STATE OF MAINE
BOARD OF NURSING
158 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0158

PAUL R. LEPAGE
GOVERNOR

MYRA A. BROADWAY, J.D., M.S., R.N.
EXECUTIVE DIRECTOR

IN RE: Jennifer Berube (MacLean)[1]	)	**DECISION & ORDER**
Case #2012-31	)	**Disciplinary Action**

I. PROCEDURAL HISTORY

Pursuant to the authority found in 32 M.R.S. Sec. 2105-A(1-A), *et seq.*, 5 M.R.S. Sec. 9051, *et seq.* and 10 M.R.S. Sec. 8003, *et seq.*, the Maine State Board of Nursing (Board) met in public session at the Board's hearing room located in Augusta, Maine at 9:00 AM on November 29, 2012. The purpose of the meeting was to conduct an adjudicatory hearing to determine whether grounds exist for the Board to take disciplinary action against Nurse Berube's license to practice as a Registered Professional Nurse. A quorum of the Board was in attendance during all stages of the proceedings. Participating and voting were Chair Margaret Hourigan, RN, EdD; Carmen Christensen, RN; Robin Brooks (public representative); Elaine A. Duguay, LPN; Valerie Fuller, APRN; Joanne Fortin, RN; and Peggy Sonesen, RN. Andrew Black, Assistant Attorney General, presented the State's case. Ms. Berube was not present and not represented by an attorney. James E. Smith, Esq. served as Presiding Officer.

The Board first determined that none of the Board members had conflicts of interest that would prevent them from participating in the hearing. The Board then took official notice of its statutes and rules and State's Exhibits 1-11 were entered into evidence. The Board subsequently found that Ms. Berube had been duly served at her Rhode Island address with the Notice of Hearing in this matter by certified and first class mail on or about November 17, 2012. The Board next heard the State's opening statement and witnesses' testimony, reviewed the submission of exhibits and considered the State's closing argument. The Board thereafter deliberated and made the following findings of fact by a preponderance of the credible evidence and conclusions of law regarding the alleged violations.

[1] According to Ms. Berube's stepfather, she has remarried and her married surname is MacLean.

II. FINDINGS OF FACT

1. Jennifer Berube, currently living in Rhode Island, was originally licensed as a Registered Professional Nurse ("RN") in Maine on July 10, 2003. The Board suspended her RN license on November 6, 2012.
2. Bruce Curran, Lowell, Maine, has been Ms. Berube's stepfather for the past 16 years. Mr. Curran was first licensed as a Maine Alcohol and Drug Counselor in 1999. As such, he is qualified to assess an individual's levels of substance abuse and dependence on drugs and/or alcohol.
3. Mr. Curran testified that approximately five years ago, Ms. Berube fell down some stairs and injured her back. She subsequently was treated with Vicodin and became addicted to drugs. At some point in 2009-2010, Respondent Berube, while hospitalized for suicidal ideation at Acadia Hospital, Bangor, Maine, admitted to her stepfather that she enjoyed crystal methamphetamine, a very addictive illegal drug.
4. Mr. Curran described Ms. Berube as being impaired during his more recent telephone contacts with her during which she usually requested money.
5. Tracy Therriault, RN, graduated from the University of Maine at Fort Kent with a BSN degree and was licensed as an RN on June 5, 2007. One of her instructors in 2005-2006 was Ms. Berube, whom Nurse Therriault described as calm, quiet, patient, and a good instructor whom she admired.
6. Nurse Therriault subsequently was employed as a nurse at the Maine Veterans' Home in Caribou, Maine in January 2011.
7. Nurse Berube was hired in her professional capacity at the Caribou Maine Veterans' Home on May 6, 2011 and Nurse Therriault was assigned to serve as her nurse manager.
8. Nurse Berube was usually the sole RN on the 10:00 PM - 6:00 AM night shift.
9. Nurse Therriault testified that Nurse Berube's nursing practices were deficient in several significant areas during most of her employment at the facility. Her notes and testimony reveal the following examples:
    A. From June 21, 2011 until approximately July 19, 2011, a patient was receiving his Oxycodone 5mg twice on Nurse Berube's shifts whereas he had been only occasionally receiving the drug on other shifts. This frequency of administration was termed "a dramatic increase" by Nurse Berube's nurse manager. The physician's order authorized the patient to receive the medication four times per day as necessary/when needed, but

administered at intervals to provide for a full day's coverage. Ms. Berube was verbally counseled for failure to follow the physician's order and possibly overdosing this resident.

B. On July 19, 2011, Nurse Berube was also verbally counseled for unacceptable levels of absenteeism.

C. Physician orders for medication and supplements were often not transcribed to the Medication Administration Record and medications were either not administered or were administered but not so recorded. These errors were compounded by Nurse Berube's failure to follow policy which required that the physician and responsible party be notified of the medication errors.

D. Nurse Berube failed to notify a physician of a patient's elevated blood pressure (187/123) and explained that the problem had been addressed the week before with a change in medication.

E. On August 13, 2011, Nurse Manager Therriault appraised Nurse Berube's nursing practices. She rated Nurse Berube's performance during the preceding 90 days as "unsatisfactory" in the following areas: acceptance of constructive criticism, good attendance, completion of monthly summaries, "frequently forgetting to enter the prescription number into narcotic bound books when new prescription arrives," "frequently forgets to sign out in the treatment books treatments that she has completed or signed them out as completed but has not done the actual treatment." She was additionally noted to be very personable with the residents and their families and to ask for extra assistance when needed.

F. Nurse Berube received her third verbal counseling on October 24, 2011 for failure to follow orders by refusing to inform staff that one of them would be mandated to remain on duty after the shift ended in order to meet staffing requirements.

G. On November 24, 2011, a patient had a cyst that ruptured. Nurse Berube cleaned and bandaged the area, but she did not document this treatment until December 12, 2011. The same patient's cyst was further excised by a surgeon on December 9, 2011. Nurse Berube did not in a timely manner document the resident's transport to surgery, his return from surgery, the status of the operative site, post-operative vital signs or pain status. She further neglected to assure that the resident received all the ordered doses of an antibiotic.

H. On December 8, 2011, a resident was sent to the hospital to be evaluated for an unresponsive episode. Nurse Berube failed to record the episode or the transport to and from the Emergency Department.

I. On December 22, 2011, Nurse Berube was given a "Performance Improvement Plan."

J. On December 23, 2011, while in the process of preparing to inject a patient, Nurse Berube, who was not wearing gloves, was advised that she was required to wear gloves when performing injections.

K. On December 30, 2011, Nurse Berube during her shift wrote on a drug wasting record that 0.9 mls of a narcotic was going to be wasted whereas the measured correct amount was only 0.63 mls. On the same shift, 2.5 mls of Ativan were unaccounted for.

10. On January 9, 2012, the Maine Veterans' Home notified the Caribou Police Department and Maine Attorney General's Office regarding missing narcotics and suspected tampering of morphine vials stored at the facility.

11. On January 11, 2012, Nurse Berube was ordered to check a patient's blood pressure since it had been elevated. The respondent did not follow through on the request.

12. On January 13, 2012, six vials of Morphine were found opened and recapped with a sealant resembling super glue, which was not normal procedure. A 30 ml bottle of liquid Oxycodone was also sealed, but the seal had puncture marks in it.

13. On January 19, 2012, a security video revealed Nurse Berube taking Schedule II e-kits out of the locked cabinet in a manner contrary to the Veterans' Home's policies and procedures. She was also recorded as accessing the specific drawer in the locked medication room where syringes are kept.

14. On January 20, 2012, Nurse Berube was terminated from employment at the Maine Veterans' Home as a result of her lack of satisfactory progress with her performance improvement plan dated December 22, 2011 and her disregard for standards of practice.

15. On March 19, 2012, the Board of Nursing sent Ms. Berube for her response a Notice of Complaint, together with the Maine Veterans' Home Provider Report which addressed her termination. These documents were sent to her last known address at the time of 20 Griffin Ridge Road in Mapleton, Maine.

16. On April 25, 2012, the Board sent Ms. Berube a reminder for her to respond to its March 19, 2012 Notice of Complaint/Provider Report.

17. On May 21, 2012, the Board issued its own Complaint for Failure to Respond, sent to Ms. Berube's last known address at the time of 20 Griffin Ridge Road in Mapleton, Maine.

18. On June 28, 2012, the Board sent Ms. Berube a reminder for her to respond to its May 21, 2012 Notice of Complaint for Failure to Respond.

19. On September 21, 2012, the Board notified Nurse Berube of its decision to meet with her in an Informal Conference.

20. On September 27, 2012, the Board notified Respondent Berube that it had scheduled an Informal Conference for October 24, 2012 at 9:00 AM.

21. On October 18, 2012, Nurse Berube spoke with Board Investigator Julian Harwood and was advised of the outstanding complaint.

22. On October 25, 2012, the Board sent the original complaint and renewal application to Jennifer Berube at the Lowell, Maine address of her mother which Ms. Berube provided to the Board.

23. The Board did not receive a response from Nurse Berube concerning her January 20, 2012 termination at the Maine Veterans' Home in Caribou.

24. Based primarily on the reports from the Maine Veterans' Home, the Board pursuant to 5 MRS §10004 (3), voted to summarily suspend for thirty (30) days pending an adjudicatory hearing Nurse Berube's license to practice nursing effective November 6, 2012. This action was because of the immediate jeopardy that her continued practice of nursing would pose to the health and physical safety of the public.

III. CONCLUSIONS OF LAW

The Board concluded by a vote of 7-0, based on the above facts and those contained in the record but not cited above, that Jennifer Berube violated the following Board statutes and rules:

1. 32 M.R.S. §2105-A (2) (B). Nurse Berube engaged in habitual substance abuse that has resulted or is foreseeably likely to result in her performing services in a manner that endangers the health or safety of patients. See Board Rule, Chapter 4. 1. A. (2).

2. 32 M.R.S. §2105-A (2) (E) (1) and (2). Incompetence in the practice for which the licensee is licensed. A licensee is considered incompetent in the practice if the licensee has engaged in conduct that evidences a lack of ability or fitness to discharge the duty owed by the licensee to a

client or patient or the general public; or engaged in conduct that evidences a lack of knowledge or inability to apply principles or skills to carry out the practice for which the licensee is licensed.

3. Chapter 4, Disciplinary Action and Violations of Law, §3(F). Nurse Berube failed to take appropriate action or to follow policies and procedures in the practice situation designed to safeguard the patient.
4. Chapter 4, Disciplinary Action and Violations of Law, §3(K). Nurse Berube inaccurately recorded, falsified or altered one or more patient or health care provider records.

IV. SANCTIONS

The Board voted 7-0 to order the following sanctions for the above violations:

1. Jennifer Berube's Registered Professional Nurse's license is hereby **REVOKED**.
2. Jennifer Berube is hereby given a **REPRIMAND** for the above violations.
3. Jennifer Berube shall pay the **costs** of this hearing **by June 12, 2013,** which **total $1987.00** (Hearing Officer: 9.50 hours @$115.00 = $1092.50 + Witness Expenses [Witness Fees, Travel, Lodging, Meals]: $747.00 + Copying Fees: 59 pp x 10 @.0$25 = $147.50). The bank check or money order shall be made payable to: "Maine State Treasurer" and mailed to Myra Broadway, J.D., M.S., R.N., Executive Director, 158 State House Station, Augusta, Maine 04333-0158. Additional costs may be assessed in the event that Jennifer Berube requests a transcript of the hearing.

The costs are in keeping with the Board's practice of assessing the costs to those who violate Board statutes and rules as opposed to sharing the costs with those licensees who obey same. Additionally, this hearing may have been rendered unnecessary had Ms. Berube met with the Board as requested.

SO ORDERED.

Dated: December 12, 2012

Margaret Hourigan, RN, EdD

Margaret Hourigan, RN, EdD
Chair, Maine State Board of Nursing

V. APPEAL RIGHTS

Pursuant to the provisions of 5 MRS Sec. 10051.3, any party that decides to appeal this Decision and Order must file a Petition for Review within 30 days of the date of receipt of this Order with the District Court having jurisdiction. The petition shall specify the person seeking review, the manner in which she/he is aggrieved and the final agency action which s/he wishes reviewed. It shall also contain a concise statement as to the nature of the action or inaction to be reviewed, the grounds upon which relief is sought and a demand for relief. Copies of the Petition for Review shall be served by Certified Mail, Return Receipt Requested upon the Maine State Board of Nursing, all parties to the agency proceedings, and the Maine Attorney General.