STATE OF VERMONT
BOARD OF NURSING

In re: Jennifer Letzler Magistrale	}	
License No. 026-0014486	}	Docket No. NU62-1108
	}	M2009-141

Decision on Motion for Reinstatement

Participating Board Members:
Alan Weiss
Sandra Norton, LNA
Donarae Metcalf, LPN
Deann Welch, LPN
Kenneth W. Bush, RN
William G. White Jr.
Deborah Robinson, RN
John Todd, ARPN

Appearances:
for Petitioner, State of Vermont: Betsy Ann Wrask
for Respondent: Pro se

Presiding Officer: Larry S. Novins

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

The Vermont Board of Nursing held a hearing in the above matter on December 14, 2009 at the National Life Building in Montpelier, Vermont.

Findings of Fact

Based on the evidence presented and a review of the record in this matter, the Board finds as follows:

1. Ms. Magistrale is licensed as a registered nurse and is therefore subject to the regulatory authority of this Board. 3 V.S.A. §§ 129, 129a, 26 V.S.A. § 1582(a), the Administrative Rules of the Board of Nursing, and the Rules of the Office of Professional Regulation.
2. Her license was suspended for six months by Stipulated Order of this Board dated May 11, 2009. Credit toward the six months term was retroactive to February 10, 2009 the day her license was summarily suspended.
3. By the terms of the Order, Ms. Magistrale bears the burden of persuading the Board that she has satisfied the conditions for reinstatement and that her request should be granted.
4. By letter dated August 15, 2009 Ms. Magistrale requested that here license be reinstated

with the conditions imposed in the May 2009 Order.

5. On October 15, 2009 her request was preliminarily denied. Ms. Magistrale requested this hearing by letter dated October 17, 2009.
6. We refer to the sanctions portion of the above-mentioned Order.
7. Last summer Ms. Magistrale began urinalysis, counseling and treatment. She had one positive UA report in July. Soon thereafter she engaged in residential treatment. She has had no positive UA's since.
8. A prerequisite to reinstatement was that Ms. Magistrale was to obtain an independent evaluation report by a licensed professional specializing in drug and alcohol abuse pre-approved by the Board. She has.
9. Her September 29, 2009 evaluation states that with conditions, Ms. Magistrale "should be allowed to return to the practice of nursing."
10. The most recent update evaluation from DayOne shows that Ms. Magistrale has been in their program since September 23, 2009. They report she has been abstinent of alcohol. Their random urinalyses confirm this.
11. With the conditions preciously imposed, we believe that Ms. Magistrale will not present a risk to the safety, health or welfare of her potential patients.

Conclusions of Law

Based on the evidence presented and Facts found above we conclude as follows:

1. Ms. Magistrale has met her burden and shown that she has satisfied the conditions for reinstatement and that her license may be reinstated with the conditions as set forth in the Stipulation and Consent Order approved by this Board on May 11, 2009.

Order

Ms. Magistrale shall be issued a license marked "conditioned." The conditions shall be those of the May 11, 2009 Order.

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, Office of Professional Regulation, National Life Bldg., North, FL2, Montpelier, Vermont 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: Deann P. Welch, LPN
Deann Welch, LPN, acting Chair

Date December 15, 2009

OFFICE OF PROFESSIONAL REGULATION

DATE OF ENTRY: 12/15/09

STATE OF VERMONT
BOARD OF NURSING

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John Todd, APRN

Appearances:
for Petitioner, State of Vermont: Betsy Ann Wrask
for Respondent: Pro se

Presiding Officer: Larry S. Novins

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

The Vermont Board of Nursing held a hearing in the above matter on May 10, 2010 at the National Life Building in Montpelier, Vermont. Respondent previously asked the Board to reinstate her license without conditions. That request was preliminarily denied. She has appealed that denial. Respondent bears the burden to persuade the Board that the preliminary denial should be reversed. 3V.S.A. § 129(e).

Findings of Fact

Based on the evidence presented and a review of the record in this matter, the Board finds as follows:

1. Ms. Magistrale is licensed as a registered nurse and is therefore subject to the regulatory authority of this Board. 3 V.S.A. §§ 129, 129a, 26 V.S.A. § 1582(a), the Administrative Rules of the Board of Nursing, and the Rules of the Office of Professional Regulation.
2. Respondent's license was suspended for six months by Stipulated Order of this Board dated May 11, 2009. Credit toward the six months term was retroactive to February 10, 2009 the day her license was summarily suspended.

3. By Order dated December 15, 2010 the Board reinstated Ms. Magistrale's license with conditions.

4. Ms. Magistrale now asks that the conditions 1) requiring direct supervision and 2) prohibiting her form administering controlled substances for a minimum of 12 weeks be stricken.

5. Ms. Magistrale states that those conditions have prevented her from finding employment. Magistrale has attempted to find nursing work in several areas of interest to her. She has not attempted to find nursing work in other areas where employment may be available. She testified she did not want to work in certain areas where she did not feel challenged.

6. Ms. Magistrale is not unable to find employment which would allow her to meet the supervision requirements necessary to assure that she is practicing safely.

7. Part of the conditions previously imposed on Ms. Magistrale require her to have random urinalyses. She has had 6 UA's since December 2009, all negative.

8. Under the random urinalysis protocol Ms. Magistrale is required to call the testing facility on a daily basis to learn whether she will be required to give a urine sample that day. She is required to call seven days a week.

9. Ms. Magistrale missed several weekend calls. She testified that, after making weekend calls for several weeks, she no longer believed weekend calls were required. Yet, she testified that on one of the weekends she missed, she did not call because she had been a yoga retreat and had made arrangements to not call. Her explanation for her failure to meet all the testing conditions is unpersuasive.

10. Ms. Magistrale was late providing her Recovery Group logs for the period January through March 2010.

11. The conditions imposed on Ms. Magistrale's license remain necessary to protect the public. We note that Ms. Magistrale's license was reinstated, she agreed to abide by these conditions.

12. Ms. Magistrale has not presented evidence which persuades us that the conditions are no longer needed.

Conclusions of Law

Based on the evidence presented and Facts found above we conclude as follows:

1. Ms. Magistrale has not met her burden to show that she has satisfied all the conditions for reinstatement, or that those conditions should be excused. She has not met her burden to persuade the Board that the preliminary denial of her request was in error. 3 V.S.A. § 129(e).

Order

Ms. Magistrale's motion to reinstate her license without conditions **is denied.** The preliminary denial of her request is **affirmed.**

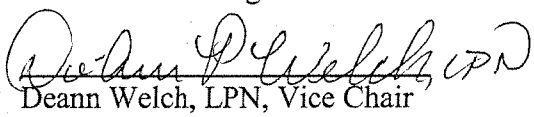
APPEAL RIGHTS

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, Office of Professional Regulation, National Life Bldg., North, FL2, Montpelier, Vermont 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: 
Deann Welch, LPN, Vice Chair

Date May 11, 2010

OFFICE OF PROFESSIONAL REGULATION

DATE OF ENTRY: 5/17/10

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

IN RE:	)	
JENNIFER LETZLER MAGISTRALE	)	**Docket No. NU62-1108**
License No. 026-0014486	)	

STIPULATION AND CONSENT ORDER

STIPULATION

NOW COMES the State of Vermont, by and through State Prosecuting Attorney Edward G. Adrian, and the Respondent, Jennifer Letzler Magistrale, 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. Jennifer Letzler Magistrale (the "Respondent") of South Burlington, Vermont is a registered nurse holding license number 026-0014486. This license was originally issued by the State of Vermont on or about November 2, 1981 and is currently set to expire on or about March 31, 2009.

3. At all relevant times, the Respondent was employed as a Registered Nurse at Fletcher Allen Health Care (the "Facility") located in Burlington, Vermont.

4. On or about November 17, 2008, the Office of Professional Regulation received a report from the Facility indicating that based on an initial investigation, the Facility was concerned with the Respondent's documentation, administration and wasting of narcotic medications. The Respondent was put on administrative leave on or about November 14, 2008 and was terminated on or about December 2, 2008 for reasons including: inappropriate handling of narcotics, unsafe patient care practices, inaccurate documentation and dispensing of narcotic medication.

5. On or about November 21, 2008 Investigator Jamie Palmisano interviewed the Respondent at her residence in South Burlington. Investigator Palmisano reviewed

concerns listed by the Facility, with the Respondent, based on the results of the audit which found discrepancies with twelve separate patient charts. The concerns, as well as the Respondent's answers to the concerns, are as follows:

a. On or about September 12, 2007, the Respondent administered (4) 50 mcg doses of Fentanyl, (1) 30 mg dose of Toradal, (2) 4 mg doses and (1) 2 mg dose of Morphine, (2) .5 doses of Dilaudid, (1) 4 mg dose of PO Dilaudid and 650 mg of Tylenol to Patient 12 between 9:50 and 11:03. The patient's chart did not indicate that vital signs were taken by the Respondent between 10:30 and 11:50 when the patient was discharged. The notes compared with the medication administration times indicate that the patient was medicated with Morphine while in the bathroom. The Respondent denied medicating the patient in the bathroom and claimed that this patient needed a lot of medication because she had a history of Heroin abuse.

b. On or about October 8, 2007, the Respondent removed 10 mg Morphine for Patient 5. 4 mg were charted as administered, but 6 mg were not charted as either administered or wasted. Although not remembering specifics, the Respondent recalled that when she went to waste the remaining 6 mg of Morphine, the patient's name had been removed and so she wasted it without documenting it or a witness.

c. On or about October 15, 2007, the Respondent withdrew and administered 100 mcg of Fentanyl to Patient 11 between 18:50 and 19:20. The Respondent also withdrew 10 mg Morphine from the Pyxis and charted as having administered 6 mg total to Patient 10 between 21:09 and 21:24, which was 1 mg more than withdrawn and 1 mg over the physician order of 5 mg. The 4 mg surplusage was unaccounted for and not documented. The Respondent admitted the amount administered was above the physician's order and that this was her fault. The Respondent did not have an explanation as to the left over 4 mg of Morphine.

d. On or about November 21, 2007, the Respondent withdrew and administered 200 mcg of Fentanyl to Patient 10 between 9:02 and 11:02. The Respondent also withdrew 10 mg Morphine from the Pyxis and charted as having administered 11 mg total to Patient 10 between 9:39 and 9:55, which was 1 mg more then withdrawn and 1 mg over the physician order of 10mg. The Respondent claimed that this was due to surplusage in the ampule. In respect to the amount of pain medication the Respondent claimed that the patient needed a lot of pain medication.

e. On or about December 1, 2007, the Respondent withdrew medications to help Nurse L. M. administer them to Patient 9. The Respondent and Nurse L.M ultimately wasted 50 mcg Fentanyl, 25 mg Demerol and 6 mg Morphine. However, 50 mcg of the Fentanyl was unaccounted for and not documented as administered or wasted. The Respondent had no explanation for this discrepancy.

f. On or about March 25, 2008, the Respondent failed to document Patient 8's vital signs from 13:00 until 14:50, even though the Respondent had administered three doses of .5 mg Dilaudid between 13:00 and 13:52. The Respondent had .5 mg Dilaudid left over and handed it off to Nurse C.S for wasting. The Respondent stated that she was unable to take vital signs because she was busy.

g. On or about October 7, 2008, the Respondent withdrew a total of 100 mcg Fentanyl for Patient 7, but documented administering a total of 150 mcg. The Respondent claimed that the extra 50 mcg was the result of a "hand-off". The Respondent removed from the Pyxis 2 Vicodin tablets at 14:33 and 2 at 14:37 and documented that she administered 2 Percocet pills at 14:36. The Respondent claimed that she documented the Vicodin as Percocet by mistake. At 15:03 the Respondent removed 10 mg of IV Morphine and documented 5 mg administered at 15:02. The patient was discharged at 15:21 and the remaining 5 mg was documented as wasted at 16:39. The Respondent claimed it was good nursing practice to administer IV Morphine shortly before discharge and stated the reason for the late charting was because she was busy.

h. On or about October 23, 2008, the Respondent made a total of 1 mg withdrawals of Dilaudid for Patient 3. In total only two of these 1mg withdrawals are documented as administered; including .5 mg documented as being administered by another nurse as the result of a "hand-off". The Respondent claimed that she "handed-off" the 1 mg of Dilaudid, but did not document this anywhere.

i. On or about October 23, 2008, the Respondent removed 1 mg of Dilaudid at 13:11 and another 1 mg at 13:33 for Patient 4. Respondent charted .5 mg administered at 13:10 and 13:19. No Dilaudid was administered at 13:33 or after and the 1 mg was documented as wasted at 14:11, seven minutes before the patient was discharged. The Respondent claimed that the 13:33 Dilaudid was withdrawn because she wanted to "be prepared" and was unable to document the wasting until 14:11 because of patient admissions.

j. On or about October 30, 2008, the records indicate that the Respondent administered 2 Percocet tablets to Patient 6 without a medication order. The Respondent admitted that she had done this, but felt it was OK since the patient had a prescription for Percocet and she gave the patient "two for the ride home."

k. On or about November 4, 2008, the Respondent withdrew 100mcg Fentanyl from the Pyxis at 14:52 for Patient 2 and charted administering 50 mcg to the patient at 14:50, leaving 50 mcg of Fentanyl as not accounted for by charting or wasting. The Respondent claimed that she had held on to the medication after Patient 2 was discharged and could not get back into the system to chart the medication as wasted. Pharmacy Director K.M stated it is very easy to reenter a patients name or number to document wasting.

l. On or about November 7, 2008, the Respondent documented that she

administered 17 mg of Morphine to Patient 1 even though the physician order only allowed for 15 mg of Morphine. The Respondent admitted that this occurred. In addition, although the total removal of Morphine from the Pyxis for this patient was 20mg, two other nurses documented that they witnessed wasting 7mg of Morphine in respect to Patient 1 during this time frame. Thus the total amount would have come to 24 mg of Morphine. When questioned about this the Respondent indicated that Morphine ampules typically contain 2-3 mg extra medication. Nurses K.M and C.H. both indicate that this was false and that at most an ampule would contain .5-1 mg extra.

m. On or about November 7, 2008, the Respondent removed 1 mg of Dilaudid for Patient 1 from the Pyxis at 15:52 and charted administering .5 mg to Patient 1 at 15:52. The Respondent made another withdrawal of 1 mg Dilaudid from the Pyxis at 16:14 and charted two doses being administered at 16:23 and 16:34. Thus .5 mg of the Dilaudid was not documented and not accounted. The Respondent indicated that this was for a "hand-off" to the next nurse whose name she could not remember. The Respondent admitted that she knew "hand-offs" were against Facility policy.

8. Throughout the time period in question the Respondent was given several written warnings for discussing personal issues at work, using vulgar language in front of a patient, making co-workers feel uncomfortable, using a cell phone in patient care areas, soliciting money from patients for charity events, and an unsafe transfer of a patient to the PICU without understanding the clinical need for patient monitoring.

9. During the interview with Investigator Palmisano, the Respondent denied any drug diversion from the Facility.

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

Charges

11. 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 nursing 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)(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);

e. 3 V.S.A. §129a(a)(7) (Willfully making or filing false reports or records in the practice of the profession; willfully impeding or obstructing the proper making or filing of reports or records or willfully failing to file the proper reports or records);

f. 3 V.S.A. § 129a(b)(1) and (2) (Failure to practice competently by reason of any cause on a single occasion or on multiple occasions may constitute unprofessional conduct, whether actual injury to a patient, client, or customer has occurred. Failure to practice competently includes: (1) performance of unsafe or unacceptable patient or client care; or (2) failure to conform to the essential standards of acceptable and prevailing practice); and

g. 3 V.S.A. § 129a(a)(3) (Failing to comply with provisions of federal or state statutes or rules governing the practice of the profession).

Understandings

12. 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.

13. 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.

14. 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.

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

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

17. 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.

18. 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.

19. 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 the date of Respondent's Summary Suspension Order**. Before applying for reinstatement, Respondent must: 1) obtain an independent evaluation report by a licensed professional specializing in drug and alcohol abuse pre-approved by the Board; 2) the results of the report with the drug and alcohol abuse independent evaluator must indicate that the Respondent does not present a risk to the safety, health or welfare of her potential patients; 3) Respondent must submit to the Board the results of a minimum of three (3) random urine analyses, collected in an observed setting, administered by a person who 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; and 4) the results of the random urine analyses 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. 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 entry below. 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 registered nursing in which she works at least forty (40) hours every two (2) weeks as a registered 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 a 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 enter into and comply with the substance abuse treatment plan approved by the Board and the treating professional.

(4) Notification to Treating Professional.

Respondent shall provide a copy of this Stipulation and Consent Order to her treating professional and cause her treating professional to inform the Board, in writing and on professional letterhead, of receipt of the Stipulation and Consent Order and the treating professional's ability to comply with the conditions related to treatment and with all other terms of this Consent Order.

(5) 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.

(6) 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.

(7) Random Drug and Alcohol Testing.

~~The parties have not reached agreement as to whether the Respondent shall be prohibited from consuming alcohol during the conditioned period. At the time of the disposition hearing, whether or not to routinely test the Respondent for alcohol use will be left open for the Board to determine.~~

Imposed as submitted

Respondent shall submit to random drug screenings at the request of the Board or its designee. Respondent shall designate a person, who 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.

(8) Abstain from Drug and Alcohol Use.

~~The parties have not reached agreement as to whether the Respondent shall be prohibited from consuming alcohol during the conditioned period. At the time of the disposition hearing, this provision will be left open for the Board to determine.~~

Imposed as submitted

Respondent shall abstain completely from the consumption or possession of drugs with the exception of medications as outlined in paragraph A.(9) for the period of time described in A.(2).

(9) Drug Use Exception.

Respondent shall not take controlled substances unless 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 establishment of the practitioner/patient relationship. Respondent shall ensure that the physician, dentist or nurse practitioner informs the Board, in writing and on appropriate letterhead, of knowledge of Respondent's substance abuse issue(s) within one (1) week of entering into the practitioner/patient relationship. Respondent shall inform the Board in writing of all scheduled/controlled medications prescribed, including the name of the prescribing practitioner, within forty-eight (48) hours of receiving the prescription.

The Board or its designee may request at any time that the practitioner document the continued necessity for the prescribed scheduled/controlled medications if the term exceeds fourteen (14) days. 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 keep a written record of all medications taken, including over the counter drugs, and produce such record upon the request of the Board or its designee.

(10) 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 registered 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 registered nursing employment, Respondent shall cause Respondent's immediate supervisor to write to the Board, on the employer's letterhead, 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 write to the Board, on school letterhead, 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.

(11) Reports from Employers/Program Director.

Within one (1) month of the date of entry of this Order or within one (1) month of the commencement of registered 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. This report shall be submitted in writing on forms issued by the Board. All employer reports shall indicate satisfactory performance 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. This report shall be submitted in writing on forms issued by the Board and accompanied by a cover letter on the school's letterhead. All nursing program reports shall indicate satisfactory performance and attendance.

(12) Practice Under Supervision.

Respondent shall practice as a registered 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.

(13) 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 registered nurse for twelve (12) weeks 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, 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.

(14) 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 during the effective period of this Consent Order.

(15) Interview with the Board or its Designee.

Respondent shall appear in person for interviews with the Board or its designee upon request.

(16) 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.

(17) Notification of Place of Employment/Personal Address/Telephone Number.

Within five (5) 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, personal address, or telephone number.

(18) 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 registered 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.

(19) 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 registered 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.

(20) 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 registered 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.

(21) Costs.

The Respondent shall bear all costs of complying with this Consent Order.

(22) 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.

(23) 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 registered nursing and that she can safely and competently perform the duties of a licensed registered 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:

Dated: 5-11-09

STATE OF VERMONT
SECRETARY OF STATE

By: _____ for
Edward G. Adrian
State Prosecuting Attorney

JENNIFER LETZLER MAGISTRALE
RESPONDENT

Dated: 5-11-09

By: Jennifer Letzler Magistrale
Jennifer Letzler Magistrale

APPROVED AND SO ORDERED:

VERMONT BOARD OF NURSING

Dated: 5/11/09

By: Janine Corr

Date of Entry: 5/14/09

Chairperson

nu.magistrale.stip

STATE OF VERMONT
BOARD OF NURSING

In re: Jennifer Letzler Magistrale License No. 026-14486	} } }	Docket No. NU62-1108

DECISION ON REQUEST FOR SUMMARY SUSPENSION ORDER

Appearances:
for Petitioner, State of Vermont: Edward G. Adrian
for Respondent: pro se

Presiding Officer: Larry S. Novins

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

On February 9, 2009 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. Letzler Magistrale did appear. 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. Letzler Magistrale is licensed 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. Letzler Magistrale made a series of errors involving regulated drugs. State further alleges that the public health, safety or welfare imperatively requires emergency action.
3. Ms. Letzler Magistrale has been provided notice of this matter via "Notice of Summary Suspension Hearing" mailed by certified mail to her last known address. The file does not contain a return showing receipt or non-delivery.
4. The Board has reviewed documents presented by the State.

5. Ms. Letzler Magistrale was put on administrative leave in November 2008 and terminated from her employment on December 2, 2008. She is currently employed as an RN at the So. Burlington Correctional Center.
6. The allegations in the Request for Summary Suspension (copy attached) have been established to the necessary degree.
7. The evidence presented does imperatively require emergency action for the public health, safety, and welfare.

Conclusions of Law

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.

Order

The State's Request for Summary Suspension is **Granted.** Ms. Letzler Magistrale'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).

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: Alan Weis
Alan Weis, Acting Chair

Date: February 9, 2009

OFFICE OF PROFESSIONAL REGULATION
DATE OF ENTRY: 2/10/09

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

IN RE: JENNIFER LETZLER MAGISTRALE) DOCKET No. NU62-1108
License No. 026-0014486)

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 and; the rules of the Board and the Vermont 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. Jennifer Letzler Magistrale (the "Respondent") of South Burlington, Vermont is a registered nurse holding license number 026-0014486, originally issued by the State of Vermont on November 2, 1981. This license is set to expire March 31, 2009.

4. At all relevant times the Respondent was employed at Fletcher Allen Health Care (the "Facility") located in Burlington, Vermont.

5. On or about November 17, 2008 the Office of Professional Regulation received a report from the Facility indicating that based on an initial investigation, the Facility was concerned with the Respondent's documentation, administration and wasting of narcotic medications. The Respondent was put on administrative leave on or about November 14, 2008 and was terminated on or about December 2, 2008 for reasons including: inappropriate handling of narcotics, unsafe patient care practices, inaccurate documentation and dispensing of narcotic medication.

6. On or about November 21, 2008 Investigator Jamie Palmisano interviewed the Respondent at her residence in South Burlington. Investigator Palmisano reviewed concerns listed by the Facility, with the Respondent, based on the results of the audit which found discrepancies with twelve separate patient charts. The concerns as well as the Respondent's answers to the concerns are as follows:

   a. On or about November 7, 2008 the Respondent documented that she administered 17 mg of Morphine to Patient 1 even though the physician order only allowed for 15 mg of Morphine. The Respondent admitted that this occurred. In addition, although the total removal of Morphine from the Pyxis

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for this patient was 20mg, two other nurses documented that they witnessed wasting 7mg of Morphine in respect to Patient 1 during this time frame. Thus the total amount would have come to 24 mg of Morphine. When questioned about this the Respondent indicated that Morphine ampules typically contain 2-3 mg extra medication. Nurses K.M and C.H. both indicates that this was false and that at most a ampule would contain .5-1 mg extra.

b. On or about November 7, 2008 the Respondent removed 1 mg of Dilaudid for Patient 1 from the Pyxis at 15:52 and charted administering .5 mg to Patient 1 at 15:52. The Respondent made another withdrawal of 1 mg Dilaudid from the Pyxis at 16:14 and charted two doses being administered at 16:23 and 16:34. Thus .5 mg of the Dilaudid was not documented and not accounted. The Respondent indicated that this was for a "hand-off" to the next nurse whose name she could not remember. The Respondent admitted that she knew "hand-offs" were against Facility policy.

c. On or about November 7, 2008 the Respondent withdrew 100mcg Fentanyl from the Pyxis at 14:52 fro Patient 2 and charted administering 50 mcg to the patient at 14:50 leaving 50 mcg of Fentanyl as not accounted for by charting or wasting. The Respondent claimed that she had held on to the medication after Patient 2 was discharged and could not get back into the system to chart the medication as wasted. Pharmacy Director K.M stated it is very easy to reenter a patients name or number to document wasting.

d. On or about October 23, 2008, the Respondent made a total of four 1 mg withdrawals of Dilaudid for Patient 3. In total only three of these 1mg withdrawals are documented as administered; including .5 mg documented as being administered by another nurse as the result of a "hand-off". The Respondent claimed that she "handed-off" the 1 mg of Dilaudid, but did not document this anywhere.

e. On or about October 23, 2008 the Respondent removed 1 mg of Dilaudid at 13:11 and another 1 mg at 13:33 for Patient 4. Respondent charted .5 mg administered at 13:10 and 13:19. No Dilaudid was administered at 13:33 or after and the 1 mg was documented as wasted at 14:11, seven minutes before the patient was discharged. The Respondent claimed that the 13:33 Dilaudid was withdrawn because she wanted to "be prepared" and was unable to document the wasting until 14:11 because of patient admissions.

f. On or about October 8, **2007** the Respondent removed 10 mg Morphine for Patient 5. 4 mg were charted as administered, but 6 mg were not charted as either administered or wasted. Although not remembering specifics the Respondent recalled that when she went to waste the remaining 6 mg of Morphine, the patient's name had been removed and so she it without documenting it or a witness.

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g. On or about October 30, 2008 the records indicate that the Respondent administered 2 Percocet tablets to Patient 6 without a medication order. The Respondent admitted that she had done this, but felt it was OK since the patient had a prescription for Percocet and she gave the patient "two for the ride home".

h. On or about October 7, 2008 the Respondent withdrew a total of 100 mcg Fentanyl for Patient 7, but documented administering a total of 150 mcg. The Respondent claimed that the extra 50 mcg was the result of a "hand-off". The Respondent removed from the Pyxis 2 Vicodin tablets at 14:33 and 2 at 14:37 and documented that she administered 2 Percocet pills at 14:36. The Respondent claimed that she documented the Vicodin as Percocet by mistake. At 15:03 the Respondent removed 10 mg of IV Morphine and documented 5 mg administered at 15:02. The patient was discharged at 15:21 and the remaining 5 mg was documented as wasted at 16:39. The Respondent claimed it was good nursing practice to administer IV Morphine shortly before discharge and stated the reason for the late charting was because she was busy.

i. On or about March 25, 2008 the failed to document Patient 8's vital signs from 13:00 until 14:50, even though the Respondent had administered three doses of .5 mg Dilaudid between 13:00 and 13:52. The Respondent had .5 mg left over and handed it off to Nurse C.S for wasting. The Respondent stated that she was unable to take vital signs because she was busy.

j. On or about December 1, 2008 the Respondent withdrew medications to help Nurse L. M. administer them to Patient 9. The Respondent and Nurse L.M ultimately wasted 50 mcg Fentanyl, 25 mg Demerol and 6 mg Morphine. However, 50 mcg of the Fentanyl was unaccounted for and not documented as administered or wasted. The Respondent had no explanation for this discrepancy.

k. On or about November 21, 2008 the Respondent withdrew and administered 200 mcg of Fentanyl to Patient 10 between 9:02 and 11:02. The Respondent also withdrew 10 mg Morphine from the Pyxis and charted as having administered 11 mg total to Patient 10 between 9:39 and 9:55, which was 1 mg more then withdrawn and 1 mg over the physician order of 10mg. The Respondent claimed that this was due to surplusage in the ampule. In respect to the amount of pain medication the Respondent claimed that the patient needed a lot of pain medication.

l. On or about October 15, 2007 the Respondent withdrew and administered 100 mcg of Fentanyl to Patient 11 between 18:50 and 19:20. The Respondent also withdrew 10 mg Morphine from the Pyxis and charted as having administered 6 mg total to Patient 10 between 21:09 and 21:24, which was 1 mg more then withdrawn and 1 mg over the physician order of 5 mg. The 4 mg surplusage was un accounted for and not documented. The Respondent admitted the

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amount administered was above the physician's order and that this was her fault. The Respondent did not have an explanation as to the left over 4 mg of Morphine.

m. On or about September 12, 2007 the Respondent administered (4) 50 mcg doses of Fentanyl, (1) 30 mg dose of Toradal, (2) 4 mg doses and (1) 2 mg dose of Morphine, (2) .5 doses of Dilaudid, (1) 4 mg dose of PO Dilaudid and 650 mg of Tylenol to Patient 12 between 9:50 and 11:03. The patient's chart did not indicate that vital signs were taken by the Respondent between 10:30 and 11:50 when the patient was discharged. The notes compared with the medication administration times indicate that the patient was medicated with Morphine while in the bathroom. The Respondent denied medicating the patient in the bathroom and claimed that this patient needed a lot of medication because she had a history of Heroin abuse.

8. Throughout the time period in question the Respondent was given several written warnings for discussing personal issues at work, using vulgar language in front of a patient, making co-workers feel uncomfortable, using a cell phone in patient care areas, soliciting money from patients for charity events, and an unsafe transfer of a patient to the PICU without understanding the clinical need for patient monitoring.

9. During the interview with Investigator Palmisano , the Respondent denied any drug diversion from the Facility.

Request for Relief

10. 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.

11. The above acts and circumstances, alone or in combination, violate: 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); 26 V.S.A. § 1582(a)(3)(is unable to practice nursing competently by reason of any cause); and Vermont Board of Nursing Administrative Rules 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); 26 V.S.A. § 1582(a)(7)(engages in conduct of a character likely to deceive, defraud or harm the public).

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

DATED at Montpelier, Vermont this 7th day of January, 2009.

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