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: Wendy E. Chamberlain)
Disciplinary Action)

DECISION & ORDER

I. PROCEDURAL HISTORY

Pursuant to the authority found in 32 M.R.S. Sec. 2105-A(1-A), *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 January 11, 2012. The purpose of the meeting was to conduct an adjudicatory hearing to determine whether grounds exist for the Board to take disciplinary action against Nurse Chamberlain'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 were Chair Pro Tem Carmen Christensen, R.N.; Margaret Hourigan, R.N., Ed.D.; Robin Brooks (public representative); Elaine A. Duguay, L.P.N.; and Valerie Fuller, A.P.R.N. Dennis Smith, Assistant Attorney General, presented the State's case. Ms. Chamberlain was not 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 State's Exhibits 1, 1A-13 were entered into evidence. The Board then found that Ms. Chamberlain had been duly served with the Notice of Hearing in this matter on or about December 24, 2011. The Board 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

1. Wendy Chamberlain, 37 years old, was first licensed to practice as a registered professional nurse in the State of Maine in June 1998 (license number R042374).

2. On January 4, 2006, Ms. Chamberlain entered into a Consent Agreement with the Board and the Office of the Attorney General in which she admitted to having a substance abuse problem and

voluntarily surrendered her registered professional nurse license based upon her diversion of drugs and drug abuse.

3. On February 4, 2010, Ms. Chamberlain entered into a Consent Agreement (Agreement) with the Board and the Office of the Attorney General for License Reinstatement & Probation with Conditions. The conditions of her probation included: (a) Ms. Chamberlain's complete abstention from the use of alcohol or drugs; and (b) Ms. Chamberlain's notification to the Board in writing within five business days after she had been terminated or separated from employment, regardless of cause, with a full explanation of the circumstances. In addition, Paragraph 6 of the Agreement authorized the Board to immediately suspend her license if the Board "receives reasonably reliable information suggesting that she has not remained substance free in accordance with the Consent Agreement."

4. Nurse Chamberlain was hired in her professional capacity by St. Mary's Health System (St. Mary's), Lewiston, Maine on July 16, 2011, where she last practiced in the Cardiac Telemetry Unit (surgery) at St. Mary's Hospital.

5. On September 22, 2011, the Board received written notification from St. Mary's pursuant to 24 M.R.S. § 2506, indicating that it had terminated the employment of Ms. Chamberlain, effective September 14, 2011.[1]

6. According to the initial information from St. Mary's, Ms. Chamberlain's employment was terminated as a result of an investigation of a complaint filed by a patient's daughter (Y).

7. At this hearing, St. Mary's Employee Relations Manager, Paige Hagerstrom, established, among other things, that Ms. Chamberlain was counseled on August 29, 2011 for not being alert while on duty. Hospital staff had noticed her eyes closing during her shift. At that time, St. Mary's had not been notified of the incident which is the subject of this licensure hearing.

8. Y, a retired registered professional nurse, provided a written statement concerning this matter and testified that she visited her mother in the St. Mary's cardiac unit on Friday, August 12, 2011. Nurse Chamberlain, among others, was assigned to Y's mother's care. During that afternoon, Y

[1] The Board subsequently conducted an investigation and, pursuant to Para. 6 of the February 4, 2010 Consent Agreement, suspended Wendy Chamberlain's registered professional nurse's license on October 11, 2011.

left her mother's room for approximately an hour and one half and when she returned, found a black zippered bag. She opened the bag and described its contents as drug paraphernalia and white powder in small baggies. Y suspected drug use and was concerned for her mother.

9. Y soon located Nurse Chamberlain in the hallway and gave her the black zippered bag. Ms. Chamberlain motioned for Y "to be quiet" and accompanied her to a conference room where she zipped up the bag, told Y to "trust me," and was adamant that Y "not talk to anyone about this." The Respondent then gave Y her personal phone number in the event that she might have any questions and said that she "knew just what to do with this" and that she would take the black zippered bag to the hospital's security office. The office was located on the floor below, approximately one minute's walk away.

10. Y, on subsequent visits to the hospital, was offered snacks by the Respondent, who was "extremely nice and kind to her."

11. Ms. Chamberlain did not inform anyone else on the unit (i.e. Patient Care Leader, Charge Nurse, or her Preceptor) about the black zippered bag containing drug paraphernalia. She took it home with her and did not turn it into hospital security until two days later, on August 14, 2011. At that time, Ms. Chamberlain was wearing street clothes, did not identify herself, and was quite visibly upset by the ordeal. The bag did not contain the white powder in small baggies and she advised the security chief that there were two hypodermic needles and a spoon inside. She told security that someone gave the bag to her telling her that it was found on the "2nd floor" of the hospital. She did not give the security chief any further information as to a more exact location. The security chief most likely would have initiated an investigation if the Respondent had identified herself as a nurse.

12. Y had continued to abide by Respondent Chamberlain's admonitions not to tell anyone of the black bag incident and was reassured by the Respondent that the matter was being investigated. However, Y eventually became suspicious and reported the incident to the Lewiston Police Department on or about September 6, 2011 and the complaint was forwarded to St. Mary's on that date.

13. By September 13, 2011, Ms. Hagerstrom had begun the hospital's investigation. On that day, she spoke with Ms. Chamberlain about the events that occurred on August 12, 2011. Ms.

Chamberlain told Ms. Hagerstrom that while on duty as a nurse at the hospital, she came into possession of a black zippered bag that contained drug paraphernalia (needles and a spoon) and that it "looked like heroin paraphernalia." Ms. Chamberlain stated that she took the black zippered bag to hospital security, but could not identify the security officer's name. Ms. Chamberlain admitted giving Y her personal phone number and stated that the reason she did so was Y seemed really upset. Ms. Chamberlain admitted that she did not offer Y the contact information for the hospital's unit manager or security. Ms. Chamberlain admitted that she asked Y not to speak with anyone else about the black zippered bag because Ms. Chamberlain did not think the bag belonged to anyone else on the unit. She also did not think it belonged to the patient or patient family members, "so why get everyone upset." Ms. Chamberlain admitted that she did not turn the black zippered bag into hospital security for two days because she had "put it in her smock and forgotten to turn it in" and she discovered it two days later when doing laundry. Ms. Chamberlain admitted that she was wearing street clothes when she turned in the black zippered bag to hospital security and explained that it was her day off work.

14. As a result of the hospital's investigation, Nurse Chamberlain's employment was terminated effective September 14, 2011.

15. On December 1, 2011, Ms. Chamberlain provided the Board with a written statement in which she stated, among other things, that:

a. On August 12, 2011, she walked into a patient's room and saw Y sitting in a chair holding a black zippered bag;
b. Ms. Chamberlain saw that the bag contained "drug paraphernalia which was needles and a spoon;"
c. Ms. Chamberlain expressed "shock" about why Y, an elderly lady, would have such things;
d. Ms. Chamberlain stated that Y was "upset" and Ms. Chamberlain told her that she would take the bag to security;
e. Ms. Chamberlain then took the bag and placed it in the left pocket of her "scrubs;"
f. Ms. Chamberlain admitted that she asked Y not to discuss the bag "with any other staff." Ms. Chamberlain explained that she did so "for the integrity of the investigation" and because she felt that she was being "singled out" (i.e. harassed) by another nurse at work;
g. Ms. Chamberlain stated that when she "left the room [she] honestly was heading to security when another patient needed something."

h. Ms. Chamberlain then stated that she "pushed aside" going to security after that because it was close to the end of her shift and she needed to finish her work; the bag only contained "paraphernalia" which Ms. Chamberlain was "maybe dulled to from working with DEA;" and she was stressed out at work from harassment by another nurse.

i. Ms. Chamberlain further wrote that she did not recall the black zippered bag with the drug paraphernalia until she found it while doing her laundry two days later. Ms. Chamberlain stated that - at that point - she "knew she lost everything;"

j. Ms. Chamberlain stated that she went to St. Mary's in street clothes as it was her day off and gave the black zippered bag to hospital security. According to Ms. Chamberlain's statement: "He (hospital security) did not write down anything nor did he ask me to sign any papers. I figured he would talk with my patient's daughter and I also figured I would lose my job on Monday."

k. Ms. Chamberlain stated that the black zippered bag did not contain any baggies of white powder and asserted:

> Please ------- Ugh! First of all I work for the federal DEA if I saw white pouches I would have bypassed security and just called them. I'm not going to risk anything for no one.... At this point its (*sic*) my word against [the patient's] family member who said she found the bag on top of her tote bag. I did not go through the bag because it's common sense not to go thru an addict's things and risk getting stabbed by a used needle. Also the security dept. kept no paperwork on this matter...

16. The Board finds that it is more likely than not the bag contained packets of a white powder in addition to drug paraphernalia.

17. Ms. Chamberlain's explanation and actions regarding the August 12, 2011 incident are not credible and demonstrate an attempt by her to shift blame and obfuscate the truth, particularly as related by Y.

III. CONCLUSIONS OF LAW

The Board concluded by a vote of 5-0, based on the above facts and those contained in the record but not cited above, that Wendy Chamberlain violated the following Board statutes and rules:

1. 32 M.R.S. § 2105-A (2) (E) (Incompetence in the practice for which the licensee is licensed. A licensee is considered incompetent in the practice if the licensee has engaged in conduct that evidences a lack of ability or fitness to discharge the duty owed by the licensee to a client or

patient or the general public; or engaged 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. § 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);

3. 32 M.R.S. § 2105-A (2) (H) (A violation of this chapter or a rule adopted by the board);

4. 10 M.R.S. § 8003(5) (A-1) (4) (Violation of terms of probation of a Consent Agreement).

IV. SANCTIONS

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

1. Wendy Chamberlain's Registered Professional Nurse's license is hereby **REVOKED**.
2. Wendy Chamberlain shall pay the **costs** of this hearing **by August 9, 2012** which **total $993.75** (Hearing Officer: 15 minutes to review record pre-hearing; 2 hours, 30 minutes at hearing; 3 hours, 30 minutes to write decision = 6 hours 15 minutes @ $115 = $718.75 + copying costs: 110 pp. x 10 copies @.25 =$275). The bank check or money order shall be made payable to: "Maine State Treasurer" and mailed to Myra Broadway, J.D., M.S., R.N., Executive Director, 158 State House Station, Augusta, Maine 04333-0158. Additional costs may be assessed in the event that Wendy Chamberlain 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.

SO ORDERED.

Dated: February 8, 2012

Carmen Christensen, R.N.
Chair Pro Tem, State Board of Nursing

V. APPEAL RIGHTS

Pursuant to the provisions of 5 M.R.S. 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 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.