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

JOHN ELIAS BALDACCI
GOVERNOR

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

IN RE:) **DECISION**
Carol Nigro) **AND**
Licensure Disciplinary Action) **ORDER**

I. PROCEDURAL HISTORY

Pursuant to the authority found in 32 M.R.S. Sec. 2105-A(1-A)(D), *et seq.*, 5 M.R.S. Sec. 9051, *et seq.* and 10 M.R.S. Sec. 8001, *et seq.*, the Maine State Board of Nursing (Board) met in public session at the Board office located in Augusta, Maine on October 21, 2008 at 9:00 a.m. The purpose of the meeting was to conduct an adjudicatory hearing to determine whether Carol Nigro violated Board statutes and rules as a registered professional nurse while licensed in Maine, as more specifically stated in the Notice of Hearing dated April 14, 2008. A quorum of the Board was in attendance during all stages of the proceedings. Participating and voting Board members were Chairman Bruce O'Donnell, C.R.N.A.; Dorothy Melanson, R.N.; Robin Brooks (Public Representative); Susan C. Baltrus, M.S.N., R.N., C.; and Carmen Christensen, R.N. John H. Richards, Assistant Attorney General, presented the State's case. Carol Nigro was neither represented by legal counsel nor present, although she had been served by first class mail with the Notice of Hearing on or about September 23, 2008. James E. Smith, Esq. served as Presiding Officer.

Following the determination that none of the Board members had conflicts of interest which would bar them from participating in the hearing, the taking of official notice of its statutes and rules, and subsequent to the opening statement by counsel, State's Exhibits 1-14 were admitted into the Record. The Board then heard the testimony, reviewed the submission of exhibits, and considered counsel's closing argument, after which it deliberated and made the following findings of fact by a preponderance of the credible evidence regarding the violations alleged in the complaint.

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II. FINDINGS OF FACT AND CONCLUSIONS OF LAW

Carol Nigro, date of birth April 3, 1955, had been licensed as a registered professional nurse in Maine since January 31, 1977 until her license lapsed on April 3, 2007. Ms. Nigro was employed by York Hospital as a registered professional nurse in August 2006. York Hospital's prescription medications are dispensed pursuant to a physician's order; they are deposited from the hospital pharmacy into the Pyxis dispensing machine, which requires that a user first enter a password and identification. The drugs are then dispensed and the practitioner is subsequently required to note the type and amount of medication on the patient's Medical Administration Record (MAR). However, since York Hospital does not have a pharmacy open 24 hours a day, an authorized individual, such as a nurse, may override the Pyxis and change the requested medication.

On or about January 8, 2007, a registered professional nurse at the hospital approached Katheryne Lane, RN, MSN-NP, who was the Director of Nursing in the medical surgical unit. The nurse expressed a patient's concern that on the previous evening, Nurse Nigro had given him a blue pill, telling him that it was pain medication. He had been taking Oxycodone (Percocet), which the hospital dispenses as a white pill. The patient did not have the same reaction that he usually did after ingesting Oxycodone. The Pyxis record revealed that Nurse Nigro had dispensed two Oxycodone tablets at 03:32 and two more at 06:13 for the patient. The patient, who required pain medication on an as-needed basis, had not requested the medication and was trying to wean himself from same. He was not administered the dispensed drugs and apparently no assessment had been performed to determine whether the patient was in need of the medication prior to its being dispensed.

A second concern was brought to Director Lane's attention by the day nurse. She stated that another patient complained of spending a "horrible night" since she did not receive her pain medication like she had in the past. Nurse Nigro had told her that she was busy and the patient would have to wait for her drugs. The patient requested the medication again and was told by Nurse Nigro that it was too soon for the medication and that she would receive some pain medication later.

In fact, Nurse Nigro dispensed pain medication from the Pyxis for the patient without first assessing her need. Although the MAR showed that the patient received the medication, such was not the case.

As a result of the above complaints, Director Lane reviewed the records of some of the patient populace for whom Nurse Nigro was responsible. She noted that a number of the patients had orders for Oxycodone for pain. She also discovered that Nurse Nigro's documentation from the evening/night shift on January 5-6, 2007 did not support the conclusion that two of the licensee's patients had indeed received Oxycodone after that drug had been removed from Pyxis at 22:19 and 23:40. Director Lane further investigated and determined that Nurse Nigro had not divulged the fact that she had previously been the subject of Board discipline in 1995 due to the diversion of narcotics, which resulted in the surrender of her license to practice. That license was later restored in 1996.

As Director Lane's investigation progressed, other instances of below standard care became evident. For example, in November 2006, Carol Nigro was responsible for a patient who was prescribed 8-16 ml. of a narcotic via an epidural catheter. Nurse Nigro was administering 42 ml. which had reduced the patient's blood pressure to 77/47. As a result, the patient experienced some symptomatic numbness and tingling without any noted assessment of same by Nurse Nigro. Additionally, some nurses also offered that Carol Nigro had volunteered to medicate their patients. A review of one of those patient's charts revealed that two Oxycodone tablets had been removed from Pyxis and then listed as wasted since the patient apparently refused same. However, there was no assessment of the patient to determine the need before the drug was drawn and therefore no documentation that the patient was in pain. Moreover, several nurses stated that they had not physically observed Nurse Nigro wasting those drugs which were not administered.

Director Lane scheduled a meeting at the hospital before the licensee's shift on January 10, 2007; another supervisor was present at the request of Ms. Lane. According to Director Lane's report, Carol Nigro smelled strongly of smoke and her eyes were bloodshot, face flushed, and speech slurred. Director Lane informed Nurse Nigro of her concerns that Ms. Nigro's documentation was unsatisfactory and that the MAR did not reflect the administration of Oxycodone that had been taken out of the Pyxis for certain patients. Additionally, the MAR entries regarding the timing and dosages of Oxycodone

were illegible. Director Lane did not receive satisfactory responses to her queries since Ms. Nigro appeared more interested in learning of the complaining patients' names than addressing their allegations. Director Lane then terminated Carol Nigro's employment at York Hospital.

As a result of the above facts and others in the record not alluded to herein, the Board unanimously concluded that Carol Nigro violated the provisions of the following Board statutes and rules: 32 M.R.S. Sec. 2105-A (2) (F) ("Unprofessional Conduct. A licensee is considered to have engaged in unprofessional conduct if the licensee violates a standard of professional behavior that has been established in the practice for which the licensee is licensed"); Sec. 2105-A (2) (A) ("The practice of fraud or deceit in obtaining a license under this chapter or in connection with service rendered within the scope of the license issued"). The Board further concluded that Carol Nigro violated Board Rule Chapter 4, Sec. 3(K) ("Inaccurate recording, falsifying or altering a patient or health care provider record"); Sec. 3(P) ("Diverting drugs, supplies or property of patients or health care provider"); and 3(Q) ("Possessing, obtaining, furnishing or administering prescription drugs to any person, including self, except as directed by a person authorized by law to prescribe drugs").

III. SANCTIONS

The Board, exercising its experience and training, and based on the above findings and conclusions, hereby orders the following disciplinary action by a unanimous vote:

1. Carol Nigro's license to practice nursing in the State of Maine is hereby **REVOKED**.

2. If Ms. Nigro applies for renewal of her Maine license to practice nursing, she shall appear in person before this Board prior to any final action regarding that application.

3. Carol Nigro shall pay the costs of this hearing, not to exceed $1,000, **by February 3, 2009**. The costs total $990 (Hearing Officer: 3½ hrs at the hearing + 2½ hrs to write decision, or 6hrs @ $115 per hour = $690, plus Court Reporter @ $300). The bank check or money order shall be made

payable to "Treasurer, State of Maine" and submitted to Myra A. Broadway, JD, MS, RN, Executive Director, at the Maine State Board of Nursing, 158 State House Station, Augusta, Maine 04333-0158. Additional costs may be assessed in the event that Carol Nigro requests a transcript of the hearing. Costs shall be paid before the Board entertains any request by Carol Nigro for relicensure. The costs are ordered since the necessity for this hearing could have been avoided had Carol Nigro surrendered her license if she did not plan to attend the hearing. Additionally, associated hearing costs are more appropriately assessed against those licensees who violate Board statutes and rules rather than those who obey same.

SO ORDERED.

11/6/2008
Date

Bruce O'Donnell, C.R.N.A., Chairman
Maine State Board of Nursing

IV. APPEAL RIGHTS

Pursuant to the provisions of 5 M.R.S.A. 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 they are aggrieved and the final agency action which they wish 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.