MAINE STATE BOARD OF NURSING

IN RE: Kyle A. Fredericks, L.P.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 Kyle Fredericks L.P.N. engaged in unprofessional and or incompetent conduct as a licensed practical nurse while employed at Brentwood Rehabilitation and Nursing Center (Brentwood). 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, Mr. Fredericks was served with notice of the Hearing and allegations against him by regular mail posted February 15, 2002 and March 12, 2002, neither of which were returned to the Board. Nurse Fredericks 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 1-4 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.

PRELIMINARY FINDINGS OF FACT

Kyle Fredericks graduated from nursing school in 1997. He became a licensed practical nurse (L.P.N.) in the State of Maine in June 1999 and subsequently began employment at Brentwood. Nurse Fredericks was functioning as an L.P.N. at that facility during the night and early morning hours of March 24-25, 2000. As such, he had supervisory responsibilities and was, in turn, supervised by a registered nurse who was located at a different area at Brentwood.

Patient X, an elderly woman, was admitted to Brentwood on March 23, 2000 with a diagnosis of Alzheimer's. At 6:00 a.m. on the 25th, employees arriving at work found patient X sitting on the ground outside the front door. Although she had an alarm attached to her ankle to prevent her leaving from the secured facility, apparently the alarm system malfunctioned. She was barefoot and wearing only her nighty and

underwear. She was reportedly cold, pale and wet and had dried blood on her legs and a big cut on her elbow. The temperature earlier in the morning had dropped to 31 degrees whereas at 6:00 a.m. it was 36 degrees. Patient X had last been seen in the facility at 3:00 a.m. and had been up and wandering.

Nurse Fredericks recorded patient X's temperature at 93.7 degrees. He faxed her treating physician and noted that she was to be checked every 30 minutes for 24 hours. He cleaned her open wounds with alcohol, placed her in bed "with lots of covers and gave patient hot tea." Eventually, this patient recovered from the experience.

FINDINGS AND 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.

Rules and Regulations of the Maine State Board of Nursing, Chapter 4.

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:

B. Assuming duties and responsibilities within the practice of nursing without adequate preparation or when competency has not been maintained.

E. Failing to supervise persons to whom nursing functions have been delegated.

F. Failing to take appropriate action or to follow policies and procedures in the

practice situation designed to safeguard the patient.

H. Intentionally or negligently causing physical or emotional injury to a patient.

I. Failing to safeguard the patient's dignity and right to privacy in providing services regardless of race, color, creed and status.

The Board finds the following violations of the above statutes, rules and standards of care. The notes regarding Patient X's treatment reveal that she should have been visited every half hour by nurses' aids who were under the supervision of the licensee. Apparently, she wasn't observed from 3:00 a.m.-6:00 a.m. Additionally, a physician or the registered nurse on duty should have been immediately contacted by Nurse Fredericks to determine whether they wanted to participate in an assessment of patient X's condition. Nurse Fredericks' fax to X's doctor shortly after 6:00 a.m. did nothing to inform him in a timely manner that there was a problem with his patient. In fact, it was other staff who called the doctor at 9:00 a.m. to alert him of the situation.

When contacted, X's physician stated that had he been immediately notified, he would have participated in her assessment or probably had her transported to the hospital. It must be noted that warming up an individual too quickly can cause increased blood potassium which can result in cardiac problems. In effect, nurse Fredericks failed to recognize the seriousness of patient X's 93.7 degree temperature.

Patient X's open wounds should not have been cleaned with alcohol. Mr. Fredericks stated that "it was so cold she didn't feel it so it was o.k." He further explained that the incident occurred at the end of a second 12 hour shift and that he was tired and not thinking straight.

The Board, by a vote of 5-0, based on the above recited facts and utilizing its members' experience and training while considering the vulnerability of the patient population, concludes that Kyle A. Fredericks, L.P.N. violated the above statutory and regulatory standards of nursing and that his **license is hereby suspended for a period of 360 days.**

SO ORDERED.

Dated: April 10, 2002

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.