STATE OF RHODE ISLAND
PROVIDENCE, SC.

RHODE ISLAND DEPARTMENT OF HEALTH:		
HEALTH SERVICES REGULATION	:	**Case No. PNS11-036**
BOARD OF NURSE REGISTRATION	:	
AND NURSING EDUCATION	:	
	:	
	:	
v.	:	
	:	
LISA MARENARO (PPNS00019, CPPNS00019, RN32695)		

SUMMARY SUSPENSION

Lisa Marenaro ("Respondent") is a Psychiatric Clinical Nurse Specialist pursuant to R.I. Gen. Law Section 5-34-9 and holds license numbers PPNS00019, RN32695 and Controlled Substances Registration CPPNS00019. Respondent is in a collaborative practice with Dr. Mindy Rosenbloom, M.D. (license #MD07316). Respondent was practicing as a psychiatric clinical nurse specialist during the events described below:

On or about December 12, 2011, Respondent entered into a Consent Order with the Board of Nurse Registration and Nursing Education (hereinafter "the Board"). This Order is attached to this Summary Suspension as Exhibit A. As part of that Order, Respondent agreed to "review RIGL § 5-34-24 and shall ensure that she maintains legal adherence to the statute at all times going forward."

On or about April 2, 2012, Patrick Kelly, Pharmacy Inspector for the Rhode Island Department of Health, presented Respondent with a subpoena for her collaborative agreement. Respondent was unable to produce the document, but stated that she had it at her house. Respondent did not produce a collaborative agreement until 4/5/12 when she produced a collaborative agreement that was not signed by the collaborating physician, Mindy Rosenbloom (see attached as Exhibit B).

On or about April 5, 2012, the Inspector sought and received a collaborative agreement which was signed by Dr. Rosenbloom on 4/2/12, the date the Inspector originally made his request. No collaborative agreement has been produced for the time

period from 3/19/12 (the expiration date of the 3/19/11 collaboration agreement) to 4/2/12.

On or about 2/29/12, the Rhode Island Department of Health received a complaint from the Director of the Town of Coventry's Department of Human Services. The Director stated that she had made numerous attempts to contact Respondent about two high-risk patients and had received no response.

On or about March 30, 2012, a PMP (Prescription Monitoring Program) review was conducted by the Rhode Island Board of Pharmacy on five of Respondent's patients. The review, coupled with an internal medical review, revealed the following:

Patient 1: Medical records deficiencies, including no problem summary list, no active controlled substance log, no active medications list, scant progress notes. Patient 1 was prescribed a 180 day supply of Amphetamine Salts (generic Adderall) in 75 days, at 90 mg/day. The usual dose is 40 mg/day. No explanation is contained in the records to explain the prescription of a dose approximately two and one-half times higher than the usual amount. There is no tracking of patient utilization, urine monitoring or assessment for suicide or substance abuse.

Patient 2: Medical records deficiencies, including no problem summary list, no active controlled substance log, no active medications list, scant progress notes. Patient 2 was prescribed a 120 day supply of Amphetamine Salts (generic Adderall) in 60 days, at 120 mg/day. The usual dose is 40 mg/day. No explanation is contained in the records to explain the prescription of a dose three times higher than the usual amount. There is no tracking of patient utilization, urine monitoring or assessment for suicide or substance abuse. One prescription for 30 days was written on 2/13/12, and another one for 30 days was written four days later on 2/17/12. No explanation is given in the chart. Notes reflect that the Respondent dismissed the patient on 9/22/11 after receiving information from pharmacies that she was refilling prescriptions early. Respondent continued to treat patient after dismissal, and continued to prescribe medications for her.

Patient 3: Medical records deficiencies, including no problem summary list, no active controlled substance log, no active medications list, scant progress notes, no vital signs. Patient 3 was prescribed dosages of Methylphenidate (generic Ritalin) of 90-

120 mg/day. The usual dose is no more than 60 mg/day. No explanation is contained in the records to explain the prescription of a dose higher than the recommended amount. There is no tracking of patient utilization, urine monitoring or assessment for suicide or substance abuse. Notes reflect that the Respondent dismissed the patient on 9/22/11. Respondent continued to treat patient after dismissal, and continued to prescribe medications for her. Respondent was notified by a pharmacy on 12/13/11 that patient was constantly getting early refills. From 12/16/11 to 2/12/12 Respondent issued five prescriptions for Methylphenidate, a total quantity of 600 tablets, in a two month period. There is a gap in the medical records.

Patient 4: Medical records deficiencies, including no problem summary list, no active controlled substance log, no active medications list, scant progress notes, no vital signs. Patient was prescribed Amphetamine Salts (generic Adderall) at 120 mg/day. The usual dose is 40 mg/day. No explanation is contained in the records to explain the prescription of a dose three times higher than the usual amount. Patient was prescribed Alprazolam (generic Xanax) at 10 mg/day. The usual dose is 4 mg/day. Two prescriptions for Amphetamine Salts 30mg were issued to the patient on the same day (1/6/12) with different directions. One prescription was for a quantity of #90 with directions of three tablets daily and one prescription was for a quantity of #120 with directions of four tablets daily. This equates to a total of 210 tablets. No explanation is contained in the records to explain the issuance of multiple prescriptions on the same day with different directions. There is no tracking of patient utilization, urine monitoring or assessment for suicide or substance abuse. Respondent was notified by DCYF in April 2011 that they believed patient was abusing drugs. No action was taken according to charts.

Patient 5: Medical records deficiencies, including no problem summary list, no active controlled substance log, no active medications list, scant progress notes, no vital signs. Patient was prescribed Amphetamine Salts (generic Adderall) at 60 mg/day. The usual dose is 40 mg/day. No explanation is contained in the records to explain the prescription of a dose one and a half times higher than the usual amount. From 12/19/11 to 2/14/12 four prescriptions for Amphetamine Salts 60mg/day were issued to the patient. One refill was approved by Respondent six days after the 1/17/12 refill, in which a 30

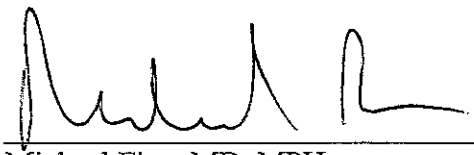
day supply had been issued. Overall, 360 tablets (a 120 day supply) were issued within a 60 day period. No explanation is given in the chart. There is no tracking of patient utilization, urine monitoring or assessment for suicide or substance abuse.

On or about April 20 and April 23, 2012 Respondent taped patient prescriptions to the outside door of her office, unsecured, and with patient names on the outsides of the envelopes. Those prescriptions could have been accessed and filled by anyone who came by, and confidential patient information was placed in an unsecure location.

Based upon the foregoing, the Director of Health has determined that the continuation of the licenses of Lisa Marenaro as a Psychiatric Clinical Nurse Specialist and as a Registered Nurse constitutes an imminent threat to the health, welfare and safety of the public. Accordingly, pursuant to R.I.G.L. section 5-34-26 the licenses (Numbers PPNS00019, CPPNS00019) of Lisa Marenaro are hereby suspended forthwith. No action is taken at this time against license no. RN32695. Said suspension shall continue indefinitely pending further Order of the Department of Health.

A hearing on this matter is scheduled for **Monday, May 14, 2012 at 230 p.m.** in the Department of Health, Cannon Building, 3 Capitol Hill, Room 401, Providence, Rode Island, 02908 unless waived or continued by request of the Respondent.

Signed this 4th day of May, 2012



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CERTIFICATION

I hereby certify that I have hand-delivered the within SUMMARY SUSPENSION to ~~Lisa Marchand, at~~ Richard Beretta, Esq + Katy Hynes Esq. at Three Capitol Hill, Rm 205, Providence, RI on this 4th day of May, 2012.

Holly J. Pham