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

In re: MICHELLE L. VANCE License No. 026.0106222	}	Docket No. 2017-1 (RN)

SUMMARY SUSPENSION ORDER

Participating Board Members:
Jeanine Carr, RN, Chair
Ellen Watson, APRN, Vice Chair
Jennifer Laurent, APRN
Virginia Hudson, RN
Deborah Swartz, RN
Luana Tredwell, LPN
Kelly Sinclair, LNA
Jill Duell LPN

Appearances:
Prosecuting the case: Elizabeth A. St. James, 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 March 6, 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 evidence presented to the Board at the hearing, the Board finds as follows:

1. Respondent is a Registered Nurse licensed in Vermont. Her license is set to expire on March 31, 2017. 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 February 27, 2017 by certified mail and regular mail.
3. The allegations in the Request for Summary Suspension 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 Bel Aire Center Nursing Home ("the facility") in Newport, Vermont, during 2016 and 2017.
4. On January 1, 2017 a medication assistant turned over a medication cart to the custody and control of the Respondent at approximately 9:45 PM. At the time of the turnover, the cart contained a partial bottle of Gabapentin which should have had approximately 270 pills in the bottle. When the cart was turned over by the Respondent to the oncoming medication assistant on January 2, 2017 at the end of the Respondent's shift, the bottle of Gabapentin was missing.
5. The facility was missing Gabapentin in other patients' accounts.
6. On December 27, 2016 the Respondent attempted to reorder a prescription for Oxycodone for a resident who had an older prescription for the drug, but which was still in place. The resident had not received a dose of Oxycodone since August of 2016. There were no valid nursing notes, doctor's orders, or other justification for the reordering of this prescription.
7. On January 26, 2017 the Respondent admitted to Investigator Lewis that she had diverted narcotics from the facility by signing out medications when a resident did not need the medication. She admitted that her drug of choice is Oxycodone and that if tested on January 26, 2017 she would likely test positive for Oxycodone, Morphine, Hydrocodone and Hydromorphone, and that she did not have a prescription for any of these drugs.
8. Upon execution of a search warrant at the home of the Respondent on January 26, 2017 the Respondent was found to be in possession of empty vials of Morphine, and empty bag of heroin, a syringe, pages of patient records, and other drugs.
9. The evidence presented show 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: Jeanine Carr
Jeanine Carr, RN, Chair

Date: March 7, 2016

DATE OF ENTRY: 3/9/17

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:	)	
MICHELLE L. VANCE	)	**Docket Nos. 2017-1**
License No. 026.0106222	)	

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. Michelle L. Vance ("Respondent) of Danville, Vermont is licensed by the State of Vermont as a Registered Nurse ("RN") under license number 026.0106222. This license was originally issued on May 19, 2016 and expires on March 31, 2017.

4. At all relevant times, Respondent was employed as an RN at Bel Aire Center Nursing Home ("Facility") in Newport, Vermont. Respondent was terminated from the Facility on January 3, 2017.

5. On December 27, 2016, Respondent sent a request to a pharmacy for a refill of an Oxycodone 5mg prescription for Resident 1.

6. Resident 1 had not received a dose of Oxycodone since mid-August 2016.

7. Respondent provided no nursing notes to indicate she had assessed Resident 1's pain and a new prescription was needed.

8. The pharmacy did not refill this prescription and the medication order was canceled.

9. On January 1, 2017, Respondent's shift began at approximately 9:45 p.m. and ended on January 2, 2017 at approximately 7:30 a.m.

10. On January 1, 2017, LNA R.G. turned the medication cart over to Respondent.

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11. At the end of Respondent's shift on January 2, 2017, Respondent turned the medication cart over to LNA A.B.

12. Resident 2 had a medication order for Gabapentin 100mg three times a day.

13. The Facility received a bottle of 300 Gabapentin 100 mg pills for Resident 2 at the Facility on November 11, 2016. This bottle was placed into service in mid-December.

14. Resident 2's Gabapentin bottle was present on the medication cart at the start of Respondent's January 1, 2017 shift.

15. On January 2, 2017, LNA A.B. attempted to administer a dose of Gabapentin to Resident 2, but the bottle was missing from the medication cart.

16. On January 2, 2017, Resident 2 had only received 30 doses from her 300 dose bottle, leaving 270 Gabapentin 100mg pills missing.

17. Resident 3 had a medication order for Gabapentin 300mg three times a day.

18. The Facility received a bottle of 90 Gabapentin 300mg pills for Resident 3 on December 29, 2016. This bottle was considered a backup bottle until her current bottle ran out.

19. On January 2, 2107, LNA A.B. attempted to administer a dose of Gabapentin to Resident 3 and discovered that Resident 3's backup bottle of 90 Gabapentin 300mg was missing.

20. During a subsequent medication reconciliation, the Facility discovered that at least four (4) other residents were missing Gabapentin.

21. Respondent has been addicted to opiates for approximately 2 years and has been attempting to wean herself off of them on her own.

22. Respondent's drug of choice is oxycodone.

23. On January 26, 2017, Respondent admitted that if she were to be drug tested on that date, she would likely test positive for Oxycodone, Morphine, Hydrocodone, and Hydromorphone, all drugs she did not have a prescription for.

24. On January 26, 2017, Respondent admitted to diverting narcotics from the Facility by signing out medications when a Resident did not need it.

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25. Respondent used the diverted medication to help her get through her shift so she would not get sick at work.

26. On January 26, 2017, Respondent was found to be in possession of vials of Morphine, Alprazolam, a syringe, Cholesyramine oral suspension, a bottle of Lidocaine, several pages of patient records, and pieces of an empty heroin bag.

27. During the relevant time period, Respondent was also employed as an RN at Weeks Memorial Hospital in New Hampshire and admitted that it is possible some of the medications and patient records she was found to be in possession of came from either the Facility or Weeks Memorial Hospital

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

28. The State re-alleges and incorporates Paragraphs 3 through 27 above.

29. As a Registered Nurse, Respondent shall not divert or attempt to divert drugs or equipment or supplies for unauthorized use.

30. Respondent diverted or attempted to divert drugs or equipment or supplies for unauthorized use as described in Paragraphs 5 through 27 above.

31. 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.

32. The State re-alleges and incorporates Paragraphs 3 through 27 above.

33. The essential standards of acceptable and prevailing practice require Registered Nurses to accurately and honestly document all nursing interventions, including the administration of medication.

34. Respondent failed to meet this standard by engaging in the conduct described in Paragraphs 5 through 27 above.

35. The essential standards of acceptable and prevailing practice require Registered Nurses to refrain from diverting medications for their own use.

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36. Respondent failed to meet this standard by engaging in the conduct described in Paragraphs 5 through 27 above.

37. 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.

38. The State re-alleges and incorporates Paragraphs 3 through 27 above.

39. As a Registered Nurse, Respondent has an obligation to provide safe and acceptable patient care.

40. The respondent provided unsafe and unacceptable patient care by engaging in the behavior described in Paragraphs 5 through 27 above.

41. 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.

42. The State re-alleges and incorporates Paragraphs 3 through 27 above.

43. As a Registered 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.

44. Paragraphs 5 through 27 above demonstrate that Respondent willfully made or filed false reports or records in the practice of the profession.

45. 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.

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46. The State re-alleges and incorporates Paragraphs 3 through 27 above.

47. As a Registered Nurse, Respondent has a responsibility not to engage in conduct of a character likely to deceive, defraud, or harm the public.

48. Respondent engaged in conduct of a character likely to deceive, defraud, or harm the public as demonstrated in Paragraphs 5 through 27 above.

49. 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.

50. The State re-alleges and incorporates Paragraphs 3 through 27 above.

51. As a Registered Nurse, Respondent shall only practice the profession when medically or psychologically fit to do so.

52. Respondent practiced the profession of nursing when medically or psychologically unfit to do so when she engaged in the conduct stated in Paragraphs 5 through 27 above.

53. 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).

Violation Seven: 26 V.S.A. §1582(a)(7) Violating confidentiality by inappropriately revealing information or knowledge about a patient or client.

54. The State re-alleges and incorporates Paragraphs 3 through 27 above.

55. As a Registered Nurse, Respondent has a duty not to violate confidentiality by inappropriately revealing information or knowledge about a patient or client.

56. Respondent inappropriately revealed information or knowledge about a patient or client by engaging in the conduct described in Paragraphs 26 and 27 above.

57. 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)(7).

58. Without emergency action, members of the public, patients, and potential patients would be unaware of Respondent's dangerous behavior and will remain unprotected

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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 **026.0106222** be summarily suspended, pending a hearing on the merits.

DATED at Montpelier, Vermont this 27th day of February, 2017.

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