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

In re: Regina Long **Docket No. 2023-169**
License No. 025.0109584

DEFAULT ORDER

Appearances:
Prosecuting Attorney: Rachel Heath, 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 February 13, 2024 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 Rachel Heath, Esq. The Respondent did not appear and was not represented by counsel.

Findings of Fact

Since the Respondent failed to file an Answer to the Specification of Charges, "the allegations of the [specification of] charges will be treated as proven and disciplinary action will be taken.. . ." Rule 3.4, Vermont Administrative Rules of Practice. Accordingly, the following facts are deemed proven.

1. Regina Long ("Respondent") of Plattsburgh, New York is licensed by the State of Vermont as a Licensed Practical Nurse ("LPN") under license number 025.0109584. This license was originally issued on April 20, 2015 and expires on January 31, 2024.

2. During the relevant time, Respondent worked as an LPN at a health and rehabilitation facility ("Facility") in Berlin, Vermont.

3. Respondent worked as a traveling nurse at the facility from November 8, 2022 until the Facility terminated her contract early on April 3, 2023.

4. Respondent has worked as an LPN in various states for approximately 18 years.

5. During her time at the Facility, Respondent failed to correctly document PRN (as needed) medications.

6. At the Facility, narcotic PRN medications had to be signed out in the narcotic log and documented in a laptop as administered in the electronic medication administration record (MAR) along with a record of a pain assessment for the patient. Nurses were also required to record the effectiveness of the medication after administration.

7. Both the narcotic log and the laptop used for the MAR were located on the medication cart where nurses withdrew medications for the patients. Each nurse was assigned their own cart for the shift.

8. Failing to document medications as administered could result in patients receiving more medication than they had been prescribed. In addition, not documenting a patient's pain assessments or the effectiveness of a medication could hinder a treating providers' subsequent evaluation of the medication for effectiveness.

9. In an interview with an OPR investigator on April 19, 2023, Respondent stated that if a patient asked her for a PRN medication, she would give the patient that medication and sign the medication out in the narcotic log, regardless of when the last administration was.

10. Respondent further acknowledged that at times she would wait until the end of the shift to document in the narcotic log all the PRN medications she withdrew for a patient.

11. Respondent said she administered the medication to patients every time she documented withdrawing the medication, regardless of whether she ever documented such in the MAR.

Patient RD

12. Between January and March 2023, Patient RD had a prescription for one 10mg Oxycodone pill every four hours as needed.

13. On January 12, 2023, Respondent documented in the narcotic log withdrawing one 10mg pill of Oxycodone at 0530, 0800, 1200, 1600, and 2000. Respondent did not document administering the medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

14. Between 0530 and 0800 is only two and a half hours. If Respondent administered Oxycodone at these times, she would have administered the medication closer in time than prescribed.

15.On the same day, a different nurse documented in the narcotic log removing one 10mg Oxycodone pill at 0514 and documented administering this at 0515 in the MAR. If Respondent did in fact administer the medication at 0530, then Respondent would have administered more medication than permitted under the patient's prescription.

16. On January 18, 2023, Respondent documented in the narcotic log withdrawing one 10mg pill of Oxycodone at 1420, 1800, and 2200. Respondent did not document administering the medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

17. On January 21, 2023, Respondent documented in the narcotic log withdrawing one 10mg pill of Oxycodone at 0800, 1230, 1600, 1900, and 2300. Respondent did not document administering the medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

18. On January 22, 2023, Respondent documented in the narcotic log withdrawing one 10mg pill of Oxycodone at 0730, 1200, and 1600. Respondent did not document administering the medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

19. On January 23, 2023, Respondent documented in the narcotic log withdrawing one 10mg pill of Oxycodone at 1530, 1900, and 2300. Respondent did not document administering the medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

20. On February 9, 2023, Respondent documented in the narcotic log withdrawing one 10mg pill of Oxycodone at 1330, 1500, 1945, and 2245. Respondent did not document administering the medication in the MAR.

Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

21. Between 1330 and 1500 is only one and a half hours. If Respondent did administer the medication at these times, she would have administered the medication closer in time than prescribed.

22. On February 10, 2023, Respondent documented in the narcotic log withdrawing one 10mg pill of Oxycodone at 0930, 1200, 1600, 1901, and 2200. Respondent did not document administering the medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

23. Between 0930 and 1200 is only two and a half hours. Between 1600 and 1901 is three hours. Between 1901 and 2200 is three hours. If Respondent did administer the medication at these times, she would have administered the medication closer in time than what had been prescribed.

24. Moreover, by consistently administering the medication one hour earlier than ordered, she would have administered more medication than what had been prescribed to Patient RD.

25. On March 2, 2023, Respondent documented in the narcotic log withdrawing one 10mg pill of Oxycodone at 1800. Respondent did not document administering the medication in the MAR.

26. On March 5, 2023, Respondent documented in the narcotic log withdrawing one 10mg pill of Oxycodone at 0800, 1200, and 1600. Respondent did not document administering the medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

27. On March 10, 2023, Respondent documented in the narcotic log withdrawing one 10mg pill of Oxycodone at 0920. Respondent did not document administering the medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

28. Also on March 10, 203, Respondent began a new page in the narcotic log, even though there were five blank lines remaining. She documented on the new page that there were 108 pills transferred, however the prior page stated there were 110 pills left.

29. There was no documentation that accounted for the two missing pills.

30. On this new page, Respondent then documented withdrawing another pill at 1000, even though the prior page stated she withdrew a pill at 0920. Respondent did not document administering the medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

31. If Respondent did administer the medication at 0920 and 1000, she would have administered the medication much closer in time than what had been prescribed.

32. On March 12, 2023, Respondent documented in the narcotic log withdrawing one 10mg pill of Oxycodone at 1810 and 2030. Respondent did not document administering the medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

33. Between 1810 and 2030 is only two hours and 20 minutes. If Respondent did administer the medication at these times, she would have administered the medication closer in time than what had been prescribed.

34. On March 13, 2023, Respondent documented in the narcotic log withdrawing one 10mg pill of Oxycodone at 0245, 0430, 1450, 1800, and 2300. Respondent did not document administering the medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

35. Between 0245 and 0430 is only one hour and 45 minutes. If Respondent did administer the medication at these times, she would have administered the medication closer in time than what had been prescribed.

36. On March 14, 2023, Respondent documented in the narcotic log withdrawing one 10mg pill of Oxycodone at 2000. Respondent did not document administering the medication in the MAR.

37. On March 15, 2023, Respondent documented in the narcotic log withdrawing one 10mg pill of Oxycodone at 0010, 0400, 1800, and 2230. Respondent did not document administering the medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

38. On March 16, 2023, Respondent documented in the narcotic log withdrawing one 10mg pill of Oxycodone at 0200, 0400, 1540, 1900, and 2245.

Respondent did not document administering the medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

39. Between 0200 and 0400 is only two hours. If Respondent did administer the medication at these times, she would have administered the medication closer in time than what had been prescribed.

40. On March 20, 2023, Respondent documented in the narcotic log withdrawing one 10mg pill of Oxycodone four times and then crossed these four lines out. Next to each line she wrote, "Error."

41. Respondent then documented withdrawing one 10mg pill of Oxycodone at 1430, 1500, 1800, 2100, and 2345.

42. Also on March 20, 2023, another nurse documented withdrawing one 10mg pill at 1312 in the narcotic log and documented administering this pill in the MAR. If Respondent did administer a pill at 1430, she would have done so only one hour and 15 minutes after the patient last received the medication.

43. Moreover, between 1430 and 1500 is only 30 minutes. If Respondent did administer the medication at these times, she would have administered the medication much closer in time than prescribed.

44. Between 1500 and 1800, and between 1800 and 2100 is only three hours. By consistently administering the medication one hour earlier than ordered, she would have administered more medication than prescribed.

45. On the next page of the narcotic log, Respondent documented withdrawing two more pills on March 20, 2023. The times Respondent documented appear to be 1800 and 2200, which is inconsistent with the timing on the prior page. Respondent did not document administering the medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

46. If Respondent did in fact administer the seven pills she documented withdrawing in the narcotic log on March 20, 2023, she would have given the patient five more pills than prescribed.

47. On March 22, 2023, Respondent documented in the narcotic log withdrawing one 10mg pill of Oxycodone at 1700, 1945, and 2350. Respondent did not document administering the medication she withdrew. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

48. On March 23, 2023, Respondent documented in the narcotic log withdrawing one 10mg pill of Oxycodone at 0345, 0800, 1200, 1400, 1800, 2100, and 2300. Respondent did not document administering the medication she withdrew. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

49. Between 1200 and 1400, and between 2100 and 2300 is only two hours. If Respondent did administer the medication at these times, she would have administered the medication closer in time than prescribed.

Patient DM

50. In the month of January 2023, Patient DM had a prescription for one 5mg Oxycodone every 4 hours.

51. On January 27, 2023, although Respondent documented in the narcotic log and the MAR withdrawing and administering the medication within the time frame of the order, she also documented in the narcotic log an additional administration of this medication outside of the order at 2200. Respondent did not document administering this additional pill in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

Patient GD

52. In February and March of 2023, Patient GD had a prescription for one 5mg Oxycodone pill every 4 hours as needed for fracture pain.

53. On February 19, 2023, Respondent documented withdrawing one 5mg Oxycodone pill at 1645 and 2025. Respondent did not document administering these medications in the MAR. Another nurse documented administering one 5mg Oxycodone pill at 2000 in the MAR, however, this nurse never documented withdrawing this medication from the narcotic log.

54. On February 20, 2023, Respondent documented withdrawing one 5mg Oxycodone pill at 0045 and 0600. Respondent did not document administering this medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

55. On February 21, 2023, Respondent documented withdrawing one 5mg Oxycodone pill at 0130, 1130, and 1530. Respondent did not document administering this medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

56. On March 2, 2023, Respondent documented in the narcotic log that she withdrew one 5mg Oxycodone pill at 1400. She crossed this out and wrote "ERROR" next to her entry. The order was for every four hours, the other two entries on the narcotic log, which are documented in the MAR, were for 1100 and 1600.

57. Respondent did not document what happened to the pill she withdrew at 1400. There is no documentation that she wasted this pill.

58. On March 5, 2023, Respondent documented withdrawing one 5mg Oxycodone pill at 1030, which she documented as administered in the MAR.

59. The next time on the narcotic log is illegible; Respondent wrote that there were 100 pills on hand, that she used one, and that 98 remained.

60. In the next entry, Respondent wrote the time as 1800, that there were 98 pills left and that she used one, and there were 97 left. Respondent crossed this line out, wrote "error" across the bottom of page and began a new page in the narcotic log, even though most of the page was blank.

61. On the new page, Respondent wrote the time as 1600 and then "transfer" and under number of pills left, she wrote 97. In the next line, Respondent wrote that at 1700, there were 97 pills on hand, she used one pill, and there remained 96 pills.

62. In the MAR, Respondent documented administering the medication at 1100 and 1600, as required by the order. While this accounts for two of the pills she withdrew, three remain unaccounted for and had they been administered to the patient, the patient would have received more medication than prescribed.

Patient LL

63. From January 2023 to February 14, 2023, Patient LL had a prescription for one 5mg Oxycodone pill every 4 hours as needed for moderate to severe pain.

64. On January 7, 2023, Respondent documented in the narcotic log that she withdrew one 5mg Oxycodone pill at 1645. Respondent did not document administering this medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

65. On January 8, 2023, Respondent documented in the narcotic log that she withdrew one 5mg Oxycodone pill at 1900 and 2300. Respondent did not document administering this medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

66. On January 19, 2023, Respondent documented in the narcotic log that she withdrew one 5mg Oxycodone pill at 1745 and 2150. Respondent did not document administering this medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

67. On January 27, 2023, Respondent documented in the narcotic log that she withdrew two 5mg Oxycodone pills at 0730, 1045, 1300, 1700, and 1900. Respondent did not document administering this medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

68. The order only permitted the patient to receive one 5 mg pill every four hours and yet Respondent documented withdrawing two pills each time.

69. In addition, between 1045 and 1300 is only two hours and 15 minutes. Between 1700 and 1900 is only two hours. If Respondent did administer the medications at these times, she would have administered more medication than prescribed.

70. On February 1, 2023, Respondent documented in the narcotic log that she withdrew one 5mg Oxycodone pill at 0800, 1230, 1700, 2130, and 2300. Respondent did not document administering this medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

71. Between 2130 and 2300 is only one and half hours. If Respondent did administer the medication at these times, she would have administered more medication than prescribed.

72. On February 3, 2023, Respondent documented in the narcotic log that she withdrew one 5mg Oxycodone pill at 1600 and 2000. Respondent did not document administering this medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

73. On February 4, 2023, Respondent documented in the narcotic log that she withdrew one 5mg Oxycodone pill at 0745, 1200, and 1530. Respondent did not document administering this medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

74. On February 14, 2023, Patient LL's order changed to one 5mg Oxycodone tablet two times a day for chronic pain.

75. On February 18, 2023, Respondent documented in the narcotic log that she withdrew one 5mg Oxycodone pill at 0900 and 1400. Although Respondent documented in the MAR administering the medication at 0800, she did not document administering the medication at 1400.

76. Moreover, the next nurse on duty administered to the patient another 5mg pill at 1930.

77. On February 19, 2023 and February 20, 2023, Respondent documented in the narcotic log that she withdrew one 5mg Oxycodone pill at 2345 and 0358, respectively. Respondent did not document administering this medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

78. On February 20, 2023, Respondent began a new page in the narcotic log for Patient LL. The last entry on the prior page documented 152 5mg Oxycodone pills remaining, but Respondent began the next page with 150 5mg Oxycodone pills. There is no documentation accounting for these two missing pills.

79. Also on February 20, 2023, Respondent documented in the narcotic log that she withdrew one 5mg pill at 1400 and 2000. Respondent documented in the MAR administering the medication at 1930, but she did not document administering the medication at 1400. Moreover, the order called for Patient LL to be given one 5mg Oxycodone pill two times a day at 0800 and 1930.

Patient EC

80. In March, Patient EC had a prescription for one 5mg Oxycodone pill every four hours as needed for pain.

81. On March 17, 2023 at 2300, March 18, 2023 at 2110, and March 19, 2023 at 0000 and 0200 Respondent documented in the narcotic log that she withdrew one 5mg Oxycodone pill. Respondent did not document administering this medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

82. Moreover, between 0000 and 0200 is only two hours. If Respondent did administer the medication at these times, she would have administered the medication closer in time than prescribed.

83. In February and March, Patient EC had a prescription for one 5mg Oxycodone pill every six hours as needed for knee pain.

84. In February, various nurses in the facility documented in the narcotic log withdrawing 25 pills of Oxycodone. However, there are only 10 instances in which a nurse also documented administering this medication in the MAR.

85. Respondent accounts for nine of the times Oxycodone pills were withdrawn in the narcotic log but not documented as administered in the MAR.

86. Of the nine pills Respondent withdrew, five were withdrawn fewer than six hours from the prior withdrawal.

87. Between March 1 and March 15, various nurses in the facility documented withdrawing 31 pills in the narcotic log. In contrast, there were only two instances in which a nurse documented administering this medication to Patient EC in the MAR.

88. Respondent accounted for 16 of the times a pill was withdrawn from the narcotic log and not documented as administered in the MAR. In contrast, Respondent only documented administering the medication one time on March 19 in the MAR.

89. Of the pills Respondent withdrew, seven of these pills were documented as having been withdrawn fewer than six hours from the prior withdrawal.

Patient MA

90. In January 2023, Patient MA had a prescription for one 5mg Oxycodone pill every eight hours as needed for pain.

91. On four occasions, Respondent documented withdrawing the medication in the narcotic log, but did not document administering the medication in the MAR. These times were: March 3, 2023 at 1500 and 2200; March 7, 2023 at 2100; and March 8 at 2100. Violation One: 3 V.S.A. § 129a(b)(2)

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 Charges are taken as proven. Accordingly, the Board concludes that the Respondent engaged in unprofessional conduct as alleged, to wit:

1. Violation of 3 V.S.A. § 129a(b)(2).

Respondent failed to practice competently by reason of any cause on multiple occasions whether actual injury to a patient occurred. Failure to practice competently includes: (2) failure to conform to the essential standards of acceptable and prevailing practice. The essential standards of acceptable and prevailing practice require that an LPN accurately document administering narcotics.

2. Violation of 3 V.S.A. § 129a(a)(13).
   Respondent performed treatments or provided services that she was not qualified to perform or that were beyond the scope of the her education, training, capabilities, experience, or scope of practice. Respondent practiced outside of her scope by deliberately providing more medication to patients whenever they asked for the medication regardless of when the last dose was administered instead of contacting the patient's treating provider to inform them of the patient's need for additional medication.

3. Violation of 3 V.S.A §129a(b)(1).
   Respondent failed to practice competently by reason of any cause on multiple occasions whether actual injury to a patient occurred. Failure to practice competently includes: (1) performance of unsafe or unacceptable patient or client care. Respondent provided unsafe and unacceptable patient care by failing to document administration of narcotic medications in the MAR, withdrawing medications more often than prescribed, and failing to document a patient's pain prior to and after administration.

4. Violation of 26 V.S.A. § 1582(a)(3).
   Respondent engaged in conduct of a character likely to deceive, defraud, or harm the public by failing to document administrating narcotic medications in the MAR, withdrawing medications more often than prescribed, incorrectly accounting for medications, and administering medications without documenting a patient's pain prior to and after administration.

5. Violation of 3 V.S.A. § 129a(a)(15)
   Respondent failed to exercise independent professional judgment in the performance of licensed activities when that judgment is necessary to avoid action repugnant to the profession by failing to document administrating narcotic medications in the MAR, withdrawing medications more often than prescribed, incorrectly accounting for medications, and administering medications without documenting a patient's pain prior to and after administration.

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's license be **SUSPENDED INDEFINITELY,** subject to the following conditions.

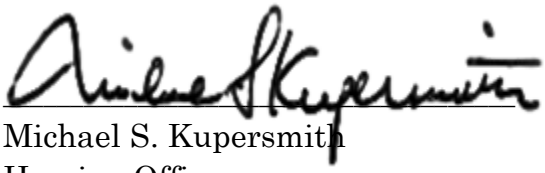
1. Respondent must petition for reinstatement. No sooner than forty-five (45) days prior to requesting reinstatement,
   Respondent must, at her own cost:
   a. Required Coursework. Respondent shall complete 12 hours of preapproved courses, which must include the following topics: medication administration and documentation. For pre-approval, Respondent must submit to the Case Manager the name of each course, the name of the sponsoring organization, and a description of the course content and/or syllabus. Respondent must achieve a passing score on the post-tests for the courses, and submit test results, workbooks completed in full and in a satisfactory manner, and certificates of completion to the Office of Professional Regulation.
   b. The coursework may not be counted toward any continuing education requirement of licensure.
2. If reinstated, Respondent's license SHALL BE CONDITIONED pursuant to the following terms and whatever additional terms are reasonable at the time of Respondent's reinstatement request, taking into account the State's Specification of Charges and the Default Order:
   a. Reports from Employers/Program Director. Within one (1) month of the date of reinstatement or within one (1) month of the commencement of employment in the profession and monthly thereafter, Respondent shall cause every nursing employer Respondent has worked for during the month to submit to the Case Manager an evaluation of Respondent's work performance and attendance during that month. In the event Respondent is attending an educational program in the profession, Respondent shall cause the Program Director to submit to the Case Manager, on a monthly basis, a written evaluation of Respondent's performance and attendance. These reports shall be submitted in writing on forms issued by the Case Manager. All employer reports shall indicate satisfactory performance (i.e. consistently meeting all standards of practice of the profession) and attendance.
   b. Practice Under Supervision. Respondent shall practice as an LPN only in a setting where Respondent is supervised for the entire shift by an LPN or RN. The level of supervision required is On-Site Supervision. On-Site Supervision means the supervising nurse is present in the same facility as Respondent.

c. Types of Employment Prohibited. Respondent shall not work in a supervisory role. Respondent shall not work for a nurse registry, traveling nurse agency, float-pool, temporary nursing employment agency, or as a home health, private duty nurse or personal care provider requiring a nursing license during the effective period of this Consent Order.

d. Administration of Medications. Respondent is prohibited from handling, managing, or administering any controlled substances. This condition may be removed only by Respondent filing a petition for modification after Respondent has worked as an LPN for six (6) months for at least forty (40) hours every two weeks (or the part-time equivalent) after the date of resuming nursing practice. The State shall consent or object to any such petition, and a hearing may be held. In any such petition, Respondent must demonstrate, to the satisfaction of the Board, that Respondent can safely and competently administer such medications. Respondent must include support from Respondent's treating professional and employer or educational program administrator and a description of the documentation and inventory control procedures in place.

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 13th day of February 2024



Michael S. Kupersmith
Hearing Officer

The Board of Nursing considered the report of findings of fact and conclusions of law at its meeting on March 11, 2024. 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 proposed discipline as set forth in the proposed order above.

/ / Accepts the report, adopts the findings of fact and conclusions of law, rejects the recommended sanction, and schedules the matter for additional hearing on sanctions.

SO ORDERED,

DocuSigned by:
Jennifer Laurent
EB1741915719477...
Board of Nursing
By: Jennifer Laurent, Chair

Date of Entry: 3/12/24

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:	**)**	
REGINA LONG	**)**	**Docket No. 2023- 169**
License No. 025.0109584	**)**	

SPECIFICATION OF CHARGES

NOW COMES the State of Vermont and makes the following charges against Licensed Practical Nurse Regina Long:

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. Regina Long ("Respondent") of Plattsburgh, New York is licensed by the State of Vermont as a Licensed Practical Nurse ("LPN") under license number 025.0109584. This license was originally issued on April 20, 2015 and expires on January 31, 2024.

3. During the relevant time, Respondent worked as an LPN at a health and rehabilitation facility ("Facility") in Berlin, Vermont.

4. Respondent worked as a traveling nurse at the facility from November 8, 2022 until the Facility terminated her contract early on April 3, 2023.

5. Respondent has worked as an LPN in various states for approximately 18 years.

6. During her time at the Facility, Respondent failed to correctly document PRN (as needed) medications.

7. At the Facility, narcotic PRN medications had to be signed out in the narcotic log and documented in a laptop as administered in the electronic medication administration record (MAR) along with a record of a pain assessment for the patient. Nurses were also required to record the effectiveness of the medication after administration.

STATE OF VERMONT

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

8. Both the narcotic log and the laptop used for the MAR were located on the medication cart where nurses withdrew medications for the patients. Each nurse was assigned their own cart for the shift.

9. Failing to document medications as administered could result in patients receiving more medication than they had been prescribed. In addition, not documenting a patient's pain assessments or the effectiveness of a medication could hinder a treating providers' subsequent evaluation of the medication for effectiveness.

10. In an interview with an OPR investigator on April 19, 2023, Respondent stated that if a patient asked her for a PRN medication, she would give the patient that medication and sign the medication out in the narcotic log, regardless of when the last administration was.

11. Respondent further acknowledged that at times she would wait until the end of the shift to document in the narcotic log all the PRN medications she withdrew for a patient.

12. Respondent said she administered the medication to patients every time she documented withdrawing the medication, regardless of whether she ever documented such in the MAR.

Patient RD

13. Between January and March 2023, Patient RD had a prescription for one 10mg Oxycodone pill every four hours as needed.

14. On January 12, 2023, Respondent documented in the narcotic log withdrawing one 10mg pill of Oxycodone at 0530, 0800, 1200, 1600, and 2000. Respondent did not document administering the medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

15. Between 0530 and 0800 is only two and a half hours. If Respondent administered Oxycodone at these times, she would have administered the medication closer in time than prescribed.

16. On the same day, a different nurse documented in the narcotic log removing one 10mg Oxycodone pill at 0514 and documented administering this at 0515 in the MAR. If Respondent did in fact administer the medication at 0530, then Respondent would have administered more medication than permitted under the patient's prescription.

17. On January 18, 2023, Respondent documented in the narcotic log withdrawing one 10mg pill of Oxycodone at 1420, 1800, and 2200. Respondent did not document administering the medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

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18. On January 21, 2023, Respondent documented in the narcotic log withdrawing one 10mg pill of Oxycodone at 0800, 1230, 1600, 1900, and 2300. Respondent did not document administering the medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

19. On January 22, 2023, Respondent documented in the narcotic log withdrawing one 10mg pill of Oxycodone at 0730, 1200, and 1600. Respondent did not document administering the medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

20. On January 23, 2023, Respondent documented in the narcotic log withdrawing one 10mg pill of Oxycodone at 1530, 1900, and 2300. Respondent did not document administering the medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

21. On February 9, 2023, Respondent documented in the narcotic log withdrawing one 10mg pill of Oxycodone at 1330, 1500, 1945, and 2245. Respondent did not document administering the medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

22. Between 1330 and 1500 is only one and a half hours. If Respondent did administer the medication at these times, she would have administered the medication closer in time than prescribed.

23. On February 10, 2023, Respondent documented in the narcotic log withdrawing one 10mg pill of Oxycodone at 0930, 1200, 1600, 1901, and 2200. Respondent did not document administering the medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

24. Between 0930 and 1200 is only two and a half hours. Between 1600 and 1901 is three hours. Between 1901 and 2200 is three hours. If Respondent did administer the medication at these times, she would have administered the medication closer in time than what had been prescribed.

25. Moreover, by consistently administering the medication one hour earlier than ordered, she would have administered more medication than what had been prescribed to Patient RD.

26. On March 2, 2023, Respondent documented in the narcotic log withdrawing one 10mg pill of Oxycodone at 1800. Respondent did not document administering the medication in the MAR.

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27. On March 5, 2023, Respondent documented in the narcotic log withdrawing one 10mg pill of Oxycodone at 0800, 1200, and 1600. Respondent did not document administering the medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

28. On March 10, 2023, Respondent documented in the narcotic log withdrawing one 10mg pill of Oxycodone at 0920. Respondent did not document administering the medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

29. Also on March 10, 203, Respondent began a new page in the narcotic log, even though there were five blank lines remaining. She documented on the new page that there were 108 pills transferred, however the prior page stated there were 110 pills left.

30. There was no documentation that accounted for the two missing pills.

31. On this new page, Respondent then documented withdrawing another pill at 1000, even though the prior page stated she withdrew a pill at 0920. Respondent did not document administering the medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

32. If Respondent did administer the medication at 0920 and 1000, she would have administered the medication much closer in time than what had been prescribed.

33. On March 12, 2023, Respondent documented in the narcotic log withdrawing one 10mg pill of Oxycodone at 1810 and 2030. Respondent did not document administering the medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

34. Between 1810 and 2030 is only two hours and 20 minutes. If Respondent did administer the medication at these times, she would have administered the medication closer in time than what had been prescribed.

35. On March 13, 2023, Respondent documented in the narcotic log withdrawing one 10mg pill of Oxycodone at 0245, 0430, 1450, 1800, and 2300. Respondent did not document administering the medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

36. Between 0245 and 0430 is only one hour and 45 minutes. If Respondent did administer the medication at these times, she would have administered the medication closer in time than what had been prescribed.

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37. On March 14, 2023, Respondent documented in the narcotic log withdrawing one 10mg pill of Oxycodone at 2000. Respondent did not document administering the medication in the MAR.

38. On March 15, 2023, Respondent documented in the narcotic log withdrawing one 10mg pill of Oxycodone at 0010, 0400, 1800, and 2230. Respondent did not document administering the medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

39. On March 16, 2023, Respondent documented in the narcotic log withdrawing one 10mg pill of Oxycodone at 0200, 0400, 1540, 1900, and 2245. Respondent did not document administering the medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

40. Between 0200 and 0400 is only two hours. If Respondent did administer the medication at these times, she would have administered the medication closer in time than what had been prescribed.

41. On March 20, 2023, Respondent documented in the narcotic log withdrawing one 10mg pill of Oxycodone four times and then crossed these four lines out. Next to each line she wrote, "Error."

42. Respondent then documented withdrawing one 10mg pill of Oxycodone at 1430, 1500, 1800, 2100, and 2345.

43. Also on March 20, 2023, another nurse documented withdrawing one 10mg pill at 1312 in the narcotic log and documented administering this pill in the MAR. If Respondent did administer a pill at 1430, she would have done so only one hour and 15 minutes after the patient last received the medication.

44. Moreover, between 1430 and 1500 is only 30 minutes. If Respondent did administer the medication at these times, she would have administered the medication much closer in time than prescribed.

45. Between 1500 and 1800, and between 1800 and 2100 is only three hours. By consistently administering the medication one hour earlier than ordered, she would have administered more medication than prescribed.

46. On the next page of the narcotic log, Respondent documented withdrawing two more pills on March 20, 2023. The times Respondent documented appear to be 1800 and 2200, which is inconsistent with the timing on the prior page. Respondent did not document administering the medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

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47. If Respondent did in fact administer the seven pills she documented withdrawing in the narcotic log on March 20, 2023, she would have given the patient five more pills than prescribed.

48. On March 22, 2023, Respondent documented in the narcotic log withdrawing one 10mg pill of Oxycodone at 1700, 1945, and 2350. Respondent did not document administering the medication she withdrew. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

49. On March 23, 2023, Respondent documented in the narcotic log withdrawing one 10mg pill of Oxycodone at 0345, 0800, 1200, 1400, 1800, 2100, and 2300. Respondent did not document administering the medication she withdrew. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

50. Between 1200 and 1400, and between 2100 and 2300 is only two hours. If Respondent did administer the medication at these times, she would have administered the medication closer in time than prescribed.

Patient DM

51. In the month of January 2023, Patient DM had a prescription for one 5mg Oxycodone every 4 hours.

52. On January 27, 2023, although Respondent documented in the narcotic log and the MAR withdrawing and administering the medication within the time frame of the order, she also documented in the narcotic log an additional administration of this medication outside of the order at 2200. Respondent did not document administering this additional pill in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

Patient GD

53. In February and March of 2023, Patient GD had a prescription for one 5mg Oxycodone pill every 4 hours as needed for fracture pain.

54. On February 19, 2023, Respondent documented withdrawing one 5mg Oxycodone pill at 1645 and 2025. Respondent did not document administering these medications in the MAR. Another nurse documented administering one 5mg Oxycodone pill at 2000 in the MAR, however, this nurse never documented withdrawing this medication from the narcotic log.

55. On February 20, 2023, Respondent documented withdrawing one 5mg Oxycodone pill at 0045 and 0600. Respondent did not document administering this medication in the MAR. Therefore, Respondent also did not document a pain

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assessment prior to administering the medication or the effectiveness of the medication after administration.

56. On February 21, 2023, Respondent documented withdrawing one 5mg Oxycodone pill at 0130, 1130, and 1530. Respondent did not document administering this medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

57. On March 2, 2023, Respondent documented in the narcotic log that she withdrew one 5mg Oxycodone pill at 1400. She crossed this out and wrote "ERROR" next to her entry. The order was for every four hours, the other two entries on the narcotic log, which are documented in the MAR, were for 1100 and 1600.

58. Respondent did not document what happened to the pill she withdrew at 1400. There is no documentation that she wasted this pill.

59. On March 5, 2023, Respondent documented withdrawing one 5mg Oxycodone pill at 1030, which she documented as administered in the MAR.

60. The next time on the narcotic log is illegible; Respondent wrote that there were 100 pills on hand, that she used one, and that 98 remained.

61. In the next entry, Respondent wrote the time as 1800, that there were 98 pills left and that she used one, and there were 97 left. Respondent crossed this line out, wrote "error" across the bottom of page and began a new page in the narcotic log, even though most of the page was blank.

62. On the new page, Respondent wrote the time as 1600 and then "transfer" and under number of pills left, she wrote 97. In the next line, Respondent wrote that at 1700, there were 97 pills on hand, she used one pill, and there remained 96 pills.

63. In the MAR, Respondent documented administering the medication at 1100 and 1600, as required by the order. While this accounts for two of the pills she withdrew, three remain unaccounted for and had they been administered to the patient, the patient would have received more medication than prescribed.

Patient LL

64. From January 2023 to February 14, 2023, Patient LL had a prescription for one 5mg Oxycodone pill every 4 hours as needed for moderate to severe pain.

65. On January 7, 2023, Respondent documented in the narcotic log that she withdrew one 5mg Oxycodone pill at 1645. Respondent did not document administering this medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

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66. On January 8, 2023, Respondent documented in the narcotic log that she withdrew one 5mg Oxycodone pill at 1900 and 2300. Respondent did not document administering this medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

67. On January 19, 2023, Respondent documented in the narcotic log that she withdrew one 5mg Oxycodone pill at 1745 and 2150. Respondent did not document administering this medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

68. On January 27, 2023, Respondent documented in the narcotic log that she withdrew two 5mg Oxycodone pills at 0730, 1045, 1300, 1700, and 1900. Respondent did not document administering this medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

69. The order only permitted the patient to receive one 5 mg pill every four hours and yet Respondent documented withdrawing two pills each time.

70. In addition, between 1045 and 1300 is only two hours and 15 minutes. Between 1700 and 1900 is only two hours. If Respondent did administer the medications at these times, she would have administered more medication than prescribed.

71. On February 1, 2023, Respondent documented in the narcotic log that she withdrew one 5mg Oxycodone pill at 0800, 1230, 1700, 2130, and 2300. Respondent did not document administering this medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

72. Between 2130 and 2300 is only one and half hours. If Respondent did administer the medication at these times, she would have administered more medication than prescribed.

73. On February 3, 2023, Respondent documented in the narcotic log that she withdrew one 5mg Oxycodone pill at 1600 and 2000. Respondent did not document administering this medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

74. On February 4, 2023, Respondent documented in the narcotic log that she withdrew one 5mg Oxycodone pill at 0745, 1200, and 1530. Respondent did not document administering this medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

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75. On February 14, 2023, Patient LL's order changed to one 5mg Oxycodone tablet two times a day for chronic pain.

76. On February 18, 2023, Respondent documented in the narcotic log that she withdrew one 5mg Oxycodone pill at 0900 and 1400. Although Respondent documented in the MAR administering the medication at 0800, she did not document administering the medication at 1400.

77. Moreover, the next nurse on duty administered to the patient another 5mg pill at 1930.

78. On February 19, 2023 and February 20, 2023, Respondent documented in the narcotic log that she withdrew one 5mg Oxycodone pill at 2345 and 0358, respectively. Respondent did not document administering this medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

79. On February 20, 2023, Respondent began a new page in the narcotic log for Patient LL. The last entry on the prior page documented 152 5mg Oxycodone pills remaining, but Respondent began the next page with 150 5mg Oxycodone pills. There is no documentation accounting for these two missing pills.

80. Also on February 20, 2023, Respondent documented in the narcotic log that she withdrew one 5mg pill at 1400 and 2000. Respondent documented in the MAR administering the medication at 1930, but she did not document administering the medication at 1400. Moreover, the order called for Patient LL to be given one 5mg Oxycodone pill two times a day at 0800 and 1930.

Patient EC

81. In March, Patient EC had a prescription for one 5mg Oxycodone pill every four hours as needed for pain.

82. On March 17, 2023 at 2300, March 18, 2023 at 2110, and March 19, 2023 at 0000 and 0200 Respondent documented in the narcotic log that she withdrew one 5mg Oxycodone pill. Respondent did not document administering this medication in the MAR. Therefore, Respondent also did not document a pain assessment prior to administering the medication or the effectiveness of the medication after administration.

83. Moreover, between 0000 and 0200 is only two hours. If Respondent did administer the medication at these times, she would have administered the medication closer in time than prescribed.

84. In February and March, Patient EC had a prescription for one 5mg Oxycodone pill every six hours as needed for knee pain.

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85. In February, various nurses in the facility documented in the narcotic log withdrawing 25 pills of Oxycodone. However, there are only 10 instances in which a nurse also documented administering this medication in the MAR.

86. Respondent accounts for nine of the times Oxycodone pills were withdrawn in the narcotic log but not documented as administered in the MAR.

87. Of the nine pills Respondent withdrew, five were withdrawn fewer than six hours from the prior withdrawal.

88. Between March 1 and March 15, various nurses in the facility documented withdrawing 31 pills in the narcotic log. In contrast, there were only two instances in which a nurse documented administering this medication to Patient EC in the MAR.

89. Respondent accounted for 16 of the times a pill was withdrawn from the narcotic log and not documented as administered in the MAR. In contrast, Respondent only documented administering the medication one time on March 19 in the MAR.

90. Of the pills Respondent withdrew, seven of these pills were documented as having been withdrawn fewer than six hours from the prior withdrawal.

Patient MA

91. In January 2023, Patient MA had a prescription for one 5mg Oxycodone pill every eight hours as needed for pain.

92. On four occasions, Respondent documented withdrawing the medication in the narcotic log, but did not document administering the medication in the MAR. These times were: March 3, 2023 at 1500 and 2200; March 7, 2023 at 2100; and March 8 at 2100.

Violation One: 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.

93. The State re-alleges and incorporates Paragraphs 2 through 92 above.

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

95. The essential standards of acceptable and prevailing practice require that an LPN accurately document administering narcotics.

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96. Paragraphs 2 through 92 above demonstrate that Respondent failed to conform to essential standards of acceptable and prevailing practice when she repeatedly failed to document in the MAR administering medication to patients.

97. The essential standards of acceptable and prevailing practice require that an LPN document pain scales before and after administering narcotics.

98. Paragraphs 2 through 92 above demonstrate that Respondent failed to conform to essential standards of acceptable and prevailing practice when she repeatedly failed to document pain scales before and after administering narcotics.

99. The essential standards of acceptable and prevailing practice require that an LPN keep proper count of narcotic medications.

100. Paragraphs 2 through 92 above demonstrate Respondent failed to conform to essential standards of acceptable and prevailing practice by failing to keep proper count of narcotic medications when she miscounted narcotics in the logs, crossed out sections of narcotic logs and wrote "error," and began new narcotic log pages that did not match up with the count on the prior page.

101. The essential standards of acceptable and prevailing practice require that an LPN administer medication in accordance with a prescription.

102. Paragraphs 2 through 92 above demonstrate Respondent failed to conform to essential standards of acceptable and prevailing practice by failing to administer medications in accordance with how the medication was prescribed, but instead administered medications more often than prescribed and administered more medications than prescribed.

103. 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).

Violation Two: 3 V.S.A. § 129a(a)(13) Performing treatments or providing services that the licensee is not qualified to perform or that are beyond the scope of the licensee's education, training, capabilities, experience, or scope of practice.

104. The State re-alleges and incorporates Paragraphs 2 through 92 above.

105. Under Vermont law, an LPN is prohibited from performing treatments or providing services that she is not qualified to perform or that are beyond the scope of her education, training, capabilities, experience, or scope of practice.

106. Paragraphs 2 through 92 above demonstrate that Respondent practiced outside of her scope by deliberately providing more medication to patients whenever they asked for the medication regardless of when the last dose was administered,

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instead of contacting the patient's treating provider to inform them of the patient's need for additional medication.

107. 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(a)(13).

Violation Three: 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.

108. The State re-alleges and incorporates Paragraphs 2 through 92 above.

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

110. Paragraphs 2 through 92 above demonstrate that Respondent provided unsafe and unacceptable patient care by failing to document administration of narcotic medications in the MAR, withdrawing medications more often than prescribed, and failing to document a patient's pain prior to and after administration.

111. 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 Four: 26 V.S.A. § 1582(a)(3) Engaging in conduct of a character likely to deceive, defraud, or harm the public.

112. The State re-alleges and incorporates Paragraphs 2 through 92 above.

113. Under Vermont law, an LPN is prohibited from engaging in conduct of a character likely to deceive, defraud, or harm the public.

114. Paragraphs 2 through 92 above demonstrate that Respondent engaged in conduct of a character likely to deceive, defraud, or harm the public by failing to document administrating narcotic medications in the MAR, withdrawing medications more often than prescribed, incorrectly accounting for medications, and administering medications without documenting a patient's pain prior to and after administration.

115. 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).

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Violation Five: 3 V.S.A. § 129a(a)(15) Failing to exercise independent professional judgment in the performance of licensed activities when that judgment is necessary to avoid action repugnant to the profession.

116. The State re-alleges and incorporates Paragraphs 2 through 92 above.

117. Under Vermont law, an LPN must exercise independent professional judgment in the performance of licensed activities when such judgment is necessary to avoid action repugnant to the profession.

118. Paragraphs 2 through 92 above demonstrate that Respondent failed to exercise independent professional judgment in the performance of licensed activities when such judgment is necessary to avoid action repugnant to the profession by failing to document administrating narcotic medications in the MAR, withdrawing medications more often than prescribed, incorrectly accounting for medications, and administering medications without documenting a patient's pain prior to and after administration.

119. 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(a)(15).

Relief Requested

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

DATED at Vermont this 27th day of November 2023.

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SECRETARY OF STATE

By: /s/ Rachel Heath

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