

**STATE OF VERMONT
BOARD OF NURSING**

In re: Marcy Lee Letourneau
License No. 025-56074

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Docket No. 2012-560, 294(LPN)

Appearances:

Prosecuting the case: S. Lauren Hibbert
Respondent: Did not appear

Presiding Officer: Larry S. Novins

DEFAULT ORDER

The Board held a hearing on the above matter on June 10, 2013 at the Office of Professional Regulation Conference Room in Schulmaier Hall at the Vermont College of Fine Arts in Montpelier, Vermont. Ms. Letourneau did not attend and was not represented by counsel.

Findings of Fact

1. Ms. Letourneau is licensed as a practical nurse and is therefore subject to the regulatory authority of this Board. 3 V.S.A. §§ 129, 129a, 26 V.S.A. § 1582(a), the Administrative Rules of the Board of Nursing, and the Rules of the Office of Professional Regulation.
2. On March 25, 2013 Ms. Letourneau was sent a Notice of Charges in this matter by certified mail to her last known address. A copy of the Specification of Charges is attached to this Default Order.
3. OPR Rule 3.3 requires that an Answer be filed within 20 days of the date on which the notice of charges was mailed by the Director.
4. Licensees are required to notify the Board of any change of address within 30 days. 3 V.S.A. § 129a(a)(14).
5. On April 1, 2013 Ms. Letourneau signed for and received the notice of charges.
6. Ms. Letourneau has not filed an answer to the charges.
7. On April 30, 2013 notice of the Default Hearing scheduled for this date was mailed to Ms. Letourneau at that same address by certified mail. It was unclaimed and returned to the office.
8. Ms. Letourneau has still not answered the charges.
9. Upon hearing the Prosecution's presentation and taking notice of its own file, the Board finds Ms. Letourneau to be in Default. The allegations contained in the Specification of Charges are therefore treated as the facts on which the Board's Order is based. OPR Rule 3.4, 3 V.S.A. § 809(d) and 3 V.S.A. § 814(c).

Conclusions of Law

Ms. Letourneau has received adequate or constructive notice of the charges in this matter as indicated by the Board's file and the Prosecution's presentation. Because Ms. Letourneau has failed to answer the charges, the factual allegations in the Stipulation and Consent Order are treated as if proved. O.P.R. Rule 3.4. Accordingly, the Board finds, in this Default Hearing held pursuant to 3 V.S.A. §809(d), that Ms. Letourneau has engaged in the unprofessional conduct alleged in the Specification of Charges.

Order

In accordance with the above Findings of Fact and Conclusions of Law, Ms. Letourneau's license is hereby **Suspended Indefinitely**, effective as of the date of the hearing. Should Ms. Letourneau apply for reinstatement, the Board at that time will determine whether any conditions can permit her to resume practice while protecting public health and safety.

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 130a1

To request a stay of the Board's decision, please refer to the attached stay instructions.

Vermont Board of Nursing

By:


Deborah Swartz, RN

Date: June 10, 2013

OFFICE OF PROFESSIONAL REGULATION

DATE OF ENTRY: 6/10/13

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

IN RE:

**MARCY LEE LETOURNEAU
License No. 025.0056074**

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**Docket Nos. 2012-294 &
2012-560**

SPECIFICATION OF CHARGES

NOW COMES the State of Vermont and makes the following Charges against the respondent, Marcy Lee Letourneau, LPN:

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. Marcy Lee Letourneau ("Respondent") of Champlain, New York is licensed by the State of Vermont as a Licensed Practical Nurse under license number 025.0056074. This license was originally issued on or about April 8, 2010 and expires on or about January 31, 2014.

Facts re: Docket No. 2012-294

3. At all times relevant, Respondent was employed as a Licensed Practical Nurse with The Converse Home in Burlington, Vermont.
4. Between February 1, 2012 and May 7, 2012, Respondent made eleven (11) medication errors at The Converse Home. These errors were documented in Medication Error Follow Up reports, which were signed by the Respondent and M.W., RN, Respondent's supervisor. The Respondent made the following errors:
 - a. In a report dated February 1, 2012, Respondent accidentally gave a second dose of Oxycontin 30mg to a resident.
 - b. In a report dated February 1, 2012, Respondent failed to document a resident receiving Calcium 600mg on seven different occasions.

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Prosecuting Attorney
Office of
Professional Regulation
National Life Building
Second Floor North
Montpelier, VT
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- c. In a report dated March 14, 2012, Respondent left medication with a resident and did not observe that resident taking the medication.
- d. In a report dated March 23, 2012, Respondent failed to give a dose of Tramadol to a patient.
- e. In a report dated March 23, 2012, Respondent failed to give a dose of Vicodin to a patient.
- f. In a report dated March 23, 2012, Respondent gave medication to a patient who was observed returning to her apartment unsupervised with the medications.
- g. In a report dated March 30, 2012, Respondent gave Morphine to a resident but did not document it on the MAR.
- h. In a report dated May 4, 2012, Respondent failed to give a patient her morning medications.
- i. In a report dated May 4, 2012, Respondent failed to give Digoxin as scheduled on the MAR for a patient.
- j. In a report dated May 4, 2012, Respondent failed to give a patient a Nitro patch and three morning medications were not signed for: Isasorbide 30mg, Isosorbide 60mg, and Lasix 40mg.
- k. In a report dated May 4, 2012, Respondent did not observe a patient taking his medication.

Facts re: Docket No. 2012-560

- 5. At all relevant times, Respondent was employed as a Licensed Practical Nurse with Rowan Court Nursing Home (the "Facility") in Barre, Vermont.
- 6. On or about August 1, 2012, Respondent signed in a pharmacy delivery for Oxycontin 15mg and Alprazolam 0.5 mg. The Alprazolam was given to J.L., LPN, the Wing One Short Hall nurse. Respondent then attempted to deliver the Oxycontin to M.R., LPN, the Wing Two Long Hall nurse. M.R. was on break and not on the floor, so Respondent attempted to give the medication to L.S., RN, who declined to accept them. Respondent held onto the Oxycontin and took it back to Wing One. The Oxycontin ultimately came up missing.
- 7. The last place the Oxycontin was seen was the Wing One nursing station. When the Facility first discovered the Oxycontin was missing, Respondent initially claimed that M.R. came by later in the shift and picked up the medication. Later, in a meeting with J.B., the Administrator of the Facility, and M.R, Respondent claimed that she did not remember if she gave the medication to M.R.

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8. On or about October 26, 2012, in an interview with Investigator Dennis Menard of the Office of Professional Regulation, Respondent stated that the last place she saw the Oxycontin was on the Wing One nursing station. Respondent stated that she should have taken the medication and locked it up, but she didn't. Respondent stated that she didn't remember M.R. taking the medication.

Charges

9. 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. 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
 - b. 26 V.S.A. § 1582(a)(3) (Is unable to practice nursing competently by reason of any cause) which includes performing unsafe or unacceptable patient care pursuant to ARBN Rule 11.2(b)(1) and failure to conform to the essential standards of acceptable and prevailing nursing practice pursuant to ARBN Rule 11.2(b)(2).

Relief Requested

WHEREFORE, the license of Marcy Lee Letourneau, LPN, should be revoked, suspended, reprimanded, conditioned, or otherwise disciplined.

DATED at Montpelier, Vermont this 22 day of March, 2013.

STATE OF VERMONT
SECRETARY OF STATE

By: S. J. Hibbert
S. Lauren Hibbert
State Prosecuting Attorney

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