STATE OF VERMONT
BOARD OF NURSING

In re: Heather E. Gilbert	}	
License No. 026-84921	}	Docket No. 2012-536 (RN)
	}	

Appearances:

Prosecuting the case: S. Lauren Hibbert
Ms. Gilbert: Did not appear

Presiding Officer: Larry S. Novins

DEFAULT ORDER

The Board held a hearing on the above matter on September 8, 2014 at the Office of Professional Regulation Conference Room at the City Center in Montpelier, Vermont. Ms. Gilbert did not attend and was not represented by counsel.

Findings of Fact

1. Ms. Gilbert is licensed as a registered nurse and is therefore subject to the regulatory authority of this Board. 3 V.S.A. §§ 129, 129a, 26 V.S.A. § 1582(a), the Administrative Rules of the Board of Nursing, and the Rules of the Office of Professional Regulation. Ms. Gilbert's license was summarily suspended by Order of this Board dated August 11, 2014.
2. On July 15, 2014 a Notice of Charges in this matter by certified mail to Ms. Gilbert at her last known address. A copy of the Specification of Charges is attached to this Default Order.
3. OPR Rule 3.3 requires that an Answer be filed within 20 days of the date on which the notice of charges was mailed by the Director.
4. Licensees are required to notify the Board of any change of address within 30 days. 3 V.S.A. § 129a(a)(14).
5. Stamps on the envelope indicate the notice of charges was "unclaimed, unable to forward."
6. Ms. Gilbert has not filed an answer to the charges.
7. On August 22, 2014 notice of the Default Hearing scheduled for this date was mailed to Ms. Gilbert at that same address by certified mail. That notice was returned marked "Attempted-Not Known; Unable to Forward."
8. Ms. Gilbert has still not answered the charges.
9. Upon hearing the Prosecution's presentation and taking notice of its own file, the Board finds Ms. Gilbert to be in Default. The allegations contained in the Specification of Charges are therefore treated as the facts on which the Board's Order is based. OPR Rule 3.4, 3 V.S.A. § 809(d), and 3 V.S.A. § 814(c).

Conclusions of Law

Ms. Gilbert has received constructive notice of the charges in this matter as indicated by the Board's file and the Prosecution's presentation. Because Ms. Gilbert has failed to answer the charges, the factual allegations in the Specification of Charges are treated as if proved. O.P.R. Rule 3.4. Accordingly, the Board finds, in this Default Hearing held pursuant to 3 V.S.A. §809(d), that Ms. Gilbert has engaged in the unprofessional conduct alleged in the Specification of Charges.

Order

In accordance with the above Findings of Fact and Conclusions of Law, Ms. Gilbert's license is hereby **Suspended Indefinitely**, effective as of the date of the hearing. Should Ms. Gilbert apply for reinstatement, the Board at that time will determine whether any conditions can permit her to resume practice while protecting public health and safety.

Appeal Rights

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

A party aggrieved by a final decision of a board 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 St., 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.

To request a stay of the Board's decision, please refer to the attached stay instructions.

Vermont Board of Nursing

By: Jeanine Carr
Jeanine Carr, RN, Chair

Date: September 8, 2014

OFFICE OF PROFESSIONAL REGULATION

DATE OF ENTRY: 9/8/14

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

IN RE:	)	
HEATHER E. GILBERT	)	**Docket No. 2012-536**
License No. 026.0084921	)	

SPECIFICATION OF CHARGES

Now comes the State of Vermont, by and through State Prosecuting Attorney Gabriel M. Gilman, and makes the following charges against respondent in this matter, Heather E. Gilbert:

Board Authority

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

Statement of Facts

2. Heather E. Gilbert ("Respondent") of Spencer, Oklahoma is licensed by the Board as a registered nurse under license number 026.0084921. The license first issued on or about February 28, 2012. The license is active at this writing and is scheduled to expire in due course on March 31, 2015. There is no history of discipline in Vermont.

3. Respondent was employed at the Centers for Living and Rehabilitation (the "Facility"), Bennington from March 2012 until her termination from the Facility in August 2012. Respondent's termination occurred within an initial assessment period and was based upon a persistent pattern of difficulty meeting minimum nursing standards and Facility policy concerning medication administration.

4. On multiple occasions in July 2012, Respondent failed to remove nitroglycerine patches from patients consistent with physician orders, and failed apply new nitroglycerine patches. On these occasions, Respondent signed medication administration records ("MARs") indicating that she had removed patches she had not in fact removed.

5. Respondent received internal counseling relative to her failure to administer nitroglycerine patches as ordered. Respondent acknowledged failing to remove patches and attributed this to distraction.

STATE OF VERMONT

Prosecuting Attorney
Office of
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6. Specific instances of medication administration and transcription errors include the following:

a. On or about July 25, 2012, Respondent incorrectly transcribed an order Lisinopril

b. On or about July 25, 2012, Respondent incorrectly transcribed an order for diltiazem, changing the dose.

c. On or about July 27, Respondent incorrectly transcribed an order for diazepam such that the new medication order did not accurately reflect discontinuation of a prior dose.

d. On or about July 30, 2012, Respondent signed out a patient's hydrocodone/acet-5/500 twice. The correct dose was one tablet.

e. On or about August 1, 2012, Respondent incorrectly transcribed an order for a resident's diet change.

f. On or about August 1, 2012, Respondent signed out a patient's hydrocodone/acet-5/500 from the controlled substance record without corresponding entry in the MAR.

g. On or about August 1, 2012, Respondent documented administering oxycodone CR 20mg on a patient's MAR, but did not sign out the medication on the controlled substance record.

h. On or about August 2, 2012, a diazepam 5mg pill was found missing from the prn count sheet. The medication was not signed out on the controlled substance record. Respondent made a MAR entry indicating the medication was not given but did not record a reason the medication was held.

i. On August 2, 2012, Respondent documented administering methadone tablets that were not signed out on the controlled substance record.

j. On or about August 3, 2012, Respondent made a MAR entry indicating a patient's hydrocodone/acet-5/500 (vicodin) was not given, but did not record a reason the medication was held.

k. On or about August 6, 2012, Respondent made MAR entries indicating two hydrocodone/acet-5/500 (vicodin) tablets were given to a patient for whom only one tablet would have been the correct dose. Respondent did not record a reason for this discrepancy.

7. On or about August 7, 2012, Respondent received additional counseling relative to errors including failure to give scheduled medications, signing out duplicate doses of medications, wasting narcotics without a witness, transcription errors, failure to

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implement new orders, failing to process new orders, and failing to remove transdermal patches. Respondent acknowledged that certain of these concerns were valid, but attributed medication administration and documentation errors to interruption.

8. On or about August 10, 2012, Respondent worked with another nurse, E.M., to complete a narcotics count on Respondent's medication cart. Respondent took a medication cup out of a drawer and advised E.M. that the cup contained pills to be wasted. E.M. advised that the two would waste the pills at the end of the count. E.M. was interrupted by a patient's call bell and left Respondent alone at the cart. When E.M. returned, the cup and pills were gone. Respondent looked through a nearby garbage receptacle but did not find the pills.

9. Despite awareness of this case and the underlying investigation, Respondent repeatedly failed to give notice of address changes to the Office of Professional Regulation and the Board. In November and December, 2013, OPR Investigator Jeff Jones attempted to locate Respondent in Hoosick Falls, New York, only to find that his efforts to reach Respondent were reaching Respondent's relatives in Oklahoma and Texas. Investigator Jones eventually learned from Respondent's mother-in-law that Respondent had moved to Iowa. Investigator Jones was able to reach Respondent's husband. These efforts did not provoke a timely response from Respondent, and Jones was forced to complete a supplemental investigative report without speaking with Respondent.

10. In the course of OPR's investigation into the practice issues identified above, Respondent authorized the Rensselaer County, New York, Department of Mental Health to release certain counseling records; however, this authorization expressly excluded "drug & alcohol information." The release did result in a January, 2013 letter from a Rensselaer County social worker alluding to "difficulty with concentration," but yielded little substantive information about Respondent's fitness to practice.

11. On or about May 13, 2014, Respondent emailed Investigator Jones. Respondent reported serious medical difficulties affecting memory and concentration and alluded to missing memories.

Basis for Discipline

12. The facts and circumstances set out above, alone or in combination, constitute unprofessional conduct pursuant to:

    a. 3 V.S.A. § 129a(a)(5) (Practicing the profession when medically or psychologically unfit to do so);

    b. 3 V.S.A. § 129a(a)(14) (Failing to report to the office within 30 days a change of name or address);

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c. 26 V.S.A. § 1582(a)(3) (Is unable to practice nursing competently by reason of any cause), which includes performance of unsafe or unacceptable patient care pursuant to ARBN Rule 11.2(b)(1) and failure to conform to the essential standards of acceptable and prevailing nursing practice pursuant to ARBN Rule 11.2(b)(2); and

d. 3 V.S.A. § 129a(b)(1) and (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: (1) performance of unsafe or unacceptable patient or client care; or (2) failure to conform to the essential standards of acceptable and prevailing practice).

Request for Relief

WHEREFORE, the license of Heather E. Gilbert should be revoked, suspended, reprimanded, conditioned, or otherwise disciplined.

DATED at Montpelier, Vermont this 14th day of July, 2014.

STATE OF VERMONT
SECRETARY OF STATE

By: _____
Gabriel M. Gilman
State Prosecuting Attorney

STATE OF VERMONT

Prosecuting Attorney
Office of
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STATE OF VERMONT
BOARD OF NURSING

In re: Heather E. Gilbert
License No. 026-84921

} Docket No. 2012-536(RN)

DECISION ON REQUEST FOR SUMMARY SUSPENSION ORDER

Appearances:
Prosecuting the case: Gabriel Gilman
Respondent: did not appear

Presiding Officer: Larry S. Novins

Summary Suspension Order
FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

This matter came before the Board of Nursing on a Request for a Summary Suspension. The hearing was held on August 11, 2014 at the Office of Professional Regulation Conference Room at the City Center in Montpelier, Vermont. Ms. Gilbert did not appear. The Board has authority to summarily suspend a license pending further action, if it determines that public health, safety, or welfare imperatively requires emergency action. 3 V.S.A. § 814(c).

Findings of Fact

Based on a Review of the pleadings and the file, and on evidence presented to the Board at the hearing, the Board finds:

1. Ms. Gilbert is a licensed registered nurse and is therefore subject to the regulatory authority of this Board. 3 V.S.A. §§ 129, 129a, 26 V.S.A. § 1582(a), the Administrative Rules of the Board of Nursing, and the Rules of the Office of Professional Regulation. 3 V.S.A. § 814(c) permits the Board to summarily suspend a license if it finds that public health, safety, or welfare imperatively requires emergency action, and incorporates a finding to that effect in its order.
2. The prosecutor has filed a "Request for Summary Suspension." A copy of the Request is attached to this Decision and Order. The Request alleges that Ms. Gilbert, while employed, made many medication errors making her a danger if practicing, and she currently suffers from serious medical/memory problems. Ms. Gilbert is believed to be residing in the State of Oklahoma.
3. The Request for Summary Suspension further alleges that the public health, safety or

welfare imperatively requires emergency action.

4. Notice of this hearing was sent to Ms. Gilbert at her last known address via certified mail dated July 15, 2014. It is unknown whether Ms. Gilbert received the notice.
5. The Board finds for purposes of this hearing that Ms. Gilbert suffers from physical and mental problems which manifest themselves in many medication errors and record keeping errors that make her a danger to practice nursing. Her own correspondence to the Office of Professional Regulation confirms her problems.
6. The allegations in the Request for Summary Suspension (copy attached) have been established to the necessary degree.
7. The evidence presented imperatively requires emergency action for the public health, safety, and welfare. Specifically, summary suspension is necessary to prevent patient harm. If summary suspension is not ordered, the Board believes that patient harm will occur.

Conclusions of Law

Our Findings of Fact and Conclusions of Law in this Summary Suspension hearing are for purposes of deciding whether ***at this time*** there is an imperative need to take emergency action. 3 V.S.A. § 814(c). Our Findings of Fact and Conclusions of Law herein are for purposes of this Order only.

The Prosecutor's Request for a Summary Suspension is supported by the evidence presented. The Board concludes that the allegations in the Request for Summary Suspension have been established to the necessary degree. For purposes of this Summary Suspension Hearing, the Findings of Fact above do support Summary Suspension of Ms. Gilbert's license. There is no/an imperative need to take emergency action. 3 V.S.A. § 814(c).

A Specification of Charges has been filed. At any merits hearing in this matter, the prosecutor will bear the burden of proving unprofessional conduct. Our Findings and Conclusions in this matter will not absolve the prosecution or Ms. Gilbert from producing or challenging relevant evidence at a merits hearing. The Findings of Fact and Conclusions of Law at a contested hearing will be based exclusively on the evidence admitted at that hearing.

Order

The Request for Summary Suspension is **Granted.** Ms. Gilbert's license is summarily suspended pending proceedings for revocation or other action. These proceedings shall be promptly instituted and determined. 3 V.S.A. § 814(c).

APPEAL RIGHTS

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

A party aggrieved by a final decision of a board 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.

To request a stay of the Board's decision, please refer to the attached stay instructions.

Vermont Board of Nursing

By: Jeanine Carr
Jeanine Carr, RN, Chair

Date: August 11, 2014

OFFICE OF PROFESSIONAL REGULATION

DATE OF ENTRY: 8/13/14

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

IN RE:	)	
HEATHER E. GILBERT	)	**Docket No. 2012-536**
License No. 026.0084921	)	

PETITION FOR SUMMARY SUSPENSION

Now comes the State of Vermont, by and through State Prosecuting Attorney Gabriel M. Gilman, and upon the following facts and allegations moves the Board to summarily suspend the license of the respondent in this matter, Heather E. Gilbert:

Board Authority

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

2. "If [an] agency finds that public health, safety, or welfare imperatively requires emergency action, and incorporates a finding to that effect in its order, summary suspension of a license may be ordered pending proceedings for revocation or other action. These proceedings shall be promptly instituted and determined." 3 V.S.A. §814(c).

Statement of Facts

3. Heather E. Gilbert ("Respondent") of Spencer, Oklahoma is licensed by the Board as a registered nurse under license number 026.0084921. The license first issued on or about February 28, 2012. The license is active at this writing and is scheduled to expire in due course on March 31, 2015. There is no history of discipline in Vermont.

4. Respondent was employed at the Centers for Living and Rehabilitation (the "Facility"), Bennington from March 2012 until her termination from the Facility in August 2012. Respondent's termination occurred within an initial assessment period and was based upon a persistent pattern of difficulty meeting minimum nursing standards and Facility policy concerning medication administration.

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   b. On or about July 25, 2012, Respondent incorrectly transcribed an order for diltiazem, changing the dose.

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   d. On or about July 30, 2012, Respondent signed out a patient's hydrocodone/acet-5/500 twice. The correct dose was one tablet.

   e. On or about August 1, 2012, Respondent incorrectly transcribed an order for a resident's diet change.

   f. On or about August 1, 2012, Respondent signed out a patient's hydrocodone/acet-5/500 from the controlled substance record without corresponding entry in the MAR.

   g. On or about August 1, 2012, Respondent documented administering oxycodone CR 20mg on a patient's MAR, but did not sign out the medication on the controlled substance record.

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   i. On August 2, 2012, Respondent documented administering methadone tablets that were not signed out on the controlled substance record.

   j. On or about August 3, 2012, Respondent made a MAR entry indicating a patient's hydrocodone/acet-5/500 (vicodin) was not given, but did not record a reason the medication was held.

   k. On or about August 6, 2012, Respondent made MAR entries indicating two hydrocodone/acet-5/500 (vicodin) tablets were given to a patient for whom only

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one tablet would have been the correct dose. Respondent did not record a reason for this discrepancy.

8. On or about August 7, 2012, Respondent received additional counseling relative to errors including failure to give scheduled medications, signing out duplicate doses of medications, wasting narcotics without a witness, transcription errors, failure to implement new orders, failing to process new orders, and failing to remove transdermal patches. Respondent acknowledged that certain of these concerns were valid, but attributed medication administration and documentation errors to interruption.

9. On or about August 10, 2012, Respondent worked with another nurse, E.M., to complete a narcotics count on Respondent's medication cart. Respondent took a medication cup out of a drawer and advised E.M. that the cup contained pills to be wasted. E.M. advised that the two would waste the pills at the end of the count. E.M. was interrupted by a patient's call bell and left Respondent alone at the cart. When E.M. returned, the cup and pills were gone. Respondent looked through a nearby garbage receptacle but did not find the pills.

10. Despite awareness of this case and the underlying investigation, Respondent repeatedly failed to give notice of address changes to the Office of Professional Regulation and the Board. In November and December, 2013, OPR Investigator Jeff Jones attempted to locate Respondent in Hoosick Falls, New York, only to find that his efforts to reach Respondent were reaching Respondent's relatives in Oklahoma and Texas. Investigator Jones eventually learned from Respondent's mother-in-law that Respondent had moved to Iowa. Investigator Jones was able to reach Respondent's husband. These efforts did not provoke a timely response from Respondent, and Jones was forced to complete a supplemental investigative report without speaking with Respondent.

11. In the course of OPR's investigation into the practice issues identified above, Respondent authorized the Rensselaer County, New York, Department of Mental Health to release certain counseling records; however, this authorization expressly excluded "drug & alcohol information." The release did result in a January, 2013 letter from a Rensselaer County social worker alluding to "difficulty with concentration," but yielded little substantive information about Respondent's fitness to practice.

12. On or about May 13, 2014, Respondent emailed Investigator Jones. Respondent reported serious medical difficulties affecting memory and concentration and alluded to missing memories.

Basis for Discipline

13. The facts and circumstances set out above, alone or in combination, constitute unprofessional conduct pursuant to:

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a. 3 V.S.A. § 129a(a)(5) (Practicing the profession when medically or psychologically unfit to do so);

b. 3 V.S.A. § 129a(a)(14) (Failing to report to the office within 30 days a change of name or address);

c. 26 V.S.A. § 1582(a)(3) (Is unable to practice nursing competently by reason of any cause), which includes performance of unsafe or unacceptable patient care pursuant to ARBN Rule 11.2(b)(1) and failure to conform to the essential standards of acceptable and prevailing nursing practice pursuant to ARBN Rule 11.2(b)(2); and

d. 3 V.S.A. § 129a(b)(1) and (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: (1) performance of unsafe or unacceptable patient or client care; or (2) failure to conform to the essential standards of acceptable and prevailing practice).

14. The public health, safety, or welfare imperatively requires emergency action pursuant to 3 V.S.A. § 814 because; (a.) there is evidence to establish that Respondent had or has a serious medical condition affecting nursing competence; (b.) Respondent's difficulties have manifested in dangerous nursing practice; (c.) Respondent has not been responsive to OPR inquiries concerning her fitness; (d.) Respondent has not come forward with evidence that the issues affecting her practice in late 2012 have been prudently addressed in a manner that renders her capable of practicing nursing safely and competently; and (e.) Respondent's Vermont license is active and unencumbered, giving no warning to potential healthcare employers or sister licensing agencies that Respondent may have the difficulties identified above.

Request for Relief

WHEREFORE, the license of Heather E. Gilbert should be suspended summarily pending the adjudication of a Specification of Charges filed this date.

DATED at Montpelier, Vermont this 14th day of July, 2014.

STATE OF VERMONT
SECRETARY OF STATE

By: _____
Gabriel M. Gilman
State Prosecuting Attorney

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