

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

In re: WENDY L. MURRAY
License No. 025.0007926

}
} Docket No. 2016-640 (LPN)
}

SUMMARY SUSPENSION ORDER

Participating Board Members:

Jeanine Carr, RN, Chair
Ellen Watson, APRN, Vice Chair
William G. White, Jr., Public Member
Jennifer Laurent, APRN
Deborah Swartz, RN
Luana Tredwell, LPN

Appearances:

Prosecuting the case: Elizabeth Jarvis, Esq.
Respondent: not present or represented

Presiding Officer:

George K. Belcher

**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 December 12, 2016, at the Office of Professional Regulation in Montpelier, Vermont.

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 as follows:

1. Respondent is a Licensed Practical Nurse, licensed in Vermont. Her license is set to expire on January 31, 2018. She is subject to the regulatory authority of this Board. 3 V.S.A. §§ 129, 129a, 26 V.S.A. Chapter 28, 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 Respondent was sent a notice of the hearing on December 8, 2016 by certified mail and regular mail.
3. The Request for Summary Suspension alleges that the public health, safety or welfare imperatively requires emergency action.
4. The allegations in the Request for Summary Suspension (copy attached) have been established to the necessary degree. The State presented the testimony of Investigator John Lewis. Mr. Lewis established through his testimony that the Respondent was employed by The Pines Rehabilitation and Health Center ("the facility") in Lyndonville, Vermont, during 2016.
5. The Respondent cared for patients J.D. and M.L. during her work at the facility. Patient J.D. had an order for .5 ml of morphine subcutaneously every hour as needed for pain. Patient M.L. had orders for .5 ml of morphine subcutaneously every hour as needed for pain and 7.5 mg of oxycodone by mouth, twice daily as needed for pain.
6. Between June 11, 2016 and August 9, 2016, the Respondent documented withdrawing .5 ml of morphine for patient J.D. 176 times but she failed to provide substantiation in the Medical Administration Record or the nursing notes for 92 of these doses. Between June 14, 2016 and July 20, 2016 the Respondent documented withdrawing .5ml of morphine for patient M.L. approximately 9 times but failed to substantiate 3 of those doses.
7. The Respondent was interviewed by Investigator Lewis on December 5, 2016. During that interview, the Respondent admitted to diverting approximately half of the doses which she withdrew for patients J.D. and M.L. and to using the diverted medications for her own use. The Respondent admitted taking the morphine by syringe and using the diverted drugs while at work at the facility. She further admitted to falsely co-signing withdrawal of morphine for these two residents for two other nursing staff members in order for these other staff members to divert the morphine for their personal use.
8. The Respondent admitted to using heroin as recently as December 1, 2016 and admitted to using heroin while at work.
9. The evidence presented show facts which imperatively requires emergency action for the public health, safety, and welfare. Specifically, summary suspension is necessary to prevent patient harm and to protect the general integrity of the medical profession.

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 Respondent'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 Respondent 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 Respondent 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**. Respondent'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).

Vermont Board of Nursing

By:

Jeanne Carr
Jeanne Carr, RN, Chair

Date: December 15, 2016

DATE OF ENTRY:

12/20/16

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.

**STATE OF VERMONT
SECRETARY OF STATE
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BOARD OF NURSING**

IN RE:

WENDY L. MURRAY

License No. 025.0007926

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Docket Nos. 2016-640

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. Wendy L. Murray ("Respondent") of East Burke, Vermont is licensed by the State of Vermont as a Licensed Practical Nurse ("LPN") under license number 025.0007926. This license was originally issued August 4, 2000, and expires on January 31, 2018.
4. At all relevant times, Respondent was employed as an LPN at the Pines Rehabilitation and Health Center ("Facility") in Lyndonville, VT.
5. The Facility's drug administration policy requires nurses to co-sign for one another when removing a narcotic from his or her own medication cart.
6. Resident J.D. had an order for .5ml of morphine, given subcutaneously every hour as needed for pain.
7. Resident M.L. had an orders for .5ml of morphine, given subcutaneously every hour as needed for pain and 7.5mg of oxycodone by mouth, twice daily as needed for pain.
8. During the relevant time period, morphine was only available at the Facility in 10mg/ml vials.
9. Between June 11, 2016 and August 9, 2016, Respondent documented withdrawing .5ml of morphine for Resident J.D. approximately one hundred seventy-six (176) times on the narcotics log.

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10. Respondent provided substantiation in the MAR or nursing notes for only approximately eighty-four (84) of those withdrawals for Resident J.D.
11. Between June 14, 2016, and July 20, 2016, Respondent documented withdrawing .5ml of morphine for Resident M.L. approximately nine (9) times in the narcotics log.
12. Respondent provided substantiation in the MAR or nursing notes for only six (6) of those withdrawals for Resident M.L.
13. Between June 2016 and August 2016, Respondent documented several instances of withdrawing .5ml doses of morphine under Resident J.D.'s name, but documented administering the dose to Resident M.L. in the narcotics log.
14. Respondent did not provide documentation in Resident M.L.'s MAR or nursing notes to substantiate the reason for administering those doses or that those doses had in fact been given.
15. Between June 2016 and August 2016, Respondent documented several instances of withdrawing .5ml doses of morphine under Resident M.L.'s name, but documented administering the dose to Resident J.D. in the narcotics log.
16. Respondent did not provide documentation in Resident J.D.'s MAR or nursing notes to substantiate the reason for administering those doses or that those doses had in fact been given.
17. Respondent admitted to diverting morphine from Residents J.D. and M.L.
18. Respondent diverted approximately half of the morphine she withdrew under Residents J.D. and M.L.'s prescriptions.
19. Respondent would draw up the morphine in a syringe and use it while at work at the Facility.
20. Respondent would discard the empty bottles in the sharps containers at the Facility.
21. Respondent admitted to co-signing for the withdrawal of morphine under Residents J.D. and M.L.'s prescriptions for two other nursing staff members in order to divert the medication their personal use.
22. Respondent admitted to undergoing treatment for addiction to Vicodin in or around 2010. As part of that treatment, Respondent was on Suboxone for approximately two (2) years and then being clean for approximately three (3) years.
23. Respondent admitted to actively using heroin currently, at least as recently as December 1, 2016.

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24. Respondent admitted to using heroin while at work.

Violation One: 26 V.S.A. §1582(a)(2) Diverting or attempting to divert drugs or equipment or supplies for unauthorized use.

25. The State re-alleges and incorporates Paragraphs 3 through 24 above.
26. As a Licensed Practical Nurse, Respondent shall not divert or attempt to divert drugs or equipment or supplies for unauthorized use.
27. Respondent diverted or attempted to divert drugs for unauthorized use as described in Paragraphs 6 through 21 above.
28. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent has committed unprofessional conduct in violation of 26 V.S.A. §1582(a)(2).

Violation Two: 3 V.S.A §129a(b)(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: (2) failure to conform to the essential standards of acceptable and prevailing practice.

29. The State re-alleges and incorporates Paragraphs 3 through 24 above.
30. The essential standards of acceptable and prevailing practice require Licensed Practical Nurses to accurately and honestly document all nursing interventions, including the administration of medication.
31. Respondent failed to meet this standard by engaging in the conduct described in Paragraphs 6 through 21 above.
32. The essential standards of acceptable and prevailing practice require Licensed Practical Nurses to refrain from diverting medications for their own use.
33. Respondent failed to meet this standard by engaging in the conduct described in Paragraphs 6 through 21 above.
34. The essential standards of acceptable and prevailing practice require Licensed Practical Nurses to refrain from using illegal drugs or drugs they are not legally prescribed.
35. The Respondent failed to meet this standard by engaging in the conduct described in Paragraphs 6 through 24 above.

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36. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent has committed unprofessional conduct in violation of 3 V.S.A. §129a(b)(2).

Violation Three: 3 V.S.A §129a(b)(1) 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.

37. The State re-alleges and incorporates Paragraphs 3 through 24 above.
38. As a Licensed Practical Nurse, Respondent has an obligation to provide safe and acceptable patient care.
39. The respondent provided unsafe and unacceptable patient care by engaging in the behavior described in Paragraphs 6 through 21 and 24 above.
40. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent has committed unprofessional conduct in violation of 3 V.S.A. §129a(b)(1).

Violation Four: 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.

41. The State re-alleges and incorporates Paragraphs 3 through 24 above.
42. As a Licensed Practical Nurse, Respondent shall not willfully make or file false reports or records in the practice of the profession; willfully impede or obstruct the proper making or filing of reports or records or willfully fail to file the proper reports or records.
43. Paragraphs 5 through 21 above demonstrate that Respondent willfully made or filed false reports or records in the practice of the profession.
44. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent has committed unprofessional conduct in violation of 3 V.S.A. §129a(a)(7).

Violation Five: 26 V.S.A. §1582(a)(3) Engaging in conduct of a character likely to deceive, defraud, or harm the public.

45. The State re-alleges and incorporates Paragraphs 3 through 24 above.

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46. As a Licensed Practical Nurse, Respondent has a responsibility not to engage in conduct of a character likely to deceive, defraud, or harm the public.
47. Respondent engaged in conduct of a character likely to deceive, defraud, or harm the public as demonstrated in Paragraphs 6 through 24 above.
48. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent has committed unprofessional conduct in violation of 26 V.S.A. §1582(a)(3).

Violation Six: 3 V.S.A. §129a(a)(5) Practicing the profession when medically or psychologically unfit to do so.

49. The State re-alleges and incorporates Paragraphs 3 through 24 above.
50. As a Licensed Practical Nurse, the Respondent shall only practice the profession when medically or psychologically fit to do so.
51. Respondent practiced the profession of nursing when medically or psychologically unfit to do so when she engaged in the conduct stated in Paragraphs 3 through 24 above.
52. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent has committed unprofessional conduct in violation of 3 V.S.A. §129a(a)(5).
53. Without emergency action, members of the public, patients, and potential patients would be unaware of Respondent's dangerous behavior and will remain unprotected if Respondent is allowed to continue to practice. 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.

WHEREFORE, the State of Vermont respectfully requests that pursuant to 3 V.S.A. § 814(c), the Respondent's nursing license number **025.0096790** be summarily suspended, pending a hearing on the merits.

DATED at Montpelier, Vermont this 8th day of December, 2016.

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