STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF PROFESSIONAL LICENSING
BOARD OF NURSING
DISCIPLINARY SUBCOMMITTEE

In the Matter of

ALISON RENEE MARSHALL, R.N.
License No. 47-04-235386, File No. 47-20-002453

Respondent.

ORDER OF SUMMARY SUSPENSION

The Department filed an *Administrative Complaint* against Respondent as provided by the Public Health Code, MCL 333.1101 *et seq*, the rules promulgated under the Code, and the Administrative Procedures Act, MCL 24.201 *et seq*.

After careful consideration and after consultation with the Chairperson of the Board of Nursing pursuant to MCL 333.16233(5), the Department finds that the public health, safety, and welfare requires emergency action.

Therefore, IT IS ORDERED that Respondent's license to practice as a registered nurse in the state of Michigan is SUMMARILY SUSPENDED, commencing the date this *Order* is served.

Under Mich Admin Code, R 792.10702, Respondent may petition for the dissolution of this Order by filing a document clearly titled **Petition for Dissolution of Summary Suspension** with the Department by email to BPL-DMS@Michigan.gov. If unable to submit a petition for dissolution by email, Respondent may submit by regular mail to the Department of Licensing and Regulatory Affairs, Bureau of Professional Licensing, P.O. Box 30670, Lansing, MI 48909.

MICHIGAN DEPARTMENT OF
LICENSING AND REGULATORY AFFAIRS

Dated: 10/20/2020

By: Debra Gagliardi, Director
Bureau of Professional Licensing

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Respondent.

ADMINISTRATIVE COMPLAINT

The Michigan Department of Licensing and Regulatory Affairs, by Debra Gagliardi, Director, Bureau of Professional Licensing, complains against Respondent Alison Renee Marshall, R.N. as follows:

1. The Michigan Board of Nursing is an administrative agency established by the Public Health Code, MCL 333.1101 *et seq.* Pursuant to MCL 333.16226, the Board's Disciplinary Subcommittee (DSC) is empowered to discipline licensees for violations of the Public Health Code.

2. Respondent holds a Michigan license to practice as a registered nurse.

3. After consultation with the Board Chairperson, the Department found that the public health, safety, and welfare requires emergency action. Therefore, pursuant to MCL 333.16233(5), the Department summarily suspended Respondent's license to practice as a registered nurse in the state of Michigan, effective upon service of the accompanying *Order of Summary Suspension*.

4. Fentanyl is an opioid schedule 2 controlled substance. Fentanyl is between 50 and 100 times as potent as morphine.

5. At all relevant times, Respondent was employed as a registered nurse at Bronson Methodist Hospital (facility), located in Kalamazoo, Michigan.

6. At all relevant times, the facility used Pyxis, an automated dispensing device to provide computer-controlled storage, dispensing, and tracking of medications, including controlled substances.

7. On August 20, 2020, facility nurse B.H.[1] discovered in the medication stock a fentanyl 2 ml vial that had adhesive on the vial cap. Nurse B.H. reported the suspect vial to a facility pharmacist. Nurse B.H. and the pharmacist did not feel comfortable using the vial and wasted it.

8. On August 21, 2020, nurse B.H. administered fentanyl from a 2 ml vial to patient J.P. that had no effect on the patient. Pharmacy staff were called to investigate and found four fentanyl 2 ml vials in Pyxis machines that appeared to be tampered with. Vials either had loose, uneven caps, were unevenly filled, or had caps that did not freely rotate, as unaltered vials from the manufacturer would.

9. Pharmacy staff called nursing staff to stop patient J.P.'s procedure. Pharmacy staff inspected the fentanyl vials being used and contacted facility management to begin an investigation.

10. Pharmacy staff reviewed data from the Pyxis machines and found that Respondent used the "remove cancelled" function more frequently than her peers beginning in July 2020, which was suspicious to management because the function opens the fentanyl drawer in the machine and provides additional access to the fentanyl vials. Facility management set up a meeting with Respondent to discuss her fentanyl access.

[1] Individuals are identified by initials to protect confidentiality.

11. On August 24, 2020, facility management met with Respondent, who admitted to diverting fentanyl 2 ml vials on eight occasions from mid-July to mid-August 2020 for personal use.

12. Respondent stated she diverted fentanyl by using a needle to remove it from the vials. Respondent admitted to replacing the fentanyl with saline, gluing the caps back on the vials, and returning the vials filled with saline to the fentanyl stock.

13. Facility management asked Respondent if she thought about the potential patient harm that could occur if patients received saline instead of fentanyl. Respondent indicated that she knew her actions could have negative consequences for patients, but she hoped that patients would receive unaltered vials and that the vials she tampered with would be wasted. Facility management subsequently suspended Respondent's employment.

14. Facility management indicated that numerous patients were at risk of being administered saline from the vials Respondent tampered with instead of the expected fentanyl to treat their pain.

15. On August 27, 2020, facility management terminated Respondent's employment and subsequently reported the matter to the Department.

16. Respondent did not respond to multiple attempts by the Department's investigator to interview her regarding this matter.

COUNT I

Respondent's conduct constitutes a violation of a general duty, consisting of negligence or failure to exercise due care, including negligent delegation to or supervision of employees or other individuals, or a condition, conduct, or practice that impairs, or may impair, the ability safely and skillfully to engage in the practice of the health profession in violation of MCL 333.16221(a).

COUNT II

Respondent's conduct, as set forth above, demonstrates Respondent's "departure from, or failure to conform to, minimal standards of acceptable and prevailing practice for the health profession, whether or not actual injury to an individual occurs," and accordingly "incompetence," in violation of MCL 333.16221(b)(i).

COUNT III

Respondent's conduct demonstrates Respondent's lack of a "propensity . . . to serve the public in the licensed area in a fair, honest, and open manner," MCL 338.41(1), and accordingly a lack of "good moral character," in violation of MCL 333.16221(b)(vi).

COUNT IV

Respondent's conduct constitutes obtaining, possessing, or attempting to obtain or possess a controlled substance or drug without lawful authority, and/or selling, prescribing, giving away, or administering drugs for other than lawful diagnostic or therapeutic purposes, in violation of MCL 333.16221(c)(iv).

RESPONDENT IS NOTIFIED that, pursuant to MCL 333.16231(8), Respondent has 30 days from the date of receipt of this Complaint to submit a written response to the allegations contained in it. Pursuant to section 16192(2) of the Code, Respondent is deemed to be in receipt of the complaint three (3) days after the date of mailing listed in the attached proof of service. The written response shall be submitted by email to the Department of Licensing and Regulatory Affairs, Bureau of Professional Licensing to BPL-DMS@michigan.gov. If unable to submit a response by email, Respondent may submit by regular mail to the Department of Licensing and Regulatory Affairs, Bureau of Professional Licensing, P.O. Box 30670, Lansing, MI 48909.

Respondent's failure to submit an answer within 30 days is an admission of all Complaint allegations. If Respondent fails to answer, the Department shall transmit this complaint directly to the Board's Disciplinary Subcommittee to impose a sanction pursuant to MCL 333.16231(9).

MICHIGAN DEPARTMENT OF
LICENSING AND REGULATORY AFFAIRS

Dated: 10/20/2020

By: Debra Gagliardi, Director
Bureau of Professional Licensing

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