

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

IN RE:)
CARRIE A. PERCEY)
License No. 026.0026717)

Docket No. 2014-326

STIPULATION AND CONSENT ORDER

NOW COME the State of Vermont, by State Prosecuting Attorney Gabriel M. Gilman, and the respondent in this matter, Carrie A. Percey, who stipulate and agree as follows:

Board Authority

1. The Vermont State Board of Nursing ("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. § 1595; the Administrative Rules of the Board of Nursing ("ARBN"); and the Rules of the Office of Professional Regulation.

Statement of Facts

2. Carrie A. Percey ("Respondent") of Bennington, Vermont is licensed by the State of Vermont as a registered nurse under license number 026.0026717. The license first issued on or about September 21, 2001 and will expire in due course on March 31, 2015. There is no history of prior Board discipline.
3. At all times relevant, Respondent was employed as a registered nurse at Crescent Manor Care Centers, Bennington (the "Facility").
4. On or about April 12, 2014, Respondent faxed a Roxanol script to a pharmacy, further to the care of a Facility patient who was actively dying. A pharmacist called Respondent because the script called for a dispensed volume that did not exist at the pharmacy. The pharmacist advised Respondent that a different volume of the same medication could be dispensed.
5. Respondent altered the volume to be dispensed without first consulting the prescriber. Respondent did send an after-hours fax the prescriber's office to make the office aware of the change.
6. Subsequent to Respondent's alteration of the script, the Facility acquired a new script for a subcutaneous narcotic. Oral morphine sulfate never was delivered or administered to the patient in question.
7. Respondent cooperated fully with internal and Board investigations of the events described above. Although Respondent's intentions were to facilitate the provision of needed pain medication, Respondent recognizes that altering any script in the manner

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described does not conform to the essential standards of acceptable and prevailing practice.

8. Following the incident in question, Respondent and Facility administrators took appropriate action to reinforce medication protocols. Respondent completed a 4-hour course, *Medication Administration in the Nursing Facility*. Respondent also worked with others at the Facility to update and improve medication documentation and script management. Finally, at the State's request, Respondent completed, through the National Council of State Boards of Nursing Learning Extension, a 6.9-hour course, *Medication Errors: Detection and Prevention*.

Basis for Discipline

9. 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) ("(b) 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.").

Understandings

10. 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.
11. Respondent specifically waives any claims that any disclosures made to the full Board during its review of this agreement prejudice her rights to a fair and impartial hearing if this agreement is not accepted by the Board and proceeds to a hearing on the merits.
12. Respondent has read and reviewed this entire document and agrees that it contains the entire agreement between the parties.
13. Respondent is not under the influence of any drugs or alcohol at the time she signs this Stipulation and Consent Order.
14. 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.
15. 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.
16. Respondent agrees that the Order set forth below may be entered by the Board.

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ORDER

Based on the Stipulation above, it is **ORDERED AND ADJUDGED** as follows:

- A. The Board of Nursing hereby **WARNS** the Respondent's license.
- 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: 1/8/2015

By: [Signature]
Gabriel Gilman
State Prosecuting Attorney

CARRIE A. PERCEY
RESPONDENT

Dated: 1-8-2015

By: [Signature]
Carrie A. Percy

APPROVED AND SO ORDERED:

VERMONT BOARD OF NURSING

Dated: 1/12/15

By: [Signature]
Chairperson

Date of Entry: 1/13/15

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