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

| | | |
|---|---|---|
| **IN RE:** | ) | |
| **Bethany G. Spear** | ) | **Docket Nos. 2020-113** |
| **License No. 026.0137168** | ) | **2020-114** |

# STIPULATION AND CONSENT ORDER

## STIPULATION

NOW COMES the State of Vermont, by and through State Prosecuting Attorney Jennifer B. Colin, and Respondent Bethany G. Spear, by and through her counsel Mark Oettinger, Esq., who hereby stipulate and agree as follows:

### Board Authority

1. The Vermont State Board of Nursing (the "Board") has jurisdiction to investigate and adjudicate allegations of unprofessional conduct committed by Registered Nurses pursuant to 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. Bethany G. Spear ("Respondent") of Hinesburg, Vermont is licensed by the State of Vermont as a Registered Nurse ("RN") under license number 026.0137168. This license was originally issued on September 17, 2018 and expired on March 31, 2021.

3. During the relevant time period, Respondent was employed as an RN in the Post Anesthesia Care Unit ("PACU") of University of Vermont Medical Center ("the Facility") in Burlington, Vermont.

4. The Facility hired Respondent at the end of December 2018 and placed Respondent on administrative leave in mid-September 2020, at which time Respondent resigned.

5. During the relevant time, Respondent worked part-time in the PACU at the Facility, approximately 20 hours per week or 40 hours every two weeks.

6. At the end of August 2020, weeks prior to Respondent being placed on administrative leave, the Assistant Nurse Manager of the Facility received information from staff that Respondent was taking extended breaks that were

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much longer than normal, was taking breaks in her car in the garage, and was acting unusual upon returning from breaks as compared to her typical demeanor.

7. The report of the change in Respondent's conduct and behavior prompted the Facility to review pharmacy records and then controlled medications charting for some of Respondent's recent patients.

8. The Facility's review of pharmacy records from June, July and August 2020 revealed that even though Respondent worked only part-time, her incidents of dispensing certain controlled medications from the Pyxis machine were significantly higher than full-time PACU nurses.

9. In June 2020, Respondent was the highest PACU dispenser of Fentanyl, dispensing 79 units, while the next-highest PACU nurse dispensed 27 units.

10. In June 2020, Respondent was the highest PACU dispenser of Hydromorphone, dispensing 310 units, while the next-highest PACU nurse dispensed 38 units.

11. In July 2020, Respondent was the highest PACU dispenser of Fentanyl, dispensing 24 units, while the next-highest PACU nurse dispensed 19 units.

12. In July 2020, Respondent was the highest PACU dispenser of Hydromorphone, dispensing 140 units, while the next-highest PACU nurse dispensed 47 units.

13. In August 2020, Respondent was the highest PACU dispenser of Fentanyl, dispensing 243 units, while the next-highest PACU nurse dispensed 51 units.

14. In August 2020, Respondent was the highest PACU dispenser of Hydromorphone, dispensing 169 units, while the next-highest PACU nurse dispensed 54 units.

15. In one shift on August 28, 2020 and while on call into the morning of August 29, 2020, Respondent dispensed from the Pyxis fifty (50) 2 ml ampules of fentanyl citrate (PF) 50mcg/1ml and twenty-one (21) syringes of hydromorphone (PF) 0.5mg (0.5ml).

16. In the PACU of the Facility, nurses are assigned to specific patients in recovery from procedures/surgeries that require anesthesia. Generally patients would be in recovery in the PACU from one hour to several hours.

17. The Facility's review of a sampling of six of Respondent's patients' records and pharmacy records revealed unusual practices used by Respondent with respect to specific controlled medications, namely Hydromorphone, Fentanyl, and Oxycodone.

18. For example, between June and August 2020, Respondent had a pattern of dispensing excessive amounts (i.e. more than the maximum ordered dose) of Fentanyl and Hydromorphone for patients using the override function on the Pyxis, rather than pulling the controlled drugs under the patients' names. The

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override function is meant to be used only in emergency or other exigent circumstances in which medications are not yet assigned to a patient.

19. Also between June and August 2020, Respondent had the unusual and prohibited practice of dispensing the maximum amounts of controlled drugs, mostly Fentanyl and Hydromorphone, for patients upon their admission to the PACU, administering only a portion of the those pain medications during their brief recovery stays, and then failing to document either returning or wasting the remainder of the controlled medications that she did not administer.

20. Respondent also engaged in a pattern of back-charting the administration of controlled medications, meaning at a given point in time, often at the end of the patient's recovery in PACU (or after the patient was out of the PACU), she would document having administered multiple doses of pain medications minutes to hours prior to the time of documenting, though she had also already documented real-time administrations of pain medications in the same cases.

21. Respondent also back-charted administering controlled medications at times before she even dispensed the medications from the Pyxis.

22. Respondent also engaged in a pattern of not scanning the patients' bar codes when administering controlled substances for immediate verification and documentation.

23. In reporting losses of controlled medications to the Drug Enforcement Administration (DEA), the Facility's Director of Pharmacy attributed to Respondent the theft or suspected theft of over 100 vials of Fentanyl (100mcg/2ml), over 60 vials of Hydromorphone (0.5mg/0.5ml syringe), and over 20 tables of Oxycodone (5mg tab).

24. In November 2020, the State filed a Petition for Summary Suspension to suspend Respondent's RN license.

25. At the summary suspension hearing on December 7. 2020, Respondent testified under oath before the Board of Nursing that she did not know what happened to the missing controlled drugs. She also denied that she personally used or sold the missing drugs.

26. On December 9, 2020, the Board entered an Order granting the State's Petition for Summary Suspension on Violation Two, 26 V.S.A. 1582(a)(3) (Engaging in conduct of a character likely to harm the public), Violation Three, 3 V.S.A. 129a(b)(1) (Failure to practice competently including performance of unsafe or unacceptable patient or client care), and Violation Four, 3 V.S.A. 129a(a)(15) (Failure to exercise independent professional judgment necessary to avoid actions repugnant to the profession).

27. In September 2021, OPR completed its extensive investigation of this case.

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28. Respondent took for her personal use the following controlled drugs in the approximate amounts indicated: 200 ampules of Fentanyl with 2ml in each (50mcg/1ml); 100 vials of Hydromorphone (0.5mg/0.5ml); 25 tablets of Oxycodone (125mg/tab); and 3 Hydromorphone tablets (2mg/tab).

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

29. Paragraphs 2 through 28 above are incorporated herein.

30. As an RN, Respondent is prohibited from diverting drugs for unauthorized use.

31. Paragraphs 2 through 28 above demonstrate that Respondent diverted drugs from the Facility for unauthorized use.

32. 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.**

33. Paragraphs 2 through 28 above are incorporated herein.

34. As an RN, Respondent must refrain from engaging in conduct of a character likely to deceive, defraud, or harm the public.

35. Paragraphs 2 through 28 demonstrate that Respondent engaged in conduct of a character likely to deceive, defraud, or harm the public by diverting controlled drugs, intentionally falsifying patient records of dispensed and administered controlled drugs, and testifying falsely before the Vermont Board of Nursing.

36. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent committed unprofessional conduct 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.**

37. Paragraphs 2 through 28 above are incorporated herein.

38. As a Registered Nurse, Respondent must provide safe and acceptable patient care.

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39. Paragraphs 2 through 28 above demonstrate that Respondent provided unsafe and unacceptable patient care by failing to accurately document the dispensing and administration of controlled drugs.

40. 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).

**Violation Four: 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. Paragraphs 2 through 28 above are incorporated herein.

42. As an RN, 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.

43. Paragraphs 2 through 28 demonstrate that Respondent failed to exercise independent professional judgment by diverting narcotics, using deceit to cloak her diversion on multiple occasions, and testifying falsely before the Board of Nursing.

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).

**Understandings**

45. Respondent admits the above-stated facts are true and that the conditions below are necessary to protect the public.

46. Respondent understands that the Board must review and accept the terms of the Consent Order. If the Board rejects any portion, the entire Stipulation and Consent Order shall be null and void.

47. Respondent specifically waives any claims that any disclosures made to the full Board during its review of this agreement have prejudiced Respondent's rights to a fair and impartial hearing if this agreement is not accepted by the Board and proceeds to a contested hearing.

48. Respondent has read and reviewed this entire document and agrees that it contains the entire agreement between the parties.

49. Respondent is not under the influence of any drugs or alcohol at the time Respondent signs this Stipulation and Consent Order.

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50. Respondent voluntarily enters into this agreement after the opportunity to consult with legal counsel and is not being coerced by anyone into signing this Stipulation and Consent Order.

51. Respondent voluntarily waives Respondent's right to a contested hearing before the Board and waives any right to appeal from this Stipulation and Consent Order.

52. Respondent agrees that the Order set forth below may be entered by the Board.

**ORDER**

Based on the Stipulation above, it is **ORDERED AND ADJUDGED** as follows:

A. A. The Board of Nursing hereby **INDEFINITELY SUSPENDS** Respondent's license to practice as a Registered Nurse **from the date of entry below**. No sooner than forty-five (45) days prior to requesting reinstatement, Respondent must, at her own cost:

1. Obtain an independent substance abuse evaluation report by a pre-approved licensed professional specializing in drug and alcohol abuse ("Independent Evaluator") who has verified receipt of this Stipulation and Consent Order. The results of the Independent Evaluation must indicate that Respondent does not present a risk to the safety, health or welfare of Respondent's potential patients, as well as any recommendations that would ensure Respondent is safe to practice. The evaluation must be submitted to the Enforcement Unit Case Manager.

2. Submit to the Enforcement Unit Case Manager the results of a minimum of three (3) random urine analyses:

   a. When Respondent is ready to petition for reinstatement, Respondent shall contact the Enforcement Unit Case Manager to set-up the drug screen process and receive instructions. Once registered with the pre-approved person or entity, Respondent will have approximately 45 days to submit a minimum of three (3) random urine analyses. The process by which Respondent learns whether she is selected to provide a sample on any given day will be governed by the policy of the pre-approved person or entity conducting the testing at that time.

   b. The drug screens must be collected in an observed setting; administered by a pre-approved person or entity; and analyzed by a pre-approved lab qualified to analyze samples for forensic purposes, the results of which shall be negative.

   c. Failure to appear for, refusal to provide, adulteration of, dilution of, or tampering with a sample for any drug screen shall cause that screen to be presumed positive; and

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3. If recommended by an Independent Evaluator, enter into a treating professional agreement and substance abuse treatment plan with a pre-approved treating professional(s) and follow all recommendations.

B. If reinstated, Respondent's license **SHALL BE CONDITIONED** pursuant to whatever terms the Board finds reasonable at the time of Respondent's reinstatement request, taking into account the independent evaluation, drug screen results, the facts above, and anything else the Board deems relevant at that time.

C. Notwithstanding any provision above, the Respondent must continue to meet all Board requirements for maintaining a license, license renewal and license reinstatement.

D. This Stipulated and Consent Order is a matter of public record and may be reported to other licensing authorities as provided in 3 V.S.A. §129(a).

E. This Stipulation and Consent Order will remain part of Respondent's licensing file and may be used for purposes of determining sanctions in any future disciplinary matter.

F. This Stipulation and Consent Order shall be applicable as a matter of law to all other licenses issued by the Board of Nursing, as provided in 3 V.S.A. §129(l).

**AGREED TO:**

STATE OF VERMONT
SECRETARY OF STATE

Dated: 2/6/23 By: _____
Jennifer B. Colin
State Prosecuting Attorney

RESPONDENT

Dated: 2/3/23 By: _____
Bethany G. Spear

**APPROVED AS TO FORM:**

ATTORNEY FOR RESPONDENT

Dated: 2/2/23 By: _____
Mark Oettinger, Esq.

STATE OF VERMONT
Prosecuting Attorney
Office of
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89 Main Street
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**APPROVED AND SO ORDERED:**

VERMONT BOARD OF NURSING

Dated: 2/14/23

By: DocuSigned by: Jennifer Laurent EB1744915719477...
Chairperson

Date of Entry: 2/14/23

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| **IN RE:** | ) | |
| **Bethany G. Spear** | ) | |
| **License No. 026.0137168** | ) | **Docket Nos. 2020-113** |
| | ) | **2020-114** |
| | ) | |

## RESPONSE TO SPECIFICATION OF CHARGES

Now comes Respondent, Bethany G. Spear, by and through her attorneys, Montroll, Oettinger & Barquist, and hereby responds to the specification of charges against her as follows:

### Authority

1. Conclusions of law; no response required.

### Statement of Facts

2. Admitted.

3. Admitted.

4. Admitted.

5. Admitted.

6. Unknown, but not contested.

7. Unknown, but not contested.

8. Unknown, but not contested.

9. Unknown, but not contested.

10. Unknown, but not contested.

11. Unknown, but not contested.

12. Unknown, but not contested.

13. Unknown, but not contested.

14. Unknown, but not contested.

15. Unknown, but not contested.

16. Admitted.

17. Unknown, but not contested.

18. Admitted.

19. Admitted.

20. Admitted.

21. Admitted.

22. Admitted.

23. Unknown, but not contested.

24. Admitted.

25. Admitted. Respondent was unrepresented at the time and hadn't yet come to grips with her behavior. That said, she never sold or gave any controlled substances to any third parties.

26. Admitted.

27. Unknown, but not contested.

28. Admitted.

29. Admitted.

30. Admitted.

31. Admitted.

32. Admitted.

33. Admitted.

34. Denied. Sentencing was withheld pending a year of probation, all in anticipation of a retroactive dismissal of the charges, expected on November 1, 2022.

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

35. No response required.

36. Admitted.

37. Admitted.

38. Admitted.

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

39. No response required.

40. Admitted.

41. Admitted, but see response to paragraph 25, above.

42. Admitted.

**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 or unsafe or unacceptable patient or client care.**

43. No response required.

44. Admitted.

45. Admitted.

46. Admitted.

**Violation Four: 3 V.S.A. §129a(a)(15) Failure 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.**

47. No response required.

48. Admitted.

49. Admitted, but see response to paragraph 25, above.

50. Admitted.

**Violation Five: 3 V.S.A. §129a(a)(10) Conviction of a crime related to the practice of the profession or conviction of a felony, whether or not related to the practice of the profession.**

51. No response required.

52. Admitted.

53. Denied. Respondent pled guilty, but acceptance of the plea (and "conviction") were withheld pending dismissal of charges expected on November 1, 2022.

54. Admitted.

Dated at Burlington, Vermont, this 26th day of September 2022.

BY: Bethany G. Spear

Mark D. Oettinger, Esq.
Montroll, Oettinger & Barquist, P.C.
Attorneys for Respondent
126 College Street, Suite 400
P.O. Box 1045
Burlington, VT 05402
(802) 540-0250
moettinger@mblawoffice.com

**STATE OF VERMONT**
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| **IN RE:** | **)** | |
| **Bethany G. Spear** | **)** | **Docket Nos. 2020-113** |
| **License No. 026.0137168** | **)** | **2020-114** |

## SPECIFICATION OF CHARGES

NOW COMES the State of Vermont and makes the following Charges against Respondent Bethany G. Spear:

### Board Authority

1. The Vermont State Board of Nursing (the "Board") has jurisdiction to investigate and adjudicate allegations of unprofessional conduct committed by Registered Nurses pursuant to 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. Bethany G. Spear ("Respondent") of Hinesburg, Vermont is licensed by the State of Vermont as a Registered Nurse ("RN") under license number 026.0137168. This license was originally issued on September 17, 2018 and expired on March 31, 2021.

3. During the relevant time period, Respondent was employed as an RN in the Post Anesthesia Care Unit ("PACU") of University of Vermont Medical Center ("the Facility") in Burlington, Vermont.

4. The Facility hired Respondent at the end of December 2018 and placed Respondent on administrative leave in mid-September 2020, at which time Respondent resigned.

5. During the relevant time, Respondent worked part-time in the PACU at the Facility, approximately 20 hours per week or 40 hours every two weeks.

6. At the end of August 2020, weeks prior to Respondent being placed on administrative leave, the Assistant Nurse Manager of the Facility received information from staff that Respondent was taking extended breaks that were much longer than normal, was taking breaks in her car in the garage, and was acting unusual upon returning from breaks as compared to her typical demeanor.

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7. The report of the change in Respondent's conduct and behavior prompted the Facility to review pharmacy records and then controlled medications charting for some of Respondent's recent patients.

8. The Facility's review of pharmacy records from June, July and August 2020 revealed that even though Respondent worked only part-time, her incidents of dispensing certain controlled medications from the Pyxis machine were significantly higher than full-time PACU nurses.

9. In June 2020, Respondent was the highest PACU dispenser of Fentanyl, dispensing 79 units, while the next-highest PACU nurse dispensed 27 units.

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14. In August 2020, Respondent was the highest PACU dispenser of Hydromorphone, dispensing 169 units, while the next-highest PACU nurse dispensed 54 units.

15. In one shift on August 28, 2020 and while on call into the morning of August 29, 2020, Respondent dispensed from the Pyxis fifty (50) 2 ml ampules of fentanyl citrate (PF) 50mcg/1ml and twenty-one (21) syringes of hydromorphone (PF) 0.5mg (0.5ml).

16. In the PACU of the Facility, nurses are assigned to specific patients in recovery from procedures/surgeries that require anesthesia. Generally patients would be in recovery in the PACU from one hour to several hours.

17. The Facility's review of a sampling of six of Respondent's patients' records and pharmacy records revealed unusual practices used by Respondent with respect to specific controlled medications, namely Hydromorphone, Fentanyl, and Oxycodone.

18. For example, between June and August 2020, Respondent had a pattern of dispensing excessive amounts (i.e. more than the maximum ordered dose) of Fentanyl and Hydromorphone for patients using the override function on the Pyxis, rather than pulling the controlled drugs under the patients' names. The override function is meant to be used only in emergency or other exigent circumstances in which medications are not yet assigned to a patient.



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19. Also between June and August 2020, Respondent had the unusual and prohibited practice of dispensing the maximum amounts of controlled drugs, mostly Fentanyl and Hydromorphone, for patients upon their admission to the PACU, administering only a portion of the those pain medications during their brief recovery stays, and then failing to document either returning or wasting the remainder of the controlled medications that she did not administer.

20. Respondent also engaged in a pattern of back-charting the administration of controlled medications, meaning at a given point in time, often at the end of the patient's recovery in PACU (or after the patient was out of the PACU), she would document having administered multiple doses of pain medications minutes to hours prior to the time of documenting, though she had also already documented real-time administrations of pain medications in the same cases.

21. Respondent also back-charted administering controlled medications at times before she even dispensed the medications from the Pyxis.

22. Respondent also engaged in a pattern of not scanning the patients' bar codes when administering controlled substances for immediate verification and documentation.

23. In reporting losses of controlled medications to the Drug Enforcement Administration (DEA), the Facility's Director of Pharmacy attributed to Respondent the theft or suspected theft of over 100 vials of Fentanyl (100mcg/2ml), over 60 vials of Hydromorphone (0.5mg/0.5ml syringe), and over 20 tables of Oxycodone (5mg tab).

24. In November 2020, the State filed a Petition for Summary Suspension to suspend Respondent's RN license.

25. At the summary suspension hearing on December 7. 2020, Respondent testified under oath before the Board of Nursing that she did not know what happened to the missing controlled drugs. She also denied that she personally used or sold the missing drugs.

26. On December 9, 2020, the Board entered an Order granting the State's Petition for Summary Suspension on Violation Two, 26 V.S.A. 1582(a)(3) (Engaging in conduct of a character likely to harm the public), Violation Three, 3 V.S.A. 129a(b)(1) (Failure to practice competently including performance of unsafe or unacceptable patient or client care), and Violation Four, 3 V.S.A. 129a(a)(15) (Failure to exercise independent professional judgment necessary to avoid actions repugnant to the profession).

27. In September 2021, OPR completed its extensive investigation of this case.

28. Respondent took for her personal use the following controlled drugs in the approximate amounts indicated: 200 ampules of Fentanyl with 2ml in each (50mcg/1ml); 100 vials of Hydromorphone (0.5mg/0.5ml); 25 tablets of Oxycodone (125mg/tab); and 3 Hydromorphone tablets (2mg/tab).



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29. In October 2021, Respondent was federally charged in United States District Court for the District of Vermont, *United States of America v. Bethany Spear*, Docket 2:21 CR-88-1, with the misdemeanor crime of Possession of Fentanyl, a Schedule II controlled substance in violation of 21 USC §844(a).

30. In October 2021, Respondent entered a Plea Agreement in her federal criminal case, pleading guilty to the federal crime of Possession of Fentanyl.

31. In the Plea Agreement, Respondent admitted that while working at the Facility between June and September 2, 2020, Respondent:

> knowingly and intentionally dispensed controlled substances, including ampules of fentanyl, for her personal use. In total, BETHANY SPEAR dispensed over 400 milliliters of fentanyl, which is a Schedule II controlled substance.

32. As part of her Plea Agreement, Respondent agreed:

> That she will not seek to obtain a nursing license in any jurisdiction for a period of not less than one year. BETHANY SPEAR further agrees not to seek reinstatement of her nursing license from the State of Vermont Office of Professional Regulation until she has satisfactorily completed any term of probation or other sentence imposed in this matter.

33. In her Plea Agreement, Respondent agreed to be placed on federal probation for a period of one year.

34. On November 1, 2021, the U.S. District Court for the District of Vermont accepted Respondent's Plea Agreement and sentenced Respondent to one year of probation. Respondent is scheduled for a termination of probation hearing on November 1, 2022.

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

35. The State re-alleges and incorporates Paragraphs 2 through 34 above.

36. As an RN, Respondent is prohibited from diverting drugs for unauthorized use.

37. Paragraphs 2 through 34 above demonstrate that Respondent diverted drugs from the Facility for unauthorized use.

38. 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).

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

39. The State re-alleges and incorporates Paragraphs 2 through 34 above.

40. As an RN, Respondent must refrain from engaging in conduct of a character likely to deceive, defraud, or harm the public.

41. Paragraphs 2 through 34 demonstrate that Respondent engaged in conduct of a character likely to deceive, defraud, or harm the public by diverting controlled drugs, intentionally falsifying patient records of dispensed and administered controlled drugs, and testifying falsely before the Vermont Board of Nursing.

42. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent committed unprofessional conduct 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.**

43. The State re-alleges and incorporates Paragraphs 2 through 34 above.

44. As a Registered Nurse, Respondent must provide safe and acceptable patient care.

45. Paragraphs 2 through 34 above demonstrate that Respondent provided unsafe and unacceptable patient care by failing to accurately document the dispensing and administration of controlled drugs.

46. 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).

**Violation Four: 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.**

47. The State re-alleges and incorporates Paragraphs 2 through 33 above.

48. As an RN, 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.

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05620-3402

49. Paragraphs 2 through 34 demonstrate that Respondent failed to exercise independent professional judgment by diverting narcotics, using deceit to cloak her diversion on multiple occasions, and testifying falsely before the Board of Nursing.

50. 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).

**Violation Five: 3 V.S.A. §129a(a)(10) Conviction of a crime related to the practice of the profession or conviction of a felony, whether or not related to the practice of the profession.**

51. The State re-alleges and incorporates Paragraphs 2 through 34 above.

52. In Vermont, unprofessional conduct includes conviction of a crime related to the practice of the profession.

53. Paragraphs 2 through 34 demonstrate that Respondent was convicted in United States District Court for the District of Vermont, *United States of America v. Bethany Spear*, Docket 2:21 CR-88-1, with the misdemeanor crime of Possession of Fentanyl, a Schedule II controlled substance in violation of 21 USC §844(a), a crime related to Respondent's practice of the nursing profession because Respondent's possession resulted from her diversion of controlled drugs from the Facility where she worked as a nurse in 2020.

54. 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)(10).

**Relief Requested**

**WHEREFORE**, the Registered Nurse license of Bethany G. Spear should be revoked, suspended, reprimanded, conditioned, or otherwise disciplined.

**DATED** at Montpelier, Vermont this _6th day of September, 2022.

STATE OF VERMONT
SECRETARY OF STATE

By: __/s/ Jennifer B. Colin_____
Jennifer B. Colin
Prosecuting Attorney
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STATE OF VERMONT

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05620-3402

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

| | | |
|---|---|---|
| In re: BETHANY SPEAR<br>License No. 026.0137168 | } | Docket Nos. 2020-113 & 114 |

Participating Board Members:
Douglas Sutton, RN, Acting Chair
Kelly Sinclair, LNA
William White, Jr., Public Member
Luana Tredwell, LPN
Daniel Coane, Public Member
Wendy Thurston, RN
Alex Farrell, *ad hoc* member
Judith Wernicke, *ad hoc* member

Appearances:
Prosecutor: Jennifer B.Colin, Esq.
Respondent: Robert H. Backus, Esq.

Presiding Officer: George K. Belcher

Exhibits:
State Exhibit 1: Investigation Spreadsheet
State Exhibit 1a: Pharmacist Audit Sheet for weekend of August 28 and 29, 2019
State Exhibit 2: RxAuditor Report, June 2019
State Exhibit 3: RxAuditor Report, July 2019
State Exhibit 4: RxAuditor Report, August 2019
State Exhibit 5: DEA Form 106
Respondent Exhibit A: Undated Reference letter from Kate Curler, RN
Respondent Exhibit B: Reference letter dated 12/2/20 from Casey Gallo, RN
Respondent Exhibit C: Undated Reference letter from Alyssa Robinson, RN

**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 electronically on December 7, 2020 with the parties, the witnesses, and the Board all participating by telephone or via electronic means pursuant to the Office of Professional Regulation Emergency Rules for Remote Hearings.

## Findings of Fact

Based on the evidence presented at the hearing, the Vermont Nursing Board finds as follows:

1. Respondent is licensed as a Registered Nurse in the State of Vermont. 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." The Respondent was sent a notice of the hearing on November 20, 2020 to the Respondent's counsel. There were no objections as to notice
3. The Respondent participated in the hearing through counsel and by her own testimony.
4. The Respondent worked at the University of Vermont Medical Center in the Post Anesthesia Care Unit ("PACU") during 2019 as a Registered Nurse. The PACU unit is responsible for the care of patients who have come from surgery or other procedures where general anesthesia or general sedation has been given.
5. Patients in the PACU unit are often recovering from procedures and the nurses in attendance follow the patients, monitor their vital signs, follow the post-procedure orders from the doctors, and assure the patients are prepared for discharge safely from the unit to the next stage of recovery. The Respondent was a part-time employee.
6. During the latter part of August, 2019 staff on the PACU unit reported that the Respondent's behavior was unusual.
7. Jennifer Robare is the interim nurse manager with supervisory responsibilities including the PACU unit. She is a Registered Nurse and has twenty years of experience working at the University of Vermont Medical Center. One of her responsibilities is disciplinary actions regarding employees within her supervision and investigation of diversion cases.
8. In response to the reported concern, an assistant nurse manager conducted a preliminary review of the Respondent's medication history for the weekend of August 28 and August 29, 2020. That review showed some discrepancies in the chart records of the Respondent. This preliminary report was given to Nurse Robare and she began a more formal review of the Respondent's medication withdrawals and charting.
9. On the PACU unit, medications are dispensed to nurse providers via a "Pyxis" delivery system. That system usually tracks; (1) when medications are withdrawn; (2) who withdraws them; (3) which patient is the medication drawn for; and (4) the amount of medications withdrawn. When medications are administered to a patient, the medication and the patient can be "scanned" into the medical record, showing the medication, the patient, and the time of delivery. Doctors' medication orders, patient health status, and other patient information is monitored in the EPIC electronic record for each patient, but the Pyxis system and the electronic record are not fully synchronized.
10. Generally speaking, if a regulated medication is withdrawn from the Pyxis machine, it should be documented that the medication was administered in a timely manner, returned to the Pyxis machine, or that the medication was "wasted" (meaning that the medication was destroyed in a documented fashion). If the medication is withdrawn, but not

administered, returned or documented as "wasted", then the drug is unaccounted for and there is a "variance".

11. At times, nurse providers need to access medications from the Pyxis machine outside of the usual documentation if there is an urgent situation or if the medication orders have not yet been entered into the system. When this happens, the access to the Pyxis machine is logged as an "override".
12. It is important in the medication charting system to chart the administration of medications near in time to the actual administration. This is necessary to avoid the possible duplication of medication, and overmedication due to a subsequent provider not being aware that a prior medication had been administered.
13. When Nurse Robare began her investigation into the medication and charting history of the Respondent she made a spreadsheet to keep her information. The information on the spreadsheet came from the Pyxis machine log and the patient chart records for the period in which the Respondent was working. The spreadsheet was admitted into evidence as State Exhibit 1. The spreadsheet reported the medications drawn by the Respondent for six patients on the dates of June 10, 2020, June 24, 2020, August 19, 2020, August 28, 2020 and August 29, 2020.
14. The evidence showed that the Respondent had a "variance" or missing drugs for the five days shown on the spreadsheet of 2000 mcg of Fentanyl and 10 mg of Hydrocodone.
15. There were striking anomalies in the medication charting by the Respondent for these drugs as well. For Patient #1 on August 29, the Respondent charted that she withdrew Fentanyl and Hydromorphone at 2201 and 2200 (10:01 PM and 11:00 PM) but that she administered the drugs at 2103 (9:03 PM). For Patient #2 on this same date, the Respondent withdrew 800 mcg of Fentanyl between 0158 and 0206 and documented giving four doses of 50 mcg each at 0130, 0137, 0146, and 0201. Not only were three of the doses documented as having been given before the drugs were withdrawn, but the physician's order for this drug was for a maximum dose of 20 mcg. Thus, the administered dose was inconsistent with the mediation order.
16. The Respondent failed to chart pain scores for several of the patients and occasionally the pain scores which were documented were inconsistent with the times that medications were administered.
17. There were delays from the time of administration of the drugs to the time of charting of medications being administered.
18. Dr. Wesley McMillian is the Director of Pharmacy at the University of Vermont Medical Center. He has 14 years of experience at the University of Vermont Medical Center and he is a Registered Pharmacist. In his role as Director of Pharmacy, he is involved in medication monitoring, management, training and investigation of diversion. He has training in the identification and statistical evaluation of medication diversion. "Diversion" in the context of Dr. McMillian's testimony includes missing medication regardless of whether it was used by the person withdrawing the medication. Dr. McMillian uses the "RxAuditor" program to evaluate the rate of withdrawal of medications by particular staff in comparison to other staff in order to gauge whether the usage by that staff is a statistical "outlier".
19. Dr. McMillian ran the RxAuditor program for the months of June, July and August for the PERIOP Unit. (Exhibits 2, 3, and 4) The PERIOP Unit includes the pre-operative unit and the post-operative unit, including the PACU unit upon which the Respondent

worked. In short, the PERIOP unit includes the Respondent's workplace.

20. The RxAuditors report show that for the month of June, 2020, the Respondent was responsible for 16.8% of all Fentanyl used on the PERIOP unit and 32.9% of the Hydromorphone for the unit; in July, 2020, the Respondent was responsible for 5.54 % of the Fentanyl used on the PERIOP Unit and was responsible for 17.2 % of the Hydromorphone used on the PERIOP unit; in August 2020, the Respondent was responsible for 35.5% of all the Fentanyl used on the PERIOP Unit and 20.36% of the Hydromorphone used on the PERIOP Unit. (See State Exhibits 2, 3 and 4). The Respondent's usage of these drugs was three (3) times greater than the mean use on the PERIOP Unit during these months and her usage was identified as an "outlier".
21. Dr. McMillian testified, and the Board finds, that there would be concern if the Respondent had this degree of outlying usage for one of the drugs involved, but it is more concerning that there is an excessive usage for these two drugs (Fentanyl and Hydromorphone) since these drugs are not usually used together. Likewise, it is a concern that the excessive usage occurred in three consecutive months. Dr. McMillian testified that the descriptives of Respondent's usage of these drugs within the investigative team were "extraordinary" and "astronomical". Dr. McMillian testified, and the Board so finds, that the usage and quantities were "really, very high". Dr. McMillian could not envision any reasonable, legitimate reason for the high volume of withdrawal of controlled substances by the Respondent. In the opinion of Dr. McMillian, the highest probable explanation for the high usage is "diversion" and a distant second possibility is "bad practice". The Board so finds.
22. Dr. McMillian filed a Drug Enforcement and Administration Form 106 (State Exhibit 5) which reported the missing regulated medications to the Federal Government. That report concluded that the missing drugs were the result of "Employee theft (or Suspected)" (See Box #2 of State Exhibit 5)
23. Nurse Robare had two meetings with the Respondent concerning the investigation into the Respondent's use and charting of the medications. The Respondent had no memory of the patients or the missing drugs. She had no explanation for the "variance" or the missing drugs except that possibly the drugs "fell out of her pockets". No drugs were recovered as found on the unit and none were delivered to the pharmacy as found drugs.
24. The Respondent was placed on leave from the UVM Medical Center and later resigned.
25. Nurse Robare recommended that the Respondent not be authorized to work in a home health practice.
26. The Respondent testified at the hearing.
27. The Respondent trained to become a nurse at the University of Portland. She became an officer in the U.S. Army and served on active duty from 2006 to 2010. She served in the Army Reserves from 2010 to 2014.
28. During her Army career, the Respondent served 18 months in a combat zone in Iraq. During that time, she observed many traumatic injuries, including injured children and women.
29. In addition to her experience with trauma patients while in the Army, the Respondent has worked in other ICU and PACU units in her career before coming to the University of Vermont Medical Center.
30. In 2018 the Respondent left the State of Washington and moved to Vermont. In January of 2019 she started at the UVM Medical Center. She was worked on the PACU during

her time at the UVM Medical Center.

31. The Respondent testified that she has severe post-traumatic stress disorder from her Army experience in Iraq. She testified that her post-traumatic stress disorder was aggravated when the COVID-19 pandemic began, including flashbacks.
32. The Respondent testified that her post-traumatic stress disorder "Really affected my charting." She testified that "... [M]y mental health was really bad at the time" and it affected her documentation in June, July and August but not her patient care. She testified that she did not get the right treatment for PTSD until she resigned from the UVM Medical Center. She testified that is now in treatment at the Vermont Trauma Institute and she is stabilized.
33. The Respondent offered letters of reference from co-workers who generally supported the nursing skill of the Respondent. (See Respondent's Exhibits A, B, and C) None of the letters showed that the authors were aware of the allegations in this case nor did they address the alleged facts in the Request for Summary Suspension.
34. There was no testimony offered from any providers who are currently treating the Respondent that she is safe to practice nursing.
35. The Respondent testified that she was "blindsided" when confronted by the investigative committee at the hospital and she became scared. She decided to resign.
36. The Respondent is currently working as a home health nurse for a home health agency.
37. In addition to her explanation of her PTSD condition, the Respondent spoke of conditions at the PACU unit as contributing factors to her charting errors. She said that the unit was understaffed causing undue time pressure and often requiring charting to be done when time became available ("back-charting"). She testified that she worked 19 hours straight on the weekend of August 28-29, 2020. She testified that she was given more difficult patients because of her long experience, compared with other PACU staff who had lesser experience. She testified that the conditions of some of the patients and the failure of equipment contributed to the inability for her to scan the wrist bracelet of patients, thus requiring "override" withdrawal of medications and delayed charting.
38. The Respondent denied that she personally used or sold the drugs which were missing.
39. When asked if she knew what happened to the large quantity of drugs which were missing, the Respondent answered that she did not know what happened to them.
40. The failure to accurately chart medications in a timely manner creates risks to the safety of patients.
41. It is an essential function of nurses who manage and deliver controlled medication that the nurse account for them so that there is an accurate record of when and how the drugs are used. This is necessary for patient safety and for the overall security of the hospital drug management.
42. The quantity of unaccounted controlled medications which were withdrawn by the Respondent has not been adequately explained by her and is beyond reason under almost any circumstance.

## Conclusions of Law

1. The Respondent requested a continuance when it became clear that a criminal citation might be issued by the Investigator of the Office of Professional Regulation, Paul

Petralia, who testified at the hearing. The continuance was requested under the authority of State v. Begins, 147 Vt. 295, 514 A.2d 719 (1986). The request was made to avoid the Respondent being faced with the choice, on the one hand, of waiving her constitutional right against self-incrimination or, on the other hand, defending her professional license. The State opposed the continuance on the grounds that public protection required that the case go forward. The requested continuance was denied because the Begins case authorizes "use immunity" to testimony in administrative cases where the same facts might be used in criminal prosecutions. The case does not, however, mandate that the administrative/civil case be put on hold until the criminal case is resolved as was requested.

2. The evidence established that the Respondent violated: Violation Three, 3 VSA Sec. 129a(b)(1) [Failure to practice competently including performance of unsafe or unacceptable patient or client care]; Violation Two, 26 VSA Sec. 1582(a)(3) [Engaging in conduct of a character likely to harm the public]; and Violation Four, 3 VSA Sec. 129a(a)(15) [failing to exercise independent judgment necessary to avoid actions repugnant to the profession]. The Board declines to find that there was a "diverting" or "attempting to divert" the drugs as is alleged in Violation One of the Request for Summary Suspension. While a "diversion" is usually defined as a "turning aside or altering the natural course of a thing"[1], the Board declines to find that a theft or personal use of the drugs occurred here since the evidence is ambiguous on this point. Moreover, the Summary Suspension is justified on the other grounds alleged. The evidence which was presented proved 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 public.
3. The 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). The Findings of Fact and Conclusions of Law herein are for purposes of this Order only.
4. The Prosecutor's Request for a Summary Suspension is supported by the evidence presented. 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).
5. 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. The 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** and shall not be subject renewal or reinstatement during the period of Summary Suspension without Board approval pending proceedings. These proceedings shall be promptly instituted and determined. 3 V.S.A. § 814(c).

[1] Black's Law Dictionary, Revised Fourth Edition

**SO ORDERED.**

Vermont Board of Nursing or Director of the Office of Professional Regulation

By: Douglas Sutton RN Date: 9 Dec., 2020

Douglas Sutton, RN
Acting Chair

OFFICE OF PROFESSIONAL REGULATION
DATE OF ENTRY: 12/9/2020

## APPEAL RIGHTS

This is a final administrative determination by the Vermont Board of Nursing or Director of the Office of Professional Regulation. A party aggrieved by a final decision of a board or hearing authority 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.