

**STATE OF VERMONT
BOARD OF NURSING**

In re: Patricia M. McCann
License No. 026-94474

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Docket No. 2014-123(RN)

Appearances:

Prosecuting the case: Annika Green
Respondent: Did not appear

Presiding Officer: Larry S. Novins

DEFAULT ORDER

The Board held a hearing on the above matter on July 14, 2014 at the Office of Professional Regulation Conference Room at the City Center in Montpelier, Vermont. Ms. McCann did not attend and was not represented by counsel.

Findings of Fact

1. Ms. McCann 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. Her license was summarily suspended by Order of this Board dated May 12, 2014.
2. On May 21, 2014 Ms. McCann 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. Stamps on the envelope indicate the notice of charges was returned marked "Return to Sender. Unclaimed. Unable to Forward."
6. Ms. McCann has not filed an answer to the charges.
7. On June 3, 2014 notice of the Default Hearing scheduled for this date was mailed to Ms. McCann at that same address by certified mail. It too was returned marked "Return to Sender. Unclaimed. Unable to forward."
8. Ms. McCann has still not answered the charges.
9. Upon hearing the Prosecution's presentation and taking notice of its own file, the Board finds Ms. McCann 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. McCann 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. McCann 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. McCann 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. McCann's license is hereby **Suspended Indefinitely** effective as of the date of the hearing. Should Ms. McCann 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.

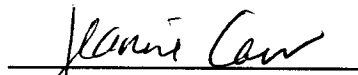
A party aggrieved by a final decision of a board may appeal this decision by filing a written Notice of Appeal with the Director of the Office of Professional Regulation, Vermont Secretary of State, 89 Main St., Fl. 3, Montpelier, VT 05620-3402 within 30 days of the entry of this Order.

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

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

Vermont Board of Nursing

By:


Jeanine Carr, RN, Chair

Date: July 14, 2014

OFFICE OF PROFESSIONAL REGULATION

DATE OF ENTRY: 7/15/14

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

IN RE:
PATRICIA MCCANN
License No. 026.0094474

Docket No. 2014-123

SPECIFICATION OF CHARGES

Board Authority

1. The Vermont Board of Nursing (the "Board") has authority to issue warnings or reprimands; suspend, revoke, limit, or condition current licenses; or prevent the renewal of a lapsed license if, after disciplinary hearing, the Board finds that the Respondent has engaged in unprofessional conduct. 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.

Statement of Facts

2. Patricia McCann (the "Respondent") of Madison, CT is licensed by the State of Vermont as a Registered Nurse under license number 026.0094474. This license is active and currently set to expire on or about March 31, 2015.
3. On or about February 20, 2014, Investigator Dennis Menard of the Office of Professional Regulation ("OPR") met with B.G., the Assistant Nurse Manager in the Dialysis Unit at Fletcher Allen Health Care ("FAHC"), and with K.M., a pharmacist at FAHC. B.G. and K.M. had conducted an audit of their internal narcotics control system and relayed the following general information to Investigator Menard about their review:
 - a. Respondent worked as a contract travel nurse at FAHC from May, 2013 through August, 2013;
 - b. On or about September 3, 2013, Respondent was hired full time in the dialysis unit;
 - c. During the course of their internal audit, B.G. and K.M. found that Respondent withdrew narcotics from the Pyxis machine at a far higher rate than her peers;
 - d. B.G. and K.M. found this higher rate of narcotic administration especially unusual given that the dialysis unit is a procedural unit with short term outpatients and due to the potential blood pressure issues, these patients in particular should not be receiving heavy doses of narcotic medications.

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Prosecuting Attorney
Office of
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89 Main Street
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4. The FAHC internal review of Respondent's narcotic administration specifically showed 14 irregularities in her administration of pain medication, documentation of medication administration and improper wasting documentation (resulting in several narcotic medications being unaccounted for) including the following:
- a. (Irregularities 1, 2, 3) Patient XXX500 had an order for Morphine every 4 hours as needed. On or about September 12, 2013, Respondent withdrew Morphine from the Pyxis at approximately 11:48AM and 12:35PM. On or about September 13, 2013, Respondent withdrew Morphine from the Pyxis at approximately 2:35PM. Respondent made no record of any of the above Morphine being given to the patient.
 - b. (Irregularity 4) Patient XXX969 had an order for Morphine every 4 hours as needed. On or about September 25, 2013, Respondent withdrew Morphine from the Pyxis at approximately 8:47AM. Respondent made no record of the Morphine being given to the patient.
 - c. (Irregularity 5) Patient XXX274 had an order for a Fentanyl 50 mcg/ml injection 25-50 mcg. On or about September 28, 2013, Respondent withdrew 100 mcg Fentanyl at approximately 7:28AM. She documented giving the patient at 8:00 AM. Respondent did not document wasting the rest of the medication.
 - d. (Irregularities 6, 7) Patient XXX969 had an order for Hydromorphone liquid 0.5-1 mg every 4 hours as needed. On or about October 1, 2013 at 10:56AM and again at 10:58AM, Respondent withdrew Hydromorphone 2 mg tablets, yet documented she gave the patient .5 mg liquid at approximately 11:08AM. No liquid was withdrawn from the Pyxis and Respondent did not document the 2 tablets.
 - e. (Irregularities 8, 9) Patient XXX648 had orders for Hydromorphone 1-2 mg tablet every 3 hours as needed and Hydromorphone .5mg IV every 3 hours as needed.
 - i. On or about December 21, 2013, at approximately 7:09AM, Respondent withdrew one Hydromorphone 2mg tablet from the Pyxis. Respondent made no record of the Hydromorphone being given to the patient.
 - ii. On or about December 23, 2013, at approximately 1:33PM, Respondent withdrew Hydromorphone 1 mg injection from the Pyxis. Respondent documented giving .5 mg to the patient at 1:42PM. Respondent did not document wasting the rest of the medication.
 - f. (Irregularity 10) Patient XXX775 had an order for Hydromorphone tablet 2-4 mg every 3 hours as needed. On or about January 4, 2014, at approximately 8:23AM, Respondent withdrew two 2 mg tablets of Hydromorphone from the Pyxis. Respondent made no record of the Hydromorphone being given to the patient.
 - g. (Irregularities 11,12) Patient XXX602 had an order for Hydromorphone 1mg injection .2-.4 mg every 3 hours as needed. On or about January 18, 2014 at

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8:32AM and again at 9:37AM, Respondent withdrew Hydromorphone 1 mg injections from the Pyxis. Respondent made no record of the Hydromorphone being given to the patient.

- h. (Irregularity 13) Patient XXX362 had an order for Oxycodone 5 mg oral 4 times daily as needed. On or about January 23, 2014, Respondent withdrew Oxycodone 5 mg tablet from the Pyxis at approximately 10:28AM. Respondent documented that at 10:38AM the patient/family refused the medication. Respondent did not document wasting the medication.
- i. (Irregularity 14) XXX007 had an order for Tramadol 50 mg tablet 2 times daily. On or about February 10, 2014, at approximately 11:25AM, Respondent withdrew a 50 mg tablet from the Pyxis. At 11:43AM, Respondent documented the medication was "not given" because the patient refused the dose. Respondent did not document wasting the medication.

Charges

- 5. 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); incorporating ARBN Part 11.2(b) ("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) and ARBN Part 11.2(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);
 - b. 26 V.S.A. § 1582(a)(7) (Engages in conduct of a character likely to deceive, defraud or harm the public);
 - c. 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);
 - 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).

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89 Main Street
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Relief Requested

WHEREFORE, the license of Patricia McCann should be revoked or otherwise disciplined.

DATED at Montpelier, Vermont this 1st day of May, 2014.

STATE OF VERMONT
SECRETARY OF STATE

By: _____

Annika Green

Annika Green
State Prosecuting Attorney

STATE OF VERMONT



Prosecuting Attorney
Office of
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89 Main Street
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**STATE OF VERMONT
BOARD OF NURSING**

In re: Patricia M. McCann
License No. 026-94474

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Docket No. 2014-123(RN)

**DECISION ON REQUEST FOR
SUMMARY SUSPENSION ORDER**

Appearances:

Prosecuting the case: Annika Green
for Respondent: did not appear

Presiding Officer: Larry S. Novins

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

This matter came before the Board of Nursing on a Request for a Summary Suspension. The hearing was held on May 12, 2014 at the Office of Professional Regulation Conference Room in Montpelier, Vermont. Ms. McCann 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. McCann 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 prosecutor has filed a "Request for Summary Suspension." A copy of the Request is attached to this Decision and Order. The Request alleges that Ms. McCann diverted narcotic drugs to her own purposes.
3. The Request for Summary Suspension further alleges that the public health, safety or welfare imperatively requires emergency action.
4. Notice of this hearing was sent to Ms. McCann at her last known address in Connecticut

via certified mail dated May 2, 2014. The return receipt shows it was signed for on Ms. McCann's behalf on May 5, 2014.

5. The Board finds for purposes of this hearing that Ms. McCann on several occasions between September, 2013 and February, 2014 withdrew Morphine from a Pyxis machine, but without documenting that it was given to a patient and that there were serious discrepancies or lapses in her record keeping regarding administration or wasting of Fentanyl and Hydromorphone. Many of her patients were in a dialysis unit where they would not be expected to need narcotic drugs. Ms. McCann was diverting those drugs for her own use.
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. Specifically, summary suspension is necessary to prevent harm to patients and the public. If summary suspension is not ordered, patient and public 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 Prosecutor's Request for a Summary Suspension is supported by the evidence presented. The Board concludes that the allegations in the Request for Summary Suspension have been established to the necessary degree. For purposes of this Summary Suspension Hearing, the Findings of Fact above do support Summary Suspension of Ms. McCann'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. McCann being afforded a prompt hearing. At any merits hearing in this matter, the prosecutor will bear the burden of proving unprofessional conduct. Our Findings and Conclusions in this matter will not absolve the prosecution or Ms. McCann from producing or challenging relevant evidence at a merits hearing. The Findings of Fact and Conclusions of Law at a contested hearing will be based exclusively on the evidence admitted at that hearing.

Order

The Request for Summary Suspension is **Granted**. Ms. McCann'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, 89 Main Street, Fl. 3, Montpelier, VT 05620-3402 within 30 days of the entry of this order.

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

Date: May 12, 2014

OFFICE OF PROFESSIONAL REGULATION

DATE OF ENTRY: 5/13/14

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

IN RE:

PATRICIA MCCANN

License No. 026.0094474

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Docket No. 2014-123

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. Patricia McCann (the "Respondent") of Madison, CT is licensed by the State of Vermont as a Registered Nurse under license number 026.0094474. This license is active and currently set to expire on or about March 31, 2015.
4. On or about February 20, 2014, Investigator Dennis Menard of the Office of Professional Regulation ("OPR") met with B.G., the Assistant Nurse Manager in the Dialysis Unit at Fletcher Allen Health Care ("FAHC"), and with K.M., a pharmacist at FAHC. B.G. and K.M. had conducted an audit of their internal narcotics control system and relayed the following general information to Investigator Menard about their review:
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 - b. On or about September 3, 2013, Respondent was hired full time in the dialysis unit;
 - c. During the course of their internal audit, B.G. and K.M. found that Respondent withdrew narcotics from the Pyxis machine at a far higher rate than her peers;
 - d. B.G. and K.M. found this higher rate of narcotic administration especially unusual given that the dialysis unit is a procedural unit with short term outpatients and due to the potential blood pressure issues, these patients in particular should not be receiving heavy doses of narcotic medications.

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5. The FAHC internal review of Respondent's narcotic administration specifically showed 14 irregularities in her administration of pain medication, documentation of medication administration and improper wasting documentation (resulting in several narcotic medications being unaccounted for) including the following:
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 - d. (Irregularities 6, 7) Patient XXX969 had an order for Hydromorphone liquid 0.5-1 mg every 4 hours as needed. On or about October 1, 2013 at 10:56AM and again at 10:58AM, Respondent withdrew Hydromorphone 2 mg tablets, yet documented she gave the patient .5 mg liquid at approximately 11:08AM. No liquid was withdrawn from the Pyxis and Respondent did not document the 2 tablets.
 - e. (Irregularities 8, 9) Patient XXX648 had orders for Hydromorphone 1-2 mg tablet every 3 hours as needed and Hydromorphone .5mg IV every 3 hours as needed.
 - i. On or about December 21, 2013, at approximately 7:09AM, Respondent withdrew one Hydromorphone 2mg tablet from the Pyxis. Respondent made no record of the Hydromorphone being given to the patient.
 - ii. On or about December 23, 2013, at approximately 1:33PM, Respondent withdrew Hydromorphone 1 mg injection from the Pyxis. Respondent documented giving .5 mg to the patient at 1:42PM. Respondent did not document wasting the rest of the medication.
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- g. (Irregularities 11,12) Patient XXX602 had an order for Hydromorphone 1mg injection .2-.4 mg every 3 hours as needed. On or about January 18, 2014 at 8:32AM and again at 9:37AM, Respondent withdrew Hydromorphone 1 mg injections from the Pyxis. Respondent made no record of the Hydromorphone being given to the patient.
- h. (Irregularity 13) Patient XXX362 had an order for Oxycodone 5 mg oral 4 times daily as needed. On or about January 23, 2014, Respondent withdrew Oxycodone 5 mg tablet from the Pxyis at approximately 10:28AM. Respondent documented that at 10:38AM the patient/family refused the medication. Respondent did not document wasting the medication.
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Request for Relief

- 6. 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.
- 7. 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); incorporating ARBN Part 11.2(b) ("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) and ARBN Part 11.2(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);
 - b. 26 V.S.A. § 1582(a)(7) (Engages in conduct of a character likely to deceive, defraud or harm the public);
 - c. 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);
 - 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

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unacceptable patient or client care; or (2) failure to conform to the essential standards of acceptable and prevailing practice); and

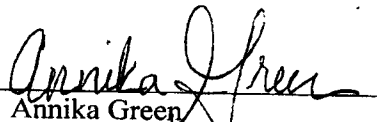
- e. 3 V.S.A. § 129a(a)(3) (Failing to comply with provisions of federal or state statutes or rules governing the practice of the profession).

WHEREFORE, the State of Vermont respectfully requests that pursuant to 3 V.S.A. § 814(c), the Respondent's nursing license number 025.0089224 be summarily suspended, pending a hearing on the merits.

DATED at Montpelier, Vermont this 1st day of May, 2014.

STATE OF VERMONT
SECRETARY OF STATE

By:


Annika Green
State Prosecuting Attorney

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