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

In re: LISA J. FOSTER License No.075.0015329	Docket No. 2015-174 (LNA)

Decision on
UNPROFESSIONAL CONDUCT CHARGE

Participating Board Members:
Jeanine Carr, RN, Chair
Ellen Watson, APRN, Vice Chair
Deborah Swartz, RN
Kelly Sinclair, LNA
Virginia Hudson, RN
John Welch, Jr., Esq., Public Member

Appearances:
Prosecuting the case: Rachel Allen, Esq.
Respondent: did not appear

Exhibits:
State Exhibit 1: Drug Diversion Report Form

Presiding Officer: George K. Belcher

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

The Vermont Board of Nursing held a hearing in the above matter on July 11, 2016 in Montpelier, Vermont. The Specification of Charges alleges that Respondent committed unprofessional conduct in violation of Vermont Statutes.

Findings of Fact

Based on the evidence presented and the Answer which the Respondent filed to the Specification of Charges, the Board finds as follows:

1. Lisa Foster, (the "Respondent") is a Licensed Nursing Assistant and is therefore subject to the regulatory authority of this Board, pursuant to 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. Her Vermont license is active and is currently set to

expire on or about November 30, 2016.

2. Notice of the Specification of Charges was sent to the Respondent on December 14, 2015. The Respondent filed an answer on January 8, 2016. The hearing was originally scheduled for May 9, 2016 and the Respondent was noticed of this hearing by notice received by her on or about January 26, 2016. The case was continued to July 11, 2016 on April 21, 2016 and a notice of the change of date was sent to the Respondent on April 21, 2016. The Notice of Continuance to the Respondent was returned, ""Unclaimed, Unable to Forward".
3. In 2015 during the times in question, the Respondent was employed as a Medical Assistant[1] at the Health Care and Rehabilitation Services facility in Brattleboro, Vermont.
4. On March 31, 2015 the Respondent attempted to dispose of 55 tablets of Methylpenidate 20 mg by placing some of the tablets in used coffee grounds which were being discarded. Methylpenidate is a controlled substance and instructions had been given that the tablets were to be disposed of by a nurse. The Respondent made the disposal without a witness. When the method of disposal was learned, Registered Nurse C.L. (who discovered the disposal) tried to locate the disposed pills in the coffee grounds. She did this in order to be able to confirm the disposal. Despite the pills being a bright orange color, only 6 of the 55 tablets could be found in the coffee grounds.
5. Nurse Manager, A. G., who is a registered nurse, completed a drug diversion report form (State Ex. 1). That report concluded that the Respondent "disregarded instructions" concerning the faulty disposal of the drugs on March 31, 2015.
6. On or about April 14, 2015 the Respondent was directed by a nursing note to fill a "pill planner" for a patient with the appropriate tablets of Methylphenidate. The nursing note instructions were for the Respondent to place 17 tablets of this drug into the pill planner. On April 21, 2015 it was discovered that the Respondent had logged out 35 tablets of the drug despite only 17 tablets being needed to fill the pill planner.
7. On April 21, 2015 the patient reported that the pill planner was short 4-5 tablets of Methylphenidate. Following further investigation on April 22, 2015, Nurse Manager A.G. determined that the pill planner was short 22 tablets of Methylphenidate and that these drugs were not accounted for.
8. The patient involved in both incidents was a "vulnerable adult" by reason of mental illness.
9. Nurse Manager A.G. testified that she had given specific instructions to the Respondent about how to fill the pill planner on several occasions.
10. The Respondent failed to follow specific instructions concerning the distribution and disposal of the medications. Neither the Respondent's answer (which she filed with the Office of Professional Regulation to the Specification of Charges), nor her answers as reported in the Review of Medication Discrepancy (State Ex. 1, page 5), adequately explain the missing medications. As such, there is strong evidence of drug diversion.
11. The failure of the Respondent to follow directions, despite her working as a medical assistant, is evidence of her inability to practice competently as a Licensed Nursing Assistant.
12. The testimony of the witnesses was accepted and the facts contained therein are found to

[1] The Specification of Charges, Paragraph #3 was amended on the day of the hearing to make it clear that the Respondent was working as a "medical assistant' and not as an LNA at the times in question.

be true and correct.

13. It was the position of the State that the Respondent's license should be indefinitely suspended. Should the Respondent apply for reinstatement, reinstatement should only be considered if the Respondent is evaluated by an independent, approved evaluator who is aware of these findings, to be conducted within 45 days of the request for reinstatement. In the event of reinstatement, the Board, in its sole discretion, may impose appropriate conditions as may be indicated by the evaluation.

Conclusions of Law

Based on the evidence presented and Facts found above we conclude as follows:

1. The prosecution has the burden of proof in this matter. To prevail on any unprofessional conduct charge, it must prove the charge by a preponderance of the evidence. 3 VSA Sec. 129a(c).
2. Re: Alleged Violation of 3 VSA Sec. 129a(b)(1) and (2): The Prosecution has proven by a preponderance of the evidence that Respondent failed to practice competently by performance of unacceptable patient care and failed to conform to the essential standards of acceptable and prevailing practice. This is unprofessional conduct.
3. The Board declines to find a violation of 3 VSA Sec. 129a(a)(3) (Failure to comply with State or Federal statutes or rules regarding the profession).

Order

For the violations above, to protect the public, health, safety and welfare, the following sanction is necessary.

14. Respondent's license is hereby **INDEFINITELY SUSPENDED**. Her license shall remain suspended until such time as she applies for reinstatement and the Board decides, in its sole discretion, that she qualifies for reinstatement. Any application for reinstatement shall be accompanied by a report, prepared by an independent and suitable evaluator, pre-approved by the Vermont Board of Nursing. The evaluation shall address at a minimum: the violations set forth above; the Respondent's substance use, if any; and her capability to practice nursing safely. The evaluation must be completed within 45 days of the application for reinstatement and shall be performed at the sole expense of the Respondent. The Board may impose appropriate conditions as may be indicated by the evaluation.

Vermont Board of Nursing

By: Jeanine Carr
Jeanine Carr, RN, Chair

Date: July , 2016

OFFICE OF PROFESSIONAL REGULATION

DATE OF ENTRY 7/14/16

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, Office of Professional Regulation, 89 Main Street, Fl. 3, Montpelier, Vermont 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. To request a stay of the Board's decision, please refer to the attached stay instructions.