**STATE OF VERMONT**
**SECRETARY OF STATE**
**OFFICE OF PROFESSIONAL REGULATION**
**VERMONT BOARD OF NURSING**

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| **In re SHERISE SIMPSON**<br>License No. 025.0097439 | } | Docket Nos. 2019-11, 12, 85, 86, & 87 |

Hearing Officer: George K. Belcher

## ORDER CORRECTING PRIOR DEFAULT ORDER

The Hearing Officer of the Vermont Board of Nursing held a hearing pursuant to 3 VSA Sec. 129(f) in the above matter on October 2, 2019 at the Office of Professional Regulation in Montpelier, Vermont. A Default Order was approved by the Board and entered soon thereafter. The Default Order contained a typographical error in that the License Number of the Respondent was listed as License Number 025.0134131 when it should have been License No. 025.0097439 (this correct number was used in a prior Summary Suspension order concerning the Respondent).

Pursuant to VRCP 60(a) clerical mistakes in orders may be corrected by the hearing authority at any time. Accordingly, the prior Default Order is hereby amended to include the correct license number as listed in the heading above.

Dated this 9th day of January, 2020.

George K. Belcher
Presiding Officer of the Vermont Board of Nursing

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| **In re SHERISE SIMPSON** | } | |
| License No. 025.0134131 | } | Docket Nos. 2019-11, 12, 85, 86, & 87 |
| | } | |

Appearances:
Prosecutor: Jennifer B. Colin, Esq.
Respondent: Did not appear

Hearing Officer: George K. Belcher

## DEFAULT ORDER

The Hearing Officer of the Vermont Board of Nursing held a hearing pursuant to 3 VSA Sec. 129(f) in the above matter on October 2, 2019 at the Office of Professional Regulation in Montpelier, Vermont. Respondent did not attend and was not represented by counsel.

### Findings of Fact

1. Respondent is a Licensed Practical Nurse and is therefore subject to the regulatory authority of this Board. 3 V.S.A. §§ 129, 129a, 26 V.S.A. Chapter 28, and the Administrative Rules of the Board of Nursing, and the Rules of the Office of Professional Regulation.
2. Charges were filed in this matter on June 27, 2019. The Respondent was sent a Notice of Charges in this matter by certified mail and first class mail to the address of the Respondent which was on file with the Office of Professional Regulation on June 27, 2019. The certified mail notice of charges was returned with the notation that the mailing was "refused". The ordinary mail notice was not returned. A copy of the Specification of Charges is attached to this Default Order.
3. OPR Rule 3.3 requires that an Answer be filed within 20 days of the date on which the notice of charges was mailed by the Director.
4. On September 13, 2019 a notice was sent to the Respondent advising of the hearing before the Board to find a default and advising that, "If you wish to contest the charges you must contact the office immediately at (802) 828-2367 and show good cause for failing to answer the charges against you." This notice was mailed by certified mail and regular mail. The certified mail notice was returned with the notation that the mailing was "refused". The regular mail notice was not returned as of the date of the hearing. The State Prosecutor likewise sent to the Respondent a copy of the State's Motion for Default and no contact was made by the Respondent to the State Prosecutor.
5. Respondent has not filed an answer to the charges, nor any communication concerning good cause for failure to answer. The Respondent did not appear at the hearing on

default.

6. Upon consideration of the Prosecution's presentation and taking notice of the OPR file, the Hearing Officer of the Board finds Respondent to be in Default. The allegations contained in the Specification of Charges are therefore treated as the facts on which the Board may issue an order of professional discipline. OPR Rule 3.4, 3 V.S.A. § 809(d), and 3 V.S.A. § 814(c).
7. It is specifically found: that in February of 2016 the Respondent was discharged from her employment for unauthorized removal of Methadone from her place of employment; that in March of 2017 the Respondent held herself out to be an "RN" when she had no such credential; that during February of 2018 the Respondent repeatedly mismanaged the medication records for administration and charting of opiate drug administration and could not properly account for missing opiate medications; [redacted]
8. It was the recommendation of the State of Vermont that the Respondent's license be revoked. That recommendation is accepted and is contained in the proposed order below.

## Conclusions of Law

Respondent has received adequate or constructive notice of the charges in this matter as indicated by the Board's file and the Prosecution's presentation. Because Respondent has failed to answer the charges, the factual allegations in the Specification of Charges are treated as if proved. O.P.R. Rule 3.4. Accordingly, the Board finds, based upon the finding of Default from this Default Hearing held pursuant to 3 V.S.A. §809(d), that Respondent has engaged in the unprofessional conduct alleged in the Specification of Charges. The Respondent committed unprofessional conduct by violating: 26 VSA Sec. 1582(a)(2) (Diverting drugs for unauthorized use); 26 VSA Sec. 1582(a)(3) (Engaging in conduct of a character likely to deceive, defraud, or harm the public); 3 VSA Sec. 129a(b)(1) (Failure to practice competently by performance of unsafe or unacceptable patient care); 3 VSA Sec. 129a(b)(2) (Failure to practice competently by failure to conform to the essential standards of acceptable and prevailing practice); 26 VSA Sec. 1584(a)(4) (Improper use of letters to indicate that a person is a registered nurse when not authorized); 3 VSA Sec. 129a(a)(7) (Willfully making false reports or records in the practice of the profession); and 3 VSA Sec. 129a(a)(15) (Failing to exercise independent professional judgment in licensed activities).

## Proposed Order

In accordance with the above Findings of Fact and Conclusions of Law, and consistent with the recommendation by the State, the Board does **ORDER** that the Respondent's Licensed Practical Nurse License be **REVOKED.** The Respondent shall not be eligible for reinstatement or re-licensure as an LPN. If any future application by the Respondent for licensure in any other profession is approved, that license **shall be conditioned** pursuant to whatever terms are found to be reasonable at the time of Respondent's licensure.

The Hearing Officer reports the above facts, conclusions of law, and the finding of DEFAULT to the Board with the recommendation that the Board approve them and enter the Order as above.

Dated this 3rd day of October, 2019.

George K. Belcher
Hearing Officer of the Vermont Board of Nursing

The Vermont Board of Nursing considered the report of findings of fact and conclusions of law at its meeting on _____. After considering the report, the Board takes the following action:

/ / Rejects the report and schedules the matter for hearing.
/ / Schedules the matter for additional evidence.
/✓/ Accepts the report, adopts the findings of fact and conclusions of law, and orders the recommended discipline as set forth in the proposed order above.

**SO ORDERED.**

Vermont Board of Nursing

By: _____ Date: 10-14 . 2019
Ellen Watson, Chair
Vermont Board of Nursing

OFFICE OF PROFESSIONAL REGULATION
DATE OF ENTRY: 10. 15. 19

## Appeal Rights

This is a final administrative determination by the Vermont Board of Nursing. A party aggrieved by a final decision of a board may appeal this decision by filing a written Notice of Appeal with the Director of the Office of Professional Regulation, Vermont Secretary of State, 89 Main St., Fl. 3, Montpelier, VT 05620-3402 within 30 days of the entry of this Order. If an appeal is filed, the Director of the Office of Professional Regulation shall assign the case to an appellate officer. The review shall be conducted on the basis of the record created before the board. In cases of alleged irregularities in procedure before the board, not shown in the record, proof on that issue may be taken by the appellate officer. 3 V.S.A. §§ 129(d) and 130a.

STATE OF VERMONT
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BOARD OF NURSING

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| IN RE: | ) | Docket No. 2019-11 |
| Sherise Simpson | ) | Docket No. 2019-12 |
| License No. 025.0134131 | ) | Docket No. 2019-85 |
| | ) | Docket No. 2019-86 |
| | ) | Docket No. 2019-87 |

## SPECIFICATION OF CHARGES

NOW COMES the State of Vermont and hereby makes the following charges against Respondent Sherise Simpson:

### Board Authority

1. The Vermont State Board of Nursing (the "Board") has authority to issue warnings or reprimands; suspend, revoke, limit, or condition current licenses; or prevent the renewal of lapsed licenses if, after disciplinary hearing, the Board finds that the Respondent has engaged in unprofessional conduct. 3 V.S.A. §129(a); 3 V.S.A. §129a; 3 V.S.A. §814(d); 26 V.S.A. Chapter 28; the Administrative Rules of the Board of Nursing (the "ARBN"); and the Rules of the Office of Professional Regulation ("OPR").

### Statement of Facts

2. Sherise Simpson (the "Respondent") is licensed by the State of Vermont as a Licensed Practical Nurse ("LPN") under license number 025.0134131. This license was originally issued on November 10, 2017, and expires on January 31, 2020.

### Practice Issues at Facility One

3. From 2013 to February 5, 2016, Respondent worked as an LPN for Centurion Managed Care providing healthcare services to inmates in the Northeast Regional Correctional Facility located in St. Johnsbury, Vermont ("Facility One").

4. In November 2015, Respondent was disciplined by Facility One for falsifying her time sheet, claiming that she forgot to punch in with her time card and then reporting over two additional hours she did not work to her timesheet.

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5. While working at Facility One, Respondent received discipline because her husband constantly called her at work during her shift and tying up the only telephone line available in the nursing work area of Facility One.

6. Respondent's nursing supervisor at Facility One stated that during the relevant time, Respondent's husband would call Facility One constantly and he would visit Facility One constantly, waiting in the parking lot for Respondent.

7. On February 5, 2016, Respondent was tasked with administering a dose of Methadone, a controlled drug, to an inmate in the segregation unit of Facility One, which was in an area different from the nursing station.

8. After removing the bottle of liquid Methadone from the cart, Respondent's husband called her indicating Respondent's daughter was sick and that he was in the parking lot with their daughter.

9. Respondent placed the Methadone in her pocket and left the secured area to go to the parking lot area for a few minutes to see her family.

10. From the parking lot, Respondent proceeded to the segregation unit, where she administered the Methadone to the inmate.

11. Upon returning to the nurses' station after going to the parking lot and then to the segregation unit to administer the Methadone. Respondent's security clearance was revoked and she was terminated from Facility One.

12. Respondent taking the controlled drug out of the secured correctional facility and into a parking lot while she visited with her family was a violation of Facility One's policies and poor nursing practice.

**Misrepresentation of Title and Fraudulent Invoice to Jay Peak**

13. In March 2017, Respondent took her children to The Pump House at Jay Peak, a waterpark in Jay, Vermont, for recreation.

14. Respondent reported to Jay Peak Management that both of her children were injured in the waterpark.

15. Respondent signed a Guest Information Questionnaire with the title "RN" in two places on the form.

16. Respondent signed numerous email correspondence to the Director of Resort Safety for Jay Peak Resort as "Sherise Simpson RN."

17. Respondent is not an RN.

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18. On April 26, 2017, Respondent emailed an alleged invoice for $906.00 on purported letterhead from ClearChoice MD Urgent Care to support the medical claim she submitted to Jay Peak Resort for her son's injury.

19. Upon receipt of the invoice from Respondent, the Director of Resort Safety questioned the document in an email to Respondent because the text of the invoice used more than one type and size of font, which was suspicious to him.

20. The Director of Resort Safety requested that Respondent sign a release so that he could obtain the billing information directly from the provider.

21. Respondent refused to provide the waiver and instructed the Director of Resort Safety not to contact her again.

22. Upon further investigation, the Director of Resort Safety learned the invoice was fake, and the Resort did not pay the claim for medical care submitted by Respondent.

**Practice Issues at Facility Two**

23. From February 12, 2018 to February 28, 2018, Respondent worked as a travelling nurse for Core Medical Group at Barre Garden Nursing Home in Barre, Vermont ("Facility Two").

24. Respondent worked shifts at Facility Two on 11 days.

25. Respondent was suspended from Facility Two on February 28, 2018 for suspicious and anomalous narcotic documentation for various residents.

26. On multiple occasions in February 2018, Respondent failed to document in the Medication Administration Record (MAR) the administration of numerous doses of oxycodone she documented withdrawing in the narcotic logs for Patients A.B., M.Bo., G.C., P.S., B.A., D.S., and J.S.

27. Facility Two policy requires: "A Nurse or Certified Medication Aide (where applicable) shall document all medications administered to each resident on the resident's medication administration record (MAR)."

28. Respondent was the only nurse who documented administering PRN oxycodone and hydrocodone and acetaminophen to several patients in February 2018, namely Patients M.B., P.S., M.Bo., and B.A.

29. In her brief time working at the Facility, Respondent documented in the narcotic logs wasting at least five oxycodone tablets on numerous occasions, stating "wrong pt," "popped too many," and "fell on the floor" twice.

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30. For three oxycodone wastes, Respondent documented wasting the tablets in front of LPN R.H., who visualized a pill during each waste, but did not verify that the pill being wasted was oxycodone.

31. For one oxycodone waste, Respondent documented wasting one oxycodone 5mg tablet in front of an RN, who later could not recall whether she visualized a pill during the waste.

32. For at least one documented oxycodone waste, Respondent had no witness.

33. On at least two occasions in February 2018, Respondent documented in the narcotic log withdrawing double PRN doses of oxycodone, i.e. two 5mg tablets of oxycodone instead of one 5mg tablet as ordered, for Patients G.C. and D.S.

34. On the two occasions cited above, Respondent documented in the MAR administering the ordered dose in both instances, meaning in each instance there was one 5mg tablet of oxycodone unaccounted for and not documented.

35. Respondent documented in narcotic logs withdrawing PRN pain medications for various patients on days she did not work.

36. On several occasions, Respondent documented follow-up for effectiveness of PRN medication administration within five minutes after the medication was documented as administered.

37. On five occasions in February, Respondent withdrew oxycodone tablets for one patient, "M.B.," whose PRN orders for the controlled drug were discontinued on January 5, 2018, over a month before Respondent started working at Facility Two.

38. Several staff members reported that while Respondent worked at Facility Two, Respondent's husband would frequently be present at the facility while Respondent was working, sitting near the nurse's station and that Respondent would often talk with him and take breaks several times per shift.

39. One staff member stated that Respondent's husband "would walk the entire facility, come up behind Sherise, rub his hand across her back and stand next to her."

40. A fellow LPN from Facility Two reported that during one evening shift, Respondent's husband was sitting in a chair near the nurse's station, not interacting with anyone, and while Respondent and the LPN were completing their narcotic count at the desk, he got up and stood a few feet behind them. Once they completed their narcotic count, Respondent and her husband had a conversation then they left.

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41. Another LPN with whom Respondent had worked at another facility as well as Facility Two stated that Respondent's husband would come in and they would go outside together several times during her shifts, which was behavior he had seen in the other facility he worked in with Respondent.

42. Respondent's contract with Facility Two was terminated.

43. On February 28, 2018, Respondent completed a drug screen for Core Medical Group and the results were negative.

44. [redacted]

**Ticket Scam**

45. On July 2, 2018, Sherise Simpson emailed her "new cell phone number," (802)745-8258, to OPR Investigator John Lewis.

46. On July 5, 2018, an individual, "S.S.," posted a message to Craigslist seeking tickets to a theater production in Cambridge, Massachusetts on July 6, 2018.

47. "Amy" responded to S.S.'s ticket inquiry, stating that she had two tickets to that show and would sell them to S.S. for $75 each or $150 total.

48. S.S. and "Amy" communicated through iMessage and the cell phone number "Amy" use was (802)745-8258.

49. Through Apple Pay, S.S. sent "Amy" $150 on July 5, 2018, but did not receive the tickets in return.

50. Through researching the cell phone number, S.S. learned that the cell phone number belonged to Everett and/or Sherise Simpson.

51. S.S. messaged Respondent through Facebook Messenger and Respondent claimed her cell phone had been stolen.

52. Respondent emailed Investigator John Lewis on July 6, 2018 claiming her cell phone had been stolen.

53. S.S. reported the scam to OPR in a complaint against Respondent.

[redacted]

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[redacted]

[redacted]

**Child Abandonment**

65. In September 2018, Respondent and her husband abandoned their 12-year-old son, which was reported to law enforcement by a family member late in night on September 11, 2018.

66. Respondent and her husband left the child, alone and unattended on or about September 11, 2018, when they failed to pick him up from school.

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67. The child took the bus home from school and his sister and his parents did not come home to the condominium in South Burlington where they were residing that day or evening.

68. Law enforcement attempted, without success, to contact Respondent and Everett Simpson.

69. South Burlington Police Department with the assistance of South Burlington Fire Department responded to the residence to take the child into protective custody.

[redacted]

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[redacted]

**Violation One: 26 V.S.A. §1582(a)(2) Diverting or attempting to divert drugs or equipment or supplies for unauthorized use.**

83. The State re-alleges and incorporates Paragraphs 2 through 82 above.

84. As an LPN, Respondent is prohibited from diverting drugs for unauthorized use.

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85. Paragraphs 23 through 44 above demonstrate that Respondent diverted drugs from the Facility for unauthorized use in violation of 26 V.S.A. §1582(a)(2).

86. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent diverted drugs for unauthorized use in violation of 26 V.S.A. §1582(a)(2).

**Violation Two: 26 V.S.A. §1582(a)(3) Engaging in conduct of a character likely to deceive, defraud, or harm the public.**

87. The State re-alleges and incorporates Paragraphs 2 through 82 above.

88. As an LPN, Respondent is required to refrain from engaging in conduct of a character likely to deceive, defraud, or harm the public.

89. Paragraphs 2 through 82 above demonstrate that Respondent engaged in conduct of a character likely to deceive, defraud or harm the public when she: falsified time cards for an employer; mispresented her title to a member of the public and presented a false invoice to Jay Peak; diverted narcotics; falsified medical records relating to administration of narcotis; engaged in a scam to defraud a member of the public by misrepresenting the sale of an event ticket; [redacted] abandoned her child; [redacted]

90. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent committed unprofessional conduct of a character likely to deceive, defraud, or harm the public in violation of 26 V.S.A. §1582(a)(3).

**Violation Three: 3 V.S.A §129a(b)(1) Failure to practice competently by reason of any cause on a single occasion or on multiple occasions may constitute unprofessional conduct, whether actual injury to a client, patient, or customer has occurred. Failure to practice competently includes: (1) performance of unsafe or unacceptable patient or client care.**

91. The State re-alleges and incorporates Paragraphs 2 through 82 above.

92. As an LPN, Respondent is required to provide safe and acceptable patient care.

93. Paragraphs 23 through 44 demonstrate that Respondent performed unsafe and unacceptable patient care by diverting drugs from patients and failing to accurately document withdrawals and administration of controlled drugs to patients.

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94. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because on multiple occasions Respondent diverted drugs from patients and failed to accurately document the administration of controlled drugs to patients, thereby performing unsafe and unacceptable patient care in violation of 3 V.S.A. §129a(b)(1).

**Violation Four: 3 V.S.A. §129a(b)(2) Failure to practice competently by reason of any cause on a single occasion or on multiple occasions may constitute unprofessional conduct, whether actual injury to a client, patient, or customer has occurred. Failure to practice competently includes: (2) failure to conform to the essential standards of acceptable and prevailing practice.**

95. The State re-alleges and incorporates Paragraphs 2 through 82 above.

96. The essential standards of Licensed Practical Nursing practice prohibit a nurse from removing a controlled drug from the facility.

97. Paragraphs 3 through 12 demonstrate that Respondent failed to practice competently by failing to conform to essential standards of acceptable and prevailing practice when she left the secured area of a correctional facility to visit a family member in the parking lot with a dose of liquid methadone in her pocket.

98. Paragraphs 23 through 44 demonstrate that Respondent failed to practice competently by failing to conform to essential standards of acceptable and prevailing practice when she diverted controlled drugs from patients.

99. Paragraphs 23 through 44 demonstrate that Respondent failed to practice competently by failing to conform to essential standards of acceptable and prevailing practice when she failed to accurately document the administration of controlled drugs to patients.

100. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent committed unprofessional conduct by diverting drugs from patients in violation of 3 V.S.A. §129a(a)(15).

[redacted]

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**Violation Six: 26 V.S.A. §1584(a)(4) Use in connection with a name any words, letters, signs, or figures which imply that a person is a registered or practical nurse or an advanced practice registered nurse when not authorized under this chapter.**

113. Paragraphs 2 through 82 above are incorporated herein.

114. In Vermont, misrepresentation of licensure by using words or letters constitutes unprofessional conduct.

115. Paragraphs 13 - 22 demonstrate that Respondent misrepresented herself as a Registered Nurse by using the letters "R.N." numerous times when communicating with a member of the public, the Director of Resort Safety at Jay Peak.

116. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent violated 26 V.S.A. §1584(a)(4).

**Violation Seven: 3 V.S.A. §129a(a)(7) Willfully making or filing false reports or records in the practice of the profession, willfully impeding or obstructing the proper making or filing of reports or records, or willfully failing to file the proper reports or records.**

117. The State re-alleges and incorporates Paragraphs 2 through 82 above.

118. As an LPN, Respondent is required to make and file accurate reports and records in the practice of the profession and must refrain from willfully making or filing false reports or records and from willfully impeding or obstructing the proper making or filing of reports or records.

119. Paragraphs 23 through 44 demonstrate that Respondent willfully made and filed false reports and records in the practice of the profession and willfully impeded or obstructed the proper making or filing of reports or records by failing to accurately document the administration of controlled substances to patients.

120. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent committed unprofessional conduct by willfully impeding or obstructing the proper making or filing of reports or records in violation of 3 V.S.A. §129a(a)(7).

**Violation Eight: 3 V.S.A. §129a(a)(15) Failing to exercise independent professional judgment in the performance of licensed activities when that judgment is necessary to avoid action repugnant to the obligations of the profession.**

121. The State re-alleges and incorporates Paragraphs 2 through 82 above.

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122. As an LPN, Respondent is required to exercise her own independent professional judgment in the performance of licensed activities when that judgment is necessary to avoid action repugnant to the obligations of the profession.

123. Paragraphs 2 through 82 demonstrate that Respondent failed to exercise independent professional judgment by diverting drugs from patients on multiple occasions, intentionally filing false reports regarding the administration of controlled drugs to patients to hide her diversion of those drugs, intentionally falsifying medical documentation, and misrepresenting herself as an RN in connection with a medical claim.

124. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent committed unprofessional conduct by diverting drugs from patients in violation of 3 V.S.A. §129a(a)(15).

**Relief Requested**

**WHEREFORE**, the license of Sherise L. Simpson should be revoked suspended, reprimanded, conditioned, or otherwise disciplined.

**DATED** at Montpelier, Vermont this 27th day of June, 2019.

STATE OF VERMONT
SECRETARY OF STATE

By: _____

Jennifer B. Colin
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| In re: SHERISE L. SIMPSON | } |
| License No. 025.0097439 | } Docket No. 2019-11 |
| | } 2019-12 (LPN) |
| | } |

**SUMMARY SUSPENSION ORDER**

Participating Board Members:
Ellen Watson, APRN, Chair
Deborah Swartz, RN
Jennifer Laurent, APRN
Virginia Hudson, RN
Luana Tredwell, LPN
William G. White, Jr., Public Member
Jeanine Carr, RN, *ad hoc* member
Daniel Coane, *ad hoc* member

Appearances:
Prosecuting the case: Jennifer B. Colin, Esq.
Respondent: was not present nor represented

Presiding Officer:
George K. Belcher

Exhibits:
State Exhibit 1: Order List; Medication Log; Patient BM
State Exhibit 2: Order List; Medication Log; MAR; Patient SP
State Exhibit 3: Order List; Medication Log; MAR; Patient BM0
State Exhibit 4: Order List; Medication Log; MAR; Progress Note; Patient AB
State Exhibit 5: Order List; Medication Log; MAR; Progress Notes; Patient BA
State Exhibit 6: Order List; Medication Log; MAR; Patient SD
State Exhibit 7: Order List; Medication Log; MAR; Patient CG

[redacted]

**Summary Suspension Order**
**FINDINGS OF FACT, CONCLUSIONS OF LAW,**
**AND ORDER**

This matter came before the Board of Nursing on a Request for a Summary Suspension. The hearing was held on February 11, 2019, at the Office of Professional Regulation in Montpelier, Vermont.

## Findings of Fact

Based on a review of the pleadings and the file, and on the evidence presented to the Board at the hearing, the Board finds as follows:

1. Respondent is licensed as a Licensed Practical Nurse in Vermont. The Respondent's license is set to expire on January 31, 2020. The Respondent is subject to the regulatory authority of this Board. 3 V.S.A. §§ 129, 129a, 26 V.S.A. Chapter 28, the Administrative Rules of the Board of Nursing, and the Rules of the Office of Professional Regulation. 3 V.S.A. § 814(c) permits the Board to summarily suspend a license if it finds that public health, safety, or welfare imperatively requires emergency action, and incorporates a finding to that effect in its order.
2. The prosecutor has filed a "Request for Summary Suspension." A copy of the Request is attached to this Decision and Order. The Respondent was sent a notice of the hearing on February 1, 2019 to the address on file with the Office of Professional Regulation. There was no evidence offered to show that the Respondent had, or had not, received the notice of hearing.
3. The State presented as evidence the testimony of former Director of Nursing at Barre Gardens Nursing Facility, Tara Starzek, RN. Nurse Starzek was the Director of Nursing during February of 2018, a time when the Respondent worked at the facility under her direction.
4. In February of 2018 Nurse Starzek received a complaint from another staff member that the Respondent was the only nurse on the unit giving PRN (as needed) oxycodone medication for several patients. As a result of the complaint, Nurse Starzek conducted an investigation to determine whether the Respondent was diverting medications. Nurse Starzek has received training on the subject of diversion investigations and she has experience in conducting such investigations.
5. The investigation initially looked at the Respondent's administration of all medications but shortly was narrowed to opiates since there were no other medication anomalies noted.
6. The investigation showed that the Respondent:
    a. Charted the removal and delivery of opiate medication to patients on days when she did not work at the facility;
    b. Charted the withdrawing of opiate medications for patients but failed to enter the administration in the Medication Administration Record;
    c. "Wasted" opiate medications without following proper wasting procedures or charting;

d. Charted the administration of opiate medications as needed for pain, yet inconsistently failed to document the required level of pain for the administration of the pain medication in the progress notes or the MAR record;
e. Charted the delivery of opiate medication five times over a month after the PRN order for that medication had been discontinued;
f. Charted the effectiveness of the opiate medication for several patients showing that the medication had been effective one minute after administration when that amount of time is inadequate to safely assess medication effectiveness;
g. Often, the Respondent was the only nurse in the facility who was administering PRN opiate medication to patients, despite other nurses caring for the same patients for significant periods of time (with no needed PRN opiate medications needed).

7. It was the conclusion of Nurse Starzek, following the investigation, that the Respondent had diverted opiate medications from patients improperly, that her charting was chaotic and inconsistent, and that the anomalies were not likely simple mistakes.
8. The facility terminated the Respondent's employment on February 28, 2018. Nurse Starzek reported her findings to various regulatory bodies.
9. Investigator John Lewis of the Office of Professional Regulation investigated the matter of the alleged diversion. The Respondent was uncooperative in the investigation and did not provide to the investigator any exculpatory information.
10. The evidence established that the Respondent violated 26 VSA Sec. 1582 (a)(3) [engaged in conduct of a character likely to deceive, defraud or harm the public]; 26 VSA Sec. 1582(a)(2) [diversion of drugs for unauthorized use]; 3 VSA Sec. 129a(a)(15) [failure to exercise independent professional judgment in performance of licensed activities]; 3 VSA Sec. 129a(b)(2) [failure to practice competently]; 3 VSA Sec. 129a(a)(7) [willfully making false reports or records in the conduct of the profession]; and 3 VSA Sec. 129a(b)(1) [performance of unsafe or unacceptable patient or client care]. On the [redacted]
11. The evidence presented show facts which imperatively require emergency action for the public health, safety, and welfare. Specifically, summary suspension is necessary to prevent patient harm, and to protect the general integrity of the medical profession.

**Conclusions of Law**

Our Findings of Fact and Conclusions of Law in this Summary Suspension hearing are for purposes of deciding whether ***at this time*** there is an imperative need to take emergency action. 3 V.S.A. § 814(c). Our Findings of Fact and Conclusions of Law herein are for purposes of this Order only.

The Prosecutor's Request for a Summary Suspension is supported by the evidence presented. The Board concludes that the allegations in the Request for Summary Suspension have been established to the necessary degree (with the exception of alleged Violation Five). For purposes of this Summary Suspension Hearing, the Findings of Fact above do support Summary Suspension of Respondent's license. There is an imperative need to take emergency action. 3 V.S.A. § 814(c).

Vermont law requires that unprofessional charges be filed promptly with Respondent being afforded a prompt hearing. At any merits hearing in this matter, the prosecutor will bear the burden of proving unprofessional conduct. Our Findings and Conclusions in this matter will not absolve the prosecution or Respondent from producing or challenging relevant evidence at a merits hearing. The Findings of Fact and Conclusions of Law at a contested hearing will be based exclusively on the evidence admitted at that hearing.

**Order**

The Request for Summary Suspension is **Granted.** Respondent's license is **Summarily Suspended** pending proceedings for revocation or other action. These proceedings shall be promptly instituted and determined. 3 V.S.A. § 814(c).

Vermont Board of Nursing

By: _____ Date: February 14, 2019
Ellen Watson, APRN, Chair

DATE OF ENTRY: 2·21·19

**APPEAL RIGHTS**

This is a final administrative determination by the Vermont Board of Nursing. A party aggrieved by a final decision of a board may appeal this decision by filing a written Notice of Appeal with the Director of the Office of Professional Regulation, Vermont Secretary of State, 89 Main Street, Fl. 3, Montpelier, VT 05620-3402 within 30 days of the entry of this order. If an appeal is filed, the Director of the Office of Professional Regulation shall assign the case to an appellate officer. The review shall be conducted on the basis of the record created before the board. In cases of alleged irregularities in procedure before the board, not shown in the record, proof on that issue may be taken by the appellate officer. 3 V.S.A. §§ 129(d) and 130a.