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: Eva Pangakis, RN50786)
Disciplinary Action #2011-273) **DECISION AND ORDER**
(Bangor Nursing & Rehabilitation Center)[1])

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 November 6, 2012. The purpose of the meeting was to conduct an adjudicatory hearing to determine whether to take disciplinary action against Eva Pangakis'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 Board members were Chairman Pro Tem Carmen Christensen, RN; Robin Brooks (public representative); Susan C. Baltrus, MSN, RNBC, CNE; Elaine A. Duguay, LPN; and Joanne Fortin, RN. John Richards, Assistant Attorney General, presented the State's case. Nurse Pangakis was 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 which would bar them from participating in the hearing. The Board then took official notice of its statutes and Rules, and subsequent to the State's opening statement, State's Exhibits 1-6, 8, and 9 were admitted into the Record.[2] The Board then heard the testimony, reviewed the exhibits, and considered the parties' closing arguments. Subsequently, the Board deliberated and made the following findings of fact by a preponderance of the credible evidence and further made conclusions of law regarding the alleged violations contained in the Notice of Hearing.

[1] See also Decision and Order re: Eva Pangakis, RN50786 - Orono Commons, Case 2011-3
[2] State's Exhibit 7 was not admitted. The State's offer of proof was placed on the record out of the Board's presence.

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II. FINDINGS OF FACT

Respondent Eva Pangakis, a 37-year-old resident of Old Town, Maine, was first licensed in Maine as a Registered Professional Nurse on February 11, 2005. Her current license expires on July 19, 2014. She is presently not employed.

Nurse Pangakis was hired in her professional capacity by Care Tree Healthcare Staffing and assigned as an agency nurse to Bangor Nursing & Rehabilitation Center (BNRC) approximately in early 2010. The BNRC is a 60-bed nursing home with a variety of patients, including those with dementia, and patients requiring skilled nursing care for medical conditions.

Bonny Small, RN and Director of Nursing at BNRC during all relevant times, conducted an investigation from May 2, 2011 until May 9, 2011 of Eva Pangakis's nursing practices due to an alleged drug diversion. The investigation revealed that on May 2, 2011, Ms. Pangakis told Director Small that she performed the 11:00 p.m. shift narcotic count on April 25, 2011 with an orientee and that the pill count was incorrect as one tablet was unaccounted for. However, no orientee worked on that date. Ms. Pangakis then wrote an entry in the Narcotic Record that a 30mg MS Contin (Morphine) had been given to patient BM at 8:00 p.m. This entry would correct the pill count. Nurse Pangakis subsequently signed the initials "CSR" on the record. There were no employees at BNRC with those initials. On the same evening, two 15mg MS Contins were administered to BM at 8:00 p.m. and documented on the Medication Administration Record (MAR) by an RN with the initials "CCR." The prescription was for one 30mg tablet at 8:00 p.m.

Nurse Pangakis explained to investigating Director Small that the narcotic count was off by one tablet and she knew that the patient received a 30mg tablet every evening at 8:00 p.m. Nurse Pangakis further explained that she thought RN "CCR" had forgotten to sign out a medication, but had incorrectly counted it on the Narcotic Record. She therefore made the entry to correct the count and signed what she thought were the RN's initials to remind RN "CCR" to sign for the drug when "CCR" returned to work the next evening. RN "CCR" initially signed on the shift count that she performed the narcotic pill count, but later denied same.

The investigation resulted in a finding, among others, that one morphine tablet was unaccounted for during Ms. Pangakis's shift. Nurse Small doubted that the count was actually performed and counseled Nurse Pangakis and RN "CCR" about incorrect documentation and not following standard procedures for shift count. There was also the possibility that patient BM was administered two doses of morphine at 8:00 p.m. instead of one.

Director Small's investigation further revealed three other disturbing instances regarding Nurse Pangakis's nursing practices. First, on March 14, 2011, a resident's narcotic record documented the signing off of Ativan doses of 0.5mg po q6h prn, but no corresponding doses to be given were documented by Nurse Pangakis, either on the front or back of the MAR as noted in a subsequent Pharmacy Recommendation Report.

Second, on April 25, 2011, a CNA dropped a bottle of Morphine Sulfate Intensol meant to be administered to patient DF at 20mg/1ml 5mg every hour prn pain for shortness of breath. Nurse Pangakis and the CNA destroyed the remaining Morphine, but the other available RN on duty did not observe the bottle get broken or destroyed, which was a violation of the procedures for medication destruction that required the destruction by two licensed nurses. The procedure is intended to ensure that containers of certain medications are actually broken and the contents fully destroyed and not diverted. Ms. Pangakis was counseled again by Nursing Director Small.

The third incident occurred on May 1, 2011, when patient LG was scheduled to be administered Percocet one 5/325 tablet po q6h. Nurse Pangakis administered the medication at 6:00 a.m. as ordered, but administered a second tablet at 6:05 a.m. The first dose was recorded by the respondent on the MAR as given, but the second dose is not recorded on the MAR and was not ordered by a physician. Both doses were recorded on the Narcotic Record. The entry on the Narcotic Record states that the patient is to receive the medicine prn, but that was not ordered by a physician so prn was removed the next day. Nurse Pangakis was counseled by Nurse Small regarding this error.

Nursing Director Small on May 3, 2011 cancelled Nurse Pangakis's remaining shifts and requested Care Tree not schedule the respondent for duty at BNRC in the future. Director Small's investigation was concluded on May 9, 2011 with the finding that, "No drug diversion noted. The one 30 mg tablet of MS Contin is not accounted for." In her investigation findings, Nurse Small further noted additional instances of the respondent's lack of documentation regarding the effectiveness on residents of administered prn medications; medicines documented on the Narcotic Record, but not on the MAR; and different times recorded on MARs and Narcotic Records, etc.

At this hearing, Nurse Pangakis explained that she administered the second Percocet tablet to LG since the patient was in pain and was thankful for the additional medication. Due to being rushed and distracted by other nursing related responsibilities, Nurse Pangakis stated that she forgot to note the extra dose in the MAR. Respondent further stated that she corrected BM's controlled substance count and inserted the nurse's initials on BM's chart to alert the nurse to document the count when her initials were discovered.

The testimony by both Witnesses Pangakis and Small additionally established that BNRC was a very busy facility and that staff, at times, were most likely overburdened, particularly in the morning before the shift change. The testimony also demonstrated that Nurse Pangakis was sloppy in her record keeping documentation.

III. CONCLUSIONS OF LAW

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

1. 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.

2. 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.

   Nurse Pangakis admitted that she forged what she believed to be the initials of RN "CCR" and misrepresented that she conducted a count on her shift. She additionally knew that she should not administer the second Percocet to LG since there was not an order to do so.

3. 32 M.R.S. Section 2105-A (2) (H) and 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.

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

IV. SANCTIONS

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

1. Eva Pangakis's Registered Professional Nurse's license is hereby placed on probation for a five-year term beginning on the day when she resumes practice as a nurse. During the probation, she shall:

(1) within six months of this Decision and Order or before she resumes practice as a nurse, demonstrate that she has successfully completed a refresher course, to include narcotics administration and documentation. Said course must be pre-approved by the Board's Executive Director.

(2) arrange for and ensure the submission to the Board of quarterly reports from her nursing employer(s) and/or clinical faculty regarding her general nursing practice. Nursing employment will be restricted during the period of probation to structured settings and shall not include assignments from temporary employment agencies, home health, school nursing, work as a travel nurse or within the correctional system.

(3) IT IS FURTHER AGREED that while Ms. Pangakis's license is subject to this Decision, she may not work outside the State of Maine pursuant to a multi-state privilege without the written permission of the Maine State Board of Nursing and the Board of Nursing in the party state in which she wishes to work.

2. Any violation of the terms of probation shall be grounds for further disciplinary action.

SO ORDERED.

Dated: November 29, 2012

Carmen Christensen, RN – Chairman Pro Tem
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, 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 Superior Court having jurisdiction. 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.