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

IN RE:	)	
THERESA A. MCAVINNEY	)	Docket No. NU54-1207
License No. 026-0022377	)	

STIPULATION AND CONSENT ORDER

STIPULATION

NOW COMES the State of Vermont, by and through State Prosecuting Attorney Edward G. Adrian, and the Respondent, Theresa A. McAvinney, 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. Theresa A. McAvinney (the "Respondent") of Westfield, Vermont is licensed by the State of Vermont as a Registered Nurse under license number 026-0022377. This license was originally issued on or about August 18, 1995 and is currently set to expire on or about March 31, 2009.

3. At all times relevant, Respondent was employed as a Registered Nurse and Director of Nursing Services at Michaud Memorial Manor (the "Facility"), an elder care facility located in Derby Line, Vermont.

4. On or about December 24, 2007 in a Mandatory Report of Unprofessional Conduct, M.M., a Licensed Clinical Social Worker for Vermont Catholic Charities, which sponsors the Facility, stated that Respondent performed treatments and provided services that Respondent was not qualified to perform or which were beyond her scope of education, training, capabilities, experience, or scope of practice.

5. Attached to the Report from M.M. were 1) a facsimile dated December 20, 2007 from Facility Administrator R.D. to Registered Nurse F.K. regarding a November 26, 2007 survey report that revealed deficiencies at the Facility found during an unannounced

onsite visit completed November 14, 2007; and 2) a corresponding written Plan of Correction signed by the Respondent on December 21, 2007 which laid out steps to avoid or correct the deficiencies revealed in the survey.

6. The November 26, 2007 survey revealed in part the following:

   a. On or about November 14, 2007 in an interview with the surveyor, Respondent admitted to administering Metamucil to Resident #1 on or about October 1, 2007 without a physician's order, and did not obtain a physician's order for the administration of Metamucil to Resident #1 until October 5, 2007 because Respondent "wanted to see if it worked" before obtaining such an order.

   b. On or about November 14, 2007 in an interview with the surveyor, Respondent admitted to not administering Imodium that was prescribed to be given to Resident #1 prior to any scheduled physician visit. Noted in the survey was a fax from Resident #1's physician dated on or about November 14, 2007 that stated that during a physician visit the day before, Resident #1 had "explosive diarrhea in the office," and that Resident #1 "needs her Imodium before doctor visits." Respondent confirmed during the interview that she did not administer the Imodium as prescribed to Resident #1 because Respondent "didn't think she'd need it."

   c. On or about November 14, 2007 in an interview with the surveyor, Respondent admitted to a violation of the Facility policy that required that the Facility "shall contract with a pharmacy for procurement of medications for the residents." During this interview, Respondent confirmed that she obtained an order for Resident #2's prescribed Omega 3 supplement by personally placing an order with a mail distribution center with which the Facility did not have a contract; personally paying the bill in total; and then billing, and subsequently receiving payment from, Resident #2 for the supplement.

   d. On or about November 14, 2007, the surveyor observed that multiple medications were stored in unlocked cupboards and an unlocked container in the refrigerator, located in the nurse's station; and in addition, the surveyor observed that there was no evidence that staff had monitored the temperature of the medication in the refrigerator. On this same date in an interview with the surveyor, Respondent confirmed that the medications were accessible to all staff who had access to the nurse's station, and that the staff had not monitored the temperature of the medication in the refrigerator.

7. On or about November 6, 2008 in an interview with State Investigator Gregory Kelly, Respondent stated that she was hired as the Facility's Director of Nursing Services in or around July 2007 and had therefore only been in that position for a short amount of time when the survey was conducted.

Charges

8. 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) which includes performance of unsafe or unacceptable patient care pursuant to ARBN Chapter 4, Rule IV(II)(B)(1); and failure to conform to the essential standards of acceptable and prevailing nursing practice pursuant to ARBN Chapter 4, Rule IV(II)(B)(2);

   b. 26 V.S.A. § 1582(a)(7) (Engages in conduct of a character likely to deceive, defraud, or harm the public) which includes performing acts beyond the limits of the statutory definitions of the practice of nursing in 26 V.S.A. § 1572(2), (3), and (4) pursuant to ARBN Chapter 4, Rule IV(II)(D)(1);

   c. 3 V.S.A. § 129a(a)(13) (Performing treatments or providing services which the licensee is not qualified to perform or which are beyond the scope of the licensee's education, training, capabilities, experience, or scope of practice);

   d. 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

   e. 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

9. 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.

10. 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.

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

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

13. 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.

14. 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.

15. 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 **REPRIMANDS** Respondent's license to practice registered nursing.

B. 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).

C. This Stipulation and Consent Order will remain part of Respondent's licensing file and may be used for purposes of determining sanctions in any future disciplinary matter.

AGREED TO:

STATE OF VERMONT
SECRETARY OF STATE

Dated: 5/1/09

By: _____
Edward G. Adrian
State Prosecuting Attorney

THERESA A. MCAVINNEY
RESPONDENT

Dated: 4/21/09

By: Theresa A. McAvinney
Theresa A. McAvinney

APPROVED AS TO FORM:

ATTORNEY FOR RESPONDENT

Dated: 4/21/09

By: David J. Williams
David J. Williams, Esq.

APPROVED AND SO ORDERED:

VERMONT BOARD OF NURSING

Dated: 5-11-09

By: _____
Chairperson

Date of Entry: 5/14/09

nu.mcavinney.stip