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

In re: DONNA M. CAMPANELLA	}	
License No. 025.0134143	}	Docket No. 2018-32
	}	

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

Hearing Officer: George K. Belcher

DEFAULT ORDER

The Hearing Officer of the Vermont Board of Nursing held a hearing pursuant to 3 VSA Sec. 129(f) in the above matter on September 27, 2018 at the Office of Professional Regulation in Montpelier, Vermont. Respondent did not attend and was not represented by counsel.

Findings of Fact

1. Respondent is a Licensed Practical Nurse and is therefore subject to the regulatory authority of this Board. 3 V.S.A. §§ 129, 129a, 26 V.S.A. Chapter 28, and the Administrative Rules of the Board of Nursing, and the Rules of the Office of Professional Regulation.
2. Charges were filed in this matter on April 19, 2018. The Respondent was sent a Notice of Charges in this matter by certified mail and first class mail to the address of the Respondent which was on file with the Office of Professional Regulation on April 25, 2018. The certified mail notice of charges was returned "undeliverable". A copy of the Specification of Charges is attached to this Default Order.
3. OPR Rule 3.3 requires that an Answer be filed within 20 days of the date on which the notice of charges was mailed by the Director.
4. On September 13, 2018 a notice was sent to the Respondent advising of the hearing before the Board to find a default and advising that, "If you wish to contest the charges you must contact the office immediately at (802) 828-2367 and show good cause for failing to answer the charges against you." This notice was mailed by certified mail. The certified mail notice was not returned as of the date of the hearing. The State Prosecutor likewise sent a copy of the Motion for Default to the Respondent on June 1, 2018 to which no answer was made.
5. Respondent has not filed an answer to the charges, nor any communication concerning good cause for failure to answer. The Respondent did not appear at the hearing on default. No contact was made by the Respondent to the attorney for the State indicating that the Respondent intended to contest the charges. Upon consideration of the

Prosecution's presentation and taking notice of the OPR file, the Hearing Officer of the Board finds Respondent to be in Default. The allegations contained in the Specification of Charges are therefore treated as the facts on which the Board may issue an order of professional discipline. OPR Rule 3.4, 3 V.S.A. § 809(d), and 3 V.S.A. § 814(c).

6. It is specifically found that in December of 2017 and January of 2018 while working at the Rutland Healthcare and Rehabilitation Center the Respondent diverted approximately 30 Oxycodone tablets for unauthorized use and failed to properly document the missing medications.
7. It was the recommendation of the State of Vermont that the Respondent's license be indefinitely suspended with conditions should the Board later determine that the Respondent's license should be reinstated. Those recommended conditions follow in the proposed order below.

Conclusions of Law

Respondent has received adequate or constructive notice of the charges in this matter as indicated by the Board's file and the Prosecution's presentation. Because Respondent has failed to answer the charges, the factual allegations in the Specification of Charges are treated as if proved. O.P.R. Rule 3.4. Accordingly, the Board may find, based up the finding of Default from this Default Hearing held pursuant to 3 V.S.A. §809(d), that Respondent has engaged in the unprofessional conduct alleged in the Specification of Charges. The Respondent committed unprofessional conduct by violating 26 VSA Sec. 1582(a)(3) (Engaging in conduct of a character likely to deceive); 3 VSA Secs. 129a(a)(7) (Willfully making false reports); 3 VSA Sec. 129a(b)(2) (Failure to practice competently); 3 VSA Sec. 129a(a)(15) (Failure to exercise independent professional judgement); and 26 VSA Sec. 1582(a)(2) (Diverting drugs).

Proposed Order

In accordance with the above Findings of Fact and Conclusions of Law, and consistent with the recommendation by the State, the Board does **ORDER** that the Respondent's license be **Indefinitely Suspended.** In the event that the Respondent seeks to regain her license, she must petition for reinstatement. Within forty-five (45) days of requesting reinstatement, Respondent must, at her own cost:

(a) Obtain an independent substance abuse and mental health evaluation report by a pre-approved licensed professional specializing in drug and alcohol abuse ("Independent Evaluator") who has verified receipt of the Default 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;

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

(i) When Respondent is ready to petition for reinstatement, Respondent shall contact the Enforcement Unit Case Manager at the Office of Professional Regulation to set up the urine analysis process and receive instructions.

Once registered with the pre-approved person or entity, Respondent will have 45 days to submit to a minimum of three (3) random urine analyses. The process by which Respondent learns whether the Respondent 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;

(ii) The urine analyses must be collected in an observed setting, administered by a pre-approved lab qualified to analyze samples for forensic purposes, the results of which shall be negative;

(iii) Failure to appear for, refusal to provide, adulteration of, dilution of, or tampering with a sample for any urine analysis shall cause that screen to be presumed positive;

(c) 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.

(d) If reinstated, Respondent's license **SHALL BE CONDITIONED** pursuant to whatever terms are reasonable at the time of Respondent's reinstatement request, taking into account the independent evaluation, urine analysis results, the facts contained in the Default Order, and any other relevant factors at that time.

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

Dated this 30 TT day of September, 2018.

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

The Vermont Board of Nursing considered the report of findings of fact and conclusions of law at its meeting on 10.8.2018. After considering the report, the Board takes the following action:

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

SO ORDERED.

Vermont Board of Nursing

By: _____ Date: 10.8, 2018
Ellen Watson, Chair
Vermont Board of Nursing

OFFICE OF PROFESSIONAL REGULATION
DATE OF ENTRY: 10-11-18

Appeal Rights

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

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BOARD OF NURSING

IN RE:	)	
Donna M. Campanella, LPN	)	**Docket No. 2018-32**
License No. 025.0134143	)	

SPECIFICATION OF CHARGES

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 a 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.

Statement of Facts

2. Donna M. Campanella ("Respondent"), who currently resides in Hammonton, New Jersey, is licensed by the State of Vermont as a Licensed Practical Nurse ("LPN") under license number 025.0134143, which was originally issued on December 15, 2017 and is set to expire on January 31, 2020.

3. During the relevant time period, Respondent was employed at the Rutland Healthcare & Rehabilitation Center ("the Facility") in Rutland, Vermont, as an LPN "travel nurse" contracted through a nursing staffing agency.

4. Respondent worked at the Facility for approximately two (2) weeks from December 23, 2017 through her termination on or about January 8, 2018.

5. On March 8, 2018, Respondent admitted to diverting approximately thirty (30) Oxycodone 5mg tablets from the Facility.

6. Respondent stated she did not divert the tablets to sell for a profit, but rather diverted the tablets for the benefit of someone important to her who had a need for the medication.

Patient 1

7. On January 6, 2018, Respondent was stationed on the first floor of the facility for her shift from 2:00 p.m. to 10:00 p.m.

8. During her January 6, 2018 shift, Respondent reported to other nursing staff that she locked her keys in a medication cart and tried to unlock or pry open the medication cart

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with a medication blister pack card that contained seven (7) Oxycodone 10mg tablets prescribed to Patient 1.

9. Respondent never looked for a second key to open the locked medication cart, and never asked other staff members or administration members of the Facility for a second key to open the locked medication cart, before reportedly using a blister pack card that contained seven (7) Oxycodone 10mg tablets to pry open the medication cart.

10. Respondent reported that the blister pack containing all seven (7) Oxycodone 10mg tablets prescribed to Patient 1 was damaged, and all seven (7) tablets were crushed, through her attempt to pry open the locked medication cart.

11. Respondent documented on Patient 1's narcotic log that she wasted the seven (7) Oxycodone 10mg tablets prescribed to Patient 1 on January 6, 2018, at 5:30 p.m.

12. Respondent initialed her documented waste of Patient 1's seven (7) Oxycodone 10mg tablets on Patient 1's narcotic log.

13. Respondent reported that a Registered Nurse ("RN"), specifically RN HB, witnessed the documented waste of Patient 1's seven (7) Oxycodone 10mg tablets on January 6, 2018, and that RN HB signed her initials on Patient 1's narcotic log as a witness to said waste.

14. RN HB did not start her shift on January 6, 2018 until 10:00 p.m., during Respondent's shift change.

15. The blister pack that contained Patient 1's seven (7) prescribed Oxycodone 10mg tablets disappeared and Respondent could not remember where the blister pack went.

16. Nursing staff searched for the blister pack that contained the seven (7) Oxycodone 10mg tablets prescribed to Patient 1, but were unable to locate the blister pack.

17. As a result of Respondent's medication cart blister pack story, and the Facility's view that Respondent's recitation of events was improbable, the Facility conducted an audit of Respondent's logged narcotic history and found medication inconsistencies related to five (5) additional patients, referred in Paragraphs 18 through 38 as Patient 2, Patient 3, Patient 4, Patient 5, and Patient 6.

Patient 2

18. Patient 2 had a prescription for Oxycodone 5mg, to be given "as needed."

19. Patient 2 deceased in early December of 2017, but still had, in a locked medication cart, a blister pack card of Oxycodone 5mg that contained forty-eight (48) tablets.

20. On December 23, 2017, Respondent's first day at the Facility, Respondent documented and initialed on Patient 2's narcotic log that she withdrew one of Patient 2's Oxycodone 5mg tablets at 4:00 p.m., and that forty-seven (47) Oxycodone 5mg tablets remained after her withdrawal.

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21. On December 23, 2017, Respondent documented on Patient 2's narcotic log that Patient 2's remaining forty-seven (47) Oxycodone 5mg tablets were wasted, without documenting a time or reason for the waste.

22. Next to Respondent's December 23, 2017 initials on Patient 2's narcotic log are the initials "LM."

23. There was only one (1) person working at the Facility on December 23, 2017 with the initials "LM," an LNA.

24. LM, LNA, did not witness the waste of Patient 2's forty-seven (47) Oxycodone 5mg tablets, and did not initial Patient 2's narcotic log.

Patient 3

25. Patient 3 had a prescription for Oxycodone 5mg tablets to be given "every 4 hours as needed."

26. Patient 3's narcotic log documents that none of Patient 3's prescribed Oxycodone 5mg tablets were withdrawn from the medical cart from November 16, 2017 through December 22, 2017.

27. On December 23, 2017, Respondent documented and initialed on Patient 3's narcotic log that she withdrew two of Patient 3's Oxycodone 5mg tablets at 4:00 p.m., and that Patient 3 had thirty-seven (37) Oxycodone 5mg tablets remaining after her withdrawal.

28. On December 26, 2017, Respondent documented on Patient 3's narcotic log that Patient 3's remaining thirty-seven (37) Oxycodone 5mg tablets were wasted, without documenting a time or reason for the waste, and with no accompanying witness signature or initial.

Patient 4

29. Patient 4 had a prescription for Oxycodone 5mg tablets to be given as needed for pain.

30. Patient 4's narcotic log documents that Patient 4's prescribed Oxycodone 5mg tablets were withdrawn on a periodic basis from August 16, 2017 through December 16, 2017.

31. None of Patient 4's Oxycodone 5mg tablets were withdrawn from December 17, 2017 through December 24, 2017.

32. From December 25, 2017 through January 7, 2018, Respondent is the only staff member who documented the withdrawal of Patient 4's Oxycodone 5mg tablets.

33. On December 31, 2017, Respondent documented on Patient 4's narcotic log that thirteen (13) Oxycodone 5mg tablets were crushed in the "card" and wasted at 3:00 p.m., with no accompanying witness signature or initial.

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Patient 5

34. Patient 5 had a prescription for Oxycodone 5mg tablets with a direction that one (1) tablet be given to Patient 5 every four (4) hours for pain.

35. On January 3, 2018, Respondent documented on Patient 5's narcotic log that one (1) Oxycodone 5mg tablet was "broken" and wasted at what appears to be 10:00 a.m., with no accompanying witness signature or initial.

Patient 6

36. Patient 6 had a prescription for Oxycodone 5mg tablets with a direction that one (1) tablet be given to Patient 6 every four (4) hours for pain.

37. From November 21, 2017 through December 23, 2017, Patient 6's narcotic log documents that only one (1) of Patient 6's prescribed Oxycodone 5mg tablets was withdrawn on two (2) separate occasions, November 21, 2017 and December 23, 2017.

38. From December 24, 2017 through January 4, 2018, Patient 6's narcotic log documents that Respondent was the only staff member to withdraw Patient 6's prescribed Oxycodone 5mg tablets, and that Respondent withdrew one (1) tablet of Patient 6's prescribed Oxycodone 5mg tablets on seven (7) different occasions.

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

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

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

41. Paragraphs 2 through 38 demonstrate that Respondent diverted drugs from the Facility for unauthorized use in violation of 26 V.S.A. § 1582(a)(2).

42. 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: 3 V.S.A. § 1582(a)(3), Engaging in conduct of a character likely to deceive, defraud, or harm the public.

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

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

45. Paragraphs 2 through 38 demonstrate that Respondent engaged in conduct of a character likely to deceive, defraud, or harm the public by intentionally falsifying reports of wasting narcotics and by forging signatures of her nursing colleagues as to the witnessing of narcotic waste.

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46. 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)(7), Willfully making or filing false reports or records in the practice of the profession, willfully impeding or obstructing the proper making or filing of reports or records, or willfully failing to file the proper reports or records.

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

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

49. Paragraphs 2 through 38 demonstrate that Respondent willfully made and filed false reports and records in the practice of the profession and willfully impeded or obstructed the proper making or filing of reports or records by falsely documenting waste of narcotics and obstructing the proper making or filing of reports by forging signatures of her nursing colleagues as to the witnessing of narcotic waste.

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

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.

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

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

53. Paragraphs 2 through 38 demonstrate that Respondent failed to exercise independent professional judgment by diverting narcotics and using deceit to cloak her diversion on multiple occasions.

54. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent committed unprofessional conduct by diverting narcotics from the Facility and deceiving her colleagues to cover up her diversion in violation of 3 V.S.A. § 129a(a)(15).

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Violation Five: 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.

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

56. As an LPN, Respondent is required to perform to the essential standards of acceptable and prevailing practice that applies to every Licensed Practical Nurse in the state of Vermont.

57. The essential standards of acceptable and prevailing practice require Licensed Practical Nurses to refrain from diverting narcotics and to refrain from falsifying reports.

58. Paragraphs 2 through 38 demonstrate that Respondent failed to perform to the essential standards of acceptable and prevailing practice of her profession by diverting narcotics and using deceit to cloak her diversion on multiple occasions.

59. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent committed unprofessional conduct by diverting narcotics from the Facility and deceiving her colleagues to cover up her diversion in violation of 3 V.S.A. § 129a(b)(2).

Relief Requested

WHEREFORE, the State requests that the Licensed Practical Nurse license of Donna M. Campanella be revoked, suspended, reprimanded, conditioned, or otherwise disciplined.

DATED in Montpelier, Vermont, this 19th day of April, 2018.

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By: _____

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