

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

In re: ERIKA WOODS
License No. 075.00014411

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Docket No. 2018-124 & 125

Appearances:

Prosecutor: Elizabeth A. St. James, Esq.

Respondent: Did not appear

Hearing Officer: George K. Belcher

DEFAULT ORDER

The Hearing Officer of the Vermont Board of Nursing held a hearing pursuant to 3 VSA Sec. 129(f) in the above matter on May 14, 2019 at the Office of Professional Regulation in Montpelier, Vermont. Respondent did not attend and was not represented by counsel.

Findings of Fact

1. Respondent is a Licensed Practical Nurse and is therefore subject to the regulatory authority of this Board. 3 V.S.A. §§ 129, 129a, 26 V.S.A. Chapter 28, and the Administrative Rules of the Board of Nursing, and the Rules of the Office of Professional Regulation.
2. Charges were filed in this matter on November 21, 2018. The Respondent was sent a Notice of Charges in this matter by certified mail and first class mail to the address of the Respondent which was on file with the Office of Professional Regulation on November 15, 2018. The certified mail notice of charges was returned with the notation "Return to sender Unclaimed". The ordinary mail notice was not returned. 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. On May 2, 2019 a notice was sent to the Respondent advising of the hearing before the Board to find a default and advising that, "If you wish to contest the charges you must contact the office immediately at (802) 828-2367 and show good cause for failing to answer the charges against you." This notice was mailed by certified mail and regular mail. Neither notice was returned as of the date of the hearing for default.
5. Respondent has not filed an answer to the charges, nor any communication concerning good cause for failure to answer. The Respondent did not appear at the hearing on default.
6. Upon consideration of the Prosecution's presentation and taking notice of the OPR file, the Hearing Officer of the Board finds Respondent to be in Default. The allegations

contained in the Specification of Charges are therefore treated as the facts on which the Board may issue an order of professional discipline. OPR Rule 3.4, 3 V.S.A. § 809(d), and 3 V.S.A. § 814(c).

7. It is specifically found that in August and September of 2018 while working at the Crescent Center in Bennington, Vermont the Respondent withdrew opiate medications for three separate patients but failed to appropriately document administration or wasting of the medication. Some of the withdrawals were suspicious in their timing.
8. It was the recommendation of the State of Vermont that the Respondent's license be indefinitely suspended with the standard drug and alcohol conditions should the Board later determine that the Respondent's license should be reinstated. Those recommended conditions follow in the proposed order below.

Conclusions of Law

Respondent has received adequate or constructive notice of the charges in this matter as indicated by the Board's file and the Prosecution's presentation. Because Respondent 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 may find, based up the finding of Default from this Default Hearing held pursuant to 3 V.S.A. §809(d), that Respondent has engaged in the unprofessional conduct alleged in the Specification of Charges. The Respondent committed unprofessional conduct by violating 26 VSA Sec. 1582(a)(2) (Diverting or attempting to divert drugs or supplies for unauthorized use); VSA Sec. 129a(b)(2) (Failure to practice competently/failure to conform to essential standards of practice); 3 VSA Sec. 129a(b)(1) (Failure to practice competently by performance of unsafe or unacceptable patient care); and 3 VSA Sec. 129a(a)(15) (failure to exercise independent judgment in the performance of licensed activities).

Proposed Order

In accordance with the above Findings of Fact and Conclusions of Law, and consistent with the recommendation by the State, the Board does **ORDER** that the Respondent's license be **Indefinitely Suspended**. In the event that the Respondent seeks to regain her license, she must petition for reinstatement. At least forty-five (45) days prior to requesting reinstatement, Respondent must, at her own cost:

- (a) Obtain an independent evaluation report by a pre-approved licensed professional specializing in drug and alcohol abuse ("Independent Evaluator") who has verified receipt of the Default Order. The results of the Independent Evaluation must indicate that Respondent does not present a risk to the safety, health or welfare of Respondent's potential patients, as well as any recommendations that would ensure Respondent is safe to practice. The evaluation must be submitted to the Enforcement Unit Case Manager;
- (b) Submit to the Enforcement Unit Case Manager the results of a minimum of three (3) random urine analyses:
 - (i) When Respondent is ready to petition for reinstatement, Respondent shall contact the Enforcement Unit Case Manager at the Office of Professional

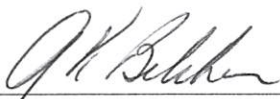
Regulation to set-up the urine analysis process and receive instructions. Once registered with the pre-approved person or entity, Respondent will have 45 days to submit to a minimum of three (3) random urine analyses. The process by which Respondent learns whether the Respondent is selected to provide a sample on any given day will be governed by the policy of the pre-approved person or entity conducting the testing at that time;

- (ii) The urine analyses must be collected in an observed setting, administered by a pre-approved lab qualified to analyze samples for forensic purposes, the results of which shall be negative;
- (iii) Failure to appear for, refusal to provide, adulteration of, dilution of, or tampering with a sample for any urine analysis shall cause that screen to be presumed positive;
- (c) If recommended by an Independent Evaluator, enter into a treating professional agreement and substance abuse treatment plan with a pre-approved treating professional(s) and follow all recommendations.

If reinstated, Respondent's license **SHALL BE CONDITIONED** pursuant to whatever terms are reasonable at the time of Respondent's reinstatement request, taking into account the independent evaluation, urine analysis results, the facts contained in the Default Order, and any other relevant factors at that time.

The Hearing Officer reports the above facts, conclusions of law, and the finding of DEFAULT to the Board with the recommendation that the Board approve them and enter the Order as above.

Dated this ^{22nd} day of May, 2019.



George K. Belcher
Hearing Officer of the Vermont Board of Nursing

The Vermont Board of Nursing considered the report of findings of fact and conclusions of law at its meeting on 10 June 2019. 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.
- ✓ Accepts the report, adopts the findings of fact and conclusions of law, and orders the recommended discipline as set forth in the proposed order above.

SO ORDERED.

Vermont Board of Nursing

By: 
Ellen Watson, Chair
Vermont Board of Nursing

Date: 10 June, 2019

OFFICE OF PROFESSIONAL REGULATION

DATE OF ENTRY: 6-11-19

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.



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MAY 23 2019

Secretary of State
Professional Regulation

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

IN RE:)
ERIKA WOODS) Docket No. 2018- 124
License No. 025.0109101)

SPECIFICATION OF CHARGES

NOW COMES the State of Vermont and makes the following Charges against the Respondent, Erika Woods.

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. Chapter 28; the Administrative Rules of the Board of Nursing (the "ARBN"); and the Rules of the Office of Professional Regulation.

Statement of Facts

2. Erika Woods ("Respondent") of Hoosick Falls, New York is licensed by the State of Vermont as a Licensed Practical Nurse ("LPN") under license number 025.0109101. This license was originally issued January 20, 2015, and expires on January 31, 2020.
3. At all relevant times, Respondent was employed as an LPN at Crescent Manor (the "Facility") in Bennington, Vermont.
4. Respondent was employed at the Facility between late August 2018 and September 17, 2018, and worked primarily on the dementia unit.
5. On any given shift, Respondent would often be responsible for medication administrations on her assigned unit.
6. During the relevant time period, Patient 1 had a physician's order for one tablet of Norco 5-325 (hydrocodone and acetaminophen) three times a day for pain.
7. Patient 1 also had a physician's order for one tablet of Norco 5-325 as needed in between the morning, afternoon, and evening doses.
8. Patient 1's Norco orders allowed for a max of 6 tabs per day.

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Office of
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89 Main Street
3rd Floor
Montpelier, VT
05620-3402

9. Nursing staff used nonverbal cues to assess Patient 1's pain levels as she could not adequately make her needs known.
10. Between August 29, 2018 and September 17, 2018, Respondent withdrew Norco 5-325 for Patient 1 approximately 8 times without documenting corresponding administration or waste of the withdrawn tablet.
11. Between August 29, 2018 and September 17, 2018, Respondent withdrew the majority of as needed Norco 5-325 doses for Patient 1.
12. Between August 29, 2018 and September 17, 2018, Respondent often documented administering an as needed dose of Norco 5-325 just an hour or two after a scheduled dose or another as needed dose.
13. Patient 2 had a physician's order for Oxycodone HCL 10mg every six (6) hours as needed for pain.
14. Despite an order for Oxycodone every 6 hours as needed, on September 10, 2018, Respondent documented 3 withdrawals of Patient 2's Oxycodone at 00:00, 03:30, and 06:00.
15. Respondent did not document administration or waste of the 03:30 and 06:00 withdrawals.
16. Patient 3 had a physician's order for Oxycodone HCL 15mg every six (6) hours as needed for pain.
17. Despite an order for Oxycodone every 6 hours as needed, on September 10, 2018, Respondent documented 3 withdrawals of Patient 3's Oxycodone at 00:00, 03:00, and 06:00.
18. Respondent did not document administration or waste of the 03:00 and 06:00 withdrawals.
19. Nursing staff reported being told by a mutual friend of Respondent's that Respondent would brag about how easy it is to take medication from the Facility.

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

20. The State re-alleges and incorporates Paragraphs 2 through 19 above.
21. As an LPN, Respondent is prohibited from diverting or attempting to divert drugs, equipment, or supplies for unauthorized use.

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

22. Respondent diverted or attempted to divert drugs for unauthorized use as demonstrated in Paragraphs 3 through 19 above.
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 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.

24. The State re-alleges and incorporates Paragraphs 2 through 19 above.
25. As an LPN, Respondent has an obligation to provide safe and acceptable patient care.
26. Paragraphs 3 through 19 above demonstrate that Respondent provided unsafe and unacceptable patient care by failing to properly document medication administration and/or waste.
27. Paragraphs 3 through 19 above demonstrate that Respondent provided unsafe and unacceptable patient care by administering medications too soon or outside of physician's orders.
28. 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: 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.

29. The State re-alleges and incorporates Paragraphs 2 through 19 above.
30. The essential standards of acceptable and prevailing practice require nurses to accurately account for all medication administrations and/or wasting of medications by accurately documenting when medication is actually administered or wasted.
31. Paragraphs 3 through 19 above demonstrate Respondent failed to meet this standard when she failed to properly document the administration or waste of medication.
32. The essential standards of acceptable and prevailing practice require nurses to follow physician's orders when administering medications.

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Office of
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89 Main Street
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05620-3402

33. Paragraphs 3 through 19 above demonstrate Respondent failed to meet this standard when she failed to properly follow physician's orders when administering medications.
34. 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 3 V.S.A. §129a(b)(2).

Violation Four: 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.

35. The State re-alleges and incorporates Paragraphs 2 through 19 above.
36. 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.
37. Respondent's conduct in Paragraphs 3 through 19 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.
38. 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 3 V.S.A. §129a(a)(15).

Relief Requested

WHEREFORE, the Licensed Practical Nurse license of Erika Woods should be revoked, suspended, reprimanded, conditioned, or otherwise disciplined.

DATED at Montpelier, Vermont this 21st day of November, 2018.

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

STATE OF VERMONT
SECRETARY OF STATE

By: Elizabeth A. St. James
Elizabeth A. St. James
State Prosecuting Attorney
(802) 828-1218
elizabeth.st.james@sec.state.vt.us

