

**MAINE STATE BOARD OF NURSING**

**IN RE: John S. Zablotny, R.N. ) DECISION  
AND  
Licensure Disciplinary Action ) ORDER**

**I. PROCEDURAL HISTORY**

Pursuant to the authority found in 32 M.R.S. Sec. 2105-A (1-A) (D), *et seq.*, 5 M.R.S. Sec. 9051, *et seq.* and 10 M.R.S. Sec. 8003, *et seq.*, the Maine State Board of Nursing (Board) met in public session at the Board’s office located in Augusta, Maine at 9:00 a.m. on April 14, 2010 and at 8:00 a.m. on May 12, 2010. The purpose of the meetings was to conduct an adjudicatory hearing to determine whether John Zablotny, R.N. violated Board statutes and rules as a registered nurse while practicing his profession at the Down East Community Hospital in Machias, Maine. A quorum of the Board was in attendance during all stages of the proceedings. Participating and voting Board members were Chairman Bruce O’Donnell, C.R.N.A.; Robin Brooks (public representative); Susan C. Baltrus, M.S., R.N.B.C.-C.N.E.; Carmen Christensen, R.N.; and Elaine A. Duguay, L.P.N. John Richards, Assistant Attorney General, presented the State’s case. Nurse Zablotny was present and represented by Joseph Baldacci, Esq. and Carol Coakley, Esq. James E. Smith, Esq. served as Presiding Officer.

The Board first found that none of the Board members had conflicts of interest which would bar them from participating in the hearing. The Board then took official notice of its statutes and rules, and subsequent to the opening statements, State’s Exhibits 1-19 and Respondent’s Exhibits 1-7 (evaluations) were admitted into the Record. The Board then heard the testimony, reviewed the submission of exhibits, and considered the parties’ closing arguments, after which it deliberated and made the following findings of fact by a preponderance of the credible evidence regarding the alleged violations.

**II. FINDINGS OF FACT**

John Zablotny, 44 years of age, was first licensed as a registered nurse in the State of Maine on February 19, 1998; his current license expires on February 14, 2012. He is a resident of Steuben, Maine.

Mr. Zablotny had been employed as a registered nurse at the Down East Medical Center (DEMC) since 1999. He served as the nurse supervisor periodically and most recently from June 2005 until January 2008. As the nurse supervisor, Nurse Zablotny was responsible for the overall operation of the hospital during his shift and for providing nursing services at times to all wards, including the emergency

room. Down East Medical Center terminated his employment on January 21, 2008. The events leading up to that termination are the subject of this decision.

Mr. E, 61 years old, was admitted as a patient to DEMC on December 27, 2008 for management of abdominal pain and possible pancreatitis secondary to alcohol abuse. At the time of admission, he weighed 145 pounds and was 6'5" tall. According to the hospital record and nurses, various pain medications were being administered regularly as prescribed. Initially, he was given a 75 mcg/hr Fentanyl patch<sup>1</sup> (to last for three days) and also periodically received doses of Dilaudid and Demerol IV. On December 31, 2008, he received an additional 25 mcg/hr Fentanyl patch. Since the genesis of his pain was not apparent, the patient plan was to transfer Patient E to Maine Medical Center when a bed and his physician were available for further testing and treatment.

During the day on January 1, 2008, a snowstorm developed which was described by some as "horrific" and one of the two worst of the year. The storm became progressively more severe during the day, with heavy snow accompanied by high winds and an outside temperature of freezing or below. Patient E was basically relaxed and nothing unusual was observed by the staff on that day until mid-late afternoon when he became noticeably agitated. As of 4:45 p.m., attending Nurse Stephanie Wood, R.N., 7 a.m. - 7 p.m. shift, recorded an increase in his pulse rate from a daytime low of 85 to a high of 105 and his diastolic blood pressure from 69 to 87. He was verbally abusive to Nurse Wood, who had also noted at 4:30 p.m. that E's demeanor had changed to "angry, suicidal" from a morning assessment of "pleasant, anxious." She phoned the on-call physician, Rabee Kiwan, M.D., who discontinued the Dilaudid and reduced the Demerol dose at 4:40 p.m. She then requested assistance from two certified nursing assistants who were also threatened by E and who observed E's aberrant behavior. E voiced his desire to leave the hospital, threw a phone against a wall, threatened to commit suicide with a gun, and threatened to punch Certified Nursing Assistant (CNA) Theresa Olsen in the face. He also appeared to be delusional as he kept insisting that he had AIDS and thought he was dying from that disease. He did not eat much due to his pain and nausea and appeared weak, which prompted CNA Sarah Maker to discourage E from getting out of bed. However, he could walk to the bathroom with assistance. Ms. Wood again called Dr. Kiwan, around 6:30 p.m., and advised him of the situation. This physician resided ten miles away in Machiasport, Maine and declined to travel to the hospital for an assessment.

At approximately 6:30 p.m., day shift supervisor Joan Miller, R.N., made her rounds in order to prepare her daily report. Nurse Wood informed her of E and stated that E was "talking crazy," may need restraints, and wanted to go home. Nurse Miller visited with E and found him quietly resting in bed. He

---

<sup>1</sup> Fentanyl is described in the record by the forensic toxicologist as a "DEA Schedule II synthetic morphine substitute anesthetic/analgesic. It is reported to be 80 to 200 times as potent as morphine and has a rapid onset of action as well as addictive properties."

repeated his request to leave the hospital, but Nurse Miller told him he didn't have a ride and the weather was bad. Nurse Miller then offered that the only way to leave was by signing the hospital's "Against Medical Advice" (AMA) form. Although E then requested that form, Nurse Miller did not want to provide one and noted that E reared up in bed, but then fell back. Nurse Miller felt that E was too weak to leave and didn't appear to acknowledge the storm.

John Zabloutny, R.N. arrived at the hospital at approximately 7:05 p.m. on January 1, 2008. At the beginning of his shift, there were three nurses on duty to care for six patients, one of whom was suicidal and required one-on-one nursing. Supervisor Miller informed Supervisor Zabloutny shortly thereafter that E was reported to have been confused, but that he was alert and weak and was receiving a large amount of narcotics. She also informed him that E wanted to leave the hospital, but she was apparently unaware that E was possibly suicidal. E's family had come and gone in the early afternoon and was not going to drive one hour in the storm to return to Machias from Eastport. E apparently had also been aware of that fact. Considering that there was a "raging storm and bitter cold," Nurse Miller told Nurse Zabloutny that, "We can't let him leave." Nurse Zabloutny responded that the patient has the right to leave if he signs the AMA form. She further told Supervisor Zabloutny that the police should be notified if E left the hospital against medical advice. She felt that it was her duty as a nurse to advocate for the patient so that no harm would come to him, although she did not believe that E was strong enough to make it to his room, much less the front door of the hospital. She further believed that the police would be contacted if E left AMA.

Sally E., E's sister, resides in Eastport, Maine. Sally has been a registered nurse for 40 years and has been employed as such in a variety of patient care assignments including long-term care, medical-surgical unit, spinal cord rehabilitation, the psychiatric ward, and other general hospital assignments. She currently is the long-term care charge nurse at a facility in Eastport. Sally was on vacation in Ohio during E's hospitalization, but kept in regular contact with him during his hospitalization and was also in contact with Nurse Wood.

Sally phoned Nurse Wood on January 1, 2008 between approximately 7:15 p.m. and 7:30 p.m. Sally inquired regarding her brother's condition and Nurse Wood responded that he was delusional and appeared to be suffering from dementia. Before leaving the hospital, Nurse Wood transferred Sally to E, who appeared to her to be delusional and paranoid. He repeated his AIDS fear to his sister and mentioned that he wasn't eating as it would cause him pain.

After Nurse Wood and Nurse Miller left the hospital, care of E, at the prior request of Supervisor Miller, was assumed by Nurse Roger Seamans who was assigned to the 7:00 p.m. - 7:00 a.m. shift. Nurse Seamans is a large individual who was not intimidated by E, who had not previously been his patient. Nurse Seamans testified that he was unaware of any gun or suicide statement and neither did he review E's chart particularly to determine when E had last received his medications. Nurse Seamans testified that

he assessed E for five to ten minutes and found him to be aware, oriented, and not delusional. E knew what day it was and where he was, and said that he was "feeling fine, no pain, but had heard that I have AIDS." Nurse Seamans refuted the latter comment, following which, E made evident that he was going to leave the hospital. Nurse Seamans reminded him that it was snowing, but E said he could walk to a friend's house. The IV was disconnected and E put on his pants between approximately 7:30 p.m. and 8:00 p.m. Nurse Seamans gathered that E did not appear to be in pain, probably due to his medication.

Nurse Seamans then left the room to initiate the request to leave AMA. However, he was soon thereafter summoned to attend to another patient and instructed Nettie-Kate Jordan, ward clerk, to advise Nurse Zabloutny of the situation. Nurse Zabloutny then assumed care of E, but first conferred with Nurse Seamans. The latter informed him that he had clinically assessed E who had stable vital signs and was mentally alert and oriented and who wanted to go AMA (no documentation of this assessment is in the patient medical record). Supervisor Zabloutny felt that Nurse Seamans felt that E was competent to sign the AMA form.

At approximately 8:00 p.m. that evening, Nurse Zabloutny for the first time observed E, who was standing in his room and looking out the window. The respondent did not observe any balance-related issues and noted that E did not have an IV, but that the hep-lock into which the IV was inserted was still in E's arm. Nurse Zabloutny asked E about the weather and E responded that he really wanted to go to be with friends across the street. He had no transportation and was advised not to go out. The plans appeared appropriate to Nurse Zabloutny, even though the nearest house was a distance of several hundred feet away and E would have had to walk around the hospital to be walking in the right direction. He would then need to walk across a field to where a few driveways could ordinarily be seen from E's hospital room. The respondent was aware that E had received a large amount of medication, although he did not know when the last dose had been given or the frequency of the doses.

Nurse Zabloutny also testified that he offered to get E where he wanted to go the next morning, but E was adamant about leaving and insisted on his rights as a patient. Nurse Zabloutny also observed that E was wearing a flannel top, pants, and footwear which turned out to be moccasins/slippers. He then stated that he took E's pulse which was in the 80's, and noted that E's respiratory rate was even. No blood pressure was taken. No record was produced confirming this assessment.

At approximately 8:15 p.m., Nurse Zabloutny provided the AMA form to E. Nurse Zabloutny had called Dr. Kiwan, who said he would sign as the physician the next morning, but would not come in that evening. The respondent did not discuss narcotic withdrawal since E had stated that he had a sufficient amount of medicine where he was going and E didn't receive any prescriptions when he left the hospital.

Nurse Zabloutny testified that he next phoned Laurie Hayward, Director of Case Management, to inform her of E's AMA request. She inquired if the physician had been called and if the patient had

transportation. Nurse Zaboltny responded that he was not sure if E had transportation and Ms. Hayward told him to “make sure you secure a ride due to the hour of the day and weather conditions.”

Nurse Zaboltny then advised E that his condition would deteriorate and he could possibly die, although there is no record to substantiate that the fatal warning was given. E then said that it was a five to ten minute walk to his friend’s house. Nurse Zaboltny did not see the need to contact the on-duty emergency ward physician at the hospital or the executive administrator on call. E then signed the AMA and Nurse Zaboltny removed the hep-lock.

E left the hospital at approximately 8:20 p.m. Nurse Zaboltny testified that he did not escort E to the exit since he got paged to go to the emergency room. Apparently a patient needed care and the emergency room nurse was absent. As the supervisor, the respondent could have assigned other personnel to attend to patient needs, but he did not feel the need to so act. There were three or four other staff around the ward desk where the respondent and E parted company. The respondent did not ask any of the others to escort E to the exit of the hospital either by walking or placing him in a wheelchair. Most witnesses were of the opinion that the hospital’s policy and/or practice was to escort patients out the door. E’s family members were not notified of his leaving AMA, apparently at E’s request.

In contrast to the above testimony at this hearing, Nurse Zaboltny had previously twice stated to Machias Police Officer Troy Leavitt that he had escorted E down the hall to the main entrance, which would have comported with the hospital’s policy. It should be additionally noted that E was confused where the exit was and was proceeding down the wrong corridor, at which time the respondent told an investigator from the Maine Department of Health and Human Services that he “pointed out front” to the exit door.

The ward clerk, Nettie-Kate Jordan, was sitting next to Nurse Zaboltny during the time of E’s exit. She testified that she was in a state of shock that E was going out into the storm and was aware of the minimal clothing that E was wearing. She asked Supervisor Zaboltny if he could call the police and Nurse Zaboltny asked her what law had been broken and that E had “free will.” The respondent further stated that E could return, but it was common knowledge that the inner set of hospital entrance doors were locked at 8:00 p.m. until 6:00 a.m.<sup>2</sup> Ms. Jordan then testified that Nurse Zaboltny said that E would come back through the emergency room “dead.” At this hearing, the respondent clarified the statement as “E will probably come back as my patient dead.” Ms. Jordan did not notify the police as she felt intimidated by the respondent.

Theresa Parent, R.N. also testified regarding her observations of E while he was at the ward desk just prior to exiting the facility. She described him as looking confused and unsure while in Nurse

---

<sup>2</sup> The hospital entrance contains two sets of doors. The outside doors lead in to a small foyer and remain unlocked. The next set of doors is locked as stated above.

Zablotny's presence. The latter soon pointed to the front door indicating where E should exit. She did not observe the respondent or anyone else escorting E to the door. She recalled the respondent, informing E that he could not go out into the snow storm. However, even though she had a good opinion of the respondent, she did not think Nurse Zablotny was being compassionate in this situation.

At approximately 8:55 p.m., E's coat was brought to members of the nursing staff by the housekeeper. They became very concerned and one of the staff went to the emergency room at 9:00 p.m. and insisted that Nurse Zablotny notify the police. The respondent then called E's wife at approximately 9:10 p.m. and informed her that E had left the hospital. She at first thought he'd been transferred, but was told he was released. She demanded that Nurse Zablotny call the police. She called him again with the same demand three minutes later. Sally E. attempted to call her brother, E, around 9:20 p.m. At that time, she was transferred to Supervisor Zablotny, who revealed that he had authorized E's release from the hospital against medical advice. Nurse Zablotny explained that E knew his name, where he lived, etc. Sally E. responded that she was a nurse and that E was delusional and under medication when she had spoken with him. She then pleaded with Supervisor Zablotny to call the police to monitor E's whereabouts. The licensee declined the request by responding, "No, patient's rights." Sally E. responded that, "Patient's rights doesn't come into play when it comes to patient safety." At 9:25 p.m., Nurse Zablotny, for the first time, called the police due to the request of E's wife.

The respondent again telephoned Director Laurie Hayward between 9:00 p.m. and 9:30 p.m. and advised her that E had left the hospital. He did not mention E's apparel. Ms. Hayward testified that patient advocacy includes patient well-being and to make sure the patient is well cared for with the appropriate services at discharge, including being escorted either by wheelchair or someone walking with the individual.

Nurse Zablotny later called the Police Chief at 9:40 p.m. and reported that E had left the hospital AMA. The police arrived around 9:45 p.m. He then waited until 5:30 a.m. to inform hospital administration. At this hearing, Nurse Zablotny stated that he "honestly doesn't know" why he didn't contact the police before more than one hour had expired.

A large search was conducted for E by various law enforcement officers. E's dead body was discovered at approximately 2:00 p.m. on January 2, 2008 some 380 feet from the door through which E exited. The medical examiner's report dated March 24, 2008 listed the cause of death as "Hypothermia and Combined Opiate (Fentanyl and Demerol) Toxicity." The report went on to state that the body was discovered covered in snow in a snow bank and clothed "in a pair of brown slippers, a pair of black socks, and a long-sleeved flannel plaid shirt, black denim pants with a brown belt, boxer undershorts and a white T-shirt." E's weight was listed as 139 pounds and 6'3" in height.

A review of the events of Patient E's Down East Medical Center's stay was performed by Karen (Young) Labonte, R.N. Ms. Labonte was the operating room manager until January 1, 2008, at which time she assumed the position of Quality Improvement Director and Senior Nurse Manager. Her review revealed, among other things, that E had signed the Medicare Discharge Rights documents which included the language: "During your hospital stay, the hospital staff will be working with you to prepare for your **safe discharge** and arrange for services you may need after you leave the hospital" (emphasis added). The AMA form, signed by Nurse Zabloutny at 8:15 p.m., was also examined. In the section captioned "Risks of refusing the offered services," only "deterioration of condition" was noted. Ms. Labonte was of the opinion that when responsibility for a patient is transferred from one nurse to another, the receiving nurse has the responsibility to review the patient's history, especially for those requesting to leave against medical advice. She also testified that a proper patient assessment regarding a discharge or AMA includes a review of the medication chart, how much time had passed since the patient consumed a meal, and how weak they are at the time of discharge.

Nurse Labonte stated the standard of care for patient advocacy included not ever placing the patient in harm's way and exercising common sense. In the event of a patient attempting to leave AMA, if ill-advised, the responsible nurse should try to talk the patient out of leaving, call family members, and contact the police if the patient is a danger to others or himself and/or have a staff member follow the patient to assure his safety. The patient should be accompanied from the unit to where s/he is exiting, usually by wheelchair or, if objected to, "just by walking them out." Veronica Conley, R.N., charge nurse for the day shift, testified that in the absence of policy, the standard of care is the safety of the patient.

Nurse Zabloutny closed his testimony by stating that the events of January 1, 2008 had caused him to entirely change his practice in similar situations. He now would have a physician assistant or physician assess a patient who requests to leave AMA and would inform the police of the matter. In his favor were the many positive comments, with the exception of the above-described events, that he received as a nurse and supervisor from the hospital's staff. He also has no record of disciplinary action by this Board.

The Board, in its deliberations, determined that there was enough staff on duty on January 1, 2008 to address any problems regarding Patient E. However, the personnel were not utilized in a manner which may have prevented the tragic outcome to Patient E. For example, the emergency room physician was not contacted for an assessment related to the AMA form. The physician could have signed an affidavit to authorize a judge to declare that E posed a threat of harm to himself and thereby be detained. Nurse Zabloutny also made no extra efforts to stop E from leaving and aided him by pointing to the exit door. E was abandoned when others were not assigned the responsibility to escort him out the door to make sure, considering the storm, that his safety was assured by either watching him or securing transportation. At the very least, the police should have been contacted before E left the hospital and

certainly when the housekeeper's discovery of E's overcoat was made known to Nurse Zabloutny. Considering that E was still under the influence of strong narcotic medication, the name of his "friend" or "friends," if any, could have been obtained and contacted to meet him or watch for him and/or transport him to his destination. Additionally, the initial requests by the hospital staff and family members to call the police or bring E back were initially disregarded.

Nurse Zabloutny also failed to take heed of the day supervisor's plea to not let E leave the building. He failed to notify the charge nurse of E's plan to leave AMA and didn't contact the appropriate hospital administrator until 5:30 a.m., long after an initial search had not located E. Furthermore, Nurse Zabloutny failed to review E's medical record, including the medications administered, and his assessment of E was minimal.

### **III. CONCLUSIONS OF LAW**

Based on the above facts and those found in the record, but not alluded to herein, the Maine Board, by the following votes, concluded that John Zabloutny violated the provisions of:

1. 32 M.R.S. Sec. 2105-A (2) (E) (Incompetent Conduct... by engaging in conduct that evidences a lack of ability or fitness to discharge the duty owed by a licensee to a client or patient or the general public and by engaging 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). (5-0)

2. 32 M.R.S. Sec. 2105-A (2) (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).

3. 32 M.R.S. Sec. 2105-A (2) (H). (Any violation of this chapter or rule adopted by the Board).<sup>3</sup> (5-0)

10. Board Rule Chapter 4, Sec. 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:

---

<sup>3</sup> The Board, by the votes of 5-0, also ruled that Nurse Zabloutny violated Board Rule Chapter 4, Sec. 1.A. (1), (5), and (6) which are basically identical to 32 M.R.S. Sec. 2105-A (2) E and F.



- F. Failing to take appropriate action or to follow policies and procedures in the practice situation designed to safeguard the patient. (5-0)
- G. Abandoning or neglecting a patient requiring nursing care. (4-1)
- H. Intentionally or negligently causing physical or emotional injury to a patient. (5-0))

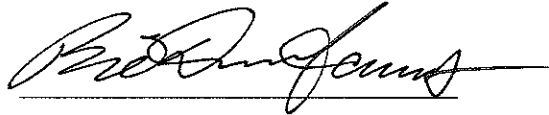
**IV. SANCTIONS**

The Board, exercising its experience and training, and based on the above findings and conclusion and those found in the record, but not alluded to herein, voted as follows:

1. John Zabloutny's Registered Nurse's license is hereby **REVOKED effective June 2, 2010 for a period of two years, during which time he shall be ineligible to apply for relicensure.** The Board reasoned that Mr. Zabloutny's nursing practices constitute a serious threat of harm to the public and, therefore, the revocation is warranted. Those practices directly resulted in the death of a patient for whom he was responsible. The Board assessed a similar sanction in another case where death also was the result of the actions/omissions of a nurse respondent. The sanction would most likely have been more severe but for the fact that Mr. Zabloutny had no previous complaints before the Board and had received positive evaluations and comments from the hospital staff. (4-1) (The dissent would have voted for a permanent revocation)
2. John Zabloutny shall pay the **COSTS** of this hearing not to exceed \$6,000 prior to submitting any application for licensure that is under the Board's authority. The check or money order shall be made payable to: "Treasurer, State of Maine" and mailed to Myra Broadway, J.D., M.S., R.N., Executive Director, Maine State Board of Nursing, 158 State House Station, Augusta, Maine 04333-0158. Additional costs may be assessed in the event that John Zabloutny requests a transcript of the hearing. The costs are in keeping with the Board's practice of assessing the costs to those who violate Board statutes and rules as opposed to sharing the costs with those licensees who obey same. (5-0)
3. John Zabloutny shall pay a **fine of \$1,500** prior to submitting any application for licensure that is under the Board's authority. The fine is the authorized maximum and reflects the seriousness of the violations. The check or money order shall be made payable to: "Treasurer, State of Maine" and mailed to Myra Broadway, J.D., M.S., R.N., Executive Director, Maine State Board of Nursing, 158 State House Station, Augusta, Maine 04333-0158. (5-0)

**SO ORDERED.**

Dated: June 2, 2010



Bruce O'Donnell, C.R.N.A., Chairman  
Maine State Board of Nursing

**V.**

**APPEAL RIGHTS**

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

The petition shall specify the person seeking review, the manner in which s/he is aggrieved and the final agency action which s/he wishes 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 Maine Attorney General.