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

In re: Lisa Greenspon **Docket No. 2022-226**
License No. 026.0020412

DEFAULT ORDER

Appearances:
Prosecuting Attorney: George L. Hasselback, 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 March 9, 2023 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 George L. Hasselback, 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 Registered Nurse (RN) 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 26, 2022. 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.

3. By notice sent with the Charges, Respondent was advised that she 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 February 14, 2023, the State filed a Motion for Default. On that date the motion as well as a notice of the default hearing was 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.

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. During the relevant time, Respondent, was employed as a RN at Durgin Pines Retirement Community ("the Facility") in Kittery, Maine.

7. As part of her responsibilities, Respondent was required to provide care for Patient A at the Facility.

8. On or about August 2, 2022, Patient A had been prescribed (among other medications) Amlodipine and Levemir to be administered at the time scheduled for evening medication administration.

9. Instead of waiting to administer these medications during the time scheduled for evening medication administration at the Facility, Respondent dispensed and administered these medications several hours early.

10. When Respondent administered Patient A's medications early, she did not dispense, nor administer, any Amlodipine or any Levemir to Patient A.

11. The Facility's orientation training nurse, who was observing Respondent, alerted Respondent to this omission and it was corrected, in that Respondent eventually administered all of Patient A's medication that she was supposed to have been administered at the time scheduled for evening medication administration (albeit early).

12. The Facility's orientation training nurse, who was observing Respondent, provided Respondent additional education and training that the dispensation/administration of medication early is discouraged due to increased potential for errors/omissions.

13. A few hours later, during the time scheduled for evening medication administration, Respondent dispensed and attempted to re-administer Patient A's medications that she had already administered (early) and had to be reminded by the Facility's orientation training nurse, who was observing Respondent, that she had already administered them.

14. Respondent claimed that she did not remember dispensing and administering Patient A's medication earlier in her shift.

15. The Facility's orientation training nurse, who was observing Respondent, reminded Respondent of the incident earlier in the shift in which she dispensed and administered early and erroneously, because of which she received corrective education/training.

16. Despite these reminders, Respondent told the Facility's orientation training nurse, who was observing Respondent, that she still did not remember giving Patient A any medication earlier in her shift, saying "I don't remember giving her medications, but if you say I did then I won't give them again," or words to that effect.

17. Throughout the rest of her August 2, 2022 shift, Respondent made the following errors in dispensing medication that was, at the time, prescribed for the Facility's patients:

    a. Respondent failed to dispense Patient D.C.'s prescribed Cymbalta.

    b. Respondent dispensed for Patient B.S. 1/3 the dose of Metoprolol and argued with Patient B.S. when the Patient asked Respondent to confirm the appropriate amount and timing of its dispensation/administration.

    c. Respondent only dispensed half of the appropriate dose of Docusate-Senna to Patient J.F.

    d. Respondent dispensed the wrong dose of Senna and Depakote to Patient M.A.

e. Respondent dispensed triple the dose of Melatonin to Patient G.S.

f. Respondent failed to dispense Atrovent to Patient M.W

g. Respondent failed to dispense a Lidocaine patch to Patient D.G.

h. Respondent dispensed the wrong dose of Depakote to Patient R.B.

i. Respondent failed to dispense Tylenol and Metoprolol to Patient B.B.

18. Each of the errors was noted prior to final administration of each patient's medication by the Facility's orientation training nurse, who was observing Respondent, and who, in turn, communicated these errors to Respondent, so that the errors were corrected prior to final administration of the medication.

19. Respondent's employment was terminated by the Facility on or about August 4, 2022, in part, due to the aforementioned errors in dispensing and administering medication.

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 may conclude that the Respondent engaged in unprofessional conduct as alleged, to wit: (1) Failed to practice competently on a single or on multiple occasions, whether or not actual injury to a patient occurred, by performing unsafe and unacceptable patient care in violation of 3 V.S.A. § 129a(b)(1); and (2) Failed to practice competently on multiple occasions, whether or not actual injury to a patient occurred, by failing to conform to the essential standards of acceptable and prevailing practice in violation of 3 V.S.A. § 129a(b)(2)..

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 **SUSPENDED INDEFINITELY.** At such time as the Respondent applies for reinstatement, the Board may impose

preconditions to reinstatement as well as conditions on her reinstated license as it deems appropriate at the time.

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 9th day of March, 2023

Michael S. Kupersmith
Hearing Officer

The Board of Nursing considered the report of findings of fact and conclusions of law at its meeting on March 13, 2023. 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.
/ / Accepts the report, adopts the findings of fact and conclusions of law, rejects the recommended sanction, and schedules the matter for additional hearing on sanctions.

SO ORDERED,

DocuSigned by:
Jennifer Laurent
EB1741915719477...

Board of Nursing
By: Jennifer Laurent, Chair

Date of Entry: 3/14/23

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.

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SPECIFICATION OF CHARGES

NOW COMES the State of Vermont (the "State") and makes the following charges against Registered Nurse, Lisa Greenspon:

Board Authority

1. 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 Rules").

Statement of Facts

2. Lisa Greenspon ("Respondent") of Somersworth, New Hampshire is licensed by the State of Vermont as a Registered Nurse ("RN") under license number 026.0020412. This license was originally issued on February 6, 1992 and expires on March 31, 2023.

3. During the relevant time, Respondent, was employed as a RN at Durgin Pines Retirement Community ("the Facility") in Kittery, Maine.

4. As part of her responsibilities, Respondent was required to provide care for Patient A at the Facility.

5. On or about August 2, 2022, Patient A had been prescribed (among other medications) Amlodipine and Levemir to be administered at the time scheduled for evening medication administration

6. Instead of waiting to administer these medications during the time scheduled for evening medication administration at the Facility, Respondent dispensed and administered these medications several hours early.

7. When Respondent administered Patient A's medications early, she did not dispense, nor administer, any Amlodipine or any Levemir to Patient A.

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8. The Facility's orientation training nurse, who was observing Respondent, alerted Respondent to this omission and it was corrected, in that Respondent eventually administered all of Patient A's medication that she was supposed to have been administered at the time scheduled for evening medication administration (albeit early).

9. The Facility's orientation training nurse, who was observing Respondent, provided Respondent additional education and training that the dispensation/administration of medication early is discouraged due to increased potential for errors/omissions.

10. A few hours later, during the time scheduled for evening medication administration, Respondent dispensed and attempted to re-administer Patient A's medications that she had already administered (early) and had to be reminded by the Facility's orientation training nurse, who was observing Respondent, that she had already administered them.

11. Respondent claimed that she did not remember dispensing and administering Patient A's medication earlier in her shift.

12. The Facility's orientation training nurse, who was observing Respondent, reminded Respondent of the incident earlier in the shift in which she dispensed and administered early and erroneously, because of which she received corrective education/training.

13. Despite these reminders, Respondent told the Facility's orientation training nurse, who was observing Respondent, that she still did not remember giving Patient A any medication earlier in her shift, saying "I don't remember giving her medications, but if you say I did then I won't give them again," or words to that effect.

14. Throughout the rest of her August 2, 2022 shift, Respondent made the following errors in dispensing medication that was, at the time, prescribed for the Facility's patients:

    a. Respondent failed to dispense Patient D.C.'s prescribed Cymbalta.

    b. Respondent dispensed for Patient B.S. 1/3 the dose of Metoprolol and argued with Patient B.S. when the Patient asked Respondent to confirm the appropriate amount and timing of its dispensation/administration.

    c. Respondent only dispensed half of the appropriate dose of Docusate-Senna to Patient J.F.

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15. Each of the errors was noted prior to final administration of each patient's medication by the Facility's orientation training nurse, who was observing Respondent, and who, in turn, communicated these errors to Respondent, so that the errors were corrected prior to final administration of the medication.

16. Respondent's employment was terminated by the Facility on or about August 4, 2022, in part, due to the aforementioned errors in dispensing and administering medication.

Violation One: 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.

17. The State re-alleges and incorporates Paragraphs 2 through 16 above.

18. Vermont law requires RNs to practice competently by providing safe and acceptable patient care.

19. Paragraphs 2 through 16 above demonstrate that Respondent failed to provide safe and acceptable patient care when Respondent (during her August 2, 2022 shift at the Facility) repeatedly failed to dispense and/or dispensed medication in incorrect dosages, dispensed and administered medication outside of the scheduled time for dispensing and administering medication, and dispensed and attempted to administer medication to a patient whose medication had already been previously administered.

20. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because the Respondent has committed unprofessional conduct in violation of 3 V.S.A. §129a(b)(1).

Violation Two: 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.

21. The State re-alleges and incorporates Paragraphs 2 through 16 above.

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22. The essential standards of acceptable and prevailing practice require that an RN follow providers orders when dispensing and administering medication and accurately document patient records.

23. Paragraphs 2 through 16 above demonstrate that Respondent failed to conform to essential standards of acceptable and prevailing practice when Respondent (during her August 2, 2022 shift at the Facility) repeatedly failed to dispense and/or dispensed medication in incorrect dosages, dispensed and administered medication outside of the scheduled time for dispensing and administering medication, and dispensed and attempted to administer medication to a patient whose medication had already been previously administered.

24. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because the Respondent has committed unprofessional conduct in violation of 3 V.S.A. §129a(b)(2).

Relief Requested

WHEREFORE, the RN license of Lisa Greespon should be revoked, suspended, reprimanded, conditioned, or otherwise disciplined.

DATED at Montpelier, Vermont this 26th day of October, 2022.

STATE OF VERMONT
SECRETARY OF STATE

By: _____
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