

State of Vermont
Vermont Board of Nursing

In re: Irma Chezhiya
License Number: 026.0095068
Docket Number: D-2015-5

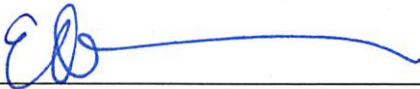
Order to Remove Conditions

On February 10, 2020, the Vermont Board of Nursing considered Irma Chezhiya's completion of two required education courses, which were imposed by a Second Stipulation and Consent Order effective April 12, 2016, under Docket Number 2015-5. Irma Chezhiya has met all conditions. After review of the follow-up file, the State does not object to removal of all conditions.

Order:

The Board hereby removes all conditions from Irma Chezhiya's Registered Nurse license.

Vermont Board of Nursing



Ellen Watson, APRN, Chair

Date: February 10, 2020

Date of Entry: 2 / 10 / 2020



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Professional Regulation

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

IN RE:
Irma Chezhiya
License No. 026.0095068

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Docket No. 2015-5

SECOND STIPULATION AND CONSENT ORDER

NOW COME the State of Vermont, by and through State Prosecuting Attorney Elizabeth A. Jarvis, and the Respondent, Irma Chezhiya, who stipulate and agree as follows:

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 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.

Stipulated Facts

2. Irma Chezhiya (the "Respondent") of Tunbridge, Vermont, is licensed by the State of Vermont as a Registered Nurse under license number 026.0095068. This license was originally issued on or about June 13, 2013, and expires on or about March 31, 2017.
3. During the relevant time period, Respondent was employed as Registered Nurse at Vermont Psychiatric Care Hospital in Berlin, Vermont.
4. On or about December 23, 2014 at or about 7:00 a.m., while on duty as a medication administration nurse, the Respondent administered 160 mg of Propranolol Immediate Release to patient M.M. Propranolol is a cardiac medication.
 - a. Patient M.M.'s medication order was for 160 mg of Propranolol Extended Release.
 - b. When Patient M.M. reported to the medication window to receive his medication, the Respondent overrode the automated medication dispensing Pyxis machine to take out four (4) forty (40) mg tablets of Propranolol Immediate Release as that was all that was available in the machine. The Respondent thought she was administering Propranolol Extended Release.

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- c. Administering Propranolol Immediate Release instead of the same dosage of Extended Release has the potential to cause cardiac arrest.
5. On or about December 23, 2014, at or about 8:00 a.m., Pharmacist D.L. received an override report that four (4) forty (40) mg tablets of Propranolol Immediate Release had been removed from a Pyxis machine. D.L. contacted the medical staff on the floor to alert them of the potential medication error at or around 9:00 a.m.
 6. Despite the fact that the Respondent stated she did not realize her medication error until D.L. alerted her to this fact, the Respondent filled out a Medical Emergency Report on or about December 23, 2014 for Patient M.M. The Respondent documented that she administered the medication at or about 7:00 a.m., and began taking ten minute vital sign readings between 7:30 a.m. and 9:00 a.m.
 7. On or about December 23, 2014, Respondent also filled out a High Risk Event Progress Note where she indicated she took vital sign readings every ten minutes starting at 8:00 a.m.
 8. Vital signs would not have been taken every ten minutes for an hour and a half if the correct dosage of Propranolol Extended Release had been administered.
 9. At no time did the Respondent alert any other medical staff to her medication error. Other medical staff learned of the error through Pharmacist D.L., and arranged for Patient M.M. to be transported to the Central Vermont Medical Center Emergency Room by ambulance. Patient M.M. returned to the Facility a few hours later.
 10. In both a letter dated February 20, 2015, and an email dated May 10, 2015, the Respondent admitted to making the medication administration error but denied being aware of the error prior to D.L. telling her about it.
 11. The essential standards of acceptable and prevailing practice require Registered Nurses to promptly report medication errors to a physician and other medical staff.

Violations

12. 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:
 - a. 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);
 - b. 3 V.S.A §129a(b)(1) and (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

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has occurred. Failure to practice competently includes: (1) performance of unsafe or unacceptable patient or client care; or (2) failure to conform to the essential standards of acceptable and prevailing practice);

Understandings

13. Respondent admits that the facts above are true and that the conditions below are necessary to protect the public.
14. Respondent understands that the Nursing 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.
15. Respondent specifically waives any claims that any disclosures made to the full Board during its review of this agreement have prejudiced her rights to a fair and impartial hearing in future hearings if this agreement is not accepted by the Board.
16. Respondent has read and reviewed this entire document and agrees that it contains the entire agreement between the parties.
17. Respondent is not under the influence of any drugs or alcohol at the time she signs this Stipulation and Consent Order.
18. 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.
19. Respondent voluntarily waives her right to a contested hearing before the Board of Nursing and waives any right to appeal from this Stipulation and Consent Order.
20. 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. The Board of Nursing hereby **REPRIMANDS** the Respondent's license.
- B. Respondent's license is **CONDITIONED** as follows:
 - a. Respondent shall, within ninety days of this Order, at her own expense, complete the following pre-approved courses:
 - i. Professional Accountability and Legal Liability for Nurses, through National Council of State Boards of Nursing (NCSBN) Learning Extension; and

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ii. Medication Errors: Causes and Prevention, through NCSBN Learning Extension.

Failure to complete these courses within the prescribed timeframe shall constitute a violation of this Order.

- b. Upon receipt of satisfactory evidence that Respondent has completed the described courses, the Board or its designee shall terminate the conditions upon Respondent's license and restore the license to unencumbered status.
- C. Notwithstanding any provision above, the Respondent must continue to meet all Nursing Board requirements for maintaining a license, license renewal and license reinstatement.
- D. This Stipulation 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.

AGREED TO:

STATE OF VERMONT
SECRETARY OF STATE

Dated: 3/23/16

By: Elizabeth A. Jarvis
Elizabeth A. Jarvis
State Prosecuting Attorney

IRMA CHEZHIYA
RESPONDENT

Dated: 3/21/16

By: Irma Chezhiya
Irma Chezhiya

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APPROVED AND SO ORDERED:

Dated: 4/11/16

Date of Entry: 4/12/16

VERMONT BOARD OF NURSING

By: Jeanne Carr
Chairperson