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: Bonnie L. Martin)
Disciplinary Action)

DECISION & 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. 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 a.m. on April 27, 2011. The purpose of the meeting was to conduct an adjudicatory hearing to determine whether to take disciplinary action against Bonnie Martin's license to practice registered professional nursing. A quorum of the Board was in attendance during all stages of the proceedings. Participating and voting Board members were Acting Chairman Margaret Hourigan, R.N., Ed. D.; Susan C. Baltrus, M.S.N., R.N.B.C., C.N.E.; Carmen Christensen, R.N.; Valerie Fuller, A.P.R.N.; and Joanne Fortin, R.N. John Richards, Assistant Attorney General, presented the State's case. Nurse Martin was neither present nor 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 which would bar them from participating in the hearing. The Board then took official notice of its statutes and Rules and determined that Bonnie Martin had been served by first class mail with the Notice of Summary Suspension of License and Notice of Hearing by April 11, 2011. The Notice of Summary Suspension was mailed on April 7, 2011 and included the time and date of this hearing; the Notice of Hearing was mailed April 8, 2011. The certified letters, also mailed April 7 and 8, 2011, respectively, were copies of those sent by first class mail and were returned to the Board as "unclaimed."

Subsequent to the State's opening statement, State's Exhibits A-0 and the Board's statutes and Rules were admitted into the Record. The Board then heard the testimony, reviewed the submission of exhibits, and considered the State's closing argument, after which it deliberated and made the following findings of fact by a preponderance of the credible evidence and conclusions of law regarding the alleged violations.

II. FINDINGS OF FACT

Respondent Bonnie Martin, a 49-year-old resident of South Thomaston, Maine, has been licensed in Maine as a Registered Professional Nurse since September 1, 2000. Her license was most recently renewed on June 26, 2010 and subsequently suspended by the Board on April 6, 2011. The suspension was based primarily on complaints from two facilities. The first, received by the Board on December 22, 2009, was filed by Windward Gardens, Nurse

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Martin's employer since September 25, 2000. The second, received by the Board on August 31, 2010, was filed by Home, Hope and Healing, Inc., Nurse Martin's employer since February 2010.

A. Windward Gardens

The records of Windward Gardens (Windward) reveal that Nurse Martin was disciplined in September 2008 for failure to correctly administer, document and waste pain medications. Windward provided Ms. Martin with supervision and education regarding these deficiencies for two months. Thereafter, a discrepancy in the medication count during Bonnie Martin's shift was discovered. Ms. Martin's count reflected 50 Lorazepam pills, whereas 49 were present. The Respondent explained that she must have popped out one of the medications accidentally.

The above incident resulted in a further investigation which revealed that from August 2009 to November 2009, multiple medications had allegedly been administered by Nurse Martin as documented in the Narcotic Book, but without corresponding documentation by her in the Medication Administration Record or the Nurse's Notes. Moreover, the Narcotic Book revealed an excessive amount of Vicodin being signed out by Ms. Martin on the 11:00 p.m. - 7:00 a.m. shift. The medication was prescribed for patients who were cognitively unable to answer questions regarding their medications or to explain the extent or existence of night episodes of pain.

More specifically, Patient CP, in order to minimize breakthrough pain, had a prescription for Hydrocodone/APAP (hydrocodone and acetaminophen) 5/500, a/k/a Vicodin, one tab by mouth four times a day, not to exceed 4gm/24hrs total APAP. Ms. Martin was scheduled to administer the meds to CP at 12 midnight and 6:00 a.m. During November and December 2009, she gave the meds at the scheduled times, but allegedly added another dose around 2:30 a.m. or 3:30 a.m. She also documented giving CP two tabs instead of one, although the prescription order clearly stated one tab.

The records of Patient HL were also reviewed. They showed only five doses of Vicodin 5/500 documented on the back of the nurse's medication sheet instead of the 27 doses actually signed out by Ms. Martin on the Individual Narcotic Record. A nurse is required to note on the medication sheet the time, medication, dosage, route, and reason for the administration, and results or response to the medication. Vicodin was not charted in the resident's Medication Administration Record or accounted for in the Nurse's Notes and no record was made detailing why HL required pain medication throughout the night.

The same deficiencies were present regarding Patient AS's records, with Vicodin being allegedly administered on at least two nights at intervals of 4 hours and 15 minutes or 4 hours and 30 minutes, rather than the ordered every six hours.

Patient LL was prescribed Alprazolam on an as-needed basis. Patient LL's records from September 4 until October 15, 2009 reveal that only the Respondent administered Alprazolam to LL, who allegedly received 24 doses with no documentation noting the administration of the medication and no mention of its effectiveness. Since October 18, 2009, LL's records demonstrate that Nurse Martin allegedly administered to LL 26 doses of Alprazolam .5mg during her shift. Only one other nurse gave LL doses of the same medication and those totaled two doses.

Other abnormalities were discovered, such as the destruction by Nurse Martin of medications in the presence of a Certified Medication Assistant, even though the latter is not permitted to destroy or co-sign for the

destruction. Other meds that were prescribed for a soon-to-be-discharged resident were allegedly destroyed by the Respondent despite the fact that they were to be kept by the patient.

Of further significance to the Board is the fact that Windward's investigator, Kitty Maynard, R.N., requested the Respondent to come to Windward on December 10 and 11, 2009 to review the incidents. Ms. Martin had excuses and did not appear until December 14th. At that time, she stated that she had planned to chart the medications but had forgotten and did not perceive any problems related to her drug destruction, even though one instance involved her destruction of 20 meds with no signature other than her own, which was against Windward's policy. Windward then terminated Bonnie Martin's employment.

B. Home, Hope and Healing, Inc.

The second complaint to the Board was received on August 31, 2010. In that document, Jill Robinson, R.N., Home, Hope and Healing's (HHH) Executive Director, informed the Board that effective August 30, 2010, "We have terminated Bonnie for failure to participate in a drug diversion investigation…" HHH, which specializes in home care, afforded Ms. Martin several opportunities to present herself and explain her actions prior to the termination. She did not avail herself of these invitations.

From February to July 2010, the Respondent provided home care nursing services for two clients. She worked Friday days for Client WM and Saturday and Sunday overnight for Client TP. The record developed by HHH revealed that from June 14, 2010 until June 30, 2010, 29 Oxycodones were allegedly administered to these patients. Of these, the Respondent actually administered 22 and, on one night, gave doses only two or three hours apart, contrary to the order of four hours apart. The same type of conduct was present on July 3 and July 26 when Ms. Martin signed off on the controlled substance sheet that there were 215 meds remaining, whereas her successor calculated a count of 181 pills remaining; 34 pills were missing.

Perhaps the most egregious act by Bonnie Martin occurred in the home of Patient TP. TP, a Licensed Practical Nurse, was elderly and terminally ill from chronic obstructive pulmonary disease. She was mentally competent and bedridden due to her illness. On July 27, 2010, Merlene, the day nurse assigned to the care of TP, arrived at TP's home at 8:00 a.m. She was relieving Respondent Martin, who had left a note stating that there was no more Clonazepam for TP and that it had to be reordered. Merlene called the pharmacy whereupon she was advised that no more would be delivered since 90 pills had been delivered on July 5, 2010. Merlene counted the pills that had been administered since July 5 and determined that 35 pills were unaccounted for. When queried, TP stated that she did not receive several pills that Nurse Martin documented as administered. Merlene reported the situation to her employer, HHH, and continued inventorying TP's other meds. She found that 58 of 120 Ativan pills were unaccounted for and 24 Oxycodone were missing.

Of significance is the fact that TP seldom took any medication for pain. Moreover, TP did not ingest any prescription pills during the night since, once asleep, she stayed asleep. Bonnie Martin, however, documented giving TP Ativan and Oxycodone at night and other pills at 5:00 a.m. This documentation was most likely untrue since, in TP's opinion, one pill would "knock her out for the night."

TP was very fond of Respondent Martin and felt that she had received good care from the Respondent. She was devastated and felt betrayed when she became aware that Nurse Martin had diverted some of the drugs meant for TP.

III. CONCLUSIONS OF LAW

Based on the above facts and those found in the record, but not alluded to herein, and utilizing its experience and training, the Board, by a vote of 5-0, concluded that Bonnie Martin violated the provisions of:

1. 32 M.R.S. Sec. 2105-A (2) (E) (1 and 2) (Incompetent Conduct… by engaging in conduct that evidences a lack of ability or fitness to discharge the duty owed by a licensee to a client or patient or the general public and by engaging 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).

2. 32 M.R.S. Sec. 2105-A (2) (F) and Board Rules Chapter 4, Sec. 1.A. (6) (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).

3. Board Rule Chapter 4, Sec. 3. Definition of Unprofessional Conduct. Nursing behavior which fails to conform to legal standards and accepted 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 not be limited to, the following:

F. Failing to take appropriate action or to follow policies and procedures in the practice situation designed to safeguard the patient.

4. 32 M.R.S. Section 2105-A (2) (A). Fraud or deceit in obtaining a license.

5. 32 M.R.S. Section 2105-A (2) (H). A violation of this chapter or a rule adopted by the Board.

6. Board Rule Chapter 4, Disciplinary Action and Violations of Law, Sections 1.A. (1) Fraud or deceit in obtaining a license or in connection with service rendered within the scope of the license issued.

7. Board Rule Chapter 4, Disciplinary Action and Violations of Law, Sections 1.A. (5) (Incompetent Conduct… by engaging in conduct that evidences a lack of ability or fitness to discharge the duty owed by a licensee to a client or patient or the general public and by engaging 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).

8. Board Rule Chapter 4, Disciplinary Action and Violations of Law, Sections 1.A. (8). A violation of this chapter or a rule adopted by the Board.

9. Board Rule Chapter 4, Section 3 (F) as evidenced by: Bonnie Martin's failure to take appropriate action or to follow policies and procedures in the practice situation designed to safeguard patients.

10. Board Rule Chapter 4, Section 3 (H) as evidenced by: Bonnie Martin intentionally or negligently caused physical or emotional harm to a patient.

11. Board Rule Chapter 4, Section 3 (K) as evidenced by: Bonnie Martin inaccurately recorded, falsified or altered a patient or health care provider record.

12. Board Rule Chapter 4, Section 3 (P) as evidenced by: Bonnie Martin diverted drugs, supplies or property of patients or health care providers.

13. Board Rule Chapter 4, Section 3 (Q) as evidenced by: Bonnie Martin administered prescription drugs to a patient except as directed by a person authorized by law to prescribe drugs.

IV. SANCTIONS

The Board voted 5-0 to order the following sanctions for the above violations:

1. Bonnie Martin's Registered Professional Nurse's license is hereby **REVOKED**. The Board reasoned that Ms. Martin's nursing practices constitute a serious threat of harm to the public and therefore the revocation is warranted.

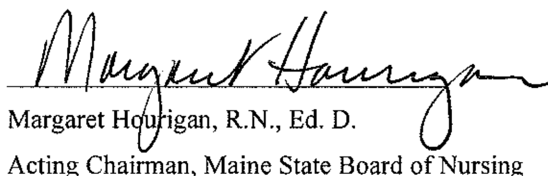
2. The Board further voted to assess Bonnie Martin the **COSTS** of this hearing not to exceed $2,000, which shall be received by the Board **no later than September 1, 2011**. The costs **total $1,626.25** (Hearing Officer: 30 minutes to review large record pre-hearing + 2 hours 15 minutes at hearing + 4 hours to write Decision & Order = 6 hours 45 minutes @ $115 = $776.25; Copying: 280 pp. x 10 copies @.25 =$700; Court Reporter: $150). The bank check or money order shall be made payable to: "Treasurer, State of Maine" and mailed Myra Broadway, J.D., M.S., R.N., Executive Director, Maine State Board of Nursing, 158 State House Station, Augusta, Maine 04333-0158. Additional costs may be assessed in the event that Bonnie Martin 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, Ms. Martin may have resolved this action without a hearing had she appeared when invited to an informal conference with the Board.

3. Bonnie Martin shall pay a **Fine of $3,000** prior to submitting any application for licensure that is under the Board's authority. The fine reflects the seriousness of the violations. The bank check or money order shall be made payable to: "Treasurer, State of Maine" and mailed to Myra Broadway, J.D., M.S., R.N., Executive Director, Maine State Board of Nursing, 158 State House Station, Augusta, Maine 04333-0158.

SO ORDERED.

June 1, 2011
Dated



Margaret Hourigan, R.N., Ed. D.
Acting Chairman, Maine State Board of Nursing

V. APPEAL RIGHTS

Pursuant to the provisions of 5 M.R.S. Sec. 10051.3 and 10 M.R.S. Sec. 8003(5)(G) and (5-A)(G), any party that appeals this Decision and Order must file a Petition for Review in the Maine District Court having jurisdiction within 30 days of receipt of this Order.

The petition shall specify the person seeking review, the manner in which s/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.