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

In re: Sheldon R. Degale	}	
License No. 025.0134591	}	Docket No. 2019-58
	}	

FINDINGS, CONCLUSIONS OF LAW AND ORDER REGARDING SPECIFICATION OF CHARGES ALLEGING UNPROFESSIONAL CONDUCT

Participating Board Members:
Ellen Watson, APRN, Chair
Deborah Swartz, RN,
Luana Tredwell, LPN
Wendy Thurston, RN
Kelly Sinclair, LNA
Krystal Bernier, LPN
Daniel Coane, public member
William G. White, Jr., public member

Appearances:
Prosecuting the case: Traci Leibowitz, Esq.
Respondent: was present and appeared *pro se*

Presiding Officer:
George K. Belcher

Exhibits:
State Exhibit 1: Medication Log and MAR for patient R.F.
State Exhibit 2: Medication Log and MAR for patient H.P.
State Exhibit 3: Medication Log and MAR for patient K.P.
State Exhibit 4: Medication Log and MAR for patient T.W.
State Exhibit 5: Summary of Professional Experience of Respondent
State Exhibit 6: Respondent's Self-assessment of Proficiencies
State Exhibit 7: Medication Log and MAR for patient V.L.
State Exhibit 8: Medication Log and MAR for patient M.F.
State Exhibit 9: Conditions of Release Caledonia Criminal Case 6/3/19
State Exhibit 10: Conditions of Release Bennington Criminal Case 8/19/19

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

This matter came before the Board of Nursing on Amended Specification of Charges alleging unprofessional conduct. The hearing was held on November 4, 2019, at the Office of Professional Regulation in Montpelier, Vermont. The State was represented by Traci Leibowitz, Esq. The Respondent appeared *pro se*.

Findings of Fact

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

1. The Respondent is subject to the regulatory authority of this Board. 3 V.S.A. §§ 129, 129a, 26 V.S.A. Chapter 28, the Administrative Rules of the Board of Nursing, and the Rules of the Office of Professional Regulation.
2. The prosecutor has filed Specification of Charges and Amended Specification of Charges. The original Specification of Charges was filed on May 22, 2019 and the Respondent answered on June 11, 2019. The Amended Specification of Charges was filed on October 14, 2019 and was sent to the Respondent on October 15, 2019. They were received by him on October 28, 2019.
3. The Respondent is licensed in Vermont as a Licensed Practical Nurse.
4. During February 2019 the Respondent was working as an LPN at the St. Johnsbury Health and Rehabilitation Facility in Vermont. His employment there was suspended on February 18, 2019. In June and July of 2019 the Respondent worked as an LPN at the Bennington Health and Rehabilitation Facility in Bennington, Vermont. On July 9, 2019 the Respondent was informed that there was an investigation of his medication handling practices at the Bennington Facility and that an audit would be performed.
5. It is the general practice in the facilities involved that a new, incoming nurse is trained in the medication charting procedures at that facility. In both the St. Johnsbury facility and the Bennington facility the Respondent was explained the process for medication access, administration, and charting. The general process at both facilities is that regulated medications are removed from a locked container, the medication log for a patient's medication is completed showing the medication, the date, the time of withdrawal, the amount of medication on hand, the amount used, the amount left, the method of administration and the nurse's identifying signature. In addition, regulated drug administrations are charted on the Electronic Medication Administration Record (EMAR) which shows the medication administered to the patient, the date and time of administration and the initials of the person administering the drug.
6. As a general matter, the medication log should match the EMAR to show that those medications which are withdrawn for a particular patient were in fact administered to the patient. This charting of medications is important to the overall control of regulated medications in the facility and for the safety of the patients (to assure that there is a clear

and accurate record of what medications a patient has been given at various times.) Where the records of medication administration are incorrect or incomplete, there is a risk to the patient that the patient may be over-medicated by subsequent medication, or that they would miss needed medications.

Resident R.F.

7. During the month of February 2019 (February 10-18) the narcotics log for Resident R.F. indicated that the Respondent removed eight (8) 2 mg tablets of Dilaudid (Hydromorphone) from the secure storage for administration to resident R.F. The EMAR for the same period does not reflect that that the Respondent administered any of the medication to the patient. (See State Exhibit 1 and Admitted Specification of Charges paragraphs 9 and 11)

Resident H.P.

8. During February 2019 the narcotics log for Resident H.P. shows that the Respondent removed seven (7) Dilaudid tablets from secure storage for Resident H.P. The EMAR record for the same period shows that only one (1) dose of the medication was given to Resident during the relevant periods (February 11-16). (See State Exhibit 2 and Admitted Specification of Charges paragraphs 15 and 77)

Resident K. P.

9. The narcotics log for the period of February 9-18, 2019 shows that the Respondent removed twenty-two (22) tablets of Oxycodone for resident K.P. but the EMAR shows that only six (6) of the tablets were administered to Resident K.P. during the period of February 14-18. (See State Exhibit 3 and Admitted Specification of Charges paragraphs 21 and 22)

Resident W.T.

10. The narcotics log for the period of February 6-18, 2019 shows that the Respondent removed nine (9) tablets of Dilaudid for resident W.T. but the EMAR shows that only one (1) of the tablets were administered to Resident W.T. on February 11, 2019. (See State Exhibit 4 and Admitted Specification of Charges paragraphs 26 and 27). The order for Dilaudid for this patient was discontinued on or about February 12 or 13, 2019. Despite this, the Respondent withdrew Dilaudid according the narcotics log on February 13, 14, and 17 (after the order expired).

Resident V.L.

11. On June 25, 2019 at the Bennington Facility the Respondent documented in the narcotics log that he withdrew six (6) 15 mg tablets of Oxycodone for patient V.L. The existing order for this patient called for only one tablet of this drug to be removed four times

daily. The EMAR for this patient shows that only one dose of this drug was given to the patient on June 25, 2019 at 6:00 P.M. The Respondent did note on the narcotics log that he had wasted the two tablets withdrawn at 4:00 P.M. but that does not explain the unordered withdrawal, or the three (3) missing tablets. (See State Exhibit 7).

12. On July 9 the Respondent documented in the narcotics log that he had withdrawn 2 tablets of Oxycodone for this patient but had wasted them because they had been crushed in error. The witness to the wasting of the drugs later stated that she could not be certain that these tablets were wasted because she had been distracted during the witnessing even though she signed that she had witnessed the wasting.
13. OPR Investigator Michael Warren interviewed Patient L.V. in June or July of 2019. She had good recall of her medication history at the facility. She told the Investigator that the Respondent had admitted to her that he had given her the wrong dose of her medication (two tabs instead of one) on June 25, 2019. She had disagreed with him (she told the Respondent that she only received one tablet). She told the Investigator that the Respondent contradicted her and insisted that she had received two tablets instead of one.

Patient M.F.

14. On June 26, 2019 the Respondent documented in the narcotics log that he withdrew six (6) 30 mg tablets of Oxycodone for patient M.F. The Respondent documented in the EMAR only administering four (4) tablets of this medication to this patient. (See State Exhibit 8)
15. Patient M.F. later came to the Director of Nursing and told her that he thought that the correct amount of pain medication had not been given to him by the Respondent on this date.
16. Patient M. F. also told OPR Investigator Michael Warren that he did not receive all his prescribed pain medication from the Respondent on this date.

17. For the most part, the Respondent appears to have properly documented medication withdrawal and administration of non-opiates and drugs scheduled for administration (non-"PRN" medications). This shows that he understood the system and was capable of correctly documenting medication administration.
18. The mis-charting of medication administration by the Respondent appeared to be focused on opiate drugs prescribed on an as-need basis ("PRN").
19. The mis-charting of medications withdrawn versus medication not administered was a gross and dangerous deviation from routine nursing practice.
20. The withdrawal of drugs following the termination of the order (State Exhibit 4) was a gross and dangerous deviation from nursing practice.
21. In a self-assessment of the Respondent's Medication Administration, the Respondent had rated himself as very proficient and experienced to "Supervises/Teach" medication administration excepting bladder irrigation and instillation. (State Exhibit 6).
22. Following an audit and investigation by the staff of the St. Johnsbury facility, the Nursing Home Administrator concluded that the missing drugs had been diverted by the Respondent.
23. The Respondent offered no evidence to contradict the evidence presented by the State. He did not explain why there was a consistent disparity between the narcotics logs and the

EMAR entries for the opiate medications. While he challenged the State's witnesses by asking questions about lack of motive testimony for the alleged diversion, he offered no testimony, witnesses or documents to counter the testimony which had been offered by the State.

24. Given that the problem of alleged diversion in the St. Johnsbury facility in February of 2019 was documented in the narcotics log and the EMAR at that facility, it is not credible that the same problem would have occurred four months later at another facility by simple error or neglect of the Respondent. The pattern of the medication administration charting problems by the Respondent shows that there was an intentional misuse of the drugs.
25. The Board is persuaded that the drug administration documentation by the Respondent was grossly deficient.
26. Moreover, the drugs involved appeared to mostly be opiates. The documentation of missing drugs was repetitive and frequent. There was a pattern to the withdrawal and failure to deliver the drugs to the patients. There was independent complaint by two patients that they had not received their medication as the Respondent had said they had. The Board is persuaded that the Respondent diverted the missing medications. This conclusion is reached, in part, because of the failure of the Respondent to offer any evidence to explain what happened to the missing drugs.

CONCLUSIONS OF LAW

1. The burden of proof in a disciplinary matter is upon the State to show by a preponderance of the evidence that the person engaged in unprofessional conduct. 3 VSA Sec. 129a(c).
2. The Board concludes, based upon the admitted facts and the evidence presented, that the Respondent committed unprofessional conduct. The Respondent violated 26 VSA Sec. 1582(a)(2) [diverting drugs for unauthorized use]; 3 VS Sec. 129a(b)(1) [failure to practice competently by performance of unsafe or unacceptable patient care]; 3 VSA Sec/ 129a(b)(2) [failure to conform to the essential standards of the profession]; 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) [failure to exercise independent judgment in the performance of licensed activities].

Based on the above, it is **ORDERED AND ADJUDGED** as follows:

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

(a) Obtain an independent evaluation report by a pre-approved licensed professional specializing in drug and alcohol abuse ("Independent Evaluator") who has verified receipt of this 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, as well as any recommendations that would

ensure Respondent is safe to practice. The evaluation must be submitted to the Enforcement Unit Case Manager;

(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;

If reinstated, Respondent's license **SHALL BE CONDITIONED** pursuant to whatever terms are reasonable at the time of Respondent's reinstatement request, including but not limited to supervised practice and additional education, taking into account the independent evaluation, urine analysis results, the facts contained in this Order, and any other relevant factors at that time.

This Order is a matter of public record and may be reported to other licensing authorities as provided in 3 V.S.A. §129(a).

This Order will remain part of Respondent's licensing file and may be used for purposes of determining sanctions in any future disciplinary matter.

SO ORDERED.

Vermont Board of Nursing

Ellen Watson, APRN, Chair

11-13-19

Date

11·20·19

Date of Entry

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.

STATE OF VERMONT
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IN RE:	)	
SHELDON R. DEGALE	)	**Docket No.** 2019-58
License No. 025.0134591	)	

AMENDED SPECIFICATION OF CHARGES

NOW COMES the State of Vermont, and makes the following charges against respondent Sheldon R. Degale:

Board Authority

1. The Vermont Board of Nursing ("Board") has authority to issue warnings or reprimands; suspend, revoke, limit, or condition current licenses; or prevent the renewal of lapsed licenses if, after preliminary hearing, the Board finds that the respondent has engaged in unprofessional conduct. 3 V.S.A. §§ 129, 129a; 26 V.S.A. Chapter 28; the Administrative Rules of the Board of Nursing; and the Rules of the Office of Professional Regulation.

Statement of Facts

2. Sheldon R. Degale ("Respondent") of Kissimmee, Florida is licensed by the State of Vermont as a Licensed Practical Nurse ("LPN") under license number 025.0134591. This license was originally issued January 25, 2019, and expires on January 31, 2020.

Facility 1

3. During February 2019, Respondent was employed as a travel nurse by Travel Care USA.

4. Respondent was sent on assignment to work as an LPN at St. Johnsbury Health and Rehabilitation Center ("Facility 1") on a contractual basis, beginning on February 4, 2019. Respondent's employment with Facility 1 was terminated on February 18, 2019 based on the misconduct described below.

5. The receipt and withdrawal of narcotics are hand-documented in narcotics log books at Facility 1. Separate pages are maintained for each controlled substance for each patient.

6. Facility protocol mandates record keeping procedures that are required when a controlled substance is withdrawn and administered to a patient. Those administering controlled substances must document when the drug is withdrawn from secure

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storage in the "narcotic log" and must document when the drug is administered to the patient in the electronic medication administration record ("EMAR" or "MAR").

7. For medication to be administered on an "as needed" basis, protocol requires performance of a pain assessment and documentation of the patient's level of pain each time "as needed" medication is administered.

Resident R.F.

8. Resident R.F. had medication orders for regularly scheduled pain medications to be administered daily. During the relevant time period, Resident R.F. had an order for 300 mg Gabapentin to be administered once per day at bedtime and an order for 100 mg Gabapentin to be administered twice per day in the morning and afternoon.

9. Resident R.F. also had an order for additional pain medication to be administered on an "as needed" basis. Between October 30, 2018 and February 18, 2019, Resident R.F. had a medication order for Dilaudid 2 mg every 24 hours on an "as needed" basis for pain.

10. During the month of February 2019, the narcotics log for Resident R.F. indicates that Respondent removed one (1) 2 mg tablet of Dilaudid from secure storage to be administered to Resident R.F. on the following occasions: February 10th; February 12th; twice on February 13th; February 14th; twice on February 17th; and February 18th.

11. Respondent acknowledged that his signatures accompany the notes in the narcotic logs documenting removal of the tablets on these dates.

12. However, the EMAR does not bear any documentation that Respondent administered the 2 mg tablet of Dilaudid to Resident R.F. at all during the month of February. Respondent confirmed that he removed the medication but did not document administration of the medication to the patient.

13. There are eight (8) 2 mg Dilaudid tablets that were not documented in the EMAR and are unaccounted for. Regarding these eight tablets, no information was entered in narrative notes and no pain assessment was documented to justify the administration of "as needed" pain medication.

Resident H.P.

14. Resident H.P. had an order for regularly scheduled pain medication to be administered daily. Beginning on January 30, 2019, Resident H.P. had an order for two (2) 100 mg Gabapentin to be administered three times per day for pain.

15. Resident H.P. also had an order for additional pain medication to be administered on an "as needed" basis. From October 19, 2018 through February 18, 2019, Resident H. P. had a medication order for Dilaudid 2 mg every 4 hours "as needed" for pain.

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16. The narcotics log for Resident H.P. indicates that Respondent removed one (1) 2 mg tablet of Dilaudid from secure storage to be administered to Resident H.P. on the following occasions: February 11th; twice on February 14th; twice on February 15th; and February 16th. There is a seventh entry documenting removal of one more 2 mg tablet with an illegible entry for the date.

17. Respondent acknowledged that his signatures accompany all seven of the entries in the narcotic logs documenting removal of the tablets on these occasions.

18. However, documentation in the EMAR shows that Respondent administered the 2 mg tablet of Dilaudid to Resident R.F. only once during the month of February on February 12, 2019. Respondent confirmed that the narcotics log records show that he removed the medication on seven occasions. Respondent stated that he does not always document administration of medication in the EMAR.

19. There are six (6) 2 mg Dilaudid tablets that were not documented in the EMAR and are unaccounted for. Regarding these six tablets, no information was entered in narrative notes and no pain assessment was documented to justify the administration of "as needed" pain medication.

Resident K.P.

20. Beginning on January 16, 2019, Resident K.P. had an order for regularly scheduled pain medication to be administered daily. Resident K.P. had an order for one (1) 20 mg Oxycontin twice per day for pain.

21. Resident K.P. also had an order for additional pain medication to be administered on an "as needed" basis. From January 16, 2019 through February 25, 2019, Resident K. P. had a medication order for Oxycodone every 4 hours "as needed" for pain. The medication orders called for one (1) 5 mg tablet for mild to moderate pain or two (2) 5 mg tablets for moderate to severe pain.

22. The narcotics log for Resident K.P. indicates that Respondent removed two (2) 5 mg tablets of Oxycodone from secure storage to be administered to Resident H.P. on the following occasions: February 9th; February 11th; twice on February 13th; February 14th; February 15th; February 16th; twice on February 17th; and twice on February 18th.

23. However, the corresponding EMAR only contains documentation that Respondent administered two (2) 5 mg tablets of oxycodone to Resident K.P. on three occasions – once on February 14th, once on February 17th and once on February 18th.

24. There are sixteen (16) 5 mg tablets of Oxycodone not documented in the EMAR and unaccounted for. Regarding these sixteen tablets, no information was entered in narrative notes and no pain assessment was documented to justify the administration of "as needed" pain medication.

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Resident W.T.

25. Resident W.T. had an order for regularly scheduled pain medication to be administered daily. From February 6, 2019 through February 18, 2019, Resident W.T. had an order for Hydromorphone to be administered during each day shift prior to each dressing change.

26. Resident W.T. also had an order for additional pain medication to be administered on an "as needed" basis. Beginning on February 5, 2019, Resident W.T. had a medication order for Dilaudid 2 mg every 12 hours "as needed" for pain. The medication order continued for 7 days and was discontinued on February 11, 2019.

27. The narcotics log for Resident W.T. indicates that Respondent removed one (1) 2 mg tablet of Dilaudid on the following occasions: February 9th; twice on February 10th; February 11th; February 12th; twice on February 13th; February 14th; and February 17th. Notably, the tablets removed on February 12th, February 13th, February 14th, and February 17th were removed after the medication order expired.

28. However, the corresponding EMAR only contains documentation that Respondent administered one (1) 2 mg tablet of Dilaudid to Resident W.T. once on February 9th, once on February 11th.

29. There are seven (7) 2 mg Dilaudid tablets that were not documented in the EMAR and are unaccounted for. Regarding these seven tablets, no information was entered in narrative notes and no pain assessment was documented to justify the administration of "as needed" pain medication.

30. On February 18, 2019, Respondent's contractual employment with Facility 1 was suspended based on the misconduct described above and eventually terminated.

Facility 2

31. In June of 2019, Respondent was connected to a new nursing position through a different travel nursing agency, CareerStaff Unlimited ("CareerStaff").

32. Information contained in CareerStaff's profile of Respondent's employment history states that from September 10, 2018 through March 1, 2019, Respondent was employed at GHC Lakeside Pavilion, a healthcare facility located in Florida. This is false because Respondent was employed at Facility 1 during February of 2019, as described above.

33. Also contained in CareerStaff's materials are self assessment evaluations. In a document signed by Respondent on August 1, 2019, Respondent assessed himself at the highest levels of proficiency in the category of "Electronic Medical Records."

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34. On June 17, 2019, Respondent was hired as an LPN at Bennington Health and Rehabilitation Center ("Facility 2").

Patient V.L.

35. On June 25, 2019, Respondent was charged with caring for patient V.L. ("Patient V.L."). Patient V.L. had an order for one (1) tablet of Oxycodone, 15 mg, to be taken by mouth four times daily for pain, to be administered at midnight, 8:00AM, 1:00PM, and 6:00PM.

36. On June 25, 2019, Respondent's documentation in the narcotic log indicates the following: Respondent withdrew two (2) 15 mg Oxycodone tablets at 4:00PM and disposed of, or "wasted," the medication due to the incorrect timing. At 6:00PM, Respondent withdrew two (2) tablets. Again at 9:00PM Respondent withdrew two (2) tablets. Thus, Respondent withdrew the incorrect number of tablets (two instead of one) three times on this date.

37. On the same date, Respondent's documentation in the EMAR indicates that Respondent only administered one (1) 15 MG Oxycodone tablet to Patient V.L. on June 25, 2019 at 6:00pm.

38. Respondent's documentation of withdrawal and administration of Oxycodone to Patient V.L. is inconsistent in the narcotic log and the EMAR and leaves three (3) tablets unaccounted for.

39. On July 9, 2019, Respondent withdrew two (2) Oxycodone tablets and documented that he wasted the tablets because he crushed the tablets and the order did not call for tablets to be crushed. However, the nurse who witnessed the wasting of the medication states that she did not witness Respondent waste the medication.

Patient M.F.

40. Respondent was charged with caring for patient M.F. ("Patient M.F."). On June 26, 2019, Patient M.F. had an order for two (2) 30 MG tablets of Oxycodone to be administered every 3 hours as needed for pain.

41. Respondent's documentation of withdrawal and administration of Oxycodone to Patient M.F. is inconsistent in the narcotic log and the EMAR and leaves four tablets unaccounted for.

42. On June 26, 2019, Respondent documented in the narcotic log that he withdrew two Oxycodone tablets at 1:30AM, two Oxycodone tablets at 4:00AM, and two Oxycodone tablets at 7:00AM.

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43. On June 26th from midnight until 4:30PM, Respondent documented in the EMAR that he only administered Oxycodone to Patient M.F. twice – two (2) tablets at 7:00AM and two (2) tablets at 4:30PM. This leaves two (2) 30 MG tablets of Oxycodone unaccounted for.

44. Respondent was criminally charged with prescription fraud for the conduct that occurred at Facility 1, described above in paragraphs 2 through 30.

45. Court ordered conditions of release prohibit Respondent from having regulated drugs. Specifically, condition of release #10 states, "You must not buy, have or use regulated drugs without a valid prescription." This court order went into effect on June 3, 2019 and remains in effect as of the date of this filing. Respondent was prohibited from having regulated drugs throughout his employment at Facility 2.

46. On July 10, 2019, OPR investigator Michael Warren interviewed Respondent. Investigator Warren explained to Respondent that the conditions of release indicate he is not to be in possession of any regulated drugs without a prescription. Respondent did not respond. However, Respondent asked if the criminal case would go away if he agreed to give up his nursing license.

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

47. The State re-alleges and incorporates Paragraphs 2 through 46 above.

48. As an LPN, Respondent shall not divert or attempt to divert drugs, equipment, or supplies for unauthorized use.

49. Respondent diverted or attempted to divert drugs for unauthorized use as demonstrated in Paragraphs 2 through 46 above.

50. 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: 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 essential standards of acceptable and prevailing practice.

51. The State re-alleges and incorporates Paragraphs 2 through 46 above.

52. As an LPN, Respondent is expected to properly account for controlled drugs.

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53. Respondent failed to conform to the essential standards of acceptable and prevailing practice when he failed to properly account for the withdrawal and administration of controlled drugs. Paragraphs 2 through 46 above demonstrate a pattern of inaccurate documentation of the withdrawal and administration of controlled drugs.

54. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent has committed unprofessional conduct in violation of 3 V.S.A. §129a(b)(2).

Violation Three: 3 V.S.A §129a(b)(1) 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.

55. The State re-alleges and incorporates Paragraphs 2 through 46 above.

56. As an LPN, Respondent has an obligation to provide safe and acceptable patient care.

57. Respondent provided unsafe and unacceptable patient care by engaging in the conduct described in Paragraphs 2 through 46 above.

58. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent has committed unprofessional conduct in violation of 3 V.S.A. §129a(b)(1).

Violation Four: 26 V.S.A. §1582(a)(3) Engaging in conduct of a character likely to deceive, defraud, or harm the public.

59. The State re-alleges and incorporates Paragraphs 2 through 46 above.

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

61. Respondent engaged in conduct of a character likely to deceive, defraud, or harm the public as demonstrated in Paragraphs 2 through 46 above.

62. 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 26 V.S.A. §1582(a)(3).

Violation Five: 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.

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63. The State re-alleges and incorporates Paragraphs 2 through 46 above.

64. As an LPN, Respondent is required to exercise his 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.

65. Respondent's conduct in Paragraphs 2 through 46 above demonstrate Respondent's failure to exercise his own professional judgment in the performance of licensed activities when that judgment is necessary to avoid action repugnant to the obligations of the profession.

66. 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, the license of Sheldon R. Degale should be revoked, suspended, reprimanded, conditioned, or otherwise disciplined.

DATED at Montpelier, Vermont this 14th day of October, 2019.

STATE OF VERMONT
SECRETARY OF STATE

By: _____
Traci Leibowitz
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OFFICE OF PROFESSIONAL REGULATION
VERMONT BOARD OF NURSING

In re: SHELDON DEGALE License No. 025.0134591	} } Docket No. 2019-58 }

SUMMARY SUSPENSION DENIAL

Participating Board Members:
Ellen Watson, APRN, Chair
Deborah Swartz, RN
Jennifer Laurent, APRN
Luana Tredwell, LPN
William G. White, Jr., Public Member
Wendy Thurston, RN
Krystal Bernier, LPN

Appearances:
Prosecuting the case: Traci Leibowitz, Esq.
Respondent: was present appearing *pro se*

Presiding Officer:
George K. Belcher

Exhibits:
State Exhibit 1: Narcotics log and MAR; Patient R. F.
State Exhibit 2: Narcotics log and MAR; Patient T.W.
State Exhibit 3: Narcotics log and MAR; Patient K.P.
State Exhibit 4: Narcotics log and MAR; Patient H.P.
Respondent Exhibit A: Email from Julie Culbertson, RN, 5/13/19
Respondent Exhibit B: Letter of Reference O. Rodriguez, RN, 5/12/19

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

This matter came before the Board of Nursing on a Request for a Summary Suspension. The hearing was held on May 13, 2019, at the Office of Professional Regulation in Montpelier, 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. Respondent is licensed as a Licensed Practical Nurse in Vermont. The Respondent's license is set to expire on January 31, 2020. The Respondent is subject to the regulatory authority of this Board. 3 V.S.A. §§ 129, 129a, 26 V.S.A. Chapter 28, the Administrative Rules of the Board of Nursing, and the Rules of the Office of Professional Regulation. 3 V.S.A. § 814(c) permits the Board to 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." The Respondent was sent a notice of the hearing on May 2, 2019 to the address on file with the Office of Professional Regulation. There were no issues raised as to notice and the Respondent appeared having received a copy of the Request for Summary Suspension.
3. The State presented as evidence the testimony Nursing Home Administrator Chrystal Locke and Investigator Michael Warren. The evidence established that there may have been some irregularities in the medication accounting of the Respondent as shown by State Exhibits 1-4. The evidence did not establish to the satisfaction of the Board that the Respondent diverted medications for unauthorized use or the other alleged violations in such a manner as to justify a summary suspension.
4. The evidence presented failed to persuasively show facts which imperatively require emergency action for the public health, safety, and welfare.

Conclusions of Law

In order to sustain a request for summary suspension, the evidence must prove facts by a preponderance of the evidence that emergency action by the Board is necessary to protect the public health, safety, or welfare of the State of Vermont. Without ruling or deciding what might happen in a merits case on a specification of charges, the Board is unable to find that summary suspension is required on the evidence presented in this case.

Order

The Request for Summary Suspension is **DENIED.**

Vermont Board of Nursing

By: _____ Date: May 28, 2019
Ellen Watson, APRN, Chair

DATE OF ENTRY: 5.30.19

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.