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

In re: Kevin J. Shiflett	}	
License No. 026.0121110	}	Docket No. 2016-399 (RN)
	}	

SUMMARY SUSPENSION ORDER

Participating Board Members:
Ellen Watson, APRN, Vice Chair
Deborah Swartz, RN
Kelly Sinclair, LNA
Virginia Hudson, RN
Jennifer Laurent, APRN
Douglas Sutton, RN
Luana Treadwell, LPN
Liz Merrill, *ad hoc*, Public Member
Daniel Coane, *ad hoc*, Public Member

Appearances:
Prosecuting the case: Rachel Allen, Esq.
Respondent: Mark Webb, Esq.

Presiding Officer: George K. Belcher

Exhibits:
State Exhibit 1: Franklin County Rehab Center Administrative Warning dated 7/1/16
State Exhibit 2: New York State Office of Professional Discipline Consent Order Dated 11/26/13

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 12, 2016 at the Office of Professional Regulation in Montpelier, Vermont. The State was represented by Rachel Allen, Esq. The Respondent

appeared with counsel, Mark Webb, Esq. 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). Prior to the evidence, the State amended its Request for Summary Suspension to revise the words "Patient 1" to read "Patient 2" in paragraphs 17 and 20. The amendment was accepted.

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 Registered Nurse, licensed in Vermont. His license is currently set to expire on or about March 31, 2017. He is therefore subject to the regulatory authority of this Board. 3 V.S.A. §§ 129, 129a, 26 V.S.A. § 1595 & 1598, 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.
3. The Request for Summary Suspension alleges that the public health, safety or welfare imperatively requires emergency action.
4. Notice of this hearing was sent to Respondent's last known address via certified mail dated September 1, 2016 and was received on September 8, 2016.
5. The evidence established that the Respondent was hired to work as a Registered Nurse at the Franklin County Rehab Center in the spring/summer of 2016. After his orientation there were problems relating to defects in his documentation.
6. On July 1, 2016 the Respondent was given a written warning which identified problems of (1) failure to maintain proper administration records of medications, (2) administration of discontinued medications, and (3) resealing medication cards for medications opened in error. (See State Exhibit 1)
7. Thereafter, following the weekend of July 16 and 17, 2016, the Director of Nursing received complaints from her staff that three patients were denying that they had received pain medications during the night which were charted as having been given. (It is common for oncoming nurses to ask patients how they did during the night and whether they received their medication.) The Respondent had worked the nightshift during the times in question. The medications involved were Oxycodone (which is also known under the brand name of Percocet).
8. The Director of Nursing then conducted an internal investigation. Following a review of the charts and medication records and an interview with each of the three residents, she concluded that the residents were not receiving the medications as charted by the Respondent. The three residents were on the "rehab" unit of the facility and were deemed by the Director of Nursing to be alert and oriented.
9. Thereafter, the Director conducted an interview with the Respondent in which he was

cooperative. He volunteered to take a drug test.

10. The Respondent was discharged from employment.

11. Dennis Menard is an investigator with the Office of Professional Regulation. Mr. Menard was assigned to investigate this matter on behalf of the Office of Professional Regulation. He examined the nursing notes, charts, medication records, and he spoke to staff members. He interviewed one of the complaining patients, as well as the Respondent. The Respondent admitted to Mr. Menard that he had been disciplined by the New York State Board for Nursing (See State Exhibit 2, Consent Order, Cal. No. 26693, March 2013). In that case, the Respondent did not contest the charge, specifically,

> Respondent, while employed as a registered professional nurse at the Champlain Valley Physicians Hospital Skilled Nursing Facility in Plattsburg, New York, in approximately November through December, 2011, failed to accurately document withdrawal and administration of Percocet for patient E.D. on multiple occasions.

The New York State Board for Nursing imposed a two year suspension (stayed during probation with conditions) and a $250 fine. (See State Exhibit 2)

12. The Respondent also told Investigator Menard that the Respondent had a current prescription for Percocet 5/325 mg and that he took this medication as needed for sleep and pain. At the time of the interview with Investigator Menard (following his discharge from Franklin County Rehab Center), the Respondent was working at another nursing facility in South Burlington, Vermont.

13. The Board is persuaded that, despite the Respondent charting that the patients received their pain medications, the patients did not receive the medications from the Respondent.

14. The evidence presented imperatively requires emergency action for the public health, safety, and welfare. Specifically, summary suspension is necessary to prevent patient harm.

Conclusions of Law and Discussion

The State has the burden of proof to establish that the public health, safety or welfare are at risk and that the proven risk to the public imperatively require emergency action. See 3 VSA Sec. 814(c). The timing, nature, and purpose of the administrative hearing may define the scope and procedural parameters of an administrative hearing. See In re Miller, 2009 VT 112, 989 A.2d 982 (Vt. 2009) at Para. 14. In summary suspension hearings, the administrative authority may look to the allegations, as well as the factual basis for the allegations, to make its findings.

In this case, the State evidence demonstrated that within a short period of employment at the Franklin County Rehab Center, the Respondent did not properly medicate patients, and did not properly chart their medications. It is particularly notable that the medications which were not received were Oxycodone (Percocet), and that these are the same medication for which the prior discipline was given to the Respondent by the New York Board for Nursing under similar circumstances. Likewise, it is notable that the Respondent takes this drug for himself for pain and sleep.

The Respondent argued that the allegations do not allege that a patient was not given medication which was needed, nor was any patient given the wrong medication. He argues that errors in charting do not create a significant risk to public which require summary suspension.

The Board disagrees. First, the failure to administer medications, whether needed or not, create a false reality about the current status of the patient which can easily affect subsequent treatment. For example if one of the patients who did not receive their medication thereafter requested medication for pain, they might not receive it based upon the previous recorded dose. Moreover, accurate medication charting is the hallmark of professional nursing. A consistent and serious deviation from accurate charting places patients at risk due to the lack of care by that nurse. There is ample evidence here that this risk accompanies the Respondent.

There is also substantial evidence that the opiate medications which did not get to the patients as charted, were diverted.

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). 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

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 13, 2016
Ellen Watson, APRN, Vice-Chair

DATE OF ENTRY: 9/19/16

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.

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IN RE:	)	
KEVIN J. SHIFLETT	)	**Docket No. 2016-399**
License No. 026.0121110	)	

REQUEST FOR SUMMARY SUSPENSION

Board Authority

1. The Vermont Board of Nursing ("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.

General Statements of Facts

3. Kevin J. Shiflett ("Respondent") of Plattsburgh, New York, is licensed by the State of Vermont as a Registered Nurse ("RN") under license number 026.0121110. This license was originally issued on June 8, 2016, and expires on March 31, 2017.

4. From June 13, 2016, to July 20, 2016, Respondent was employed as a Registered Nurse at the Franklin County Rehab Center ("Facility"), in St. Albans, Vermont.

5. On July 1, 2016, Respondent was given a written warning and additional training from the Facility due to failure to maintain proper administration records of medications, administration of discontinued medications, and resealing medication cards for medications open in error.

6. During the weekend of July 16, 2016, to July 17, 2016, Respondent's nursing notes stated he administered Oxycodone to three patients who had not previously reported being in pain to staff. All three patients reported to A.B., a RN and Director of Nursing at the Facility, that during this weekend they were not in pain, did not ask for pain medication, and did not receive pain medication from Respondent.

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Patient 1

7. From July 1, 2016, to July 20, 2016, Respondent was the only nurse who documented administering Oxycodone to Patient 1.

8. Oxycodone HCL 2.5mg could be given to Patient 1 by mouth everyone four hours as needed for moderate breakthrough pain.

9. On July 16, 2016, at 3:33am, Respondent documented giving Patient 1 Oxycodone HCL 2.5mg for pain.

10. However, on July 16, 2016, at 10:39pm, Patient 1 stated that she was not in pain.

11. On July 17, 2016, at 2:38am, Respondent documented giving Patient 1 Oxycodone HCL 2.5mg for pain.

12. However, on July 17, 2016, at 10:19pm, Patient 1 stated that she was not in pain.

13. On July 18, 2016, at 1:21am, Respondent documented giving Patient 1 Oxycodone HCL 2.5mg for pain.

14. However, on July 19, 2016, at 12:58am, Patient 1 stated that she was not in pain.

15. At all times relevant, Patient 1 was alert, oriented, and able to make all wants and needs known.

16. At all times relevant, Patient 1 did not receive Oxycodone.

Patient 2

17. Oxycodone HCL 5mg could be given to Patient 2 by mouth everyone four hours as needed for moderate to severe pain.

18. On July 16, 2016, at 1:47am, Respondent documented giving Patient 1 Oxycodone HCL 5mg for pain.

19. However, on July 17, 2016, at 10:27pm, Patient 2 stated that she was not in pain.

20. On July 18, 2016, at 1:22am, Respondent documented giving Patient 1 Oxycodone HCL 5mg for pain.

21. However, on July 19, 2016, at 12:57am, Patient 2 stated that she was not in pain.

22. At all times relevant, Patient 2 was alert, oriented, and able to make all wants and needs known.

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23. At all times relevant, Patient 2 did not receive Oxycodone from Respondent.

Patient 3

24. From July 1, 2016, to July 18, 2016, Respondent was the only nurse who documented administering Oxycodone to Patient 3.

25. Oxycodone HCL 2.5mg could be given to Patient 3 by mouth everyone four hours as needed for moderate pain. Oxycodone HCL 5mg could be given to Patient 3 by mouth everyone four hours as needed for severe pain.

26. On July 16, 2016, at 5:45am, Respondent documented giving Patient 3 Oxycodone HCL 5mg for pain and reported that Patient 3 was yelling out in pain during sleep. A few minutes later, at 5:59am, Respondent documented giving Patient 3 Oxycodone HCL 5mg for pain and reported that Patient 3 was yelling out in pain during sleep.

27. On July 16, 2016, at 10:20pm, Patient 3 stated that he was not in pain.

28. On July 17, 2016, at 2:04am, Respondent documented giving Patient 3 Oxycodone HCL 5mg for pain.

29. However, on July 17, 2016, at 10:36pm, Patient 3 stated that he was not in pain.

30. On July 17, 2016, at 11:40pm, Respondent documented giving Patient 3 Oxycodone HCL 2.5mg for pain and reported that Patient 3 was yelling out in pain.

31. On July 18, 2016, at 3:40am, Respondent documented giving Patient 3 Oxycodone HCL 5mg for pain and reported that Patient 3 was yelling out in pain.

32. On July 19, 2016, at 12:55am, Patient 3 stated that he was not in pain.

33. Patient 3 stated that during the night of July 17, 2016 to July 18, 2016, he was not in pain, slept well, and did not receive any pain medication.

34. At all times relevant, Patient 3 was alert, oriented, and able to make all wants and needs known.

35. At all times relevant, Patient 3 did not receive Oxycodone.

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

36. The State re-alleges and incorporates Paragraphs 3 through 35 above.

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37. The facts alleged in Paragraphs 6 through 35 demonstrate that Respondent documented administering Oxycodone to Patients 1, 2, and 3, but this medication was never received or taken by the documented recipient.

38. Respondent takes prescribed Oxycodone, 5/325 Percocet, three times a day for back pain. Respondent has been taking Percocet for approximately five months. Respondent takes prescribed Clonazepam three times a day for an anxiety disorder.

39. The facts alleged in Paragraphs 6 through 35 and Paragraph 30 demonstrate that Respondent diverted or attempted to divert Oxycodone.

40. 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 26 V.S.A. § 1582(a)(2).

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

41. The State re-alleges and incorporates Paragraphs 3 through 35 above.

42. The facts alleged in Paragraphs 6 through 35 demonstrate that Respondent engaged in conduct of a character likely to deceive when he recorded inaccurate nursing notes to deceive co-workers and divert or attempt to divert Oxycodone.

43. 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 26 V.S.A. § 1582(a)(3).

Violation Three: 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.

44. The State re-alleges and incorporates Paragraphs 3 through 35 above.

45. For the safety and wellbeing of the patient, nursing notes are relied on by nurses at the Facility to know what occurred on each shift and what medications were administered.

46. The facts alleged in Paragraphs 5 through 35 demonstrate Respondent performed unsafe or unacceptable patient care by failing to document accurate nursing notes and diverting or attempting to divert Oxycodone from the Facility.

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47. The facts alleged in Paragraphs 5 through 35 demonstrate Respondent failed to conform to the essential standards of acceptable and prevailing practice by failing to document accurate nursing notes and diverting or attempting to divert Oxycodone from the Facility.

48. The essential standards of acceptable and prevailing practice require a RN to maintain accurate administration of records of medications and nursing notes.

49. 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 3 V.S.A. § 129a(b)(1) and (2).

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.

50. The State re-alleges and incorporates Paragraphs 3 through 35.

51. The facts alleged in Paragraphs 6 through 35 demonstrate that Respondent created false records while caring for patients at the Facility.

52. On November 19, 2013, the New York Board of Regents granted the Respondent's Application for Consent Order, Cal. No. 26693, In the Matter of the Disciplinary Proceedings against Kevin Shiflett ("NY Order").

53. While employed as an RN in New York, Respondent failed to accurately document withdraw and administration of Percocet for a patient on multiple occasions from November to December 2011. Respondent was charged with unprofessional conduct, violation 8 NYCRR § 29.1(a)(3) for the failure to maintain accurate records.

54. On November 26, 2013, the NY Order went into effect. Respondent's license was suspended for two years, stayed for a probationary period of two years, and fined $250.

55. The facts alleged in Paragraphs 52 through 54 demonstrate that Respondent was disciplined by the state of New York for failure to maintain accurate records. This act also constitutes unprofessional conduct in Vermont.

56. The Board has the power to "discipline any licensee or refuse to license any person who has had a license application denied or a license revoked, suspended, limited, conditioned, or otherwise disciplined by a licensing agency in another jurisdiction for conduct which would constitute unprofessional conduct in this State, or has surrendered a license while under investigation for unprofessional conduct." *See* 3 V.S.A. § 129(a)(5).

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57. 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 3 V.S.A. § 129(a)(5).

Request for Relief

58. Emergency action is required because Respondent's continued licensure is a significant threat to the health, safety and welfare of the people of the State of Vermont because a Registered Nurse must maintain proper and accurate administration records of medications and is prohibited from diverting or attempting to divert narcotics for unauthorized use.

59. 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), Kevin J. Shiflett's nursing license number 026.0121110 be summarily suspended, pending a hearing on the merits.

DATED at Montpelier, Vermont this 1st day of September, 2016.

STATE OF VERMONT
SECRETARY OF STATE

By: _____

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