

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

In re: CHRISTINA M. KITTREDGE
License No. 025.0096790

}
} Docket No. 2016-613 (LPN)
}

SUMMARY SUSPENSION ORDER

Participating Board Members:

Jeanine Carr, RN, Chair
Ellen Watson, APRN, Vice Chair
William G. White, Jr., Public Member
Jennifer Laurent, APRN
Deborah Swartz, RN
Luana Tredwell, LPN

Appearances:

Prosecuting the case: Elizabeth Jarvis, Esq.
Respondent: participated by telephone but was not represented

Presiding Officer:

George K. Belcher

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

This matter came before the Board of Nursing on a Request for a Summary Suspension. The hearing was held on December 12, 2016, at the Office of Professional Regulation in Montpelier, Vermont.

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 as follows:

1. Respondent is a Licensed Practical Nurse, licensed in Vermont. Her license is set to expire on January 31, 2018. She is subject to the regulatory authority of this Board. 3 V.S.A. §§ 129, 129a, 26 V.S.A. Chapter 28, the Administrative Rules of the Board of Nursing, and the 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 prosecutor has filed a "Request for Summary Suspension." A copy of the Request is attached to this Decision and Order. The Respondent was sent a notice of the hearing on December 8, 2016 by certified mail and regular mail. The Respondent received the notice of hearing and Request for Summary Suspension prior to the hearing.
 3. The Request for Summary Suspension alleges that the public health, safety or welfare imperatively requires emergency action.
 4. The allegations in the Request for Summary Suspension (copy attached) have been established to the necessary degree. The State presented the testimony of Investigator John Lewis. Mr. Lewis established through his testimony that the Respondent was employed by The Pines Rehabilitation and Health Center ("the facility") in Lyndonville, Vermont, during 2016.
 5. The Respondent cared for patients J.D. and M.L. during her work at the facility. Patient J.D. had an order for .5 ml of morphine subcutaneously every hour as needed for pain. Patient M.L. had orders for .5 ml of morphine subcutaneously every hour as needed for pain and 7.5 mg of oxycodone by mouth, twice daily as needed for pain.
 6. Between July 15, 2016 and August 9, 2016, the Respondent documented withdrawing .5 ml of morphine for patient J.D. 44 times but she failed to provide substantiation in the Medical Administration Record or the nursing notes for 42 of these doses. On November 7, 2016 the Respondent withdrew 15 mg of oxycodone for Resident M.L. but only documented administering half of that dose.
 7. The Respondent was interviewed by Investigator Lewis on December 2, 2016. During that interview, the Respondent admitted using heroin off and on since 2008 and was "reintroduced" to that drug in May of 2016 and was continuing to use it until October of 2016. The Respondent admitted to Mr. Lewis diverting morphine from patient J.D. between 5 and 10 times for her personal use and on one occasion from patient M.L. The Respondent admitted to taking morphine from the facility.
 8. The Respondent admitted that she would co-sign for another staff-member when that staff-member was diverting drugs from the patient for her own use.
 9. The evidence presented show facts which imperatively requires emergency action for the public health, safety, and welfare. Specifically, summary suspension is necessary to prevent patient harm and to protect the general integrity of the medical profession. The admitted facts show: that the Respondent has recently been a regular user of heroin; that the Respondent has diverted controlled drugs from her patients for her own illegal drug use; and that she has assisted in the falsification of medical records

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 of Fact and Conclusions of Law herein are for purposes of this Order only.

The Prosecutor's Request for a Summary Suspension is supported by the evidence

presented. The Board concludes that the allegations in the Request for Summary Suspension have been established to the necessary degree. For purposes of this Summary Suspension Hearing, the Findings of Fact above do support Summary Suspension of Respondent's license. There is an imperative need to take emergency action. 3 V.S.A. § 814(c).

Vermont law requires that unprofessional charges be filed promptly with Respondent being afforded a prompt hearing. At any merits hearing in this matter, the prosecutor will bear the burden of proving unprofessional conduct. Our Findings and Conclusions in this matter will not absolve the prosecution or Respondent 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 exclusively on the evidence admitted at that hearing.

Order

The Request for Summary Suspension is **GRANTED**. Respondent's license is **Summarily Suspended** pending proceedings for revocation or other action. These proceedings shall be promptly instituted and determined. 3 V.S.A. § 814(c).

Vermont Board of Nursing

By: Jeanine Carr
Jeanine Carr, RN, Chair

Date: December 15, 2016

DATE OF ENTRY: 12/20/16

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, 89 Main Street, Fl. 3, 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.

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

IN RE:

CHRISTINA M. KITTREDGE

License No. 025.0096790

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Docket Nos. 2016-613

REQUEST FOR SUMMARY SUSPENSION

Board Authority

1. The Vermont Board of Nursing (the "Board") has jurisdiction to investigate and adjudicate allegations of unprofessional conduct committed by Nurses pursuant to 3 V.S.A. §§ 129, 129a; 26 V.S.A. Chapter 28; the Administrative Rules of the Board of Nursing ("ARBN"); and the Rules of the Office of Professional Regulation.
2. The Board of Nursing is authorized by 3 V.S.A. § 814 to summarily suspend the license of a nurse when it finds that the public health, safety, or welfare imperatively requires emergency action.

Statement of Facts

3. Christina M. Kittredge ("Respondent") of Lyndonville, Vermont is licensed by the State of Vermont as a Licensed Practical Nurse ("LPN") under license number 025.0096790. This license was originally issued July 23, 2013, and expires on January 31, 2018.
4. At all relevant times, Respondent was employed as an LPN at the Pines Rehabilitation and Health Center ("Facility") in Lyndonville, VT. Respondent was terminated from the Facility in mid-November 2016.
5. Respondent is scheduled to begin working at Woodridge Nursing Home on December 12, 2016.
6. Resident J.D. had an order for .5ml of morphine, given subcutaneously every hour as needed for pain.
7. During the relevant time period, morphine was only available at the Facility in 10mg/ml vials.
8. The Facility's drug administration policy requires nurses to co-sign for one another when removing a narcotic from his or her own medication cart.

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Prosecuting Attorney
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89 Main Street
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9. From July 15, 2016 to August 9, 2016, Respondent documented withdrawing .5ml's of morphine for Resident J.D. forty-four (44) times in the narcotic log.
10. From July 15, 2016 to August 9, 2016, Respondent only substantiated 2 of the withdrawals mentioned in Paragraph 8 above in the MAR or in nursing notes for Resident J.D.
11. Respondent admitted to diverting morphine from Resident J.D. prescription between five (5) and ten (10) times.
12. Respondent would draw .5ml into a syringe and take the syringe home where she would use it by injecting it subcutaneously.
13. Respondent would also co-sign for at least one other nursing staff member when that member would divert morphine from J.D.'s prescription for her own use.
14. Resident M.L. had an orders for .5ml of morphine, given subcutaneously every hour as needed for pain and 7.5mg of oxycodone by mouth, twice daily as needed for pain.
15. During the relevant time period, oxycodone was available at the Facility in 15mg tablets.
16. On November 7, 2016, Respondent documented withdrawing .5ml of morphine for Resident M.L. at 11:30 and 13:00.
17. Respondent also documented wasting .5ml each time from each 10mg/ml vial.
18. Respondent documented withdrawing 15mg of oxycodone for Resident M.L. at 07:15.
19. Respondent documented giving 7.5mg of oxycodone to Resident M.L. in the MAR but did not document wasting the other 7.5mg.
20. While co-signing for a separate medication withdrawal, LPN M.B. noticed that her initials appeared next to Respondent's 07:15 withdrawal of oxycodone for Resident M.L. LPN M.B. did not co-sign for this withdrawal.
21. Respondent admitted to withdrawing one (1) 10mg/ml vial of morphine on November 7, 2016, from Resident M.L.'s prescription for her own use.
22. Respondent withdrew the morphine into a syringe, which she brought home and used for herself.
23. Respondent has been using heroin off and on since 2008.

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24. Before Respondent began using heroin, she used other narcotics including 15mg oxycodone, vicodin, and percocet.
25. Respondent would obtain the drugs listed in Paragraph 24 above by buying them from a dealer.
26. Respondent has not undergone any treatment for substance abuse.

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

27. The State re-alleges and incorporates Paragraphs 3 through 26 above.
28. As a Licensed Practical Nurse, Respondent shall not divert or attempt to divert drugs or equipment or supplies for unauthorized use.
29. Respondent diverted or attempted to divert drugs for unauthorized use as described in Paragraphs 9 through 22 above.
30. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent has committed unprofessional conduct in violation of 26 V.S.A. §1582(a)(2).

Violation Two: 3 V.S.A §129a(b)(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: (2) failure to conform to the essential standards of acceptable and prevailing practice.

31. The State re-alleges and incorporates Paragraphs 3 through 26 above.
32. The essential standards of acceptable and prevailing practice require Licensed Practical Nurses to accurately and honestly document all nursing interventions, including the administration of medication.
33. Respondent failed to meet this standard by engaging in the conduct described in Paragraphs 9 through 22 above.
34. The essential standards of acceptable and prevailing practice require Licensed Practical Nurses to refrain from diverting medications for their own use.
35. Respondent failed to meet this standard by engaging in the conduct described in Paragraphs 9 through 22 above.

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36. The essential standards of acceptable and prevailing practice require Licensed Practical Nurses to refrain from using illegal drugs or drugs they are not legally prescribed.
37. Respondent failed to meet this standard by engaging in the conduct described in Paragraphs 9 through 26 above.
38. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent has committed unprofessional conduct in violation of 3 V.S.A. §129a(b)(2).

Violation Three: 3 V.S.A §129a(b)(1) Failure to practice competently by reason of any cause on a single occasion or on multiple occasions may constitute unprofessional conduct, whether actual injury to a client, patient, or customer has occurred. Failure to practice competently includes: (1) performance of unsafe or unacceptable patient or client care.

39. The State re-alleges and incorporates Paragraphs 3 through 26 above.
40. As a Licensed Practical Nurse, Respondent has an obligation to provide safe and acceptable patient care.
41. The respondent provided unsafe and unacceptable patient care by engaging in the behavior described in Paragraphs 9 through 22 above.
42. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent has committed unprofessional conduct in violation of 3 V.S.A. §129a(b)(1).

Violation Four: 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.

43. The State re-alleges and incorporates Paragraphs 3 through 26 above.
44. As a Licensed Practical Nurse, Respondent shall not willfully make or file false reports or records in the practice of the profession; willfully impede or obstruct the proper making or filing of reports or records or willfully fail to file the proper reports or records.
45. Paragraphs 9 through 22 above demonstrate that Respondent willfully made or filed false reports or records in the practice of the profession.

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46. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent has committed unprofessional conduct in violation of 3 V.S.A. §129a(a)(7).

Violation Five: 26 V.S.A. §1582(a)(3) Engaging in conduct of a character likely to deceive, defraud, or harm the public.

47. The State re-alleges and incorporates Paragraphs 3 through 26 above.
48. As a Licensed Practical Nurse, Respondent has a responsibility not to engage in conduct of a character likely to deceive, defraud, or harm the public.
49. Respondent engaged in conduct of a character likely to deceive, defraud, or harm the public as demonstrated in Paragraphs 9 through 26 above.
50. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent has committed unprofessional conduct in violation of 26 V.S.A. §1582(a)(3).

Violation Six: 3 V.S.A. §129a(a)(5) Practicing the profession when medically or psychologically unfit to do so.

51. The State re-alleges and incorporates Paragraphs 3 through 26 above.
52. As a Licensed Practical Nurse, Respondent shall only practice the profession when medically or psychologically fit to do so.
53. Respondent practiced the profession of nursing when medically or psychologically unfit to do so when she engaged in the conduct stated in Paragraphs 3 through 26 above.
54. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent has committed unprofessional conduct in violation of 3 V.S.A. §129a(a)(5).
55. Without emergency action, members of the public, patients, and potential patients would be unaware of Respondent's dangerous behavior and will remain unprotected if Respondent is allowed to continue to practice. The facts as set out above establish that in order to protect the public health, safety, or welfare of the people of the State of Vermont, emergency action is imperative.

WHEREFORE, the State of Vermont respectfully requests that pursuant to 3 V.S.A. § 814(c), the Respondent's nursing license number **025.0096790** be summarily suspended, pending a hearing on the merits.

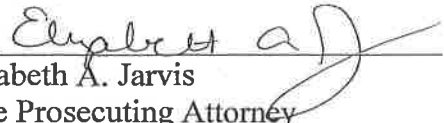
DATED at Montpelier, Vermont this 8th day of December, 2016.

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