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

In re: JODI A. STEWART
License No. 025.0009501
{ Docket No. 2015-315 (LPN)

Appearances:
Prosecutor: S. Lauren Hibbert, Esq.
Respondent: Appeared pro se

Hearing Officer: George K. Belcher

Exhibits:
State Exhibit 1: J.D. Prescription dated 6/5/15
State Exhibit 2: J.D. Prescription dated 6/18/15
State Exhibit 3: J.D. Draft Prescription dated 7/2/15
State Exhibit 4: Prescription Record from Walmart for J. D.
State Exhibit 5: Prescription dated 6/26/15 for Respondent
State Exhibit 6: Respondent’s medical chart summary from Dr. M.W.
Respondent Exhibit A: Substance abuse assessment dated 4/25/16

FINDINGS OF FACT CONCLUSIONS OF LAW AND ORDER

The Hearing Officer of the Vermont Board of Nursing held a hearing pursuant to 3 VSA Sec. 129(f) in the above matter on May 27, 2016 at the Office of Professional Regulation in Montpelier, Vermont. Respondent attended but was not represented by counsel.

Findings of Fact

1. Respondent is licensed as a Licensed Practical Nurse and is therefore subject to the regulatory authority of this Board. 3 V.S.A. §§ 129, 129a, 26 V.S.A. Chapter 28, and the Administrative Rules of the Board of Nursing, and the Rules of the Office of Professional Regulation.

2. Charges were filed in this matter on November 4, 2015. The Respondent filed an answer on January 7, 2016 which contested the main allegations. Attached to her answer were a series of documents which were considered as evidence at the hearing with approval of the parties.

3. The charges allege that the Respondent committed unprofessional conduct, diverted drugs for unauthorized use, engaged in conduct “of a character likely to deceive, defraud or harm the public”, failed to practice competently, and, in particular, failed to conform to the essential standards of acceptable and prevailing practice.

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4. The charges break down into two separate categories of alleged problem behavior by the Respondent. The first involves her securing a prescription for herself from medical providers at her place of work. The second involves her securing prescriptions for her fiancé at her place of work.

5. During the times in question the Respondent worked as an LPN at the Battenkill Valley Health Center in Arlington, Vermont. The treating providers at that facility are Dr. M.W., FNP A. P., and ANP K. T.

6. The Respondent has a self-reported medical history which includes but is not limited to dental problems, chronic headaches, and cervical spine disc bulges. The headaches were not included as a diagnosis in the medical records of her primary care physician. Likewise, the primary care physician did not diagnose “migraine headaches” anywhere in her medical records.

The Prescription for the Respondent

7. It was the credible testimony of the Respondent that it was common practice in the medical practice for the nurses to prepare prescriptions for the signature of the prescribers. Sometimes the prescription would be written as the result of a “structured visit” by the patient with the provider, and other times the prescription would be written as a result of a telephone call from the patient to the provider. The nurses were not authorized to alter the dosage of medications for patients.

8. Clearly, there was a history of the Respondent receiving medical care and prescriptions from the office in which she worked.

9. The Respondent received numerous prescriptions from the providers at her office. A summary of the relevant prescriptions for the Respondent which were introduced into evidence is as follows:

Medication history of prescriptions for specific medications for Respondent as per Exhibit 5 and attachments to her answer:

<table>
<thead>
<tr>
<th>Date</th>
<th>Medication</th>
<th>Strength</th>
<th>Provider</th>
<th># Tabs</th>
<th>length</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/18/13</td>
<td>Hydrocodone/Aceta</td>
<td>5-500 mg tab</td>
<td>M.W.</td>
<td>30</td>
<td>8</td>
</tr>
<tr>
<td>12/16/13</td>
<td>Hydrocodone/Aceta</td>
<td>5-325 mg tab</td>
<td>M.W.</td>
<td>30</td>
<td>8</td>
</tr>
<tr>
<td>1/9/14</td>
<td>Hydrocodone/Aceta</td>
<td>5-325 mg tab</td>
<td>M.W.</td>
<td>30</td>
<td>8</td>
</tr>
<tr>
<td>2/3/14</td>
<td>Hydrocodone/Aceta</td>
<td>5-325 mg tab</td>
<td>M.W.</td>
<td>30</td>
<td>8</td>
</tr>
<tr>
<td>2/26/14</td>
<td>Hydrocodone/Aceta</td>
<td>5-325 mg tab</td>
<td>M.W.</td>
<td>30</td>
<td>8</td>
</tr>
<tr>
<td>3/15/14</td>
<td>Hydrocodone/Abap</td>
<td>5-325 mg tab</td>
<td>M.W.</td>
<td>30</td>
<td>8</td>
</tr>
<tr>
<td>3/26/14</td>
<td>Hydrocodone/Abap</td>
<td>5-325 mg tab</td>
<td>M.W.</td>
<td>20</td>
<td>5</td>
</tr>
<tr>
<td>8/15/14</td>
<td>Hydrocodone/Aceta</td>
<td>5-325 mg tab</td>
<td>M.W.</td>
<td>30</td>
<td>8</td>
</tr>
<tr>
<td>11/7/14</td>
<td>Hydrocodone/Apap</td>
<td>5-325 mg tab</td>
<td>M.W.</td>
<td>30</td>
<td>8</td>
</tr>
<tr>
<td>2/4/15</td>
<td>Hydrocodone/Apap</td>
<td>5-325 mg tab</td>
<td>M.W.</td>
<td>30</td>
<td>8</td>
</tr>
<tr>
<td>2/13/15</td>
<td>Hydrocodone/Apap</td>
<td>5-325 mg tab</td>
<td>M.W.</td>
<td>30</td>
<td>8</td>
</tr>
<tr>
<td>6/26/15*</td>
<td>Hydrocodone/Apap</td>
<td>7.5-325 mg tab</td>
<td>K.T</td>
<td>60</td>
<td>30</td>
</tr>
</tbody>
</table>

*Script prepared by Jodi Stewart and signed by provider
10. The Respondent testified that her first two prescriptions by Dr. M.W. were for her “dental work” and that the balance of the prescriptions signed by him were for chronic headaches.

11. She further testified that only two of the prescriptions written by Dr. M.W. were the product of a “structured visit” with the doctor and that the balance were simply written upon her request.

12. On June 12, 2015 the Respondent was seen at the Southwestern Vermont Medical Center Emergency Room by Dr. A.C. The recorded reason for the visit was “Vomiting, Chest Pressure” but the Respondent testified that Dr. A.C. had diagnosed her as having “migraine variant” during this visit. This is corroborated by her health record from the visit. See Health Portal Printout attached to Respondent’s answer.

13. On June 26, 2015 the Respondent was working at the office on a Friday afternoon. ANP K.T. was the only prescriber working that afternoon. (ANP K. T. had treated the Respondent at least once before for a panic attack and had evaluated her at that time.) At 3:00 P.M. the Respondent began to have a headache and asked ANP K.T. to sign a prescription which the Respondent had prepared. She told ANP K.T. that Dr. M.W. had previously written her prescriptions for her migraine headaches. ANP K.T. then signed the prescription dated June 26, 2015 which was, as shown above, for Hydrocodone/Apap, 7.5-325 mg. (State Ex. 5) This dosage had never been previously prescribed by Dr. M.W. No examination or questions were asked before the prescription was signed.

14. The Respondent testified that the increased dose as contained in the June 26, 2015 prescription (7.5-325 mg) was simply an error on her part and that she should have written the prescription for the previous dose of 5-325 mg.

15. The complete medical records of the Respondent were not introduced into evidence but the Respondent’s “Visit History” printout from the Health Portal shows 30 healthcare visits. None of the entries show “migraine” as a diagnosis. (See Visit History attached to Respondent’s answer.) Likewise, in the Respondent’s Active Problem List from her Patient Summary (State Ex. #6), no “migraine headaches” or “headaches” are listed in the statement of active problems. The Respondent had no explanation for this contradiction in her testimony.

16. The State has charged that, “Respondent secured the signature of KT, APRN, on the prescription, based on the false information that Respondent had previously been prescribed this medication for migraines.” The Respondent testified that she believed that Dr. M.W. was prescribing the medications for her headaches and that if she used the word “migraines” she must have “used the wrong word”. This testimony is not credible, given the lack of any medical records from Dr. M.W. showing migraine headaches or general headaches as a diagnosis.

17. The Respondent denied that she misused any medication that had been prescribed to her. She testified that any medicine prescribed to her had been used by her alone.

18. The Respondent offered into evidence an assessment by a Licensed Clinical Mental Health Counselor who concluded in April of 2016 that, based upon the Respondent’s information and a clear urine screen, the Respondent did not meet the criteria for a
substance use disorder. (See Respondent Ex. A) This assessment was based upon information solely provided by the Respondent and did not include information from independent sources such as the Office of Professional Regulation, the Respondent’s past employer, or her medical and psychiatric providers. While it is some evidence that the Respondent is free from a substance abuse problem, it is not compelling evidence on this issue.

The Prescriptions for J.D.

19. J.D. is the fiancé and domestic partner of the Respondent. They have been together for five years, more or less, and they lived together during the times in question. He began to be a patient of the Respondent’s place of employment in August of 2014.

20. A summary of selected prescriptions for J.D. is as follows:

<table>
<thead>
<tr>
<th>Date</th>
<th>Medication</th>
<th>Strength</th>
<th>Prescriber</th>
<th>Quantity</th>
<th>Days Supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/22/15</td>
<td>Hydrocodone/Aceta</td>
<td>5-325 mg tab</td>
<td>A.P.</td>
<td>30</td>
<td>8</td>
</tr>
<tr>
<td>2/2/15</td>
<td>Hydrocodone/Aceta</td>
<td>5-325 mg tab</td>
<td>A.P.</td>
<td>30</td>
<td>8</td>
</tr>
<tr>
<td>2/9/15</td>
<td>Hydrocodone/Aceta</td>
<td>5-325 mg tab</td>
<td>A.P.</td>
<td>30</td>
<td>8</td>
</tr>
<tr>
<td>2/23/15</td>
<td>Hydrocodone/Aceta</td>
<td>5-325 mg tab</td>
<td>A.P.</td>
<td>60</td>
<td>15</td>
</tr>
<tr>
<td>2/28/15</td>
<td>Oxycod/Aceta</td>
<td>7.5-325 mg tab</td>
<td>K.T.</td>
<td>60</td>
<td>15</td>
</tr>
<tr>
<td>3/14/15</td>
<td>Oxycod/Aceta</td>
<td>7.5-325 mg tab</td>
<td>K.T.</td>
<td>60</td>
<td>15</td>
</tr>
<tr>
<td>3/28/15</td>
<td>Oxycod/Aceta</td>
<td>7.5-325 mg tab</td>
<td>K.T.</td>
<td>60</td>
<td>15</td>
</tr>
<tr>
<td>4/12/15</td>
<td>Oxycod/Aceta</td>
<td>7.5-325 mg tab</td>
<td>K.T.</td>
<td>60</td>
<td>15</td>
</tr>
<tr>
<td>4/27/5/15</td>
<td>Oxycod/Aceta</td>
<td>7.5-325 mg tab</td>
<td>A.P.</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>6/5/15*</td>
<td>Oxycod/Aceta</td>
<td>7.5-325 mg tab</td>
<td>K.T.</td>
<td>60</td>
<td>30</td>
</tr>
<tr>
<td>6/18/15*</td>
<td>Oxycod/Aceta</td>
<td>7.5-325 mg tab</td>
<td>K.T.</td>
<td>90</td>
<td>23</td>
</tr>
</tbody>
</table>

*Script prepared by Jodi Stewart and signed by provider

21. The Respondent admitted that it would violate essential standards of practice for her to act in a dual role for a patient with whom she is domestic partner or “significant other”. As testified,

Q. Prosecutor: And would you agree with me that if you had been [acting as the LPN and part of the treatment team for your fiancé] that that would violate essential standards of care, that that would be abnormal for you to act in a dual role?

A. Respondent: I’m going to have to say yes to that.

22. During the visit by J.D. at the office on April 27, 2015, the provider indicated to J.D. (in
the Respondent’s presence while she was acting as his family member and not as a nurse) that additional testing would be necessary to continue the treatment plan. At that time the prescribed medication was reduced to Oxycod/Aceta 7.5-325mg, 30 tabs for thirty days.

23. Although she admitted that essential standards of practice prevented her from acting in a dual role, the Respondent prepared two scripts for signature for medications for J.D. The first was on June 5, 2015. (State Ex. 1) The Respondent testified that J.D. did not appear for an appointment on June 5, 2015, but rather, she prepared this script because she knew that his supply of medications was running low. She was unable to credibly explain why she changed the dosage from 30 tablets for 30 days (on April 27, 2015) to 60 tablets for 30 days on the June 5, 2015 prescription. She speculated that J.D. might have telephoned asking for a change, but there was no corroboration in the records to support this.

24. Before the June 5, 2015 prescription was due for refill, on June 18, 2015 the Respondent prepared another prescription for J.D. for signature by provider ANP K.T. (State Ex. 2) This prescription again changed the dose, calling for 90 tablets every 6 hours as needed. The Respondent initially testified that the dosage must have been changed by an intervening visit with a provider. When confronted by the prescription record to show that no intervening prescriptions were written, she then testified that the Respondent must have come in for an office visit on June 18, 2015. If this were true, then there would have been no need for her to prepare the prescription since the provider could have prepared it. The Respondent was unclear about what prompted her to write this prescription since the prior prescription would not have been used within the intervening time period. The Respondent later testified that J.D. had hurt his back in the intervening period (between June 5 and June 18) and that he might have “called in” to change the prescription. This explanation was not credible since there was no evidence of an office visit, examination, or diagnosis of a new work-related injury which might have justified the change in prescription.

25. Although it was never signed by a provider, the Respondent prepared a third prescription for J.D. on July 2, 2015. (State Ex. 3). This prescription was found under the keypad of the computer of the Respondent at work. The prescription was for 7.5-325 Oxycod/Aceta, 90 tabs, as needed, every 4-6 hours. The Respondent testified that this was partially prepared in advance but was not finished because she was interrupted by a telephone call during its preparation and that she set it aside to complete later. The prescription was prepared by the Respondent on July 2, 2015 before the prior prescription would have run out. When the Respondent prepares prescriptions in advance it is her practice to write on the prescription that it is not to be filled until a date set forth on the prescription. She usually writes this limitation when she calculates the date of expiration of the prior prescription. In this case she calculated the date the prior prescription would run out, but she did not write on the prescription form that it was being prepared in advance and was restricted as was her usual practice. Once again, this prescription would have increased the dosage rate from every 6 hours as needed to every 4-6 hours as needed. The Respondent did not explain why she was preparing this prescription in advance.

26. It is clear that the Respondent was deeply involved as a treatment team member in the preparation and presentation for signature of the prescriptions for J.D. There is overwhelming evidence that she not only prepared the prescriptions for his opiate

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medications, but that she also was increasing the dosage in the prescriptions.

Conclusions of Law and Discussion

27. The State has the burden to prove each and every allegation upon which it relies in order to sustain a finding of unprofessional conduct. 3 VSA Sec. 129a(c).

28. The Specification of Charges allege (1) diversion of drugs, (2) conduct of a character likely to deceive, defraud, or harm the public, and (3) failure to conform to the essential standards of acceptable practice. (The Prosecutor withdrew allegations of a violation of state and federal statutes or rules.)

29. In common parlance a “diversion” is “a diverting; turning aside”1. To “divert” is “to turn (a person or thing) aside (from a course); to deflect”.2

30. In this case there was no evidence that drugs which were intended for one person were redirected to another. Moreover, the history of prescriptions for both the Respondent and J.D. make it clear that they had, in the past, legitimately been prescribed the kind of drugs involved here. While there may have been actions by the Respondent which altered the quantity of the drugs as prescribed by the provider, it was not a “diversion” within the ordinary meaning of the word. The State has not met its burden to establish unprofessional conduct concerning the “diversion” charge.

31. The State next charged that the Respondent engaged in conduct of a character likely to deceive, defraud or harm the public. On this charge, the facts show that the Respondent told a prescribing provider that she had been regularly given a drug for migraine headaches, when this was untrue. As the Respondent herself stated, if she used the word “migraines”, she used the wrong word. Moreover, the prescription which was presented to the prescriber was not for the strength of medication which had been previously prescribed to the Respondent from any source. Her presentation of the medication prescription, at such a novel dosage, for the reason she stated, constituted “conduct of a character likely to deceive”. As such, her preparation and presentation of State Ex. 5, the June 26, 2015 prescription, was unprofessional conduct. 26 VSA Sec. 1582(3).

32. The State also charged that the Respondent failed to conform to the essential standards of acceptable and prevailing practice. Although no independent expert testimony was offered on this point, the Respondent, herself, admitted that it would be a violation of the essential standards of care for her to be acting as a nurse as part of the treatment team for her fiancé. Clearly, her judgment as a nurse might be swayed and influenced if she were acting as a nurse concerning her fiancé.

33. While not directly applicable to the Respondent, it is worthwhile noting that in Vermont medical doctors are not authorized to prescribe controlled substances for their own use or for family members, including spouses or spousal equivalents. See 26 VSA Sec. 1354 (a)(37) and Medical Practice Board Rule 4.3. In the case now before the Board, the

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1 Webster’s New World Dictionary, College Edition, 1966
2 Id.
practical effect of the Respondent’s behavior was that the Respondent was a driving wheel in the machine by which controlled drugs were prescribed to her domestic partner and to herself.

34. With this in mind, the facts above show that the Respondent: (1) initiated prescription refills for J.D., (2) presented them to providers for signature; (3) changed the dosage of his medication by presenting dosages which were not based upon office visits or examination by providers; (4) wrote and presented prescriptions for J.D. before his prior prescription should have run out; and (5) relied upon her personal knowledge of his circumstances to gauge the frequency of refills.

35. Concerning the unsigned prescription form which she prepared on July 5, 2015 (State Ex. 3), the Respondent was preparing to present for signature an additional prescription before it was needed and without any restriction that it not be filled until a date in the future.

36. The State has met its burden to prove unprofessional conduct by the Respondent’s failure to conform to the essential standards of acceptable practice. 3 VSA Sec. 129a(b)(2).

37. Finally, it should be noted that the Respondent’s lack of credibility was a significant factor in this case. She changed her testimony repeatedly during the hearing. For example, she first testified that she prepared a prescription for J.D. directly from his medication chart without him being examined. When asked why the prescription changed, she then testified that he must have been examined on the day she prepared the prescription. Several times when she was confronted by inconsistencies in her testimony, she simply indicated that she had no explanation.

38. The Respondent suggested that this case was simply a series of “mistakes”, poor record-keeping, and the office practice where she worked. Nonetheless, the combined effect of her variant testimony, her relationship to the patient involved, the nature of the prescriptions she prepared, and the changes made in the prescriptions (upward in dose and quantity), make the State’s case compelling.

**Proposed Order**

In accordance with the above Findings of Fact and Conclusions of Law, and consistent with the recommendation by the State, and for the protection of the public, the Board does **INDEFINITELY SUSPEND** the license of the Respondent, and continue the summary suspension which is currently in effect. Her license shall continue as suspended until such time as the Respondent completes an acceptable, independent substance abuse assessment by a qualified substance abuse counsellor who is pre-approved by the Vermont Nursing Board, at her own expense. In the event that the assessment is negative, showing that the Respondent does not have a substance abuse problem, then the Respondent may apply for a conditional license subject to such work monitoring conditions as may be ordered by the Board for a period of two years. In the event that the substance abuse assessment shows that the Respondent does have a substance abuse problem, then the Respondent may apply for reinstatement on a conditional license subject to the standard substance abuse conditions, including random screening, for a period of three years. Any reinstatement and any order of conditions shall be at the discretion of the Board.
following the substance abuse assessment.

The Hearing Officer reports the above facts, conclusions of law, and the proposed order to the Board with the recommendation that the Board approve them and enter the Order as above.

Dated this 13th day of June, 2016.

George K. Belcher
Hearing Officer of the Vermont Board of Nursing

ORDER OF THE BOARD

The Vermont Board of Nursing considered the report of findings of fact and conclusions of law at its meeting on July 11, 2016. After considering the report, the Board takes the following action:

/ /  Rejects the report and schedules the matter for hearing.
/ /  Schedules the matter for additional evidence.
\  Accepts the report, adopts the findings of fact and conclusions of law, and orders the recommended discipline as set forth above.

SO ORDERED.

Vermont Board of Nursing
By: [Signature]
Chair/Acting Chair
Vermont Board of Nursing

DATE OF ENTRY: 7/11/16

OFFICE OF PROFESSIONAL REGULATION

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 St., 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.
STATE OF VERMONT
SECRETARY OF STATE
OFFICE OF PROFESSIONAL REGULATION
VERMONT BOARD OF NURSING

In re: JODI A. STEWART 
License No. 025.0009501 
Docket No. 2015-315

DECISION ON REQUEST FOR
SUMMARY SUSPENSION ORDER

Appearances:
Prosecuting the case: S. Lauren Hibbert, Esq.
Respondent: pro se

Board members participating:
Deborah Swartz, RN, Acting Chair
John Welch, Jr.
William G. White, Jr.
Douglas Sutton, RN
Virginia Hudson, RN
Sheila Davis, LPN
Luana Tredwell, LPN
Jennifer Laurent, APRN
Kelly Sinclair, LNA

Presiding Officer: George K. Belcher

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

This matter came before the Vermont Board of Nursing on a Request for a Summary Suspension. The hearing was held on November 9, 2015 at the Office of Professional Regulation Conference Room at the City Center in Montpelier, Vermont. The Respondent appeared via telephone without 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. 3 V.S.A. § 814(c).

Findings of Fact

Based on a review of the pleadings and on the evidence presented at the hearing, the Board finds as follows:
(1) Respondent is a Licensed Practical Nurse and is therefore subject to the regulatory authority of this Board. 3 V.S.A. §§ 129, 129a, 814(c), and 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” dated November 4, 2015. A copy of the Request is attached to this Decision and Order. The Request alleges that the Respondent failed to practice competently (3 VSA Sec. 129a(b) (1) and (2)), diverted drugs for unauthorized use (26 VSA Sec.1582(2)), engaged in conduct of a character likely to deceive, defraud or harm the public (26 VSA Sec. 1582(3)), and failed to comply with provisions of federal or state statutes (3 VSA Sec. 129a(a)(3)). The Request for Summary Suspension further alleges that the public health, safety or welfare imperatively requires emergency summary suspension of the license of the Respondent.

(3) The Respondent received the Request for Summary Suspension on November 6, 2015 by personal service.

(4) The Office of Professional Regulation investigator, Dennis Menard, investigated this matter. He interviewed the complainants at the Battenkill Valley Health Center in Arlington, Vermont. He also reviewed prescription records at that facility and pharmacy records at the local Walmart pharmacy.

(5) In his investigation, Mr. Menard found that the Respondent had written a prescription in June, 2015 for herself for 60 tablets of Hydrocodone, APAP 7.5/325 mg, and she asked a co-worker, APRN K.T., to sign the prescription based upon her statement to APRN K.T. that the Respondent had a previous prescription and diagnosis of migraine headaches. Mr. Menard could find no prior diagnosis of migraine headaches in his review of the medical records for the Respondent.

(6) The Respondent testified that she had been prescribed “Hydrocodone 5/325 mg” about three months prior to her request to APRN K.T. to sign the June prescription. This prior prescription was not found by Mr. Menard and, in any event, the prescription written by the Respondent for herself is 50% higher than the prior dose to which she testified she had previously.

(7) The Respondent also filled out three prescriptions to Respondent’s fiancé, J.D., for Oxycodone-Acetaminophen 7.5/325 mg (June 5, 2015 for 60 tablets, June 18, 2015 for 90 tablets, and July 2, 2015 for 90 tablets). The first two of these prescriptions were signed by APRN K.T. at the request of the Respondent and were filled. The third prescription was written by Respondent but was not signed or filled. It was found under the Respondent’s keyboard and not signed by a provider.

(8) Mr. Menard’s investigation showed that on April 27, 2015 J.D. was told by his medical provider that the provider would not continue prescribing controlled substances to J.D.

(9) The Board considered: (1) the explanations of the Respondent; (2) the context of a patient requesting a colleague to sign a prescription as requested without independent examination, diagnosis, or review; (3) the nature of the drugs requested and the quantities requested over the time period involved; and (4) the potential risk to the public if addiction and diversion is the likely explanation for the prescriptions.

(10) The risk of harm to the public health, safety and welfare includes diversion of regulated drugs from places where the drugs are monitored and needed by patients.
(11) The Respondent is currently working at another health care facility and presumably has access to regulated drugs. The nature of the complaint and the facts as alleged and as found above, show that protection of the public requires immediate and imperative emergency action.

CONCLUSIONS OF LAW

(1) 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 V.S.A 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. Where further hearings are necessary to resolve factual disputes, the Respondent should be afforded the ability to seek a post-summary-suspension review. See In re Dahmad, 201 Ariz. 394, 36 P.3d 742 (2001).

(2) In this case the State has adequately established that the public health, safety and welfare are at risk where the Respondent is working with access to regulated drugs and that the proven risk to the public requires emergency action.

(3) The 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). The Findings of Fact and Conclusions of Law herein are for purposes of this Order only.

(4) 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. The 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. This order is subject to motions for reconsideration, which may be filed at any time, but this order shall be effective immediately upon entry.

Order

The Request for Summary Suspension is Granted. Respondent's license as a Licensed Practical Nurse is hereby SUMMARILY SUSPENDED. Further proceedings shall be promptly instituted and determined. 3 V.S.A. § 814(c).

APPEAL RIGHTS

This is a final administrative determination by the Vermont Office of Professional Regulation. 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. To request a stay of the Board's decision, please refer to the attached stay instructions.

The Vermont Board of Nursing

By:  

Deborah Swartz, RN
Acting Chair of the Board

Date:  November 6, 2015

OFFICE OF PROFESSIONAL REGULATION
DATE OF ENTRY:  11/06/15
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 licensed nursing assistants pursuant to 3 V.S.A. §§ 129, 129a; 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.

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

Statement of Facts

3. Jodi A. Stewart (the "The Respondent") of Bennington, Vermont is licensed by the State of Vermont as a Licensed Practical Nurse under license number 025.0009501. This license was originally issued on or about June 23, 2008 and is currently set to expire on or about January 21, 2016.

4. During the relevant time period, Respondent was employed as an LPN at Battenkill Valley Health Center in Arlington, Vermont.

5. On June 26, 2015, Respondent wrote a prescription for herself for 60 tablets of Hydrocodone APAP 7.5/325 mg.

   a. Respondent secured the signature of KT, APRN, on the prescription, based on the false information that Respondent had previously been prescribed this medication for migraines.

6. Respondent wrote three prescriptions for Respondent’s domestic partner, J.D., for Oxycodone-Acetaminophen 7.5/325 mg. One prescription written on June 5, 2015 was for 60 tablets, a second prescription on June 18 was for 90 tablets, and a third prescription, on July 2, 2015, was for 90 tablets.
a. Respondent secured the signature of KT, APRN, on two of these prescriptions for J.D., even though J.D. had been told by his provider A.P. at Battenkill Valley Health Center that A.P. would no longer prescribe controlled substances to J.D. due to lack of diagnostic evidence that such medication was warranted for J.D.

b. The third prescription, written on July 2, 2015, was found under her keyboard fully completed but without a provider’s signature.

7. Respondent admitted to OPR Investigator Dennis Menard that she wrote the prescriptions. She stated that she had been diagnosed with migraines in the past but that it was in an ED and she could not recall when that diagnosis occurred or the treatment provider who made the diagnosis.

Request for Relief

8. 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.

9. The above acts and circumstances, alone or in combination, violate:

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

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

c. 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); and

d. 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).

WHEREFORE, the State of Vermont respectfully requests that pursuant to 3 V.S.A. § 814(c), the Respondent’s nursing license number 025.0009501 be summarily suspended, pending a hearing on the merits.

DATED at Montpelier, Vermont this 9 day of November, 2015.

STATE OF VERMONT
SECRETARY OF STATE