

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

IN RE:  
DERMOT J. HANNA  
License No. 025.0053892

)  
)  
)  
Docket No. 2019-136

VOLUNTARY INDEFINITE SUSPENSION STIPULATION

NOW COMES the State of Vermont, by and through State Prosecuting Attorney, Traci Leibowitz, and the Respondent, Dermot J. Hanna, who stipulate and agree as follows:

1. To moot summary suspension proceedings under 3 V.S.A. § 814(c) in the matter captioned above, the State and Respondent request that license no. 025.0053892 be voluntarily suspended, for an indefinite period, pending adjudication of the above-captioned matter on the merits.
2. This Stipulation is neither an admission of responsibility by the Respondent nor a concession by the State of Vermont that its Request for Summary Suspension is not well-founded
3. Proceedings on the merits should be promptly instituted and determined.
4. Respondent understands that this agreement is a matter of public record and that this suspension pending adjudication on the merits may be reported to other licensing authorities as provided in 3 V.S.A. 129(a)(6).

ORDER

The Board of Nursing hereby suspends license no. 025.0053892 pending adjudication on the merits of the matter captioned above.

AGREED TO:

STATE OF VERMONT  
SECRETARY OF STATE

Dated: 9-6-19

By:   
Traci Leibowitz  
State Prosecuting Attorney  
(802) 828-0041  
traci.leibowitz@sec.state.vt.us

STATE OF VERMONT



Prosecuting Attorney  
Office of  
Professional Regulation  
89 Main Street  
3rd Floor  
Montpelier, VT  
05620-3402

Dated: 8/5/19

DERMOT J. HANNA  
RESPONDENT

By: [Signature]  
Dermot J. Hanna

APPROVED AND SO ORDERED:

Dated: 9.9.2019

Vice By: [Signature]  
Board Chair

Date of Entry: 9.10.19

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IN RE: )  
DERMOT J. HANNA )  
License No. 025.0053892 )

Docket No. 2019-134

REQUEST FOR SUMMARY SUSPENSION

NOW COMES the State of Vermont, by and through State Prosecuting Traci Leibowitz, and petitions the Board of Nursing to summarily suspend the license of Licensed Practical Nurse Dermot J. Hanna. In support of such petition, the State alleges the following:

**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. Dermot J. Hanna ("Respondent") of Rutland, Vermont is licensed by the State of Vermont as a Licensed Practical Nurse ("LPN") under license number 025.0053892. This license was originally issued July 31, 2009 and will expire on January 31, 2020.
4. Respondent previously held a temporary LPN permit, license number 025.0055088-PRMT, which was issued on July 10, 2009 and expired on September 19, 2009. Respondent was previously licensed as a Licensed Nursing Assistant under license number 075.0014474, which was issued on June 16, 2004 and expired on November 30, 2010.
5. During all relevant times, Respondent was employed at Mountain View Center, a nursing home located in Rutland, Vermont (the "Facility"). Respondent was employed with the Facility for approximately 15 years, first as a Licensed Nursing Assistant, then as a LPN.
6. One of Respondent's patients was Patient ("Patient"). Patient was receiving care at the Facility due to injuries that resulted from extreme neglect by her family.

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7. Throughout the month of February 2019, Patient's treatment plan called for two types of opioid narcotic pain medication to be administered "as needed" for ongoing pain management.
8. Patient was prescribed 1 MG hydromorphone, otherwise known as Dilaudid, every 2 hours as needed for pain and morphine sulfate, otherwise known as Roxanol, 5 MG every hour as needed for pain.
9. Patient died on February 17, 2019.
10. Respondent was responsible for administering medication and providing care to Patient on the day that she died.
11. Record keeping procedures are employed when a controlled substance is obtained by a nurse and administered to a patient. Those administering controlled substances must document when the drug is withdrawn from secure storage in the "narcotic log" and must document when the drug is administered to the patient in the medication administration record ("MAR").
12. On the day of Patient's death, Respondent documented in the narcotic log that he withdrew multiple doses of hydromorphone for Patient. However, the MAR indicates that not a single dose of hydromorphone was actually administered to Patient.
13. An autopsy was performed on Patient. Results of the autopsy showed no evidence of hydromorphone in Patient's system.
14. Autopsy results did show evidence of Haldol and Seroquil in Patient's system. Neither Haldol nor Seroquil were prescribed to Patient.
15. Respondent admitted to diverting hydromorphone for personal use.
16. Respondent admits that, on the date of Patient's death, he took multiple doses of pain medication that was prescribed for Patient for his personal use.
17. Respondent admits to taking Seroquil that had been prescribed to other residents and administering it to Patient in an attempt to make her comfortable because he was taking her pain medication for his personal use.
18. There are 10 other instances during the month of February 2019 where Respondent's documentation in the narcotic log and the MAR indicate that an opioid narcotic pain medication was withdrawn but not administered to Patient.
19. Respondent diverted controlled substances from other patients at the Facility.

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20. The narcotic log and the MAR records kept by Respondent show a pattern of withdrawing controlled substances from the narcotics cart and then “wasting” or disposing of the medication without a witness.
21. From January 2019 through August 2019, Respondent withdrew a controlled substance from the narcotics cart then wasted the medication without a witness 21 times. These prescription medications were diverted from 10 different patients.
22. Respondent admits that each time he indicated on the narcotic log and MAR that he withdrew medication and wasted it without a witness, he took the medication for personal use.

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

23. The State re-alleges and incorporates Paragraphs 3 through 22 above.
24. As an LPN, Respondent shall not divert or attempt to divert drugs, equipment, or supplies for unauthorized use.
25. Respondent diverted or attempted to divert drugs for unauthorized use as demonstrated in Paragraphs 3 through 22 above.
26. 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)(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.**

27. The State re-alleges and incorporates Paragraphs 3 through 22 above.
28. As an LPN, Respondent has an obligation to provide safe and acceptable patient care.
29. Respondent provided unsafe and unacceptable patient care by engaging in the conduct described in Paragraphs 3 through 22 above.
30. 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 Three: 26 V.S.A. §1582(a)(3) Engaging in conduct of a character likely to deceive, defraud, or harm the public.**

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31. The State re-alleges and incorporates Paragraphs 3 through 22 above.
32. As an LPN, Respondent is required to refrain from engaging in conduct of a character likely to deceive, defraud, or harm the public.
33. Respondent engaged in conduct of a character likely to deceive, defraud, or harm the public as demonstrated in Paragraphs 3 through 22 above.
34. 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 Four: 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.**

35. The State re-alleges and incorporates Paragraphs 3 through 22 above.
36. 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.
37. Respondent's conduct in Paragraphs 3 through 22 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.
38. 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**

39. Respondent currently has an unencumbered license. Members of the public, patients, and potential patients have no way of learning of Respondent's dangerous behavior and will remain unprotected pending suspension of Respondent's license. 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.

**WHEREFORE**, the State of Vermont respectfully requests that pursuant to 3 V.S.A. § 814(c), the Respondent's registered nursing license, number 025.0053892, be summarily suspended, pending a hearing on the merits.

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DATED at Montpelier, Vermont this 27<sup>th</sup> day of August, 2019.

STATE OF VERMONT  
SECRETARY OF STATE

By: \_\_\_\_\_

  
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