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

In Re: Donna M. Campanella, LPN	) Docket no.: 2018-32
License no.: 025.0134143	)

SUMMARY SUSPENSION ORDER

Participating Board Members:
Ellen Watson, APRN, Chair
Jennifer Laurent, APRN
Deborah Swartz, RN
Jill Duell, LPN
Kelly Sinclair, LNA
William G. White, Jr.
Daniel Coane, Public Member, *ad hoc*
Michael Doyle, Public Member, *ad hoc*

Prosecuting the case: Maguire Curran, Esq.
Respondent: Did not appear

Presiding Officer: Stephen A. Reynes

Summary Suspension Order
FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

This matter came before the Board of Nursing on a Request for Summary Suspension. The hearing was held on April 9, 2018, at the Division of Fire Safety Conference Room, 1311 US Route 302, Barre, Vermont.

Findings of Fact

Based on a Review of the pleadings and the file, and on the evidence presented to the Board at the hearing, the Board finds as follows:

1. The Respondent is licensed by the State of Vermont as a Licensed Practical Nurse under license number 025.0134143, originally issued on December 15, 2017 and is set to expire on January 31, 2020. The Respondent currently resides in Hammonton, New Jersey. She is subject to the regulatory authority of this Board. 3 V.S.A. §§ 129, 26 V.S.A. Chapter 28, the Administrative Rules of the Board of Nursing, and the Rules of the Office of Professional Regulation. Under 3 V.S.A. § 814(c) the Board may 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," a copy of which is attached to this Decision and Order. The Respondent was sent notice of the hearing by Certified Mail at her New Jersey address and she received the notice prior to the hearing.

3. During the relevant period, the 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. She worked at the Facility for approximately two (2) weeks from December 23, 2017 through her termination on or about January 8, 2018. During that period the Respondent's husband would often show up at the Facility shortly after the Respondent started a shift and he would linger about the Facility.

4. The State presented as evidence the testimony of Dennis Menard, an Investigator with the Office of Professional Regulation. His testimony described a situation in which the Respondent told other nursing staff that she had locked her keys in a medication cart and that she attempted to unlock, or pry open the cart with a medication blister card which contained seven (7) Oxycodone 10 mg tablets prescribed for a certain patient. The Respondent did not ask other staff about another key to unlock the medicine cart. The Respondent dented the cart in her efforts to open it. The Respondent reported that all seven of the Oxycodone tablets were crushed and destroyed through her attempts to use the card as a tool to pry open the cart to retrieve her keys.

5. The Respondent reported that a certain Registered Nurse (HB) had witnessed the documented waste of the subject medication blister card for a certain Patient (Patient 1) on January 6, 2018 at 5:30 p.m. and had signed her (HB's) initials on that patient's narcotic log. However, RN HB did not begin her shift on January 6, 2018 until 10:00 p.m., during the Respondent's shift change. The blister pack containing the seven (7) prescribed Oxycodone was not located and the Respondent initially stated she could not remember where it went.

6. The foregoing led the Facility to conduct an audit of the Respondent's narcotic administration history, which found other detailed medication inconsistencies involving the Respondent and "wasted" Oxycodone for patients. Documentation was flawed as to same, including failure to give a reason for the waste and no accompanying witness signature or initials.

7. OPR Investigator Dennis Menard conducted a phone interview with the Respondent on March 8, 2018, in which the Respondent admitted to diverting approximately thirty (30) Oxycodone tablets from the Facility for the benefit of someone important to her who had a need for the medication.

8. The evidence established that the Respondent violated:

- 26 V.S.A. § 1582(a)(2) [diverting or attempting to divert drugs for unauthorized use];
- 26 V.S.A. § 1582(a)(3) [engaging in conduct of a character likely to deceive, defraud, or harm the public];[1]

[1] The State's Request for Summary Suspension incorrectly cites the conduct in alleged Violation Two as being a violation of 3 V.S.A. § 1582(a)(3); it is clear from the language of the alleged conduct and the remainder of the citation that the reference to 3 V.S.A. was a typo and that 26 V.S.A. was intended.

- 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];
- 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]; and
- 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].

9. The evidence presented show 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 general integrity of the medical profession.

Conclusions of Law

Our 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). Our Findings of Fact and Conclusions of Law herein are for purposes of this Order only.

The Prosecutor's Request for a Summary Suspension is supported by the evidence presented. The Board concludes that the allegations in the Request for Summary Suspension have been established to the necessary degree. For purposes of this Summary Suspension Hearing, the Findings of Fact above do support Summary Suspension of the Respondent's license. There is an imperative need to take emergency action. 3 V.S.A. §814(c).

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. Our Findings and Conclusions in this proceeding will not absolve the prosecution or the 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 pending proceedings for revocation or other action. These proceedings shall be promptly instituted and determined. 3 V.S.A. § 814(c).

Vermont Board of Nursing

By: Ellen Watson
Ellen Watson, APRN, Chair

Date: May 14, 2018

DATE OF ENTRY: 5/14/18

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

REQUEST FOR SUMMARY SUSPENSION

NOW COMES the State of Vermont and hereby requests summary suspension of the license of Respondent Donna M. Campanella 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 a Licensed Practical Nurse pursuant to 3 V.S.A. § 129(a); 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").

2. The Board of Nursing is authorized by 3 V.S.A. § 814(c) to summarily suspend the license of a Licensed Practical Nurse when it finds the public health, safety, or welfare imperatively requires emergency action.

Statement of Facts

3. 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.

4. 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.

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

6. During her 2 weeks with the Facility, Respondent's husband would often show up to the Facility shortly after Respondent started a shift, and would linger around the facility.

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.

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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 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.

10. Respondent dented the medication cart through her attempt to pry open the locked medication cart to retrieve her keys.

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

12. 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.

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

14. 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, at 5:30 p.m., and that RN HB signed her initials on Patient 1's narcotic log as a witness to the waste.

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

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

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

18. As a result of the medication cart blister pack situation and the Facility's view that Respondent's recitation of events was improbable, the Facility conducted an audit of Respondent's narcotic administration history and found medication inconsistencies related to five (5) additional patients, referred in Paragraphs 19 through 39 as Patient 2, Patient 3, Patient 4, Patient 5, and Patient 6.

Patient 2

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

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

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21. 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 the withdrawal.

22. 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.

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

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

25. LNA LM 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

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

27. Prior to Respondent's employment at the Facility, Patient 3's narcotic log documents that none of Patient 3's prescribed Oxycodone 5mg were withdrawn from the medical cart at any time between November 16, 2017 through December 22, 2017.

28. On December 23, 2017, Respondent's first day at the Facility, 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 the withdrawal.

29. 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

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

31. 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.

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

33. 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.

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34. 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.

Patient 5

35. 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.

36. 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

37. 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.

38. 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.

39. 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.

Respondent

40. OPR Investigator, Dennis Menard, conducted a phone interview with Respondent on March 8, 2018.

41. During the interview, Respondent admitted to diverting approximately thirty (30) Oxycodone 5mg tablets from the Facility.

42. During the interview, 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.

43. The Vermont Board of Health, pursuant to 18 V.S.A. §§ 4201-4202, designates regulated drugs.

44. Vermont Health Regulations, Regulated Drugs, Part II, designates Oxycodone as a narcotic.

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

45. The State re-alleges and incorporates Paragraphs 3 through 44 above.

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

47. Paragraphs 3 through 44 demonstrate that Respondent diverted drugs from the Facility for unauthorized use in violation of 26 V.S.A. § 1582(a)(2).

48. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for summary suspension 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.

49. The State re-alleges and incorporates Paragraphs 3 through 44 above.

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

51. Paragraphs 3 through 44 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 to document waste of narcotics.

52. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for summary suspension 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.

53. The State re-alleges and incorporates Paragraphs 3 through 44 above.

54. 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.

55. Paragraphs 3 through 44 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 deceiving her nursing colleagues to document waste of narcotics.

56. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for summary suspension because Respondent committed unprofessional conduct by willfully making and filing false reports in the practice of the profession and willfully

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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.

57. The State re-alleges and incorporates Paragraphs 3 through 44 above.

58. 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.

59. Paragraphs 3 through 44 demonstrate that Respondent failed to exercise independent professional judgment by diverting narcotics and using deceit to cloak her diversion on multiple recent occasions.

60. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for summary suspension 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).

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.

61. The State re-alleges and incorporates Paragraphs 3 through 44.

62. 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.

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

64. Paragraphs 3 through 44 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 recent occasions.

65. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for summary suspension 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).

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Relief Requested

66. Members of the public, patients, and potential patients have no way of learning of Respondent's dangerous behavior and will remain unprotected during the pendency of these proceedings. The facts as set forth above establish that in order to protect the public health, safety, and/or welfare of the people of the State of Vermont, emergency action is imperative.

WHEREFORE, the State of Vermont respectfully requests that pursuant to 3 V.S.A. § 814(c), Respondent's Licensed Practical Nurse license, number 025.0134143, be summarily suspended, pending hearing on the merits.

DATED in Montpelier, Vermont this 29th day of March, 2018.

STATE OF VERMONT
SECRETARY OF STATE

By: _____

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