State of Vermont
Office of the Secretary of State

Office of Professional Regulation
89 Main Street, 3rd Floor
Montpelier, VT 05620-3402
sos.vermont.gov

James C. Condos, Secretary of State
Christopher D. Winters, Deputy Secretary
S. Lauren Hibbert, Director

September 13, 2022

Timothy Hammonds
50 Westerlo Street
Albany, NY 12202

Case: In Re Timothy Hammonds
Credential:
Docket No.: 2022-182

Dear Mr. Hammonds:

Enclosed, please find a *Default Order* in the matter captioned above. This is a final administrative determination.

If you are aggrieved by this decision, you may begin the appeal process by filing a Notice of Appeal with the Office of Professional Regulation. **The notice must be received no later than 30 days from the decision's date of entry** (see last page of order). Send the appeal to:

Office of Professional Regulation
Attn: S. Lauren Hibbert, Director
89 Main Street, 3rd Floor
Montpelier, VT 05620-3402

The appeal does not stop the disciplinary action from going into effect. If you wish to have the disciplinary action stayed during the appeals process, you must specifically request a stay in writing. Your request for a stay will be considered, and a decision to grant or deny your request will be issued. Please see the enclosed instructions.

If you have questions, please do not hesitate to contact the Office at (802) 828-2367.

Sincerely,

DocuSigned by:
S. Lauren Hibbert
9CDAB598B5C54EE...
S. Lauren Hibbert
Director

Enclosure: *Default Order*

cc: Michael Kupersmith, Hearing Officer
Ultan Doyle, Esq., Prosecuting Attorney
Kristin Donnelly, Case Manager
Timothy Hammonds, Respondent, First Class Mail, Certified Mail & Email

STATE OF VERMONT
SECRETARY OF STATE
OFFICE OF PROFESSIONAL REGULATION
BOARD OF NURSING

In re: Timothy Hammonds **Docket No. 2022-182**

DEFAULT ORDER

Appearances:

Prosecuting Attorney: Ultan Doyle, Esq.
Respondent: Did not appear

Hearing Officer: Michael S. Kupersmith, Esq.

Introduction

The Hearing Officer conducted a default hearing in the above-entitled matter on September 6, 2022 pursuant to 3 V.S.A. § 129(f). The hearing was conducted remotely as provided in the Emergency Rules for Remote Hearings adopted by the Office of Professional Regulation (OPR). The State requested a default order because the Respondent had not responded to the Specification of Charges filed in this case. The State was represented by Ultan Doyle, Esq. The Respondent did not appear and was not represented by counsel.

Findings of Fact

1. Respondent Timothy Hammonds of Albany, New York, is currently licensed as a Licensed Practical Nurse (LPN) by the State of New York under license number 283835. The license was originally issued on March 22, 2006 and expires on May 31, 2023. Respondent's New York license is in good standing, but he has not been granted a formal LPN license by the State of Vermont.
2. Act 6 and Act 91, emergency legislation passed in Vermont to provide health care regulatory flexibility during and after the COVID-19 pandemic, extended to out-of-state licensed health care workers, such as Respondent, the privilege to practice their licensed professions in the State of Vermont without formal licenses issued by OPR. These laws were in effect until March 31, 2022.
3. The Vermont State Board of Nursing (the "Board") has jurisdiction to investigate and adjudicate allegations of unprofessional conduct pursuant to 3 V.S.A. §129(a); 3 V.S.A. §129a; 3 V.S.A. §814(d); 26 V.S.A. Chapter 28; the

Administrative Rules of the Board of Nursing (the "ARBN"); and the Rules of the Office of Professional Regulation ("OPR"). The Board has jurisdiction over acts of misconduct by the Respondent within the State of Vermont even though he was not formally licensed in this State.

4. In 2021, Respondent was hired by Medical Solutions to work in Vermont as an LPN pursuant to Acts 6 and 91. Respondent worked through Medical Solutions at the Pines at Rutland Center for Nursing and Rehabilitation in Rutland, Vermont ("the Facility") from August 6, 2021 until he was terminated by the facility on December 1, 2021.
5. A Specification of Charges was filed by the Prosecuting Attorney on or about July 19, 2022. On July 20, 2022 date a copy of the Charges and Notice of Hearing was sent to the Respondent at the address which is on file with OPR, by certified mail and first class mail.
6. By notice sent with the Charges, Respondent was advised that he was required to file an Answer within 20 days. See Administrative Rules of Practice 3.3. As of the default hearing, the Respondent had failed to submit an Answer.
7. On August 30, 2022, the State filed a Motion for Default. On August 31, 2022, the motion as well as a notice of the default hearing were sent via certified mail and first class mail to the Respondent at the address on file with OPR. As of this date, no response to the Motion for Default has been received by either the Docket Clerk or the Prosecuting Attorney. Furthermore, no communication has been received by either office since the filing of the Specification of Charges.
8. Upon consideration of the State's presentation, and taking judicial notice of the OPR file in this matter, the Hearing Officer finds the Respondent to be in default. Pursuant to the Administrative Rules of Practice 3.4, the allegations made in the Specification of Charges are treated as proven and the Board may take disciplinary action based on its findings. See also 3 V.S.A. §§ 809(d) and 814(c). A copy of the Specification of Charges is appended to this Order.
9. It is specifically found that during the night of November 28 and 29, 2021, Respondent provided unsafe and unacceptable patient care by pre-pouring medications and leaving the keys to the Facility's medication cart unattended on the cart, and that consequently he was unable to account for a patient's missing narcotic medication.
10. It is the recommendation of the Prosecuting Attorney that because the Respondent is not now, and has not ever been licensed in the State of Vermont, that the Board order that a reprimand be placed on his record.

Conclusions of Law

Respondent has received adequate actual and/or constructive notice of the Charges in this matter as indicated by the Board's file and the Prosecutor's presentation. Because the Respondent has failed to file an Answer, the factual allegations contained in the Specification of Charge are taken as proven. Accordingly, the Board concludes that the Respondent engaged in unprofessional conduct as alleged, to wit: (1) failing to practice competently by reason of performance of unsafe and unacceptable patient care in violation of 3 V.S.A. § 129a(b)(1); and (2) failing to practice competently by reason of his failure to conform to the essential standards of acceptable and prevailing practice in violation of 3 V.S.A. § 129a(b)(2).

PROPOSED ORDER

In accordance with the Findings of Fact and Conclusions of Law set forth above, and consistent with the recommendations of the Prosecuting Attorney, the Board orders that the Respondent is hereby **REPRIMANDED.**

The Hearing Officer reports the above facts, conclusions of law, and finding of default to the Board with the recommendation that the Board approve them and enter the Order as above.

Dated this 8th day of September, 2022

Michael S. Kupersmith
Hearing Officer

The Board of Nursing considered the report of findings of fact and conclusions of law at its meeting on September 12, 2022. After considering the report, the Board takes the following action:

/ / Rejects the report and schedules the matter for hearing.
/ / Schedules the matter for additional evidence.
/ x / Accepts the report, adopts the findings of fact and conclusions of law, and orders the recommended discipline as set forth in the proposed order above.

SO ORDERED,

DocuSigned by:
Jennifer Laurent
EB1741915719477...

Board of Nursing
By: Jennifer Laurent, Chair

Date of Entry: 9/13/22

Appeal Rights

This is a final administrative determination by the Board of Nursing. A party aggrieved by a final decision by the Board may appeal this decision by filing a written Notice of Appeal with the Director of the Office of Professional Regulation, 89 Main Street, 3rd floor, Montpelier, VT 05620-3402, within 30 days of the date of entry of this order. If an appeal is filed, the Director of the Office of Professional Regulation shall assign the case to an Appellate Officer. The appeal shall be conducted based on the record created before the Board. In cases of alleged irregularities in procedure before the Board not shown on the record, proof of that issue may be taken by the Appellate Officer. 3 V.S.A. §§ 129(d) and 130a. A stay of this Order may also be requested.

STATE OF VERMONT
SECRETARY OF STATE
OFFICE OF PROFESSIONAL REGULATION
BOARD OF NURSING

IN RE:	)	
Timothy Hammonds	)	**Docket No. 2022-182**
	)	

SPECIFICATION OF CHARGES

NOW COMES the State of Vermont and makes the following Charges against the Respondent, Timothy Hammonds:

Board Authority

1. The Vermont State Board of Nursing (the "Board") has jurisdiction to investigate and adjudicate allegations of unprofessional conduct pursuant to 3 V.S.A. §129(a); 3 V.S.A. §129a; 3 V.S.A. §814(d); 26 V.S.A. Chapter 28**;** the Administrative Rules of the Board of Nursing (the "ARBN"); and the Rules of the Office of Professional Regulation ("OPR").

Statement of Facts

2. Timothy Hammonds ("Respondent") of Albany, New York is currently licensed by the State of New York as a Licensed Practical Nurse ("LPN") under license number 283835. This license was originally issued on March 22, 2006 and expires on May 31, 2023.

3. Respondent's New York LPN license is in good standing.

4. Respondent has not been granted a formal LPN license by the State of Vermont.

5. Act 6 and Act 91, emergency legislation passed in Vermont to provide health care regulatory flexibility during and after the COVID-19 pandemic, extended to out-of-state licensed health care workers, such as Respondent, the privilege to practice their licensed professions in the State of Vermont without formal licenses issued by OPR. This law was in effect until March 31, 2022.

6. In 2021, Respondent was hired by Medical Solutions to work in Vermont as an LPN pursuant to Acts 6.

7. Respondent worked through Medical Solutions at the Pines at Rutland Center for Nursing and Rehabilitation in Rutland, Vermont ("the Facility") from August 6, 2021 until he was terminated from the Facility on December 1, 2021.

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8. On November 28, 2021, Respondent worked the night shift (11:00pm to 7:00am) at the Facility.

9. One of the patients Respondent cared for that night was Patient H.H., who had a PRN order for Oxycodone 5mg.

10. On the morning of November 29, 2021, T.N., an RN at the Facility, who was taking over the next shift from Respondent, noticed that there was only four Oxycodone 5mg pills in the narcotic cart for Patient H.H. instead of five pills, as there had been for the past month that T.N. had cared for H.H.

11. T.N. questioned Respondent about the medication count, at which time Respondent became agitated.

12. S.S., an LPN at the Facility, said that she had been at the medication cart at 3:00pm on November 28, 2021, and that at that time, there were five Oxycodone pills on Patient H.H.'s card.

13. Patient H.H. told T.U., the Facility's administrator, that at approximately 2:00am on November 29, 2021, he requested an Oxycodone pill or Tylenol pill for pain in his leg.

14. Patient H.H. reported that Respondent said he could not have an Oxycodone pill or a Tylenol pill, but instead gave him what Respondent described as a "pain blocker."

15. The Medication Administration record ("MAR") showed that Respondent had administered some of Patient H.H.'s regularly scheduled medications during the night shift on November 28, 2021.

16. The MAR does not show that Patient H.H. was administered Oxycodone on November 28, 2021 or any other day since October 27, 2021.

17. On October 27, LPN, M.J., administered one Oxycodone 5mg pill to Patient H.H and noted with her signature in the Facility's narcotic logbook for Patient H.H. that the Oxycodone 5mg pill count went from six to five.

18. The last entry in the Facility's narcotic logbook for Patient H.H. showed that on October 28, 2021, the Oxycodone pill count changed from five to four, and that the pill was removed under a signature purporting to be that of M.J.

19. M.J. acknowledged that the signature from October 27, 2021 was hers, but said that the signature from October 28, 2021 was not hers. The signatures do not appear to be the same.

20. S.S. reported that it appeared that someone had started to write the date "11/28/21" in the narcotic logbook, but then changed it to "10/28/21."

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21. Respondent later was interviewed by OPR investigators and said he began his shift by doing a medication count with the out-going nurse, whose name he could not remember, and recalled that there was nothing out of ordinary.

22. Respondent indicated he "pre-poured" patient medications for overnight administration in order to get a head start on his shift, which he acknowledged was a mistake.

23. Respondent stated that he left the medication cart to use bathroom and left the medication keys on the cart, something which he did not realize until near the end of his shift due to fatigue he was experiencing that night.

24. Respondent said that Patient H.H.'s narcotic medication was the first in the locked narcotics box in the medication cart.

25. According to Respondent, he spent "significant time" away from the medication cart, while the keys were left there unattended, in order to use the bathroom and to help care for a patient.

26. Respondent indicated that at the end of his shift, at approximately 7:00am, he and T.N. did a medication count and that she noted that Patient H.H. had taken a narcotic in the past few days, which she said was not normal for him. According to Respondent, he asked T.N. if they should call a supervisor and she looked at the narcotic logbook and told him the count was good, at which time he handed the keys of the medication cart to her.

27. When investigators asked Respondent about administering a "pain blocker" to Patient H.H. during the night of November 28, 2021, Respondent said that he did not remember whether he had administered any medication to Patient H.H. that night. However, Respondent specifically said he never gave Patient H.H. anything that he would have to referred to as a "pain blocker."

28. Respondent denied taking the missing Oxycodone pill and said he thought that someone may have taken it from the locked narcotic box in the medication cart and then falsified the narcotic logbook.

29. Respondent also denied writing the entry from October 28, 2021 in the narcotics logbook.

30. Respondent told OPR investigators that he took responsibility for the medication cart and not having the keys for it with him for a period of time that night.

31. Respondent learned two days later that the Facility had reported a pill was missing and that his contract was being terminated.

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Violation One: 3 V.S.A. §129a(b)(1) Failure to practice competently by reason of any cause on a single occasion or on multiple occasions may constitute unprofessional conduct, whether actual injury to a client, patient, or customer has occurred. Failure to practice competently includes: (1) performance of unsafe or unacceptable patient or client care.

32. The State re-alleges and incorporates Paragraphs 2 through 31 above.

33. As an LPN, Respondent must provide safe and acceptable patient care.

34. Paragraphs 2 through 31 above demonstrate that Respondent provided unsafe and unacceptable patient care by pre-pouring medication and leaving the keys to the Facility's medication cart unattended on the cart, thereby resulting in his inability to account for Patient H.H.'s missing narcotic medication.

35. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent has committed unprofessional conduct in violation of 3 V.S.A. §129a(b)(1).

Violation Two: 3 V.S.A. § 129a(b)(2) Failure to practice competently by reason of any cause on a single occasion or on multiple occasions may constitute unprofessional conduct, whether actual injury to a client, patient, or customer has occurred. Failure to practice competently includes: (2) failure to conform to the essential standards of acceptable and prevailing practice.

36. The State re-alleges and incorporates Paragraphs 2 through 31 above.

37. Under Vermont law, an LPN must practice competently by conforming to the essential standards of acceptable and prevailing practice.

38. As an LPN, Respondent is subject to the standards of acceptable care and prevailing practice, which require an LPN to not pre-pour medication or leave a medication cart unattended with the keys accessible for anyone to use.

39. Paragraphs 2 through 31 above demonstrate that Respondent failed conform to the essential standards of acceptable and prevailing practice when he pre-poured medication and forgot that he had left the keys to the medication cart unattended on top of the cart.

40. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent committed unprofessional conduct in violation of 3 V.S.A. § 129a(b)(2).

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Relief Requested

WHEREFORE, the State of Vermont respectfully requests that the Board warn, reprimand, suspend, revoke, limit, condition, or otherwise discipline Respondent's Licensed Practical Nurse license.

DATED at Montpelier, Vermont this 19th day of July, 2022.

STATE OF VERMONT
SECRETARY OF STATE

By: Ultan Doyle

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