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

In re: ELIZABETH ROHR	}
Multistate License No. 213982	} Docket No. 2023-101
	}

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

Participating Board Members:
Jennifer Laurent, APRN
Matthew Choate, RN
William Floyd, RN
Jennifer Lyon, RN
Luana Tredwell, LPN
Daniel Coane, Public Member
Marcia Arend, RN, *ad hoc* member

Appearances:
Prosecuting the case: George L. Hasselbach, Esq.
Respondent: participated electronically and was represented by Edward G. Adrian, Esq.

Presiding Officer:
George K. Belcher

Exhibits:
State Exhibit 1: Three-page Incident Report
Respondent Exhibit A: two photos of Foil capped cup of saline
Respondent Exhibit B: photo of three plastic bottles

This matter came before the Board of Nursing on Specification of Charges dated 10 July 2023. The Respondent filed an answer on or about September 8, 2023. The hearing was held electronically on February 12, 2024, with the Attorneys, the Respondent, the witnesses and the Board members all participating by telephone or via electronic means pursuant to the Office of Professional Regulation Rules.

Findings of Fact

Based on the evidence presented at the hearing and the arguments of counsel, the Vermont Nursing Board finds as follows:

1. Respondent, of Russellville, Arkansas, is licensed as a Licensed Practical Nurse in Arkansas. She possesses a multistate license which was issued on March 11, 2021, and expires on April 30, 2024. The Respondent does not have a Vermont License. The

Respondent is subject to the regulatory authority of this Board. 3 V.S.A. §§ 129, 129a, 26 V.S.A. Chapter 28, the Administrative Rules of the Board of Nursing, and the Rules of the Office of Professional Regulation.

2. The Respondent participated in the hearing and there were no objections to notice.
3. The Respondent graduated from a nursing program in Arkansas in 2020. She worked at several Veteran's Administration facilities in Arkansas.
4. The Respondent worked at the Vermont Veteran's Home in Bennington, Vermont (the facility) for approximately one year.
5. On May 10, 2023, the Respondent was assigned to work at the facility with a patient whose treatment included a Peripherally Inserted Central Catheter which is also known as a PICC line. The PICC line is a method of providing long term fluid and medicine to the patient's vein. The PICC line needs routine flushing to keep it clear with sterile saline solution approved for intravenous use. If the PICC line is exposed to non-sterile substances or materials, there's a risk for sepsis, a severe infection. The Respondent flushed the patient's PICC line on May 10, 2023.
6. The patient with the PICC line who was treated by the Respondent was the only patient with a PICC line in the facility on May 10, 2023.
7. Anne Hatton was the day-shift Supervisor at the facility on May 10, 2023. She is a seven-year nurse and had supervisory responsibility at the facility. She was contacted by another nurse (LPN) who asked about the process for flushing a PICC line. In this discussion Nurse Hatton was told that the Respondent had flushed the PICC line using a process other than using a pre-sterilized, pre-packaged syringe and saline (which were available on the floor for the purpose of flushing a PICC line). Nurse Hatton contacted the Respondent by telephone on May 10, 2023, and inquired how the Respondent had flushed the PICC line. According to Nurse Hatton, she was told by the Respondent "...that she had gotten a cup of normal saline from the utility room on American Wing and drawn it up to make a flush." State Exhibit 1. Nurse Hatton then told the Respondent that the process used by the Respondent to flush the PICC line was not acceptable. Respondent was told where the sterile saline flushes were kept and that all the Respondent needed to do was call a supervisor.
8. Nurse Hatton testified that there are other ways to flush a PICC line than to use a sterile pre-packaged flushing kit, but that the Respondent did not use a proper method. One acceptable method would be to draw the saline from a sterile vial.
9. Nurse Hatton was not told by the Respondent that she had drawn the sterile solution from anything other than a saline cup.
10. Nurse Hatton reported her conversation with the Respondent to the charge nurse.
11. The Respondent testified at the hearing that she had, in fact, flushed the PICC line on May 10, 2023. At the time of the flushing, the Respondent could not find any pre-packaged saline syringes for flushing. Rather, she testified that she flushed the PICC line by using a sterile syringe, drawing saline from a plastic bottle and sterilizing the cap of the bottle with alcohol. The bottle of saline came from the supply closet in the facility and was similar to the bottles shown on Respondent's Exhibit B. The Respondent denied that she used saline from a cup. The Respondent testified that after she drew the saline from the bottle, she put a cap on the syringe, found another staff person to assist her with the patient, and then flushed the PICC line.
12. The Respondent had never flushed a PICC line at the facility before.

13. The Respondent did not contact a supervisor to find the sterile pre-packaged flushing kits or to learn the facility policy or practices regarding proper flushing of a PICC line.
14. The Respondent did not testify whether or not she consulted the practice manual for the facility regarding the procedure for flushing a PICC line.
15. The patient whose PICC line was flushed was unharmed.
16. The Respondent was discharged from the facility following the conversation between Nurse Hatton and the Respondent. The Respondent promptly notified her placement agency of the discharge and the reasons for the discharge. She continued to work for the agency.
17. The Board finds that the Respondent failed to safely flush the PICC line in accordance with proper and safe nursing practice. Her conduct was unsafe for the patient.
18. The failure of the Respondent to seek guidance or supervision regarding the location of the pre-packaged sterile flushing kits, and the facility practices regarding the procedure in question are of concern to the Board.

Conclusions of Law

1. The pleadings and evidence presented shows facts which justify a finding of unprofessional conduct by the Respondent and specifically violations of: 26 VSA Sec. 1582(a)(3) [Engaging in conduct of a character likely to deceive, defraud or harm the public]; 3 VSA Sec. 129a(b)(1) [Failure to practice competently including performance of unsafe or unacceptable patient or client care]; and 3 VSA Sec. 129a(b)(2) [Failure to practice competently due to failure to conform to the essential standards of acceptable and prevailing practice]. The Board finds these statutes were violated.
2. Pursuant to the findings and conclusions above, the Board does order as follows.

Order

The multistate licensure privilege of the Respondent is hereby REPRIMANDED.

SO ORDERED.

Vermont Board of Nursing

By: DocuSigned by: Jennifer Laurent EB17410167418477... Date: _____, 2024

Jennifer Laurent, APRN
Chair

OFFICE OF PROFESSIONAL REGULATION
DATE OF ENTRY: 2/20/24

APPEAL RIGHTS

This is a final administrative determination by the Vermont Board of Nursing or Director

of the Office of Professional Regulation. A party aggrieved by a final decision of a board or hearing authority may appeal this decision by filing a written Notice of Appeal with the Director of the Office of Professional Regulation, Vermont Secretary of State, 89 Main Street, Fl. 3, Montpelier, VT 05620-3402 within 30 days of the 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 review shall be conducted on the basis of the record created before the board. In cases of alleged irregularities in procedure before the board, not shown in the record, proof on that issue may be taken by the appellate officer. 3 V.S.A. §§ 129(d) and 130a.
https://www.nfpa.org/Codes-and-Standards/All-Codes-and-Standards/List-of-Codes-and-Standards

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

In re: Elizabeth Rohr	**)**	**Docket No. 2023-101**
Multistate License no. 213982	**)**	

SPECIFICATION OF CHARGES

NOW COMES the State of Vermont (the "State") and makes the following charges against LPN Elizabeth Rohr:

Board Authority

1. The Board has authority to issue warnings or reprimands; suspend, revoke, limit, or condition current licenses; or prevent the renewal of lapsed licenses if, after disciplinary hearing, the Board finds that the Respondent has engaged in unprofessional conduct. 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 Rules").

Statement of Facts

2. Elizabeth Rohr ("Respondent") of Russellville, Arkansas is licensed as a Licensed Practical Nurse ("LPN") in Arkansas (multistate license #213982) that was originally issued March 11, 2021 and expires on April 30, 2024. Respondent does not have a Vermont license.

3. At all times relevant to this matter, Respondent was employed as a travel LPN by Maxim Healthcare ("Employer"), a professional placement agency.

4. At all times relevant to this matter, Respondent was assigned by Employer to work as an LPN at the Vermont Veteran's Home in Bennington, Vermont ("the Facility").

5. On or about May 10, 2022, Respondent was working at the Facility.

6. On that occasion, Respondent provided care to a patient identified by the initials "B.R."

7. That care included Respondent flushing B.R.'s peripherally inserted central catheter ("PICC line") with saline.

8. To perform the PICC line flush, Respondent secured a cup of normal saline from the Facility's supply room, used a syringe to "draw up" the saline to make a flush, and administered the normal saline to flush B.R.'s PICC line.

9. Subsequently, another LPN employed by the Facility ("J.G.") sought the advice of the

STATE OF VERMONT

Prosecuting Attorney
Office of
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89 Main Street
3rd Floor
Montpelier, VT
05620-3402

Facility's Nurse Manager, identified by the initials "A.H." as to the proper procedure to flush a PICC line.

10. A.H. informed J.G. that administering a PICC line in this fashion was incorrect, and that the Facility had sterile flushes that should have been used.

11. A.H. also reported Respondent's actions to the Facility's Assistant Director of Nursing who instructed A.H. to gather more information about Respondent's actions.

12. A.H. spoke with Respondent regarding how she flushed B.R.'s PICC line.

13. During this conversation, Respondent told A.H. that instead of using a sterile flush to flush B.R.'s PICC line, Respondent used a cup of normal saline.

14. B.R. was unharmed.

15. The Facility terminated Respondent's contract immediately due to unsafe professional practice.

Violation One: 26 V.S.A. § 1582(a)(3) Engaging in conduct of a character likely to harm the public.

16. The State re-alleges and incorporates Paragraphs 2 through 15 above.

17. As an LPN, Respondent is required to refrain from engaging in conduct of a character likely to harm the public.

18. Paragraphs 2 through 15 demonstrate that Respondent engaged in conduct of a character likely to harm the public when she did not use the proper sterile flush to flush a patient's PICC line, but instead used a cup of normal saline to do so.

19. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent committed unprofessional conduct in violation of 26 V.S.A. § 1582(a)(3).

Violation Two: 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.

20. The State re-alleges and incorporates Paragraphs 2 through 15 above.

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

22. Paragraphs 2 through 15 above demonstrate that Respondent provided unsafe and unacceptable patient care by using the improper saline to perform a PICC line flush.

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23. 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 Three: 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.

24. The State re-alleges and incorporates Paragraphs 2 through 15 above.

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

26. As an LPN, Respondent is subject to the standards of acceptable care and prevailing practice, which require an LPN to use the proper sterile flushes to perform PICC line flushes.

27. Paragraphs 2 through 15 above demonstrate that Respondent failed conform to the essential standards of acceptable and prevailing practice when Respondent failed to use the proper sterile flushes to perform a PICC line flush, instead using a cup of normal saline to draw up said flush.

28. 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).

Relief Requested

WHEREFORE, the State of Vermont respectfully requests that the Board take adverse action against Respondent's multistate licensure privilege, such as revocation, suspension, probation, or any other action that affects her authorization to practice under a multistate licensure privilege, including a cease-and-desist action.

DATED at Montpelier, Vermont this 10 day of July, 2023.

STATE OF VERMONT
SECRETARY OF STATE

By: _____
George Lloyd Hasselback
State Prosecuting Attorney
Office of Professional Regulation
802.828.0350
george.hasselback@vermont.gov

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
89 Main Street
3rd Floor
Montpelier, VT
05620-3402