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

In re: JACQUELENE S. HOLCOMB	}
Vt. License No. 025.0135765	} Docket No. 2023-105
Multistate License No. LPN053124 (GA)	}

FINDINGS AND ORDER

Participating Board Members:
Matthew Choate, RN
Deborah Belcher, Public Member
Jennifer Laurent, APRN
Douglas Sutton, RN, *ad hoc*
Raequel Gordon, LPN
Marsha Arend, RN

Appearances:
Prosecuting the case: George Hasselback, Esq.
Respondent: did not participate or appear in the hearing; she was not represented

Presiding Officer:
George K. Belcher

Exhibits:
State Exhibit 1: North Dakota Cease and Desist Order
State Exhibit 2: Stipulation for Settlement of the North Dakota case
State Exhibit 3: Redacted Evaluation by Jeffrey Klopper, MD 6/6/23

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

This matter came before the Board of Nursing on Specification of Charges which are dated 8 February, 2024. The hearing was held electronically on August 12, 2024. Notice of the hearing was sent to the Respondent on March 8, 2024, by first class mail, certified mail and email. The Respondent filed an undated answer, but she did not appear at the hearing. During the hearing, the Respondent was sent the information by which she could log onto the hearing electronically, but she did not appear.

Findings of Fact

Based on the evidence presented at the hearing, the Vermont Nursing Board finds as follows:

1. Jacquelene Holcomb ("Respondent") of Carrollton, Georgia is licensed by the

State of Vermont as a Licensed Practical Nurse ("LPN") under license number 025.0135765. This license was originally issued on July 18, 2021and expired on January 31, 2024. Respondent also holds a multistate license issued by Georgia under the number LPN053124. This license was originally issued on December 20, 1995, and expires on March 31, 2025.

2. In January of 2023, Respondent was employed by LRS Healthcare of Omaha, Nebraska ("the Employer") and assigned to work at SMP Health-St. Raphael, in Valley City, North Dakota ("the Facility"). While working at the Facility, Respondent was responsible for the administration of medication to several patients, including those patients identified hereinafter as Patient A through Patient V inclusive. While working at the Facility on January 1, 2, and 3, 2023, Respondent made the following medication administration errors:

a. Respondent failed to administer to Resident A three medications: gabapentin, diltiazem, or furosemide;
b. Respondent signed off gabapentin as administered to Resident B, however, the medication was later found in its bubble pack;
c. Respondent signed off metoprolol as administered to Resident C, however, the medication was later found in its bubble pack;
d. Resident D's Ativan medication card was missing and was found in the shred bin and Respondent was the last person to sign out Ativan as administered. Respondent also signed off Resident D's duloxetine as administered; however, the medication was later found in its bubble pack;
e. Respondent signed off sertraline and quetiapine as administered to Resident E, however, the medications were later found in their respective bubble packs;
f. Respondent signed off Abilify, clonazepam, hydralazine, and Lipitor as administered to Resident F; however, the medications were later found in their respective bubble packs;
g. Respondent failed to administer to Resident G three medications: aripiprazole, mirtazapine, and gabapentin ;
h. Resident H was missing bubble pack cards for metoprolol, paliperidone, and prazosin and the cards were found in the shred bin. Respondent was the last person to sign out those medications as administered. Respondent also failed to give Resident H a dose of metoprolol;
i. Resident I was missing a bubble pack and dose of Tramadol, both of which were found in the shred bin. Respondent was the person who signed out the last dose of Tramadol;
j. Respondent signed off gabapentin and baclofen as administered to Resident J; however, the medications were later found in their respective bubble packs;
k. On January 3, 2022, Respondent failed to administer any 6:00 am or 7:00 AM medications; and some of the medication cards placed in the shred bin by Respondent still had medications in them.

While working at the Facility on January 6, 2023, Respondent made the following medication administration errors:

a. Respondent signed off buspirone and amlodipine as administered to Resident K; however, the medications were later found in their respective bubble packs;

b. Respondent signed off gabapentin as administered to Resident A, however, the medication was later found in its bubble pack;
c. Respondent signed off Seroquel and Zyprexa as administered to Resident L, however, the medications were later found in their respective bubble packs;
d. Respondent signed off gabapentin as administered to Resident B, however, the medication was later found in its bubble pack; and
e. Respondent signed off atorvastatin as administered to Resident M, however, the medication remained in its bubble pack.

On January 7, 2023, the Facility discovered that medication for three patients, to whom Respondent was providing care, was missing from bubble packs.

a. Resident G was missing omeprazole;
b. Resident K was missing esomeprazole; and
c. Resident N was missing quetiapine, pravastatin, memantine, and donepezil.

While working at the Facility on January 8, 2023, Respondent made the following medication administration errors:

a. Resident O's scheduled buspirone, hydrocodone, and torsemide were still in their respective bubble packs and were not administered by Respondent;
b. Resident P's scheduled prednisone and torsemide were still in their respective bubble packs and were not administered by Respondent;
c. One of Resident Q's two scheduled potassium medications remained in its bubble pack, yet both medications were signed off as administered by Respondent. Resident Q's scheduled coumadin was still in its bubble pack, yet it was signed off as administered by Respondent;
d. Resident R's scheduled warfarin was still in its bubble pack and was not administered by Respondent;
e. Respondent signed off ibuprofen and Seroquel as administered to Resident S; however, the medications were later found in their respective bubble packs; and
f. Resident S complained that she did not receive her morning medications from Respondent until 10:30 AM and when Respondent finally arrived to administer the morning medications, she was missing the following scheduled medications: calcium, Seroquel, and Tylenol. Resident S reported that she sent Respondent back to the medication cart twice before Respondent came back with the correct medications. Resident S also reported that Respondent forgot to administer her evening ibuprofen and Neurontin. The night nurse later found the Neurontin in its bubble pack.

While working at the Facility on January 8, 2023, Respondent also failed to complete the following treatments:

a. Resident Q's weight was not obtained;
b. Resident U's Accu-Chek was not completed; and
c. Resident O's and Resident V's wound treatments were not signed off. (See State Exhibit 2)

10. While working at the Facility on January 8, 2023, Respondent was trying to find a

particular patient to whom she was intending to administer medication that Respondent had in a cup in her hand.
11. A staff nurse at the Facility corrected Respondent, informing her that Respondent was not responsible for administering medication to this particular patient.
12. In response, instead of returning the medication to the medication cart, or otherwise properly disposing of it, Respondent threw the cup of medication away stating, "I guess I don't need those."
13. On January 8, 2023, Respondent did not administer Resident O's morning medications until after 2 p.m. and administered Resident O's 2 p.m. medications three hours late.
14. On January 9, 2023, Respondent was removed from the work schedule at the Facility due to the repeated medication errors.
15. The same day, the Facility's Director of Nursing ("the DON") contacted Respondent and asked Respondent to submit to a drug screen.
16. Based upon the above alleged facts, the North Dakota Board of Nursing ("the ND BOD") issued a Cease-and-Desist Order on March 20, 2023 that prohibited Respondent from practicing nursing in the State of North Dakota. On 5 April, 2024, the Respondent stipulated to the majority of the above facts and agreed to have an encumbered license in North Dakota subject to conditions.
17. On or about March 28, 2023, Vermont's OPR received an auto-notification of this discipline from the ND BOD.
18. The investigation of this matter by OPR was completed on or about July 6, 2023 Respondent's Vermont license was suspended and she was ordered to cease-and desist the practice of nursing in Vermont on or about August 23, 2023 by this Board's order.

Conclusions of Law

Violation One: The Respondent violated 3 V.S.A. Sec. 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.

Violation Two: The Respondent violated 3 V.S.A. Sec. 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.

Violation Three: The Respondent violated 3 V.S.A. Sec. 129a(a)(7) Willfully making or filing false reports or records in the practice of the profession.

The Cease and Desist Order from North Dakota (State Exhibit 1) and the Stipulation for Settlement from North Dakota (State Exhibit 2) called for the Respondent to file with the North

Dakota Board a chemical dependency evaluation and a mental health and physical evaluation in order to seek reinstatement of her North Dakota license. In a report from Dr. Jeffrey Klopper, MD, on 6/6/23, it was recommended that the Respondent have a "further evaluation" including neuro-psychological testing and a "work-up" with her medical doctor. None of these were shown to the Vermont Board as having been done. Accordingly, it was the view of the Vermont Board of Nursing that the Respondent's license should be indefinitely suspended until such time as she applied for reinstatement and provides evidence that the recommended and ordered evaluations have been successfully completed.

Order

1. The indefinite suspension of the Respondent's license is ordered until the Respondent petitions for reinstatement and the Board has reinstated her license.
2. The Respondent is ordered to cease and desist from any nursing practice in the State of Vermont until the Respondent successfully petitions for reinstatement of her Vermont nursing license.
3. Prior to seeking reinstatement, the Respondent shall petition for reinstatement. Within 45 days of petitioning for reinstatement the Respondent shall file with the Board a written evaluation which satisfies the terms of the North Dakota Cease and Desist Order and Stipulation for Settlement in North Dakota. The evaluation(s) must be accepted by the Vermont Board of Nursing. If reinstated, Respondent's license shall be conditioner pursuant to whatever terms are reasonable at the time of Respondent's reinstatement request taking into account the evaluation(s), the facts contained in this Order, and any other relevant factors at that time.

SO ORDERED.

Vermont Board of Nursing

By: Signed by: Jennifer Laurent EB17419157194477... Date: _____, 2024

Jennifer Laurent, APRN
Chair

OFFICE OF PROFESSIONAL REGULATION
DATE OF ENTRY: 8/26/24

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.

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BOARD OF NURSING

IN RE:	)	
Jacquelene S. Holcomb	)	**Docket No. 2023-105**
VT License No. 025.0135765	)	
Multistate License No. LPN053124 (GA)	)	

SPECIFICATION OF CHARGES

NOW COMES the State of Vermont and hereby makes the following charges against Respondent Jacquelene S. Holcomb:

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. Jacquelene Holcomb ("Respondent") of Carrollton, Georgia is licensed by the State of Vermont as a Licensed Practical Nurse ("LPN") under license number 025.0135765. This license was originally issued on July 18, 2021 and expired on January 31, 2024. Respondent also holds a multistate license issued by Georgia under the number LPN053124. This license was originally issued on December 20, 1995, and expires on March 31, 2025.

3. In January of 2023, Respondent was employed by LRS Healthcare of Omaha, Nebraska ("the Employer") and assigned to work at SMP Health-St. Raphael, in Valley City, North Dakota ("the Facility").

4. While working at the Facility, Respondent was responsible for the administration of medication to several patients, including those patients identified hereinafter as "Patient A" through "Patient V" inclusive.

5. While working at the Facility on January 1, 2, and 3, 2023, Respondent made the following medication administration errors:

   a. Respondent failed to administer to Resident A three medications: gabapentin, diltiazem, or furosemide;

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b. Respondent signed off gabapentin as administered to Resident B, however, the medication was later found in its bubble pack;

c. Respondent signed off metoprolol as administered to Resident C, however, the medication was later found in its bubble pack;

d. Resident D's Ativan medication card was missing and was found in the shred bin and Respondent was the last person to sign out Ativan as administered. Respondent also signed off Resident D's duloxetine as administered; however, the medication was later found in its bubble pack;

e. Respondent signed off sertraline and quetiapine as administered to Resident E; however, the medications were later found in their respective bubble packs;

f. Respondent signed off Abilify, clonazepam, hydralazine, and Lipitor as administered to Resident F; however, the medications were later found in their respective bubble packs;

g. Respondent failed to administer to Resident G three medications: aripiprazole, mirtazapine, and gabapentin;

h. Resident H was missing bubble pack cards for metoprolol, paliperidone, and prazosin and the cards were found in the shred bin. Respondent was the last person to sign out those medications as administered. Respondent also failed to give Resident H a dose of metoprolol;

i. Resident I was missing a bubble pack and dose of Tramadol, both of which were found in the shred bin. Respondent was the person who signed out the last dose of Tramadol;

j. Respondent signed off gabapentin and baclofen as administered to Resident J; however, the medications were later found in their respective bubble packs;

k. On January 3, 2022, Respondent failed to administer any 6:00 am or 7:00 am medications; and some of the medication cards placed in the shred bin by Respondent still had medications in them.

6. While working at the Facility on January 7, 2023, Respondent made the following medication administration errors:

a. Respondent signed off buspirone and amlodipine as administered to Resident K; however, the medications were later found in their respective bubble packs;

b. Respondent signed off gabapentin as administered to Resident A, however, the medication was later found in its bubble pack;

c. Respondent signed off Seroquel and Zyprexa as administered to Resident L, however, the medications were later found in their respective bubble packs;

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d. Respondent signed off gabapentin as administered to Resident B, however, the medication was later found in its bubble pack; and

e. Respondent signed off atorvastatin as administered to Resident M, however, the medication remained in its bubble pack.

7. On January 7, 2023, the Facility discovered that medication for three patients, to whom Respondent was providing care, was missing from bubble packs.

a. Resident G was missing omeprazole;

b. Resident K was missing esomeprazole; and

c. Resident N was missing quetiapine, pravastatin, memantine, and donepezil.

8. While working at the Facility on January 8, 2023, Respondent made the following medication administration errors:

a. Resident O's scheduled buspirone, hydrocodone, and torsemide were still in their respective bubble packs and were not administered by Respondent;

b. Resident P's scheduled prednisone and torsemide were still in their respective bubble packs and were not administered by Respondent;

c. One of Resident Q's two scheduled potassium medications remained in its bubble pack, yet both medications were signed off as administered by Respondent. Resident Q's scheduled coumadin was still in its bubble pack, yet it was signed off as administered by Respondent;

d. Resident R's scheduled warfarin was still in its bubble pack and was not administered by Respondent;

e. Respondent signed off ibuprofen and Seroquel as administered to Resident S; however, the medications were later found in their respective bubble packs; and

f. Resident S complained that she did not receive her morning medications from Respondent until 10:30 am., and when Respondent finally arrived to administer the morning medications, she was missing the following scheduled medications: calcium, Seroquel, and Tylenol. Resident S reported that she sent Respondent back to the medication cart twice before Respondent came back with the correct medications. Resident S also reported that Respondent forgot to administer her evening ibuprofen and Neurontin. The night nurse later found the Neurontin in its bubble pack.

9. While working at the Facility on January 8, 2023, Respondent also failed to complete the following treatments:

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a. Resident Q's weight was not obtained;

b. Resident U's Accu-Chek was not completed; and

c. Resident O's and Resident V's wound treatments were not signed off.

10. While working at the Facility on January 8, 2023, Respondent was trying to find a particular patient to whom she was intending to administer medication that Respondent had in a cup in her hand.

11. A staff nurse at the Facility corrected Respondent, informing her that Respondent was not responsible for administering medication to this particular patient.

12. In response, instead of returning the medication to the medication cart, or otherwise properly disposing of it, Respondent threw the cup of medication away stating, "I guess I don't need those."

13. On January 8, 2023, Respondent did not administer Resident O's morning medications until after 2 p.m. and administered Resident O's 2 p.m. medications three hours late.

14. On January 9, 2023, Respondent was removed from the work schedule at the Facility due to the repeated medication errors.

15. The same day, the Facility's Director of Nursing ("the DON") contacted Respondent and asked Respondent to submit to a drug screen.

16. Respondent initially agreed to, but then terminated the call.

17. The DON contacted the Employer and informed them that Respondent was required to take a drug screen and that Respondent's contract was terminated immediately due to her multiple medication administration errors and inability to perform tasks related to the job.

18. Based upon the above alleged facts, the North Dakota Board of Nursing ("the ND BOD") issued a Cease-and-Desist Order on March 20, 2023 that prohibited Respondent from practicing nursing in the State of North Dakota.

19. On or about March 28, 2023, OPR received an auto-notification of this discipline from the ND BOD.

20. The investigation of this matter by OPR was completed on or about July 6, 2023.

21. Respondent's Vermont license was suspended and she was ordered to cease-and-desist the practice of nursing in Vermont on or about August 23, 2023 by this Board's order.

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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.

22. The State re-alleges and incorporates Paragraphs 2 through 21 above.

23. Vermont law requires LPNs to practice competently by providing safe and acceptable patient care.

24. Paragraphs 2 through 21 above demonstrate that Respondent failed to provide safe and acceptable patient care when Respondent repeatedly failed to administer medication in incorrect dosages, administered medication outside of the scheduled time for administering medication, and failed to perform ordered procedures.

25. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because the 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.

26. The State re-alleges and incorporates Paragraphs 2 through 21 above.

27. The essential standards of acceptable and prevailing practice require that an LPN follow providers orders when dispensing and administering medication and accurately document patient records.

28. Paragraphs 2 through 21 above demonstrate that Respondent failed to conform to essential standards of acceptable and prevailing practice when Respondent repeatedly failed to administer and/or administered medication in incorrect dosages, administered medication outside of the scheduled time for administering medication, and failed to perform ordered procedures.

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

Violation Three: 3 V.S.A. §129a(a)(7) Willfully making or filing false reports or records in the practice of the profession.

30. The State re-alleges and incorporates Paragraphs 2 through 21 above.

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31. Vermont law prohibits LPNs to refrain from willfully making or filing false reports or records in the practice of their profession.

32. Paragraphs 2 through 21 above demonstrate that Respondent willfully made and filed false reports or records when she documented in medical records that medication had been administered, when in fact it had not, and when she documented that medical procedures had been performed, when in fact they had not.

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

Relief Requested

WHEREFORE, Respondent's license should be revoked, suspended, reprimanded, conditioned, or otherwise disciplined.

DATED at Montpelier, Vermont this 8th day of February, 2024.

STATE OF VERMONT
SECRETARY OF STATE

By: _____
George Lloyd Hasselback
Prosecuting Attorney
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