent sought to file Exhibit C and Prosecuting Counsel sought to file Exhibit D. There was no demonstration of good cause for the late submission of these documents and the AHC declines to admit them into the record. Even if the exhibits had been admitted into the record, the AHC would have given them little weight. They were used primarily for cross-examination and demonstrative purposes and other than the testimony they elicited had insufficient relevancy to this stage of the proceeding.

A. Stipulated Facts

1. On or about October 1, 1992, the Board issued to Respondent a license to engage in the practice of nursing as an RN in the Commonwealth of Massachusetts. That license is current and will expire on March 23, 2016, unless renewed.

2. From approximately February 2012 through March 2012 the Respondent was employed by Core Medical Group (Core) as an RN working for Partners HealthCare at Home (Partners) as a home health nurse.

3. Partners policy required that documentation be prepared of all care and that said documentation be completed by the end of the same day the care was provided.

Patient A

4. On or about February 25, 2012, while employed as an RN for Core and working for Partners Respondent provided care to Patient A.

5. On or about March 5, 2012, Respondent completed the documentation regarding the condition of and care provided to Patient A on February 25, 2012.

6. On or about February 26, 2012, while employed as an RN for Core and working for Partners Respondent provided care to Patient A.

7. On or about March 5, 2012, Respondent completed the documentation regarding the condition of and care provided to Patient A on February 26, 2012.

8. On or about February 27, 2012, while employed as an RN for Core and working for Partners Respondent provided care to Patient A.

9. On or about March 5, 2012, Respondent completed the documentation regarding the condition of and care provided to Patient A on February 27, 2012.

Patient B

10. On or about February 22, 2012, while employed as an RN for Core and working for Partners Respondent provided care to Patient B.

11. On or about March 6, 2012, Respondent completed the documentation regarding the condition of and care provided to Patient B on February 22, 2012.

12. On or about February 25, 2012, while employed as an RN for Core and working for Partners Respondent provided care to Patient B.

13. On or about March 6, 2012, Respondent completed the documentation regarding the condition of and care provided to Patient B on February 25, 2012.

14. On or about February 27, 2012, while employed as an RN for Core and working for Partners Respondent provided care to Patient B.

15. On or about March 6, 2012, Respondent completed the documentation regarding the condition of and care provided to Patient B on February 27, 2012.

16. On or about February 29, 2012, while employed as an RN for Core and working for Partners Respondent provided care to Patient B.

17. On or about March 6, 2012, Respondent completed the documentation regarding the condition of and care provided to Patient B on February 29, 2012.

18. On or about March 6, 2012, Respondent completed documentation that indicated based on her observation during her February 22, 2012 care and treatment that Patient B had a tender area that had "a lot of crud."

Patient C

19. On or about February 23, 2012, while employed as an RN for Core and working for Partners Respondent provided care to Patient C.

20. On or about February 25, 2012, Respondent completed the documentation regarding the condition of and care provided to Patient C on February 23, 2012.

Patient D

21. On or about February 27, 2012, while employed as an RN for Core and working for Partners Respondent provided care to Patient D.

22. On or about March 5, 2012, Respondent completed the documentation regarding the condition of and care provided to Patient D on February 27, 2012.

B. Stipulated Grounds for Discipline

A. Respondent agrees her conduct as stipulated above warrants disciplinary action by the Board against her license to practice as an RN pursuant to Board regulation 244 CMR 9.03 (5) for failing to engage in the practice of nursing in accordance with accepted standards of practice;

B. Respondent agrees her conduct as stipulated above warrants disciplinary action by the Board against her license to practice as an RN pursuant to Board regulation 244 CMR 9.03 (44) for failing to make complete, accurate, and legible entries in all records required by federal and state laws and regulations and accepted standards of nursing practice;

C. Respondent agrees her conduct as stipulated above warrants disciplinary action by the Board against her license to practice as an RN pursuant to Board regulation 244 CMR 9.03 (47) for engaging in any other conduct that fails to conform to accepted standards of nursing practice or in any behavior that is likely to have an adverse effect upon the health, safety, or welfare of the public;

D. Respondent agrees her conduct as stipulated above warrants disciplinary action by the Board against her license to practice as an RN pursuant to G.L. c. 112, § 61 for deceit, malpractice and gross misconduct in the practice of the profession and for offenses against the laws of the Commonwealth relating thereto; and

E. Respondent agrees her conduct as stipulated above also constitutes unprofessional conduct and conduct which undermines public confidence in the integrity of the profession. *Sugarman v. Board of Registration in Medicine*, 422 Mass. 338, 342 (1996); see also *Kvitka v. Board of Registration in Medicine*, 407 Mass. 140, cert. denied, 498 U.S. 823 (1990); *Raymond v. Board of Registration in Medicine*, 387 Mass. 708, 713 (1982).

V. <u>Presentations at Sanction Hearing</u>

Respondent's Presentation Relative to Sanction

At the relevant time period, February 2012 through March 2012, Respondent, was employed by Core Medical Group (Core) as an RN working for Partners HealthCare (Partners) as a home health nurse. She worked in that position from May 2011 through March 2012. Respondent admits that she did not timely

complete her documentation for four (4) patients for visits that took place from February 22-29, 2012, due to a confluence of unusual and extenuating circumstances. At the time, Respondent was dealing with a demanding family situation and an unusually heavy and complicated patient case load. She completed the documentation approximately 6-12 days late, on March 5 and 6, 2012, before she left on March 9, 2012, for vacation, instead of completing it on the same day that the care was provided. On the dates of the patient visits she wrote some documentation which other clinicians would have been able to view on the computer system. She was the only nurse seeing each of these patients at the time. She represents that she was in communication with her nurse manager the whole time, providing her timely verbal reports, apprising her that she was not able to complete the paperwork on a timely basis and the reasons why, and explaining that she would complete it prior to leaving for vacation, which she did. She worked up until a few days before she was to depart for a vacation abroad: a trip to Cancun, Mexico that she had won from her employer, CORE. Respondent took several vacation days off work prior to departing for her March 9, 2012 trip. She had planned to use the extra days to get ready, but instead spent the two (2) days, March 5 and 6, 2012, completing the documentation. She did not bill for the time it took to complete the documentation.

At the time, she was seeing 8-10 patients a day, whereas a typical caseload would be 5-6 patients. She was working extremely long hours, getting up at 4 or 5 a.m., leaving for work at approximately 8 a.m. and often not returning home until 10-11 p.m. In the mornings, patient visits would be delayed because of frequent

changes, sometimes 4-5 times in one morning -- a not infrequent occurrence in the home health field. She worked a large territory that required a lot of travel time. She loves home health care because of the tremendous amount of good she feels she does for her patients in that setting. She represents that she would give each of her patients undivided attention and the time needed for her to assess and stabilize the patient, to perform tasks according to patient care plans, to call patients' doctors, speak with and teach family members and to perform exceptional patient care. One of her patients at the relevant time period was actively dying of metastatic cancer and required BID (twice a day) care, requiring two trips a day to the patient's home. This patient required IV fluids and other medications and she provided extensive teaching and support to the family, not only about patient care, but about death and dying and having the patient transferred to hospice. The patient died several days after she left for vacation.

The Respondent submitted as Exhibit A thirteen (13) letters of reference dated June 2014 through February 2015, from appreciative patients, co-workers, friends, and former supervisors emphasizing her caring, kindness, ability, patience and trustworthiness. Before the Board at page 8 of Exhibit A is a glowing letter of support for Respondent from the son and daughter-in-law of the patient for whom she rendered care during the February-March 2012 time period and who passed away while she was on vacation. In the letter, the patients' family express their gratitude for her professionalism, love, compassion, dedication, and guidance at this "trying, difficult time" and thanking her for never rushing her visits, taking the time to show them "over and over" how to set up the IV line, and coming to them,

no matter the weather, as if she were part of the family, and making a "difficult time... more bearable". In another letter a mother of a teenage patient with end-stage cancer described her as a "gift to our family." A former supervisor, Bill Murray of MAS Medical Staffing, wrote in a June 27, 2014 email sent from his business email address, that she did a great job, there were no complaints, and he would hire her again. Another former supervisor, Robert Ford, of All Care VNA, in an email sent from what appears to be a personal email address, recommends her and describes her dedication, skill, and compassion as a nurse. Ford was Respondent's supervisor for the first 6 months of her employment at CORE. Respondent did not submit performance appraisals from a current employer.

At the time of the February–March 2012 incident, Respondent was dealing with several significant family matters. Respondent's daughter, Katherine, who testified at the hearing, explained that in December 2011 she was homeless and had recently given birth to a baby who was born two months premature. In January 2012, the baby was released from the hospital and Katherine and the new born moved in with Respondent into her one bedroom apartment in Braintree, MA. At times, the newborn's father and Katherine's four-year-old son also lived with them. The newborn had apnea and Respondent spent time teaching Katherine how to recognize it, how to position the baby and what to do if he stopped breathing. This living arrangement, including having a new born in the apartment who at the time was thought to have sleep apnea, caused Respondent to get woken up several times during the night. At all times Respondent had wanted to complete the

documentation timely, but was not able to because of the unusual demands of her case load and living with an acutely ill new-born.

Respondent represents that in this proceeding she promptly did all that the Board has requested of her, including, but not limited to, submitting the letters of reference cited above. Respondent and Prosecuting Counsel represent that Respondent is up to date on her required continuing education units and, in addition, as evidenced by Exhibit B, has completed all of the continuing education units suggested by the Board. Respondent and Prosecuting Counsel also represent that other than this matter currently pending before the Board, Respondent has had no complaints or other disciplinary action against her Massachusetts license.

In her closing, Respondent asserts that she has learned from this experience. Now, she timely completes her documentation. This past year, when she took vacation time from work to spend it with her daughter who had recently given birth to a third son, all of her documentation had been timely completed beforehand. Respondent respectfully requests that the Board dismiss this matter and not impose discipline on her license, not even a reprimand. She represents that after over 20 years of dedicated and compassionate, patient-centered practice, she has an unblemished record as a nurse that she would like to maintain, that she understands the importance of timely completing her documentation and has been doing it and will continue to do so going forward.

Prosecuting Counsel's Presentation Relative to Sanction

Prosecuting Counsel does not request a specific sanction and instead asks the Board to impose an appropriate sanction.

VI. Discussion

The Board is charged with the responsibility of protecting the public health, safety, and welfare and ensuring the public's confidence in the integrity of the nursing profession. It has broad authority to regulate the conduct of the profession and broad discretion in determining an appropriate sanction. *Sugarman v. Board of Registration in Medicine*, 422 Mass. 338, 342 (1996); see also *Kvitka v. Board of Registration in Medicine*, 407 Mass. 140, cert. denied, 498 U.S. 823 (1990); *Raymond v. Board of Registration in Medicine*, 387 Mass. 708, 713 (1982).

The Board, in making its determination on sanction, must weigh the seriousness of the violation, and its effect on public health, safety, welfare, patient safety and the public's perception of the profession. Proper and timely documentation of patient condition and care is an important requirement for a nurse. Its primary purpose is to provide protection for the patient. Although no patient was physically harmed in this matter, the Board has long recognized that improper documentation by a nurse, including a failure to timely complete documentation, harms a patient by failing to provide proper protection for the patient and puts the patient at risk of not receiving proper medical care. The Board is cognizant of, and has given careful consideration to, the facts and information presented in the record, including

Respondent's presentation at the sanction hearing. The Board issues the following order.

Order to be issued by the Board.

Board of Registration in Nursing

By: _____
Beverly Kogut, Esq.
Administrative Hearings Counsel
Office of General Counsel
Department of Public Health
Division of Health Professions Licensure
239 Causeway Street, Suite 500, 5th Floor
Boston, MA 02114
Tel: 617-973-0813

Tentative Decision Issued: April 29, 2015

VIA EMAIL, FIRST CLASS MAIL
AND CERTIFIED MAIL RETURN RECEIPT REQUESTED
NO. 7012 0470 0001 3526 8442
Laurie G. Cleveland
redact

VIA EMAIL AND INTEROFFICE DELIVERY
Beth Oldmixon, Prosecuting Counsel
Office of Prosecutions
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