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OFFICE OF PROFESSIONAL REGULATION
VERMONT STATE BOARD OF NURSING

IN RE: Lisa Marie Harding)
Case File No. NU92-0602) DEFAULT ORDER
License No. ~~75-11734~~)
25-07031

Introduction

The Board of Nursing held a default hearing in the above matter on November 4, 2002 at 81 River Street in Montpelier, Vermont. Board members Sandra Norton, Susan Farrell, Alan Weiss, De-Ann Welch, Sue Cota, Linda Rice, Elayne Clift and Pat Rock participated in the decision. Senior Assistant Attorney General Robert Gagnon did not attend for the State. The Respondent did not attend and was not represented.

Findings of Fact

The Respondent was sent notice of the Charges against her by certified mail and first class mail on September 17, 2002 to her last known address.

2. That certified mail return receipt was returned to the Office of Professional Regulation (OPR) on October 7, 2002, marked "unclaimed". The first class mail was not returned.

3. Notice of the default hearing was mailed to that same address by certified and regular mail on October 24, 2002.

4. The Respondent has not answered the charges against her.

5. After taking notice of its own file, the Board found the Respondent to be in default. The allegations contained in the State's Specification of Charges dated September 10, 2002 (copy attached) are therefore treated as the facts on which the Board's order is based.

Conclusions of Law

The Respondent has received adequate notice of the charges against her as indicated by the Board's file. Because the Respondent has failed to answer the charges against her, the State's factual allegations are treated as if proved. Accordingly, the Board finds, in the default

hearing held pursuant to 3 V.S.A. §809(d), that the Respondent has engaged in the unprofessional conduct alleged in the State's Specification of Charges.

Order

In accordance with the above findings of fact and conclusions of law, the license of the Respondent is hereby INDEFINITELY SUSPENDED, effective as of the date of the hearing.

Appeal Rights

This is a final administrative determination by the Vermont State Board of Nursing. You may appeal by sending a notice of appeal in writing to the Director of the Office of Professional Regulation within 30 days of the date of entry of this order. If you wish to request a stay of the Board's decision, please refer to the attached stay instructions.

By: Susan Farrell Date: Nov. 18, 2002
Susan Farrell, R.N.
Chair

OFFICE OF PROFESSIONAL REGULATION

DATE OF ENTRY: 11/22/02

STATE OF VERMONT
BOARD OF NURSING

In re:	)	
Lisa Marie Harding	)	Docket No. NU92-0602
License No. 25-07031	)	

SPECIFICATION OF CHARGES

1. Respondent, Lisa Marie Harding is licensed by the State of Vermont as an license practical nurse holding license No. 25-07031.

2. The Board of Nursing has jurisdiction to investigate complaints of unprofessional conduct and approve consent orders pursuant to 3 V.S.A. §129, and 26 V.S.A. §§1574, 1582.

3. Respondent is licensed as a practical nurse holding license number 25-07031. During all relevant times herein, Respondent worked as a licensed practical nurse at the Centers for Living in Bennington, Vermont.

4. Respondent has diverted controlled drugs from Centers for Living in Bennington, Vermont. This occurred from on or about April 2002 through May of 2002. Specifically the drugs diverted were oxycontin and Vicoden.

5. A pharmacy profile check in the Bennington area regarding Respondent indicated she had a record of receiving narcotic drugs. Sine 1999 she had received regulated drugs from twenty-one different practitioners in the Bennington area.

6. Respondent is addicted to habit-forming drugs and has been abusing prescription drugs.

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7. The Respondent, when confronted with the above, admitted to being addicted to drugs and admitted to diverting drugs from the facility and falsifying the records.

8. The conduct described above is unprofessional conduct pursuant to 26 V.S.A. §1582(3)(4)(5) and (7).

WHEREFORE, the nursing license of Lisa Marie Harding should be. revoked, suspended, reprimanded, conditioned, or otherwise disciplined.

STATE OF VERMONT

WILLIAM H. SORRELL
ATTORNEY GENERAL

Dated: 9-10-02

by: _____
Robert W. Gagnon
Senior Assistant
Attorney General

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109 State Street
Montpelier, VT
05609

STATE OF VERMONT
BOARD OF NURSING

In re: Lisa Marie Harding License No.25-7031	}	Docket No. NU92-0602

SUMMARY SUSPENSION ORDER

On August 12, 2002, this case came before the Board of Nursing for a hearing on the State's request for summary suspension.

Based upon the evidence presented by the parties, the Board finds that the allegations in the request for summary suspension have been established to the necessary degree. Therefore, the Board finds that the public health, safety, or welfare imperatively require emergency action against the Respondent's license.

Pursuant to 3 V.S.A. § 814(c), Respondent Lisa Marie Harding's nursing license is summarily suspended and shall remain so pending a fully contested hearing or any other resolution of this case.

BOARD OF NURSING

By: Susan Farrell
Chair

Dated: August 12, 2002

OFFICE OF PROFESSIONAL REGULATION

DATE OF ENTRY: 8/13/02

State of Vermont

AFFIDAVIT

Bennington County S.S.

NOW COMES Stephen Kennedy, affiant, being duly sworn and on oath, deposes and says he has probable cause to believe that Lisa Harding DOB 8/14/68 has committed the offenses of Obtaining a Regulated Drug by Fraud or Deceit, a violation of Title 18, Vermont Statutes Annotated section 4223 (a) (c).

Defendant
Lisa Marie Harding
54 Northview Drive
Pownal, VT 05261
8/14/68

The above stated offense occurred in the Town of Bennington, Bennington County VT.

1. I am a full time law enforcement officer certified by the Vermont Criminal Justice Training Counsel since April of 1977. I am employed as an investigator for the Secretary of State.

2. I was assigned to investigate a possible case of case of drug diversion at the Centers for Living in Bennington. The Centers for Living is located at 160 Hospital Drive and is affiliated with Southwest Vermont Healthcare.

3. On 6/24/02 I met with Leah Matteson at the facility. Ms. Matteson is the Director of Nursing at the Center. Ms. Matteson told me that on 5/24/02 the pharmacy at the hospital had called and reported a discrepancy in the narcotic count of resident W.B. The drug was oxycontin 40 mg. The resident had physician order for oxycontin 40 mg two tablets, two times a day. Ms. Matteson said she checked the narcotic records for resident W.B. and discovered a pattern of errors on the records.

4. I observed and obtained copies of the narcotic record for this resident. The following discrepancies were observed on the record. On 5/19/02 Lisa Harding signed out for two oxycontin. On the record she then writes that she wasted the drug. There was no witness to the waste. Harding is required to have a witness sign on the record for all wasted narcotics. On 5/16/02 Harding signed out for five tablets of oxycontin. She writes on the record that three were wasted. There was no witness signature for the waste. On 5/15/02 Harding signed out for two tablets of oxycontin. She writes on the record that two tablets were wasted. There was no witness signature for the waste. On 5/14/02 at 7.30am Harding signed out for two oxycontin for the resident. Then at

9.45am she signs out for three more oxycontin. She indicates a waste of the three and a Julie Thompson witnesses the waste. This was unusual, as the resident had already been given his morning dose of oxycontin at 7.30am. On 5/2/02 Harding signs out for two oxycontin. She indicates on the record that she wasted the two oxycontin with no witness and the count goes from 25 to 21. If she had taken two and wasted them the count should have gone to 23. On 5/1/02 at 9.30am Harding signed out for 5 Dilauded and 2 oxycontin for the resident. She writes on the record that the 2 oxycontin were wasted. Then at 1115am she signs out for 5 more Dilauded, which she then wastes. Sharon Long witnessed the waste. There was no reason for Harding to have taken out any narcotics at 1115am as the morning dose had already been given by her earlier. On 4/22/02 Harding takes 2 oxycontin. She wastes 2 and she writes the inventory count from 25 to 21. If two were taken the count would have been 23. Terry Bellini witnessed the waste. On 4/21/02 Harding signs out for two oxycontin. At 9.30am she again sings out for 2 oxycontin and wastes them. Mary Cicerello singes as a witness to the waste. There should have no reason for the 9.30 sign out as the resident had already been dispensed the oxycontin earlier by Harding. On 4/18/02 Harding signed out for 2 oxycontin. She wrote the inventory count going from 22 to 18. It should have been 20. When Tammy Russell and Martha Culler counted the inventory at the end of that shift, the count was 18. Two pills were not accounted for. On 4/15 02 Harding signed out for 2 oxycontin. She indicated she wasted the 2 pills and Julie Thompson witnessed this. Harding wrote the inventory count from 12 to 8. It should have gone from 12 to 10. On 4/4/02 Harding signed out 4 oxycontin. She indicates she wasted 2. There was no signature to a witness to this waste.

5. Lisa Harding was employed at the Centers for Living from 4/16/97 to 5/28/02. Harding is a Licensed Practical Nurse and was so employed at the facility. She is issued license 025-0007031. On 7/30/94 her license was suspended for drug dependence. She was reissued a conditioned license on 12/15/95. On 5/11/99 she was reissued an active license by the Board of Nursing.

6. Leah Matteson told me that Harding had committed to many errors for continued employment and she was terminated. Matteson said she spoke to Harding on 5/28/02and that Harding had no explanation for the errors. Matteson recalls Harding telling her that none of this made any sense.

7. On 6/24/02 I spoke to Julianne Thompson at he facility. She was a witness to the waste on 5/14/02. She recalls Harding telling her that she had just taken out too many pills by mistake. I also spoke to Sharon Long. She was a witness to the 5/1/02 waste. She said she recalled Harding telling her that she had taken out too many pills by mistake. I also spoke to Teresa Bellini and Mary Cicerello additional signatories on the records. They did not recall what the reasons for the waste might have been.

8. I also spoke to Donna Baron a nurse manager at the facility. Ms. Barron had become aware of problems with records of two other residents. The residents are M.D. and J.W. Baron had reviewed records for these two patients that showed errors. On

5/6/02 Vicoden was signed out for resident M.D. There were no initials on the record and no record on the medication administration record. The nurses' notes indicate an entry that the medication was effective and that entry was made by Harding. Barons thought this unusual as two tablets were signed out. She said the resident only receives one not two tablets. On 5/6/02 Harding was assigned to resident J.W. He was given Vicoden. The vicoden was not signed out and no documentation in the nurse's note. The resident had always in the past been given Tylenol for any pain he might have had.

9. I conducted a pharmacy profile check in the Bennington area of Harding. Records were obtained from Brooks, Family Meds and the Southwest Vermont Medical Center. Harding had a record of receiving narcotic drugs. Since 1999 she had received regulated drugs from twenty-one different practitioners in the Bennington area.

10. Janet Beardsley of Green Health Care in Bennington told me that their office suspected Harding of drug seeking tendencies in November of 2000 and discontinued writing prescriptions for regulated drugs.

11. On 7/17/02 I interviewed Lisa Harding at the Bennington Police Department. Ms. Harding was informed it was a non-custodial interview. Harding first told me that the errors were simple mistakes and denied taking any drugs. She told me that "I know I have a past". I asked her why she did not get anyone to sign as a witness to any of the narcotic waste. She told me that she just did not get to sign. I confronted Harding with the information I obtained during the profile record check. Harding then admitted to me she was a drug addict. She told me she had just gone withdrawal and had not any drugs in the past three weeks. Harding admitted to me that she stole the drugs at the facility and falsified the records to do so. She told me that she took the drugs because she had access to them. Harding told me that she never deprived a resident from the drugs they were supposed to get. Harding also made the same admissions to Sgt. Doucette of the Bennngton P.D.

12. Pursuant to the provisions of Title 18, Chapter 84 section 4210, records are to be kept for the administration of regulated drugs. The records shall show the name, date, amount and person administering the regulated drug. Narcotic and medication administration records are regulated drug records for purposes of this chapter.

13. Pursuant to the provisions of Title 18 sections 4101-4102, the Department of Health designates regulated drugs. Vermont Health Regulations Part III, chapter 1, section 3 classifies Oxycontin and Hydrocodone (Vivcoden) as narcotic drugs.

14. Pursuant to Title 18, section 4223 (c) no person shall willfully make a false statement on a record required under this chapter. Title 18, section 4223 (a) (1) prohibits anyone from obtaining any regulated drug by fraud, deceit, misrepresentation or subterfuge.

15. Base on a review of the records and by the defendant's own admission, I believe she has committed the above stated offense. On at least thirteen different occasions, Lisa Harding made false statements on regulated drug records for the purpose of obtaining regulated drugs.

16. Harding was issued a citation to appear in Bennington District Court for September 9, 2002.

Subscribed and sworn before me on
This 29th day of July 2002.

Ronald West
Notary Public

Affiant

7/29/02
Date

STATE OF VERMONT
BOARD OF NURSING

In re:	)	
Lisa Marie Harding	)	Docket No. NU92-0602
License No. 25-07031	)	

REQUEST FOR SUMMARY SUSPENSION

NOW COMES the State of Vermont and requests the summary suspension of the nursing assistant license of Lisa Marie Harding on the following grounds:

1. Respondent, Lisa Marie Harding is licensed by the State of Vermont as an license practical nurse holding license No. 25-07031.

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

3. Respondent worked as a licensed practical nurse at the Centers for Living in Bennington, Vermont.

4. Respondent has diverted controlled drugs from Centers for Living in Bennington, Vermont. This occurred from on or about April 2002 through May of 2002. Specifically the drugs diverted were oxycontin and Vicoden.

5. A pharmacy profile check in the Bennington area regarding Respondent indicated she had a record of receiving narcotic drugs. Sine 1999 she had received regulated drugs from twenty-one different practitioners in the Bennington area. Respondent is addicted to habit-forming drugs and has been abusing prescription drugs.

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6. The Respondent, when confronted with the above, admitted to being addicted to drugs and admitted to diverting drugs from the facility and falsifying the records.

7. The conduct described above is unprofessional conduct pursuant to 26 V.S.A. §1595(6) and (7).

8. The health, safety, and welfare of the public imperatively require emergency action against the license of respondent.

WHEREFORE, the nursing assistant license of Lisa Marie Harding should be summarily suspended.

STATE OF VERMONT

WILLIAM H. SORRELL
ATTORNEY GENERAL

Dated: 7/24/02 by: _____

Robert W. Gagnon
Senior Assistant
Attorney General

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