MSBON

MAINE STATE BOARD OF NURSING
35 ANTHONY AVENUE
STATE HOUSE STATION 158
AUGUSTA, MAINE 04333-0158
207/624-5275 FAX 207/624-5290
TDD 207/624-5288

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL &
FINANCIAL REGULATION

DIVISION OF
ADMINISTRATIVE HEARINGS
DOCKET NO. PR-01

MAINE STATE BOARD OF NURSING)
)
Petitioner)
)
Brenda S. Lynch)
of Caribou, ME)
License #P003649)
)
Respondent)

DECISION AND ORDER

INTRODUCTION

The Maine State Board of Nursing (henceforth "the Board") held an adjudicatory hearing on November 16, 1995. The Respondent, Brenda S. Lynch (henceforth "Ms. Lynch") was notified of the hearing by letter dated November 1, 1995 (henceforth "the Notice") (State Exhibit 3). The hearing was held at the offices of the Maine State Board of Nursing in Augusta, Maine.

Members of the Board who participated in the hearing and deliberations were: Monica M. Collins, R.N.C., M.S., Chair; Kathleen A. Dugas, L.P.N., Marie D. Fisher, R.N.C., M.S., Timothy M. McBrady, L.P.N., Kathi F. Murray, R.N., B.S., and Karen L. Tripp.

Shari B. Broder, an attorney and hearing officer with the Department of Labor Division of Administrative Hearings, acted as Presiding Officer at the hearing. Jean C. Caron, R.N., M.S., Executive Director for the Board, was present, and was represented by Assistant Attorney General Ruth McNiff. Ms. Lynch was not present or represented.

ISSUES PRESENTED

Whether grounds exist for the Board to take disciplinary action against Brenda S. Lynch's license to practice practical nursing; specifically, whether Ms. Lynch violated 32 M.R.S.A. Section 2105-A(2)(B), (2)(E), and (2)(F) by engaging in habitual substance abuse that has resulted or may result in performing services in a manner that endangers the health or safety of patients; engaging in unprofessional conduct; and incompetency in the practice of nursing.

FINDINGS OF FACT

Brenda S. Lynch was a licensed practical nurse employed at L'Acadie, a long term care facility in Van Buren, Maine from 1992 until August 17, 1994.

On October 12, 1992, Ms. Lynch left prescription medications on the microwave in the L'Acadie kitchen. When a certified nursing assistant returned the pills to the medication cart, she found it unlocked. The cart was supposed to be locked at all times. Ms. Lynch was the medication nurse at the time, and was on break. She received a written counseling for not keeping the medications secure and locked.

Records indicate that on November 28 and 29, 1992, Ms. Lynch gave a resident 13 Empirin with Codeine and 12 Percocet over the course of two days, but she did not document the reason for giving this high level of pain medications. On December 1, 1992, while Ms. Lynch was on duty, 3 Empirin with Codeine were not accounted for. The same resident was to be given one or two tabs every four to six hours p.r.n. Although Ms. Lynch was responsible for administering the medication, she dispensed it without entering in the nursing notes how many tabs were actually given.

On December 4 and 6, 1992, Kathleen Ashley, Director of Nurses at L'Acadie, documented the fact that Ms. Lynch likely falsified a resident's medical records and did not properly medicate the resident according to her doctor's instructions. Ms. Lynch received a disciplinary notice on December 22, 1992 for the above conduct. Among other job performance issues, the notice also addressed Ms. Lynch's illegal destruction of 2 Percocet tablets, and signing medications ahead of time.

On February 4, 1994, several nurses met with Ms. Ashley regarding a resident whom Ms. Lynch had documented giving large doses of medication in a shorter time span than prescribed by her doctor and following this with more medications with similar effects. They were concerned because the resident should have been drowsier, had she actually been given the documented amounts of medication. On February 18, Ms. Lynch was given a disciplinary notice about these problems. Due to the seriousness of the offenses, Ms. Lynch was suspended from work for four days.

In May 1994, the Department of Human Services Division of Licensing and Certification ("DHS") conducted its annual survey of the facility. During that time, Ms. Ashley expressed her concern that Ms. Lynch as administering more Schedule II drugs than necessary and was overmedicating the residents. Erlene Russell, a registered nurse and health service consultant for DHS, considered this a patient safety issue, and investigated the report. The results of her investigation was introduced at the hearing as State Exhibit 1. This exhibit included all of the documents referred to above.

Ms. Lynch's record keeping indicated that she had given a resident an unusual amount of Percocet during the previous ten months. The other problems with medications set forth above were also brought to DHS's attention. The administrator stated in writing on May 4, 1995 that Ms. Lynch would not be permitted to administer medication without direct supervision of another L.P.N. There was no evidence that such supervision was provided. State Exhibit 1.

On August 8, 1994, Ms. Lynch came to work noticeably under the influence of scheduled drugs, and administered medications to residents without supervision and while under the influence. Upon learning this, Ms. Ashley confronted Ms. Lynch, who claimed to be taking a prescribed drug, and said she was having side effects. Ms. Ashley placed Ms. Lynch on ten days' administrative leave to allow an investigation to be conducted, and requested that Ms. Lynch produce evidence of the substance prescribed. Ms. Lynch did not produce the prescription, and resigned on August 18, 1994.

On March 9, 1995, Ms. Lynch was notified by the Board of an informal conference to be held on April 5, 1995 to discuss her response to the DHS report. State Exhibit 2. Ms. Lynch said she could not attend, as she had an accident and subsequent surgery, which prevented her from driving. The conference was rescheduled for June 7, 1995. State Exhibit 4. Ms. Lynch failed to appear for the conference. Three hours before the conference was scheduled to begin, a woman named Pam Pelletier, who represented herself to be Ms. Lynch's sister, called Jean Caron to report that Ms. Lynch had an accident and could not attend the conference. Ms. Caron subsequently spoke with Ms. Lynch's employer, Marsha Young, who reported that Ms. Lynch worked all day on June 7, as well as the other days surrounding the alleged accident. Ms. Caron concluded that there had been no accident and that Ms. Lynch simply fabricated an excuse for not attending the informal conference.

Ms. Lynch's license to practice nursing lapsed in September of 1995.

CONCLUSIONS

The Board has the statutory authority, pursuant to 32 M.R.S.A. Section 2105-A, to investigate complaints regarding noncompliance with or violations of Maine statutes and rules regulating the practice of nursing. Pursuant to this statute, if the Board finds that the factual basis of the complaint is true and is of sufficient gravity to warrant further action, it may take appropriate disciplinary action.

Based upon the uncontroverted evidence set forth in its findings of fact, the Board unanimously concludes that Ms. Lynch violated 32 M.R.S.A. Section 2105-A (2)(E) in that her serious errors in

the handling and documentation of controlled substances, and excessively medicating patients or diverting medications constitute incompetency in the practice of practical nursing.

The Board further unanimously concludes that Ms. Lynch violated 32 M.R.S.A. Section 2105-A (2)(B) by engaging in habitual substance abuse that has resulted and is foreseeably likely to result in the licensee performing services in a manner that endangers the health and safety of patients.

The Board further unanimously concludes that Ms. Lynch's improper handling and administration of medications and appearance at work under the influence of controlled substances constitutes unprofessional conduct in violation of 32 M.R.S.A. Section 2105-A (2)(F).

ORDER

For Brenda Lynch's violations of the Maine Statutes and Rules and Regulations governing the practice of nursing set forth above, the Board unanimously takes the following actions:

1. Ms. Lynch's license to practice nursing shall not be renewed.

2. This matter shall be referred to Administrative Court for proceedings to revoke Ms. Lynch's license.

3. The Board requests that the Office of Attorney General investigate to determine whether Ms. Lynch is engaged in the unauthorized practice of nursing.

FOR THE MAINE STATE BOARD OF NURSING:

DATED: DECEMBER 13, 1995

Monica M Collins RNC MS

MONICA M. COLLINS, R.N.C., M.S.
Chair