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

In re: NICK HANSEN	)	Docket No. 2023-162
Multistate License No. 026.014828	)	
	)	

Participating Board Members:
Matthew Choate, RN, Acting Chair
Deborah Belcher, Public Member
Raequel Gordon, LPN, *ad hoc* Member
Danielle Rubalcaba, *ad hoc* Public Member
Jill Neary, LPN
Luana Tredwell, LPN
Marsha Arend, RN

Appearances:
Prosecutor: George Hasselback, Esq.
Respondent: did not participate and was not represented

Presiding Officer: George K. Belcher

Exhibits:
State Exhibit 1: Investigation timeline 5/27/23 – 6/16/23
State Exhibit 2.1: Redacted Visits Note #1
State Exhibit 2.2: Redacted Visit Note #2
State Exhibit 3: HCHB Email to Northern Counties Health Care dated approximately June 16, 2023
State Exhibit 5: Transcript of Testimony of David Allen on 11/13/23

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

This matter came before the Board of Nursing on Specification of Charges dated 1/25/24 and the Respondent's Answer dated 2/19/24. The hearing was held electronically on July 8, 2024, with the attorneys, witnesses, and the Board members all participating by telephone or via electronic means pursuant to the Office of Professional Regulation Rules for Remote Hearings. The Notice of

hearing was mailed to the Respondent on 2/23/24 by regular mail, certified mail and email. There were no objections to notice. The Respondent did not participate, and he was not represented, in the hearing.

Findings of Fact

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

1. Respondent holds a multistate license to practice as a Registered Nurse in the State of Vermont. During the times in question set forth below, the Respondent was practicing nursing at the Northern Counties Health Care, Home Health and Hospice. The Respondent is subject to the regulatory authority of this Board.
2. On May 27, 2023, the Respondent was working as a visiting nurse at Northern Counties Health Care. He made a visit to a patient at the patient's home on that date. (Testimony of patient "D.A" Exhibit 5 and Exhibit 1). The Respondent was not the patient's regular nurse. The visit was documented in the electronic medical records and included the servicing of a medication pump. The patient was a cancer patient who had a medication pump which would deliver pain medication (Hydromorphone) to the patient via an intravenous tube. The pump is called a CCAD pump (Central Access Delivery Device). On May 27, 2023, the Respondent applied a new "cassette" of medication to the pump. (Exhibit 1)
3. On June 1, 2023, at about 7:00 PM, the Respondent again appeared at patient "D.A.'s" home. This visit was unusual because it was not noticed to the patient in advance, and it occurred at a time (evening) when such visits do not normally occur.
4. The Respondent told the patient that he needed to see the medication pump. The Respondent removed the pump from the IV line and then took the pump to his car which was parked outside the residence. The patient's daughter who lived nearby, came to the home to see who was visiting her father. She saw the Respondent sitting in the driver's seat of his car. The Respondent was out of the house for about 15 minutes. Thereafter, the Respondent returned to the house with the machine, connected it to the IV line, and mentioned that the Respondent noted "moisture" in the machine. At no time during the visit did the Respondent mention to the patient that he was concerned that the machine had malfunctioned or that the purpose of the visit was for the

Respondent to recover the Respondent's missing computer or tablet.

5. No nurse during prior visits had removed the pump from the home of the patient.
6. The patient had not noticed any leaks or drips coming from the pump prior to the June 1, 2023, visit.
7. Between May 27, 2023, and the visit on June 1, 2023, neither the patient nor his daughter had seen a computer tablet or any form of computer belonging to the Respondent in the patient's home.
8. There were no notes entered by the Respondent in the electronic medical record of the Respondent's visit to the patient on June 1, 2023 (no date of the visit, no time of the visit, no purpose of the visit, and no services rendered during the visit).
9. When the patient had his next regular home health visit on June 2, 2023, the patient reported to nurse "J. G." the news of Respondent's visit on June 1, 2023. Nurse "J. G." and the agency investigated the pump performance and determined that the pump was missing approximately 30 cc of Hydromorphone. (Exhibit 1)
10. The agency conducted an investigation including interviews with the Respondent on June 6 and June 8, 2023.
11. During the interviews with the Respondent, he reported that he had made the visit on June 1, 2023, to the patient's home to retrieve his tablet computer which he had left there on May 27, 2023. When asked how he made entries to the medical records while the tablet was missing, the Respondent told the agency representatives that he had not made any recorded entries between May 27 and June 1. The agency then checked with their information technology vendor and learned that the Respondent had made two electronic medical record entries on May 30, 2023. (Exhibits 2.2 and 2.3) According to Agency staff, the only way the Respondent could make the entries to the medical record would be for him to use the computer tablet (which he stated he had left at the patient's residence between May 27 and June 1, 2023). When the Respondent was confronted with the actual entries he made to the electronic record on May 30, 2023 (Exhibits 2.1 and 2.2), the Respondent stated that those records were inaccurate, and the dates were wrong. The discrepancies were not adequately explained to the agency. The Respondent's employment was terminated for dishonesty.
12. The patient's testimony was clear that the Respondent removed the CCAD pump from the patient's home to his personal vehicle. It was the opinion of professional, home-health staff that there would be no legitimate reason to remove the pump from the home of the patient and

certainly no legitimate reason to take the pump to his personal vehicle during an unannounced, after-normal-hours, undocumented visit.

13. Although the facts which were proven created a strong suspicion that the Respondent may have removed medication from the pump, there was a lack of medication tracking evidence to show when the medication was placed in the pump and how much, what would be normal usage, when the medication discrepancy was noticed, how it was measured, how much was wasted and when, etc. In short, the allegation of drug diversion was not adequately proven by the records which were introduced into evidence.
14. On the other hand, the failure of the Respondent to document his surprise visit, his deceitful and variant explanation for the June 1, 2023 visit itself, and his false claim of not having access to his work-tablet, and the removal of the pump from the home to his personal vehicle … all of these facts support violations Two and Three.

Conclusions of Law

1. The evidence established, and the Board finds, that the Respondent violated: 26 VSA Sec. 1582(a)(3) [Engaging in conduct of a character likely to deceive, defraud or harm the public]; and 3 VSA Sec. 129a(a)(15) [Failing to exercise independent professional judgment in the performance of licensed activities].

Order

1. Based upon the facts established, the Board orders that the license of the Respondent in the State of Vermont be **INDEFINITELY SUSPENDED**.
2. The indefinite suspension of the Respondent's license is continued until the Respondent petitions for reinstatement and the Board has reinstated his license.
3. Prior to seeking reinstatement, the Respondent shall petition the Board for reinstatement. If the Board grants a request for reinstatement, it may condition the license of the Respondent with such conditions as are deemed by the Board to be appropriate given the facts and conclusions of this decision.
4. Pursuant to 26 VSA Sec. 1647c(d) the Respondent is hereby ordered to cease and desist from any nursing practice within the State of Vermont under any multistate licensure privilege until his license is reinstated by this Board.

SO ORDERED.

Vermont Board of Nursing

By: DocuSigned by: Matthew Choate 43D8849C1C474EF... Date: 7/10, 2024

Matthew Choate, Acting Chair

OFFICE OF PROFESSIONAL REGULATION
DATE OF ENTRY: 7/10/24

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.

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IN RE:	)	
Nick Hansen	)	**Docket No. 2023-162**
Multistate License No. 026.0142828	)	

SPECIFICATION OF CHARGES

NOW COMES the State of Vermont and hereby makes the following charges against Respondent Nick Hansen:

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 ("RNs") 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. Nick Hansen ("Respondent") of Lyndonville, Vermont, holds a multistate license to practice as an RN under license number 026.0142828. This license was originally issued on June 18, 2020, and expires on March 31, 2025.

3. At all times relevant to this matter, Respondent was working as a home-health nurse for a home-health agency located in Vermont ("the Agency").

4. As part of that employment and on or about May 27, 2023, Respondent was assigned to visit a patient diagnosed with terminal cancer identified by the initials "D.A" to address an emergency that had arisen with D.A.'s intravenous medication pump ("the pump").

5. The pump was used to administer intravenous pain medication to D.A., specifically Hydromorphone.

6. The pump was set up to administer a constant dose of medication to D.A. and to supplement such dosage on D.A.'s demand.

7. On or about June 1, 2023, Respondent visited D.A.'s home for the second time.

8. Respondent was not scheduled to visit D.A.'s home on that date.

9. Respondent had only visited D.A. on the one prior occasion on May 27, 2023.

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10. D.A. did not call ahead (as every other nurse assigned by the Facility to treat D.A. had in the past), but instead showed up at D.A.'s home unannounced.

11. Respondent arrived at D.A.'s home in the evening between 6:30 and 7:00 p.m., which was also unusual for a visit from a home health nurse assigned by the Agency.

12. Respondent told D.A. that Respondent needed to check D.A.'s intravenous pump.

13. Respondent unhooked the pump from D.A.'s PIC line and walked out of D.A.'s residence with it.

14. No other nurse that had visited D.A. had ever disconnected the pump and removed it from the residence to "check" it before.

15. Respondent took the pump to his vehicle.

16. While in his vehicle, Respondent removed approximately 30cc's of Hydromorphone from the pump.

17. Later, Respondent returned the pump to D.A.'s residence and informed D.A. that there was some "moisture" in the pump.

18. Respondent then asked D.A. if he had pain pills that he (D.A.) could take if the pump was not sufficiently addressing his pain.

19. No nurse had ever asked D.A. about using pain pills instead of the pump before.

20. Respondent then left D.A.'s residence.

21. Subsequently, another home health nurse employed by the Agency (identified by the initials "J.G.") made a scheduled visit to D.A.'s residence.

22. During this visit, J.G. changed the Hydromorphone IV cassette in D.A.'s pump.

23. The pump indicated that there should be 35.4cc of Hydromorphone remaining in the cassette.

24. When J.G. was disposing of the remaining Hydromorphone in the cassette, she determined that there was only 6cc remaining in the cassette despite what the pump indicated should be present.

25. When made aware of this discrepancy, the Agency investigated what had occurred.

26. Respondent explained that he visited D.A.'s home unannounced and unscheduled to retrieve his Agency-issued tablet that he had left at D.A.'s home on the previous visit on May 27, 2023.

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27. This tablet was used by Respondent to make chart entries into patients' electronic medical records ("EMR") following treatment.

28. The Agency asked Respondent how Respondent had done charting between May 27, 2023 (when he supposedly left his tablet at D.A.'s home) and June 1, 2023 (when he supposedly retrieved the tablet from D.A.'s home).

29. Respondent answered that he had not done any charting during this time.

30. The Agency requested a review by its EMR vendor of the dates and times that Respondent had done charting from his tablet.

31. The Agency's EMR vendor responded that Respondent documented treatment in another patient's records on May 30, 2023, when Respondent claimed his tablet was at D.A.'s home.

32. Respondent was subsequently terminated from his position at the Agency.

33. On or about November 20, 2023, Respondent's license was summarily suspended by order of the Board.

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

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

35. As an RN Respondent is prohibited from diverting or attempting to divert drugs, equipment, or supplies for unauthorized use.

36. Paragraphs 2 through 33, Respondent diverted or attempted to divert drugs for unauthorized use.

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

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

39. As a licensed RN in the State of Vermont, Respondent is required to refrain from engaging in conduct of a character likely to deceive, defraud, or harm the public.

40. Paragraphs 2 through 33 demonstrate that Respondent engaged in conduct of a character likely to harm the public when he removed medication from a patient without informing either the patient, the patient's primary care physician, or anyone else that the patient's medication was removed.

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41. 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(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.

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

43. Vermont law requires an RN 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.

44. Paragraphs 2 through 33 demonstrate that Respondent failed to exercise independent professional judgment in the performance of licensed activities when that judgment was necessary to avoid action repugnant to the obligations of the profession by entering the home of a terminally ill cancer patient under false pretenses, removing that patient's intravenous pump, removing pain medication from that pump, returning the pump to the patient with a false story about a potential malfunction, and then lying about why he had made the visit in the first place when asked by his employer.

45. 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(a)(15).

Relief Requested

WHEREFORE, Respondent's license should be revoked, suspended, reprimanded, conditioned, or otherwise disciplined.

DATED at Montpelier, Vermont this 25th day of January, 2024.

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SECRETARY OF STATE

By: _____

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