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

In re: MICHAEL DAVID PRIVEE	}	
License No. 026.0038414	}	Docket No. 2017-434 (RN)
	}	

SUMMARY SUSPENSION ORDER

Participating Board Members:
Deborah Swartz, RN, Acting Chair
Jennifer Laurent, APRN
Douglas Sutton, RN
Virginia Hudson, RN
Luana Tredwell, LPN
Kelly Sinclair, LNA
Jill Duel, LPN
William G. White, Jr., Public Member

Appearances:
Prosecuting the case: Jennifer B. Colin, Esq.
Respondent: was not present and not represented

Presiding Officer:
George K. Belcher

Exhibits:
State Ex. 2: SICU Investigation Summary 7/7/17
State Ex. 3: ED Chart of Respondent's ED Stat withdrawals
State Ex. 4: ED Diversion Investigation Summary

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 September 11, 2017, at the Office of Professional Regulation in Montpelier, Vermont.

Findings of Fact

Based on a Review of the pleadings and the file, and on the evidence presented to the Board at the hearing, the Board finds as follows:

1. Respondent is a Registered Nurse licensed in Vermont. His license is set to expire on March 31, 2019. He 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 require 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. By letter dated August 10, 2017 Attorney Brooks G. McArthur filed a notice of appearance on behalf of the Respondent with the Office of Professional Regulation. Notice of the hearing concerning the Request for Summary Suspension was sent to Attorney McArthur by letter dated September 7, 2017. The prosecutor indicated at the commencement of the hearing that she had been in communication with Attorney McArthur prior to the hearing and he indicated to her that neither he, nor his client, intended to appear at the hearing.
3. The allegations in the Request for Summary Suspension have been established to the necessary degree. The State presented as evidence testimony from two nurse managers from the UVM Medical Center.
4. Janice Ploof is the Nurse Manager at the Surgical Intensive Care Unit (SICU) at the UVM Medical Center hospital. She has received training in identifying drug diversion by nursing staff. She supervised the Respondent for a significant amount of time on that unit. As Nurse Manager she received complaints about the Respondent taking unusually long breaks, arguing with certain medical orders, failing to adequately document nursing treatments, and acting as "a cowboy".
5. Because of the complaints, she initiated an investigation into his access and use of, medications. The investigation included a summary of his withdrawal of, wasting of, and return of regulated medications while working on the unit. The investigation also included a review of patients' charts where the Respondent had withdrawn regulated medications for particular patients.
6. The investigation showed concerns in the following areas: (a) the Respondent withdrew hydromorphone (Dilaudid) in an excessive frequency when compared to other nurses on the unit; (b) the Respondent, when "wasting" a controlled drug, documented that he wasted the entire dose which was withdrawn which is unusual (and means that the patient received none of the medication withdrawn for that patient); (c) The Respondent tended to withdraw regulated drugs just as he was coming on shift and just before ending his shift which is an indicator of diversion; (d) the drug withdrawal of pain medications did not consistently align with patient pain scores before or after the withdrawal of the pain medications indicating that the pain medications were not being directed to the documented patient need; (e) the Respondent often held the withdrawn pain medications for long periods of time before he documented either administering the drug or wasting it; (f) frequently, the Respondent failed to document whether a withdrawn pain medication was administered, wasted, or returned (thus, making it unclear what happened to the pain

medication); (g) the Respondent had an unusually high number of "overrides" which are withdrawals of regulated drugs without a corresponding physician's drug order (either contemporaneous or retroactive).

7. Most of the breaches of drug withdrawal and accounting practice involved hydromorphone (Dilaudid) but some also involved Morphine and Fentanyl. Most other drugs (other than regulated pain medications) withdrawn by the Respondent were not subject to his excessive lack of accounting and proper administration.
8. Based upon the knowledge of the Nurse Manager of the Surgical ICU Unit, and her review of the charts and the pharmacy report, her conclusion was that the Respondent was diverting drugs from the unit and failing to properly administer them to patients. The Board accepts her conclusion and so finds.
9. The Respondent also worked part time at the emergency room of the UVM Medical Center. The Nurse Manager at the "ED" (emergency department) was made aware of the investigation by SICU concerning possible diversion by the Respondent. She too conducted an investigation into the drug withdrawal and charting by the Respondent in the Emergency Department. She also has training concerning investigation of drug diversion by nursing staff. In the emergency room practice at the UVM Medical Center it is possible to remove a regulated drug for administration without an immediate record showing to which patient the drug is being given or which doctor has ordered it. The code for this circumstance is that the drug is being withdrawn for "E.D. Stat". It is the policy of the UVM Medical Center that such withdrawal of pain drugs under "E.D. Stat" are rare and strongly discouraged. (If a pain drug is removed under this heading, the proper course is to reconcile the order and patient by a subsequent entry showing the missing information.) Likewise, it is improper to waste drugs under an "E.D. Stat" withdrawal.
10. The Emergency Department Nurse Manager did an exhaustive study of the Respondent's withdrawal of pain medications in the emergency department from 1 March, 2017 to 20 May, 2017. The number of withdrawals of pain medications by the Respondent under the "E.D. Stat" justification was excessive and far above any other nurse during the time period. Likewise, the Respondent had a pattern of wasting the full dose of pain medication he withdrew which is very unusual. A comparison of his drug withdrawal to the charts of four specific patients showed "glaring problems", including failure to chart the administration or wasting of a withdrawn drug, withdrawing a drug after the patient had been discharged, and withdrawing a pain drug for a minor patient as the patient was being transferred to the pediatric unit with a condition which usually does not require pain medication. The Respondent's unusual withdrawal and failure to account for pain drug administration usually involved hydromorphone and no other non-pain medications. Although hydromorphone is usually dispensed in 1mg vials, on one occasion in March of 2017 the Respondent withdrew a 30mg dosage which he documented to have wasted. This dosage was extremely unusual and concerning in the opinion of the Nurse Manager. After conducting her review of medication usage and four charts of patients, it was the opinion (and "only conclusion") of the ED Nurse Manager that the Respondent had been diverting drugs from the unit. The Board accepts her opinion and so finds.
11. The facts as shown by the testimony of the witnesses and the exhibits demonstrate a diversion of regulated pain medications by the Respondent, as well as improper and fraudulent charting of nursing records.
12. There was adequate evidence presented by the State that the Respondent was involved in

diversion of drugs for unauthorized use (26 VSA Sec. 1582(a)(2), failure to practice competently (3 VSA Sec. 129a(b)(1), willfully making false reports (3 VS Sec. 129a(a)(7)), and engaging in conduct of a character likely to deceive (26 VS Sec. 1582(a)(3)).

13. The evidence presented establishes facts which imperatively require 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: _____ Date: September 12, 2017
Deborah Swartz, RN, Acting Chair

DATE OF ENTRY: 9/15/17

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.

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BOARD OF NURSING

IN RE:	)	
Michael D. Privee	)	**Docket No. 2017-434**
License No. 026.0038414	)	

REQUEST FOR SUMMARY SUSPENSION

NOW COMES the State of Vermont and petitions the Board of Nursing to summarily suspend the license of Registered Nurse Michael D. Privee. In support of such petition, the State alleges the following:

Board Authority

1. The Vermont State Board of Nursing (the "Board") has jurisdiction to investigate and adjudicate allegations of unprofessional conduct committed by Registered Nurses pursuant to 3 V.S.A. §129(a); 3 V.S.A. §129a; 3 V.S.A. §814(d); 26 V.S.A. Chapter 28; the Administrative Rules of the Board of Nursing (the "ARBN"); and the Rules of the Office of Professional Regulation ("OPR").

2. The Board of Nursing is authorized by 3 V.S.A. §814 to summarily suspend the license of a registered nurse when it finds the public health, safety, or welfare imperatively requires emergency action.

Statement of Facts

3. Michael D. Privee ("Respondent") of Hyde Park, Vermont is licensed by the State of Vermont as a Registered Nurse ("RN") under license number 026.0038414. This license was originally issued on July 19, 2007, and expires on March 31, 2019.

4. During the relevant time period, Respondent practiced as a per diem RN in the Emergency Department ("ED") and the Surgical Intensive Care Unit ("SICU") at the University of Vermont Medical Center ("the Facility") in Burlington, Vermont.

5. As a per diem nurse, Respondent worked part-time in both the ED and SICU at the Facility and most often worked the overnight shift.

6. Respondent worked as a nurse at the Facility for almost ten years.

7. Nurse managers at the Facility have been trained to recognize "red flags" of diversion, which include behavioral changes, poor record-keeping or charting of administration of narcotics that does not make sense, frequent and/or prolonged breaks from the floor that exceed or vary from Facility protocol, and unusual patterns of administration of narcotics.

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8. In May 2017, Respondent's demeanor had changed, he had become lax about patient care, the quality of his documentation had become poor, and Respondent was taking frequent, long breaks while working, often leaving the floor on an hourly basis, at times for up to an hour, which violated Facility policy.

9. Based on Respondent's behavior, the SICU Nurse Manager requested that the Facility pharmacy run "Rx Diversion Index" reports to determine whether there were any concerning patterns in Respondent's withdrawal of narcotics.

10. The "Rx Diversion Index" reports identified Respondent as a statistical anomaly in all Facility departments for the withdrawal of hydromorphone (brand name Dilaudid) and morphine in a significantly greater number of instances than his nursing colleagues.

11. Based on the "Rx Diversion Index" reports, both the SICU and ED Nurse Managers conducted investigations within their respective departments regarding Respondent's withdrawal, wasting, and documentation of controlled medications.

Emergency Department

12. In the Emergency Department, medication is stored in a Pyxis machine which requires each authorized staff member to enter an identification number unique to him/her in order to withdraw medication and equipment.

13. The Pyxis machine also requires the withdrawing staff member to link the withdrawal to a patient.

14. Nurses are also required to document any waste of medication in the Pyxis machine, again using the identification number unique to the nurse and attributing the wasted medication to a particular patient.

15. At the Facility, nurses are required to waste controlled substances in front of another nurse, who then enters his/her id number in the Pyxis as the witness.

16. The Facility's protocol for wasting medication does not provide the witness to the wasting of medication the ability to independently verify what medication or substance is being wasted, and relies upon the wasting nurse's identification of the medication. This is particularly true of intravenous (IV) medications, which are clear liquids that are wasted by syringe either into a sink or into a Cactus (a controlled substance waste management receptacle).

17. In the ED, the Pyxis has a patient profile of "Stat ED Patient" that can be used by a nurse when a medication needs to be withdrawn on an emergency basis for a life or limb threatening condition of a patient whose profile or orders have not yet been entered into the Pyxis system.

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18. After withdrawing medication under the Stat ED Patient profile, a nurse must go back into Pyxis once the patient's profile and order are entered in the system to link the medication withdrawn to that specific patient.

19. During the relevant time period, it was an unwritten policy at the Facility that medications should not be wasted under Stat ED Patient because the medication could not be linked to a patient, rendering it untraceable.

20. These Pyxis protocols exist, in part, to deter diversion of narcotics and to maintain accurate records of medication administration.

21. The ED Nurse Manager ran Pyxis reports of all medications withdrawn and wasted under Stat ED Patient between March 1, 2017 and May 20, 2017.

22. From March 1, 2017 through May 20, 2017, Respondent worked 23 shifts in the ED as a per diem nurse. For some of those 23 shifts, Respondent was a charge nurse, which meant that he was not assigned to specific patients and provided little, if any, patient care.

23. By comparison, a full-time nurse working standard 12-hour shifts in the same time period would have worked approximately 36 shifts.

24. From March 1, 2017 through May 20, 2017, while working part-time, Respondent withdrew Dilaudid, a controlled substance administered for pain management, over 40 times from Pyxis under Stat ED Patient.

25. From March 1, 2017 through May 20, 2017, while working part-time, Respondent documented in Pyxis under Stat ED Patient wasting narcotics over 40 times, more than all other ED nurses combined during that same time period.

26. Approximately 30 of the instances of Respondent's purported narcotics wasted under Stat ED Patient were Dilaudid.

27. The nurse with the next highest number of recorded instances of narcotics waste under the Stat ED Patient profile in Pyxis during the same time period had four recorded instances.

28. Under the Stat ED Patient profile, Respondent often withdrew and then purportedly wasted the entire narcotic, which is rarely necessary.

29. During the period covered by the Pyxis reports, Respondent withdrew under Stat ED Patient a 30 milliliter syringe of Dilaudid and then purported to waste the entire amount, also under Stat ED Patient.

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30. Respondent withdrew Dilaudid for a diabetes patient just prior to discharge from the ED even though Respondent had no interaction with the patient in the ED until just prior to discharge, the patient had no orders for pain medication, and diabetes does not typically warrant pain management.

31. Respondent followed the proper Stat ED Patient medication withdrawal and waste protocols for other medications, such as Ketorolac, Ondansetron, Duonebs and others, during the same reporting period of March 2, 2017 to May 20, 2017.

Surgical Intensive Care Unit

32. The SICU uses a Pyxis medication administration system and also follows the same protocols as the ED, referenced in Paragraphs 12 through 16 above, with respect to withdrawals and wasting of medications.

33. A Pyxis "override" in SICU means the patient for whom medication is withdrawn does not have orders in the Pyxis system for the medication withdrawn.

34. As part of her investigation into potential diversion by Respondent, the SICU Nurse Manager compiled data from Pyxis reports for Respondent's narcotic medication administration to specific patients between February 27, 2017 and May 25, 2017.

35. Between February 27, 2017 and May 25, 2017, as a part-time per diem nurse, Respondent withdrew from Pyxis: Dilaudid 57 times with five overrides; Fentanyl 18 times with two overrides; and morphine 18 times.

36. Between February 27, 2017 and May 25, 2017, Respondent's narcotic medication administration Pyxis records contained many inexplicable discrepancies, mostly involving Dilaudid.

37. On many occasions, Respondent purportedly wasted the entire amount of narcotic pain medication he withdrew.

38. Respondent often held on to narcotic medications for hours before purportedly wasting them.

39. Respondent withdrew Dilaudid for patients who did not have orders for Dilaudid.

40. Respondent removed narcotic pain medications with no documentation of patients' pain scores.

41. Respondent removed Dilaudid within minutes of purportedly wasting Dilaudid for the same patient.

42. Respondent administered portions of narcotic pain medication to patients, but did not document wasting the remaining amount.

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Respondent's Resignation from the Facility

43. As a result of the Respondent's actions in Paragraphs 8 through 42 above, the Facility placed Respondent on administrative leave in May, 2017 pending completion of a review of Respondent's medication withdrawal and administration practices.

44. In June 2017, Respondent resigned from his positions at the Facility.

45. In early July 2017, the Facility completed its review and determined that Respondent diverted controlled substances.

46. Respondent declined to meet with the Facility to discuss the investigative findings. As a result, Respondent was deemed to have "Resigned in Lieu of Termination" and is not eligible for rehire.

47. Though Respondent no longer works at the Facility, his license remains active at this time and has no restrictions or conditions.

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

48. The State re-alleges and incorporates Paragraphs 3 through 47 above.

49. As an RN, Respondent is prohibited from diverting drugs for unauthorized use.

50. Paragraphs 3 through 44 above demonstrate that Respondent diverted drugs from the Facility for unauthorized use in violation of 26 V.S.A. §1582(a)(2).

51. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for summary suspension because Respondent diverted drugs for unauthorized use in violation of 26 V.S.A. §1582(a)(2).

Violation Two: 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.

52. The State re-alleges and incorporates Paragraphs 3 through 47 above.

53. As an RN, Respondent is required to provide safe and acceptable patient care.

54. Paragraphs 3 through 47 demonstrate that Respondent performed unsafe and unacceptable patient care by engaging in the conduct described above.

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Amended as noted 9/11/17 g.v.b.

55. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for summary suspension because on multiple occasions Respondent ~~removed pain-relieving patches from the patient for whom they were prescribed,~~ DIVERTED NARCOTICS thereby performing unsafe and unacceptable patient care in violation of 3 V.S.A. §129a(b)(1).

Violation Three: 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.

56. The State re-alleges and incorporates Paragraphs 3 through 47 above.

57. As an RN, 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.

58. Paragraphs 3 through 47 above demonstrate that Respondent willfully made or filed false reports or records in the practice of the profession.

59. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for summary suspension because Respondent has committed unprofessional conduct in violation of 3 V.S.A. §129a(a)(7).

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

60. The State re-alleges and incorporates Paragraphs 3 through 47 above.

61. As an RN, Respondent is required to refrain from engaging in conduct of a character likely to deceive, defraud, or harm the public.

62. Respondent engaged in conduct of a character likely to deceive, defraud, or harm the public as demonstrated in Paragraphs 3 through 47 above.

63. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for summary suspension because the Respondent has committed unprofessional conduct in violation of 26 V.S.A. §1582(a)(3).

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Violation Five: 3 V.S.A. §129a(a)(15) Failing to exercise independent professional judgment in the performance of licensed activities when that judgment is necessary to avoid action repugnant to the obligations of the profession.

64. The State re-alleges and incorporates Paragraphs 3 through 47 above.

65. As an RN, Respondent is required to exercise his own independent professional judgment in the performance of licensed activities when that judgment is necessary to avoid action repugnant to the obligations of the profession.

66. Respondent's conduct in Paragraphs 4 through 47 above demonstrate that Respondent failed to exercise his own professional judgment in the performance of licensed activities when that judgment was necessary to avoid action repugnant to the obligations of the profession.

67. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for summary suspension because the Respondent has committed unprofessional conduct in violation of 3 V.S.A. §129a(a)(15).

Relief Requested

68. Respondent's diversion of narcotics endangers the health, safety and welfare of the public and presents significant risk of impaired nursing practice by Respondent.

69. Respondent displayed impaired judgment in diverting narcotics from the Facility and in falsifying medication records.

70. 3 V.S.A. §814(c) provides in part:

> If the agency finds that public health, safety, or welfare imperatively requires emergency action, and incorporates a finding to that effect in its order, summary suspension of a license may be ordered pending proceedings for revocation or other action.

71. Members of the public, patients, potential patients, health care facilities, and potential employers of Respondent have no way of learning of Respondent's dangerous behavior and will remain unprotected during the pendency of these proceedings if Respondent's license remains active and unconditioned.

72. The facts as set forth above establish that in order to protect the public health, safety, and/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), Respondent's Registered Nurse license, number 026.0038414, be summarily suspended, pending hearing on the merits.

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DATED at Montpelier, Vermont this 7th day of September, 2017.

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SECRETARY OF STATE

By: _____

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