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

IN RE:	)	
LAUREL L. SICKLER	)	Docket No. 2017-352
License No.: 025.0009568	)	

VOLUNTARY INDEFINITE SUSPENSION STIPULATION

NOW COME the State of Vermont, by and through State Prosecuting Attorney Elizabeth A. St. James, and the Respondent, Laurel L. Sickler, represented by Gary D. McQuesten, Esq., who stipulate and agree as follows:

1. To avoid summary suspension proceedings under 3 V.S.A. § 814(c) in the matter captioned above, the State and Respondent request that license no. 025.0009568 be voluntarily suspended, for an indefinite period, pending adjudication on the merits.

2. Proceedings on the merits shall be promptly instituted and determined.

3. Respondent understands that this agreement is a matter of public record and that this suspension pending adjudication on the merits may be reported to other licensing authorities as provided in 3 V.S.A. 129(a)(6).

ORDER

The Vermont Board of Nursing hereby suspends license no. 025.0009568 pending adjudication on the merits of the matter captioned above.

AGREED TO:

STATE OF VERMONT
SECRETARY OF STATE

Dated: 9/8/17

By: Elizabeth A St. James
Elizabeth A. St. James
State Prosecuting Attorney

LAUREL L. SICKLER
RESPONDENT

Dated: 9/8/2017

By: Laurel Sickler
Laurel L. Sickler

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

APPROVED AS TO FORM:

GARY D. MCQUESTEN, ESQ.
ATTORNEY FOR RESPONDENT

Dated: 9/8/17

By: _____
Gary D. McQuesten, Esq.

APPROVED AND SO ORDERED:

VERMONT BOARD OF NURSING

Dated: 9/11/2017

By: _____
Chairperson

Date of Entry: 9/12/17

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IN RE:	)	
LAUREL L. SICKLER	)	**Docket No. 2017-352**
License No. 025.0009568	)	

REQUEST FOR SUMMARY SUSPENSION

NOW COMES the State of Vermont, by and through State Prosecuting Attorney Elizabeth A. St. James, and petitions the Board of Nursing to summarily suspend the license of Licensed Practical Nurse Laurel L. Sickler. In support of such petition, the State alleges the following:

Board Authority

1. The Vermont Board of Nursing (the "Board") has jurisdiction to investigate and adjudicate allegations of unprofessional conduct committed by Licensed Nursing Assistants 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. The Board of Nursing is authorized by 3 V.S.A. § 814 to summarily suspend the license of a nurse when it finds that the public health, safety, or welfare imperatively requires emergency action.

Statement of Facts

3. Laurel L. Sickler ("Respondent") of South Burlington, Vermont is licensed by the State of Vermont as a Licensed Practical Nurse ("LPN") under license number 025.0009568. This license was originally issued July 9, 2008, and expires on January 31, 2018.

4. At all relevant times, Respondent was employed as an LPN at Starr Farm Nursing Center (the "Facility") in Burlington, Vermont, beginning in January 2017.

5. The receipt and withdrawal of narcotics are hand-documented in narcotic log books at the Facility. Separate pages are maintained for each controlled drug for each patient.

6. Facility protocol requires a co-signature from another nurse when transferring a narcotic log to a new page in the narcotic log book.

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7. Between March 19, 2017, and June 12, 2017, Resident N.R. had a medication order for Oxycodone HCI 5 mg tablets to be given orally every three (3) hours as needed for pain, not to exceed 30 mg in a twenty-four (24) hour period.

8. Between March 19, 2017, and June 12, 2017, the documented amount of Oxycodone "on-hand" and the "amount left" were altered in the narcotics log book by writing new numbers over numbers already recorded for N.R.'s Oxycodone withdrawals. These alterations occurred in over 25 separate entries. The alterations appeared to occur when N.R. was the sole nurse responsible for the medication cart.

9. Between March 19, 2017, and June 12, 2017, Respondent prematurely transferred documentation of N.R.'s Oxycodone withdrawals to a new page in the narcotics log book approximately six (6) times, with either no co-signing nurse or an unrecognizable and unidentifiable co-signature.

10. On at least one occasion in May 2017, Respondent indicated she was starting a new page because the medication had expired in April of 2017. There was no documentation to indicate whether the remaining tablets had been destroyed.

11. The pharmacy indicated that expiration dates on outgoing Oxycodone at the time N.R.'s medication was dispensed were in May and July of 2019.

12. On June 8, 2017, Respondent indicated N.R.'s Oxycodone was being discarded as the dose or medication had changed. There was no change in N.R.'s Oxycodone medication order at this time. Additionally, the nursing staff signatures on the narcotics log allegedly indicating the medication was destroyed do not match any approved signatures for the medication destruction process, nor was the facility policy for the destruction of bulk waste followed.

13. On several of Respondent's narcotics log entries, nurses' co-signatures that accompany Respondent's signature were unrecognizable and unidentifiable.

14. Respondent made approximately 120 of the over 180 documented withdrawals for Resident N.R. despite being only one (1) of twenty (20) nurses caring for Resident N.R. between March 19, 2017, and June 12, 2017.

15. Respondent only documented approximately 33 of her over approximately 120 Oxycodone withdrawals in either the nursing notes or Medication Administration Record ("MAR").

16. During the relevant time period, the alterations made to N.R.'s narcotics log, as well as the unnecessary destruction of medication, left over 230 Oxycodone HCL 5 mg tablets unaccounted for.

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Resident J.B.

17. In February 2017, Resident J.B. had a medication order for Oxycodone 5 mg, 2.5 mg scheduled three (3) times a day and 2.5 mg every three (3) hours as needed for pain.

18. On February 21, 2017, at approximately 2141, J.B.'s Oxycodone order was discontinued.

19. On February 22, 2017, Respondent had possession of the medication cart from 0700 to 1500.

20. On February 22, 2017, at approximately 0715 and 1200, Respondent documented withdrawing one tablet, despite J.B.'s Oxycodone order being discontinued the previous day. Respondent was the last nurse to document withdrawal of this medication for J.B.

21. On February 22, 2017, J.B.'s Oxycodone withdrawal log indicates the medication was discontinued and removed. The signatures of the releasing and accepting nurses appear to be in the same handwriting yet are unrecognizable and unidentifiable.

22. The Facility's bulk waste protocol for a discontinued drug was not documented, leaving approximately 156 tablets unaccounted for.

Resident M.B.

23. In March 2017, Resident M.B. had a medication order for Oxycodone 5 mg tablet to be given every three (3) hours as needed for pain.

24. On March 20, 2017, Respondent documented wasting 2 tablets of Oxycodone.

25. The witnessing nurse's co-signature is unrecognizable and unidentifiable.

26. RN C.M, the other nurse working the unit with Respondent that day, did not co-sign for Respondent's alleged waste.

Resident F.C.

27. In April 2017, Resident F.C. had a medication order for Oxycodone 5 mg tablet to be given every four (4) hours as needed for pain.

28. On April 19, 2017, the Facility received a delivery of 120 Oxycodone 5 mg tablets from the pharmacy.

29. Respondent documented receipt of the Oxycodone in the narcotics log book, but altered the beginning number from 120 to 90.

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30. Respondent then moved F.C.'s oxycodone documentation unnecessarily to a new page, indicating the transfer was to "rewrite," despite only 4 lines being used on the previous page.

31. Respondent was the last nurse to document withdrawal of Oxycodone for Resident F.C on April 30, 2017.

32. The bottom right corner of the narcotics log page for this medication indicates that with 68 tablets left, the medication was destroyed. The date and nurse's signature are illegible. The control number used for a bulk waste was false, facility protocol was not followed for a bulk waste, and the authorized nursing staff did not participate in a bulk waste of this medication, leaving approximately 68 tablets of Oxycodone unaccounted for.

Resident J.K.

33. In June 2017, Resident J.K. had a medication order for Dilaudid 2 mg two (2) tablets every three (3) hours as needed for pain.

34. On June 10, 2017, Respondent documented in the narcotics log book withdrawing Dilaudid for Resident J.K. at 1015.

35. Respondent did not work at the Facility on June 10, 2017.

36. On June 13, 2017, LPN K.E. turned the medication cart over to LPN R.O. at 0700. At that time, the narcotics log book showed the last dose being withdrawn on June 11, 2017, by Respondent.

37. LPN R.O. did not make any withdrawals of Dialudid for Resident J.K. on either June 12th or June 13th.

38. On June 13, 2017, LPN R.O. turned the medication cart over to Respondent at 1500 hours.

39. LPN K.E. returned to the Facility on the night of June 13, 2017, and discovered that there were now 2 documented withdrawals of Dialudid on June 12, 2017, that were not there when LPN K.E. left the Facility that morning. These withdrawals have un-identifiable signatures and the administration of these withdrawals were not documented in the MAR or nursing notes.

Resident W.F.

40. In June 2017, Resident W.F. had a medication order for 60 mg morphine extended release to be given two (2) tablets four (4) times a day for pain, two (2) doses for each day out on pass, six (6) days per month.

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41. On June 11, 2017, Respondent documented withdrawing two (2) tablets of 60 mg Morphine at 1210 and then documenting a second withdrawal of two (2) additional tablets of 60 mg Morphine, also at 1210.

42. Respondent documented discarding the second withdrawal due to error.

43. The witnessing nurse's signature appears to be that of LPN V.W., but V.W. did not witness this waste. Her shift at the Facility did not begin until 1500 on June 11, 2017.

Resident B.A.

44. Between April 15, 2017, and June 7, 2017, Resident B.A. had a medication order for Tramadol 50 mg to be given every six (6) hours as needed for pain not responsive to Tylenol.

45. On May 18, 2017, Respondent documented withdrawing one (1) tablet of Tramadol 50 mg at 1410.

46. Respondent did not work at the Facility on May 18, 2017.

47. Between April 15, 2017, and June 7, 2017, Respondent documented withdrawing approximately twenty-nine (29) of the approximately thirty-nine (39) withdrawals for this medication.

48. Respondent never documented giving Resident B.A. Tylenol first, and only documented administration of her withdrawals approximately three (3) out of approximately twenty-nine (29) times.

Resident I.M.

49. In April 2017, Resident I.M. had a medication order for Lorazepam Concentrate 2 mg/ml to be given 0.25 mg by mouth every two (2) hours as needed for agitation, anxiety, and/or nausea.

50. On April 10, 2017, Respondent documented the only withdrawal of this medication at 0740.

51. On April 12, 2017, Respondent documented that the medication was discontinued, with an unrecognizable and unidentifiable nurse's co-signature.

52. There is no documentation in Resident I.M.'s medical records to indicate this medication order had been discontinued on April 12, 2017.

53. The remaining Lorazepam concentrate was documented as bulk waste, with no signature indicating who destroyed the medication. The control number used was false and Facility protocol for bulk destruction of medication was not followed.

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Violation One: 26 V.S.A. §1582(a)(2) Diverting or attempting to divert drugs or equipment or supplies for unauthorized use.

54. The State re-alleges and incorporates Paragraphs 3 through 53 above.

55. As an LPN, Respondent shall not divert or attempt to divert drugs, equipment, or supplies for unauthorized use.

56. Respondent diverted or attempted to divert drugs for unauthorized use as demonstrated in Paragraphs 4 through 53 above.

57. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for summary suspension because Respondent has committed unprofessional conduct in violation of 26 V.S.A. §1582(a)(2).

Violation Two: 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.

58. The State re-alleges and incorporates Paragraphs 3 through 53 above.

59. As an LPN, Respondent has an obligation to provide safe and acceptable patient care.

60. Respondent provided unsafe and unacceptable patient care by engaging in the conduct described in Paragraphs 4 through 53 above.

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

62. The State re-alleges and incorporates Paragraphs 3 through 53 above.

63. As an LPN, Respondent is required to refrain from engaging in conduct of a character likely to deceive, defraud, or harm the public.

64. Respondent engaged in conduct of a character likely to deceive, defraud, or harm the public as demonstrated in Paragraphs 4 through 53 above.

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65. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for summary suspension because the Respondent has committed unprofessional conduct in violation of 26 V.S.A. §1582(a)(3).

Violation Four: 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 or filing of reports or records or willfully failing to file the proper reports or records.

66. The State re-alleges and incorporates Paragraphs 3 through 53 above.

67. As an LPN, Respondent shall not willfully make or file false reports or records in the practice of the profession, willfully impede or obstruct the proper making or filing of reports or records, or willfully fail to file the proper reports or records.

68. Paragraphs 4 through 53 above demonstrate that Respondent willfully made or filed false reports or records in the practice of the profession.

69. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for summary suspension because Respondent has committed unprofessional conduct in violation of 3 V.S.A. §129a(a)(7).

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 obligations of the profession.

70. The State re-alleges and incorporates Paragraphs 3 through 53 above.

71. As an LPN, Respondent is required to exercise her own independent professional judgment in the performance of licensed activities when that judgment is necessary to avoid action repugnant to the obligations of the profession.

72. Respondent's conduct in Paragraphs 4 through 53 above demonstrate Respondent's failure to exercise her own professional judgment in the performance of licensed activities when that judgment is necessary to avoid action repugnant to the obligations of the profession.

73. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for summary suspension because the Respondent has committed unprofessional conduct in violation of 3 V.S.A. §129a(a)(15).

Relief Requested

74. Respondent currently has an unencumbered license. Members of the public, patients, and potential patients have no way of learning of Respondent's dangerous behavior

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and will remain unprotected pending suspension of Respondent's license. The facts as set out above establish that in order to protect the public health, safety, or welfare of the people of the State of Vermont, emergency action is imperative.

WHEREFORE, the State of Vermont respectfully requests that pursuant to 3 V.S.A. § 814(c), the Respondent's LPN license, number 025.0009568, be summarily suspended, pending a hearing on the merits.

DATED at Montpelier, Vermont this 31st day of August, 2017.

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SECRETARY OF STATE

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