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

IN RE:	)	
MARTHA L. CROZIER-POVEY	)	**Docket No. 2008-444 (NU61-1108)**
License No. 026.0026644	)	

STIPULATION AND CONSENT ORDER

STIPULATION

NOW COME the State of Vermont, by and through State Prosecuting Attorney Edward G. Adrian, and the Respondent, Martha L. Crozier-Povey, RN, 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. § 1582; the Administrative Rules of the Board of Nursing (the "ARBN"); and the Rules of the Office of Professional Regulation.

Statement of Facts

2. Martha L. Crozier-Povey (the "Respondent") of Castleton, Vermont is licensed by the State of Vermont as a Registered Nurse under license number 026.0026644. This license was originally issued on or about August 20, 2001 and is currently set to expire on or about March 31, 2011.

3. At all times relevant, Respondent was employed as a Registered Nurse at Rutland Regional Medical Center (the "Facility"), located in Rutland, Vermont.

4. On or about November 14, 2008 in a Mandatory Report of Unprofessional Conduct, Registered Nurse D.W. reported that on seven (7) separate incidences, Respondent removed controlled medications from the Omnicell electronic medication dispensing system at the Facility and did not document administering these medications in the Medication Administration Record (the "MAR") or in Nurse's Notes, nor did Respondent document the medications were wasted, and therefore these controlled medications were unaccounted for, in violation of Facility policy.

5. A review of Respondent's discrepancies is as follows:

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Montpelier, VT
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a. On or about August 24, 2008, Respondent removed three (3) tablets of Oxycodone for Patient J.L. Respondent did not document administering the medication on the MAR. Nurse's Notes indicate "no pain."

b. On or about September 3, 2008, Respondent removed three (3) tablets of Xanax for Patient B.E. Respondent documented that two (2) tablets were wasted; however, Respondent did not document whether the remaining one (1) tablet was wasted or administered.

c. On or about September 9, 2008, Respondent removed two (2) tablets of Oxycodone for Patient S.C. Respondent did not document administering the medication on the MAR.

d. On or about September 16, 2008, Respondent removed one (1) tablet of Clonazapam for Patient M.P. Respondent did not document administering the medication on the MAR.

e. On or about October 1, 2008, Respondent removed two (2) tablets of Oxycodone for Patient S.C. Respondent did not document administering the medication on the MAR. Nurse's Notes indicate "no pain."

f. On or about October 3, 2008, Respondent removed two (2) tablets of Oxycodone for Patient S.C. Respondent did not document administering the medication on the MAR.

g. On or about October 28, 2008, Respondent removed two (2) tablets of Xanax for Patient J.W. Respondent did not document administering the medication on the MAR. J.W. then reported needing an anxiety medication to Nurse D.E. D.E. checked the Omnicell chart and saw that Respondent had removed this medication earlier; however, J.W. advised D.E. that he did not receive the medication.

6. On or about December 4, 2008 in an interview with State Investigator Steve Kennedy, Facility Compliance Officer J.W. stated that when he spoke to Respondent on or about November 12, 2008 regarding the above-described discrepancies, Respondent denied diverting any medications but acknowledged her documentation practices were substandard. J.W. advised that Respondent offered to take a drug test, but because the Facility did not request a drug test, one was not taken. J.W. advised that Respondent was terminated from the Facility on or about November 14, 2008 for her documentation practices. Moreover, J.W. advised that there were no other issues with Respondent's work history, and that no staff had witnessed Respondent appearing under the influence or engaging in any other behavior that would indicate diversion.

7. On or about December 22, 2008 in a telephone interview with Investigator Kennedy, Respondent denied diverting any medications; admitted to failing to document

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administering the medications; but stated that she did administer the medications. Respondent advised that she has a medical condition that was exacerbated by the stressful working conditions at the Facility and that the omissions were the result of being very busy and not having the time to go back and make any documentation. Respondent advised she does not drink alcohol or take drugs.

8. By failing to document the administration of medications, Respondent performed unsafe and unacceptable patient care and failed to conform to the essential standards of acceptable and prevailing nursing practice.

Charges

9. 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. 26 V.S.A. § 1582(a)(3) (Is unable to practice nursing competently by reason of any cause) which includes performance of unsafe or unacceptable patient or client care pursuant to ARBN Chapter 4, Subchapter 4, Rule II(B)(1); and failure to conform to the essential standards of acceptable and prevailing nursing practice pursuant to ARBN Chapter 4, Subchapter 4, Rule II(B)(2);

   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 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); and

   c. 3 V.S.A. § 129a(a)(3) (Failing to comply with provisions of federal or state statutes or rules governing the practice of the profession).

Understandings

10. Respondent admits the facts above are true and that the conditions below are necessary to protect the public.

11. 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.

12. 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.

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13. Respondent has read and reviewed this entire document and agrees that it contains the entire agreement between the parties.

14. Respondent is not under the influence of any drugs or alcohol at the time she signs this Stipulation and Consent Order.

15. 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.

16. 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.

17. 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:

The Board of Nursing hereby **INDEFINITELY SUSPENDS** the Respondent's license to practice nursing **from the date of entry below**. If the Respondent wishes to have her license reinstated in the future, she recognizes that the Board will impose conditions both precedent and subsequent to reinstatement that are reasonable and necessary to protect the public.

A. 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).

B. 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:

Dated: 8/7/09

STATE OF VERMONT
SECRETARY OF STATE

By: _____
Edward G. Adrian
State Prosecuting Attorney

MARTHA L. CROZIER-POVEY
RESPONDENT

Dated: 7/30/2009

By: _____
Martha L. Crozier-Povey

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APPROVED AND SO ORDERED:

VERMONT BOARD OF NURSING

Dated: 8-10-09

By: Janine Carr
Chairperson

Date of Entry: 8/12/09
nu.crozier-povey.stip2

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