IN THE MATTER OF	*	**BEFORE THE MARYLAND**
TORREY BLOOMFIELD, RCP	*	**STATE BOARD OF**
Respondent	*	**PHYSICIANS**
License Number: L05422	*	**Case Number: 2016-0916A**

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ORDER FOR SUMMARY SUSPENSION OF LICENSE TO PRACTICE AS A RESPIRATORY CARE PRACTITIONER

Disciplinary Panel A of the Maryland State Board of Physicians (the "Board") hereby **SUMMARILY SUSPENDS** the license of Torrey Bloomfield, RCP (the "Respondent"), License Number L05422, to practice as a respiratory care practitioner in the State of Maryland. Disciplinary Panel A takes such action pursuant to its authority under Md. Code Ann., State Gov't § 10-226(c)(2)(i) (2014 Repl. Vol. & 2015 Supp.), concluding that the public health, safety, or welfare imperatively requires emergency action.

INVESTIGATIVE FINDINGS

Based on information received by, and made known to Disciplinary Panel A of the Board, and the investigatory information obtained by, received by and made known to and available to Disciplinary A and the Office of the Attorney General, including the instances described below, Disciplinary Panel A has reason to believe that the following facts are true:[1]

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[1] The statements regarding the Respondent's conduct are intended to provide the Respondent with notice of the basis of the suspension. They are not intended as, and do not necessarily represent a complete description of the evidence, either documentary or testimonial, to be offered against the Respondent in connection with this matter.

BACKGROUND

1. At all times relevant, the Respondent was licensed to practice as a respiratory care practitioner ("RCP") in the State of Maryland. The Respondent was initially licensed in Maryland on or about July 2, 2010, and her license is scheduled to expire on or about May 30, 2018.

2. At all times relevant, the Respondent was employed by Hospital A[2] in Baltimore, Maryland, as a Respiratory Therapist.

3. The Respondent was employed at Hospital A from July 12, 2010 through May 5, 2016, when Hospital A terminated her from employment for reasons set forth below.

4. On or about May 16, 2016, Hospital A filed a Mandated 10-Day Report (the "Report") with the Board notifying the Board the Respondent's employment had been terminated based on her diversion of intravenous ("IV") fentanyl, a Schedule II controlled dangerous substance ("CDS"), from a patient's IV bag.

5. After receiving notification of the Report, the Board initiated an investigation into the allegations.

6. The Board's investigation into the complaint as set forth below included issuing subpoenas to obtain the Respondent's personnel and fitness for duty files from Hospital A, obtaining treatment records, and conducting interviews of Hospital A's staff and the Respondent.

7. On or about July 6, 2016, the Board notified the Respondent of its investigation and requested a response.

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[2] In order to maintain confidentiality, facility, patient and employee names will not be used in this document, but will be provided to the Respondent on request.

8. On or about July 18, 2016, the Respondent submitted a written response to the Board, acknowledging that at 5:30 a.m. on April 23, 2016, after making patient rounds, while in the restroom at Hospital A, she injected fentanyl into her thigh, and "passed out," subsequently vomiting. A co-worker ("Employee A") located the Respondent in the restroom at the time she (the Respondent) was to have provided an end-of-shift Report.

INVESTIGATIVE FINDINGS

Hospital A

Prior History at Hospital A

9. On or about July 29, 2015, while on duty, between 3:00 a.m. and 4:00 a.m., the Respondent lost consciousness at work after she overdosed on CDS including oxycodone, morphine, fentanyl and Suboxone. She reportedly was being treated for pain for a medical condition, and took more medication than had been prescribed. The Respondent was evaluated by Hospital A's emergency room and treated with Narcan, a medication used to block the use of opioids. The Respondent was counseled not to take narcotics while at work, and that she should find "alternate medications."

Incident giving rise to termination from Hospital A

10. The incident giving rise to the Respondent's termination from Hospital A took place on or about April 23, 2016, when she was assigned to the Surgical Intensive Care Unit.

11. The Respondent was scheduled to work the night shift, which began on April 22, 2016 at 6:30 p.m. and ended on April 23, 2016, at 7:00 a.m.

12. At approximately 6:00 a.m. on April 23, 2016, two of the Respondent's co-workers, Employees A and B, attempted to locate the Respondent, who was missing from the unit. And subsequently, at 6:30 a.m., the Respondent was not present at shift report.

13. At approximately 6:55 a.m., Employee A located the Respondent in a toilet stall in the employee locker room. According to Employee A, the Respondent was "covered in vomit and there was a syringe on the floor." The Respondent's speech was slurred.

14. Employee A assisted the Respondent with cleaning and changing the Respondent's scrub suit, and based on the Respondent's condition, Employee A drove her to Employee A's residence. During the ride, the Respondent "confessed" to taking a bag of fentanyl from the unit.[3]

15. The Respondent told Employee A that she had injected the fentanyl into her thigh.

16. At Employee A's residence, Employee A searched the Respondent's bag, and found additional syringes filled with fluid.

17. According to Employee A, the Respondent represented that she would seek help from the Employee Assistance Program ("EAP") the next day. The Respondent did not report to the EAP, and instead proceeded to work additional shifts.

18. The incident was initially reported to the Director of Respiratory Therapy at Hospital A by Employee C on May 2, 2016.

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[3] Employee A subsequently reported the Respondent's conduct to Employee C, who reported it to the Director of Respiratory Care Services (the "Director").

19. On or about May 2, 2016, the Respondent's manager sent her for a Fitness for Duty Evaluation. The Director noted that the evaluation was based on the Respondent's disappearance from work, and complaints from other employees.

20. The Respondent's urine toxicology screen tested positive for naloxone (generic name for Narcan), fentanyl and buprenorphine (generic name for Suboxone).

21. On or about May 3, 2016, the Director conducted an investigation, and determined that "large volumes" of "drugs" had been missing from ICU units at Hospital A on six separate dates in April 2016 in which the Respondent had been on duty.

22. As a result of the Respondent's conduct, Hospital A terminated her from employment.

INVESTIGATIVE FINDINGS BY BOARD STAFF

September 13, 2016 Interview of Respondent

23. On September 13, 2016, Board staff interviewed the Respondent under oath.

24. The Respondent described the July 2015 incident at Hospital A as taking place during her shift at approximately 3:00 a.m. to 4:00 a.m. She was assigned to a trauma unit that night, and had ingested oxycodone, morphine, and had placed a fentanyl patch. She was not being prescribed the fentanyl any longer, but used a patch she had from a previous prescription, and reportedly had removed it before reporting for work.

25. According to the Respondent, her health condition during the beginning of 2016 necessitated that she was unable to perform her best at work, and often had to "call out."

26. The Respondent entered an outpatient treatment program in August 2015, following the July 2015 incident at Hospital A. She was undergoing treatment during the incident that gave rise to her termination.

27. The Respondent had been assigned approximately eight patients during the night shift of April 22/23, 2016.

28. The Respondent acknowledged that she had used fentanyl at work on April 2[3] at approximately 5:30 a.m. and that she had obtained it from an IV from one of her patients. At the time, she was being prescribed Suboxone, which is a medication prescribed for opioid dependence.

29. The Respondent due to her condition was not able to provide a verbal report to the day shift therapist; she provided her with her written notes from the night shift.

30. The Respondent stated during the interview that she only took the fentanyl from a patient on one occasion. The Respondent stated that she reported for additional shifts after the April 23, 2016 incident because she had been feeling better.

September 29, 2016 interview of Respondent

31. On September 29, 2016, the Respondent contacted Board staff by telephone, and was sworn in by Board staff. The Respondent's reason for the telephone call was to "give the whole truth."

32. The Respondent acknowledged that she had taken fentanyl from Hospital A on more than one occasion from a patient. She stated that this occurred during the latter part of April 2016, and it was on approximately four to five occasions.

33. The Respondent diverted the fentanyl from ports on sterile IV bags.

34. The Respondent stated that she had used the fentanyl she diverted on only one occasion, [on April 23, 2016]. The Respondent stated that other than the fentanyl she had used on April 23, 2016, she gave the fentanyl diverted on the other dates to a co-worker for the purpose of disposal.

CONCLUSION OF LAW

Based on the foregoing facts, the Board concludes that the public health, safety or welfare imperatively require emergency action in this case, pursuant to Md. Code Ann., State Gov't. § 10-226 (c)(2)(i) (2014 Repl. Vol. & 2015 Supp.).

ORDER

Based on the foregoing, it is:

ORDERED that pursuant to the authority vested by Md. Code Ann., State Gov't § 10-226(c)(2), the Respondent's license L05422 to practice as a respiratory care practitioner in the State of Maryland be and is hereby **SUMMARILY SUSPENDED**; and be it further

ORDERED that a post-deprivation hearing in accordance with Md. Code Regs. 10.32.02.08B(7)(c), D and E on the Summary Suspension, in which Panel A will determine whether the summary suspension will continue, has been scheduled for **November 2, 2016**, at **9:00 a.m.**, at the Maryland State Board of Physicians, 4201 Patterson Avenue, Baltimore, Maryland 21215-0095; and be it further

ORDERED that at the conclusion of the **SUMMARY SUSPENSION** hearing held before the Board, the Respondent, if dissatisfied with the result of the hearing, may request within ten (10) days an evidentiary hearing, such hearing to be held within thirty

(30) days of the request, before an Administrative Law Judge at the Office of Administrative Hearings, Administrative Law Building, 11101 Gilroy Road, Hunt Valley, Maryland 21031-1301; and be it further

ORDERED that on presentation of this Order, the Respondent **SHALL SURRENDER** to the Board's Compliance Analyst, the following items:

(1) the Respondent's original Maryland License **L05422**; and

(2) the Respondent's current renewal certificate; and be it further

ORDERED that a copy of this Order of Summary Suspension shall be filed with the Board in accordance with Md. Code Ann., Health Occ. § 14-407 (2014 Repl. Vol.& 2015 Supp.); and be it further

ORDERED that this is a Final Order of the Board and, as such, is a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., Gen. Prov. §§ 4–101 *et seq.*

10/18/2016
Date

Christine A. Farrelly
Christine A. Farrelly
Executive Director
Maryland State Board of Physicians