BEFORE THE VIRGINIA BOARD OF NURSING

IN RE: **LILLIE B. HARRIS, L.P.N.**
License Number: 0002-016811
Case Number: 175118

ORDER

JURISDICTION AND PROCEDURAL HISTORY

Pursuant to Virginia Code §§ 2.2-4019 and 54.1-2400(10), a Special Conference Committee of the Virginia Board of Nursing ("Board") held an informal conference on October 4, 2017, in Henrico County, Virginia, to inquire into evidence that Lillie B. Harris, L.P.N., may have violated certain laws and regulations governing the practice of practical nursing in the Commonwealth of Virginia.

Lillie B. Harris, L.P.N., appeared at this proceeding and was not represented by legal counsel.

NOTICE

By letter dated July 5, 2017, the Board sent a Notice of Informal Conference ("Notice") to Ms. Harris notifying her that an informal conference would be held on August 7, 2017. The Notice was sent by certified and first class mail to the legal address of record on file with the Board. By letter dated August 9, 2017, the Board notified Ms. Harris that the informal conference was rescheduled for October 4, 2017.

Upon consideration of the evidence, the Committee adopts the following Findings of Fact and Conclusions of Law and issues the Order contained herein.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. Lillie B. Harris, L.P.N., was issued License Number 0002-016811 to practice practical nursing on April 28, 1972, which is scheduled to expire on February 28, 2019. At all times relevant to

the findings contained herein, said license was current and active. Her primary state of residence is Virginia.

2. Ms. Harris violated Virginia Code § 54.1-3007(2), (5) and (8) and 18 VAC 90-20-300(A)(2)(f) of the Regulations Governing the Practice of Nursing (currently found at 18 VAC 90-19-230(A)(2)(f) effective February 24, 2016) ("Regulations") in that during the course of her employment with Heaven's Touch Nursing Services, L.L.C., Richmond, Virginia ("Heaven's Touch"), while caring for Client A, a six-month-old child born prematurely with a primary diagnosis of respiratory failure, in April and May 2016, while assigned 16-hour shifts, she failed to follow the client's care plan and/or failed to properly document the client's medical record, as evidenced by the following:

a. She failed to follow Client A's care plan, which required him to be connected to a ventilator at all times, as evidenced by the following:

i. By her own admission, on at least one occasion, she allowed Client A to be unplugged from the ventilator for one and one-half hours.

ii. By her own admission, she failed to take vital signs after observing Client A's caregiver repeatedly remove him from his ventilator because the baby "seemed to be breathing o.k."

b. She failed to follow Client A's care plan, which required that she monitor his weight and dehydration level, by failing to weigh Client A. By her own admission, she checked for dehydration and weight loss by pulling Client A's skin only, as there was no scale available in the home.

c. On May 21, 2016, she failed to properly document Client A's medical record, as evidenced by the following:

i. She failed to document in Client A's pediatric visit log that Client A's caregiver removed him from the ventilator at 6:15 p.m. By her own admission, despite observing Client

A's caregiver remove the child from the ventilator on two occasions, she failed to document the incidents.

ii. She failed to document in Client A's medical record that the milk in the feeding bag was curdled when she arrived at Client A's residence for her shift.

iii. She failed to document Client A's decreased urine output. She documented that Client A had one wet and one soiled diaper change during that day's 16-hour shift. By her own admission, she had changed more than one wet diaper for Client A during prior 16-hour shifts, and she acknowledged to the Department of Health Professions investigator that the reduction was indication of a decreased output.

iv. She failed to document that Client A's pulse oximeter and tracheal tube monitor, which were ordered to monitor continuously, were turned off or unplugged by Client A's caregiver.

v. She failed to document the ordered twice per day application of Bacitracin to Client A's PEG tube site.

3. Ms. Harris violated Virginia Code § 54.1-3007(5) in that between April 24, 2016 and May 21, 2016, she documented in Client A's pediatric visit logs that the client was receiving adequate nutrition. However, by her own admission, she was "very concerned" that he was not receiving adequate nutrition.

4. Ms. Harris violated Virginia Code § 54.1-3007(2) and (5) and 18 VAC 90-20-300(A)(2)(o) of the Regulations (currently found at 18 VAC 90-19-230(A)(2)(o) effective February 24, 2016) in that, despite her observations that (a) Client A's caregiver disconnected his ventilator pulse oximeter and tracheal tube monitor on multiple occasions, (b) Client A was left unattended, (c) there was curdled milk in Client A's feeding bag and feeding tube on more than one occasion, and (d) Client

A was not receiving adequate nutrition because he was emaciated and dehydrated, she failed to report the conditions to Child Protective Services. Ms. Harris stated that it was not her place to report the incidents.

5. Client A was hospitalized and admitted to the PICU on May 23, 2016, 36 hours after Ms. Harris' last shift, with diagnoses including hypoglycemia, failure to thrive, weight loss and dehydration.

6. Ms. Harris acknowledged that she accepted the assignment without seeing the client's care plan. She was unable to articulate an adequate understanding of normal vital sign parameters for a six-month old infant.

7. Ms. Harris stated that she always performed her duties, but did not always document. She also acknowledged that she was not aware that she was a mandated reporter. Ms. Harris' employment with Heaven's Touch Nursing Services, L.L.C., was terminated on July 25, 2016.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, the Virginia Board of Nursing hereby ORDERS as follows:

1. Lillie B. Harris, L.P.N., is REPRIMANDED.

2. Within 90 days from the date of entry of this Order, Ms. Harris shall provide written proof satisfactory to the Board of successful completion of the following NCSBN courses: *Documentation: A Critical Aspect of Client Care*; *Professional Accountability & Legal Liability for Nurses*; and *Sharpening Critical Thinking Skills*.

3. Continuing education obtained through compliance with this term shall not be used toward licensure renewal.

4. Ms. Harris shall comply with all laws and regulations governing the practice of practical nursing in the Commonwealth of Virginia.

5. Any violation of the foregoing terms and conditions of this Order or any statute or regulation governing the practice of practical nursing shall constitute grounds for further disciplinary action.

Pursuant to Virginia Code §§ 2.2-4023 and 54.1-2400.2, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record, and shall be made available for public inspection and copying upon request.

FOR THE BOARD

Jay Douglas, M.S.M., R.N., C.S.A.C., F.R.E.
Executive Director
Virginia Board of Nursing

ENTERED AND MAILED: November 2, 2017

NOTICE OF RIGHT TO APPEAL

Pursuant to Virginia Code § 54.1-2400(10), Ms. Harris may, not later than 5:00 p.m., on December 5, 2017, notify Jay Douglas, M.S.M, R.N., C.S.A.C., F.R.E., Executive Director, Board of Nursing, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233, in writing that she desires a formal administrative hearing before the Board. Upon the filing with the Executive Director of a request for the hearing, this Order shall be vacated. This Order shall become final on December 5, 2017, unless a request for a formal administrative hearing is received as described above.

Certified True Copy
By
Virginia Board of Nursing