MAINE STATE BOARD OF NURSING

IN RE: Pauline A. Covel, R.N. )
) DECISION AND ORDER
Licensure Disciplinary Action )

PROCEDURAL HISTORY

Pursuant to the authority found in 32 M.R.S.A. Sec. 2105-A(1-A)(D), et seq., 5 M.R.S.A. Sec. 9051, et seq. and 10 M.R.S.A. Sec. 8001, et seq., the Maine State Board of Nursing (Board) met in public session at the Board’s offices located in Augusta, Maine on March 28, 2002 for the purpose of determining whether Pauline Covel, R.N. engaged in unprofessional and or incompetent conduct as a registered nurse while employed by Rainbow Coverage Nursing, Inc. (Rainbow) A quorum of the Board was in attendance during all stages of the proceedings. Participating and voting Board members were Chairman Richard L. Sheehan, M.S., R.N., Kathleen A. Dugas, L.P.N., Jody L. Deegan, M.S.N., R.N.C., Betty A. Kent-Conant, R.N. and Jeanne B. Delicata, R.N.C.

In accordance with Maine law, Ms. Covel was served with notice of the Hearing and allegations against her by regular mail posted February 15, 2002 and March 12, 2002, neither of which were returned to the Board. Ms. Covel failed to appear either in person or by counsel. John H. Richards, Ass’t. Attorney General, presented the State’s case. James E. Smith, Esq. served as Presiding Officer.

Subsequent to the opening statement by counsel, State’s Exhibits 1-3 were admitted into the Record. Following the taking of testimony, submission of exhibits, and closing argument, the Board deliberated and made the following findings of fact by a preponderance of the credible evidence regarding the violations alleged in the Complaint.

FINDINGS OF FACT

Pauline Covel received her nursing degree in 1964 in the Commonwealth of Massachusetts. She has been a licensed registered nurse in the State of Maine since October 1997 and was hired in that capacity by Rainbow. Subsequently, she was assigned to perform her duties at Gorham House, a nursing home situated in Gorham, Maine. On September 29, 1999, she made 6 errors regarding the administration of medications. In all instances, she failed to utilize the “bingo” cards from which the meds are to be removed. On review, those cards still held the drugs that were supposed to have been given to the patients. Nurse Covel, in her response to her supervisor, stated that she had administered the drugs to the patients but that she could not locate their “bingo” cards and borrowed the correct meds from other patients. She further stated that the medication cart was very disorganized despite the fact that
she was overall responsible for the organization of that cart. Additional concerns were expressed by her superiors that she had left the building for extended breaks without informing the staff as to her whereabouts.

Nurse Covel was also assigned by her employer to perform nursing services at Evergreen Manor, a nursing home located in Saco, Maine. While at Evergreen, sometime between the late evening-early morning on January 17-18, 2000, Ms. Covel made 3 medication errors. First, she prepared medications, placed them in cups on which she wrote the patient’s room number, and administered them to some patients without checking their photo identifications in order to confirm that the drugs matched their intended recipients. Second, she administered Dilantin to a patient who was alert and oriented who was not under orders to receive that medication. This patient spit the medication out. Before giving the Dilantin, the patient informed Nurse Covel that she did not take morning medications. Third, she failed to administer medication to that patient’s roommate and an antibiotic was found on the floor of a resident’s room that morning. Apparently, the resident did not receive her antibiotic at the correct time.

Nurse Covel denied any wrongdoing regarding the above allegations although she failed to appear at the scheduled informal conference before the Board to discuss the above issues. Additionally, no other complaints have been forwarded to the Board regarding her nursing skills or ability to perform the duties of her profession pursuant to her license which is active until December 4, 2002.

CONCLUSIONS OF LAW

The relevant statutory and regulatory provisions regarding the above matter and as stated in the Complaint/Notice of Hearing are as follows:

32 M.R.S.A. Sec. 2105-A.2. Grounds for discipline. The board may suspend or revoke a license pursuant to Title 5 section 10004. The following are grounds for an action to issue, modify, suspend, revoke or refuse to renew the license of an individual licensed under this chapter:

E. Incompetence in the practice for which the licensee is licensed. A licensee is considered incompetent in the practice if the licensee has:

1. Engaged in conduct that evidences a lack of ability or fitness to discharge the duty owed by the licensee to a client or patient or the general public; or
2. Engaged in conduct that evidences a lack of knowledge or inability to apply principles or skills to carry out the practice for which the licensee is licensed.

F. Unprofessional conduct. A licensee is considered to have engaged in unprofessional conduct if the licensee violates a standard of professional behavior that has been established in the practice for which the licensee is licensed.

H. A violation of this chapter or a rule adopted by the board.
3. Definition of Unprofessional Conduct. Nursing behavior which fails to conform to legal standards and accepted standards of the nursing profession, and which could reflect adversely on the health and welfare of the public shall constitute unprofessional conduct and shall include, but not be limited to, the following:

F. Failing to take appropriate action or to follow policies and procedures in the practice situation designed to safeguard the patient.

K. Inaccurate recording, falsifying or altering a patient or health care provider record.

The Board, by a vote of 4-1, based on the above recited facts and the vulnerability of the patient population, concludes that Pauline A. Covell, R.N. violated the above statutory and regulatory standards of nursing and that she is to receive this Letter of Warning and pay a fine of $1,500 within 60 days of the date of this Order. The check shall be made payable to: Treasurer, State of Maine and mailed to the clerk of this Board.

SO ORDERED.

Dated: April 10, 2002

[Signature]
Richard L. Sheehan, Chairman
Maine State Board of Nursing

Appeal Rights

Pursuant to the provisions of 5 M.R.S.A. Sec. 10051.3 and 10 M.R.S.A. Sec. 8003, any party that appeals this Decision and Order must file a Petition for Review in the Maine Superior Court within 30 days of receipt of this Order.

The petition shall specify the person seeking review, the manner in which they are aggrieved and the final agency action which they wish reviewed. It shall also contain a concise statement as to the nature of the action or inaction to be reviewed, the grounds upon which relief is sought and a demand for relief. Copies of the Petition for Review shall be served by Certified Mail, Return Receipt Requested upon the Maine State Board of Nursing, all parties to the agency proceedings and the Attorney General.