

MAINE STATE BOARD OF NURSING

IN RE: Daniel D. Melland, R.N. ) DECISION AND ORDER  
Licensure Disciplinary Action )

I. PROCEDURAL HISTORY

Pursuant to the authority found in 32 M.R.S.A. Sec. 2105-A(1-A)(D), *et seq.*, 5 M.R.S.A. Sec. 9051, *et seq.* and 10 M.R.S.A. Sec. 8001, *et seq.*, the Maine State Board of Nursing (Board) met in public session at the Board's offices located in Augusta, Maine on August 15, 2007 for the purpose of determining primarily whether Daniel Melland, R.N. engaged in fraudulent or deceitful or unprofessional or incompetent conduct as a registered nurse while licensed in Maine as more specifically stated in the Notice of Hearing dated July 25, 2007. A quorum of the Board was in attendance during all stages of the proceedings. Participating and voting Board members were Chairwoman, Therese B. Shipp, D.N. Sc., R.N. , Bruce O'Donnell, C.R.N.A., Dorothy Melanson, R.N., Robin Brooks, (public representative), Susan L. Brume, L.P.N., and Carmen Christenson, R.N. Jack Richards, Ass't. Attorney General, presented the State's case. Daniel Melland was not present although he had been served with the Notice of Hearing on July 26, 2007.<sup>1</sup> James E. Smith, Esq. served as Presiding Officer.

Following the determination that none of the Board had conflicts of interest which would bar them from participating in the hearing, the taking of official notice of its statutes and rules, and subsequent to the opening statement by counsel, State's Exhibits 1-8 (including 5A) were admitted into the Record. The Board then heard the testimony, reviewed the submission of exhibits and considered counsel's closing argument after which it deliberated and made the following findings

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<sup>1</sup> Mr. Melland left a telephone message with the Board on August 14, 2007 at 11:32 a.m. He stated that he did not have transportation and so could not attend the hearing and requested a continuance. He also stated that he would enter a drug treatment program but lacked the necessary funds. He did not give a telephone number for the Board to make further inquiry regarding his request. The Board denied the request since good cause was not sufficiently demonstrated.

of fact by a preponderance of the credible evidence regarding the violations alleged in the Complaint.

## **II. FINDINGS OF FACT**

Daniel D. Melland was first licensed as a R.N. in the State of Maine on October 15, 1996 and remained in that status until July 9, 2007. On that date, the Board held a meeting and revoked his license pursuant to 5 M.R.S.A. § 10004 (3) pending hearing on the instant allegations. Previously, the Board and Daniel Melland had entered into a Consent Agreement on January 28, 2003 which contained the following language relevant to this proceeding:

Daniel D. Melland resigned from Ross Manor on July 25, 2002, because of an incident regarding 15 tablets of missing Vicodin. Mr. Melland denied taking the Vicodin and an internal investigation at Ross Manor did not substantiate that Mr. Melland diverted the Vicodin; however, it was determined that Mr. Melland did not waste the Vicodin in accordance with the policies and procedures adopted by Ross Manor and in compliance with accepted nursing practices. Mr. Melland was aware of the drug wasting policy and procedure adopted by Ross Manor. Prior to the discovery of the missing Vicodin, Mr. Melland was reported to have glazed-over eyes which Mr. Melland explained was a lack of sleep. Mr. Melland stated that he was fatigued from working back-to-back shifts and had only four hours of sleep.

Daniel Melland was placed on probation for one year as a result of the above and successfully complied with the terms of the probation.

More recently, on March 14, 2007, Detective Jeff Wrigley interviewed the licensee in relation to an incident(s) of the diversion and drug switching of liquid Morphine and Oxycontin pills from Cummings Healthcare in Howland, Maine. Although Melland was the predominant suspect, he initially denied any involvement but eventually made admissions to the abuse of opiate drugs. The investigation continued but the licensee had left his employment at Cummings Healthcare<sup>2</sup>. Soon thereafter, he began practicing his profession at Penobscot Nursing Home in

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<sup>2</sup> At some point, the licensee became employed by M.S.N. staffing company.

Penobscot, Maine. He then left that employment and began work at Sea Brook Nursing Home in Westbrook, Maine where the diversion of a bottle of Oxyfast and 14 vials of Dilaudid was being investigated. By June 19, 2007, Melland was working as a registered nurse at Gregory Wing Nursing Facility, a branch of St. Andrew's Hospital in Boothbay Harbor, Maine.

On June 22, 2007, Det. Wrigley in cooperation with hospital officials and other law enforcement officers installed two cameras into the ceiling of the Gregory Wing room which contained the facility's drugs. On June 26, 2007, Millie Farnham, the Director of Nursing at the Gregory Wing, reported the diversion of 40 cc's of liquid Morphine. This individual had been approached by Melland who said that he had found an outdated bottle of liquid Morphine and wanted to immediately waste it. She objected and secured the bottle while noting that its contents were transparent, like water, rather than the usual bright pink.

Det. Wrigley was informed of the above and viewed the DVD recording of the activities in the medication room. According to Det. Wrigley, the tape revealed that the licensee entered the med room at approximately 12:13 a.m. on June 26, 2007, went directly to the sink where he filled a small white bottle with tap water. He then threw something into the trash can and put a bottle into his pocket while walking out of the room. It was later determined that the bottle in the trash contained a clear liquid, most probably water, and no pink Morphine

On June 26, 2007, Det. Wrigley and other officers arrested Daniel Melland. Melland confessed to taking the Morphine and relinquished the remaining portion of that substance to Det. Wrigley. He then confessed to both being "sick" and diverting/drug switching at Gregory Wing Nursing Facility (Morphine replaced with water and added food coloring), Sea Brook Nursing Care Center (Oxyfast), Penobscot Nursing Home (4-6 Vicodin), Cummings Healthcare (Ativan and Morphine), Brewer Rehabilitation and Living Center (Morphine replaced with water and added food coloring), and Ross Manor (Vicodin). Daniel Melland also revealed a swollen area on his right arm where he had been injecting drugs and admitted that he was taking Seroquil which he had obtained from his brother.

### III.

### CONCLUSIONS OF LAW

The relevant statutory and regulatory provisions regarding the above matter and as stated in the Complaint/Notice of Hearing are as follows:

32 M.R.S.A. Sec. 2105-A.2. Grounds for discipline. The board may suspend or revoke a license pursuant to Title 5 section 10004. The following are grounds for an action to issue, modify, suspend, revoke or refuse to renew the license of an individual licensed under this chapter:

A. The practice of fraud or deceit in obtaining a license under this chapter or in connection with services rendered within the scope of the license issued. Nurse Melland was deceitful and practiced fraud by diverting drugs for his own use and failing to note same in the patients' records. His patients were relying on the diverted drugs for their treatment. The licensee also did not properly record the alleged disposal of certain medications.

B. Habitual substance abuse that has resulted or is foreseeably likely to result in the licensee performing services in a manner that endangers the health or safety of patients. Daniel Melland practiced nursing while under the influence of drugs.

E. Incompetence in the practice for which the licensee is licensed. A licensee is considered incompetent in the practice if the licensee has:

1. 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.
2. 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.

The facts found in this Decision support the conclusion that Daniel Melland is incompetent in his practice of nursing since he was not truthful about his reasons for ordering certain drugs for patients, did not truthfully record how some drugs were disposed of, and diverted drugs for his own purposes while depriving certain patients of their prescribed medicine. He substituted water and food coloring which was administered to some patients instead of their prescribed pain medication.

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.

The facts found in this Decision support the conclusion that Daniel Melland was unprofessional in his practice of nursing since he: stole Morphine and other drugs; did not properly dispose of wasted drugs; caused patient harm by not administering drugs to patients and caused altered drugs to be administered to patients. Moreover, he lied in his 2003 Consent Agreement by denying that he had diverted Vicodin from the Ross Manor facility.

H. A violation of this chapter or a rule adopted by the board, including "Rules and Regulations of the Maine State Board of Nursing, Chapter 4," Section:

1.A. Grounds for Discipline

(1) The practice of fraud or deceit in obtaining a license under this chapter or in connection with service rendered within the scope of the license issued. Daniel Melland did not administer or cause to be administered certain drugs to some patients who were relying on them while using those drugs for his own benefit.

2) Habitual intemperance in the use of alcohol or the habitual use of narcotic or hypnotic or other substances the use of which has resulted or may result in the licensee performing his duties in a manner which endangers the health or safety of his patients. (See above)

(5) Incompetence in the practice for which he is licensed. A licensee shall be deemed incompetent in the practice if the licensee has:

a. Engaged in conduct which 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

b. Engaged in conduct which evidences a lack of knowledge, or inability to apply principles or skills to carry out the practice for which he is licensed; (See above)

(6) Unprofessional conduct. A licensee shall be deemed to have engaged in unprofessional conduct if he violates any standard of professional behavior which has been established in the practice for which the licensee is licensed; (See above)

(8) Any violation of this chapter or any rule adopted by the Board of Nursing.

Chapter 4, Sections 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:

B. Assuming duties and responsibilities within the practice of nursing without adequate preparation or when competency has not been maintained; (See above)

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

K. Inaccurate recording, falsifying or altering a patient or health care provider record.

Nurse Melland did not record the diversion of drugs from their intended patients.

N. Practicing nursing when unfit to perform procedures and make decisions in accordance with the license held because of physical, psychological or mental impediment; (See above)

O. Practicing nursing when physical or mental ability to practice is impaired by alcohol or drugs; (See above)

P. Diverting drugs, supplies or property of patients or health care provider. (See above)

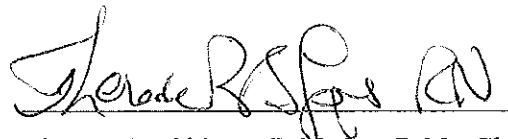
Q. Possessing, obtaining, furnishing or administering prescription drugs to any person, including self, except as directed by a person authorized by law to prescribe drugs. (See above)

#### IV. SANCTIONS

The Board, by a vote of 6-0, based on the above recited facts and its training and expertise, concluded that Daniel Melland, R.N., violated the above statutory and regulatory standards of nursing. The Board then voted 6-0 to effective immediately **REVOKE** Daniel Melland's license to practice as a registered nurse pursuant to 10 M.R.S.A. Sec. 8003. The Board further ordered him to pay the costs related to the hearing by November 15, 2007 which **total \$875**. (Hearing officer – 2 hours at the hearing, 3.0 hours to write decision @ \$115 per hour = \$575; Court reporter services = \$300. The check or money order shall be made payable to: Maine State Board of Nursing and mailed to Myra Broadway, J.D., M.S., R.N., Exec. Director, 158 State House Station, Augusta, Maine 04333-0158. Additional costs may be assessed in the event that Daniel Melland requests a transcript of the hearing. Costs shall be paid before the Board entertains any request by Daniel Melland for relicensure.

#### SO ORDERED.

Dated: August 16, 2007  
Signed by  
Chair  
August 29, 2007



Therese B. Shipps, D.N. Sc., R.N., Chairwoman  
Maine State Board of Nursing

V.

**APPEAL RIGHTS**

Pursuant to the provisions of 5 M.R.S.A. 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 they are aggrieved and the final agency action which they wish 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.