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

IN RE:	)	
SHANNON ELIZABETH GODDEAU	)	Docket No. 2010-484
License Nos. 026.0027410	)	

STIPULATION AND CONSENT ORDER

STIPULATION

NOW COME the State of Vermont, by and through State Prosecuting Attorney S. Lauren Hibbert, and the Respondent, Shannon Elizabeth Goddeau, 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. Shannon Elizabeth Goddeau (the "Respondent") of Cadyville, New York is licensed by the State of Vermont as a Registered Nurse under license number 026.0027410. This license was originally issued on or about July 26, 2002 and is currently set to expire on or about March 31, 2011. Respondent has also been licensed by the State of Vermont as a Licensed Nursing Assistant under license number 075.0010154. Respondent's LNA license was originally issued on or about May 3, 1999 and lapsed on or about February 1, 2001.

3. At all times relevant, Respondent was employed as a Registered Nurse at Fletcher Allen Heath Care (the "Facility"), located in Burlington,Vermont. Respondent worked at the Facility on the 7pm – 7am shift in the Facility's SICU/MICU/PICU unit. Respondent worked at the Facility on a part-time basis until on or about May 17, 2010, when she began working at the Facility full-time.

4. On or about August 20, 2010 in a phone call to Chief Investigator Amy Carlson, Facility Director of Pharmacy Services K.M. advised that an Anomalous Usage report indicated that Respondent had withdrawn a large number of intravenous Fentanyl and Hydromorphone (Dilaudid).

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

5. In this same interview, K.M. advised that a preliminary chart review indicated that Respondent had been charting patient pain scales in blocks (meaning that Respondent performed the actual documentation of the various pain scales she reportedly gathered all at once), generally at the end of her shift. Moreover, K.M. advised that several nursing staff had recently reported that Respondent had been exhibiting odd behavior; that she was slow to get her work done; and that she had been taking numerous breaks to smoke cigarettes.

6. Respondent has twice declined to meet with the Facility's EAP (Employee Assistance Program) when Facility concerns regarding her narcotic handling have been raised.

7. Respondent has also been seen reconstituting an IV medication – thought to be Fentanyl – into smaller syringes. Although there is no Facility policy prohibiting this practice, it is contrary to normal practice. Moreover, such practice results in a lack of accountability for the narcotics that were withdrawn and administered. Common practice at the Facility is to remove medications as needed and to waste the remainder.

Statement of Facts re: Respondent's Anomalous Usage

8. A Facility Anomalous Usage Report for the period of July 1, 2010 through July 31, 2010 in Respondent's SICU unit indicates that Respondent had withdrawn from the Pyxis (electronic medication dispensing system) one hundred sixty-four (164) ampules of Fentanyl 100mcg/2ml for this period, when the mean number of withdrawals of this specific narcotic in the SICU was eleven (11), and the next highest number of withdrawals made by another nurse for this specific narcotic was thirty-six (36).

9. This same Anomalous Usage Report indicates that for this period, Respondent removed from the Pyxis seventy-five (75) ampules of Fentanyl 250mcg/5ml, when the mean number of withdrawals for this specific narcotic in the SICU was eight (8), and the next highest number of withdrawals made by another nurse for this specific narcotic was sixteen (16).

10. This same Anomalous Usage Report indicates that for this period, Respondent removed from the Pyxis twenty-seven (27) ampules of Hydromorphone (Dilaudid) 1mg/1ml, when the mean number of withdrawals for this specific narcotic in the SICU was four (4), and the next highest number of withdrawals made by another nurse for this specific narcotic was twelve (12).

11. A Facility Anomalous Usage Report for the period of May 7, 2010 through August 4, 2010 in Respondent's SICU unit indicates that Respondent had withdrawn from the Pyxis two hundred fifty-seven (257) ampules of Fentanyl 100mcg/2ml, when the mean number of withdrawals for this specific narcotic in the SICU was twenty-three

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

(23), and the next highest number of withdrawals made by another nurse for this specific narcotic was fifty-six (56).

12. This same Anomalous Usage Report for this three month period indicates that Respondent removed from the Pyxis seventy-five (75) ampules of Fentanyl 250mcg/5ml, when the mean number of withdrawals for this specific narcotic in the SICU was seven (7), and the next highest number of withdrawals made by another nurse for this specific narcotic was sixteen (16).

13. This same Anomalous Usage Report for this three month period indicates that Respondent removed from the Pyxis thirty-four (34) ampules of Hydromorphone (Dilaudid) 1mg/1ml, when the mean number of withdrawals for this specific narcotic in the SICU was five (5), and the next highest number of withdrawals made by another nurse for this specific narcotic was twenty-six (26).

14. A Facility Anomalous Usage Report for the period of April 3, 2010 through July 1, 2010 in Respondent's SICU unit indicates that Respondent had withdrawn from the Pyxis ninety-six (96) ampules of Fentanyl 100mcg/ml, when the mean number of withdrawals for this specific narcotic in the SICU was twenty (20), and the next highest number of withdrawals made by another nurse for this specific narcotic was forty-eight (48). During part of this period – April 3, 2010 through May 16, 2010 – Respondent was only employed at the Facility part-time.

Statement of Facts re: the Facility's Internal Audit

15. On or about October 8, 2010 in an interview with Chief Investigator Carlson, Assistant Nurse Manager J.P.; Assistant Nurse Manager K.C.; Nurse Manager M.R.; and Nursing Director D.L. advised in part the following information that they gathered pursuant to a chart audit they conducted of Respondent's withdrawals, documentation, and administration of medication. These nurses provided the complete results of their audit, enumerated in part below, to Chief Investigator Carlson.

16. On or about June 6, 2010, the shift prior to Respondent administered 250mcg Fentanyl IV to Patient #12, and the shift after Respondent administered 325mcg Fentanyl IV to this patient. However, Respondent documented that she administered 950mcg Fentanyl IV to this patient during her shift. Moreover, a review of Respondent's withdrawals of this narcotic and documented administrations indicate that 275mcg Fentanyl IV was unaccounted for. Furthermore, Respondent had documented this patient's pain scales in blocks of time, and not at the times of alleged assessments. Respondent also documented that she hung this patient's Fentanyl IV bag at 20:45, but didn't withdraw this narcotic from the Pyxis until 22:06.

17. On or about June 10, 2010, Respondent removed from the Pyxis a total of 4mg Morphine IV for Patient #22, but failed to document a pain scale before or after administration.

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

18. On or about June 11, 2010, Patient #22 was ordered to be administered Oxycodone 5-20mg tablet every four hours as needed; with 20mg to be administered only for a pain scale greater than "7." On this date, Respondent documented that she administered 20mg Oxycodone to this patient at 00:00 and again 04:56, without documenting this patient's pain scale before or after these two documented administrations.

19. On or about June 11, 2010 at 01:45, Respondent documented that she administered 50mcg Fentanyl to Patient #23; however, Respondent made no corresponding removal of this narcotic from the Pyxis prior to this documented administration. Moreover, Respondent did not document a pain scale prior to this documented administration.

20. On or about June 11, 2010, Respondent removed from the Pyxis a total of 500mcg Fentanyl IV for Patient #23; documented that she administered a total of 350mcg to this patient; and documented that 100mcg of this narcotic was wasted. Therefore, at least 50mcg of this narcotic is unaccounted for.

21. On or about June 13, 2010 at 22:59, Respondent documented that Patient #13 had a pain scale of "2" at 21:00. At 21:46, Respondent removed from the Pyxis 2mg Morphine IV for this patient, then documented at 21:58 that she administered 1mg Morphine IV to this patient at 20:30, over an hour prior to the time she actually removed this narcotic from the Pyxis. Moreover, Respondent did not document wasting the remaining 1mg Morphine IV, and this amount is therefore unaccounted for. Respondent made no nurse's notes regarding this patient. Furthermore, during this shift, Respondent removed 2mg Midazolam (Versed) (a short-acting benzodiazepine) for this patient using the override function, as this narcotic was not ordered by this patient's physician. Respondent did not document administering or wasting any of this narcotic, and therefore this amount is unaccounted for.

22. On or about June 19, 2010, Respondent failed to document wasting approximately 1.2mg Hydromorphone (Dilaudid) IV for Patient #3, and therefore that amount of this narcotic is unaccounted for. Respondent documented this patient's pain scales prior to and after the purported administrations in blocks of time. Respondent documented that this patient had a pain scale of "6" fifteen minutes after another nurse had documented this patient had a pain scale of "2." The shift after Respondent documented that this patient had much lower pain scales than those documented by Respondent.

23. On or about June 19, 2010, Respondent documented eleven (11) pain scales prior to documenting the administration of Hydromorphone IV to Patient #3 in five (5) blocks of time. Moreover, Respondent documented twelve (12) administrations of this narcotic to this patient in three (3) blocks of time.

24. On or about June 26, 2010, the waste of Fentanyl IV documented by Respondent for Patient #6 was short by approximately 125mcg. Three pain scales were documented

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

at the same time. One pain scale was documented as "0" prior to the administration of Fentanyl 35mcg, and then "5" after Respondent documented that she administered this narcotic. Three documented administrations of Fentanyl IV lacked pain scales before or after the administrations. Moreover, Respondent documented no nurse's notes regarding this patient's pain issues.

25. On or about June 30, 2010, the shift prior to Respondent administered to Patient #6 a total of 100mcg Fentanyl IV, and the shift after Respondent administered to this patient 125 mcg Fentanyl IV. However, Respondent documented that she administered to this patient 270mcg Fentanyl IV during her shift. Respondent failed to document Patient #6's pain scale prior to some of her documented administrations; prior to one purported administration Respondent documented the pain scale as "0"; and this patient's documented pain scale did not decrease after other purported administrations. Moreover, Respondent documented no nurse's notes regarding this patient's pain issues.

26. On or about July 11, 2010 at 22:00, a nurse other than Respondent administered 50mcg Fentanyl IV to Patient #5. At 22:03, Respondent documented that this patient had a pain scale of "5" at 22:00, but then waited until 00:10 to remove from the Pyxis 100mcg Fentanyl IV for this patient. At 07:58, Respondent documented that she administered 100mcg Fentanyl to this patient at 00:00. Respondent medicated this patient for another nurse.

27. On or about July 12, 2010, Respondent failed to document a pain scale for Patient #5 prior to Respondent removing from the Pyxis 100mcg Fentanyl IV for this patient at 19:34. Respondent documented that she administered the entire 100mcg Fentanyl to this patient at 19:44, although the previous nurse administered 50mcg of this narcotic to this patient at 17:00. Respondent medicated this patient for another nurse.

28. On or about July 24, 2010, the shift prior to Respondent administered to Patient #7 a total of 25mcg Fentanyl IV. However, Respondent documented that she administered to this patient 575mcg Fentanyl IV during her shift. Respondent documented one administration of this narcotic without specifying the amount administered. Respondent documented pain scales in blocks of time. Respondent documented pain scales which did not decrease after her alleged administrations, and she documented no nurse's notes regarding this patient's pain issues.

29. On or about August 6, 2010, Respondent documented that she administered a total of 1mg Dilaudid IV to Patient #10. However, the shift prior to Respondent administered none of this narcotic to this patient, and the shift after Respondent administered only 0.2mg of this narcotic to this patient. In her documentation regarding the first administration of this narcotic, Respondent documented that this patient had a pain scale of "3" at 20:00, but she had already removed this narcotic from the Pyxis approximately one hour prior, at 19:03, and documented that she administered this narcotic at 19:05. Respondent also documented that she administered this narcotic to

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

this patient when s/he had a pain scale of "2," but then failed to document the pain scale after the purported administration of this narcotic.

30. On or about August 8, 2010, Respondent documented that she administered a total of 1mg Dilaudid IV to Patient #10. However, the shift prior to Respondent administered none of this narcotic to this patient, and the shift after Respondent administered only 0.4mg of this narcotic to this patient. Moreover, Respondent made absolutely no documentation of this patient's pain scale either prior to or after her purported five administrations of this narcotic to this patient during her shift. Respondent made her documentation regarding the administration of this narcotic in blocks of time, and not at the time of the purported administrations. Regarding her last purported administration of 0.2mg Dilaudid IV to this patient, Respondent failed to document the time of wasting of the remaining 0.8mg, and had no witness for this waste.

31. On or about August 9, 2010, Patient #26 had an order for Fentanyl IV 25-50mcg every hour as needed. During her shift, Respondent documented that she administered a total of 475mcg Fentanyl to this patient, who was on comfort care. However, the shift prior to Respondent administered only 200mcg Fentanyl to this patient, and the shift after Respondent only administered 125mcg Fentanyl, plus 20mg Morphine to this patient. Respondent failed to document the administration of Fentanyl IV after two of her removals of this narcotic from the Pyxis.. There is approximately 150mcg Fentanyl unaccounted for after considering all of Respondent's removals from the Pyxis and documented administrations and wastes. Respondent made documentation regarding her twenty-one (21) withdrawals in four (4) blocks of time. Respondent failed to document this patient's pain scale before or after twelve (12) of her documented administrations of this narcotic. In all but one of the remaining nine (9) instances when Respondent actually did document a pain scale prior to a documented administration, Respondent documented that the patient had a pain scale of a "1" or a "2."

32. On or about August 11, 2010, Respondent made inconsistent administrations of Fentanyl IV compared to Patient #28's pain scales, in that Respondent documented that she administered 25mcg Fentanyl IV to this patient when s/he had a pain scale of both "5" and "2," but later documented that she administered 50mcg of this narcotic to this patient when s/he had a pain scale of "1." During this shift, approximately 350mcg Fentanyl was unaccounted for in wastes; this calculation is despite Respondent documenting that after she removed 100mcg Fentanyl IV, she administered 50mcg to this patient, and then wasted 75mcg. Moreover, during this shift, Respondent documented that a Morphine continuous infusion IV bag hung for this patient only lasted six (6) hours, when the previous bag hung for this patient by another nurse lasted twelve (12) hours.

33. On or about August 12, 2010, Patient #10 had an order for Lorazepam (Ativan) 0.5mg every six hours as needed. At 20:31 on this date, Respondent removed from the Pyxis two (2) tablets Lorazepam 0.5mg for Patient #10, in excess of this patient's order. At 23:27 (approximately three hours later), Respondent documented that she

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

administered one (1) tablet Lorazepam to this patient at 20:30, but did not document administering or wasting the other tablet, and therefore this narcotic tablet is unaccounted for.

34. On or about August 12, 2010, Respondent removed from the Pyxis a total of 8mg Hydromorphone (Dilaudid) IV for Patient #10 by removing 1mg of this narcotic in eight separate withdrawals. A total of 6.4mg of this narcotic was documented as being wasted with a witness in blocks of time, and therefore 1.2mg of this narcotic should have been administered to this patient. The shift prior to Respondent administered this patient 0.4mg of this narcotic, and the shift after Respondent administered this patient 0.6mg of this narcotic. However, for two of her withdrawals, Respondent failed to document administering or wasting this narcotic, rendering 0.4 of this narcotic unaccounted for. Respondent's first removal of this narcotic on this shift was at 19:01, but Respondent documented that she didn't administer this narcotic to the patient until approximately three hours later at 22:00. Moreover, at 07:18 Respondent documented that she had administered 0.2mg Dilaudid to this patient at 05:00, but Respondent hadn't removed this narcotic until 05:17.

35. On or about August 12, 2010, Respondent documented that she administered a total of 16mg Dilaudid tablets to Patient #10. However, the shift prior to Respondent administered 6mg of this narcotic to this patient, and the shift after Respondent administered only 4mg of this narcotic to this patient.

Statement of Facts re: Respondent's Interview

36. On or about August 25, 2010 in an interview with Chief Investigator Carlson, Respondent denied diverting narcotics from the Facility. When asked to explain Respondent's pattern of administering more medication than her peers, Respondent stated, "That is probably because I work nights. I feel like people should be sleeping at night and maybe I try to medicate them to go to sleep." Respondent advised that she "had a problem with alcohol before," approximately 12-13 years ago, and attended outpatient counseling for such, but that she no longer engages in any treatment regarding alcohol addiction.

Statement of Facts re: Respondent's Return to the Facility

37. On or about November 5, 2010 in a phone call to Chief Investigator Carlson, Nursing Director D.L. reported that after the Facility had placed Respondent on paid administrative leave for five (5) weeks, Respondent had recently returned to the Facility with the condition that she receive one day worth of education and a review of the expectations upon her return. D.L. advised that over the weekend of October 29, 2010, Respondent had to stay past her regularly scheduled shift by approximately one and a half (1.5) hours to complete her assignments, and appeared jittery and unorganized.

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

38. In this same interview, D.L. advised that while caring for a patient who required intubation, Respondent left this patient with another nurse so that Respondent could go on a cigarette break, and the covering nurse quickly realized that this patient was experiencing respiratory decompensation. D.L. advised that Respondent should have recognized the warning signs and continued to provide care for this patient, instead of going on a cigarette break.

39. In this same interview, D.L. advised that one of Respondent's patients received "excessive medication administration" after intubation, and that neither the shift before or after Respondent's shift medicated this patient in the same manner.

40. In this same interview, D.L. reported that the Facility had concerns regarding Respondent's treatment of a family member who just lost one child to a car accident, and was visiting with his/her surviving child – Respondent's patient – who survived this accident.

41. In this same interview, D.L. advised that Respondent had requested a one-patient assignment because her two-patient assignment was too much for Respondent to handle due to Respondent having difficulties with ADD. D.L. reported that the Facility denied Respondent's request due to concerns for patient safety.

42. On or about November 8, 2010, the Board summarily suspended Respondent's license.

Charges

43. 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);

b. ARBN Chapter 4, Subchapter 4, Rule II(B)(1) and (2) ("Inability to practice nursing competently" includes: (1) performance of unsafe or unacceptable patient care; and (2) failure to conform to the essential standards of acceptable and prevailing nursing practice);

c. 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

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

d. 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

44. This Stipulation is neither an admission of liability by the Respondent nor a concession by the State of Vermont that its charges are not well-founded. To avoid delay, uncertainty, inconvenience, and expense of protracted litigation of the charges above, the Parties reach a full and final Stipulation pursuant to these Understandings and the Order below. The Respondent does not dispute that the State could prove at least some of charges by a preponderance of the evidence if this matter went to a hearing and agrees that the conditions below are necessary and appropriate.

45. 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.

46. 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.

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

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

49. 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.

50. 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.

51. 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 **INDEFINITELY SUSPENDS** the Respondent's license to practice nursing. Within forty-five (45) days of requesting reinstatement, Respondent must: **1)** obtain an independent evaluation report by a licensed professional specializing in drug and alcohol abuse, pre-approved by the Board, who has verified receipt of this Order and will address the Respondent's ADD diagnosis in his or her assessment and the results of which must indicate that the Respondent does not present a risk to the

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

safety, health or welfare of her potential patients; and **2)** submit to the Board the results of a minimum of three (3) random urine analyses, collected in an observed setting; administered by a person or entity that has been pre-approved by the Board; and analyzed by a lab qualified to analyze samples for forensic purposes and pre-approved by the Board, the results of which shall be negative; 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. The Respondent's license shall not be reinstated until these prerequisites are met. Once reinstated, Respondent's license will be **CONDITIONED FOR A MINIMUM OF THREE (3) YEARS** commencing with the date of reinstatement. The conditions will be as follows:

(1) Re-issue of License.

Upon the commencement of these conditions, Respondent shall be issued a license labeled "conditioned."

(2) Length of Time of Conditions Imposed.

The conditions shall remain in place until Respondent has completed all conditions ordered. Respondent shall be subject to the conditions until Respondent completes **a minimum of three (3) years** of supervised nursing in which she works at least forty (40) hours every two (2) weeks as a nurse. Part time hours of less than forty (40) hours every two (2) weeks shall be credited on a prorated basis. Respondent shall be prohibited from working more than forty (40) hours per week.

(3) Completion of Substance Abuse Counseling and Treatment Plan.

Respondent shall enter into and continue substance abuse counseling with the treating professional pre-approved by the Board until the treating professional shall certify in writing to the Board that such counseling is no longer necessary. Respondent shall comply with the substance abuse treatment plan approved by the Board and the treating professional.

(4) Reports from Treating Professional.

Respondent shall authorize and cause her treating professional to submit to the Board evidence of satisfactory progress with the treatment plan during the effective period of this Consent Order. These reports shall be submitted in writing on forms issued by the Board. The first report is due commencing the month after the date of the commencement of the conditions and subsequent reports are due **monthly** thereafter.

Respondent shall authorize her treating professional to provide all information requested by the Nursing Board, either orally or in writing, at any time during the period this Consent Order is in effect.

(5) Participation in Recovery Group(s).

Respondent shall attend if recommended by her treating professional in substance abuse recovery group(s), and shall submit **quarterly** reports documenting such attendance on forms issued by the Board.

(6) Random Drug and Alcohol Testing.

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

Respondent shall submit to random drug and alcohol screenings at the request of the Board or its designee. Respondent shall designate a person or entity that has been pre-approved by the Board or its designee to administer random drug and alcohol screens. All testing shall be done on a random, unannounced basis and analyzed by a lab qualified to analyze samples for forensic purposes and approved by the Board. All urine specimens collected for tests shall be collected in an observed setting. All screens shall be negative.

Failure to appear for, refusal to provide, adulteration of, dilution of, or tampering with a sample for any urine screen shall cause that screen to be presumed positive. Any positive screen shall act as a violation of this Order.

(7) Abstain from Drug and Alcohol Use.

Respondent shall abstain completely from the consumption or possession of alcohol and drugs with the exception of medications as outlined in paragraph A.(8) for the period of time described in A.(2).

(8) Drug Use Exception.

Respondent shall not take controlled substances unless medically necessary. Respondent may take scheduled/controlled medications lawfully prescribed for a bona fide illness or condition by a physician, dentist, or nurse practitioner whose identity shall be made known to the Board in writing by Respondent within forty-eight (48) hours of the prescription. Respondent shall cause the physician, dentist or nurse practitioner to inform the Board, in writing and on appropriate letterhead, of knowledge of this Stipulation and Consent Order within seven (7) days of entering into the practitioner/patient relationship. Moreover, the Respondent shall cause this prescribing practitioner to inform the Board, in writing and on appropriate letterhead, of all scheduled/controlled medications prescribed – and the anticipation of how long such prescriptions will need to be taken – within seven (7) days of the prescription.

The Board or its designee may request at any time that the practitioner document the necessity for the prescribed scheduled/controlled medications or other medications known to have abuse potential. This includes medications to be administered as necessary. It is not anticipated that Respondent would be prescribed scheduled/controlled medication during the term of this Consent Order for a period greater than fourteen (14) days, but if so, then the conditions herein may be revoked by the Board.

Respondent shall provide the Board with a current medication list of any medications taken on a scheduled or as-needed basis on forms issued by the Board within seven (7) days of the date of reinstatement and shall update this list within forty-eight (48) hours of any change in these medications.

(9) Notification to Employers/Nursing School.

Respondent shall provide a copy of this Stipulation and Consent Order to all employers in any current or future setting in which Respondent practices as a nurse and inform them of Respondent's conditional license status.

Within ten (10) days of the date of entry of this Consent Order or of any subsequent nursing employment, Respondent shall cause Respondent's immediate supervisor to submit to the Board an employer agreement form approved by the Board, acknowledging receipt of

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

the Stipulation and Consent Order and the ability to comply with the conditions in the Consent Order.

In the event the Respondent is attending a nursing program which has a clinical portion that involves actual patient care, Respondent shall provide a copy of the Stipulation and Consent Order to the Program Director. Respondent shall cause the Program Director to submit to the Board a nursing program agreement form approved by the Board, acknowledging receipt of the Stipulation and Consent Order and the ability of the program to comply with the conditions in the Consent Order during clinical experience.

(10) Reports from Employers/Program Director.

Within one (1) month of the date of reinstatement or within one (1) month of the commencement of nursing employment and **monthly** thereafter, Respondent shall cause every nursing employer the Respondent has worked for during the month to submit to the Board an evaluation of Respondent's work performance and attendance during that month. Moreover, on a **quarterly** basis, these reports shall include the results of the employer's medication audits of Respondent's medication administration and practices. These reports shall be submitted in writing on forms issued by the Board. All employer reports shall indicate satisfactory performance (ie., consistently meeting all standards of nursing practice) and attendance.

In the event the Respondent is attending a nursing program, Respondent shall cause the Program Director to submit to the Board, on a monthly basis, a written evaluation of her performance and attendance. These reports shall be submitted in writing on forms issued by the Board. All nursing program reports shall indicate satisfactory performance (ie., consistently meeting all standards of nursing practice) and attendance.

(11) Practice Under Supervision.

Respondent shall practice as a nurse only in a setting where Respondent has direct supervision for the entire shift by a licensed registered nurse that is in good standing with the Board. If the Respondent is hired to work in a doctor's office that does not have another RN working when the Respondent is there then the Respondent may petition the Board to allow that doctor to supervise her.

(12) Administration of Medications.

Respondent is prohibited from administering any controlled substances. This condition may be removed only by the Respondent filing a petition with the Board after she has worked as a nurse for six (6) months for at least forty (40) hours every two weeks (or the part time equivalent) after the date of reinstatement.

In any such petition, the Respondent must demonstrate, to the satisfaction of the Nursing Board or its designee, that she can safely and competently administer such medications. In any such petition, the Respondent must include appropriate support from her treating professional and employer or nursing school administrator and a description of the documentation and inventory control procedures in place.

The removal of this prohibition shall not automatically result in the reinstatement of all medication privileges. The Board may gradually restore those privileges through whatever intermediary steps it determines are appropriate.

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

(13) Types of Employment Prohibited.

Respondent shall not work in a supervisory role. Respondent shall not work for a nurse registry, traveling nurse agency, float-pool, home health care agency, temporary nursing employment agency, or as a private duty nurse or personal care provider requiring a nursing or nursing assistant license during the effective period of this Consent Order.

(14) Interview with the Board or its Designee.

Respondent shall appear in person for interviews with the Board or its designee upon request.

(15) Out-of-State Practice.

Before any out-of-state practice can be credited toward fulfillment of these terms and conditions, Respondent shall first obtain approval from the Board prior to Respondent practicing nursing outside the State of Vermont. If Respondent fails to receive such approval before practicing nursing outside the State of Vermont, none of the time spent practicing nursing out-of-state will be credited toward the fulfillment of the terms and conditions of this Consent Order. The Board will approve out-of-state nursing practice so long as the Respondent can still comply with the provisions of this Consent Order.

If the Respondent receives discipline on a nursing license held in another state during the conditioned period, the Respondent must inform the Board of such, in writing, within ten (10) days of receiving such discipline.

(16) Notification of Place of Employment/Personal Address/Telephone Number.

Within ten (10) days of the date of entry of this Consent Order, Respondent shall notify the Board, in writing, of her current place of employment, personal address, and telephone number. Respondent shall further notify the Board, in writing, within forty-eight (48) hours of any change in employment (including resignation or termination), personal address, or telephone number.

(17) Notification to Other States.

In the event that the Respondent is licensed in nursing in any other state(s), she must inform the nursing licensing board of the state(s) in which the Respondent is licensed of the conditional status of her Vermont nursing license within thirty (30) days of the date of entry of this Order. If the Respondent fails to provide such notification, it will be considered a violation of this Order.

(18) License Renewal.

If the Respondent's license expires while this Order is still in effect, this Order does not automatically extend the license. In that situation, in order to continue to practice as a nurse, the Respondent must timely apply for renewal, pay the applicable fee and demonstrate that she has otherwise complied with the requirements for license renewal.

(19) Release of Information Forms.

The conditions of this Order require the Respondent to authorize drug and/or alcohol treatment providers to report information in verbal and/or written format and/or to discuss the Respondent and any and all treatment rendered to the Respondent for drugs and/or alcohol

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

with the Board or its designee. The conditions of this Order must allow any and all information from the Respondent's treatment providers to also be provided to the Office of Professional Regulation investigators and that the information may be used for further prosecutions if so warranted or if the Office of Professional Regulation determines that said information violates the terms of this Order or any rules or laws governing the profession of nursing.

The Respondent is entitled to revoke this consent at any time. However, any revocation by the Respondent of such consent to disclosure during the term of this Order shall be considered a violation of this Order.

This consent expires when the conditions are removed from the Respondent's nursing license.

This Stipulation and Consent Order shall constitute a valid written consent pursuant to the requirements of 42 C.F.R. § 2.31.

The Respondent understands that her treatment provider may require her to sign a separate and distinct consent meeting the requirements of 42 C.F.R. § 2.31.

(20) Costs.

The Respondent shall bear all costs of complying with this Consent Order.

(21) Violation of this Order.

If the Respondent violates the terms of this Order in any respect, the Board, after giving the Respondent notice and an opportunity to be heard, may rescind or modify this Order and impose additional appropriate disciplinary actions. If a complaint of unprofessional conduct is made against the Respondent during the term of this Order, this Order shall be automatically extended until the unprofessional conduct matter is concluded.

(22) Completion of Conditional License Period.

After the conditional license period, the Respondent may petition the Board to remove any and all conditions on her license. The Respondent must present proof that she has fully complied with the terms of this Order. The Respondent must also present proof of successful substance abuse rehabilitation and she must demonstrate, to the satisfaction of the Board, that she poses no danger to the public or the practice of nursing and that she can safely and competently perform the duties of a licensed nurse.

B. Notwithstanding any provision above, the Respondent must continue to meet all Nursing Board requirements for maintaining a license, license renewal and license reinstatement.

C. 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).

D. 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

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

Dated: 4/6/11

By: _____
S. Lauren Hibbert
State Prosecuting Attorney

Dated: 4/1/11

SHANNON ELIZABETH GODDEAU
RESPONDENT

By: _____
Shannon Elizabeth Goddeau

APPROVED AS TO FORM:

Dated: 4/11/11

ATTORNEY FOR RESPONDENT

By: _____
John L. Pacht, Esq.

APPROVED AND SO ORDERED:

Dated: 4-11-11

VERMONT BOARD OF NURSING

By: _____
Chairperson

Date of Entry: 4/12/11

Cadyville, NY

STATE OF VERMONT
BOARD OF NURSING

In re: Shannon Elizabeth Goddeau License No. 026-27410	}	Docket No. 2010-484 (RN)

DECISION ON REQUEST FOR SUMMARY SUSPENSION ORDER

Appearances:
for Petitioner, State of Vermont: Betsy Ann Wrask
for Respondent: did not appear

Presiding Officer: Larry S. Novins

Summary Suspension Order
Findings of Fact, Conclusions of Law, and Order

On November 8, 2010 this matter came before the Board of Nursing on the State's Request for a Summary Suspension pursuant to 3 V.S.A. § 814(c). Ms. Goddeau did not appear. The Board has authority to summarily suspend a license pending further action, if it determines that public health, safety, or welfare imperatively requires emergency action.

Findings of Fact

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

1. Ms. Goddeau is licensed by and subject to the disciplinary authority of this Board. 26 V.S.A. Chapter 28, 3 V.S.A. § 129, the Administrative 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 State has filed a "Request for Summary Suspension." A copy of the Request is attached to this Decision and Order. The Request alleges that Ms. Goddeau, between July and August 2010 had been documenting administration of unusually large amounts of narcotic drugs, that she has been exhibiting odd behavior consistent with drug abuse, and had failed to even discuss the issue of narcotic handling with her employer's Employee Assistance Program.
3. The State further alleges that the public health, safety or welfare imperatively requires emergency action.

4. On November 1, 2010 Notice of this hearing was sent to attorney John Pacht for Ms. Goddeau by first class mail. Mr. Pacht informed the prosecuting attorney that Respondent will not attend the hearing.
5. The Board has reviewed documents presented by the State.
6. The Board finds for purposes of this hearing that Ms. Goddeau has been diverting drugs
7. The allegations in the Request for Summary Suspension (copy attached) have been established to the necessary degree.
8. The evidence presented does imperatively require emergency action for the public health, safety, and welfare. Specifically, summary suspension is necessary to prevent Ms. Goddeau from practicing in an impaired state and harming patients. If summary suspension is not ordered, the Board believes that patient harm will occur.

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 and Conclusions herein are for purposes of this Order only.

The State'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 Ms. Goddeau'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 Ms. Goddeau being afforded a prompt hearing. At any merits hearing in this matter, the State will bear the burden of proving unprofessional conduct. Our Findings and Conclusions in this matter will not absolve the State or Ms. Goddeau 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 on the evidence admitted at that hearing only.

Order

The State's Request for Summary Suspension is **Granted.** Ms. Goddeau'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).

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, National Life Bldg., North, FL2, 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. To request a stay of the Board's decision, please refer to the attached stay instructions.

Vermont Board of Nursing

By: Ellen Leff
Ellen Leff, RN, Chair

Date: November 8, 2010

OFFICE OF PROFESSIONAL REGULATION

DATE OF ENTRY: 11/9/10

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

IN RE:	)	
SHANNON ELIZABETH GODDEAU	)	Docket No. 2010-484
License No. 026.0027410	)	

REQUEST FOR SUMMARY SUSPENSION

Board Authority

1. The Vermont Board of Nursing (the "Board") has jurisdiction to investigate and adjudicate allegations of unprofessional conduct committed by Nurses pursuant to 3 V.S.A. §§ 129, 129a; 26 V.S.A. Chapter 28; the Administrative Rules of the Board of Nursing ("ARBN"); and the Rules of the Office of Professional Regulation.

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

Statement of Facts

3. Shannon Elizabeth Goddeau (the "Respondent") of Bennington, Vermont is licensed by the State of Vermont as a Registered Nurse under license number 026.0027410. This license was originally issued on or about July 26, 2002 and is currently set to expire on or about March 31, 2011. Respondent has also been licensed by the State of Vermont as a Licensed Nursing Assistant under license number 075.0010154. Respondent's LNA license was originally issued on or about May 3, 1999 and lapsed on or about February 1, 2001.

4. At all times relevant, Respondent was employed as a Registered Nurse at Fletcher Allen Heath Care (the "Facility"), located in Burlington, Vermont. Respondent worked at the Facility on the 7pm – 7am shift in the Facility's SICU/MICU/PICU unit. Respondent worked at the Facility on a part-time basis until on or about May 17, 2010, when she began working at the Facility full-time.

5. On or about August 20, 2010 in a phone call to Chief Investigator Amy Carlson, Facility Director of Pharmacy Services K.M. advised that an Anomalous Usage report indicated that Respondent had withdrawn a large number of intravenous Fentanyl and Hydromorphone (Dilaudid).

6. In this same interview, K.M. advised that a preliminary chart review indicated that Respondent had been charting patient pain scales in blocks (meaning that Respondent performed the actual documentation of the various pain scales she reportedly gathered

TATE OF VERMONT
'rosecuting Attorney
Office of
'ofessional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

all at once), generally at the end of her shift. Moreover, K.M. advised that several nursing staff had recently reported that Respondent had been exhibiting odd behavior; that she was slow to get her work done; and that she had been taking numerous breaks to smoke cigarettes. K.M. advised that Respondent had been placed on administrative leave on this date.

7. Respondent has twice declined to meet with the Facility's EAP (Employee Assistance Program) when Facility concerns regarding her narcotic handling have been raised.

8. Respondent has also been seen reconstituting an IV medication – thought to be Fentanyl – into smaller syringes. Although there is no Facility policy prohibiting this practice, it is contrary to normal practice. Moreover, such practice results in a lack of accountability for the narcotics that were withdrawn and administered. Common practice at the Facility is to remove medications as needed and to waste the remainder.

Statement of Facts re: Respondent's Anomalous Usage

9. A Facility Anomalous Usage Report for the period of July 1, 2010 through July 31, 2010 in Respondent's SICU unit indicates that Respondent had withdrawn from the Pyxis (electronic medication dispensing system) one hundred sixty-four (164) ampules of Fentanyl 100mcg/2ml for this period, when the mean number of withdrawals of this specific narcotic in the SICU was eleven (11), and the next highest number of withdrawals made by another nurse for this specific narcotic was thirty-six (36).

10. This same Anomalous Usage Report indicates that for this period, Respondent removed from the Pyxis seventy-five (75) ampules of Fentanyl 250mcg/5ml, when the mean number of withdrawals for this specific narcotic in the SICU was eight (8), and the next highest number of withdrawals made by another nurse for this specific narcotic was sixteen (16).

11. This same Anomalous Usage Report indicates that for this period, Respondent removed from the Pyxis twenty-seven (27) ampules of Hydromorphone (Dilaudid) 1mg/1ml, when the mean number of withdrawals for this specific narcotic in the SICU was four (4), and the next highest number of withdrawals made by another nurse for this specific narcotic was twelve (12).

12. A Facility Anomalous.Usage Report for the period of May 7, 2010 through August 4, 2010 in Respondent's SICU unit indicates that Respondent had withdrawn from the Pyxis two hundred fifty-seven (257) ampules of Fentanyl 100mcg/2ml, when the mean number of withdrawals for this specific narcotic in the SICU was twenty-three (23), and the next highest number of withdrawals made by another nurse for this specific narcotic was fifty-sex (56).

STATE OF VERMONT

Prosecuting Attorney
Office of
rofessional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

13. This same Anomalous Usage Report for this three month period indicates that Respondent removed from the Pyxis seventy-five (75) ampules of Fentanyl 250mcg/5ml, when the mean number of withdrawals for this specific narcotic in the SICU was seven (7), and the next highest number of withdrawals made by another nurse for this specific narcotic was sixteen (16).

14. This same Anomalous Usage Report for this three month period indicates that Respondent removed from the Pyxis thirty-four (34) ampules of Hydromorphone (Dilaudid) 1mg/1ml, when the mean number of withdrawals for this specific narcotic in the SICU was five (5), and the next highest number of withdrawals made by another nurse for this specific narcotic was twenty-six (26).

15. A Facility Anomalous Usage Report for the period of April 3, 2010 through July 1, 2010 in Respondent's SICU unit indicates that Respondent had withdrawn from the Pyxis ninety-six (96) ampules of Fentanyl 100mcg/ml, when the mean number of withdrawals for this specific narcotic in the SICU was twenty (20), and the next highest number of withdrawals made by another nurse for this specific narcotic was forty-eight (48). During part of this period – April 3, 2010 through May 16, 2010 – Respondent was only employed at the Facility part-time.

Statement of Facts re: the Facility's Internal Audit

16. On or about October 8, 2010 in an interview with Chief Investigator Carlson, Assistant Nurse Manager J.P.; Assistant Nurse Manager K.C.; Nurse Manager M.R.; and Nursing Director D.L. advised in part the following information that they gathered pursuant to a chart audit they conducted of Respondent's withdrawals, documentation, and administration of medication. These nurses provided the complete results of their audit, enumerated in part below, to Chief Investigator Carlson.

17. On or about June 4, 2010, Respondent failed to document a pain scale for Patient #1 prior to removing 30cc Dilaudid IV from the Pyxis for this patient. Respondent removed this narcotic at 02:08, then documented at 02:44 that she administered this patient this narcotic at 03:00.

18. On or about June 6, 2010, the shift prior to Respondent administered 250mcg Fentanyl IV to Patient #12, and the shift after Respondent administered 325mcg Fentanyl IV to this patient. However, Respondent documented that she administered 950mcg Fentanyl IV to this patient during her shift. Moreover, a review of Respondent's withdrawals of this narcotic and documented administrations indicate that 275mcg Fentanyl IV was unaccounted for. Furthermore, Respondent had documented this patient's pain scales in blocks of time, and not at the times of alleged assessments. Respondent also documented that she hung this patient's Fentanyl IV bag at 20:45, but didn't withdraw this narcotic from the Pyxis until 22:06.

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

19. On or about June 10, 2010, Respondent removed from the Pyxis a total of 4mg Morphine IV for Patient #22, but failed to document a pain scale before or after administration.

20. On or about June 11, 2010, Patient #22 was ordered to be administered Oxycodone 5-20mg tablet every four hours as needed; with 20mg to be administered only for a pain scale greater than "7." On this date, Respondent documented that she administered 20mg Oxycodone to this patient at 00:00 and again 04:56, without documenting this patient's pain scale before or after these two documented administrations.

21. On or about June 11, 2010 at 01:45, Respondent documented that she administered 50mcg Fentanyl to Patient #23; however, Respondent made no corresponding removal of this narcotic from the Pyxis prior to this documented administration. Moreover, Respondent did not document a pain scale prior to this documented administration.

22. On or about June 11, 2010 at 03:33, Respondent removed from the Pyxis 100mcg Fentanyl for Patient #23 without first documenting a pain scale for this patient. Respondent documented that she administered 50mcg Fentanyl to this patient, but did not document wasting the remaining 50mcg.

23. On or about June 11, 2010 at 06:06, Respondent removed from the Pyxis 100mcg Fentanyl for Patient #23, without first documenting a pain scale for this patient. Moreover, there is no corresponding administration or wasting of this removed narcotic.

24. On or about June 11, 2010, Respondent removed from the Pyxis a total of 500mcg Fentanyl IV for Patient #23; documented that she administered a total of 350mcg to this patient; and documented that 100mcg of this narcotic was wasted. Therefore, at least 50mcg of this narcotic is unaccounted for.

25. On or about June 13, 2010 at 22:59, Respondent documented that Patient #13 had a pain scale of "2" at 21:00. At 21:46, Respondent removed from the Pyxis 2mg Morphine IV for this patient, then documented at 21:58 that she administered 1mg Morphine IV to this patient at 20:30, over an hour prior to the time she actually removed this narcotic from the Pyxis. Moreover, Respondent did not document wasting the remaining 1mg Morphine IV, and this amount is therefore unaccounted for. Respondent made no nurse's notes regarding this patient. Furthermore, during this shift, Respondent removed 2mg Midazolam (Versed) (a short-acting benzodiazepine) for this patient using the override function, as this narcotic was not ordered by this patient's physician. Respondent did not document administering or wasting any of this narcotic, and therefore this amount is unaccounted for.

26. On or about June 14, 2010 at 00:54, Respondent removed from the Pyxis 100mcg Fentanyl IV for Patient #4, and at 01:03 documented that she administered 25mcg of this narcotic to this patient at 00:50. However, Respondent documented at 02:14 that

TATE OF VERMONT

Prosecuting Attorney
Office of
rofessional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

this patient had a pain scale of "1" at 01:00. On this date at 03:59, Respondent removed from the Pyxis 100mcg Fentanyl IV for this patient, documented that she administered 25mcg of this narcotic at 04:12, but did not waste the 75mcg remainder of this narcotic until 04:41. On this date at 06:59, Respondent removed 100mcg Fentanyl IV for this patient and documented that she administered 25mcg of this narcotic to this patient at 07:02, but did not waste the 75mcg remainder of this narcotic until 07:31. On this date, a review of Respondent's withdrawals, administrations, and wastes during her shift indicates that 75mcg of Fentanyl IV is unaccounted for.

27. On or about June 18, 2010, Respondent made three (3) removals of Fentanyl IV for Patient #3, but failed to document this patient's pain scales before or after any of her documented administrations.

28. On or about June 19, 2010, Respondent failed to document wasting approximately 1.2mg Hydromorphone (Dilaudid) IV for Patient #3, and therefore that amount of this narcotic is unaccounted for. Respondent documented this patient's pain scales prior to and after the purported administrations in blocks of time. Respondent documented that this patient had a pain scale of "6" fifteen minutes after another nurse had documented this patient had a pain scale of "2." The shift after Respondent documented that this patient had much lower pain scales than those documented by Respondent.

29. On or about June 19, 2010, Respondent documented eleven (11) pain scales prior to documenting the administration of Hydromorphone IV to Patient #3 in five (5) blocks of time. Moreover, Respondent documented twelve (12) administrations of this narcotic to this patient in three (3) blocks of time.

30. On or about June 25, 2010, the waste of Fentanyl IV documented by Respondent for Patient #6 was short by approximately 40mcg.

31. On or about June 26, 2010, the waste of Fentanyl IV documented by Respondent for Patient #6 was short by approximately 125mcg. Three pain scales were documented at the same time. One pain scale was documented as "0" prior to the administration of Fentanyl 35mcg, and then "5" after Respondent documented that she administered this narcotic. Three documented administrations of Fentanyl IV lacked pain scales before or after the administrations. Moreover, Respondent documented no nurse's notes regarding this patient's pain issues.

32. On or about June 30, 2010, the shift prior to Respondent administered to Patient #6 a total of 100mcg Fentanyl IV, and the shift after Respondent administered to this patient 125 mcg Fentanyl IV. However, Respondent documented that she administered to this patient 270mcg Fentanyl IV during her shift. Respondent failed to document Patient #6's pain scale prior to some of her documented administrations; prior to one purported administration Respondent documented the pain scale as "0"; and this patient's documented pain scale did not decrease after other purported

ATE OF VERMONT
osecuting Attorney
Office of
fessional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

administrations. Moreover, Respondent documented no nurse's notes regarding this patient's pain issues.

33. On or about July 11, 2010 at 22:00, a nurse other than Respondent administered 50mcg Fentanyl IV to Patient #5. At 22:03, Respondent documented that this patient had a pain scale of "5" at 22:00, but then waited until 00:10 to remove from the Pyxis 100mcg Fentanyl IV for this patient. At 07:58, Respondent documented that she administered 100mcg Fentanyl to this patient at 00:00. Respondent medicated this patient for another nurse.

34. On or about July 12, 2010, Respondent failed to document a pain scale for Patient #5 prior to Respondent removing from the Pyxis 100mcg Fentanyl IV for this patient at 19:34. Respondent documented that she administered the entire 100mcg Fentanyl to this patient at 19:44, although the previous nurse administered 50mcg of this narcotic to this patient at 17:00. Respondent medicated this patient for another nurse.

35. On or about July 15, 2010, Patient #11 had an order for Fentanyl 100-350mcg every hour as needed. Respondent documented that she administered a total of 2625mcg Fentanyl IV to this patient during her shift. However, the shift prior to Respondent only administered to this patient 700mcg of this narcotic, and the shift after Respondent only administered to this patient 400mcg of this narcotic. Respondent made absolutely no pain scale documentation regarding this patient before or after any of her purported eleven (11) administrations of this narcotic. At 20:05, Respondent made two (2) withdrawals of Fentanyl 500mcg from the Pyxis, for a total of Fentanyl 1000mcg, in excess of this patient's order. Respondent made much of her documentation and many of the wastes in blocks of time. During this shift, Respondent's documented administration times do not correlate with the times of wastes. There were errors in waste documentation indicating duplicate wasting, in that Respondent removed from the Pyxis a total of 4000mcg Fentanyl; documented that she administered 2625mcg; and recorded a total of 1775mcg being wasted, which leaves a negative balance of 400mcg Fentanyl.

36. On or about July 17 and 18, 2010, Respondent documented that she administered three doses of 25mcg Fentanyl IV to Patient #27, but did not actually document these administrations until the end of her shift at approximately 06:21. By the end of Respondent's shift, there was approximately 400-625mcg Fentanyl IV unaccounted for. Several of Respondent's Pyxis removals were made without corresponding administrations, wastes, or returns to the Pyxis. Moreover, there was approximately 2mg Versed unaccounted for. During this shift, Respondent made much of her documentation in blocks of time.

37. On or about July 24, 2010, the shift prior to Respondent administered to Patient #7 a total of 25mcg Fentanyl IV. However, Respondent documented that she administered to this patient 575mcg Fentanyl IV during her shift. Respondent documented one administration of this narcotic without specifying the amount administered. Respondent documented pain scales in blocks of time. Respondent documented pain

:ATE OF VERMONT

rosecuting Attorney
Office of
ofessional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

scales which did not decrease after her alleged administrations, and she documented no nurse's notes regarding this patient's pain issues.

38. On or about July 25, 2010, the shift prior to Respondent administered to Patient #7 a total of 0.2mg Dilaudid IV, and the shift after Respondent administered to this patient a total of 0.4 Dilaudid IV. However, during her shift, Respondent administered to this patient a total of 2mg Dilaudid IV. During her shift, Respondent removed from the Pyxis one (1) Dilaudid 1mg/ml ampule; one (1) Dilaudid tablet; and one (1) Ativan tablet without documenting that she administered or wasted these narcotics.

39. On or about August 6, 2010, Respondent documented that she administered a total of 1mg Dilaudid IV to Patient #10. However, the shift prior to Respondent administered none of this narcotic to this patient, and the shift after Respondent administered only 0.2mg of this narcotic to this patient. In her documentation regarding the first administration of this narcotic, Respondent documented that this patient had a pain scale of "3" at 20:00, but she had already removed this narcotic from the Pyxis approximately one hour prior, at 19:03, and documented that she administered this narcotic at 19:05. Respondent also documented that she administered this narcotic to this patient when s/he had a pain scale of "2," but then failed to document the pain scale after the purported administration of this narcotic.

40. On or about August 7, 2010, Respondent documented that she administered a total of 1.2mg Dilaudid IV to Patient #10. However, the shift prior to Respondent administered 0.2mg of this narcotic to this patient, and the shift after Respondent administered none of this narcotic to this patient. In her documentation regarding the first administration of this narcotic, Respondent documented that this patient had a pain scale of "8" at 14:00, but Respondent did not remove Dilaudid IV for this patient until 19:26. Respondent documented that she administered 0.2mg Dilaudid IV to this patient at 00:45 after she had assessed this patient as having a pain scale of "1" at 00:00, but then documented that this patient had a higher pain scale of "3" at 01:00. Respondent documented that this patient had a pain scale of "5" at 04:00, then removed Dilaudid IV for this patient at 04:15; however, Respondent documented that she administered this narcotic to this patient at 04:00 (15 minutes prior to removal time), and then documented that this patient had a higher pain scale of "6" at 05:00. Respondent failed to document this patient's pain scale after her final purported administration of Dilaudid IV to this patient.

41. On or about August 8, 2010, Respondent documented that she administered a total of 1mg Dilaudid IV to Patient #10. However, the shift prior to Respondent administered none of this narcotic to this patient, and the shift after Respondent administered only 0.4mg of this narcotic to this patient. Moreover, Respondent made absolutely no documentation of this patient's pain scale either prior to or after her purported five administrations of this narcotic to this patient during her shift. Respondent made her documentation regarding the administration of this narcotic in blocks of time, and not at the time of the purported administrations. Regarding her last purported

TATE OF VERMONT

Prosecuting Attorney
Office of
rofessional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

administration of 0.2mg Dilaudid IV to this patient, Respondent failed to document the time of wasting of the remaining 0.8mg, and had no witness for this waste.

42. On or about August 9, 2010, Patient #26 had an order for Fentanyl IV 25-50mcg every hour as needed. During her shift, Respondent documented that she administered a total of 475mcg Fentanyl to this patient, who was on comfort care. However, the shift prior to Respondent administered only 200mcg Fentanyl to this patient, and the shift after Respondent only administered 125mcg Fentanyl, plus 20mg Morphine to this patient. Respondent failed to document the administration of Fentanyl IV after two of her removals of this narcotic from the Pyxis. There is approximately 150mcg Fentanyl unaccounted for after considering all of Respondent's removals from the Pyxis and documented administrations and wastes. Respondent made documentation regarding her twenty-one (21) withdrawals in four (4) blocks of time. Respondent failed to document this patient's pain scale before or after twelve (12) of her documented administrations of this narcotic. In all but one of the remaining nine (9) instances when Respondent actually did document a pain scale prior to a documented administration, Respondent documented that the patient had a pain scale of a "1" or a "2."

43. On or about August 11, 2010, Respondent documented that she administered a total of 1.2mg Dilaudid IV to Patient #10. However, the shift prior to Respondent administered none of this narcotic to this patient, and the shift after Respondent administered only 0.4mg of this narcotic to this patient. Moreover, Respondent made absolutely no documentation of this patient's pain scale either prior to or after her purported six administrations of this narcotic to this patient during her shift. For three of these purported administrations, Respondent documented that she administered Dilaudid IV to this patient prior to Respondent removing this narcotic from the Pyxis.

44. On or about August 11, 2010, Respondent made inconsistent administrations of Fentanyl IV compared to Patient #28's pain scales, in that Respondent documented that she administered 25mcg Fentanyl IV to this patient when s/he had a pain scale of both "5" and "2," but later documented that she administered 50mcg of this narcotic to this patient when s/he had a pain scale of "1." During this shift, approximately 350mcg Fentanyl was unaccounted for in wastes; this calculation is despite Respondent documenting that after she removed 100mcg Fentanyl IV, she administered 50mcg to this patient, and then wasted 75mcg. Moreover, during this shift, Respondent documented that a Morphine continuous infusion IV bag hung for this patient only lasted six (6) hours, when the previous bag hung for this patient by another nurse lasted twelve (12) hours.

45. On or about August 12, 2010, Patient #10 had an order for Lorazepam (Ativan) 0.5mg every six hours as needed. At 20:31 on this date, Respondent removed from the Pyxis two (2) tablets Lorazepam 0.5mg for Patient #10, in excess of this patient's order. At 23:27 (approximately three hours later), Respondent documented that she administered one (1) tablet Lorazepam to this patient at 20:30, but did not document

TATE OF VERMONT

Prosecuting Attorney
Office of
ofessional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

administering or wasting the other tablet, and therefore this narcotic tablet is unaccounted for.

46. On or about August 12, 2010, Respondent removed from the Pyxis a total of 8mg Hydromorphone (Dilaudid) IV for Patient #10 by removing 1mg of this narcotic in eight separate withdrawals. A total of 6.4mg of this narcotic was documented as being wasted with a witness in blocks of time, and therefore 1.2mg of this narcotic should have been administered to this patient. The shift prior to Respondent administered this patient 0.4mg of this narcotic, and the shift after Respondent administered this patient 0.6mg of this narcotic. However, for two of her withdrawals, Respondent failed to document administering or wasting this narcotic, rendering 0.4 of this narcotic unaccounted for. Respondent's first removal of this narcotic on this shift was at 19:01, but Respondent documented that she didn't administer this narcotic to the patient until approximately three hours later at 22:00. Moreover, at 07:18 Respondent documented that she had administered 0.2mg Dilaudid to this patient at 05:00, but Respondent hadn't removed this narcotic until 05:17.

47. On or about August 12, 2010, Respondent documented that she administered a total of 16mg Dilaudid tablets to Patient #10. However, the shift prior to Respondent administered 6mg of this narcotic to this patient, and the shift after Respondent administered only 4mg of this narcotic to this patient.

48. On or about August 12 and 13, 2010, during the two (2) night shifts that Respondent worked, Respondent documented that she administered Patient #9 with a total of 1.5mg Hydromorphone IV (Dilaudid), as well as eight (8) tablets Percocet. However, the shifts prior and subsequent to Respondent's on both of these dates administered neither of these narcotics to this patient. Moreover, Respondent did not document pain scales for this patient at any time on either of these dates prior to or after she documented administering any these narcotics. Furthermore, on or about August 13, 2010, Respondent performed a waste of 0.25mg Hydromorphone IV for which there was no corresponding Pyxis removal or documented administration.

Statement of Facts re: Respondent's Interview

49. On or about August 25, 2010 in an interview with Chief Investigator Carlson, Respondent denied diverting narcotics from the Facility. When asked to explain Respondent's pattern of administering more medication than her peers, Respondent stated, "That is probably because I work nights. I feel like people should be sleeping at night and maybe I try to medicate them to go to sleep." Respondent advised that she "had a problem with alcohol before," approximately 12-13 years ago, and attended outpatient counseling for such, but that she no longer engages in any treatment regarding alcohol addiction.

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

Request for Relief

50. The facts as set out above establish that in order to protect the public health, safety, or welfare of the people of the State of Vermont, emergency action is imperative.

51. The above acts and circumstances, alone or in combination, violate:

a. 26 V.S.A. § 1582(a)(3) (Is unable to practice nursing competently by reason of any cause);

b. ARBN Chapter 4, Subchapter 4, Rule II(B)(1) and (2) ("Inability to practice nursing competently" includes: (1) performance of unsafe or unacceptable patient care; and (2) failure to conform to the essential standards of acceptable and prevailing nursing practice);

c. ARBN Chapter 4, Subchapter 4, Rule II(C) ("Any cause" includes, but is not limited to, reasons of physical or mental disability or use of drugs, narcotics, chemicals, or any other type of materials);

d. 26 V.S.A. § 1582(a)(7) (Engages in conduct of a character likely to deceive, defraud, or harm the public) which includes falsifying or altering clinical records or making inaccurate or misleading entries pursuant to ARBN Chapter 4, Subchapter 4, Rule II(D)(3); and diverting supplies, equipment, or drugs for personal or other unauthorized use pursuant to ARBN Chapter 4, Subchapter 4, Rule II(D)(4);

e. 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);

f. 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

g. 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).

WHEREFORE, the State of Vermont respectfully requests that pursuant to 3 V.S.A. § 814(c), the Respondent's nursing license number 026.0027410 be summarily suspended, pending a hearing on the merits.

DATED at Montpelier, Vermont this 29th day of October, 2010.

'TATE OF VERMONT

'rosecuting Attorney
Office of
'ofessional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

STATE OF VERMONT
SECRETARY OF STATE

By: _____
BetsyAnn Wrask
State Prosecuting Attorney

nu.goddeau.sumsusp

STATE OF VERMONT

Prosecuting Attorney
Office of
rofessional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107