STATE OF VERMONT
BOARD OF NURSING

In re: Louise W. Hearn License No. 026-42345	}	Docket No. NU29-1008

Appearances:
Petitioner, State of Vermont: Betsy A. Wrask
Respondent: Did not appear

Presiding Officer: Larry S. Novins

DEFAULT ORDER

The Board held a hearing on the above matter on May 11, 2009 at the National Life Building in Montpelier, Vermont. Ms. Hearn did not attend and was not represented by counsel.

Findings of Fact

1. Ms. Hearn is licensed as a registered nurse and is therefore subject to the regulatory authority of this Board. 3 V.S.A. §§ 129, 129a, 26 V.S.A. §§ 1582(a) , the Administrative Rules of the Board of Nursing, and the Rules of the Office of Professional Regulation.
2. On February 25, 2009 Ms. Hearn was sent notice of Charges in this matter by certified mail to her last known address. A copy of the Specification of Charges is attached to this Default Order.
3. OPR Rule 3.3 requires that an Answer be filed within 20 days of the date on which the notice of charges was mailed by the Director.
4. Licensees are required to notify the Board of any change of address within 30 days. 3 V.S.A. § 129a(a)(14).
5. The certified mail return receipt on the envelope indicate the notice of charges was received by a family member.
6. Ms. Hearn has not filed an answer to the charges.
7. On April 27, 2009 Notice of the default hearing scheduled for May 11, 2009 was mailed to Ms. Hearn at that same address by certified mail. The file shows no return on this mailing.
8. Ms. Hearn has still not answered the charges.
9. Upon hearing the State's presentation and taking notice of its own file, the Board finds Ms. Hearn to be in Default. The allegations contained in the State's Specification of Charges are therefore treated as the facts on which the Board's Order is based. OPR Rule 3.4, 3 V.S.A. § 809(d) and 3 V.S.A. § 814(c).

Conclusions of Law

Ms. Hearn has received adequate or constructive notice of the charges in this matter as indicated by the Board's file and the State's presentation. Because Ms. Hearn has failed to answer the charges, the State's factual allegations are treated as if proved. O.P.R. Rule 3.4. Accordingly, the Board finds, in this Default Hearing held pursuant to 3 V.S.A. §809(d), that Ms. Hearn 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, Ms. Hearn's license is hereby **Suspended Indefinitely**, effective as of the date of the hearing.

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, R.N., Chair

Date: May 11, 2009

OFFICE OF PROFESSIONAL REGULATION

DATE OF ENTRY: 5/14/09

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

IN RE: LOUISE W. HEARN License No. 026-0042345	)))	Docket No. NU29-1008

SPECIFICATION OF CHARGES

NOW COMES the State of Vermont and makes the following Charges against the Respondent, Louise W. Hearn, RN:

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. Louise W. Hearn (the "Respondent") of Winston Salem, North Carolina, is licensed by the Board as a Registered Nurse under license number 026-0042345. This license was originally issued on or about June 4, 2008 and is currently set to expire on or about March 31, 2009.

3. At all times relevant, Respondent was employed by PPR Health Care Staffing ("PPR"), located in Jacksonville, Florida. Respondent worked through PPR as a traveler nurse at Brattleboro Memorial Hospital (the "Facility"), located in Brattleboro, Vermont, from on or about June 10, 2008, until she was terminated from the Facility on or about October 8, 2008.

4. On or about October 9, 2008 in a Mandatory Report of Unprofessional Conduct, Nurse Manager M.M. stated that on or about October 8, 2008, Respondent was scheduled to work from 7:00 p.m. to 7:00 a.m. and soon after reporting for work, Respondent received a post-operative patient. M.M. stated that a surgeon, Dr. E.M., was in the room with Respondent and the patient and Dr. E.M. immediately became uncomfortable with Respondent because, according to Dr. E.M., Respondent appeared intoxicated, was slurring her speech, and seemed unable to hang IV fluids. Dr. E.M. then called for another nurse to enter the room, and paged the nursing supervisor. M.M. reported that Respondent told the nursing supervisor that Respondent had taken Darvacet for arthritis. Moreover, M.M. reported that the

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nursing supervisor told M.M. that Respondent was clearly impaired, had slurred speech, and was unable to stay awake. M.M. stated that Respondent's husband took Respondent home at that time. M.M. reported that on the date of the Mandatory Report, she called PPR and terminated Respondent's contract with the Facility.

5. Moreover, in her Mandatory Report, M.M. reported that the above-described incident occurred after an instance over the previous weekend where Respondent documented giving Vicodin to a patient that the patient said she never received.

6. On or about November 10, 2008 in an interview with State Investigator Steve Kennedy, Dr. E.M. stated that on or about October 8, 2008, Respondent received a patient post-operation. Dr. E.M. stated that Respondent did not understand anything Dr. E.M. said to her; Respondent appeared as though she was not present during their conversation; and that Respondent was not competent and Dr. E.M. was not comfortable with Respondent caring for her patient. Dr. E.M. stated that she reported Respondent's behavior to the nursing supervisor [M.H.].

7. On or about November 10, 2008 in an interview with Investigator Kennedy, Registered Nurse J.A. stated that on or about October 4, 2008 at approximately 9:00 a.m., J.A. assessed Patient T.N. and discussed with T.N. that T.N. had a pain medication at approximately 1:00 a.m. that morning. J.A. stated that although Respondent documented signing out Vicodin for T.N. at approximately 1:00 a.m. in the Medication Administration Record (the "MAR"), T.N. told J.A. that she did not receive any pain medication at that time.

8. The MAR for October 4, 2008 shows Respondent signed off as giving Vicodin Regular to Patient T.N. at 1:00 a.m., and Registered Nurse J.A.'s Progress Notes for October 4, 2008 at 9:00 a.m. document that Patient T.N. denied receiving Vicodin at 1:00 a.m. as noted on the MAR.

9. On or about November 12, 2008 in a telephone interview with Investigator Kennedy, Nursing Supervisor M.H. stated that on or about October 8, 2008, Dr. H.M. had reported to M.H. that he was concerned about Respondent's monitoring, in that Respondent had not taken the vital signs of Patient E.S. Thereafter, M.H. stated that Dr. E.M. reported her concerns – as described above in Paragraph 6 – regarding Respondent. M.H. stated that she then went into the room where Respondent and Registered Nurse N.H. were located, and that N.H. stated to M.H. that there was something wrong with Respondent. M.H. stated that when she asked Respondent how she felt, Respondent told M.H. that she was fine, but that she had taken a Darvocet for arthritis. M.H. stated that during her conversation with Respondent, Respondent never made eye contact; was slow to speak; spoke with a somewhat of a slur; and moved very slowly. M.H. stated Respondent followed M.H. to her office like a robot. After calling Nurse Manager M.M., M.H. sent Respondent home with her husband.

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10. On or about November 12, 2008 in a telephone interview with Investigator Kennedy, Registered Nurse N.H. stated on or about October 8, 2008, N.H. was Charge Nurse and walked into the room where Respondent was with a patient. N.H. stated that Respondent was attempting to hang an IV, but there was no line connected to it. N.H. also stated that Respondent was pushing the button pad on the IV pump, but was not touching any of the numbers. N.H. stated that Respondent was moving very slowly, and N.H. knew that something was not right with her.

11. On or about November 18, 2008 in a telephone interview with Investigator Kennedy, P.L., who worked at the Facility as a traveler nurse, stated that on a date she could not recall (which was reported to Investigator Kennedy by Nurse Manager M.M. to be October 4, 2008) at approximately 8:00 p.m., P.L. witnessed Respondent asleep at the nurse's desk with a sandwich in her hand and mayonnaise that had run onto her face. P.L. stated that she gave Respondent a poke and asked if she was fine, to which Respondent responded that she was. P.L. stated that she then heard Respondent mutter to herself. Later on this same night, P.L. stated that she saw Respondent asleep at the computer station in the hall and poked her again to wake her up.

12. On or about November 19, 2008 in an interview with Investigator Kennedy, Respondent denied being asleep at work on or about October 4, 2008. Moreover, Respondent stated that if she had signed out the Vicodin for Patient T.N., then T.N. must have received it. Respondent stated that on or about October 8, 2008, she had taken Darvocet for arthritis prior to going to work, but was not impaired; Respondent offered no further explanation for her behavior on that date. Respondent denied being impaired while on duty at the Facility.

13. On or about February 9, 2009, the Board summarily suspended Respondent's license.

Charges

14. 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, Rule IV(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 practice);

c. ARBN Chapter 4, Rule IV(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);

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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, Rule IV(II)(D)(3);

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).

Relief Requested

WHEREFORE, the license of Louise W. Hearn should be revoked, suspended, reprimanded, conditioned, or otherwise disciplined.

DATED at Montpelier, Vermont this 17th day of February, 2009.

STATE OF VERMONT
SECRETARY OF STATE

By: _____
Edward G. Adrian
State Prosecuting Attorney

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