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: SHARI A. SNOW, L.P.N.	)	**CONSENT AGREEMENT FOR**
of Newport, Maine	)	**VOLUNTARY SURRENDER**
License #P007170	)	**OF LICENSE**

INTRODUCTION

This document is a Consent Agreement ("Agreement") regarding Shari A. Snow's license to practice licensed practical nursing in the State of Maine. The parties to this Agreement are Shari A. Snow ("Ms. Snow" or "Licensee"), Maine State Board of Nursing ("Board") and the Office of the Attorney General, State of Maine. The parties enter into this Agreement pursuant to 32 M.R.S.A. § 2105-A (1-A) (C), 10 M.R.S.A. §§ 8003 (A-1) (4), 8003 (5) (B) and 10 M.R.S.A. § 8003 (5) (D).

FACTS

1. Shari A. Snow has been a licensed practical nurse licensed to practice in Maine since November 23, 1981. At the time of the incidents discussed in this Agreement, Ms. Snow was licensed by the Board.

2. Shari A. Snow was hired by Arcadia Health Care ("Arcadia") located in Auburn, Maine on November 5, 2004. Arcadia is an agency that provides temporary nurse staffing for home health care and medical facilities throughout the state. Ms. Snow was hired to provide temporary staffing as a licensed practical nurse for Arcadia's clients, which included Lakewood Continuing Care Center ("Lakewood") located in Waterville; Shore Village Rehabilitation & Nursing Center ("Shore Village") located in Rockland; Seaside Rehabilitation & Healthcare ("Seaside") located in Portland; and Woodlawn Rehabilitation & Nursing Center ("Woodlawn") located in Skowhegan.

3. Shari A. Snow started assignments at Lakewood August 2, 2006; she was terminated from this facility on February 6, 2007. The Board issued a complaint dated March 29, 2007 on the basis of a provider report from Lakewood, which stated Ms. Snow was terminated for failure to follow company policies regarding pain medication administration and documentation of pain management, specifically, Oxycodone. The investigation of this matter disclosed the following adverse actions:

   a. Ms. Snow medicated scheduled drugs to patients who were not routinely medicated; she did not provide the documentation to justify administration of said pain medications.
   b. Ms. Snow documented that she administered scheduled drugs to patients who, in fact, never received the medications. These were patients who were cognizant and stated they never received the medications documented by Ms. Snow.

c. Patients with medication orders for scheduled drugs of one to two tablets were regularly medicated with two tablets by Ms. Snow, without the supportive documentation.
d. Patients with medication orders for scheduled drugs to be administered every six hours were documented by Ms. Snow as receiving their medications every four hours. These were patients who reported pain and were in need of pain medication, but were inconsistent with Ms. Snow's documentation of pain medication administration.
e. Ms. Snow medicated scheduled drug medications to patients who were not assigned to her and failed to notify the primary nurse of said patients and her medication administration to them.
f. Certain patients who had not received pain medication for an extended period of time were regularly medicated by Ms. Snow when she was working.
g. During a routine narcotics count at Ms. Snow's out-going shift change, it was determined that one Oxycodone pill was missing and could not be accounted for. Ms. Snow had possession of the narcotic cart keys during her shift.
h. It was reported by several CNAs that Ms. Snow was medicating long term patients whom the CNAs had cared for over a long time and who had not complained of pain. When the CNAs asked the patients about their pain, they reported they did not have any, nor did they receive pain medication.
i. Ms. Snow documented that she administered a Fentanyl patch to a patient; however, the patch could not be found on the patient, in the patient's clothing, bedding or the immediate area.

4. Shari A. Snow started assignments at Shore Village on January 2, 2006; she was terminated from this facility on March 23, 2007. The Board issued a complaint dated May 22, 2007 on the basis of a provider report from Shore Village, which stated Ms. Snow was terminated for misappropriating a resident's medication. The investigation disclosed that Vicodin was signed out for a resident whom Ms. Snow claimed was hollering out in pain. This is contrary to several eyewitness accounts who observed the same resident sleeping at the time in question. The Vicodin was documented by Ms. Snow as being administered to the resident; however, Ms. Snow was not observed entering the resident's room to administer the medication during this episode. Ms. Snow was, however, observed crushing the pain medication and going into a nearby maintenance room. One of the CNAs entered the room and observed Ms. Snow holding the empty pill bag that contained the crushed pain medication and a plastic pen body, minus the ink tube and tip.

5. Shari A. Snow started assignments at Seaside on January 10, 2006; she was terminated from this facility on February 3, 2008 for drug diversion, alteration of narcotics records, and practicing while in a physically unfit condition. On November 11, 2007, the nursing staff became concerned about Ms. Snow's behavior, which had changed from observations made approximately 10 minutes earlier. Her speech was slurred, she seemed off balance and her eyes were dilated. The determination from the Nursing Supervisor was to send Ms. Snow home because she was not safe to practice. Before Ms. Snow was sent home, a drug count was conducted in her presence.

a. The first count involved Resident A, described as a very alert and oriented individual. Resident A's medication orders were for Oxycodone 5mg, one tablet every four hours as needed for pain. On the Individual Narcotic Record, Ms. Snow had noted that she gave Resident A one tablet, leaving 49 tablets. The number of remaining tablets on the record against the "bingo card" blister pack was found to be consistent. However, Ms. Snow had not written the time the tablet was given to Resident A in the record. Ms. Snow was allowed to enter the time administered which she noted at 7:05PM. The nurse conducting the count then spoke with Resident A and asked him if he had received his pain medication this evening. He said no. When asked if he had received his Oxycodone tablet, he said no, that he was not in that much pain. The Resident said he had received two Tylenol tablets from Ms. Snow an hour earlier. The nurse went to the med tech and confirmed that Resident A had received the Tylenol at approximately 6:00PM.
b. The second count involved Resident B, who was on Oxycodone 5mg, one or two tablets every three hours as needed for pain. On the Individual Narcotic Record, Ms. Snow documented that she had administered two tablets to Resident B at 12:40PM. On the Resident Log In and Out sheet, it was noted that Resident B had been taken out of the facility to have lunch with his daughter at 12:20PM, 20 minutes earlier than Ms. Snow's medication documentation indicated. When questioned if Ms. Snow had administered the Oxycodone, both Resident B and his daughter said no.
c. The second count involved Resident C, a gentleman in his 60's, who was alert and well-oriented. Resident C had orders for Oxycodone 10mg, one to two tablets as needed for pain for a two-day period. On the record, Ms. Snow indicated she had administered the medication upon Resident C's request. When Resident C was asked if he had received or requested the medication, Resident C said no.

6. Shari A. Snow started assignments at Woodlawn on January 29, 2008; she was terminated from this facility on August 11, 2008 for alleged misappropriation of property, drug diversion, inappropriate medication handling/wasting, and staying over shift hours. The investigation of this matter disclosed the following adverse actions:

a. Reviewing the medical administration record of Resident D, out of the 65 doses of Oxycodone prn administered to Resident D, Ms. Snow had administered all but one dose. This appeared to be unusual because a) it was "prn" medication (i.e., medicate for pain if needed, typically done for only seven days); b) with the exception of the one dose administered by another nurse, other nursing staff did not see the need to treat Resident D's pain with the prn medication); and c) Ms. Snow administered the meds after her regularly scheduled hours. This occurred during a period from July 21 to August 4, 2008.
b. Ms. Snow had an inordinate amount of scheduled medication wasting compared to other nurses. She routinely noted in the medical administration record that her patients either refused their meds, vomited them or the meds were damaged when the resident spilled something on them. Ms. Snow also noted several times that she had spilled her own coffee on the medications and they had been wasted.

As part of the wasting protocol, nurses are required to have a witness when they destroy wasted scheduled medications by dissolving them in a cup of water. When Ms. Snow wasted medication and asked a witness to observe, the medication was not visible in the water, but Ms. Snow indicated that it had been dissolved.

AGREEMENT

7. In lieu of a hearing before the Board, Shari A. Snow understands and agrees that she will voluntarily surrender her nursing license. The Maine State Board of Nursing will accept Shari A. Snow's offer to voluntarily surrender her licensed practical nurse license, #P007170.

8. Shari A. Snow understands that based upon the above-stated facts, this document imposes discipline regarding her license to practice as a licensed practical nurse in the State of Maine. The grounds for discipline for violations are under 32 M.R.S.A.§ 2105-A(2)(A), (2)(B), (2)(F), (2)(H) and Chapter 4, sections 1(A)(1), 1(A)(2), 1(A)(6), 1(A)(8) and Chapter 4, sections 3(K), 3(P) and 3(Q) of the Rules and Regulations of the Maine State Board of Nursing. Specifically, the violations are:

   a. M.R.S.A. § 2105-A (2) (A). The practice of fraud and deceit in connection with service rendered within the scope of the license issued to Ms. Snow by diverting scheduled drugs for her own personal use. (See also Rule Chapter 4. Section 1.A.1)

   b. M.R.S.A. § 2105-A (2) (B). Habitual substance abuse that has resulted or is foreseeably likely to result in the licensee performing services in a manner that endangers the health or safety of patients. (See also Rule Chapter 4. Section 1.A.2)

   c. M.R.S.A. § 2105-A (2) (F). Unprofessional Conduct. Ms. Snow engaged in unprofessional conduct because she violated a standard of professional behavior that has been established in the practice for which she is licensed. (See also Rule Chapter 4, Section 1.A.6.)

   d. M.R.S.A. § 2105-A (2) (H). A violation of this chapter or a rule adopted by the Board. (See also Rule Chapter 4, Section 1.A.6.)

   e. Rule Chapter 4, Section 3. *Unprofessional conduct* is defined as *nursing behavior which fails to conform to legal standards of the nursing profession, and which could reflect adversely on the health and welfare of the public shall constitute unprofessional conduct and shall include, but shall not be limited to, the following:*

   1) Chapter 4, Section 3(K). Ms. Snow inaccurately recorded, falsified or altered a health care provider record.

   2) Chapter 4, Section 3(P). Ms. Snow diverted drugs from patients and a health care provider.

3) Chapter 4, Section Q. Ms. Snow possessed, obtained and administered prescription drugs to herself, except as directed by a person authorized by law to prescribe drugs.

9. Shari A. Snow neither admits nor denies the facts contained herein; however, she acknowledges that if this matter went to a hearing before the Board it is more likely than not the above-stated facts and underlying investigative information would support the Board's findings in this Consent Agreement.

10. Shari A. Snow understands and agrees that her license will remain on surrender status and subject to the terms of this Agreement indefinitely until and unless the Board, at Ms. Snow's written request, votes to reinstate her license. Ms. Snow agrees and understands that if the Board reinstates her license, it will be for a probationary period.

11. The State of Maine is a "party state" that has adopted the Nurse Licensure Compact ("Compact"), which is set out in Chapter 11 of the Rules and Regulations of the Maine State Board of Nursing. The State of Maine is Ms. Snow's "home state" of licensure and primary state of residence, which means she has declared the State of Maine as her fixed permanent and principle home for legal purposes; her domicile. Other party states in the Compact are referred to as "remote states," which means party states other than the home state that have adopted the Compact. Ms. Snow understands this document is a Consent Agreement subject to the Compact.

12. Ms. Snow understands that she does not have to execute this Consent Agreement and has the right to consult with an attorney before entering into the Agreement.

13. Shari A. Snow shall not work or volunteer in any capacity for a health care provider as defined by Title 24 M.R.S.A. § 2502 (2) or in any position holding herself out as a licensed practical nurse or with the designation "LPN," including in a veterinarian's office, while her nursing license is surrendered. In addition, Ms. Snow is not to seek employment where the handling or dispensing of drugs is part of the job responsibility.

14. This Agreement is a public record within the meaning of 1 M.R.S.A. § 402 and will be available for inspection and copying by the public pursuant to 1 M.R.S.A. § 408.

15. Modification of this Agreement must be in writing and signed by all parties.

16. This Agreement is not subject to review or appeal by the Licensee, but may be enforced by an action in the Superior Court.

17. Shari A. Snow affirms that she executes this Agreement of her own free will.

18. This Agreement becomes effective upon the date of the last necessary signature below.

I, SHARI A. SNOW, L.P.N., HAVE READ AND UNDERSTAND THE FOREGOING CONSENT AGREEMENT. I UNDERSTAND THAT BY SIGNING IT, I WAIVE CERTAIN RIGHTS. I SIGN IT VOLUNTARILY, WITHOUT ANY THREAT OR PROMISE. I UNDERSTAND THAT THIS CONSENT AGREEMENT CONTAINS THE ENTIRE AGREEMENT AND THERE IS NO OTHER AGREEMENT OF ANY KIND.

DATED: 8/14/09

Shari Snow

SHARI A. SNOW, L.P.N.

DATED: 9/2/09

RONALD W. SCHNRIDER, JR., ESQ.
Attorney for Shari A. Snow

FOR THE MAINE STATE BOARD OF NURSING

DATED: 8/17/09 orig. FAX

Myra Broadway 9/8/09

MYRA A. BROADWAY, J.D., M.S., R.N.
Executive Director

FOR THE OFFICE OF THE ATTORNEY GENERAL

DATED: 9/19/09

JOHN H. RICHARDS
Assistant Attorney General