

**IDAHO PERSONNEL COMMISSION**

**STATE OF IDAHO**

JENNIFER DRUMMOND,

Petitioner,

vs.

IDAHO DIVISION OF VETERANS  
SERVICES,

Respondent.

IPC No. 24-11  
OAH No. 24-194-13

**DECISION AND ORDER ON PETITION  
FOR REVIEW**

This matter is on petition for review from the June 11, 2025, decision of Hearing Officer Leslie Hayes (hereinafter “Hearing Officer”). After an evidentiary hearing, the Hearing Officer affirmed the dismissal of Jennifer Drummond (hereinafter “Petitioner” or “Drummond”) by the Idaho Division of Veterans Services (“IDVS”) for failure to follow policy in placing a resident’s catheter.

Although not in a traditional format, Drummond’s Petition for Review was timely filed. The Idaho Personnel Commission (“Commission”) heard oral argument in this matter on December 5, 2025. Drummond represented herself. Karen Sheehan appeared on behalf of IDVS. On February 20, 2026, Drummond filed a Motion to Expedite Decision, which is hereby rendered moot by issuance of this Decision and Order on Petition for Review.

**I.**

**FACTS, BACKGROUND AND PRIOR PROCEEDINGS**

**A. Facts**

Drummond began working as a Senior Registered Nurse at the Post Falls Veterans Home (“IDVS–PS”) on April 10, 2023. She initially served as staff development coordinator in charge of training IDVS staff in nursing procedures. In January 2024, Drummond transferred to floor cart nurse which was considered a lateral move. She remained in that position until her dismissal on November 18, 2024.

IDVS's reasons for disciplining Drummond arise from her care of Resident 1 ("R1") on the morning of October 25, 2024. Both Drummond and IDVS have provided detailed timelines in their briefing, although Drummond has not identified specific citations in the record in support of her appeal. For the sake of brevity, we have referenced the Hearing Officer's Preliminary Order ("Order"), the Hearing Transcript ("Tr."), Hearing Exhibits ("Ex.") or the parties' briefs.

### **October 25, 2024**

Drummond's shift started at 6:00 a.m. in the Sawtooth Wing of IDVS-PS. Three certified nursing assistants ("CNA") Jazmin Brumwell ("Brumwell"), Suzan Ellis ("Ellis") and Sarah Hobbs ("Hobbs") worked with Drummond to care for R1. No CNA recalls being with Drummond and R1 the entire time nor seeing Drummond administer any of R1's medications.

At IDVS-PS, nurses supervise CNAs. They perform most of the practical tasks involved in resident care, but do not dispense medications, make assessments of a resident's medical condition or perform treatments, such as catheter insertion. A CNA may report her observations of a resident or a resident's communications to supervising nurses. *See* Tr., p. 230, ll. 21-25; p. 231, ll. 1-24.

After she attended a staff meeting from 6:30 a.m. until 7:10 a.m., Drummond was advised R1 was not doing well. Her entries into R1's medical administration records ("MAR")<sup>1</sup> show that she administered his 15 daily prescriptions between 8:34 a.m. and 8:35 a.m. that morning.<sup>2</sup> These include a transdermal patch, inhalants administered with a nebulizer, as well as several pills prescribed to treat a number of medical conditions, including buprenorphine for chronic pain. Buprenorphine comes in pill form and is taken sublingually as it dissolves under the patient's tongue. *See* IDVS Ex. 8, pp. 1-3.

---

<sup>1</sup>The Post Falls Veterans Home Medication carts contain drawers where medications are stored. They are locked when not in use. *See* IDVS Ex. 11, p. 1. A computer is mounted on the rolling medication cart. After medications are given to residents, the nurse enters the time on the computer. If a resident refuses a medication, the home's medical administration policy requires that the nurse indicate this. *See* Tr., p. 114, ll. 24-25; p. 115, ll. 1-10.

<sup>2</sup> Inexplicably the MAR also shows Samantha Da Silva, LPN ("Da Silva") dispensing two of R1's medications at 11:17 a.m. when R1 had already been transported to the hospital emergency room. IDVS Ex. 8, p. 2.

Shortly after responding to R1's 9:00 a.m. call request, Hobbs and Brumwell, with assistance from Ellis, prepared R1 for a bed bath but had to stop due to his complaints of intense abdominal pain. They reported R1's pain to Drummond.<sup>3</sup> She examined R1, noting his distended abdomen and absence of urine in his catheter bag. *See* IDVS Ex. 12, pp. 4-5, IDVS Ex. 7. To comfort R1, he was given warm blankets, pillows, lotion, light bladder massage and worked through breathing exercises to help him relax. *See* IDVS Ex. 3, p. 5.

After unsuccessfully attempting to flush R1's catheter, Drummond removed and replaced it.<sup>4</sup> Drummond inserted a new Foley catheter, inflating the catheter balloon to ten ccs, rather than 20 ccs as recommended, due to concerns R1's bladder may already be full. *See* Tr., p. 420, ll. 7-12. Despite these efforts, R1 was still in pain. Drummond texted Director of Nursing Services Lydia Thompson, RN ("Thompson") at 9:01 a.m. to inquire about a bladder scanner. *See* IDVS Ex. 12, p.5.

Drummond gave R1 buprenorphine, although she is unsure of the exact time. She told Ellis and Hobbs she would take a break while the medication took effect.<sup>5</sup> Drummond left R1's room and interrupted a morning clinical meeting attended by several staff members including Adara Tredway, RN ("Tredway"), Da Silva and Thompson to ask if the bladder scanner was available. She told those present that R1 was in ten-out-of-ten pain and had no urine output for 24 hours. She explained her attempt to flush the catheter was unsuccessful, and that after replacing the Foley catheter, he still had no urine output. Drummond also indicated she was going to send R1 to the hospital emergency room. When asked if she needed help, she replied, "No, I've got it."

---

<sup>3</sup> Drummond claims the CNAs told her R1 was not doing well around 8:20 a.m. Tr., p. 412, ll. 18-20. She has stated the CNAs came and found her to report R1's pain. *See* IDVS Ex. 12, p. 4. The CNAs recall reporting R1's pain to Drummond when she entered his room. It is undisputed that once informed, Drummond worked to evaluate R1's condition almost immediately.

<sup>4</sup>Although not part of the record, a Foley catheter consists of a thin, flexible rubber or plastic tube inserted through the urethra into the bladder. One drainage port drains into a urine collection bag and the other pathway connects to a balloon at the tip of the tube. After the catheter is inserted, the balloon is inflated with sterile water to hold the Foley catheter in place in the bladder.

*See* <https://my.clevelandclinic.org/health/treatments/foley-catheter> last accessed October 30, 2025.

<sup>5</sup>Buprenorphine is prescribed for R1's chronic lower back pain, but Drummond hoped it would provide some relief for R1's acute pain that morning. *See* IDVS Ex. 7; IDVS Ex. 27.

*See* Tr., p. 95, ll. 9-22; Tr., p. 166, ll. 11-19; IDVS Ex. 20. Drummond did not discuss administering pain medication with anyone before leaving the meeting. Based on video surveillance records, the parties agree Drummond was on break from 9:46 a.m. until 10:02 a.m. *See* IDVS Ex. 2, p.2; Tr., p. 412, l. 23 – p. 413, l. 4.

The meeting ended several minutes after Drummond's departure. Tredway could hear R1's screaming in pain as she left the meeting. She learned Drummond was on break from speaking with staff at the nurses' station, went to R1's room and with his permission attempted to examine him. She had to stop because R1's complaints grew more intense, and he asked her to stop touching him. Tredway told R1 he would be transported to the hospital, called 911 and advised the operator of her assessment of R1. DaSilva also heard R1 screaming after leaving the meeting and assisted Tredway with R1's discharge paperwork. Drummond returned from her break and after hearing R1 was being transported to the ER, thanked Tredway and stated she was giving R1 time for vagal response. *See* IDVS Ex. 6. Tredway remained with R1 until EMTs arrived. Drummond was instructed to continue administering medications to the other patients in her care because she had attended mandatory training at 10:30 a.m. She provided R1's history to the EMTs. *See* Id., Tr., p. 99, ll. 17-18; T p. 413, ll. 4-10.

R1 was transported to the hospital at 10:40 a.m. He was diagnosed with a urinary tract infection and pneumonia. In the emergency room records Dr. Eric Schatz noted the Foley catheter balloon was most likely "inflated within the prostate and not the bladder and this was removed with improvement of systems. He has no urinary retention on ultrasound." *See* IDVS Ex. 9, p. 5.

After R1 left, Drummond continued administering medications to other residents. She asked DaSilva to take over her medical cart to pass the remaining medications for one patient so that she could leave for mandatory trauma care training. She was ultimately not able to attend because she arrived late. *See* Tr., p. 413, ll. 17-25.

At 11:00 a.m. Tredway made a neglect allegation to Home Director Amber Goodchild stating Drummond left a resident who was unable to void his bladder and in ten-out-of-ten pain<sup>6</sup> to go on a 15-minute break. *See* IDVS Ex. 12, p. 1. IDVS-PS is a mandatory reporter for elder abuse under both state and federal law. *See* IDVS Ex. 15; IDVS Ex. 28. According to IDVS Freedom from Resident Abuse, Neglect, Mistreatment & Exploitation Policy and Procedure, the person accused of neglect is required to leave the Home for his or her own protection and may not work at any IDVS home until the investigation is complete. *See* IDVS Ex. 15, p. 9. Thompson and Goodchild met with Drummond from 11:00 a.m. to 11:16 a.m., advised her of the allegation, and placed her on administrative leave pending an investigation.

Drummond prepared and signed the following written statement that morning:

This am I went to assess [R1] with complaint of 10/10 pain. Upon assessment this nurse found that his foley was not draining and upon further assessment this nurse realized he hadn't urinated in more than 24 hours. Foley flushed without effectiveness, foley completely changed with no urine output. Pain pill Buprenorphine given [illegible]. The Resident was in 10/10 pain. This Rn told CNAs Jazmine and Sarah Hobbs I was going to take a 15 minute break while I allowed pain Rx to "kick in" so the Resident would vasodilate and then I could reassess urinary output and proceed with ER trip if applicable.

*See* IDVS Ex. 7.

During their meeting, Thompson gave Drummond a letter regarding administrative leave. *See* IDVS Ex. 1. She was advised verbally and in writing not to contact anyone at IDVS except for Goodchild or Human Resources Officer Bri Watkins ("Watkins") during the investigation. Later that evening she texted Tredway and DaSilva explaining she had given R1 a sublingual pain pill, chosen to take a 15-minute break while the medication took effect and planned to reassess R1's pain level and urine output upon her return from break.

He had already gone greater than 24 hours with no urinary output, another q15 minutes to treat and reassess the situation wasn't going to make a difference and might have actually relieved him. That was intentional on my part. Not everything

---

<sup>6</sup>IDVS Post Falls Home pain scale is from one to ten with zero being no pain and ten being the worst pain a resident has ever experienced. *See* Tr., p. 107, ll. 18-22.

is an emergency, you will both learn as you gain experience... but that comes with time.

*See* IDVS Ex. 4, pp. 17-18.

An Abuse Response Team (“ART”) led by Kelcie Devitt (“Devitt”) was assigned to investigate the allegation that same day. Devitt interviewed R1, Tredway, Drummond and ten others. The investigation was completed on November 1, 2024 and included a follow-up with R1 who “sustained no emotional distress” and “has expressed feelings of safety.” R1 told Devitt he remembers pain when Drummond removed the catheter and inserted a new one, does not remember being given any pain medication at IDVS-PS and recalls that hospital staff told him the catheter was not inserted correctly. *See* IDVS Ex. 12, p. 7. The ART concluded that the neglect allegation was verified and the investigation was turned over to IDVS-PS Human Resources for further disciplinary action. *See Id.*, pp. 8-9.

IDVS provided Drummond a Notice of Contemplated Action (“NOCA”) on November 1, 2024. The NOCA cited IDAPA 15.04.01.190.01.b (Inefficiency, incompetency, or negligence in performing duties, or job performance that fails to meet established performance standards) and (e) (Insubordination or conduct unbecoming a state employee or conduct detrimental to good order and discipline in the agency) as the as the legal bases for taking disciplinary action. *See* IDVS Ex. 2, p. 1.

As grounds for discipline, IDVS made a number of claims. IDVS alleged Drummond did not follow IDVS catheter insertion procedure in replacing the R1’s Foley Catheter because she inflated the balloon prior to seeing any urine output and had determined proper catheter placement using a stethoscope to listen for the “whoosh sound.” *See* IDVS Ex. 10; IDVS Ex. 12, p.5; IDVS Ex. 2, p.2. The NOCA further alleged Drummond failed to follow the Medication Administration and Medication Order Procedure regarding other patients’ medications when she asked DaSilva to dispense medications to her patients so she could attend mandatory training. Finally, the NOCA alleged she violated a directive by texting Tredway and DaSilva after being placed on

administrative leave and being instructed such communications were prohibited. *See* IDVS Ex. 2, pp. 2-4.

In addition to witness statements, IDVS relied on documentation to claim that Drummond's account did not align with R1's medical records. The NOCA asserted Drummond's claim R1 had no urinary output for 24 hours was erroneous and made without verifying information in R1's chart based on review of CNA Maria Martinez Garay's note of R1's urinary output of 3500 ccs at 5:55 that morning. It further cited medication administration records showing Drummond gave R1's medications earlier than 9:15 a.m. despite her statement to investigators.

Finally, the NOCA noted possible neglect because Drummond took her break after leaving the meeting she had interrupted rather than sending R1 to the hospital as directed. On November 2, 2024, Drummond provided her response and hand-delivered it on November 12, 2024. She addressed it to each person on the letterhead including the governor, chief of administration, the home administrator and the human resources officer. In her response, Drummond claimed she checked out R1's pain pill from the medication cart but he was not able to take it, stated she did both procedures to check for catheter placement, and examined R1's catheter bag after reviewing the chart because the bag's maximum capacity is 2,000 ccs making the note of 3500 ccs physically impossible. *See* IDVS Ex. 3, pp. 10-11. Drummond also alleged that she was being personally targeted in retaliation for various past complaints she made about Goodchild and Thompson. *See Id.*, p. 16.

Based on her response, IDVS advised Drummond of her dismissal in a Letter of Disciplinary Action ("LODA") on November 18, 2024 citing four reasons:

- 1) Substantiated Neglect based on leaving a resident in ten-out-of-ten pain to take a break;
- 2) Substantiated Neglect based on improper catheter placement;
- 3) Failure to Follow Medication policy including a new allegation Drummond failed to properly document the time R1 was given buprenorphine; and

- 4) Interference with an investigation based on the text messages Drummond sent to Tredway and DaSilva on administrative leave.

*See* IDVS Ex. 4 p. 2-4. On November 26, 2024, Drummond emailed her intent to appeal her termination, again claiming the neglect allegations against her were in retaliation, were an abuse of power, and called for an investigation of the Division Administrator and Home Director.

The matter was assigned to a hearing officer on December 4, 2024. IDVS filed a Motion to Dismiss because Drummond asked for an investigation as a remedy rather than reinstatement. The Hearing Officer denied the Motion, finding the scope of the appeal would be confined to her termination.

On March 28, 2025, the Hearing Officer presided over a one-day evidentiary hearing at the College of Northern Idaho. She entered 121 Findings of Fact, 49 Conclusions of Law and a Preliminary Order on June 11, 2025, finding that IDVS had failed to prove by a preponderance of the evidence that there was proper cause for Rule 190 dismissal as to the interference with an investigation, failure to follow medication policy, and neglect for taking a break while R1 was in pain. As for improper placement of R1's catheter, the Hearing Officer concluded IDVS did meet its burden for neglect and affirmed Drummond's dismissal.

**B. Appeal to Personnel Commission**

Drummond sent a series of emails to DHR indicating she wished to appeal the Hearing Officer's decision. Although not in a traditional format, her appeal as well as her 20-page email brief was timely filed. In her Petition for Review, Drummond only addresses the improper catheter placement. IDVS streamlined its response to address the catheter placement, the neglect allegation due to Drummond's break and asked to strike certain findings of fact. IDVS did not file a cross-appeal.

**II.**

**ISSUE**

Did IDVS prove by a preponderance of the evidence that Appellant violated Idaho Code 67-5309(m) and IDAPA Rule 15.04.01.190.01 (b) and (e)?

### III.

#### STANDARD OF REVIEW

The standard of review in disciplinary appeals to the Commission is as follows:

When a matter is appealed to the Idaho Personnel Commission (IPC or the Commission) it is initially assigned to a Hearing Officer. I.C. § 67-5316(3). The Hearing Officer may allow motion and discovery practice and conduct a full evidentiary hearing before entering a decision containing findings of fact and conclusions of law. In cases involving Rule 190 discipline, the state agency bears the burden of proof by a preponderance of evidence that there was justification for the disciplinary action. *Whittier v. Dept. of Health & Welfare*, 137 Idaho 75, 78 (2002). Discipline must be based upon one of the reasons set forth in IPC Rule 190 and any one rule violation supports the level of discipline the state agency decides to enforce. *Idaho Dept. of Health & Welfare v. Arnold*, IPC No. 04-26 (January 5, 2006). If cause for discipline exists, IPC does not have jurisdiction to decide the level of discipline the agency decides to impose. *McClure v. Idaho Department of Correction*, IPC Case No. 21-6 (July 5, 2023).

On a petition for review to the IPC from the Hearing Officer's Preliminary Order, the Commission reviews the record of the proceeding before the hearing officer, the transcript of the hearing and any briefs submitted by the parties. Idaho Code § 67-5317(1). The hearing before the Commission on a petition for review is limited to oral arguments regarding issues of law and fact as may be found in the record before the Hearing Officer and any post hearing orders. IPC Rule 202.03. Findings of fact must be supported by substantial, competent evidence. *Hansen v. Idaho Dep't of Correction*, IPC No. 94-42 (December 15, 1995). IPC exercises free review over issues of law. The Commission may affirm, reverse, or modify the decision of the Hearing Officer, may remand the matter, or may dismiss it for lack of jurisdiction. I.C. § 67-5317(1); *Soong v. Idaho Department of Welfare*, IPC No. 94-03 (February 21, 1996), *aff'd*, 132 Idaho 166, 968 P.2d 261 (Ct. App. 1998).

### IV.

#### DISCUSSION

##### A. Proof of Cause for Discipline

The first question before the Commission is whether IDVS established proper cause for Drummond's termination by a preponderance of the evidence as to each of the allegations lodged against Drummond and whether the Hearing Officer's findings of fact are supported by substantial

competent evidence. Drummond has only addressed the catheter insertion allegation in her Petition for Review and Briefing but we will briefly discuss the other allegations.

1. Interference with an Investigation in Violation of a Directive

IDVS alleges that when Drummond texted DaSilva and Tredway the evening of October 25, 2024, she violated Goodchild's instruction not to contact anyone other than Goodchild or Human Resources Officer Watkins while the investigation was pending. Goodchild and Watkins both testified Drummond was told not to communicate with anyone from IDVS other than Goodchild, Watkins or the ART investigators. Goodchild also testified that she handed the letter to Drummond but later learned Drummond left it in Goodchild's office. *See* IDVS Ex. 1; Tr., p. 287, ll. 24-25; p. 288, ll. 1-5. DaSilva and Tredway forwarded Drummond's text messages to Goodchild and the following Monday, Goodchild and Watkins called Drummond and reminded her of the restriction on contacting IDVS staff.

Drummond stated in her NOCA that she wasn't given the letter prior to being escorted from the building on October 25, 2024. *See* IDVS Ex. 3, p. 1. At the hearing Drummond testified that nothing was handed to her at the meeting, that when she asked if she needed to take any paperwork with her, she was told no and that she did not remember receiving the directive until the October 28, 2024 phone call. *See* Tr., p. 409, ll. 21-25; p. 410, pp 1-4.

The Hearing Officer heard Drummond's testimony and evaluated her credibility. The IPC will typically defer to the Hearing Officer when a witness' credibility is at issue. *See Wikse v. Dep't of Health and Welfare*, IPC No. 96-12 (1998) and Idaho Courts have agreed.

“Where credibility is crucial and where first-hand exposure to the witnesses may strongly affect the outcome, we think the Personnel Commission should not override the hearing officer's impressions unless it makes a cogent explanation of its reasons for doing so”. *Dep't of Health and Welfare v. Sandoval*, 113 Idaho 186, 742 P.2d 992 9(Ct. App. 1987).

Furthermore, since it is undisputed Drummond left IDVS-PS on October 25, 2024 without the letter and complied with the directive once she was reminded in the October 28, 2024 phone call, the Hearing Officer found there is no evidence to support a finding that Drummond acted

willfully in her noncompliance with the directive. Therefore, she did not find factual support for a finding of insubordination on Drummond's part when she sent the text messages to DaSilva and Tredway on October 25, 2024. *See* Order, pp. 32-33. We agree.

2. Medication Policy Violations

IDVS alleged Drummond violated the Medication Administration and Medication Orders Policy by 1) failing to accurately document when R1 received buprenorphine and 2) in asking DaSilva to finish administering medications to Drummond's resident so that she could attend mandatory training. IDVS-PS policy requires that no medications should be set up in advance of giving them to a resident, should not be stored on the top of the cart, and must be removed from the cart drawers by the nurse dispensing the medication. *See* IDVS Ex. 11, p.1.

a. *Administration of Buprenorphine*

A classified state employee must be given notice and an opportunity to respond before an agency's disciplinary dismissal, suspension, demotion or involuntary transfer becomes effective *See* Idaho Code § 67-5315(2). An agency must provide notice of contemplated action, the basis for the contemplated action, and an explanation of the evidence supporting the contemplated action to both the employee and the administrator concurrently. The employee must be given an opportunity to respond and present reasons why the agency should not take the contemplated action. *See* IDAPA 15.04.01.200.06.

With respect to Drummond's failure to properly chart when R1 received buprenorphine, the Hearing Officer points out, Drummond was not given notice IDVS was contemplating disciplinary action for this violation of the medication policy until she received the LODA. Although the timing of R1's taking Buprenorphine was discussed, Drummond was not asked about this possible violation during the ART investigation, and it was not part of the NOCA. The Hearing Officer correctly found that IDVS did not properly put Drummond on notice that, as part of the contemplated action, IDVS was relying on evidence that she allegedly violated the Medication Policy by not properly documenting the time the buprenorphine was administered. *See* Order, p. 26-28. ¶¶ 8-16. We affirm the Hearing Officer's findings in this regard.

b. *Drummond's Request that DaSilva Complete her Medication Administration*

IDVS has also alleged that Drummond further violated the medication policy when she asked DaSilva to give medications to Drummond's residents because Drummond needed to attend a mandatory training. IDVS sought to prove this allegation through witness testimony as no MARs were introduced into evidence for any patients other than R1. Tredway testified the request was not inappropriate and that she could not verify if Drummond had set up her medications prior to giving them to residents because she only saw a medication cup on the cart but not its contents. *See Tr.*, p. 104, ll. 3-15, *Tr.* p. 113, ll 15-25; p. 114, ll. 1-10. DaSilva testified that when Drummond made the request, Drummond had three residents needing morning medications and that she only agreed to help with one resident's medications. Drummond completed the other two. *See Tr.* p. 155, ll. 12-25; p. 156, ll 1-2. DaSilva was also apparently disciplined for assisting Drummond. *Tr.*, p. 156, ll. 3-19.

Drummond recalls that two of the residents were standing by the medication cart waiting for their medications and that one resident took some of his pills and wanted to take the remaining ones when he returned from physical therapy. Drummond testified that when she spoke with DaSilva, she told her she could discard the medication or give it to the resident when he returned from physical therapy. *Tr.*, p. 431, ll. 20-25; p. 434, ll. 1-9. The Hearing Officer found that based on Drummond's testimony, she acted according to IDVS-PS policy when she set up the residents' medications prior to dispensing them to the residents. DaSilva testified that medications were pre-poured. *Tr.*, p. 155, ll. 17-25; p. 156, ll. 1-2. The Hearing Officer found both witnesses to be equally credible and determined IDVS did not carry its burden as to this alleged policy violation. We agree with the Hearing Officer's reasoning as she heard the testimony, had the benefit of the appearance and demeanor of both testifying witnesses, evaluated each witness's credibility and found IDVS did not meet its burden. *See Order*, pp. 31-32, ¶¶ 35-42. We affirm this finding.

3. Drummond's Break

In deciding to discipline Drummond, IDVS determined her decision to take a break rather than returning to R1's room or arranging for transport to the hospital was neglect and did not meet the standard of care for a reasonably prudent nurse. The Hearing Officer heard from two expert witnesses<sup>7</sup>, Tredway and Thompson, about the nursing standard of care. Standard of care for nurses is typically defined as what a reasonable and prudent nurse would do when caring for a similar patient in the same or similar circumstances. *See Fisk v. McDonald*, 167 Idaho 870, 477 P.3d 924 (2020).

In Thompson's opinion, a reasonably prudent nurse would not take a break when a patient is in extreme pain but should stay with the resident to provide comfort and help determine the cause of the pain. Tr., p. 245, ll. 20-25; p. 246, ll. 1-7. Although she made the original neglect allegation against Drummond and has been a nurse for almost six years, Tredway was also qualified as an expert over Drummond's objections. She also testified that a reasonably prudent nurse would not have left R1 in the condition Tredway found him in to take a break. *See Tr.*, p. 103, ll. 12-22.

The Hearing Officer found that because Drummond gave R1 the buprenorphine, left to look for a bladder scanner and elected to take a break to see if the pain medication would take effect, she had a care plan in place for R1 and thus, IDVS did not meet its burden of proving Drummond neglected R1. *See Order*, p. 30.

IDVS has maintained that the timing of the pain medication had no effect on the outcome of the investigation and is immaterial. *See Tr.*, p. 301, ll. 23-25; p. 302, ll. 1-6. IDVS also disputes that Drummond had any care plan in place and asserts that had Drummond remained with R1, he could have been taken by ambulance to the hospital earlier, and the source of his pain determined more quickly. Drummond has also argued she believed a doctor's order was required before R1

---

<sup>7</sup> It is not lost on the Commission that the expert witnesses are IDVS employees, and one is the main accuser on the neglect accusation. This presents issues regarding fairness and an appearance of partiality and undermines objectivity required of expert testimony.

could be transported to the hospital which IDVS also disputes. Thompson testified that a doctor's order is recommended but not required. *See Tr.*, p. 106, ll. 8-17.

Ultimately, the Hearing Officer found IDVS did not carry its burden to show that the source of R1's pain could have been determined more quickly had Drummond not left to take a break. *See Order*, pp. 29-30, ¶¶ 19-28. We agree. Although leaving a patient in what has been described as excruciating pain to take a break, for whatever reason, would not be the type of action IDVS would want to encourage, and even accepting Treadway and Thompson's testimony on the nursing standard of care, no evidence was offered that when Drummond left R1's room he was screaming in pain or was in the condition that Tredway discovered him in after the meeting concluded. At all times, Drummond has maintained she wanted some time to see if the medication would take effect and R1 is not able to provide the details of his pain escalation that morning.

#### 4. Improper Catheter Placement

In her Petition for Review, Drummond addresses one area as error – the finding of neglect due to improper catheter placement. In the IDVS' investigation, Kelcie Devitt, leading the Abuse Response Team, asked Drummond how she determined proper placement of the catheter before inflating the balloon. She stated: "There is a couple of different ways to do it. If there was urine output, or you can put a stethoscope up to his bladder to listen to the whoosh sounds which is what I did. There were 15CCs in the normal balloon that was in prior, and when you put in the new balloon, I only put in 10 CCs due to concerns of his bladder being full already." *See IDVS Ex. 12*, p. 5.

Drummond argues these were Devitt's words and that she was misquoted. *See July 5, 2025 Drummond Email*, p.1 (Drummond Petition for Review). Drummond asserts she used the stethoscope to listen for bowel and bladder sounds and not to determine proper catheter placement.

Drummond called three CNAs as witnesses. Only Brumwell mentioned the stethoscope because she saw Drummond auscultate the R1's abdomen and Drummond explained why she was doing this. Abuse Response Team lead investigator Devitt was also a witness at the evidentiary

hearing, but Drummond did not ask Devitt any questions about misquoting her. She also did not raise the issue during the testimony of IDVS's two expert witnesses Thompson and Tredway.

Finally, Drummond in briefing to the Commission on petition for review, now disputes ever inflating the Foley catheter balloon. *See* Written Brief for IPC, p. 7 filed August 4, 2025. This contradicts her statement in a follow-up interview with Devitt, (see above) and also when questioned under oath at the evidentiary hearing. When questioned by the Hearing Officer whether she inflated the balloon after placing the catheter when there was minimal urine output, Drummond testified as follows: "I inflated 10 cc's when the typical is 30 cc's. So I inflated – I inflated just enough to get in in there and to get – to let the nasty start draining." *See* Tr., p. 420, ll. 7-12.

The Hearing Officer did not find this testimony credible because it contradicted multiple documents in the record and also the testimony of several witnesses in the record, including Drummond's own prior statements, including on October 25, 2024 (IDVS Ex. 7). *See* Order, p. 20, ¶ 92. The Hearing Officer found there was no urine output at the time Drummond placed the catheter. We agree and affirm the Hearing Officer's finding.

IDVS has proven a factual basis for the imposition of discipline on Drummond by a preponderance of the evidence, with respect to proving Drummond improperly inserted a Foley catheter in violation of IDVS policy by not waiting for urine output prior to inflating the balloon.

## V.

### CONCLUSION

While not finding IDVS proved any of the other multiple allegations by a preponderance of the evidence, the Hearing Officer did conclude IDVS had proper cause for discipline because IDVS established a single allegation that Drummond did not follow catheter placement policy when she inflated the balloon prior to detecting urine output. That failure is a proper basis for discipline pursuant to IDAPA 15.04.01.190.01(b). The findings and conclusions are supported by substantial and competent evidence in the administrative record and just cause for discipline exists.

The Hearing Officer's decision is affirmed.

Each party shall bear its own attorneys' fees and costs.

IT IS SO ORDERED.

V.

**STATEMENT OF APPEAL RIGHTS**

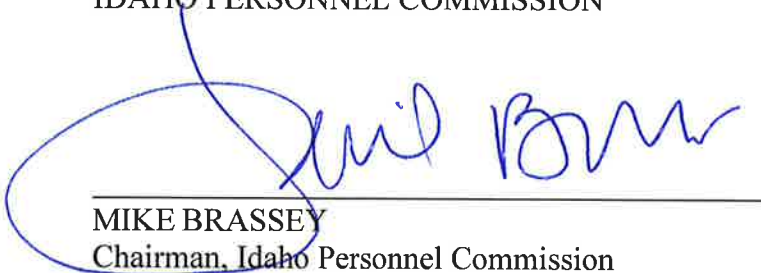
Either party may appeal this decision to the District Court. A notice of appeal must be filed in the District Court within forty-two (42) days of the filing of this decision. Idaho Code § 67-5317(3). The District Court has the power to affirm, or set aside, and remand the matter to the Commission upon the following grounds, and shall not set the same aside on any other grounds:

- (1) That the findings of fact are not based on any substantial, competent evidence;
- (2) That the commission has acted without jurisdiction or in excess of its powers;
- (3) That the findings of fact by the commission do not as a matter of law support the decision.

Idaho Code § 67-5318.

DATED THIS 26<sup>TH</sup> day of February, 2026.

BY ORDER OF THE  
IDAHO PERSONNEL COMMISSION



MIKE BRASSEY  
Chairman, Idaho Personnel Commission

COMMISSIONERS NANCY MERRILL AND ERIKA MALMEN CONCUR.

**CERTIFICATE OF SERVICE**

I hereby certify that on February 24, 2026, I forwarded a true and correct copy of the foregoing to the following via electronic mail:

Jennifer Drummond  
[DDJDTarlton@outlook.com](mailto:DDJDTarlton@outlook.com)  
*Petitioner*

Karen Sheehan  
Deputy Attorney General  
[karen.sheehan@ag.idaho.gov](mailto:karen.sheehan@ag.idaho.gov)  
*Attorney for Respondent*



---

Secretary to the  
Idaho Personnel Commission