



**State of Vermont
Office of the Secretary of State**

Office of Professional Regulation
89 Main Street, 3rd Floor
Montpelier, VT 05620-3402
sos.vermont.gov

**James C. Condos, Secretary of State
Christopher D. Winters, Deputy Secretary
S. Lauren Hibbert, Director**

September 13, 2022

Dermot Hanna
59 Chestnut Avenue
Rutland, VT 05701

Case: In Re Dermot Hanna
Credential: License # 025.0053892
Docket No.: 2019-136

Dear Mr. Hanna:

Enclosed, please find a *Default Order* in the matter captioned above. This is a final administrative determination.

If you are aggrieved by this decision, you may begin the appeal process by filing a Notice of Appeal with the Office of Professional Regulation. **The notice must be received no later than 30 days from the decision's date of entry (see last page of order).** Send the appeal to:

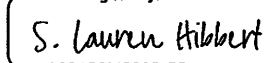
Office of Professional Regulation
Attn: S. Lauren Hibbert, Director
89 Main Street, 3rd Floor
Montpelier, VT 05620-3402

The appeal does not stop the disciplinary action from going into effect. If you wish to have the disciplinary action stayed during the appeals process, you must specifically request a stay in writing. Your request for a stay will be considered, and a decision to grant or deny your request will be issued. Please see the enclosed instructions.

If you have questions, please do not hesitate to contact the Office at (802) 828-2367.

Sincerely,

DocuSigned by:


9CDA8598B5054EE
S. Lauren Hibbert
Director

Enclosure: *Default Order*

cc: Michael Kupersmith, Hearing Officer
Jennifer Colin, Esq., Prosecuting Attorney
Kristin Donnelly, Case Manager
Dermot Hanna, Respondent, First Class Mail, Certified Mail & Email

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

**In re: Dermot Hanna
License No. 025.0053892**

Docket No. 2019-136

DEFAULT ORDER

Appearances:

Prosecuting Attorney: Jennifer B. Colin, Esq.

Respondent: Did not appear

Hearing Officer: Michael S. Kupersmith, Esq.

Introduction

The Hearing Officer conducted a default hearing in the above-entitled matter on September 6, 2022 pursuant to 3 V.S.A. § 129(f). The hearing was conducted remotely as provided in the Emergency Rules for Remote Hearings adopted by the Office of Professional Regulation (OPR). The State requested a default order because the Respondent had not responded to the Specification of Charges filed in this case. The State was represented by Jennifer B. Colin, Esq. The Respondent did not appear and was not represented by counsel.

Findings of Fact

1. The Respondent is licensed by the State of Vermont as a Licensed Practical Nurse (LPN) and is therefore subject to the regulatory authority of the Board of Nursing. See 3 V.S.A. §§ 129 and 129a; 26 V.S.A. Chapter 28; the Administrative Rules of the Board of Nursing; and the Rules of the Office of Professional Regulation.
2. A Specification of Charges was filed by the Prosecuting Attorney on or about October 6, 2021. On that date a copy of the Charges and Notice of Hearing was sent to the Respondent at the address which is on file with OPR, by certified mail and first class mail. Respondent's Answer was due on October 26, 2021.
3. By notice sent with the Charges, Respondent was advised that he was required to file an Answer within 20 days. See Administrative Rules of

Practice 3.3. As of the default hearing, the Respondent had failed to submit an Answer.

4. On August 17, 2022, the State filed a Motion for Default. On that date the motion as well as a notice of the default hearing were sent via certified mail and first class mail to the Respondent at the address on file with OPR. As of the default hearing, no response to the Motion for Default had been received by either the Docket Clerk or the Prosecuting Attorney. Furthermore, no communication has been received by either office since the filing of the Specification of Charges. (The State filed a Request for Summary Suspension in this matter, and on September 6, 2019, the Respondent agreed to a Voluntary Indefinite Suspension Stipulation. The Board adopted the stipulation and suspended Respondent's license on September 9, 2019.)
5. Upon consideration of the State's presentation, and taking judicial notice of the OPR file in this matter, the Hearing Officer finds the Respondent to be in default. Pursuant to the Administrative Rules of Practice 3.4, the allegations made in the Specification of Charges are treated as proven and the Board may take disciplinary action based on its findings. See also 3 V.S.A. §§ 809(d) and 814(c). A copy of the Specification of Charges is appended to this Order.
6. It is specifically found that during the year 2019, the Respondent on multiple occasions diverted controlled substances from patients under his care for his own personal use. He falsely documented administering the drugs to the patients. Also, on multiple occasions he withdrew controlled substances for patients and then wasted them without a witness. He used the "wasted" drugs for his personal use as well.
7. It is the recommendation of the Prosecuting Attorney that in consideration of the serious nature of the Respondent's misconduct and the probability that harm was caused to his patients, his license as a Licensed Practical Nurse be revoked.

Conclusions of Law

Respondent has received adequate actual and/or constructive notice of the Charges in this matter as indicated by the Board's file and the Prosecutor's presentation. Because the Respondent has failed to file an Answer, the factual allegations contained in the Specification of Charge are taken as proven. Accordingly, the Board concludes that the Respondent engaged in unprofessional conduct as alleged, to wit: (1) diverting drugs for unauthorized use in violation of 26 V.S.A. § 1582(a)(2); (2) engaging in conduct of a character likely to deceive, defraud, or harm the public in violation of 26 V.S.A. § 1582(a)(3); (3) failing to practice competently because of performance of unsafe or unacceptable patient care in violation of 3 V.S.A. § 129a(b)(1); (4) performing treatments that were beyond the

scope of the licensee's practice, in violation of 3 V.S.A. § 129a(a)(13); (5) willfully making false reports in the practice of the profession, in violation of 3 V.S.A. § 129a(a)(7); and (6) 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 in violation of 3 V.S.A. § 129a(a)(15).

PROPOSED ORDER

In accordance with the Findings of Fact and Conclusions of Law set forth above, and consistent with the recommendations of the Prosecuting Attorney, the Board orders that the Respondent's license be **REVOKED**.

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

Dated this 8th day of September, 2022



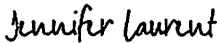
Michael S. Kupersmith
Hearing Officer

The Board of Nursing considered the report of findings of fact and conclusions of law at its meeting on September 12, 2022. 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.
- / X / 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,

DocuSigned by:



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Board of Nursing

By: Jennifer Laurent, Chair

Date of Entry: 9/13/22

APPEAL RIGHTS

This is a final administrative determination by the Board of Nursing. A party aggrieved by a final decision by the Board may appeal this decision by filing a written Notice of Appeal with the Director of the Office of Professional Regulation, 89 Main Street, 3rd floor, Montpelier, VT 05620-3402, within 30 days of the date of 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 appeal shall be conducted based on the record created before the Board. In cases of alleged irregularities in procedure before the Board not shown on the record, proof of that issue may be taken by the Appellate Officer. 3 V.S.A. §§ 129(d) and 130a. A stay of this Order may also be requested.

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

IN RE:)
Dermot J. Hanna) **Docket No. 2019-136**
License No. 025.0053892)

SPECIFICATION OF CHARGES

NOW COMES the State of Vermont and hereby makes the following charges against Respondent Dermot J. Hanna:

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. Dermot J. Hanna (“Respondent”) of Rutland, Vermont is licensed by the State of Vermont as a Licensed Practical Nurse (“LPN”) under license number 025.0053892. This license was originally issued on July 31, 2009 and expired on January 31, 2020.
3. Respondent was previously licensed by the State of Vermont as Licensed Nursing Assistant (“LNA”) under license number 075.0014474. This license was originally issued June 16, 2004 and expired on November 30, 2010.
4. During the relevant time, Respondent was employed as an LPN at Mountain View Center, a skilled nursing, medical and rehabilitative care facility, located in Rutland, Vermont (“Facility”).
5. In 2018 and 2019, Respondent provided nursing care to an elderly female resident (“Patient 1”), who was at the Facility after an extended hospital stay for significant medical issues resulting from extreme neglect by family members.
6. At the Facility, Patient 1 was receiving end-of-life care, which included pain management with orders for Dilaudid (hydromorphone) 2mg tablet, 0.5 tab (1mg) every 2 hours as needed and Roxanol (morphine sulfate) 20 mg/ml, 0.25ml (5mg) po/sl (orally, sublingual), every hour as needed.

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7. February 15, 16 and 17, 2019, Respondent documented withdrawing and administering numerous doses of Dilaudid for Patient 1.
8. Patient 1 died on February 17, 2019.
9. An autopsy of Patient 1 revealed that Patient 1 had no hydromorphone in her system.
10. The autopsy of Patient 1 revealed that Patient 1 had two anti-psychotic medications in her system, haloperidol (Haldol) and quetiapine (Seroquel).
11. Patient 1 did not have current orders for Haldol or Seroquel, nor did Patient 1's medical records show that Haldol and Seroquel had been administered to her in the time leading up to her death.
12. In an interview with OPR Investigators, Respondent admitted he diverted Patient 1's hydromorphone for his own personal use.
13. Respondent admitted he diverted Seroquel from other patients and administered it to Patient 1.
14. Facility records for other patients show that Respondent often withdrew controlled substances and documented wasting the medication without a witness.
15. Between January and August 2019, Respondent wasted controlled drugs without a witness on over twenty occasions.
16. Respondent admitted to OPR Investigators that each time the narcotic logs showed he withdrew a controlled drug for a patient and wasted it without a witness, he diverted those medications for his own personal use.
17. Respondent admitted to OPR Investigators that he had taken other controlled drugs from various patients, documented administering the medications to the patients, and then used/consumed the medications himself.
18. Respondent admitted that at the Facility while working he consumed controlled drugs he diverted from patients and for which he did not have prescriptions.
19. The State filed a Request for Summary Suspension in this matter in August 2019. Respondent agreed to an indefinite suspension of his LPN license, which the Board entered as an order on September 16, 2019.

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

20. The State re-alleges and incorporates Paragraphs 2 through 19 above.
21. As an LPN, Respondent is prohibited from diverting drugs for unauthorized use.

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22. Paragraphs 2 through 19 above demonstrate that Respondent diverted drugs from the Facility for unauthorized use in violation of 26 V.S.A. §1582(a)(2).
23. 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.

24. The State re-alleges and incorporates Paragraphs 2 through 19 above.
25. As an LPN, Respondent must refrain from engaging in conduct of a character likely to deceive, defraud, or harm the public.
26. Paragraphs 2 through 19 demonstrate that Respondent engaged in conduct of a character likely to deceive, defraud, or harm the public by diverting controlled drugs and intentionally falsifying patient records of dispensed and administered controlled drugs.
27. 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.

28. The State re-alleges and incorporates Paragraphs 2 through 19 above.
29. As an LPN, Respondent must provide safe and acceptable patient care.
30. Paragraphs 2 through 19 above demonstrate that Respondent provided unsafe and unacceptable patient care by failing to administer pain medications to Patient 1 and other patients.
31. Paragraphs 2 through 19 above demonstrate that Respondent provided unsafe and unacceptable patient care by falsely documenting the administration of controlled drugs to Patient 1 and other patients.
32. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent has committed unprofessional conduct in violation of 3 V.S.A. §129a(b)(1).

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Violation Four: 3 V.S.A. §129a(a)(13) Performing treatments or providing services that the licensee is not qualified to perform or that are beyond the scope of the licensee's education, training, capabilities, experience, or scope of practice.

33. The State re-alleges and incorporates Paragraphs 2 through 19 above.
34. As an LPN, Respondent is prohibited from performing treatments or providing services that he is not qualified to perform or that are beyond the scope of his practice.
35. Paragraphs 2 through 19 demonstrate that Respondent failed to administer ordered pain medications for Patient 1 and instead administered two medications to Patient 1 that were not ordered.
36. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent committed unprofessional conduct by performing treatments or providing services that were beyond the scope of his nursing practice in violation of 3 V.S.A. §129a(a)(13).

Violation Five: 3 V.S.A. §129a(a)(7) Willfully making or filing false reports or records in the practice of the profession.

37. The State re-alleges and incorporates Paragraphs 2 through 19 above.
38. Vermont law prohibits licensed practical nurses from willfully making or filing false reports in the practice of nursing.
39. Paragraphs 2 through 19 demonstrate that Respondent willfully made and filed false reports and records in the practice of nursing when he falsely documented information in narcotic logs of the Facility and in patient medication administration records.
40. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent committed unprofessional conduct in violation of 3 V.S.A. §129a(a)(7).

Violation Six: 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.

41. The State re-alleges and incorporates Paragraphs 2 through 19 above.
42. As an LPN, Respondent is required to exercise his 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.

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43. Paragraphs 2 through 19 demonstrate that Respondent failed to exercise independent professional judgment by diverting narcotics from patients and using false documentation to cloak his diversion on numerous occasions.
44. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent committed unprofessional conduct in violation of 3 V.S.A. §129a(a)(15).

Relief Requested

WHEREFORE, the license of Dermot J. Hanna should be revoked, suspended, reprimanded, conditioned, or otherwise disciplined.

DATED this 4th day of October, 2021.

STATE OF VERMONT
SECRETARY OF STATE

By: /s/ Jennifer B. Colin
Jennifer B. Colin
Prosecuting Attorney
(802)522-8987
Jennifer.Colin@vermont.gov

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Prosecuting Attorney
Office of
Professional Regulation
89 Main Street
3rd Floor
Montpelier, VT
05620-3402