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

IN RE:	)	
TRACI ANN HULL	)	Docket No. 2009-485
License No. 026.0037839	)	

STIPULATION AND CONSENT ORDER

STIPULATION

NOW COME the State of Vermont, by and through State Prosecuting Attorney BetsyAnn Wrask, and the Respondent, Traci Ann Hull, 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. Traci Ann Hull (the "Respondent") of Fairfax, Vermont is licensed by the State of Vermont as a Registered Nurse under license number 026.0037839. This license was originally issued on or about June 12, 2007 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 Practical Nurse under license number 025.0008506. This license was originally issued on or about June 29, 2004 and expired on or about January 31, 2008.

3. At all times relevant, Respondent was employed part-time (approximately twenty (20) hours per week) as a Registered Nurse at the postpartum mother/baby unit ("Shepardson 5") at Fletcher Allen Healthcare (the "Facility"), located in Burlington, Vermont.

4. On or about October 20, 2009, Facility Director of Pharmacy Services K.M. reported to Chief Investigator Amy Carlson that Respondent was suspected of drug diversion. K.M. advised that Respondent had been withdrawing narcotics from PYXIS (an electronic medication dispensing system) for several patients who were not assigned to Respondent, and that Respondent's removal of Morphine and Oxycodone from

PYXIS was far greater and outside the norm compared to other nurses on Shepardson 5.

5. On or about October 21, 2009 in an interview with State Investigator Karl Packer, Director of Pharmacy Services K.M. advised that Respondent was placed on leave for suspicion of drug diversion.

6. After Respondent was placed on administrative leave, Respondent advised Nurse Manager M.C. that she had checked herself into Day One. Day One is the Facility's out-patient clinic for substance use and co-occurring disorders which provides screening, assessment, treatment, and referral for addictions.

7. Morphine is not commonly used in Shepardson 5. Postpartum pain is normally controlled with Ibuprofen or Tylenol. In cases of greater postpartum pain, Percocet would normally be used.

8. Morphine in the PYXIS is held exclusively in 10mg ampules.

9. It is not common for nurses to medicate another nurse's patient in Shepardson 5.

Statement of Facts re: Patient N.D.

10. On or about September 30, 2009, Respondent was not assigned to Patient N.D.

11. On or about September 30, 2009 at 15:55, N.D. was discharged from the Facility.

12. On or about September 30, 2009 at 17:50, Respondent withdrew from the PYXIS two (2) Oxycodone I.R. 5mg tablets for N.D.

Statement of Facts re: Patient K.L.

13. On or about September 30, 2009, Respondent was assigned to Patient K.L.

14. On or about September 30, 2009 at 17:09, Respondent withdrew from the PYXIS one (1) Morphine 10mg 1ml ampule for K.L. Respondent documented in the Medication Administration Record (the "MAR") that she administered Morphine 5mg to K.L. at 17:00, but did not document wasting the remaining 5mg.

15. On or about September 30, 2009 at 17:11, Respondent withdrew from the PYXIS two (2) Oxycodone I.R. 5mg tablets for K.L. However, Respondent documented in the MAR that she did not administer this narcotic until 18:15.

16. On or about September 30, 2009 at 18:50, Respondent withdrew from the PYXIS one (1) Morphine 10mg 1ml ampule for K.L. Respondent documented in the MAR that she administered Morphine 5mg to K.L. at 18:30 – 20 minutes prior to this removal time – and did not document wasting the remaining 5mg.

17. On or about September 30, 2009, Respondent documented in the MAR that she administered Morphine 5mg to K.L. at 20:00. However, there are no corresponding removals or wastes of this narcotic in the PYXIS.

18. On or about September 30, 2009, Respondent documented in the MAR that she administered Morphine 5mg to K.L. at 22:00. However, there are no corresponding removals or wastes of this narcotic in the PYXIS.

19. On or about September 30, 2009 at 22:46, Respondent withdrew from the PYXIS two (2) Oxycodone I.R. 5mg tablets for K.L. Respondent documented in the MAR that she administered Oxycodone 10 mg to K.L. at 22:35.

Statement of Facts re: Patient D.E.

20. On or about September 30, 2009 and October 1, 2009, Respondent was assigned to Patient D.E.

21. On or about September 30, 2009 at 16:08, Respondent withdrew from the PYXIS one (1) Morphine 10mg 1ml ampule for D.E. Respondent documented in the MAR that she administered Morphine 5mg to D.E. at 16:00, but did not document wasting the remaining 5mg.

22. On or about September 30, 2009 at 17:10, Respondent withdrew from the PYXIS one (1) Morphine 10mg 1ml ampule for D.E. Respondent documented in the MAR that she administered Morphine 5mg to D.E. at 17:30, but did not document wasting the remaining 5mg.

23. On or about September 30, 2009 at 18:49, Respondent withdrew from the PYXIS one (1) Morphine 10mg 1ml ampule for D.E. Respondent documented in the MAR that she administered Morphine 5mg to D.E. at 19:00, but did not document wasting the remaining 5mg.

24. On or about September 30, 2009 at 21:00 and 22:30, Respondent documented in the MAR that she administered Morphine 5mg to D.E. However, there are no corresponding removals or wastes of this narcotic in the PYXIS.

25. On or about September 30, 2009 at 23:57, Respondent withdrew from the PYXIS two (2) Oxycodone I.R. 5mg tablets for D.E. Respondent did not document administering this narcotic to D.E. in the MAR.

26. On or about October 1, 2009 at 15:48, Respondent withdrew from the PYXIS two (2) Oxycodone I.R. 5mg tablets for D.E. Respondent did not document administering these narcotics to D.E. in the MAR.

27. On or about October 1, 2009 at 16:14, Respondent withdrew from the PYXIS one (1) Morphine 10mg 1ml ampule for D.E. Respondent documented in the MAR that she administered Morphine 5mg to D.E. at 16:00, but did not document wasting the remaining 5mg.

28. On or about October 1, 2009 at 17:49, Respondent withdrew from the PYXIS one (1) Morphine 10mg 1ml ampule for D.E. Respondent documented in the MAR that she administered Morphine 5mg to D.E. at 17:30, but did not document wasting the remaining 5mg.

29. On or about October 1, 2009 at 19:00, Respondent documented in the MAR that she administered Morphine 5mg to D.E. However, there are no corresponding removals or wastes of this narcotic in the PYXIS.

30. On or about October 1, 2009 at 19:37, Respondent withdrew from the PYXIS two (2) Oxycodone I.R. 5mg tablets for D.E. Respondent did not document administering this narcotic to D.E. in the MAR.

31. On or about October 1, 2009 at 21:12, Respondent withdrew from the PYXIS one (1) Morphine 10mg 1ml ampule for D.E. Respondent documented in the MAR that she administered Morphine 5mg to D.E. at 21:00, but did not document wasting the remaining 5mg.

32. On or about October 1, 2009 at 22:30, Respondent documented in the MAR that she administered Morphine 5mg to D.E. However, there are no corresponding removals or wastes of this narcotic in the PYXIS.

Statement of Facts re: Patient A.O.

33. On or about October 1, 2009, Respondent was not assigned to Patient A.O.

34. On or about October 1, 2009 at 15:30, A.O. was discharged from the Facility.

35. On or about October 1, 2009 at 15:46, Respondent withdrew from the PYXIS two (2) Oxycodone I.R. 5mg tablets for A.O.

Statement of Facts re: Patients S.L.; E.G.; M.T.; L.C.; and E.R.

36. On or about October 3, 2009, Respondent was not assigned to Patients S.L.; E.G.; M.T.; L.C.; and E.R.

37. On or about October 3, 2009, Respondent withdrew from the PYXIS Morphine 10mg/ml ampules; Hydromorphone 2mg tablets; or Oxycodone I.R. 5mg tablets for these patients.

38. On or about October 3, 2009 at 15:05, E.R. was discharged from the Facility.

39. On or about October 3, 2009 at 15:43:40 and again at 15:43:52, Respondent withdrew from the PYXIS one (1) Morphine 10mg/1ml ampule – for a total of 20mg Morphine – for E.R., after she had been discharged.

40. On or about October 3, 2009 at 15:44, Respondent withdrew from the PYXIS two (2) Oxycodone I.R. 5mg tablets for E.R., after she had been discharged.

41. On or about October 4, 2009, Respondent was not assigned to Patient S.L.

42. On or about October 4, 2009 at 13:30, S.L. was discharged from the Facility.

43. On or about October 4, 2009 at 13:37:17, Respondent withdrew from the PYXIS six (6) Oxycodone I.R. 5mg tablets for S.L., after she had been discharged.

44. On or about October 4, 2009 at 13:37:41, Respondent withdrew from the PYXIS two (2) Morphine 10mg/1ml ampules for S.L., after she had been discharged.

Statement of Facts re: Patient N.N.

45. On or about October 3 and 4, 2009, Respondent was assigned to Patient N.N.

46. On or about October 3, 2009 at 08:06, Respondent withdrew from the PYXIS one (1) Oxycodone I.R. 5mg tablet for N.N. Respondent documented in the MAR that she administered Oxycodone I.R. 5mg to N.N. at 10:05, approximately two (2) hours after she withdrew this narcotic. Respondent did not document this administration until on or about October 4, 2009 at 10:02.

47. On or about October 3, 2009 at 10:48, Respondent withdrew from the PYXIS one (1) Oxycodone I.R. 5mg tablet for N.N. Respondent documented in the MAR that she administered Oxycodone I.R. 5mg to N.N. at 13:30, over two and a half (2 ½) hours after she withdrew this narcotic. Respondent did not document this administration until on or about October 4, 2009 at 10:02 (same documentation time as above).

48. On or about October 4, 2009 at 10:54, Respondent withdrew one (1) Oxycodone I.R. 5mg tablet from the PYXIS for N.N. Respondent documented in the MAR that she administered Oxycodone I.R. 5mg to N.N. at 11:30. N.N. was discharged from the Facility at 11:30. Normally a vaginal delivery such as N.N.'s would not require this medication at discharge.

Statement of Facts re: Patient M.H.

49. On or about October 14, 2009, Respondent was assigned to Patient M.H.

50. On or about October 14, 2009 at 17:00, M.H. was discharged from the Facility.

51. On or about October 14, 2009 at 17:08, Respondent withdrew from the PYXIS one (1) Morphine 10mg/ml ampule for M.H., after she had been discharged.

52. On or about October 14, 2009 at 17:09:08, Respondent withdrew from the PYXIS two (2) Oxycodone I.R. 5mg tablets for M.H., after she had been discharged.

53. On or about October 14, 2009 at 17:09:40, Respondent cancelled a withdrawal from the PYXIS of Morphine 10mg/1ml ampule for M.H., after she had been discharged.

Statement of Facts re: Patients M.L.; K.D.; M.Z.; and R.D.

54. On or about October 14, 2009, Respondent was not assigned to Patients M.L.; K.D.; M.Z.; and R.D.

55. On or about October 14, 2009, Respondent withdrew from the PYXIS Oxycodone I.R. 5mg tablets; Hydromorphone 1mg/1ml ampules; or Morphine 10mg/1ml ampules for these patients.

56. On or about October 15, 2009, Respondent was not assigned to Patient M.Z.

57. On or about October 15, 2009 at 19:10, M.Z. was discharged from the Facility.

58. On or about October 15, 2009 at 19:14:25, and again at 19:14:39, Respondent removed from the PYXIS two (2) Oxycodone I.R. 5mg tablets for M.Z. – for a total of 20mg Oxycodone – after M.Z. had been discharged.

Statement of Facts re: Patient K.A.

59. On or about October 15, 2009, Respondent was not assigned to Patient K.A.

60. On or about October 15, 2009 at 13:50, K.A. was discharged from the Facility.

61. On or about October 15, 2009 at 15:52 and again at 16:52, Respondent withdrew from the PYXIS two (2) Oxycodone I.R. 5mg tablets – for a total of 20mg Oxycodone – for K.A., after she had been discharged.

Statement of Facts re: Patient D.H.

62. On or about October 15, 2009, Respondent was not assigned to Patient D.H.

63. On or about October 15, 2009 at 16:05, Respondent withdrew from the PYXIS one (1) Morphine 10mg/1ml ampule for D.H.

64. On or about October 15, 2009 at 17:40, D.H. was discharged from the Facility.

65. On or about October 15, 2009 at 17:57:05; 17:57:20; 20:09:23; and 20:09:39, Respondent withdrew from the PYXIS one (1) Morphine 10mg/1ml ampule – for a total of 40mg Morphine – for D.H., after she had been discharged.

66. On or about October 15, 2009 at 20:10, Respondent withdrew from the PYXIS two (2) Oxycodone I.R. 5mg tablets for D.H., after she had been discharged.

Statement of Facts re: Patient N.L.

67. On or about October 15, 2009, Respondent was not assigned to Patient N.L.

68. On or about October 15, 2009 at 16:54:15 and again at 16:54:38, Respondent withdrew from the PYXIS one (1) Morphine 10mg/1ml ampule – for a total of 20mg Morphine – for N.L.

Statement of Facts re: Patient J.A.

69. On or about October 17, 2009, Respondent was not assigned to Patient J.A.

70. On or about October 17, 2009 at 13:30, J.A. was discharged from the Facility.

71. Respondent documented in J.A.'s MAR that she administered Morphine 5mg to J.A. on four (4) occasions on or about October 17, 2009 at 08:00; 10:00; 11:30; and 13:00. However, Respondent did not make any withdrawals from the PYXIS of Morphine 10mg 1ml for Patient J.A. on this date until two (2) simultaneous withdrawals at 15:56 (for a total of Morphine 20mg), after J.A. had been discharged from the Facility. Moreover, Respondent documented these four (4) administrations simultaneously at 15:53 on this date.

72. Respondent documented in J.A.'s MAR that she administered Oxycodone I.R. tablets to J.A. on three (3) occasions on or about October 17, 2009: 5mg at 08:00; 5mg at 10:30; and 10mg at 13:30. However, Respondent did not make any withdrawals from the PYXIS of Oxycodone I.R. 5mg tablets for Patient J.A. on this date until a withdrawal of two (2) Oxycodone I.R. 5mg tablets at15:50, and another withdrawal of two (2) Oxycodone I.R. 5mg tablets at 15:51, after J.A. had been discharged from the Facility. Moreover, Respondent documented these three (3) administrations at 15:53 at 15:54 on this date.

Statement of Facts re: Patient A.C.

73. On or about October 17, 2009, Respondent was not assigned to Patient A.C.

74. On or about October 17, 2009 at 13:30, A.C. was discharged from the Facility.

75. On or about October 17, 2009 at 15:49 and again at 15:50, Respondent withdrew from the PYXIS two (2) Oxycodone I.R. 5mg tablets – for a total of 20mg Oxycodone – for A.C., after she had been discharged.

Statement of Facts re: Patient M.C.

76. On or about October 17, 2009, Respondent was assigned to Patient M.C.

77. On or about October 17, 2009 at 13:20, Respondent withdrew from the PYXIS one (1) Hydromorphone 1mg/1ml for M.C. Respondent provided the override justification of "Urgent Need" in order to make this withdrawal. Respondent documented in the MAR that she administered 0.6 mg Hydromorphone to M.C. at 13:30. Respondent did not document wasting the remaining 0.4 mg Hydromorphone.

78. On or about October 17, 2009 at 13:21 (one minute after the previous withdrawal), Respondent withdrew from the PYXIS two (2) Hydromorphone 2 mg tablets for M.C. Respondent provided the override justification of "Urgent Need" in order to make this withdrawal. Respondent documented in the MAR that she administered 4mg of Hydromorphone tablets to M.C. at 13:30 (Respondent's documented administration of this narcotic is simultaneous with her documented administration of injectable Hydromorphone, above).

79. Overrides with a justification of urgent need are unusual for a vaginal delivery.

80. On or about October 17, 2009 at 13:40, Respondent withdrew from the PYXIS two (2) Hydromorphone 2mg tablets for M.C. Respondent documented in the MAR that she administered 4mg of Hydromorphone tablets at 17:00. However, Respondent did not document this administration until on or about October 18, 2009 at 07:08.

81. On or about October 17, 2009 at 13:42 (two minutes after the previous withdrawal), Respondent withdrew from the PYXIS one (1) Hydromorphone 1mg/1ml for M.C. Respondent documented in the MAR that she administered 0.6 mg Hydromorphone to M.C. at 15:00, and had a witness to waste the remaining 0.4 mg Hydromorphone. However, Respondent did not document her administration of this narcotic until on or about October 18, 2009 at 07:08 (same documentation time as above).

82. Hydromorphone injections and tablets are an unusual choice of drugs for a vaginal delivery.

Statement of Facts re: Patient K.M.

83. On or about October 17, 2009, Respondent was not assigned to Patient K.M.

84. On or about October 17, 2009 at 13:55, K.M. was discharged from the Facility.

85. On or about October 17, 2009 at 14:26, Respondent withdrew from the PYXIS two (2) Oxycodone I.R. 5mg tablets for K.M., after she had been discharged. Moreover, Respondent documented that she administered this narcotic at 12:30, prior to her withdrawal. Respondent did not document this administration until 15:58 on this date.

Statement of Facts re: Patient S.N.

86. On or about October 17, 2009, Respondent was not assigned to Patient S.N.

87. On or about October 17, 2009 at 11:30, S.N. was discharged from the Facility.

88. On or about October 17, 2009 at 11:32, Respondent withdrew from the PYXIS four (4) Oxycodone I.R. 5mg tablets for S.N., after she had been discharged.

Statement of Facts re: Patient T.C.

89. On or about October 17 and 18, 2009, Respondent was assigned to Patient T.C.

90. On or about October 17, 2009, Respondent clocked in at the Facility at 07:03 and clocked out at 15:58.

91. On or about October 18, 2009, Respondent clocked in at the Facility at 06:54 and clocked out at 14:15.

92. At all times relevant, T.C. was ordered to be administered Morphine injections 5mg every two (2) hours PRN (as needed).

93. On or about October 17, 2009 at 09:14 and again at 09:15, Respondent withdrew from the PYXIS one (1) Morphine 10mg/1ml ampule for T.C., for a total of 20mg Morphine. Respondent documented in the MAR that she administered Morphine 5mg to T.C. at 12:00; however, Respondent did not document this administration until on or about October 18, 2009 at 11:50. Moreover, Respondent did not document wasting the remaining 15mg Morphine.

94. On or about October 17, 2009, Respondent documented in the MAR that she administered Morphine 5mg to T.C. at 13:30. There was no corresponding withdrawal or wasting documented in the PYXIS for this administration. Moreover, Respondent did not document this administration until on or about October 18, 2009 at 11:50 (same documentation time as above).

95. On or about October 17, 2009, Respondent documented in the MAR that she administered Morphine 5mg to T.C. at 15:00. There was no corresponding withdrawal or wasting documented in the PYXIS for this administration. Moreover, Respondent did not document a pain assessment to justify why this narcotic was administered sooner than was ordered. Furthermore, Respondent did not document

this administration until on or about October 18, 2009 at 11:50 (same documentation time as above).

96. On or about October 17, 2009, Respondent documented in the MAR that she administered Morphine 5mg to T.C. at 16:30. Respondent had already clocked out of the Facility by 15:58 on this date. There was no corresponding withdrawal or wasting documented in the PYXIS for this administration. Moreover, Respondent did not document a pain assessment to justify why this narcotic was administered sooner than was ordered. Furthermore, Respondent did not document this administration until on or about October 18, 2009 at 11:50 (same documentation time as above).

97. On or about October 17, 2009, Respondent documented in the MAR that she cancelled an administration of Morphine 5mg to T.C. at 18:00. Respondent had already clocked out of the Facility by 15:58 on this date. There was no corresponding withdrawal or wasting documented in the PYXIS for this cancelled administration. Moreover, Respondent did not document this cancelled administration until on or about October 18, 2009 at 11:51 (documentation time similar to above).

98. On or about October 18, 2009 at 11:52, Respondent documented that she administered Morphine 5mg to T.C. at 00:00 (documentation time similar to above). However, Respondent did not clock in at the Facility until 06:54 on this date.

99. On or about October 18, 2009 at 11:52, Respondent documented that she administered Morphine 5mg to T.C. at 02:00 (documentation time same as above). However, Respondent did not clock in at the Facility until 06:54 on this date.

100. On or about October 18, 2009 at 11:52, Respondent documented that she administered Morphine 5mg to T.C. at 03:30 (documentation time same as above). However, Respondent did not clock in at the Facility until 06:54 on this date.

101. On or about October 18, 2009 at 07:29 and again at 07:30, Respondent removed from the PYXIS one (1) Morphine 10mg/1ml ampule for T.C., for a total of 20mg Morphine. Respondent documented in the MAR that she administered Morphine 5mg to T.C. at 05:00. However, Respondent did not clock in at the Facility on this date until 06:54. Moreover, Respondent did not document wasting the remaining 15mg Morphine. Furthermore, Respondent did not document this administration until 11:52 on this date (documentation time same as above).

102. On or about October 18, 2009, Respondent documented in the MAR that she administered Morphine 5mg to T.C. at 06:30. However, Respondent did not clock in at the Facility on this date until 06:54. There was no corresponding withdrawal or wasting documented in the PYXIS for this administration. Moreover, Respondent did not document a pain assessment to justify why this narcotic was administered sooner than was ordered. Furthermore, Respondent did not document this administration until 11:52 on this date (documentation time same as above).

103. On or about October 18, 2009, Respondent documented in the MAR that she administered Morphine 5mg to T.C. at 08:00. There was no corresponding withdrawal or wasting documented in the PYXIS for this administration. Moreover, Respondent did not document a pain assessment to justify why this narcotic was administered sooner than was ordered. Furthermore, Respondent did not document this administration until 11:52 on this date (documentation time same as above).

104. On or about October 18, 2009, Respondent documented in the MAR that she administered Morphine 5mg to T.C. at 09:30. There was no corresponding withdrawal or wasting documented in the PYXIS for this administration. Moreover, Respondent did not document a pain assessment to justify why this narcotic was administered sooner than was ordered. Furthermore, Respondent did not document this administration until 11:51 on this date (documentation time similar to above).

105. On or about October 18, 2009 at 09:53, Respondent withdrew from the PYXIS one (1) Morphine 10mg/1ml ampule for T.C. Respondent documented in the MAR that she administered Morphine 5mg to T.C. at 11:00. T.C. was discharged from the Facility at 11:16. Respondent did not document wasting the remaining 5mg Morphine. Moreover, Respondent did not document this administration until 11:51 on this date (documentation time same as above).

106. Nurses in Shepardson 5 do not normally give patients morphine right before they are discharged.

107. On or about October 18, 2009 at 11:27, Respondent withdrew from the PYXIS one (1) Morphine 10mg/1ml ampule for T.C. T.C. had already been discharged from the Facility at 11:16 on this date.

108. At all times relevant, T.C. was ordered to be administered Oxycodone 5-10mg every four (4) hours PRN (as needed).

109. On or about October 18, 2009 at 11:50, Respondent documented that she administered Oxycodone 10mg to T.C. at 03:00. Respondent did not clock in to the Facility until 06:54 on this date.

110. On or about October 18, 2009 at 07:30, Respondent withdrew from the PYXIS two (2) Oxycodone I.R. 5mg tablets for T.C. Respondent documented in the MAR that she administered Oxycodone 10mg to T.C. at 07:30. Respondent did not document this administration until 11:49 on this date.

111. On or about October 18, 2009 at 09:39, Respondent withdrew from the PYXIS two (2) Oxycodone I.R. 5mg tablets for T.C. Respondent documented in the MAR that she administered Oxycodone 10mg to T.C. at 11:00. T.C. was discharged from the Facility at 11:16. Respondent did not document a pain assessment to justify why this narcotic was administered sooner than was ordered. Moreover, Respondent did not

document this administration until 11:49 on this date (documentation time same as above).

112. On or about October 18, 2009 at 11:28, Respondent withdrew from the PYXIS two (2) Oxycodone I.R. 5mg tablets for T.C. T.C. had already been discharged from the Facility at 11:16 on this date. Respondent made no documentation regarding this withdrawal in the MAR.

Statement of Facts re: Patient K.G.

113. On or about October 18, 2009, Respondent was not assigned to Patient K.G.

114. On or about October 18, 2009 at 12:25, K.G. was discharged from the Facility.

115. On or about October 18, 2009 at 12:40 and again at 12:41, Respondent withdrew from the PYXIS two (2) Oxycodone I.R. 5mg tablets – for a total of 20 mg Oxycodone I.R. – for K.G., after K.G. had been discharged.

Statement of Facts re: Patient K.D.

116. On or about October 18, 2009, Respondent was not assigned to Patient K.D. Patient K.D. was assigned to Registered Nurse K.D.

117. On or about October 18, 2009 at 10:27, Respondent withdrew from the PYXIS three (3) Hydromorphone 2mg tablets for Patient K.D. Respondent did not document administering this narcotic in the MAR.

118. Thereafter, on or about October 18, 2009, RN K.D. queried PYXIS regarding the last medication administration for this patient. RN K.D. saw that Respondent had withdrawn the three (3) Hydromorphone tablets at 10:27 for Patient K.D., but saw that no administration was documented in the MAR. Therefore, RN K.D. asked this patient whether she had been administered this pain medication, and the patient stated she had not. RN K.D. then reported this information to Charge Nurse V.C.

Statement of Facts re: Respondent's Anomalous Use by Month

119. Respondent worked part-time at Shepardson 5, usually working around twenty (20) hours per week.

120. The mean withdrawal numbers reported below include full-time and part-time nurses.

121. In or around April 2009, Respondent made forty (40) Oxycodone 5mg tablet withdrawals. The mean withdrawal amount for all nurses in Shepardson 5 during this month was thirteen (13). Respondent made no Morphine or Hydromorphone withdrawals.

122. In or around May 2009, Respondent made sixty-two (62) Oxycodone 5mg tablet withdrawals. The mean withdrawal amount for Shepardson 5 during this month was eleven (11). Respondent made eleven (11) Morphine 10mg/1ml ampule withdrawals during this month; the mean for Shepardson 5 was two (2). Respondent made no Hydromorphone withdrawals.

123. In or around June 2009, Respondent made thirty-four (34) Oxycodone 5mg tablet withdrawals. The mean withdrawal amount for Shepardson 5 during this month was ten (10). Respondent made twenty-five (25) Morphine 10mg/1ml ampule withdrawals during this month; the mean for Shepardson 5 was three (3). Respondent made no Hydromorphone withdrawals.

124. In or around July 2009, Respondent made forty-one (41) Oxycodone 5mg tablet withdrawals. The mean withdrawal amount for Shepardson 5 during this month was fourteen (14). Respondent made forty-five (45) Morphine 10mg/1ml ampule withdrawals during this month; the mean for Shepardson 5 was three (3). Respondent made no Hydromorphone withdrawals.

125. In or around August 2009, Respondent made fifty-three (53) Oxycodone 5mg tablet withdrawals. The mean withdrawal amount for Shepardson 5 during this month was seventeen (17). Respondent made fifty-three (53) Morphine 10mg/1ml ampule withdrawals during this month; the mean for Shepardson 5 was three (3). Respondent made five (5) Hydromorphone 2mg tablet withdrawals during this month; the mean for Shepardson 5 was two (2).

126. In or around September 2009, Respondent made one hundred fifty-one (151) Oxycodone 5mg tablet withdrawals. The mean withdrawal amount for Shepardson 5 during this month was eighteen (18). Respondent made ninety-one (91) Morphine 10mg/1ml ampule withdrawals during this month; the mean for Shepardson 5 was seven (7). Respondent made thirty-two (32) Hydromorphone 2mg tablet withdrawals during this month; the mean for Shepardson 5 was eleven (11).

127. From on or about October 1, 2009 through on or about October 8, 2009, Respondent made ninety-one (91) Oxycodone 5mg tablet withdrawals. The mean withdrawal amount for Shepardson 5 during this time period was thirteen (13). Respondent made thirty-eight (38) Morphine 10mg/1ml ampule withdrawals during this time period; the mean for Shepardson 5 was four (4). Respondent made fifteen (15) Hydromorphone 2mg tablet withdrawals during this time period; the mean for Shepardson 5 was seven (7).

128. On or about October 27, 2009, State Investigator Karl Packer and DEA Diversion Investigator Chris Paquette met with the Respondent at her home and were told by the Respondent that she was declining to speak with them based on the advice of her attorney.

129. On or about May 12, 2010, the Board summarily suspended Respondent's license.

Charges

130. 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);

d. 26 V.S.A. § 1582(a)(5) (Is habitually intemperate or is addicted to the use of habit-forming drugs);

e. 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); and diverting supplies, equipment, or drugs for personal or other unauthorized use pursuant to ARBN Chapter 4, Rule IV(II)(D)(4);

f. 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);

g. 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

h. 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

131. 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 these charges by a preponderance of the evidence if this matter went to a hearing and agrees that the conditions below are necessary to protect the public.

132. 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.

133. 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.

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

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

136. 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.

137. 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.

138. 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 for a **MINIMUM OF SIX (6) MONTHS retroactive to date of Respondent's summary suspension, May 12, 2010**. 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 and who has verified receipt of this Order, the results of which must indicate that the Respondent does not present a risk to the safety, health or welfare of her potential patients; **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; **3)** enter into a treating professional agreement with a treating professional pre-approved by the Board; and **4)** enter into a substance abuse treatment plan approved by the Board with the pre-approved treating professional. The Respondent's license shall not be reinstated until these prerequisites are met, regardless of whether more than six (6) months have passed since the suspension went into effect. 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 participate as 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.

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 Respondent's substance abuse issue(s) 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

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.

(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.

(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 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
SECRETARY OF STATE

Dated: 10·4·10

By: _____
BetsyAnn Wrask
State Prosecuting Attorney

TRACI ANN HULL
RESPONDENT

Dated: 9/29/10

By: _____
Traci Ann Hull

APPROVED AS TO FORM:

ATTORNEY FOR RESPONDENT

Dated: 9/29/10

By: _____
John L. Pacht, Esq.

APPROVED AND SO ORDERED:

VERMONT BOARD OF NURSING

Dated: 10·11·10

By: _____
Chairperson

Date of Entry: 10/13/10
nu.hull.stip3

STATE OF VERMONT
BOARD OF NURSING

In re: Traci Ann Hull	}	
License No. 026-37839 and 025-8506	}	Docket No. 2009-485
	}	

DECISION ON REQUEST FOR SUMMARY SUSPENSION ORDER

Appearances:
for Petitioner, State of Vermont: Betsy Ann Wrask
for Respondent: John L. Pacht (entered appearance, did not participate in hearing)

Presiding Officer: Larry S. Novins

Summary Suspension Order
FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

On May 10, 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. Hull did not appear. Her attorney entered an appearance on her behalf and by letter dated May 6, 2010 informed the Board that Ms. Hull would not contest the summary suspension of her license.

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. Hull is licensed as both a registered nurse and practical nurse 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. Hull was diverting and mishandling controlled substances.
3. The State further alleges that the public health, safety or welfare imperatively requires

emergency action.

4. Notice of this hearing was sent to Ms. Hull at her last known address via certified mail dated which she has received.
5. The Board has reviewed documents presented by the State.
6. The Board finds for purposes of this hearing that Ms. Hull while employed was mishandling controlled substances and was abusing controlled substances.
7. Ms. Hull does not contest the State's request to summarily suspend her license.
8. The allegations in the Request for Summary Suspension (copy attached) have been established to the necessary degree.
9. The evidence presented does imperatively require emergency action for the public health, safety, and welfare.

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 and Ms. Hull's agreement to the suspension do support Summary Suspension of her 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. Hull 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. Hull 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. Hull's licenses are 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: _____ Date: May 10, 2010
Ellen Leff, RN, Chair

OFFICE OF PROFESSIONAL REGULATION

DATE OF ENTRY: 5/12/10

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

IN RE:	)	
TRACI ANN HULL	)	Docket No. 2009-485
License Nos. 026.0037839; 025.0008506	)	

REQUEST FOR SUMMARY SUSPENSION

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. Traci Ann Hull (the "Respondent") of Fairfax, Vermont is licensed by the State of Vermont as a Registered Nurse under license number 026.0037839. This license was originally issued on or about June 12, 2007 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 Practical Nurse under license number 025.0008506. This license was originally issued on or about June 29, 2004 and expired on or about January 31, 2008.

4. At all times relevant, Respondent was employed part-time (approximately twenty (20) hours per week) as a Registered Nurse at the postpartum mother/baby unit ("Shepardson 5") at Fletcher Allen Healthcare (the "Facility"), located in Burlington, Vermont.

5. On or about October 20, 2009, Facility Director of Pharmacy Services K.M. reported to Chief Investigator Amy Carlson that Respondent was suspected of drug diversion. K.M. advised that Respondent had been withdrawing narcotics from PYXIS (an electronic medication dispensing system) for several patients who were not assigned to Respondent, and that Respondent's removal of Morphine and Oxycodone from PYXIS was far greater and outside the norm compared to other nurses on Shepardson 5.

6. On or about October 21, 2009 in an interview with State Investigator Karl Packer, Director of Pharmacy Services K.M. advised that Respondent was placed on leave for suspicion of drug diversion.

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

7. After Respondent was placed on administrative leave, Respondent advised Nurse Manager M.C. that she had checked herself into Day One. Day One is the Facility's out-patient clinic for substance use and co-occurring disorders which provides screening, assessment, treatment, and referral for addictions.

8. Morphine is not commonly used in Shepardson 5. Postpartum pain is normally controlled with Ibuprofen or Tylenol. In cases of greater postpartum pain, Percocet would normally be used.

9. Morphine in the PYXIS is held exclusively in 10mg ampules.

10. It is not common for nurses to medicate another nurse's patient in Shepardson 5.

Statement of Facts re: Patient N.D.

11. On or about September 30, 2009, Respondent was not assigned to Patient N.D.

12. On or about September 30, 2009 at 15:55, N.D. was discharged from the Facility.

13. On or about September 30, 2009 at 17:50, Respondent withdrew from the PYXIS two (2) Oxycodone I.R. 5mg tablets for N.D.

Statement of Facts re: Patient K.L.

14. On or about September 30, 2009, Respondent was assigned to Patient K.L.

15. On or about September 30, 2009 at 17:09, Respondent withdrew from the PYXIS one (1) Morphine 10mg 1ml ampule for K.L. Respondent documented in the Medication Administration Record (the "MAR") that she administered Morphine 5mg to K.L. at 17:00, but did not document wasting the remaining 5mg.

16. On or about September 30, 2009 at 17:11, Respondent withdrew from the PYXIS two (2) Oxycodone I.R. 5mg tablets for K.L. However, Respondent documented in the MAR that she did not administer this narcotic until 18:15.

17. On or about September 30, 2009 at 18:50, Respondent withdrew from the PYXIS one (1) Morphine 10mg 1ml ampule for K.L. Respondent documented in the MAR that she administered Morphine 5mg to K.L. at 18:30 – 20 minutes prior to this removal time – and did not document wasting the remaining 5mg.

18. On or about September 30, 2009, Respondent documented in the MAR that she administered Morphine 5mg to K.L. at 20:00. However, there are no corresponding removals or wastes of this narcotic in the PYXIS.

STATE OF VERMONT

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

19. On or about September 30, 2009, Respondent documented in the MAR that she administered Morphine 5mg to K.L. at 22:00. However, there are no corresponding removals or wastes of this narcotic in the PYXIS.

20. On or about September 30, 2009 at 22:46, Respondent withdrew from the PYXIS two (2) Oxycodone I.R. 5mg tablets for K.L. Respondent documented in the MAR that she administered Oxycodone 10 mg to K.L. at 22:35.

Statement of Facts re: Patient D.E.

21. On or about September 30, 2009 and October 1, 2009, Respondent was assigned to Patient D.E.

22. On or about September 30, 2009 at 16:08, Respondent withdrew from the PYXIS one (1) Morphine 10mg 1ml ampule for D.E. Respondent documented in the MAR that she administered Morphine 5mg to D.E. at 16:00, but did not document wasting the remaining 5mg.

23. On or about September 30, 2009 at 17:10, Respondent withdrew from the PYXIS one (1) Morphine 10mg 1ml ampule for D.E. Respondent documented in the MAR that she administered Morphine 5mg to D.E. at 17:30, but did not document wasting the remaining 5mg.

24. On or about September 30, 2009 at 18:49, Respondent withdrew from the PYXIS one (1) Morphine 10mg 1ml ampule for D.E. Respondent documented in the MAR that she administered Morphine 5mg to D.E. at 19:00, but did not document wasting the remaining 5mg.

25. On or about September 30, 2009 at 21:00 and 22:30, Respondent documented in the MAR that she administered Morphine 5mg to D.E. However, there are no corresponding removals or wastes of this narcotic in the PYXIS.

26. On or about September 30, 2009 at 23:57, Respondent withdrew from the PYXIS two (2) Oxycodone I.R. 5mg tablets for D.E. Respondent did not document administering this narcotic to D.E. in the MAR.

27. On or about October 1, 2009 at 15:48, Respondent withdrew from the PYXIS two (2) Oxycodone I.R. 5mg tablets for D.E. Respondent did not document administering these narcotics to D.E. in the MAR.

28. On or about October 1, 2009 at 16:14, Respondent withdrew from the PYXIS one (1) Morphine 10mg 1ml ampule for D.E. Respondent documented in the MAR that she administered Morphine 5mg to D.E. at 16:00, but did not document wasting the remaining 5mg.

STATE OF VERMONT

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

29. On or about October 1, 2009 at 17:49, Respondent withdrew from the PYXIS one (1) Morphine 10mg 1ml ampule for D.E. Respondent documented in the MAR that she administered Morphine 5mg to D.E. at 17:30, but did not document wasting the remaining 5mg.

30. On or about October 1, 2009 at 19:00, Respondent documented in the MAR that she administered Morphine 5mg to D.E. However, there are no corresponding removals or wastes of this narcotic in the PYXIS.

31. On or about October 1, 2009 at 19:37, Respondent withdrew from the PYXIS two (2) Oxycodone I.R. 5mg tablets for D.E. Respondent did not document administering this narcotic to D.E. in the MAR.

32. On or about October 1, 2009 at 21:12, Respondent withdrew from the PYXIS one (1) Morphine 10mg 1ml ampule for D.E. Respondent documented in the MAR that she administered Morphine 5mg to D.E. at 21:00, but did not document wasting the remaining 5mg.

33. On or about October 1, 2009 at 22:30, Respondent documented in the MAR that she administered Morphine 5mg to D.E. However, there are no corresponding removals or wastes of this narcotic in the PYXIS.

Statement of Facts re: Patient A.O.

34. On or about October 1, 2009, Respondent was not assigned to Patient A.O.

35. On or about October 1, 2009 at 15:30, A.O. was discharged from the Facility.

36. On or about October 1, 2009 at 15:46, Respondent withdrew from the PYXIS two (2) Oxycodone I.R. 5mg tablets for A.O.

Statement of Facts re: Patients S.L.; E.G.; M.T.; L.C.; and E.R.

37. On or about October 3, 2009, Respondent was not assigned to Patients S.L.; E.G.; M.T.; L.C.; and E.R.

38. On or about October 3, 2009, Respondent withdrew from the PYXIS Morphine 10mg/ml ampules; Hydromorphone 2mg tablets; or Oxycodone I.R. 5mg tablets for these patients.

39. On or about October 3, 2009 at 15:05, E.R. was discharged from the Facility.

40. On or about October 3, 2009 at 15:43:40 and again at 15:43:52, Respondent withdrew from the PYXIS one (1) Morphine 10mg/1ml ampule – for a total of 20mg Morphine – for E.R., after she had been discharged.

STATE OF VERMONT

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

41. On or about October 3, 2009 at 15:44, Respondent withdrew from the PYXIS two (2) Oxycodone I.R. 5mg tablets for E.R., after she had been discharged.

42. On or about October 4, 2009, Respondent was not assigned to Patient S.L.

43. On or about October 4, 2009 at 13:30, S.L. was discharged from the Facility.

44. On or about October 4, 2009 at 13:37:17, Respondent withdrew from the PYXIS six (6) Oxycodone I.R. 5mg tablets for S.L., after she had been discharged.

45. On or about October 4, 2009 at 13:37:41, Respondent withdrew from the PYXIS two (2) Morphine 10mg/1ml ampules for S.L., after she had been discharged.

Statement of Facts re: Patient N.N.

46. On or about October 3 and 4, 2009, Respondent was assigned to Patient N.N.

47. On or about October 3, 2009 at 08:06, Respondent withdrew from the PYXIS one (1) Oxycodone I.R. 5mg tablet for N.N. Respondent documented in the MAR that she administered Oxycodone I.R. 5mg to N.N. at 10:05, approximately two (2) hours after she withdrew this narcotic. Respondent did not document this administration until on or about October 4, 2009 at 10:02.

48. On or about October 3, 2009 at 10:48, Respondent withdrew from the PYXIS one (1) Oxycodone I.R. 5mg tablet for N.N. Respondent documented in the MAR that she administered Oxycodone I.R. 5mg to N.N. at 13:30, over two and a half (2 ½) hours after she withdrew this narcotic. Respondent did not document this administration until on or about October 4, 2009 at 10:02 (same documentation time as above).

49. On or about October 4, 2009 at 10:54, Respondent withdrew one (1) Oxycodone I.R. 5mg tablet from the PYXIS for N.N. Respondent documented in the MAR that she administered Oxycodone I.R. 5mg to N.N. at 11:30. N.N. was discharged from the Facility at 11:30. Normally a vaginal delivery such as N.N.'s would not require this medication at discharge.

Statement of Facts re: Patient M.H.

50. On or about October 14, 2009, Respondent was assigned to Patient M.H.

51. On or about October 14, 2009 at 17:00, M.H. was discharged from the Facility.

52. On or about October 14, 2009 at 17:08, Respondent withdrew from the PYXIS one (1) Morphine 10mg/ml ampule for M.H., after she had been discharged.

53. On or about October 14, 2009 at 17:09:08, Respondent withdrew from the PYXIS two (2) Oxycodone I.R. 5mg tablets for M.H., after she had been discharged.

STATE OF VERMONT

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

54. On or about October 14, 2009 at 17:09:40, Respondent cancelled a withdrawal from the PYXIS of Morphine 10mg/1ml ampule for M.H., after she had been discharged.

Statement of Facts re: Patients M.L.; K.D.; M.Z.; and R.D.

55. On or about October 14, 2009, Respondent was not assigned to Patients M.L.; K.D.; M.Z.; and R.D.

56. On or about October 14, 2009, Respondent withdrew from the PYXIS Oxycodone I.R. 5mg tablets; Hydromorphone 1mg/1ml ampules; or Morphine 10mg/1ml ampules for these patients.

57. On or about October 15, 2009, Respondent was not assigned to Patient M.Z.

58. On or about October 15, 2009 at 19:10, M.Z. was discharged from the Facility.

59. On or about October 15, 2009 at 19:14:25, and again at 19:14:39, Respondent removed from the PYXIS two (2) Oxycodone I.R. 5mg tablets for M.Z. – for a total of 20mg Oxycodone – after M.Z. had been discharged.

Statement of Facts re: Patient K.A.

60. On or about October 15, 2009, Respondent was not assigned to Patient K.A.

61. On or about October 15, 2009 at 13:50, K.A. was discharged from the Facility.

62. On or about October 15, 2009 at 15:52 and again at 16:52, Respondent withdrew from the PYXIS two (2) Oxycodone I.R. 5mg tablets – for a total of 20mg Oxycodone – for K.A., after she had been discharged.

Statement of Facts re: Patient D.H.

63. On or about October 15, 2009, Respondent was not assigned to Patient D.H.

64. On or about October 15, 2009 at 16:05, Respondent withdrew from the PYXIS one (1) Morphine 10mg/1ml ampule for D.H.

65. On or about October 15, 2009 at 17:40, D.H. was discharged from the Facility.

66. On or about October 15, 2009 at 17:57:05; 17:57:20; 20:09:23; and 20:09:39, Respondent withdrew from the PYXIS one (1) Morphine 10mg/1ml ampule – for a total of 40mg Morphine – for D.H., after she had been discharged.

67. On or about October 15, 2009 at 20:10, Respondent withdrew from the PYXIS two (2) Oxycodone I.R. 5mg tablets for D.H., after she had been discharged.

STATE OF VERMONT

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

Statement of Facts re: Patient N.L.

68. On or about October 15, 2009, Respondent was not assigned to Patient N.L.

69. On or about October 15, 2009 at 16:54:15 and again at 16:54:38, Respondent withdrew from the PYXIS one (1) Morphine 10mg/1ml ampule – for a total of 20mg Morphine – for N.L.

Statement of Facts re: Patient J.A.

70. On or about October 17, 2009, Respondent was not assigned to Patient J.A.

71. On or about October 17, 2009 at 13:30, J.A. was discharged from the Facility.

72. Respondent documented in J.A.'s MAR that she administered Morphine 5mg to J.A. on four (4) occasions on or about October 17, 2009 at 08:00; 10:00; 11:30; and 13:00. However, Respondent did not make any withdrawals from the PYXIS of Morphine 10mg 1ml for Patient J.A. on this date until two (2) simultaneous withdrawals at 15:56 (for a total of Morphine 20mg), after J.A. had been discharged from the Facility. Moreover, Respondent documented these four (4) administrations simultaneously at 15:53 on this date.

73. Respondent documented in J.A.'s MAR that she administered Oxycodone I.R. tablets to J.A. on three (3) occasions on or about October 17, 2009: 5mg at 08:00; 5mg at 10:30; and 10mg at 13:30. However, Respondent did not make any withdrawals from the PYXIS of Oxycodone I.R. 5mg tablets for Patient J.A. on this date until a withdrawal of two (2) Oxycodone I.R. 5mg tablets at15:50, and another withdrawal of two (2) Oxycodone I.R. 5mg tablets at 15:51, after J.A. had been discharged from the Facility. Moreover, Respondent documented these three (3) administrations at 15:53 at 15:54 on this date.

Statement of Facts re: Patient A.C.

74. On or about October 17, 2009, Respondent was not assigned to Patient A.C.

75. On or about October 17, 2009 at 13:30, A.C. was discharged from the Facility.

76. On or about October 17, 2009 at 15:49 and again at 15:50, Respondent withdrew from the PYXIS two (2) Oxycodone I.R. 5mg tablets – for a total of 20mg Oxycodone – for A.C., after she had been discharged.

Statement of Facts re: Patient M.C.

77. On or about October 17, 2009, Respondent was assigned to Patient M.C.

STATE OF VERMONT

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

78. On or about October 17, 2009 at 13:20, Respondent withdrew from the PYXIS one (1) Hydromorphone 1mg/1ml for M.C. Respondent provided the override justification of "Urgent Need" in order to make this withdrawal. Respondent documented in the MAR that she administered 0.6 mg Hydromorphone to M.C. at 13:30. Respondent did not document wasting the remaining 0.4 mg Hydromorphone.

79. On or about October 17, 2009 at 13:21 (one minute after the previous withdrawal), Respondent withdrew from the PYXIS two (2) Hydromorphone 2 mg tablets for M.C. Respondent provided the override justification of "Urgent Need" in order to make this withdrawal. Respondent documented in the MAR that she administered 4mg of Hydromorphone tablets to M.C. at 13:30 (Respondent's documented administration of this narcotic is simultaneous with her documented administration of injectable Hydromorphone, above).

80. Overrides with a justification of urgent need are unusual for a vaginal delivery.

81. On or about October 17, 2009 at 13:40, Respondent withdrew from the PYXIS two (2) Hydromorphone 2mg tablets for M.C. Respondent documented in the MAR that she administered 4mg of Hydromorphone tablets at 17:00. However, Respondent did not document this administration until on or about October 18, 2009 at 07:08.

82. On or about October 17, 2009 at 13:42 (two minutes after the previous withdrawal), Respondent withdrew from the PYXIS one (1) Hydromorphone 1mg/1ml for M.C. Respondent documented in the MAR that she administered 0.6 mg Hydromorphone to M.C. at 15:00, and had a witness to waste the remaining 0.4 mg Hydromorphone. However, Respondent did not document her administration of this narcotic until on or about October 18, 2009 at 07:08 (same documentation time as above).

83. Hydromorphone injections and tablets are an unusual choice of drugs for a vaginal delivery.

Statement of Facts re: Patient K.M.

84. On or about October 17, 2009, Respondent was not assigned to Patient K.M.

85. On or about October 17, 2009 at 13:55, K.M. was discharged from the Facility.

86. On or about October 17, 2009 at 14:26, Respondent withdrew from the PYXIS two (2) Oxycodone I.R. 5mg tablets for K.M., after she had been discharged. Moreover, Respondent documented that she administered this narcotic at 12:30, prior to her withdrawal. Respondent did not document this administration until 15:58 on this date.

Statement of Facts re: Patient S.N.

87. On or about October 17, 2009, Respondent was not assigned to Patient S.N.

STATE OF VERMONT

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

88. On or about October 17, 2009 at 11:30, S.N. was discharged from the Facility.

89. On or about October 17, 2009 at 11:32, Respondent withdrew from the PYXIS four (4) Oxycodone I.R. 5mg tablets for S.N., after she had been discharged.

Statement of Facts re: Patient T.C.

90. On or about October 17 and 18, 2009, Respondent was assigned to Patient T.C.

91. On or about October 17, 2009, Respondent clocked in at the Facility at 07:03 and clocked out at 15:58.

92. On or about October 18, 2009, Respondent clocked in at the Facility at 06:54 and clocked out at 14:15.

93. At all times relevant, T.C. was ordered to be administered Morphine injections 5mg every two (2) hours PRN (as needed).

94. On or about October 17, 2009 at 09:14 and again at 09:15, Respondent withdrew from the PYXIS one (1) Morphine 10mg/1ml ampule for T.C., for a total of 20mg Morphine. Respondent documented in the MAR that she administered Morphine 5mg to T.C. at 12:00; however, Respondent did not document this administration until on or about October 18, 2009 at 11:50. Moreover, Respondent did not document wasting the remaining 15mg Morphine.

95. On or about October 17, 2009, Respondent documented in the MAR that she administered Morphine 5mg to T.C. at 13:30. There was no corresponding withdrawal or wasting documented in the PYXIS for this administration. Moreover, Respondent did not document this administration until on or about October 18, 2009 at 11:50 (same documentation time as above).

96. On or about October 17, 2009, Respondent documented in the MAR that she administered Morphine 5mg to T.C. at 15:00. There was no corresponding withdrawal or wasting documented in the PYXIS for this administration. Moreover, Respondent did not document a pain assessment to justify why this narcotic was administered sooner than was ordered. Furthermore, Respondent did not document this administration until on or about October 18, 2009 at 11:50 (same documentation time as above).

97. On or about October 17, 2009, Respondent documented in the MAR that she administered Morphine 5mg to T.C. at 16:30. Respondent had already clocked out of the Facility by 15:58 on this date. There was no corresponding withdrawal or wasting documented in the PYXIS for this administration. Moreover, Respondent did not document a pain assessment to justify why this narcotic was administered sooner than

STATE OF VERMONT

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

was ordered. Furthermore, Respondent did not document this administration until on or about October 18, 2009 at 11:50 (same documentation time as above).

98. On or about October 17, 2009, Respondent documented in the MAR that she cancelled an administration of Morphine 5mg to T.C. at 18:00. Respondent had already clocked out of the Facility by 15:58 on this date. There was no corresponding withdrawal or wasting documented in the PYXIS for this cancelled administration. Moreover, Respondent did not document this cancelled administration until on or about October 18, 2009 at 11:51 (documentation time similar to above).

99. On or about October 18, 2009 at 11:52, Respondent documented that she administered Morphine 5mg to T.C. at 00:00 (documentation time similar to above). However, Respondent did not clock in at the Facility until 06:54 on this date.

100. On or about October 18, 2009 at 11:52, Respondent documented that she administered Morphine 5mg to T.C. at 02:00 (documentation time same as above). However, Respondent did not clock in at the Facility until 06:54 on this date.

101. On or about October 18, 2009 at 11:52, Respondent documented that she administered Morphine 5mg to T.C. at 03:30 (documentation time same as above). However, Respondent did not clock in at the Facility until 06:54 on this date.

102. On or about October 18, 2009 at 07:29 and again at 07:30, Respondent removed from the PYXIS one (1) Morphine 10mg/1ml ampule for T.C., for a total of 20mg Morphine. Respondent documented in the MAR that she administered Morphine 5mg to T.C. at 05:00. However, Respondent did not clock in at the Facility on this date until 06:54. Moreover, Respondent did not document wasting the remaining 15mg Morphine. Furthermore, Respondent did not document this administration until 11:52 on this date (documentation time same as above).

103. On or about October 18, 2009, Respondent documented in the MAR that she administered Morphine 5mg to T.C. at 06:30. However, Respondent did not clock in at the Facility on this date until 06:54. There was no corresponding withdrawal or wasting documented in the PYXIS for this administration. Moreover, Respondent did not document a pain assessment to justify why this narcotic was administered sooner than was ordered. Furthermore, Respondent did not document this administration until 11:52 on this date (documentation time same as above).

104. On or about October 18, 2009, Respondent documented in the MAR that she administered Morphine 5mg to T.C. at 08:00. There was no corresponding withdrawal or wasting documented in the PYXIS for this administration. Moreover, Respondent did not document a pain assessment to justify why this narcotic was administered sooner than was ordered. Furthermore, Respondent did not document this administration until 11:52 on this date (documentation time same as above).

STATE OF VERMONT

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

105. On or about October 18, 2009, Respondent documented in the MAR that she administered Morphine 5mg to T.C. at 09:30. There was no corresponding withdrawal or wasting documented in the PYXIS for this administration. Moreover, Respondent did not document a pain assessment to justify why this narcotic was administered sooner than was ordered. Furthermore, Respondent did not document this administration until 11:51 on this date (documentation time similar to above).

106. On or about October 18, 2009 at 09:53, Respondent withdrew from the PYXIS one (1) Morphine 10mg/1ml ampule for T.C. Respondent documented in the MAR that she administered Morphine 5mg to T.C. at 11:00. T.C. was discharged from the Facility at 11:16. Respondent did not document wasting the remaining 5mg Morphine. Moreover, Respondent did not document this administration until 11:51 on this date (documentation time same as above).

107. Nurses in Shepardson 5 do not normally give patients morphine right before they are discharged.

108. On or about October 18, 2009 at 11:27, Respondent withdrew from the PYXIS one (1) Morphine 10mg/1ml ampule for T.C. T.C. had already been discharged from the Facility at 11:16 on this date.

109. At all times relevant, T.C. was ordered to be administered Oxycodone 5-10mg every four (4) hours PRN (as needed).

110. On or about October 18, 2009 at 11:50, Respondent documented that she administered Oxycodone 10mg to T.C. at 03:00. Respondent did not clock in to the Facility until 06:54 on this date.

111. On or about October 18, 2009 at 07:30, Respondent withdrew from the PYXIS two (2) Oxycodone I.R. 5mg tablets for T.C. Respondent documented in the MAR that she administered Oxycodone 10mg to T.C. at 07:30. Respondent did not document this administration until 11:49 on this date.

112. On or about October 18, 2009 at 09:39, Respondent withdrew from the PYXIS two (2) Oxycodone I.R. 5mg tablets for T.C. Respondent documented in the MAR that she administered Oxycodone 10mg to T.C. at 11:00. T.C. was discharged from the Facility at 11:16. Respondent did not document a pain assessment to justify why this narcotic was administered sooner than was ordered. Moreover, Respondent did not document this administration until 11:49 on this date (documentation time same as above).

113. On or about October 18, 2009 at 11:28, Respondent withdrew from the PYXIS two (2) Oxycodone I.R. 5mg tablets for T.C. T.C. had already been discharged from the Facility at 11:16 on this date. Respondent made no documentation regarding this withdrawal in the MAR.

STATE OF VERMONT

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

Statement of Facts re: Patient K.G.

114. On or about October 18, 2009, Respondent was not assigned to Patient K.G.

115. On or about October 18, 2009 at 12:25, K.G. was discharged from the Facility.

116. On or about October 18, 2009 at 12:40 and again at 12:41, Respondent withdrew from the PYXIS two (2) Oxycodone I.R. 5mg tablets – for a total of 20 mg Oxycodone I.R. – for K.G., after K.G. had been discharged.

Statement of Facts re: Patient K.D.

117. On or about October 18, 2009, Respondent was not assigned to Patient K.D. Patient K.D. was assigned to Registered Nurse K.D.

118. On or about October 18, 2009 at 10:27, Respondent withdrew from the PYXIS three (3) Hydromorphone 2mg tablets for Patient K.D. Respondent did not document administering this narcotic in the MAR.

119. Thereafter, on or about October 18, 2009, RN K.D. queried PYXIS regarding the last medication administration for this patient. RN K.D. saw that Respondent had withdrawn the three (3) Hydromorphone tablets at 10:27 for Patient K.D., but saw that no administration was documented in the MAR. Therefore, RN K.D. asked this patient whether she had been administered this pain medication, and the patient stated she had not. RN K.D. then reported this information to Charge Nurse V.C.

Statement of Facts re: Respondent's Anomalous Use by Month

120. Respondent worked part-time at Shepardson 5, usually working around twenty (20) hours per week.

121. The mean withdrawal numbers reported below include full-time and part-time nurses.

122. In or around April 2009, Respondent made forty (40) Oxycodone 5mg tablet withdrawals. The mean withdrawal amount for all nurses in Shepardson 5 during this month was thirteen (13). Respondent made no Morphine or Hydromorphone withdrawals.

123. In or around May 2009, Respondent made sixty-two (62) Oxycodone 5mg tablet withdrawals. The mean withdrawal amount for Shepardson 5 during this month was eleven (11). Respondent made eleven (11) Morphine 10mg/1ml ampule withdrawals during this month; the mean for Shepardson 5 was two (2). Respondent made no Hydromorphone withdrawals.

124. In or around June 2009, Respondent made thirty-four (34) Oxycodone 5mg tablet withdrawals. The mean withdrawal amount for Shepardson 5 during this month was

STATE OF VERMONT

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

ten (10). Respondent made twenty-five (25) Morphine 10mg/1ml ampule withdrawals during this month; the mean for Shepardson 5 was three (3). Respondent made no Hydromorphone withdrawals.

125. In or around July 2009, Respondent made forty-one (41) Oxycodone 5mg tablet withdrawals. The mean withdrawal amount for Shepardson 5 during this month was fourteen (14). Respondent made forty-five (45) Morphine 10mg/1ml ampule withdrawals during this month; the mean for Shepardson 5 was three (3). Respondent made no Hydromorphone withdrawals.

126. In or around August 2009, Respondent made fifty-three (53) Oxycodone 5mg tablet withdrawals. The mean withdrawal amount for Shepardson 5 during this month was seventeen (17). Respondent made fifty-three (53) Morphine 10mg/1ml ampule withdrawals during this month; the mean for Shepardson 5 was three (3). Respondent made five (5) Hydromorphone 2mg tablet withdrawals during this month; the mean for Shepardson 5 was two (2).

127. In or around September 2009, Respondent made one hundred fifty-one (151) Oxycodone 5mg tablet withdrawals. The mean withdrawal amount for Shepardson 5 during this month was eighteen (18). Respondent made ninety-one (91) Morphine 10mg/1ml ampule withdrawals during this month; the mean for Shepardson 5 was seven (7). Respondent made thirty-two (32) Hydromorphone 2mg tablet withdrawals during this month; the mean for Shepardson 5 was eleven (11).

128. From on or about October 1, 2009 through on or about October 8, 2009, Respondent made ninety-one (91) Oxycodone 5mg tablet withdrawals. The mean withdrawal amount for Shepardson 5 during this time period was thirteen (13). Respondent made thirty-eight (38) Morphine 10mg/1ml ampule withdrawals during this time period; the mean for Shepardson 5 was four (4). Respondent made fifteen (15) Hydromorphone 2mg tablet withdrawals during this time period; the mean for Shepardson 5 was seven (7).

129. On or about October 27, 2009, State Investigator Karl Packer and DEA Diversion Investigator Chris Paquette met with the Respondent at her home and were told by the Respondent that she was declining to speak with them based on the advice of her attorney.

Request for Relief

130. 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.

131. 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);

STATE OF VERMONT

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

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);

d. 26 V.S.A. § 1582(a)(5) (Is habitually intemperate or is addicted to the use of habit-forming drugs);

e. 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); and diverting supplies, equipment, or drugs for personal or other unauthorized use pursuant to ARBN Chapter 4, Rule IV(II)(D)(4);

f. 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);

g. 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

h. 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 licenses numbers 026.0037839 and 025.0008506 be summarily suspended, pending a hearing on the merits.

DATED at Montpelier, Vermont this 23rd day of April, 2010.

STATE OF VERMONT
SECRETARY OF STATE

By: _____
BetsyAnn Wrask
State Prosecuting Attorney

STATE OF VERMONT

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

nu.hull.sumsusp