Montpelier

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

IN RE: CHRISTOPHER PAUL WALCZAK) DOCKET No. NU24-1005
License No. 025-0008440)

STIPULATION AND CONSENT ORDER

STIPULATION

NOW COMES the State of Vermont, through State Prosecuting Attorney, Edward G. Adrian, and the Respondent, Christopher Paul Walczak, who stipulate and agree as follows:

Board Authority

1. The Vermont State Board of Nursing ("the Board") has authority to issue warnings or reprimands, suspend, revoke, limit, 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. §1582; the Administrative Rules of the Board of Nursing ("ARBN"); and the Rules of the Office of Professional Regulation.

Statement of Facts

2. Christopher Paul Walczak (the "Respondent") of Montpelier, Vermont is a licensed practical nurse holding license number 025-0008440, issued by the State of Vermont. This license was originally issued on or about September 23, 2003 and is set to expire on January 31, 2006.

3. On November 21, 2005 the Respondent's license was summarily suspended. On November 23, 2005 by agreement of the parties the suspension was stayed in order to allow the Board to consider stipulated to evidence. On December 2, 2005 after considering the evidence the stay was vacated and the suspension reinstated.

4. At all times relevant the Respondent was employed at Central Vermont Medical Center (the "Facility") located in Berlin, Vermont. During the relevant time period the Respondent was assigned to the Express Care Unit of the facility where patients who do not require emergency room care are referred.

5. Chief Deputy Investigator Amy Carlson was assigned to investigate the allegations surrounding the Respondent and prepared an affidavit and supplemental affidavit pursuant to that investigation. Investigator Carlson recently went on maternity leave and Investigator Derek Everett was assigned to follow up on elements of the investigation.

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

6. Between July 17, 2005 and August 30, 2005 the Respondent was responsible for 57 entries into the Express Care Pyxis machine. 37 of these entries were cancelled. 20 of the cancelled entries were for Hydrocodone and 17 were for Oxycodone. When a transaction is cancelled in the Pyxis machine, the medication is still delivered to the operator of the machine. Hospital personnel advised that a typical nurse might have to cancel one Pyxis order ever week or two weeks. There were several instances where the Respondent had three cancellations in one day.

7. Out of the 37 cancelled entries 23 were 911 (emergency) entries. Facility personnel indicate that 911 entries in the Express Care Unit would not be justified.

8. An inventory conducted of the Pyxis machine on or about September 12, 2005 revealed 7 missing Percocet (Oxycodone) and 6 missing Vicodin (Hydrocodone).

9. On or about September 13, 2005 the Respondent advised Facility personnel that it was his practice to do a narcotic count every few hours. These counts were not witnessed. Facility protocol required one witnessed count to be done on a weekly basis.

10. Another inventory conducted on or about October 2, 2005 revealed that another 2 Vicodin (Hydrocodone) were missing.

11. Between July 13, 2005 and August 21, 2005 the Respondent withdrew medications from the Express Care Pyxis including Oxycodone and Hydrocodone for various patients with written prescriptions for these medications. The written prescriptions were to be filled by the patients after they left the Express Care Unit. The Respondent withdrew medications for R.A., R.S., M.W., and K.P. None of the patients' medical records indicate having received these medications.

12. On or about August 3, 2005 the Respondent accessed two different Pyxis machines to fill one order for patient B.C. Hospital personnel advised that this was unusual behavior.

13. Between July 18 and August 15, 2005 the Respondent entered the Express Care Pyxis under the following patient initials and accessed and then cancelled orders of Oxycodone and/or Hydrocodone, for J.M., M.K., A.P., B.P., M.W., I.G., T.W., and J.T. None of these patients had orders for either of these medications.

14. Between July 4 and August 25, 2005 the Respondent entered the Emergency Department Pyxis under the following patient initials and withdrew and then cancelled orders of at least one of the following medications Hydrocodone, Tramadol, Hydromorphone, Lorazepam and Oxycodone, for R.M.,W.S., R.P., R.G. and M.N. These patients either did not have an order for these medications and/or there is no documentation in the patient charts that they ever received these medications.

15. On or about December 1, 2005 Investigator Everett was informed by patient R.M. that she had been treated in the Emergency Department at the Facility on July 3-4, 2005. R.M. informed the Investigator that she never received any pain pills during her visit to the ER and

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

was only given intravenous medication. The Pyxis report for July 4, 2005 indicates that the Respondent withdrew Hydrocodone under R.M.'s name.

16. On or about November 22, 2005 Investigator Everett inquired of patient W.S. as to whether he would have received care from the Facility Emergency Department on August 20, 2005. W.S. indicated that he has been in the Emergency Department on numerous occasions as a result of chronic bronchitis and emphysema. W.S. informed the Investigator that he was given a nebulizer to help him breath easier, but that he did not have any injections of Lorazepam (Ativan) when he was in the Emergency Department. The Pyxis report for August 20, 2005 indicates that the Respondent withdrew a vial of Lorazepam under W.S.'s name.

17. On or about September 13, 2005 the Respondent was advised by the Facility that his inventory counts would need to be witnessed and he could no longer access narcotics from the Pyxis machines without a witness. On or about September 18, 2005 the Respondent failed to have some of his narcotic entries co-signed.

18. On or about October 1, 2005 the Respondent was one of two individuals who accessed Vicodin from the Emergency Department Pyxis machine. It was discovered that two Vicodin pills were missing and on October 3, 2005 the Respondent was suspended with pay by the Facility.

19. On or about November 3, 2005 Investigator Carlson interviewed the Respondent in the presence of his Attorney, L. Brooke Dingledine. The Respondent denied diverting any medications from the Facility. The Respondent advised that he utilized the 911 code and patient names to conduct regular narcotic counts since this is what he had been taught as a medic in the military while recently stationed in Iraq. The Respondent claimed that Nurse Karen Boyce advised him to use the 911 codes. Nurse Boyce advised that she never instructed the Respondent to use the 911 code to do a narcotic count.

Charges

20. The acts, omissions and/or circumstances described above constitute grounds for discipline because the Respondent has committed unprofessional conduct in violation of:

(i) 3 V.S.A. § 129a(a)(3) (failing to comply with provisions of federal or state statutes or rules governing the practice of the profession);

(ii) 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 or reports or records or willfully failing to file the proper reports or records);

(iii) 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. Failure to practice competently includes failure to conform to the essential standards of acceptable and prevailing practice);

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

(iv) 26 V.S.A. § 1582(a)(3)(is unable to practice nursing competently by reason of any cause); Vermont Board of Nursing Administrative Rules Chapter 4, Rule IV, II, C ("Any cause" includes, but is not limited to, reasons of physical or mental disability or use of drugs, narcotics, chemicals or any other type of materials); and

Understandings

21. Respondent admits the facts above are true and that the conditions below are necessary to protect the public.

22. 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.

23. Respondent specifically waives any claims that any disclosures made to the full Board during its review of this agreement have prejudiced his rights to a fair and impartial hearing in future hearings if this agreement is not accepted by the Board.

24. Respondent has read and reviewed this entire document and agrees that it contains the entire agreement between the parties.

25. Respondent is not under the influence of any drugs or alcohol at the time he signs this Stipulation and Consent Order.

26. 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.

27. Respondent voluntarily waives his right to a contested hearing before the Board of Nursing and waives any right to appeal from this Stipulation and Consent Order.

28. Respondent agrees that the Order set forth below may be entered by the Board.

ORDER

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

A. The Board of Nursing hereby **INDEFINITELY SUSPENDS THE RESPONDENT'S LICENSE**. Before applying for reinstatement, Respondent must obtain (1) an independent evaluation report by a licensed professional specializing in drug and alcohol abuse pre-

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

approved by the Board; and (2) the results of the treatment with the drug and alcohol abuse evaluator must indicate that the Respondent does not present a risk to the safety, health or welfare of his potential patients. Once reinstated, his license will be **CONDITIONED FOR THREE (3) YEARS** and limited pursuant to the Laws of the State of Vermont and the Rules of this Board. The conditions will be as follows:

(1) Re-issue of License.

Upon the commencement of these conditions, Respondent shall be issued a license labeled "conditioned."

(2) Length of Time Conditions Imposed.

The conditions shall remain in place until Respondent has completed all conditions ordered. Respondent shall be subject to the conditions until Respondent completes three (3) years of supervised practical nursing in which he works forty (40) hours every two (2) weeks as a practical nurse. Part time hours of less than forty (40) hours every two (2) weeks shall be credited on a prorated basis. Respondent shall be prohibited from working more than forty (40) hours per week, in the profession of nursing.

(3) Completion of Substance Abuse Counseling and Treatment Plan.

Respondent shall enter into and continue substance abuse counseling with a treating professional approved by the Board until the treating professional shall certify in writing to the Nursing Board that such counseling is no longer necessary. Respondent shall enter into and comply with the substance abuse treatment plan approved by the Board and the treating professional. **The Veteran's Administration program in White River Junction shall satisfy this requirement and those requirements listed below dealing with substance abuse counseling and reporting.**

(4) Notification to Treating Professional.

Respondent shall provide a copy of this Stipulation and Consent Order to his treating professional and cause his treating professional to inform the Board, in writing and on professional letterhead, of receipt of the Stipulation and Consent Order and the treating professional's ability to comply with the conditions related to treatment and with all other terms of this Consent Order.

(5) Reports from Treating Professional.

Respondent shall authorize and cause his treating professional to submit to the Board evidence of satisfactory progress with the treatment plan during the effective period of this Consent Order. These reports shall be submitted in writing on forms issued by the Board. The first report is due commencing the month after the date of the commencement of the conditions and subsequent reports are due **monthly** thereafter.

Respondent shall authorize his treating professional to provide all information requested by the Nursing Board, either orally or in writing, at any time during the period this Consent Order is in effect.

(6) Notification to Employers/Nursing School.

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

Respondent shall provide a copy of this Stipulation and Consent Order to all employers in any current or future setting in which Respondent practices as a practical nurse and inform them of Respondent's conditional license status.

Within ten (10) days of the date of entry of this Consent Order or of any subsequent practical nursing employment, Respondent shall cause Respondent's immediate supervisor to write to the Board, on the employer's letterhead, acknowledging receipt of the Stipulation and Consent Order and the ability to comply with the conditions in the Consent Order.

In the event the Respondent is attending a nursing program, Respondent shall cause the Program Director to write to the Board, on school letterhead, acknowledging receipt of the Stipulation and Consent Order and ability of the program to comply with the conditions in the Consent Order during clinical experience.

(7) Reports from Employers.

Within one (1) month of the date of entry of this Order or within one (1) month of the commencement of registered nursing employment and **monthly** thereafter, Respondent shall cause every registered nursing employer the Respondent has worked for during the month to submit to the Board an evaluation of Respondent's work performance and attendance during that month. This report shall be submitted in writing on forms issued by the Board.

In the event the Respondent is attending a nursing program, Respondent shall cause the Program Director to submit to the Board, on a monthly basis, a written evaluation of his performance and attendance. This report shall be submitted in writing on forms issued by the Board and accompanied by a cover letter on the school's letterhead.

(8) Practice Under Supervision.

Respondent shall practice only in a practical nurse setting where Respondent has direct supervision for the entire shift by a licensed nurse that is in good standing with the Board.

(9) Participation in Recovery Groups.

Respondent shall participate as recommended by his treating professional, in Narcotics Anonymous meetings and/or other recovery group(s).

(10) Random Drug and Alcohol Testing.

Respondent shall submit to random drug and alcohol screenings at the request of the Board or its designee. Respondent shall designate a person, who has been approved by the Board or its designee, to administer random drug and alcohol screens. All testing shall be done on a random, unannounced basis and analyzed by a lab qualified to analyze samples for forensic purposes and approved by the Board. All urine specimens collected for tests shall be collected in an observed setting. All screens shall be negative.

(11) Abstain from Drug and Alcohol Use.

Respondent shall abstain completely from the consumption or possession of alcohol and drugs with the exception of medications as outlined in paragraph A.(12) for the period of time described in paragraph A.(2).

(12) Drug Use Exception.

The Respondent shall not take controlled substances unless necessary. Respondent may take scheduled/controlled medications lawfully prescribed for a bona fide illness or condition

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

by a physician, dentist, or nurse practitioner whose identity shall be made known to the Board in writing by Respondent within forty-eight (48) hours of the establishment of the practitioner/patient relationship. Respondent shall ensure that the physician, dentist or nurse practitioner informs the Board, in writing and on appropriate letterhead, of knowledge of Respondent's substance abuse issue(s) within one (1) week of entering into the practitioner/patient relationship. Respondent shall inform the Board in writing of all scheduled/controlled medications prescribed, including the name of the prescribing practitioner, within forty-eight (48) hours of receiving the prescription.

The Board or its designee may request at any time that the practitioner document the continued necessity for the prescribed scheduled/controlled medications if the term exceeds 14 days. This includes medications to be administered as necessary. It is not anticipated that Respondent would be prescribed scheduled/controlled medication during the term of this Consent Order for a period greater than 14 days, but if so, then the conditions herein may be revoked by the Board.

Respondent shall keep a written record of all medications taken, including over the counter drugs, and produce such record upon the request of the Board or its designee.

(13) Interview with the Board or its Designee.

Respondent shall appear in person for interviews with the Board or its designee upon request.

(14) Types of Employment Prohibited.

Respondent shall not work in a supervisory role. Respondent shall not work for a nurse registry, traveling nurse agency, float-pool, home health care agency, temporary nursing employment agency or as a personal care provider during the effective period of this Consent Order.

(15) Out of State Practice/Residence.

Before any out-of-state practice or residence can be credited toward fulfillment of these terms and conditions, Respondent shall first obtain approval from the Board prior to Respondent leaving the State of Vermont. If Respondent fails to receive such approval before leaving the State, none of the time spent out-of-state will be credited toward the fulfillment of the terms and conditions of this Consent Order. The Board will approve out-of-state practice so long as the Respondent can still comply with the provisions of this Consent Order.

(16) Notification of Place of Employment/Personal Address/Telephone Number.

Within five (5) days of the date of entry of this Consent Order, Respondent shall notify the Board, in writing, of his current place of employment, personal address, and telephone number. Respondent shall further notify the Board, in writing, within forty-eight (48) hours of any change in employment, personal address, or telephone number.

(17) Notification to Other States.

In the event that the Respondent is licensed in nursing in any other state(s), he must inform the nursing licensing board of the state(s) in which the Respondent is licensed of the conditional status of his Vermont practical nursing license within thirty (30) days of the date

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

of entry of this Order. If the Respondent fails to provide such notification, it will be considered a violation of this Order.

(18) License Renewal.

If the Respondent's license expires while this Order is still in effect, this Order does not automatically extend the license. In that situation, in order to continue to practice as a practical nurse, the Respondent must timely apply for renewal, pay the applicable fee and demonstrate that he has otherwise complied with the requirements for license renewal.

(19) Release of Information Forms.

The conditions of this Order require the Respondent to authorize drug and/or alcohol treatment providers to report information in verbal and/or written format and/or to discuss the Respondent and any and all treatment rendered to the Respondent for drugs and/or alcohol with the Board or its designee. The conditions of this Order must allow any and all information from the Respondent's treatment providers to also be provided to the Office of Professional Regulation investigators and that the information may be used for further prosecutions if so warranted or if the Office of Professional Regulation determines that said information violates the terms of this Order or any rules or laws governing the profession of nursing.

The Respondent is entitled to revoke this consent at any time. However, any revocation by the Respondent of such consent to disclosure during the term of this Order shall be considered a violation of this Order.

This consent expires when the conditions are removed from the Respondent's practical nursing license.

This Stipulation and Consent Order shall constitute a valid written consent pursuant to the requirements of 42 C.F.R. § 2.31.

The Respondent understands that his treatment provider may require him to sign a separate and distinct consent meeting the requirements of 42 C.F.R. § 2.31.

(20) Costs.

The Respondent shall bear all costs of complying with this Consent Order.

(21) Violation of this Order.

If the Respondent violates the terms of this Order in any respect, the Board, after giving the Respondent notice and an opportunity to be heard, may rescind or modify this Order and impose additional appropriate disciplinary actions. If a complaint of unprofessional conduct is made against the Respondent during the term of this Order, this Order shall be automatically extended until the unprofessional conduct matter is concluded.

(22) Completion of Conditional License Period.

After the conditional license period, the Respondent may petition the Board to remove any and all conditions on his license. The Respondent must present proof that he has fully complied with the terms of this Order. The Respondent must also present proof of successful

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

substance abuse rehabilitation and he must demonstrate, to the satisfaction of the Nursing Board, that he poses no danger to the public or the practice of nursing and that he can safely and competently perform the duties of a licensed practical nurse.

B. Notwithstanding any provision above, the Respondent must continue to meet all Nursing Board requirements for maintaining a license, license renewal and license reinstatement.

C. 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).

D. 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:

Dated: 6/5/06

STATE OF VERMONT
SECRETARY OF STATE

By: _____
Edward G. Adrian
State Prosecuting Attorney

CHRISTOPHER PAUL WALCZAK
RESPONDENT

Dated: 5/26/06

By: _____
Christopher Paul Walczak

APPROVED AS TO FORM:

Dated: 5/26/06

ATTORNEY FOR RESPONDENT

By: _____
L. Brooke Dingledine, Esq.

APPROVED AND SO ORDERED:
VERMONT BOARD OF NURSING

Dated: 6/12/06

By: _____
Chairperson

Date of Entry: 6/12/06

nu.walczak.stip

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

STATE OF VERMONT
BOARD OF NURSING

In re: Christopher Paul Walczak License No. 025-0008440	} } }	Docket No. NU24-1005

Supplemental
DECISION ON REQUEST FOR SUMMARY SUSPENSION ORDER

Appearances:
for Petitioner, State of Vermont: Edward G. Adrian
for Respondent: L. Brooke Dingledine

Presiding Officer: Larry S. Novins

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

On November 18, 2005, this matter came before the Board of Nursing on the prosecution's Request for Summary Suspension pursuant to 3 V.S.A. § 814(c). The respondent did appear at the original hearing and was represented by counsel. After the hearing the Board issued an Order filed on November 21, granting the State's request and summarily suspending Mr. Walczak's license pending further proceedings. On November 21, before the parties received notice of the Order, the State by email clarified for the Board and Respondent's attorney that the total number of missing drugs was 7 Oxycodone (Percocet) And 8 Hydrocodone (Vicodin). This clarification resulted in the State and Respondent filing a Stipulated Motion for a Stay of the Summary Suspension so that the Board could consider what, if any, impact this clarifying information might have on the Board's previous Order. The Stay was granted on November 23, 2005.

The Board held a deliberative session on December 2, 2005 to consider additional clarifying information submitted.

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.

Findings of Fact

Based on a Review of the pleadings and the file, and on evidence presented to the Board at the hearing, and afterward by consent of the parties afterward, the Board finds:

1. The respondent is licensed by and subject to the disciplinary authority of this Board. 26 V.S.A. Chapter 28, 3 V.S.A. § 129(a), the Administrative Rules of the Office of Professional Regulation.
2. The prosecution has filed a "Request for Summary Suspension" dated November 7, 2005 alleging among other things that between July 17, 2005 and August 30, 2005 while employed at Central Vermont Hospital and assigned to the Express Care Unit, Mr. Walczak accessed Pyxis machines for medication for patients who never received them, and that during that time controlled substance drugs were delivered to the machine's operators even when the order for the drugs was cancelled, and that Mr. Walczak was present when drugs went missing from the machine, that Mr. Walczak was advised in September that his inventory counts would have to be witnessed and that he failed to have some narcotic entries co-signed, and that he was one of two persons who accessed the Pyxis machine when two Vicodin pills were missing.
3. Mr. Walczak was suspended with pay from his job by the hospital on October 3, 2005.
4. The State's additional information submitted indicates that the total number of missing pills was less than the Board initially believed. However, the number of pills does not affect the Board's view of the seriousness of Mr. Walczak's failures to follow hospital procedures regarding controlled substances. The missing drugs were intended for, but not provided to patients.
5. The State's allegations contained in its specification of charges (attached), and as clarified by the corrected number of pills missing does prove to the necessary degree that there is an imperative need for emergency action to protect the public health, safety, and welfare.

Conclusions of Law

The prosecution's Request for a Summary Suspension continues to be supported by the evidence presented.

Order

The Stay of the Summary Suspension is vacated. The Board's initial Order of Summary Suspension is reinstated. Mr. Walczak'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).

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, 26 Terrace Street, Montpelier, Vermont 05609-1101 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. To request a stay of the Board's decision, please refer to the attached stay instructions.

Vermont Board of Nursing

By: Alan H Weiss
Alan H. Weiss, Acting Chair

Date: December 2, 2005

OFFICE OF PROFESSIONAL REGULATION

DATE OF ENTRY: 12/2/05

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

IN RE: CHRISTOPHER PAUL WALCZAK) DOCKET No. NU24-1005
License No. 025-0008440)

SPECIFICATION OF CHARGES

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 and; the rules of the Board and the Vermont Office of Professional Regulation.

Statement of Facts

2. Christopher Paul Walczak (the "Respondent") of Montpelier, Vermont is a licensed practical nurse holding license number 025-0008440, issued by the State of Vermont. This license was originally issued on or about September 23, 2003 and is set to expire on January 31, 2006.

3. On November 21, 2005 the Respondent's license was summarily suspended. On November 23, 2005 by agreement of the parties the suspension was stayed in order to allow the Board to consider stipulated to evidence. On December 2, 2005 after considering the evidence the stay was vacated and the suspension reinstated.

4. At all times relevant the Respondent was employed at Central Vermont Medical Center (the "Facility") located in Berlin, Vermont. During the relevant time period the Respondent was assigned to the Express Care Unit of the facility where patients who do not require emergency room care are referred.

5. Chief Deputy Investigator Amy Carlson was assigned to investigate the allegations surrounding the Respondent and prepared an affidavit and supplemental affidavit pursuant to that investigation. Investigator Carlson recently went on maternity leave and Investigator Derek Everett was assigned to follow up on elements of the investigation.

6. Between July 17, 2005 and August 30, 2005 the Respondent was responsible for 57 entries into the Express Care Pyxis machine. 37 of these entries were cancelled. 20 of the cancelled entries were for Hydrocodone and 17 were for Oxycodone. When a transaction is cancelled in the Pyxis machine, the medication is still delivered to the operator of the machine. Hospital personnel advised that a typical nurse might have to cancel one Pyxis order ever week or two weeks. There were several instances where the Respondent had three cancellations in one day.

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

7. Out of the 37 cancelled entries 23 were 911 (emergency) entries. Facility personnel indicate that 911 entries in the Express Care Unit would not be justified.

8. An inventory conducted of the Pyxis machine on or about September 12, 2005 revealed 7 missing Percocet (Oxycodone) and 6 missing Vicodin (Hydrocodone).

9. On or about September 13, 2005 the Respondent advised Facility personnel that it was his practice to do a narcotic count every few hours. These counts were not witnessed. Facility protocol required one witnessed count to be done on a weekly basis.

10. Another inventory conducted on or about October 2, 2005 revealed that another 2 Vicodin (Hydrocodone) were missing.

11. Between July 13, 2005 and August 21, 2005 the Respondent withdrew medications from the Express Care Pyxis including Oxycodone and Hydrocodone for various patients with written prescriptions for these medications. The written prescriptions were to be filled by the patients after they left the Express Care Unit. The Respondent withdrew medications for R.A., R.S., M.W., and K.P. None of the patients' medical records indicate having received these medications.

12. On or about August 3, 2005 the Respondent accessed two different Pyxis machines to fill one order for patient B.C. Hospital personnel advised that this was unusual behavior.

13. Between July 18 and August 15, 2005 the Respondent entered the Express Care Pyxis under the following patient initials and accessed and then cancelled orders of Oxycodone and/or Hydrocodone, for J.M., M.K., A.P., B.P., M.W., I.G., T.W., and J.T. None of these patients had orders for either of these medications.

14. Between July 4 and August 25, 2005 the Respondent entered the Emergency Department Pyxis under the following patient initials and withdrew and then cancelled orders of at least one of the following medications Hydrocodone, Tramadol, Hydromorphone, Lorazepam and Oxycodone, for R.M.,W.S., R.P., R.G. and M.N. These patients either did not have an order for these medications and/or there is no documentation in the patient charts that they ever received these medications.

15. On or about December 1, 2005 Investigator Everett was informed by patient R.M. that she had been treated in the Emergency Department at the Facility on July 3-4, 2005. R.M. informed the Investigator that she never received any pain pills during her visit to the ER and was only given intravenous medication. The Pyxis report for July 4, 2005 indicates that the Respondent withdrew Hydrocodone under R.M.'s name.

16. On or about November 22, 2005 Investigator Everett inquired of patient W.S. as to whether he would have received care from the Facility Emergency Department on August 20, 2005. W.S. indicated that he has been in the Emergency Department on

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

numerous occasions as a result of chronic bronchitis and emphysema. W.S. informed the Investigator that he was given a nebulizer to help him breath easier, but that he did not have any injections of Lorazepam (Ativan) when he was in the Emergency Department. The Pyxis report for August 20, 2005 indicates that the Respondent withdrew a vial of Lorazepam under W.S.'s name.

17. On or about September 13, 2005 the Respondent was advised by the Facility that his inventory counts would need to be witnessed and he could no longer access narcotics from the Pyxis machines without a witness. On or about September 18, 2005 the Respondent failed to have some of his narcotic entries co-signed.

18. On or about October 1, 2005 the Respondent was one of two individuals who accessed Vicodin from the Emergency Department Pyxis machine. It was discovered that two Vicodin pills were missing and on October 3, 2005 the Respondent was suspended with pay by the Facility.

19. On or about November 3, 2005 Investigator Carlson interviewed the Respondent in the presence of his Attorney, L. Brooke Dingledine. The Respondent denied diverting any medications from the Facility. The Respondent advised that he utilized the 911 code and patient names to conduct regular narcotic counts since this is what he had been taught as a medic in the military while recently stationed in Iraq. The Respondent claimed that Nurse Karen Boyce advised him to use the 911 codes. Nurse Boyce advised that she never instructed the Respondent to use the 911 code to do a narcotic count.

Charges

20. The acts, omissions and/or circumstances described above constitute grounds for discipline because the Respondent has committed unprofessional conduct in violation of:

(i) 3 V.S.A. § 129a(a)(3) (failing to comply with provisions of federal or state statutes or rules governing the practice of the profession);

(ii) 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 or reports or records or willfully failing to file the proper reports or records);

(iii) 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. Failure to practice competently includes failure to conform to the essential standards of acceptable and prevailing practice);

(iv) 26 V.S.A. § 1582(a)(3)(is unable to practice nursing competently by reason of any cause); Vermont Board of Nursing Administrative Rules Chapter 4, Rule IV, II, C ("Any cause" includes, but is not limited to, reasons

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

of physical or mental disability or use of drugs, narcotics, chemicals or any other type of materials);

(v) 26 V.S.A. § 1582(a)(7)(engages in conduct of a character likely to deceive, defraud or harm the public); Vermont Board of Nursing Administrative Rules Chapter 4, Rule IV, II, D, 3 and 4 (conduct likely to deceive, defraud, or harm the public means any instance of unprofessional conduct including: (3) falsifying or altering clinical records or making inaccurate or misleading entries and (4) diverting supplies, equipment, or drugs for personal or other unauthorized use.

WHEREFORE, the license of Christopher Paul Walczak should be revoked, suspended, reprimanded, conditioned or otherwise disciplined.

DATED at Montpelier, Vermont this 6th day of December, 2005.

STATE OF VERMONT
SECRETARY OF STATE

By: _____
Edward G. Adrian
State Prosecuting Attorney

NU005.soc.wpd

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

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

IN RE: CHRISTOPHER PAUL WALCZAK)
License No. 025-0008440)

Docket No. NU-24-1005

STIPULATED MOTION FOR STAY

NOW COME the parties in the above captioned matter and hereby request, agree and stipulate that the Chair of the Nursing Board Order a Stay of its **Decision on Request for Summary Suspension Order** dated November 18, 2005 and entered by the Office of Professional Regulation on November 21, 2005 to suspend the license of the Respondent in order for the Board to take evidence of and consider the following information provided by Edward G. Adrian, Prosecuting Attorney on Monday, November 21, 2005:

> Dear Mr. Novins and Ms. Dingledine:
>
> Based on Ms. Dingledine's representations about the amount of drugs missing from CVMC at the summary suspension hearing on 11/18/05, I have made inquiry into this matter with Investigator Carlson. While the plain language of the affidavit reflects the language in the State's charges, Investigator Carlson has informed me that the TOTAL amount of missing drugs that should be interpreted from the affidavit is as follows:
>
> 7 Oxycodone (Percocet)
> 8 Hydrocodone (Vicodin)
>
> I wanted to make the Respondent aware of this, as well as the Board as soon as possible. I do not yet know the decision of the Board in this matter, but should it be necessary, this office would not oppose any procedural intervention to allow the Board to consider these facts.
>
> Thank you both for your consideration in this matter.
>
> Very truly yours,
>
> Ed Adrian

WHEREFORE, the parties respectfully request that the Nursing Board Chair Order a Stay of the Suspension of the Respondent's nursing license number 025-0008440 pending an

opportunity for the Board to take evidence of and consider the information provided by Attorney Adrian as detailed above.

Dated at City of Barre, County of Washington and State of Vermont this 22nd day of November, 2005.

L. BROOKE DINGLEDINE, ESQ.
Attorney for Respondent

Dated at City of Montpelier, County of Washington and State of Vermont this 22nd day of November, 2005.

EDWARD G. ADRIAN, ESQ.
State Prosecuting Attorney

SO ORDERED:

28 NOV 05
Date

VERMONT BOARD OF NURSING

by: Alan H. Weiss, Acting Chair

Approved Orally
23 NOV 05.

L.SANGIACOMO.
A & McQUESTEN PC
P.O. Box 609
VT. VERMONT 05641
802-476-4181

STATE OF VERMONT
BOARD OF NURSING

In re: Christopher Paul Walczak	}	
License No. 025-0008440	}	Docket No. NU24-1005
	}	

DECISION ON REQUEST FOR SUMMARY SUSPENSION ORDER

Appearances:
for Petitioner, State of Vermont: Edward G. Adrian
for Respondent: L. Brooke Dingledean

Presiding Officer: Larry S. Novins

Summary Suspension Order
FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

On November 18, 2005 this matter came before the Board of Nursing on the prosecution's Request for Summary Suspension pursuant to 3 V.S.A. § 814(c). The respondent did appear and was represented by counsel.

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.

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:

1. The respondent is licensed by and subject to the disciplinary authority of this Board. 26 V.S.A. Chapter 28, 3 V.S.A. § 129(a), the Administrative Rules of the Office of Professional Regulation.
2. The prosecution has filed a "Request for Summary Suspension" dated November 7, 2005 alleging among other things that between July 17, 2005 and August 30, 2005 while employed at Central Vermont Hospital and assigned to the Express Care Unit, Mr. Walczak accessed Pyxis machines for medication for patients who never received them, and that during that time controlled substance drugs were delivered to the machine's operators even when the order for the drugs was cancelled, and that Mr. Walczak was present when drugs went missing from the machine, that Mr. Walczak was advised in September that his inventory counts would have to be witnessed and that he failed to have some narcotic entries co-signed, and that he was

one of two persons who accessed the Pyxis machine when two Vicodin pills were missing.

3. Mr. Walczak was suspended with pay from his job by the hospital on October 3, 2005.
4. The prosecution further alleges that the public health, safety or welfare imperatively requires emergency action.
5. The Respondent has been provided notice of this matter via "Notice of Summary Suspension Hearing."
6. The Board has reviewed documents presented by the State, heard the testimony of the respondent's witnesses, and heard the arguments of counsel.
7. The State's presentation in this case consisted of hearsay presented via an affidavit of an Office of Professional Regulation investigator.
8. The allegations in the Request for Summary Suspension (copy attached) have been established to the necessary degree.
9. The evidence presented does imperatively require emergency action for the public health, safety, and welfare.

Conclusions of Law

The prosecution'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.

The Board issues the following order which shall remain in effect until further action by the Board. 3 V.S.A. § 814(c).

Order

The 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).

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, 26 Terrace Street, Montpelier, Vermont 05609-1101 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. To request a stay of the Board's decision, please refer to the attached stay instructions.

Vermont Board of Nursing

By: Alan H. Weiss
Alan H. Weiss, Acting Chair

Date: November 18, 2005

OFFICE OF PROFESSIONAL REGULATION

DATE OF ENTRY: 11/21/05

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

IN RE: CHRISTOPHER PAUL WALCZAK) DOCKET No. NU24-1005
License No. 025-0008440)

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 and; the rules of the Board and the Vermont 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. Christopher Paul Walczak (the "Respondent") of Montpelier, Vermont is a licensed practical nurse holding license number 025-0008440, issued by the State of Vermont. This license was originally issued on or about September 23, 2003 and is set to expire on January 31, 2006.

4. At all times relevant the Respondent was employed at Central Vermont Medical Center (the 'Facility") located in Berlin, Vermont. During the relevant time period the Respondent was assigned to the Express Care Unit of the facility where patients who do not require emergency room care are referred.

5. Chief Deputy Investigator Amy Carlson was assigned to investigate the allegations surrounding the Respondent and prepared an affidavit and supplemental affidavit pursuant to that investigation.

6. That between July 17, 2005 and August 30, 2005 the Respondent was responsible for 57 entries into the Pyxis machine. 37 of these entries were cancelled. 20 of the cancelled entries were for Hydrocodone and 17 were for Oxycodone. When a transaction is cancelled in the Pyxis machine, the medication is still delivered to the operator of the machine.

7. Out of the 37 canceled entries 23 were 911 (emergency) entries. Facility personal indicate that 911 entries in the Express Care Unit would not be justified.

8. An inventory conducted of the Pyxis machine on or about September 11, 2005 revealed 7 missing Percocet (Oxycodone) and 14 missing Hydrocodone.

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

9. On or about September 13, 2005 the Respondent advised Facility personnel that it was his practice to do a narcotic count every few hours. This count was not witnessed. Facility protocol required one witnessed count to be done on a weekly basis.

10. Another inventory conducted on or about October 2, 2005 revealed that another 7 Hydrocodone were missing.

11. Between July 13, 2005 and August 21, 2005 the Respondent withdrew medications including Vicodin, Lorcet and Hydrocodone for various patients with written prescriptions for these medications. The written prescriptions were to be filled by the patients after they left the Express Care Unit. The Respondent withdrew medications for R.A., R.S. M.W. and K.P. None of the patients' medical records indicate having received these medications.

12. On or about August 3, 2005 the Respondent accessed two different Pyxis machines to fill one order for patient B.C.

13. Between July 18 and August 15, 2005 the Respondent entered Pyxis under the following patient initials and withdrew and then cancelled orders of Oxycodone and/or Hydrocodone, for J.M., M.K., A.P., B.P., M.W., I.G., T.W., and J.T. None of these patients had orders for either of these medications.

14. Between July 4 and August 25, 2005 the Respondent entered Pyxis under the following patient initials and withdrew and then cancelled orders of at least one of the following medications Hydrocodone, Tramadol, Hydromorphone, Lorazepam and Oxycodone, for R.M.,W.S., R.P., R.G. and M.N. These patients either did not have an order for these medications and/or there is no documentation in the patient charts that they ever received these medications.

15. On or about September 2, 2005 the Respondent received a personal prescription for a 15 day supply of Tramadol from PA Suzanne Reid. On or about September 13, 2005 the Respondent received a 50 tablet prescription for Tramadol from Dr. Michael Rappaport. PA Reid and Dr. Rappaport are not affiliated and work in two different facilities.

16. On or about September 13, 2005 the Respondent was advised by the Facility that his inventory counts would need to be witnessed and he could no longer access narcotics from Pyxis without a witness. On or about September 18, 2005 the Respondent failed to have some of his narcotic entries co-signed.

17. On or about October 1, 2005 the Respondent was one of two individuals who accessed Vicodin from the Pyxis machine. It was discovered that two Vicodin pills were missing and on October 3, 2005 the Respondent was suspended with pay by the Facility.

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

18. The Facility pharmacy director advised that no missing narcotics had been discovered by the Facility since October 2, 2005.

19. On or about November 3, 2005 Investigator Carlson interviewed the Respondent. The Respondent denied diverting any medications from the Facility. The Respondent advised that he utilized the 911 code and patient names to conduct regular narcotic counts since this is what he had been taught as a medic in the military while recently stationed in Iraq. The Respondent claimed that Nurse Karen Boyce advised him to use the 911 codes. Nurse Boyce advised that she never instructed the Respondent to use the 911 code to do a narcotic count.

Request for Relief

20. 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.

21. The above acts and circumstances, alone or in combination, violate: 3 V.S.A. § 129a(a) (3) (failing to comply with provisions of federal or state statutes or rules governing the practice of the profession); 26 V.S.A. § 1582(a)(3)(is unable to practice nursing competently by reason of any cause); Vermont Board of Nursing Administrative Rules Chapter 4, Rule IV, II, C ("Any cause" includes, but is not limited to, reasons of physical or mental disability or use of drugs, narcotics, chemicals or any other type of materials). 26 V.S.A. § 1582(a)(5) (is addicted to the use of habit forming drugs); 26 V.S.A. § 1582(a)(7)(engages in conduct of a character likely to deceive, defraud or harm the public); Vermont Board of Nursing Administrative Rules Chapter 4, Rule IV, II, D, 4 (conduct likely to deceive, defraud, or harm the public means any instance of unprofessional conduct including diverting supplies, equipment, or drugs for personal or other unauthorized use).

WHEREFORE, the State of Vermont respectfully requests that pursuant to 3 V.S.A. § 814(c), the Respondent's nursing license number 025-0008440 be summarily suspended, pending a hearing on the merits.

DATED at Montpelier, Vermont this 7 day of November, 2005.

STATE OF VERMONT
SECRETARY OF STATE

By: _____
Edward G. Adrian
State Prosecuting Attorney

NU117.sum.susp.lit.wpd

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107