

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

IN RE:

VERNA CHARLENE HALLOCK
License No. 025.0007157

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Docket Nos. 2009-594; 2010-5

STIPULATION AND CONSENT ORDER

STIPULATION

NOW COME the State of Vermont, by and through State Prosecuting Attorney BetsyAnn Wrask, and the Respondent, Verna Charlene Hallock, LPN, who 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 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. § 1582; the Administrative Rules of the Board of Nursing (the "ARBN"); and the Rules of the Office of Professional Regulation.

Statement of Facts

2. Verna Charlene Hallock (the "Respondent") of Colchester, Vermont is licensed by the State of Vermont as a Licensed Practical Nurse under license number 025.0007157. This license was originally issued on or about September 28, 1994 and is currently set to expire on or about January 31, 2012.
3. At all times relevant, Respondent was employed as a Licensed Practical Nurse at Burlington Health & Rehabilitation Center (the "Facility"), located in Burlington, Vermont.

Docket No. 2009-594

4. On or about July 22, 2009, Facility Director of Nursing M.S. reported to State Investigator Greg Kelly that fifty-nine (59) Oxycodone IR 5mg tablets had been stolen from Facility Patient T.K. on or about July 21, 2009. On or about July 23, 2009, M.S. advised Investigator Kelly that whoever took these tablets attempted to cover up the theft by removing the narcotic sheet(s) associated with the medication, and that without the narcotic sheet(s), the inventory of the medication

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cart would be correct. M.S. advised that Respondent was one of three (3) nurses who had access and control of the Oxycodone medication at the time of the theft.

5. Based on the circumstances, identifying the person who diverted these narcotics has not been achieved.
6. On or about July 23, 2009 in an interview with State Investigator Jamie Palmisano, Respondent admitted that on or about July 21, 2009 when she reported for her shift, she failed to inventory the medication cart with the off-going nurse before Respondent took possession of the cart. Respondent admitted that she accepted the cart "as is."
7. By failing to inventory the medication cart before she took possession of it, Respondent has violated Facility policy and 3 V.S.A. § 129a(b)(1) and (2).

Docket No. 2010-5

Statement of Facts re: Patient T.K.

8. On or about December 18, 2009, Respondent documented in Patient T.K.'s Controlled Drug Receipt/Record/Disposition Form (the "Disposition Form") that she wasted two (2) Oxycodone 5mg IR tablets at 08:35 that had been "dropped." This waste was allegedly co-signed as being witnessed by Registered Nurse B.C.
9. On or about December 18, 2009, Respondent documented in T.K.'s Disposition Form that she wasted two (2) Oxycodone 5mg IR tablets at 14:40 that had been "dropped." The signature of the alleged co-signer who witnessed this waste is illegible and unrecognizable.

Statement of Facts re: Patient N.R.

10. On or about December 18, 2009, Respondent documented in Patient N.R.'s Disposition Form that she wasted one (1) Clonazepam 2mg tablet at 13:30 that was "out by mistake." This waste was allegedly co-signed as being witnessed by Registered Nurse B.C.

Statement of Facts re: Patient B.D.

11. On or about December 2, 2009, Respondent documented in Patient B.D.'s Disposition Form that she wasted one (1) Hydrocodone/APAP 5-500mg tablet at 11:00 that "fell out." This waste was allegedly co-signed as being witnessed by Registered Nurse B.C.
12. On or about December 14, 2009, Respondent documented in B.D.'s Disposition Form that she wasted one (1) Hydrocodone/APAP 5-500mg tablet at 13:00 that "dropped." This waste was allegedly co-signed as being witnessed by Registered Nurse B.C.

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Statement of Facts re: Patient R.T.

13. On or about November 13, 2009, Respondent documented in Patient R.T.'s Disposition Form that she wasted three (3) Hydromorphone 2mg tablets at 14:30 that "fell out." The signature of the alleged co-signer who witnessed this waste is illegible and unrecognizable.
14. On or about December 14, 2009, Respondent documented in R.T.'s Disposition Form that she wasted four (4) Hydromorphone 2mg tablets at 12:00 that "fell out." This waste was allegedly co-signed as being witnessed by Registered Nurse B.C.
15. On or about December 15, 2009, Respondent documented in R.T.'s Disposition Form that she wasted five (5) Hydromorphone 2mg tablets at 14:35 because the "back [was] open." This waste was allegedly co-signed as being witnessed by Registered Nurse J.N.
16. On or about December 17, 2009, Respondent documented in R.T.'s Disposition Form that she wasted one (1) Hydromorphone 2mg tablet at 12:40 because it "dropped." This waste was allegedly co-signed as being witnessed by Registered Nurse B.C.
17. On or about December 17, 2009, Respondent documented in R.T.'s Disposition Form that she wasted six (6) Hydromorphone 2mg tablets at 14:10 because they "fell out." This waste was allegedly co-signed as being witnessed by Licensed Practical Nurse J.C.
18. On or about December 18, 2009, Respondent documented in R.T.'s Disposition Form that she wasted five (5) Hydromorphone 2mg tablets at 12:35 because they "fell out." This waste was allegedly co-signed as being witnessed by Registered Nurse B.C.

Statement of Facts re: Interview of Respondent

19. On or about March 31, 2010 in an interview with State Investigator Jamie Palmisano, Respondent denied diverting medications from the Facility. Respondent initially insisted that all medications listed as wasted in patient medical records were disposed of properly. However, Respondent subsequently admitted that on occasion she would waste medications without obtaining the required witness. Respondent stated that on those occasions, she would simply scribble an illegible name to give the appearance that another staff member witnessed the waste. Respondent stated that she adopted this practice of wasting medications without the required witness because she did not want to ask LPN S.C. to witness wastes because S.C. appeared to be "put off" when asked to do so. During the interview, while reviewing patient records, Respondent specifically admitted that the waste of Patient R.T.'s four (4) Hydromorphone tablets at 12:00 on December 14, 2009 was not done according to policy. Respondent stated that she wasted these tablets without a witness, and then scribbled an illegible name to give the appearance that she wasted the medications properly.

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20. Shortly after Respondent made the admission that she did not always waste medications with the required witness, she advised Investigator Palmisano of her intent to seek legal representation prior to answering further questions. The interview then concluded.

Statement of Facts re: Registered Nurse B.C.

21. On or an about March 31, 2010 in an interview with Investigator Palmisano and after reviewing the waste witnessing attributed to her (referenced above in ¶¶ 4, 6, 7, 8, 10, 12, and 14) RN B.C. advised that none of the signatures purported to be hers were actually signed by her. B.C. indicated that someone had fraudulently signed her name to indicate that she witnessed the disposal of the narcotics.

Statement of Facts re: Registered Nurse J.N.

22. On or about April 2, 2010 in an interview with Investigator Palmisano and after reviewing the waste witnessing attributed to her (referenced above in ¶11), RN J.N. advised that she did not witness the disposal of this narcotic. J.N. advised that due to the amount of the narcotic being disposed of (five (5) Hydromorphone 2mg tablets), she would have located another staff member to co-sign the waste, in addition to her.

Statement of Facts re: Licensed Practical Nurse J.C.

23. On or about April 5, 2010 in an interview with Investigator Palmisano and after reviewing the waste witnessing attributed to her (referenced above in ¶13), LPN J.C. denied witnessing Respondent waste six (6) Hydromorphone 2mg tablets. J.C. recalled that she only signed and witnessed Respondent waste one (1) tablet of this narcotic on that date. J.C. insisted that had Respondent requested that J.C. co-sign the wasting of six (6) tablets of Hydromorphone, she would have questioned it, and would have remembered wasting that amount of narcotic as it was not typical.

Charges

24. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because the Respondent has committed unprofessional conduct in violation of:
- a. 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 Chapter 4, Subchapter 4, Rule II(B)(1); and failure to conform to the essential standards of acceptable and prevailing nursing practice pursuant to ARBN Chapter 4, Subchapter 4, Rule II(B)(2);
 - b. 26 V.S.A. § 1582(a)(7) (Engages in conduct of a character likely to deceive, defraud, or harm the public) which includes falsifying or altering clinical records or making inaccurate or misleading entries pursuant to ARBN Chapter 4,

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Subchapter 4, Rule II(D)(3); and diverting supplies, equipment, or drugs for personal or other unauthorized use pursuant to ARBN Chapter 4, Subchapter 4, Rule II(D)(4);

- c. 3 V.S.A. § 129a(a)(7)(Willfully making or filing false reports or records in the practice of the profession; willfully impeding or obstructing the proper making of reports or records or willfully failing to file the proper reports or records);
- 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); and
- e. 3 V.S.A. § 129a(a)(3) (Failing to comply with provisions of federal or state statutes or rules governing the practice of the profession).

Understandings

- 25. This Stipulation is neither an admission of liability by the Respondent nor a concession by the State of Vermont that its charges are not well-founded. To avoid delay, uncertainty, inconvenience, and expense of protracted litigation of the charges above, the Parties reach a full and final Stipulation pursuant to these Understandings and the Order below. The Respondent does not dispute that the State could prove these charges by a preponderance of the evidence if this matter went to a hearing and agrees that the discipline below is necessary to protect the public.
- 26. 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.
- 27. 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.
- 28. Respondent has read and reviewed this entire document and agrees that it contains the entire agreement between the parties.
- 29. Respondent is not under the influence of any drugs or alcohol at the time she signs this Stipulation and Consent Order.
- 30. 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.

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31. 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.
32. Respondent agrees that the Order set forth below may be entered by the Board.

ORDER

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

- A. The Board of Nursing hereby **INDEFINITELY SUSPENDS** Respondent's license to practice practical nursing **from the date of entry below.**
- B. Notwithstanding any provision above, the Respondent must continue to meet all Nursing Board requirements for maintaining a license, license renewal and license reinstatement.
- C. 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).
- D. 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:

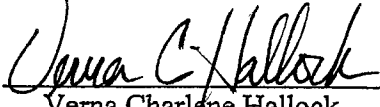
STATE OF VERMONT
SECRETARY OF STATE

Dated: 9.21.10

By: 
Betsy Ann Wrask
State Prosecuting Attorney

VERNA CHARLENE HALLOCK
RESPONDENT

Dated: 9/17/10

By: 
Verna Charlene Hallock

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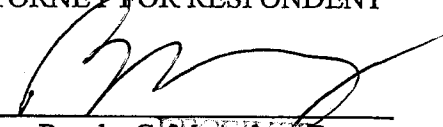


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APPROVED AS TO FORM:

ATTORNEY FOR RESPONDENT

Dated: 9/17/10

By: 
Brooks G. McArthur, Esq.

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APPROVED AND SO ORDERED:

VERMONT BOARD OF NURSING

Dated: 10-11-10

By: *[Signature]*
Chairperson

Date of Entry: 10/13/10
nu.hallock.stip

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