

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

**IN RE:** )  
**ELIZABETH VALLEJO** ) **Docket No. 2023- 85**  
**Multistate License no. 831345** )

**STIPULATION AND CONSENT ORDER**

**STIPULATION**

NOW COME the State of Vermont, by and through State Prosecuting Attorney Rachel Heath and Respondent Elizabeth Vallejo who hereby Stipulate and Agree as follows:

**Board Authority**

1. The Vermont State Board of Nursing (the "Board") has authority to issue warnings or reprimands; suspend, revoke, limit, or condition current licenses or privileges to practice; 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; 26 V.S.A. § 1647c(d); 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").

**Stipulated Facts**

1. Elizabeth Vallejo ("Respondent") of Humble, Texas is licensed as a Registered Nurse ("RN") in Texas with a multistate license number 831345. This license was first issued on February 5, 2013 and expires on June 30, 2024. Respondent does not have a Vermont license.
2. At all relevant times, Respondent worked as a traveling nurse on a 13-week contract at Central Vermont Home Health and Hospice (the "Facility").
3. As a result of the following events, Respondent's contract with the Facility was terminated early at ten weeks.
4. On or about May 23, 2022, Respondent went to a patient's ("Patient") home to provide home health services. Patient is in her 20's, a home health patient, and was alert and oriented.
5. While in the home, Respondent drew blood from Patient through her peripherally inserted central catheter line ("PICC line") using a syringe.

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6. A PICC line is a type of long catheter inserted through a peripheral vein, such as the arm, used when intravenous treatment is required for a long period of time.
7. A PICC line requires careful care and monitoring for complications, such as an infection or blood clots.
8. Patient's PICC line was under her armpit and Patient used crutches. As a result of this placement, the site was dirty and bloody.
9. Respondent partially withdrew the PICC line from Patient's arm and attempted to push the PICC line back into Patient's arm, increasing the risk of infection to the Patient.
10. Respondent did not measure the PICC line at any time, including before leaving Patient's home.
11. By not measuring the PICC line, Respondent risked causing a situation that could be fatal without emergency care.
12. Respondent did not have a vacutainer with her and therefore could not transfer the blood from the syringe to the lab vial in the home in front of the client.
13. Instead, Respondent carried the syringe out to her car and transferred the blood in her car, thereby risking contaminating the sample.
14. During this transfer, she spilled blood on herself and her clothes risking exposure to blood born pathogens.
15. Because Respondent did not transfer the blood in the home, Respondent could not have the patient verify her name and date of birth on the lab vial.
16. Respondent failed to correctly label the lab vial with anything more than Patient's last name; as a result the lab was not able to complete testing.
17. Because of Respondent's treatment, Patient went to the Emergency Room that day to have the line examined.
18. At the Emergency Room, Patient learned the PICC line had been withdrawn 9 cm.
19. Patient had to have the PICC line replaced and her blood drawn again as result of Respondent's failure to conform with standards of care.

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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.**

20. Paragraphs 2 through 19 above are incorporated herein.
21. As an RN, Respondent must provide safe and acceptable patient care.
22. Paragraphs 2 through 19 above demonstrate that Respondent provided unsafe and unacceptable patient care by pulling the PICC line out 9 cm and failing to measure the PICC line, attempting to push the PICC line back into the patient, failing to use the appropriate equipment in the home to transfer the blood in the home, failing properly label the vial for lab testing, and failing to confirm with the patient that the information on the vial was correct.
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 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.**

24. Paragraphs 2 through 19 above are incorporated herein.
25. Under Vermont law, an RN must practice competently by conforming to the essential standards of acceptable and prevailing practice.
26. Essential standards of acceptable care and prevailing practice require an RN to measure PICC lines.
27. Essential standards of acceptable care and prevailing practice require an RN to refrain from pushing a PICC line back into a patient.
28. Essential standards of acceptable care and prevailing practice require an RN to notify supervisors and the treating physician when a PICC line has been withdrawn or there is a risk that a PICC line has been withdrawn.
29. Essential standards of acceptable care and prevailing practice require an RN to use the appropriate equipment to transfer blood from a syringe before leaving a client's home.

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30. Essential standards of acceptable care and prevailing practice require an RN to properly label vials for lab testing and confirm with the patient that the information on the vial is correct.
31. Paragraphs 2 through 19 above demonstrate that Respondent failed conform to the essential standards of acceptable and prevailing practice when she failed to measure the PICC line after drawing blood, attempted to push the PICC line back in, failed to notify her supervisor or the treating physician the PICC line had been withdrawn or there was a risk the PICC line had been withdrawn, failed to use the appropriate equipment to transfer blood before leaving Patient's home, and failed to properly label the vial for lab testing and confirm with the patient the information on the vial was correct.
32. 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).

#### **Understandings**

33. Respondent admits the facts above are true and that the conditions below are necessary to protect the public.
34. Respondent understands that the Nursing Board must review and accept the terms of the Consent Order. If the Board rejects any portion, the entire Stipulation and Consent Order shall be null and void.
35. Respondent specifically waives any claims that any disclosures made to the full Board during its review of this agreement have prejudiced her rights to a fair and impartial hearing in future hearings if this agreement is not accepted by the Board.
36. Respondent has read and reviewed this entire document and agrees that it contains the entire agreement between the parties.
37. Respondent is not under the influence of any drugs or alcohol at the time she signs this Stipulation and Consent Order.
38. Respondent voluntarily enters into this agreement after the opportunity to consult with legal counsel and is not being coerced by anyone into signing this Stipulation and Consent Order.
39. Respondent voluntarily waives her right to a contested hearing before the Board of Nursing and waives any right to appeal from this Stipulation and Consent Order.
40. Respondent agrees that the Board may enter the Order set forth below.

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## ORDER

Based on the Stipulation above, it is **ORDERED AND ADJUDGED** as follows:

A. The Board of Nursing hereby **CONDITIONS** Respondent's privilege to practice commencing with the date of entry of this Stipulation and Consent Order. The conditions will be as follows:

1. Notification to Other States. If Respondent is licensed in nursing in any other state(s), Respondent must inform the nursing licensing board of the state(s) in which Respondent is licensed of the conditional status of Respondent's Vermont privilege to practice within thirty (30) days of the date of entry of this Order.
2. Required Coursework. Respondent shall, at her own expense and within ninety (90) days of the date of entry of this Stipulation and Consent Order, successfully complete (i.e., receive a passing score, if applicable) eight-hours of coursework pre-approved by the Enforcement Case Manager that pertains to safe medication administration.

Respondent shall submit the certificates of completion, completed assignment book(s) and quiz results, if applicable, to the Enforcement Case Manager. Failure to satisfactorily complete the courses shall constitute a violation of this Order. The coursework may not be counted toward any continuing education requirement of licensure.

3. Costs. Respondent shall bear all costs of complying with this Consent Order.
4. Violation of this Order. If Respondent violates this Order the Board, after giving Respondent notice and an opportunity to be heard, may rescind or modify this Order and impose additional appropriate disciplinary actions. If a complaint of unprofessional conduct is made against Respondent during the term of this Order, this Order shall be automatically extended until the unprofessional conduct matter is concluded.
5. Completion of Conditional Period. Respondent shall submit a petition to the Docket Clerk to remove any and all conditions on Respondent's privilege to practice. The State may assent to or oppose Respondent's petition. The Board will conduct a hearing if necessary. Respondent bears the burden and must present proof that Respondent has fully complied with the terms of this Order and these conditions are no longer necessary to protect the public.

B. Respondents shall pay an **ADMINISTRATIVE PENALTY** in the amount of \$250.00. This Penalty shall be paid within six months of the date of entry of this Order.

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- C. Notwithstanding any provision above, the Respondent must continue to meet all Nursing Board requirements for maintaining a license, license renewal and license reinstatement.
- D. This Stipulation and Consent Order is a matter of public record and may be reported to other licensing authorities as provided in 3 V.S.A. § 129(a).
- E. This Stipulation and Consent Order will remain part of Respondent's licensing file and may be used for purposes of determining sanctions in any future disciplinary matter.

**AGREED TO:**

Dated: 2/8/2024

STATE OF VERMONT  
SECRETARY OF STATE  
DocuSigned by:  
Rachel Heath  
PC331807D202420...  
By: Rachel Heath  
Prosecuting Attorney

Dated: 2/8/2024

RESPONDENT  
DocuSigned by:  
Elizabeth Vallejo  
8DF8E11A85EB48C...  
By: Elizabeth Vallejo

**APPROVED AND SO ORDERED:**

Dated: 2/13/24

VERMONT BOARD OF NURSING  
DocuSigned by:  
William James Floyd  
3B82E783001248E...  
By: William James Floyd  
Chairperson

Date of Entry: 2/14/24

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**IN RE:** )  
**ELIZABETH VALLEJO** ) **Docket No. 2023- 85**  
**Multistate License no. 831345** )

**SPECIFICATION OF CHARGES**

NOW COMES the State of Vermont and makes the following charges against Registered Nurse Elizabeth Vallejo:

**Board Authority**

1. The Board has authority to take adverse action against a nurse's multistate licensure privilege, such as revocation, suspension, probation, or any other action that affects a nurse's authorization to practice under a multistate licensure privilege, including cease and desist actions. 26 V.S.A. § 1647c(d); 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 Vallejo ("Respondent") of Humble, Texas is licensed as a Registered Nurse ("RN") in Texas with a multistate license number 831345. This license was first issued on February 5, 2013 and expires on June 30, 2024. Respondent does not have a Vermont license.
3. At all relevant times, Respondent worked as a traveling nurse on a 13-week contract at Central Vermont Home Health and Hospice (the "Facility").
4. As a result of the following events, Respondent's contract with the Facility was terminated early at ten weeks.
5. On or about May 23, 2022, Respondent went to a patient's ("Patient") home to provide home health services. Patient is a home health patient alert and oriented in her 20's.
6. While in the home, Respondent drew blood from Patient through her peripherally inserted central catheter line ("PICC line") using a syringe.
7. A PICC line is a type of long catheter inserted through a peripheral vein, such as the arm, used when intravenous treatment is required for a long period of time.

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8. A PICC line requires careful care and monitoring for complications, such as an infection or blood clots.
9. Patient's PICC line was under her armpit and Patient used crutches. As a result of this placement, the site was dirty and bloody.
10. Respondent partially withdrew the PICC line from Patient's arm and attempted to push the PICC line back into Patient's arm, increasing the risk of infection to the Patient.
11. Respondent did not measure the PICC line at any time, including before leaving Patient's home.
12. By not measuring the PICC line, Respondent risked causing a situation that could be fatal without emergency care.
13. Respondent did not have a vacutainer with her and therefore could not transfer the blood from the syringe to the lab vial in the home in front of the client.
14. Instead, Respondent carried the syringe out to her car and transferred the blood in her car, thereby risking contaminating the sample.
15. During this transfer, she spilled blood on herself and her clothes risking exposure to blood born pathogens.
16. Because Respondent did not transfer the blood in the home, Respondent could not have the patient verify her name and date of birth for the lab vial.
17. Respondent failed to correctly label the lab vial with anything more than Patient's last name; as a result the lab was not able to complete testing.
18. Because of Respondent's treatment, Patient went to the Emergency Room that day to have the line examined.
19. At the Emergency Room, Patient learned the PICC line had been withdrawn 9 cm.
20. Patient had to have the PICC line replaced and her blood drawn again as result of Respondent's failure to conform with standards of care.

**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.**

21. The State re-alleges and incorporates Paragraphs 2 through 20 above.
22. As an RN, Respondent must provide safe and acceptable patient care.

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23. Paragraphs 2 through 20 above demonstrate that Respondent provided unsafe and unacceptable patient care by pulling the PICC line out 9 cm and failing to measure the PICC line, attempting to push the PICC line back into the patient, failing to use the appropriate equipment in the home to transfer the blood in the home, failing properly label the vial for lab testing, and failing to confirm with the patient that the information on the vial was correct.
24. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent has committed unprofessional conduct in violation of 3 V.S.A. §129a(b)(1).

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

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29. Essential standards of acceptable care and prevailing practice require an RN to notify supervisors and the treating physician when a PICC line has been withdrawn or there is a risk that a PICC line has been withdrawn.
30. Essential standards of acceptable care and prevailing practice require an RN to use the appropriate equipment to transfer blood from a syringe before leaving a client's home.
31. Essential standards of acceptable care and prevailing practice require an RN to properly label vials for lab testing and confirm with the patient that the information on the vial is correct.
32. Paragraphs 2 through 20 above demonstrate that Respondent failed conform to the essential standards of acceptable and prevailing practice when she failed to measure the PICC line after drawing blood, attempted to push the PICC line back in, failed to notify her supervisor or the treating physician the PICC line had been withdrawn or there was a risk the PICC line had been withdrawn, failed to use the appropriate equipment to transfer blood before leaving Patient's home, and failed

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to properly label the vial for lab testing and confirm with the patient the information on the vial was correct.

33. 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 Elizabeth Vallejo'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 Vermont this 23<sup>rd</sup> day of May 2023.

STATE OF VERMONT  
SECRETARY OF STATE

By: /s/ Rachel Heath  
Rachel Heath  
State Prosecuting Attorney  
Enforcement Unit  
(802) 828-0041  
Rachel.Heath@vermont.gov

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