

Deanna K. Malec, PA

**STATE OF VERMONT
BOARD OF NURSING**

In re: Deanna K. Malec
License No. 026-81009

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}

Docket No. 2011- 709

Appearances:

Petitioner, State of Vermont: Lauren Hibbert
Respondent: Did not appear

Presiding Officer: Larry S. Novins

DEFAULT ORDER

The Board held a hearing on the above matter on April 9, 2012 at the National Life Building in Montpelier, Vermont. Ms. Malec did not attend and was not represented by counsel.

Findings of Fact

1. Ms. Malec was licensed as a registered nurse and is therefore subject to the regulatory authority of this Board. 3 V.S.A. §§ 129, 129a, 814(d), 26 V.S.A. § 1582(a), the Administrative Rules of the Board of Nursing, and the Rules of the Office of Professional Regulation.
2. Ms. Malec's license was summarily suspended by this Board on November 16, 2011.
3. On February 1, 2012 Ms. Malec 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.
4. 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.
5. Licensees are required to notify the Board of any change of address within 30 days. 3 V.S.A. § 129a(a)(14).
6. The return receipt shows that Ms. Malec received the Specification of Charges on February 6, 2012.
7. Ms. Malec has not filed an answer to the charges.
8. On March 27, 2012 notice of the Default Hearing scheduled for this date was mailed to Ms. Malec at that same address by certified mail. The file shows no return on this mailing.
9. Ms. Malec has still not answered the charges.
10. Upon hearing the State's presentation and taking notice of its own file, the Board finds Ms. Malec to be in Default. The allegations contained in the State's Specification of Charges are therefore treated as the facts on which the Board's Order is based. OPR Rule 3.4, 3 V.S.A. § 809(d) and 3 V.S.A. § 814(c).

Conclusions of Law

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

Order

In accordance with the above Findings of Fact and Conclusions of Law, Ms. Malec's license is hereby **Revoked** effective as of the date of the hearing.

Appeal Rights

This is a final administrative determination by the Vermont Board of Nursing.

A party aggrieved by a final decision of a board may appeal this decision by filing a written Notice of Appeal with the Director of the Office of Professional Regulation, Vermont Secretary of State, National Life Bldg., North, FL2, Montpelier, VT 05620-3402 within 30 days of the entry of this order.

If an appeal is filed, the Director of the Office of Professional Regulation shall assign the case to an appellate officer. The review shall be conducted on the basis of the record created before the board. In cases of alleged irregularities in procedure before the board, not shown in the record, proof on that issue may be taken by the appellate officer. 3 V.S.A. §§ 129(d) and 130a.

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

Vermont Board of Nursing

By:

Jeanine Carr
Jeanine Carr, R.N., Chair

Date: April 9, 2012

OFFICE OF PROFESSIONAL REGULATION

DATE OF ENTRY:

4/10/12

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

IN RE:

DEANNA K. MALEC

License No. 026.0081009,

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)
)

Docket No. 2011-709

SPECIFICATION OF CHARGES

NOW COMES the State of Vermont and makes the following Charges against the Respondent, Deanna K. Malec, RN:

Board Authority

1. The Vermont State Board of Nursing (the "Board") has authority to issue warnings or reprimands; suspend, revoke, limit, or condition current licenses; or prevent the renewal of lapsed licenses if, after disciplinary hearing, the Board finds that the Respondent has engaged in unprofessional conduct. 3 V.S.A. § 129(a); 3 V.S.A. § 129a; 3 V.S.A. § 814(d); 26 V.S.A. § 1582; the Administrative Rules of the Board of Nursing (the "ARBN"); and the Rules of the Office of Professional Regulation.

Statement of Facts

2. Deanna K. Malec (the "Respondent") of Carnegie, Pennsylvania is licensed by the State of Vermont as a Registered Nurse under license number 026.0081009. This license was originally issued on or about November 4, 2011 and is currently set to expire on or about March 31, 2013. Additionally, the Respondent is licensed as Temporary Registered Nurse under license number 026.0081013-TEMP which was originally issued on or about September 7, 2011 and expires on or about December 6, 2011.
3. At all times relevant, Respondent was employed at North Country Hospital (the "Facility"), located in Newport, Vermont.
4. On or about October 14, 2011, the Office of Professional Regulation received a Drug Diversion Reporting Form from the Facility alleging that the Respondent had been diverting narcotics from the Facility's emergency room.
5. On or about October 10, 2011, L.L., Director of Nursing for the Facility, after receiving a complaint about the Respondent's conduct initiated an investigation of the Respondent's narcotic withdrawal practices while she was employed at that Facility from September 7, 2011 to October 8, 2011. L.L.'s investigation consisted of review of narcotic records, including removal of narcotics from Pyxis, with patient records,

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that within the twenty one (21) days the Respondent worked for the Facility she diverted narcotics a total of ninety (90) times. Examples of the Respondent's diversion include, in part, the following:

- a. On or about September 7, 2011, at 4:03 pm, the Respondent removed 2mg of Hydromorphone from the Emergency Room Pyxis under a patient id of someone who was not in the Emergency Room on that date.
- b. On or about September 8, 2011, at 7:15 am, the Respondent removed 2mg of Hydromorphone from the Emergency Room Pyxis under a patient id of someone who was not in the Emergency Room on that date.
- c. On or about September 8, 2011, at 11:08 am, the Respondent removed 2mg of Hydromorphone from the Emergency Room Pyxis even though there was not a doctor's order for Hydromorphone and there was not documentation that the narcotic was administered to the patient.
- d. On or about September 8, 2011, at 3:15 pm, the Respondent removed 5mg of Oxycodone from the Emergency Room Pyxis even though there was not a doctor's order for Oxycodone and there was not documentation that the narcotic was administered to the patient. The patient left the Emergency Room at 3:12 pm.
- e. On or about September 10, 2011, at 1:14 pm, the Respondent removed 2mg of Hydromorphone from the Emergency Room Pyxis even though there was not a doctor's order for Hydromorphone and there was not documentation that the narcotic was administered to the patient. The patient left the Emergency Room at 11:32 am.
- f. On or about September 10, 2011, at 3:20 pm, the Respondent removed 2mg of Hydromorphone from the Emergency Room Pyxis even though there was not a doctor's order for Hydromorphone and there was not documentation that the narcotic was administered to the patient.
- g. On or about September 10, 2011, at 8:22 pm, the Respondent removed 2mg of Hydromorphone from the Emergency Room Pyxis even though there was not a doctor's order for Hydromorphone and there was not documentation that the narcotic was administered to the patient.
- h. On or about September 16, 2011, at 8:49 am, the Respondent removed 2mg of Hydromorphone from the Emergency Room Pyxis even though there was not a doctor's order for Hydromorphone and there was not documentation that the narcotic was administered to the patient. The patient left the Emergency Room at 10:55 pm on September 15, 2011.

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Montpelier, VT
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- i. On or about September 16, 2011, at 5:17 pm, the Respondent removed 2mg of Hydromorphone from the Emergency Room Pyxis even though there was not a doctor's order for Hydromorphone and there was not documentation that the narcotic was administered to the patient. The patient left the Emergency Room at 10:55 pm on September 15, 2011.
- j. On or about September 16, 2011, at 8:53 pm, the Respondent removed 2mg of Hydromorphone from the Emergency Room Pyxis even though there was not a doctor's order for Hydromorphone and there was not documentation that the narcotic was administered to the patient. The patient left the Emergency Room at 6:49 pm.
- k. On or about September 23, 2011, at 8:55 am, the Respondent removed 2mg of Hydromorphone from the Emergency Room Pyxis even though there was not a doctor's order for Hydromorphone and there was not documentation that the narcotic was administered to the patient.
- l. On or about September 23, 2011, at 12:35 pm, the Respondent removed 2mg of Hydromorphone from the Emergency Room Pyxis even though there was not a doctor's order for Hydromorphone and there was not documentation that the narcotic was administered to the patient.
- m. On or about September 23, 2011, at 4:29 pm, the Respondent removed 2mg of Hydromorphone from the Emergency Room Pyxis even though there was not a doctor's order for Hydromorphone and there was not documentation that the narcotic was administered to the patient. The patient left the Emergency Room at 2:49 pm.

Request for Relief

- 7. 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.
- 8. 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);
 - b. 26 V.S.A. § 1582(a)(7) (Engages in conduct of a character likely to deceive, defraud or harm the public);
 - c. ARBN Chapter 4, Subchapter 4, Rule 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);

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- d. ARBN Chapter 4, Subchapter 4, Rule 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);
- e. 3 V.S.A. § 129a(a)(7) (Willfully making or filing false reports or records in the practice of the profession; willfully impeding or obstructing the proper making or filing of reports or records; or willfully failing to file the proper reports or records);
- f. 3 V.S.A. § 129a(b)(1) and (2) (Failure to practice competently by reason of any cause on a single occasion or on multiple occasions may constitute unprofessional conduct, whether actual injury to a client, patient, or customer has occurred. Failure to practice competently includes: (1) performance of unsafe or unacceptable patient or client care; or (2) failure to conform to the essential standards of acceptable and prevailing practice); and
- g. 3 V.S.A. § 129a(a)(3) (Failing to comply with provisions of federal or state statutes or rules governing the practice of the profession).

WHEREFORE, the State of Vermont respectfully requests that pursuant to 3 V.S.A. § 814(c), the Respondent's nursing license number 026.0081009 be summarily suspended, pending a hearing on the merits.

DATED at Montpelier, Vermont this 10 day of November, 2011.

STATE OF VERMONT
SECRETARY OF STATE

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

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STATE OF VERMONT



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**STATE OF VERMONT
BOARD OF NURSING**

In re: Deanna K. Malec	}	
License No. 026-0081009	}	
026-0081013 (temp)	}	Docket No. 2011-709(RN)

**DECISION ON REQUEST FOR
SUMMARY SUSPENSION ORDER**

Appearances:

for Petitioner, State of Vermont: Lauren Hibbert
for Respondent: Did not appear

Presiding Officer: Larry S. Novins

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

On November 14, 2011 this matter came before the Board of Nursing on the State's Request for a Summary Suspension. Ms. Malec did not 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. 3 V.S.A. § 814(c).

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. Malec is a licensed 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. 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 between September 7, 2011 and October 8, 2011 when she was terminated from her employment at North Country Hospital in Newport, Vermont, Ms. Malec diverted narcotic drugs approximately 90 times.
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. Malec at her last known address in Pennsylvania via certified mail dated November 10, 2011. There is no evidence in the file to show whether or not Ms. Malec is aware of the State's request for Summary Suspension.
5. Testimony of investigator Karl Packer revealed that Ms. Malec is currently in a drug treatment program in Pittsburgh, Pennsylvania.
6. The Board finds for purposes of this hearing that Ms. Malec did divert narcotic drugs on multiple occasions as set forth in the State's Request for Summary Suspension.
7. The allegations in the Request for Summary Suspension (copy attached) have been established to the necessary degree.
8. The evidence presented does imperatively require emergency action for the public health, safety, and welfare. Specifically, summary suspension is necessary to prevent Ms. Malec from injuring patients by taking drugs intended for them, or injuring patients by falsifying patient records to cover up her diversion of drugs intended for patients. If summary suspension is not ordered, the Board finds that patient harm will occur.

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 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 above do support Summary Suspension of Ms. Malec'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 Ms. Malec 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. Malec 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 State's Request for Summary Suspension is **Granted**. Ms. Malec'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: 
Ellen Leff, RN, Chair

Date: November 14, 2011

OFFICE OF PROFESSIONAL REGULATION

DATE OF ENTRY: 11/16/11

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

IN RE:

DEANNA K. MALEC

License No. 026.0081009,

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Docket No. 2011-709

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. Deanna K. Malec (the "Respondent") of Carnegie, Pennsylvania is licensed by the State of Vermont as a Registered Nurse under license number 026.0081009. This license was originally issued on or about November 4, 2011 and is currently set to expire on or about March 31, 2013. Additionally, the Respondent is licensed as Temporary Registered Nurse under license number 026.0081013-TEMP which was originally issued on or about September 7, 2011 and expires on or about December 6, 2011.
4. At all times relevant, Respondent was employed at North Country Hospital (the "Facility"), located in Newport, Vermont.
5. On or about October 14, 2011, the Office of Professional Regulation received a Drug Diversion Reporting Form from the Facility alleging that the Respondent had been diverting narcotics from the Facility's emergency room.
6. On or about October 10, 2011, L.L., Director of Nursing for the Facility, after receiving a complaint about the Respondent's conduct initiated an investigation of the Respondent's narcotic withdrawal practices while she was employed at that Facility from September 7, 2011 to October 8, 2011. L.L.'s investigation consisted of review of narcotic records, including removal of narcotics from Pyxis, with patient records, including doctor's orders and medication administration. The investigation revealed

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that within the twenty one (21) days the Respondent worked for the Facility she diverted narcotics a total of ninety (90) times. Examples of the Respondent's diversion include, in part, the following:

- a. On or about September 7, 2011, at 4:03 pm, the Respondent removed 2mg of Hydromorphone from the Emergency Room Pyxis under a patient id of someone who was not in the Emergency Room on that date.
- b. On or about September 8, 2011, at 7:15 am, the Respondent removed 2mg of Hydromorphone from the Emergency Room Pyxis under a patient id of someone who was not in the Emergency Room on that date.
- c. On or about September 8, 2011, at 11:08 am, the Respondent removed 2mg of Hydromorphone from the Emergency Room Pyxis even though there was not a doctor's order for Hydromorphone and there was not documentation that the narcotic was administered to the patient.
- d. On or about September 8, 2011, at 3:15 pm, the Respondent removed 5mg of Oxycodone from the Emergency Room Pyxis even though there was not a doctor's order for Oxycodone and there was not documentation that the narcotic was administered to the patient. The patient left the Emergency Room at 3:12 pm.
- e. On or about September 10, 2011, at 1: 14 pm, the Respondent removed 2mg of Hydromorphone from the Emergency Room Pyxis even though there was not a doctor's order for Hydromorphone and there was not documentation that the narcotic was administered to the patient. The patient left the Emergency Room at 11:32 am.
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- g. On or about September 10, 2011, at 8:22 pm, the Respondent removed 2mg of Hydromorphone from the Emergency Room Pyxis even though there was not a doctor's order for Hydromorphone and there was not documentation that the narcotic was administered to the patient.
- h. On or about September 16, 2011, at 8:49 am, the Respondent removed 2mg of Hydromorphone from the Emergency Room Pyxis even though there was not a doctor's order for Hydromorphone and there was not documentation that the narcotic was administered to the patient. The patient left the Emergency Room at 10:55 pm on September 15, 2011.

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- i. On or about September 16, 2011, at 5:17 pm, the Respondent removed 2mg of Hydromorphone from the Emergency Room Pyxis even though there was not a doctor's order for Hydromorphone and there was not documentation that the narcotic was administered to the patient. The patient left the Emergency Room at 10:55 pm on September 15, 2011.
- j. On or about September 16, 2011, at 8:53 pm, the Respondent removed 2mg of Hydromorphone from the Emergency Room Pyxis even though there was not a doctor's order for Hydromorphone and there was not documentation that the narcotic was administered to the patient. The patient left the Emergency Room at 6:49 pm.
- k. On or about September 23, 2011, at 8:55 am, the Respondent removed 2mg of Hydromorphone from the Emergency Room Pyxis even though there was not a doctor's order for Hydromorphone and there was not documentation that the narcotic was administered to the patient.
- l. On or about September 23, 2011, at 12:35 pm, the Respondent removed 2mg of Hydromorphone from the Emergency Room Pyxis even though there was not a doctor's order for Hydromorphone and there was not documentation that the narcotic was administered to the patient.
- m. On or about September 23, 2011, at 4:29 pm, the Respondent removed 2mg of Hydromorphone from the Emergency Room Pyxis even though there was not a doctor's order for Hydromorphone and there was not documentation that the narcotic was administered to the patient. The patient left the Emergency Room at 2:49 pm.

Request for Relief

- 7. 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.
- 8. 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);
 - b. 26 V.S.A. § 1582(a)(7) (Engages in conduct of a character likely to deceive, defraud or harm the public);
 - c. ARBN Chapter 4, Subchapter 4, Rule 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);

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- d. ARBN Chapter 4, Subchapter 4, Rule 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);
- e. 3 V.S.A. § 129a(a)(7) (Willfully making or filing false reports or records in the practice of the profession; willfully impeding or obstructing the proper making or filing of reports or records; or willfully failing to file the proper reports or records);
- f. 3 V.S.A. § 129a(b)(1) and (2) (Failure to practice competently by reason of any cause on a single occasion or on multiple occasions may constitute unprofessional conduct, whether actual injury to a client, patient, or customer has occurred. Failure to practice competently includes: (1) performance of unsafe or unacceptable patient or client care; or (2) failure to conform to the essential standards of acceptable and prevailing practice); and
- g. 3 V.S.A. § 129a(a)(3) (Failing to comply with provisions of federal or state statutes or rules governing the practice of the profession).

WHEREFORE, the State of Vermont respectfully requests that pursuant to 3 V.S.A. § 814(c), the Respondent's nursing license number 026.0081009 be summarily suspended, pending a hearing on the merits.

DATED at Montpelier, Vermont this 10 day of November, 2011.

STATE OF VERMONT
SECRETARY OF STATE

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

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STATE OF VERMONT



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