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

IN RE:	)	
Wanda Rawlings	)	**Docket No. 2022-170**
License No. 026.0116973	)	

STIPULATED VOLUNTARY SURRENDER OF LICENSE

STIPULATION

NOW COMES the State of Vermont, by and through Prosecuting Attorney Ultan Doyle, and Respondent, Wanda Rawlings, who hereby 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. Chapter 28; the Administrative Rules of the Board of Nursing (the "ARBN"); and the Rules of the Office of Professional Regulation.

Stipulated Facts

2. Wanda Rawlings ("Respondent") of Swanton, Vermont is licensed by the State of Vermont as a Registered Nurse ("RN") under license number 026.0116973. This license was originally issued on November 16, 2015 and expires on March 31, 2023.

Incident One

3. During the relevant time period, Respondent was employed as an RN by Northwestern Medical Center ("Facility 1"), located in St. Albans, Vermont.

4. On June 29, 2019, Respondent was charged with providing care for patient, G.W. (Patient 1) from 7:00pm until 7:30 the following morning.

5. Prior to the start of Respondent's shift, at approximately 3:20pm, R.N., R.C., noted the following in Patient 1's chart: "asymptomatic to high BP, will notify NP."

6. At approximately 9:25pm, Licensed Nursing Assistant, H.B., took Patient 1's vital signs and documented a high blood pressure reading of 196/77.

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7. On June 30, 2019, at approximately 4:56am, H.B. took Patient 1's vital signs again and documented another high blood pressure reading of 216/76.

8. Shortly thereafter, H.B. told Respondent about Patient 1's blood pressure reading of 216/76.

9. Respondent took Patient 1's blood pressure herself to verify the reading, but failed to document that reading anywhere.

10. Respondent did not ask H.B. about any earlier blood pressure readings from that night.

11. Respondent also did not recall noticing Patient 1's earlier blood pressure reading when she checked her chart in the system.

12. Respondent did not notify a provider about Patient 1's high blood pressure reading and did not document any assessment or follow up.

13. Respondent also did not ask Patient 1 any questions in response to her high blood pressure reading, such as whether she had any chest pain/tightness, a headache or lightheadedness.

14. Instead, Respondent decided to administer Patient 1's Metoprolol (used to treat high blood pressure) at approximately 5:08am, almost 5 hours earlier than Patient 1 was scheduled to receive that medication.

15. Respondent also decided to administer Patient 1's Lisinopril (also used to treat high blood pressure), at approximately 5:09am, also almost 5 hours earlier than Patient 1 was scheduled to receive that medication.

16. Respondent did not receive seek or receive provider authorization to administer either of Patient 1's blood pressure medications earlier than they were scheduled.

17. Respondent was aware that medications should only have been administered within one hour of administration time.

18. At 6:51am, H.B. documented that Patient 1's blood pressure reading was still high at 182/68.

19. Respondent also did not report this reading to a provider and did not document any assessment or follow up.

20. Respondent did not complete any notes during the course of her overnight shift from June 29 to 30.

21. Respondent acknowledged in an interview with OPR investigators that she should have notified a provider of Patient 1's high blood pressure.

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22. At approximately 7:22am, Respondent completed documentation for SBAR handoff communication to R.N., R.C..

23. At approximately 8:10am, R.C. conducted a physical focused assessment and noted that patient complained of left sided chest pain and that her blood pressure was 192/66.

24. At 8:10am, R.C. noted the following: "BP rechecked 192/66, nights gave HTN meds around 0500 for high BP's. pt reporting left sided chest pain (left breast), 5/10 stabbing non-radiating pain. pt states pain has been present since the night but had not reported... NP notified."

25. Patient 1 ended up having EKG changes and required IV medications to respond to her hypertension.

Incident Two

26. During the relevant time period, Respondent continued to be employed as an RN by Facility 1.

27. On July 2, 2019, Respondent was charged with providing care during the overnight shift for patient, S.M. (Patient 2), who was recovering from a recent surgery.

28. At approximately 7:56pm, an LNA documented that Patient 2's blood oxygen level, which had previously been documented at 95-97%, dropped to 93%.

29. It is unclear from the medical records whether Respondent was aware of this issue at the time.

30. At 8:24pm, Respondent orally administered 5mg of Valium to Patient 2 for shoulder spasms.

31. At 8:25pm, Respondent administered 3mg IV of Hydromorphone.

32. At 9:00pm, Patient 2 was scheduled to be administered 0.5mg of Ativan, which had been ordered QID (every 6 hours). Without consulting with a provider, Respondent did not administer this medication until 1:57am.

33. Respondent also administered 2mg IV Hydromorphone at 1:57am.

34. At 2:38am, Respondent documented that Patient 2's blood pressure reading was at 78/61 and that her blood oxygen level was at 78%.

35. There is no evidence that Respondent notified a provider of these readings.

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36. When interviewed by OPR investigators, Respondent indicated that the low blood oxygen level could have resulted from the medications she had just administered.

37. Respondent told OPR investigators that she would have needed a provider's order to administer a scheduled drug outside of the scheduled time. Respondent did not seek such an order nor did she document a reason for administering medication outside of the scheduled time. Respondent told investigators that at this time, she should have notified a provider of what was going on.

38. Respondent also added that looking back it, she had done a "really bad job."

39. Rather than notify a provider, Respondent decided on her own initiative to treat Patient 2 with 4 liters of oxygen.

40. At 2:48am, Respondent documented a blood pressure reading of 113/62 and a blood oxygen level of 100%.

41. Respondent again did not notify a provider of her findings or seek help or guidance from a provider.

42. At 5:02am, Respondent administered Patient 2 another 0.5mg of Ativan even though she was not scheduled to receive the medication until 8:00am. Respondent documented the administration in the MAR under the scheduled 8:00am dose.

43. Respondent also administered 2mg IV Hyrdomorphone at 5:02am.

44. There is no documentation that Respondent took Patient 2's vital signs prior to administering these two medications.

45. At 5:25am, a licensed nursing assistant documented that Patient 2's blood pressure reading was down to 93/53. Patient 2's blood oxygen level was 98%, but only because she was being supported by 3 liters of oxygen at the time.

46. There is no documentation that Respondent notified a provider of these findings.

47. Patient 2 was required to have intravenous fluids running at 125ml/hour until she could tolerate more than 1000ml by mouth.

48. Respondent paused these intravenous fluids at 6:15am even though Patient 2 had not met the oral intake requirement for discontinuation (the last oral fluid intake documented by WR was 240ml at 4:12am).

49. Respondent told OPR investigators that Patient 2 told her that she had had sufficient oral fluid intake. However, this was not documented in Patient 2's records.

50. On July 10, 2019, Respondent's employment was terminated by Facility 1.

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Incident 3

51. During the relevant time period, Respondent was employed as an RN by the University of Vermont Medical Center ("Facility 2"), located in Burlington, Vermont.

52. On July 11, 2022, L.F., an RN who worked with Respondent, discovered that Respondent had sent a Seizure Action Plan ("SAP") to a school nurse which listed the incorrect dosage of a medication.

53. The action plan was electronically signed by APRN B.C. on July 6, 2022.

54. L.F. spoke to Respondent about the error on the SAP and learned from Respondent that she had not reviewed the SAP with B.C. prior to signing his name to it and sending it to the school nurse.

55. L.F. reported the incident to Respondent's supervisor.

56. On July 14, 2022, B.C. spoke to Respondent's supervisor and told her that he had not reviewed the SAP in question and had not signed it.

57. The same day, Respondent met with her supervisor and admitted to her that she had signed the SAP as though she was B.C. and did not review it with him prior to signing it.

58. On July 19, 2022 during a meeting with Facility's Assistant Director of Neurology and Psychology and the Human Resources Business Partner, when asked why she signed the SAP without the provider's knowledge or approval, Respondent said she must have forgotten to ask B.C. to review the action plan.

59. Respondent also admitted in the July 19, 2022 meeting that she had signed other SAPs on providers' behalf without their knowledge and approval.

60. A review by the Facility confirmed that Respondent had created and sent several SAPs without provider approval. These SAPs contained either the provider's signature or no signature.

61. On July 21, 2022, Respondent was terminated from the Facility for signing the July 6, 2022 SAP as if she were the provider, and also for signing other SAPs on behalf of providers without their review and approval.

62. On August 24, 2022, Respondent told an OPR investigator she had sent an SAP containing an error to a school without having it first verified by a provider and said, "It's completely my mistake."

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Violation One: 3 V.S.A. §129a(a)(13) Performing treatments or providing services that the licensee is not qualified to perform or that are beyond the scope of the licensee's education, training, capabilities, experience, or scope of practice.

63. Paragraphs 2 through 62 above are incorporated herein.

64. As an RN, Respondent is required to refrain from performing treatments or providing services that she is not qualified to perform or that are beyond the scope of her education, training, capabilities, experience, or scope of practice.

65. Paragraphs 2 through 62 demonstrate that Respondent performed a treatment that was beyond the scope of her education, training, capabilities, experience, or scope of practice when she administered blood pressure medication to Patient 1 outside of the provider's order, without notifying the provider, and she administered Ativan to Patient 2 on two occasions also outside of the provider's order, without notifying the provider; when she signed the July 6, 2022 SAP using a provider's signature without the provider's knowledge and approval; and when she signed other SAPs on providers' behalf without their knowledge and approval.

66. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent committed unprofessional conduct of a character likely to deceive, defraud, or harm the public in violation of 3 V.S.A. §129a(a)(13).

Violation Two: 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.

67. Paragraphs 2 through 62 above are incorporated herein.

68. As an RN, 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.

69. Paragraphs 2 through 62 demonstrate that Respondent failed to exercise independent professional judgment when she failed to notify a provider about Patient 1's high blood pressure; failed to document an assessment or follow up; failed to ask questions about chest pain/tightness, a headache or lightheadedness; administered blood pressure medication outside of the provider's order without notifying the provider; failed to notify a provider of Patient 2's low blood pressure and low blood oxygen levels; administered 4 liters of oxygen to Patient 2 without first checking with a provider; administered Ativan to Patient 2 on two occasions outside of the provider's order, without notifying the provider; discontinued the administration of intravenous fluids to Patient 2 prematurely; and when she signed the July 6, 2022 SAP using a provider's signature without the provider's knowledge and approval; and when she signed other SAPs on providers' behalf without their knowledge and approval.

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

Violation Three: 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.

71. Paragraphs 2 through 62 above are incorporated herein.

72. Vermont law requires RNs to practice competently by providing safe and acceptable patient care.

73. Paragraphs 2 through 62 above demonstrate that Respondent failed to provide safe and acceptable patient care when she failed to notify a provider about Patient 1's high blood pressure; failed to document an assessment or follow up; failed to ask questions about chest pain/tightness, a headache or lightheadedness; administered blood pressure medication outside of the provider's order without notifying the provider; failed to notify a provider of Patient 2's low blood pressure and low blood oxygen levels; administered 4 liters of oxygen to Patient 2 without first checking with a provider; administered Ativan to Patient 2 on two occasions outside of the provider's order, without notifying the provider; discontinued the administration of intravenous fluids to Patient 2 prematurely; when she signed the July 6, 2022 SAP using a provider's signature without the provider's knowledge and approval; and when she signed other SAPs on providers' behalf without their knowledge and approval.

74. 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)(1).

Violation Four: 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.

75. Paragraphs 2 through 62 above are incorporated herein.

76. The essential standards of acceptable and prevailing practice require that an RN follow providers orders when administering medication and accurately document patient records.

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77. Paragraphs 2 through 62 above demonstrate that Respondent failed to conform to essential standards of acceptable and prevailing practice when she failed to notify a provider about Patient 1's high blood pressure; failed to document an assessment or follow up; failed to ask questions about chest pain/tightness, a headache or lightheadedness; administered blood pressure medication outside of the provider's order without notifying the provider; failed to notify a provider of Patient 2's low blood pressure and low blood oxygen levels; administered 4 liters of oxygen to Patient 2 without first checking with a provider; administered Ativan to Patient 2 on two occasions outside of the provider's order, without notifying the provider; discontinued the administration of intravenous fluids to Patient 2 prematurely; when she signed the July 6, 2022 SAP using a provider's signature without the provider's knowledge and approval; and when she signed other SAPs on providers' behalf without their knowledge and approval.

78. 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).

Understandings

79. Respondent admits that the facts above are true and desires to voluntarily surrender her Registered Nurse license. The Parties reach a full and final Stipulation pursuant to these Understandings, the Acceptance of Voluntary Surrender, and Order below.

80. Respondent understands that this Voluntary Surrender Stipulation and Order will be reviewed and the Board may accept or reject the Order set forth below. If the Board rejects all or any portion of the Order, then this entire document shall be null and void.

81. Respondent specifically waives any claim that any disclosures made to the Board during its review of this agreement prejudice Respondent's right to a fair and impartial hearing if this agreement is not accepted and proceeds to a merits hearing before the same tribunal.

82. Respondent has read and reviewed this entire document and agrees that it contains the entire agreement between the parties.

83. Respondent is not under the influence of any drugs or alcohol at the time she signs this Stipulated Voluntary Surrender of License.

84. Respondent voluntarily enters into this agreement after the opportunity to consult with legal counsel and is not being coerced by anyone into signing this Stipulated Voluntary Surrender of License.

85. Respondent agrees the Order set forth below may be entered, will be a binding Order upon Respondent, and will be made public.

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ACCEPTANCE OF VOLUNTARY SURRENDER AND ORDER

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

A. The Board of Nursing hereby **ACCEPTS** Respondent's **VOLUNTARY SURRENDER** of her Registered Nurse license.

B. Any future application for licensure shall be subject to the licensing requirements of that particular profession. If a future application for licensure in the State of Vermont is approved, that license shall be conditioned pursuant to whatever terms are found to be reasonable at the time of Respondent's application for licensure, taking into account the stipulated facts above.

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: 11/23/2022 By: DocuSigned by: Ultan Doyle
Ultan Doyle
Prosecuting Attorney

RESPONDENT

Dated: 11/21/2022 By: DocuSigned by: Wanda Rawlings
Wanda Rawlings

APPROVED AND SO ORDERED:

VERMONT BOARD OF NURSING

Dated: 12/12/2022 By: DocuSigned by: Jennifer Laurent
Chairperson

Date of Entry: 12/12/2022

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IN RE:	)	
Wanda Rawlings	)	**Docket No. 2022-170**
License No. 026.0116973	)	

AMENDED SPECIFICATION OF CHARGES

NOW COMES the State of Vermont and makes the following Charges against the Respondent, Wanda Rawlings:

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. Wanda Rawlings ("Respondent") of Swanton, Vermont is licensed by the State of Vermont as a Registered Nurse ("RN") under license number 026.0116973. This license was originally issued on November 16, 2015 and expires on March 31, 2023.

Incident One

3. During the relevant time period, Respondent was employed as an RN by Northwestern Medical Center ("Facility 1"), located in St. Albans, Vermont.

4. On June 29, 2019, Respondent was charged with providing care for patient, G.W. (Patient 1) from 7:00pm until 7:30 the following morning.

5. Prior to the start of Respondent's shift, at approximately 3:20pm, R.N., R.C., noted the following in Patient 1's chart: "asymptomatic to high BP, will notify NP."

6. At approximately 9:25pm, Licensed Nursing Assistant, H.B., took Patient 1's vital signs and documented a high blood pressure reading of 196/77.

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7. On June 30, 2019, at approximately 4:56am, H.B. took Patient 1's vital signs again and documented another high blood pressure reading of 216/76.

8. Shortly thereafter, H.B. told Respondent about Patient 1's blood pressure reading of 216/76.

9. Respondent took Patient 1's blood pressure herself to verify the reading, but failed to document that reading anywhere.

10. Respondent did not ask H.B. about any earlier blood pressure readings from that night.

11. Respondent also did not recall noticing Patient 1's earlier blood pressure reading when she checked her chart in the system.

12. Respondent did not notify a provider about Patient 1's high blood pressure reading and did not document any assessment or follow up.

13. Respondent also did not ask Patient 1 any questions in response to her high blood pressure reading, such as whether she had any chest pain/tightness, a headache or lightheadedness.

14. Instead, Respondent decided to administer Patient 1's Metoprolol (used to treat high blood pressure) at approximately 5:08am, almost 5 hours earlier than Patient 1 was scheduled to receive that medication.

15. Respondent also decided to administer Patient 1's Lisinopril (also used to treat high blood pressure), at approximately 5:09am, also almost 5 hours earlier than Patient 1 was scheduled to receive that medication.

16. Respondent did not receive seek or receive provider authorization to administer either of Patient 1's blood pressure medications earlier than they were scheduled.

17. Respondent was aware that medications should only have been administered within one hour of administration time.

18. At 6:51am, H.B. documented that Patient 1's blood pressure reading was still high at 182/68.

19. Respondent also did not report this reading to a provider and did not document any assessment or follow up.

20. Respondent did not complete any notes during the course of her overnight shift from June 29 to 30.

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21. Respondent acknowledged in an interview with OPR investigators that she should have notified a provider of Patient 1's high blood pressure.

22. At approximately 7:22am, Respondent completed documentation for SBAR handoff communication to R.N., R.C..

23. At approximately 8:10am, R.C. conducted a physical focused assessment and noted that patient complained of left sided chest pain and that her blood pressure was 192/66.

24. At 8:10am, R.C. noted the following: "BP rechecked 192/66, nights gave HTN meds around 0500 for high BP's. pt reporting left sided chest pain (left breast), 5/10 stabbing non-radiating pain. pt states pain has been present since the night but had not reported... NP notified."

25. Patient 1 ended up having EKG changes and required IV medications to respond to her hypertension.

Incident Two

26. During the relevant time period, Respondent continued to be employed as an RN by Facility 1.

27. On July 2, 2019, Respondent was charged with providing care during the overnight shift for patient, S.M. (Patient 2), who was recovering from a recent surgery.

28. At approximately 7:56pm, an LNA documented that Patient 2's blood oxygen level, which had previously been documented at 95-97%, dropped to 93%.

29. It is unclear from the medical records whether Respondent was aware of this issue at the time.

30. At 8:24pm, Respondent orally administered 5mg of Valium to Patient 2 for shoulder spasms.

31. At 8:25pm, Respondent administered 3mg IV of Hydromorphone.

32. At 9:00pm, Patient 2 was scheduled to be administered 0.5mg of Ativan, which had been ordered QID (every 6 hours). Without consulting with a provider, Respondent did not administer this medication until 1:57am.

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34. At 2:38am, Respondent documented that Patient 2's blood pressure reading was at 78/61 and that her blood oxygen level was at 78%.

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35. There is no evidence that Respondent notified a provider of these readings.

36. When interviewed by OPR investigators, Respondent indicated that the low blood oxygen level could have resulted from the medications she had just administered.

37. Respondent told OPR investigators that she would have needed a provider's order to administer a scheduled drug outside of the scheduled time. Respondent did not seek such an order nor did she document a reason for administering medication outside of the scheduled time. Respondent told investigators that at this time, she should have notified a provider of what was going on.

38. Respondent also added that looking back it, she had done a "really bad job."

39. Rather than notify a provider, Respondent decided on her own initiative to treat Patient 2 with 4 liters of oxygen.

40. At 2:48am, Respondent documented a blood pressure reading of 113/62 and a blood oxygen level of 100%.

41. Respondent again did not notify a provider of her findings or seek help or guidance from a provider.

42. At 5:02am, Respondent administered Patient 2 another 0.5mg of Ativan even though she was not scheduled to receive the medication until 8:00am. Respondent documented the administration in the MAR under the scheduled 8:00am dose.

43. Respondent also administered 2mg IV Hyrdomorphone at 5:02am.

44. There is no documentation that Respondent took Patient 2's vital signs prior to administering these two medications.

45. At 5:25am, a licensed nursing assistant documented that Patient 2's blood pressure reading was down to 93/53. Patient 2's blood oxygen level was 98%, but only because she was being supported by 3 liters of oxygen at the time.

46. There is no documentation that Respondent notified a provider of these findings.

47. Patient 2 was required to have intravenous fluids running at 125ml/hour until she could tolerate more than 1000ml by mouth.

48. Respondent paused these intravenous fluids at 6:15am even though Patient 2 had not met the oral intake requirement for discontinuation (the last oral fluid intake documented by WR was 240ml at 4:12am).

49. Respondent told OPR investigators that Patient 2 told her that she had had sufficient oral fluid intake. However, this was not documented in Patient 2's records.

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50. On July 10, 2019, Respondent's employment was terminated by Facility 1.

Incident 3

51. During the relevant time period, Respondent was employed as an RN by the University of Vermont Medical Center ("Facility 2"), located in Burlington, Vermont.

52. On July 11, 2022, L.F., an RN who worked with Respondent, discovered that Respondent had sent a Seizure Action Plan ("SAP") to a school nurse which listed the incorrect dosage of a medication.

53. The action plan was electronically signed by APRN B.C. on July 6, 2022.

54. L.F. spoke to Respondent about the error on the SAP and learned from Respondent that she had not reviewed the SAP with B.C. prior to signing his name to it and sending it to the school nurse.

55. L.F. reported the incident to Respondent's supervisor.

56. On July 14, 2022, B.C. spoke to Respondent's supervisor and told her that he had not reviewed the SAP in question and had not signed it.

57. The same day, Respondent met with her supervisor and admitted to her that she had signed the SAP as though she was B.C. and did not review it with him prior to signing it.

58. On July 19, 2022 during a meeting with Facility's Assistant Director of Neurology and Psychology and the Human Resources Business Partner, when asked why she signed the SAP without the provider's knowledge or approval, Respondent said she must have forgotten to ask B.C. to review the action plan.

59. Respondent also admitted in the July 19, 2022 meeting that she had signed other SAPs on providers' behalf without their knowledge and approval.

60. A review by the Facility confirmed that Respondent had created and sent several SAPs without provider approval. These SAPs contained either the provider's signature or no signature.

61. On July 21, 2022, Respondent was terminated from the Facility for signing the July 6, 2022 SAP as if she were the provider, and also for signing other SAPs on behalf of providers without their review and approval.

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62. On August 24, 2022, Respondent told an OPR investigator she had sent an SAP containing an error to a school without having it first verified by a provider and said, "It's completely my mistake."

Violation One: 3 V.S.A. §129a(a)(13) Performing treatments or providing services that the licensee is not qualified to perform or that are beyond the scope of the licensee's education, training, capabilities, experience, or scope of practice.

63. The State re-alleges and incorporates Paragraphs 2 through 62 above.

64. As an RN, Respondent is required to refrain from performing treatments or providing services that she is not qualified to perform or that are beyond the scope of her education, training, capabilities, experience, or scope of practice.

65. Paragraphs 2 through 62 demonstrate that Respondent performed a treatment that was beyond the scope of her education, training, capabilities, experience, or scope of practice when she administered blood pressure medication to Patient 1 outside of the provider's order, without notifying the provider, and she administered Ativan to Patient 2 on two occasions also outside of the provider's order, without notifying the provider; when she signed the July 6, 2022 SAP using a provider's signature without the provider's knowledge and approval; and when she signed other SAPs on providers' behalf without their knowledge and approval.

66. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent committed unprofessional conduct of a character likely to deceive, defraud, or harm the public in violation of 3 V.S.A. §129a(a)(13).

Violation Two: 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.

67. The State re-alleges and incorporates Paragraphs 2 through 62 above.

68. As an RN, 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.

69. Paragraphs 2 through 62 demonstrate that Respondent failed to exercise independent professional judgment when she failed to notify a provider about Patient 1's high blood pressure; failed to document an assessment or follow up; failed to ask questions about chest pain/tightness, a headache or lightheadedness; administered blood pressure medication outside of the provider's order without notifying the provider; failed to notify a provider of Patient 2's low blood pressure and low blood oxygen levels; administered 4 liters of oxygen to Patient 2 without first checking

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with a provider; administered Ativan to Patient 2 on two occasions outside of the provider's order, without notifying the provider; discontinued the administration of intravenous fluids to Patient 2 prematurely; and when she signed the July 6, 2022 SAP using a provider's signature without the provider's knowledge and approval; and when she signed other SAPs on providers' behalf without their knowledge and approval.

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

Violation Three: 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.

71. The State re-alleges and incorporates Paragraphs 2 through 62 above.

72. Vermont law requires RNs to practice competently by providing safe and acceptable patient care.

73. Paragraphs 2 through 62 above demonstrate that Respondent failed to provide safe and acceptable patient care when she failed to notify a provider about Patient 1's high blood pressure; failed to document an assessment or follow up; failed to ask questions about chest pain/tightness, a headache or lightheadedness; administered blood pressure medication outside of the provider's order without notifying the provider; failed to notify a provider of Patient 2's low blood pressure and low blood oxygen levels; administered 4 liters of oxygen to Patient 2 without first checking with a provider; administered Ativan to Patient 2 on two occasions outside of the provider's order, without notifying the provider; discontinued the administration of intravenous fluids to Patient 2 prematurely; when she signed the July 6, 2022 SAP using a provider's signature without the provider's knowledge and approval; and when she signed other SAPs on providers' behalf without their knowledge and approval.

74. 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)(1).

Violation Four: 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.

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75. The State re-alleges and incorporates Paragraphs 2 through 62 above.

76. The essential standards of acceptable and prevailing practice require that an RN follow providers orders when administering medication and accurately document patient records.

77. Paragraphs 2 through 62 above demonstrate that Respondent failed to conform to essential standards of acceptable and prevailing practice when she failed to notify a provider about Patient 1's high blood pressure; failed to document an assessment or follow up; failed to ask questions about chest pain/tightness, a headache or lightheadedness; administered blood pressure medication outside of the provider's order without notifying the provider; failed to notify a provider of Patient 2's low blood pressure and low blood oxygen levels; administered 4 liters of oxygen to Patient 2 without first checking with a provider; administered Ativan to Patient 2 on two occasions outside of the provider's order, without notifying the provider; discontinued the administration of intravenous fluids to Patient 2 prematurely; when she signed the July 6, 2022 SAP using a provider's signature without the provider's knowledge and approval; and when she signed other SAPs on providers' behalf without their knowledge and approval.

78. 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).

Relief Requested

WHEREFORE, the RN license of Wanda Rawlings should be revoked, suspended, reprimanded, conditioned, or otherwise disciplined.

DATED at Montpelier, Vermont this 26th day of October, 2022.

STATE OF VERMONT
SECRETARY OF STATE

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