

State of Vermont
Vermont Board of Nursing

In re: Lucas Hall
License Number: 026.0103871
Docket Number: 2022-196 & 2022-197

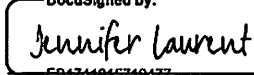
Order to Remove Conditions

On June 10, 2024, the Vermont Board of Nursing considered Lucas Hall's request for Removal of Conditions imposed pursuant to a Stipulation & Consent Order under Docket Numbers 2022-196 and 2022-197. Mr. Hall has met the conditions. After review of the compliance file, the State does not object to removal of all conditions.

Order:

The Board hereby removes all conditions from Lucas Hall's RN license.

Vermont Board of Nursing

DocuSigned by:

EB1741915719477...
Jennifer Laurent, Chair

Date: 6/10/24

Date of Entry: 6/10/24

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

IN RE:)
Lucas Hall) Docket No. 2022-196 & 2022-197
License No. 026.0103871)

**STATE'S RESPONSE TO RESPONDENT'S REQUEST TO REMOVE
CONDITIONS**

After review of the compliance file, the State has no objection to Respondent's request to remove all conditions on his license. Attached to this response is a proposed Order should the Board decide to grant Respondent's request.

Respectfully submitted, this 5th day of June 2024.

STATE OF VERMONT
SECRETARY OF STATE

By: /s/ Rachel Heath
Rachel Heath
State Prosecuting Attorney
802-828-0041
Rachel.Heath@vermont.gov

STATE OF VERMONT



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



State of Vermont
Office of the Secretary of State

Sarah Copeland Hanzas, Secretary of State
S. Lauren Hibbert, Deputy Secretary
Kevin Rushing, Director

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

June 4, 2024

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

Case: Lucas Hall
Credential: 026.0103871
Docket No: 2022-196 & 197

Dear Attorney Heath:

Please find the enclosed **Request to remove conditions** filed on the above captioned docket number. Pursuant to the Office of Professional Regulation's Administrative Rule 3.8 you have 10 days to respond to the motion.

You may contact me at (802) 828-2367 if you have any questions.

Sincerely,

/s/ Julie Bowen
Docket Clerk

Enc: *Request to Remove Conditions*

Cc: Kristin Donnelly, Case Manager
Lucas Hall, Respondent

Bowen, Julie

From: Lucas Hall <lhall92@gmail.com>
Sent: Monday, June 3, 2024 6:59 PM
To: SOS - Docket Clerk
Subject: Petition for Removal of Conditions

EXTERNAL SENDER: Do not open attachments or click on links unless you recognize and trust the sender.

Hello Docket Clerk and Vermont Board of Nursing,

I am officially petitioning to have the conditions imposed on my nursing license removed. I have been in touch with my case manager Kristin who has confirmed that I have met all my requirements. My docket numbers are 2022-196 & 2022-197.

Please email me to confirm that this has been received and if there is anything else I need to do.

Regards,

Lucas Hall, BSN, RN-C, FP-C



State of Vermont
Office of the Secretary of State
Office of Professional Regulation
89 Main Street, 3rd Floor
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Sarah Copeland Hanzas, Secretary of State
S. Lauren Hibbert, Deputy Secretary
Kevin Rushing, Director

April 10, 2023

Attorney Sandra Strempe
209 Battery Street
Burlington, Vt 05401

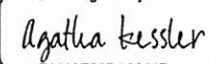
CASE: Lucas Hall
Docket No.: 2022-196 & 197

Dear Attorney Strempe:

Enclosed please find a copy of the approved *Stipulation and Consent Order*

For questions about complying with this Order, please contact the Case Manager at 802-828-2875

Sincerely,

DocuSigned by:

74418E28DA26447
Agatha Kessler
Deputy Director

Enc: *Stipulation and Consent Order*

cc: Rachel Heath, Prosecuting Attorney
Kristin Donnelly, Case Manager

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

IN RE:)
Lucas Hall) **Docket No. 2022- 196, 2022- 197**
License No. 026.0103871)

STIPULATION AND CONSENT ORDER

STIPULATION

NOW COME the State of Vermont, by and through State Prosecuting Attorney Rachel Heath, and Respondent Lucas Hall, represented by Sandra Strempel, Esq. who Stipulate and Agree as follows:

Board Authority

1. The Vermont State Board of Nursing (the "Board") has authority to issue warnings or reprimands; suspend, revoke, limit, or condition current licenses; or prevent the renewal of lapsed licenses if, after disciplinary hearing, the Board finds that the Respondent has engaged in unprofessional conduct. 3 V.S.A. §129; 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 ("OPR").

Alleged Facts

2. Lucas Hall ("Respondent") of Bennington, Vermont is licensed by the State of Vermont as a Registered Nurse ("RN") under license number 026.0103871. This license was originally issued on August 21, 2014 and expires on March 31, 2025.
3. During the relevant time, Respondent worked as an RN for Southwestern Vermont Medical Center ("Facility"), located in Bennington, Vermont.
4. Respondent has worked in the Emergency Department of the Facility since April 2018.
5. On the evening of May 24, 2022, a male patient ("Patient 1") in his 30s with a progressive neurological disease, Autism, and PTSD, was admitted to the Emergency Department from a nursing home. Patient 1 had a medical guardian and was considered a vulnerable adult.
6. Between May 24 and May 28, Patient 1's behaviors escalated, with Patient 1 exhibiting physical and verbal aggression due to his progressive neurological disease.

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7. In the evening of May 28, 2022, Patient 1 began to exhibit acute upset and tumultuous behaviors. At or around 8:45 pm, Patient 1 expressed a desire to punch staff so that he could go to jail. Patient 1 was told that he would be restrained if he punched anyone.
8. Subsequently, Patient 1 began to punch or attempt to punch staff.
9. Two security officers and a personal care assistant ("PCA") escorted Patient 1 to his room.
10. Patient 1 bit the PCA, who was later treated in the Emergency Department after the following events occurred.
11. Security called "code green," indicating a mental health crisis for which all staff were needed.
12. The attending physician was informed of the situation, and he ordered restraints and a sedative.
13. The two security guards and the PCA initiated a restraint of Patient 1 on his bed.
14. The patient was lying on his back on the bed, but was resisting the restraint.
15. One security officer was holding Patient 1's right leg, another officer was holding patient's left arm and Patient 1's face so that he would spit into a pillow. The PCA was holding Patient 1's left leg.
16. Patient 1 spit multiple times while he was being restrained.
17. The charge nurse asked Respondent to assist the security officers and PCA.
18. A float nurse had also been called to put restraints on Patient 1.
19. Respondent looked at the video screen for the room Patient 1 was in and observed the staff struggling to place the restraints on Patient 1. Subsequently, Respondent reported he was concerned that the patient would injure someone.
20. Respondent entered the room. Respondent was feeling frustration, an "amp of energy," and "very emotionally charged" before entering the room.
21. Respondent pushed the security guard's hand away from Patient 1's face and held Patient 1's right arm.
22. Patient 1 was being held down to the bed so that the float nurse could place restraints on him.

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23. During the restraint, Patient 1 continued thrashing and spitting. Patient 1 was being held down by four men, one of whom was Respondent.
24. Respondent claimed he placed his hand in front of Patient 1's face to shield him from spitting and biting staff.
25. As Patient 1 was spitting, Respondent told Patient 1 to stop and said, "that's fucking disgusting."
26. Respondent then slapped Patient 1 across the face. According to the PCA, Patient 1 became harder to control after Respondent hit him.
27. The patient was heard voicing discomfort from this slap.
28. Moments later, Respondent slapped Patient 1 across the face again, causing the patient to jolt.
29. Respondent slapped the patient twice across his face.
30. Once the float nurse had placed all of the restraints on the patient, Respondent had to be told to let go of Patient 1.
31. The Facility completed an internal investigation on June 1, 2022. Respondent was suspended during the investigation from June 1, 2022 until June 11, 2022 and required to take one additional e-learning training for de-escalation. In addition, Respondent was asked to review material on Patient 1's progressive neurological disease. Respondent completed these requirements before returning to work.
32. Respondent initially denied slapping the patient and instead insisted that his hand made contact with the Patient's face three times.
33. In February 2023, Respondent completed an independent mental health evaluation by a pre-approved provider, who recommended, among other things, that Respondent engage in Eye Movement Desensitization (EMDR), attend monthly support groups through the Frontline Foundations, and complete training in physical management of emotionally dysregulated patients.

Violation One: 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 care.

34. Paragraphs 2 through 33 above are incorporated herein.
35. As an RN, Respondent is required to perform safe and acceptable patient care, regardless of whether there was injury to a patient.

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36. Paragraphs 2 through 33 above demonstrate that Respondent failed to perform safe and acceptable patient care by slapping Patient 1 in the face twice while he was restrained and telling the patient that his spitting was "fucking disgusting."
37. 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 Two: 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.

38. Paragraphs 2 through 33 above are incorporated herein.
39. The essential standards of acceptable and prevailing practice require that an RN refrain from putting patients at a risk of harm by using harmful restraints and slapping, regardless of whether there was injury to a patient.
40. Paragraphs 2 through 33 above demonstrate that Respondent failed to conform to essential standards of acceptable and prevailing practice when he slapped the patient across the face twice, when he was restrained, and when he told Patient 1 that his spitting was "fucking disgusting."
41. 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

42. This Stipulation is neither an admission of liability by the Respondent nor a concession by the State of Vermont that its charges are not well-founded. To avoid delay, uncertainty, inconvenience, and the expense of protracted litigations, the Parties reach a full and final Stipulation pursuant to these Understandings and the Order below. The Respondent agrees that the State could prove the charges by a preponderance of the evidence if this matter went to a hearing and agrees to the conditions outlined below.
43. Respondent acknowledges that slapping is not and is never appropriate. Upon reflection and counseling, Respondent believes the stress of this chaotic event and other stressors resulted in this conduct.

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44. Respondent understands that the Nursing Board must review and accept the terms of the Consent Order. If the Board rejects any portion, the entire Stipulation and Consent Order shall be null and void.
45. Respondent specifically waives any claims that any disclosures made to the full Board during its review of this agreement have prejudiced his rights to a fair and impartial hearing in future hearings if this agreement is not accepted by the Board.
46. Respondent has read and reviewed this entire document and agrees that it contains the entire agreement between the parties.
47. Respondent is not under the influence of any drugs or alcohol at the time he signs this Stipulation and Consent Order.
48. Respondent voluntarily enters into this agreement after the opportunity to consult with legal counsel and is not being coerced by anyone into signing this Stipulation and Consent Order.
49. Respondent voluntarily waives his right to a contested hearing before the Board of Nursing and waives any right to appeal from this Stipulation and Consent Order.
50. Respondent agrees that the Order set forth below may be entered by the Board.

ORDER

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

- A. The Board of Nursing hereby **REPRIMANDS** Respondent's license.
- B. The Board of Nursing hereby **CONDITIONS** Respondent's license commencing with the date of entry of this Stipulation and Consent Order. The conditions will be as follows:
 1. Re-issuance of License. Upon the commencement of these conditions, Respondent shall be issued a license labeled "conditioned."
 2. License Renewal. This Order does not automatically extend the license and Respondent must comply with the requirements for license renewal.
 3. Length of Time of Conditions Imposed. Respondent shall be subject to the conditions until Respondent has fully completed all conditions as ordered and for a **minimum period of one year** of registered nurse practice in which Respondent works at least eighty (80) hours every calendar month as a registered nurse. Part time hours of fewer than eighty (80) hours every calendar month shall be credited on a prorated basis.

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4. **Monitoring.** The Office of Professional Regulation, through the Enforcement Case Manager, shall be responsible for monitoring Respondent's compliance with these Conditions. All reports or correspondence regarding compliance with these conditions shall be submitted to the Case Manager in accordance with the Conditions listed below.
5. **Mental Health Counseling.** Respondent shall enter into a treating professional agreement and engage in individual mental health counseling with his current counselor or another pre-approved qualified provider ("Treating Professional"), until the Treating Professional certifies in writing that such counseling is no longer necessary and Respondent successfully petitions the Board for a modification of these conditions. If Respondent's Treating Professional deems appropriate, or another qualified provider, Respondent shall engage in EMDR (Eye Movement Desensitization Reprocessing). The Treating Professional must hold an active, unencumbered license, registration, and/or certification by the State of Vermont as a Psychologist, Social Worker, Marriage & Family Therapist, Advanced Practice Registered Nurse, or Clinical Mental Health Counselor.

Respondent shall cause the Treating Professional to submit to the Case Manager, on forms the Case Manager provides, acknowledgement of receipt of this Stipulation and Consent Order along with Respondent's treatment plan.

Respondent shall cause the Treating Professional to submit **monthly reports** to the Case Manager, on forms the Case Manager provides. Respondent shall authorize the Treating Professional to provide all information the Board or its designee requests during the period this Consent Order is in effect.

If Respondent is prescribed medications as part of his mental health counseling and treatment, Respondent's monthly treating professional reports must also indicate his current dosage and whether he is appropriately taking the medication as prescribed. Respondent must continue to take such medication as prescribed until the Treating Professional certifies in writing that the medication is no longer necessary. Should Respondent's medications be monitored by someone other than his Treating Professional, Respondent shall cause the prescribing provider to certify in writing, at intervals determined by the Case Manager, whether Respondent is appropriately taking the medication as prescribed. Respondent must continue to take such medications as prescribed until the prescribing provider certifies in writing that such medication is no longer necessary.

6. **Support Groups.** Respondent shall attend at least one support group meeting a month that addresses trauma or stress/anger management. These meetings may include the monthly support group meetings hosted by Frontline Foundations. Any other support group meeting must be pre-approved by the Enforcement Case Manager. Respondent shall quarterly provide to the Case Manager a log listing the name of the support group, the dates and locations for meetings he attended, and his signature at the bottom attesting to having attended the meetings.

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7. Reports from Employers/Program Director. Within one (1) month of the date of reinstatement or within one (1) month of the commencement of nursing employment and monthly thereafter, Respondent shall cause every nursing employer Respondent has worked for during the month to submit to the Board an evaluation of Respondent's work performance and attendance during that month. In the event Respondent is attending a nursing program, Respondent shall cause the Program Director to submit to the Board, on a monthly basis, a written evaluation of Respondent's performance and attendance. These reports shall be submitted in writing on forms issued by the Board. All employer reports shall indicate satisfactory performance (i.e., consistently meeting all standards of nursing practice) and attendance.
8. Interview with the Board or its Designee. Respondent shall appear in person for interviews with the Board or its designee upon request.
9. Out-of-State Practice. Before any out-of-state practice can be credited toward fulfillment of these terms and conditions, Respondent shall first obtain approval from the Board or its designee. The Board will approve out-of-state nursing practice so long as Respondent can still comply with the provisions of this Consent Order. If Respondent receives discipline on a nursing license held in another state during the conditioned period, Respondent must inform the Board of such, in writing, within ten (10) days of receiving such discipline.
10. Notification to Employers/Nursing School. Respondent shall provide a copy of this Stipulation and Consent Order to all employers in any current or future setting in which Respondent practices as a nurse and inform them of Respondent's conditional license status. Within ten (10) days of the date of entry of this Consent Order or of any subsequent nursing employment, Respondent shall cause Respondent's immediate supervisor to submit to the Board an employer agreement form approved by the Board, acknowledging receipt of the Stipulation and Consent Order and the ability to comply with the conditions in the Consent Order.

In the event Respondent is attending a nursing program that has a clinical portion that involves actual patient care, Respondent shall provide a copy of the Stipulation and Consent Order to the Program Director. Respondent shall cause the Program Director to submit to the Board a nursing program agreement form approved by the Board, acknowledging receipt of the Stipulation and Consent Order and the ability of the program to comply with the conditions in the Consent Order during clinical experience.

11. Notification of Place of Employment/Personal Address/Telephone Number. Within ten (10) days of the date of entry of this Consent Order, Respondent shall notify the Board, in writing, of Respondent's current place of employment, personal address, and telephone number. Respondent shall further notify the Board, in writing, within forty-eight (48) hours of any change in employment (including resignation or termination), personal address, or telephone number.

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12. Notification to Other States. If Respondent is licensed in nursing in any other state(s), Respondent must inform the nursing licensing board of the state(s) in which Respondent is licensed of the conditional status of Respondent's Vermont nursing license within thirty (30) days of the date of entry of this Order.

13. Required Coursework. Respondent shall, at his own expense and within ninety (90) days of the date of entry of this Stipulation and Consent Order, successfully complete (i.e., receive a passing score, if applicable) eight hours of coursework on professional accountability, ethics, and physical restraints and/or physical management of emotionally dysregulated patients. The coursework must be pre-approved by the Enforcement Case Manager.

Respondent shall submit the certificates of completion, completed assignment book(s) and quiz results, if applicable, to the Enforcement Case Manager. Failure to satisfactorily complete the courses within the prescribed timeframe shall constitute a violation of this Order. The coursework may not be counted toward any continuing education requirement of licensure.

14. Costs. Respondent shall bear all costs of complying with this Consent Order.

15. Violation of this Order. If Respondent violates this Order the Board, after giving Respondent notice and an opportunity to be heard, may rescind or modify this Order and impose additional appropriate disciplinary actions. If a complaint of unprofessional conduct is made against Respondent during the term of this Order, this Order shall be automatically extended until the unprofessional conduct matter is concluded.

16. Completion of Conditional License Period. Respondent shall submit a petition to the Docket Clerk to remove any and all conditions on Respondent's license. The State will assent to or oppose Respondent's petition. The Board will conduct a hearing if necessary. Respondent bears the burden and must present proof that Respondent has fully complied with the terms of this Order and these conditions are no longer necessary to protect the public.

- C. Notwithstanding any provision above, the Respondent must continue to meet all Nursing Board requirements for maintaining a license, license renewal and license reinstatement.
- D. 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).
- E. 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.

STATE OF VERMONT



Prosecuting Attorney
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89 Main Street
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AGREED TO:

Dated: March 31, 2023

STATE OF VERMONT
SECRETARY OF STATE

By: /s/ Rachel Heath
Rachel Heath
Prosecuting Attorney

Dated: 3/30/2023

RESPONDENT

By: Lucas Hall
Lucas Hall

APPROVED AS TO FORM:

Dated: 3/30/2023

ATTORNEY FOR RESPONDENT

By: /s/Sandra A. Strempel
Sandra A. Strempel, Esq.

APPROVED AND SO ORDERED:

Dated: 4/10/23

VERMONT BOARD OF NURSING

By: Jennifer Laurent
Chairperson

Date of Entry: 4/10/23

STATE OF VERMONT



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

IN RE:	)	
Lucas Hall	)	Docket No. 2022-196, 2022-197
License No. 026.0103871	)	

RESPONDENT'S ANSWER TO SPECIFICATION OF CHARGES

Respondent Lucas Hall submits the following answer to the Specification of Charges,
dated November 3, 2022.

Board Authority

1. This paragraph states a conclusion of law to which no response is required.

Statement of Facts

2. Admitted.
3. Admitted.
4. Admitted.
5. Admitted that Patient 1 was admitted to the Emergency Department from a nursing home. Without present information or knowledge sufficient to form a belief as to the truth of the remaining allegations of this paragraph, therefore, denied.
6. Respondent does not have personal knowledge of all of Patient 1's behaviors during this time but does not dispute that Patient 1's behaviors escalated and that he exhibited physical and verbal aggression. Without present information or knowledge sufficient to form a belief as to the cause of his behaviors, therefore, the remaining allegation of this paragraph is denied.

7. Respondent does not have personal knowledge of all of Patient 1's behaviors during this evening, or what he or others said, but Respondent does not dispute the allegations of this paragraph.

8. Respondent did not personally observe Patient 1 punching or attempting to punch staff, but Respondent does not dispute this allegation.

9. Respondent did not personally observe Patient 1 being escorted but Respondent does not dispute this allegation.

10. Respondent did not personally observe Patient 1 bite the PCA but Respondent does not dispute this allegation. Respondent admits the remaining allegation of this paragraph.

11. Without present information or knowledge sufficient to form a belief as to the truth of the allegations of this paragraph, therefore, denied.

12. Respondent did not personally observe what occurred prior to his entry into the room but he does not dispute the allegations of this paragraph.

13. Admitted that at times Patient 1 was lying on his back on a bed. To the extent this paragraph is alleging Patient 1 did not move from this position, denied.

14. Respondent does not have personal knowledge of what occurred prior to his entry into the room, but does not dispute that 2 security officers and a PCA were attempting to restrain Patient 1 as described.

15. Admitted that Patient 1 spit multiple times while staff was attempting to restrain him.

16. Admitted.

17. Admitted.

18. Denied as stated.

19. Denied that Respondent "pushed" the security guard's hand away from Patient 1's face. Admitted that Respondent held Patient 1's right arm.

20. Admitted that the guards and staff were attempting to hold Patient 1 on the bed to allow the float nurse to place restraints on him.

21. Admitted that during the attempted "hands on" restraint, Patient 1 continued thrashing and spitting. Denied that Patient 1 was "fully" held down at this time.

22. Respondent does not dispute this allegation.

23. Denied as stated.

24. Denied as stated.

25. Denied as stated

26. Denied as stated.

27. Denied as stated.

28. Without present information or knowledge sufficient to form a belief as to the truth of this allegation, therefore, denied.

29. Admitted that the Facility conducted an investigation which was completed on June 15, 2022. Admitted that Respondent was suspended during that investigation, from June 1-

11. Admitted that Respondent was asked, and he completed, training in de-escalation and on Huntington's disease.

30. Denied as stated.

Violation One: 3 V.S.A. § 129a(b)(1)

31. Respondent repeats and incorporates by reference his responses to paragraphs 2 through 30 above.

32. This paragraph states a conclusion of law to which no response is required.

33. Denied.

34. Denied.

Violation Two: 26 V.S.A. § 1582(a)(3)

35. Respondent repeats and incorporates by reference his responses to paragraphs 2 through 30 above.

36. This paragraph states a conclusion of law to which no response is required.

37. Denied.

38. Denied.

Violation Three: 3 V.S.A. §129a(b)(2)

39. Respondent repeats and incorporates by reference his responses to paragraphs 2 through 30 above.

40. This paragraph states a conclusion of law to which no response is required.

41. Denied.

42. Denied.

Violation Four: 3 V.S.A. § 129A(a)(15)

43. Respondent repeats and incorporates by reference his responses to paragraphs 2 through 30 above.

44. This paragraph states a conclusion of law to which no response is required.

45. Denied.

46. Denied.

DEFENSES

To the extent disclosed by discovery, this matter may be barred in whole or in part by the following:

1. Respondent did not engage in unprofessional conduct as alleged; and
2. Respondent reserves the right to raise additional defenses as revealed in discovery.

WHEREFORE, the Respondent denies the relief requested.

DATED at Burlington, Vermont this 18th day of November 2022.

By: /s/ Sandra A. Stempel
Sandra A. Stempel, Esq.
DINSE PC
209 Battery Street
Burlington, VT 05401
802-864-5751
sstempel@dinse.com

For Respondent Lucas Hall

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

IN RE:)
Lucas Hall) **Docket No. 2022- 196, 2022- 197**
License No. 026.0103871)

SPECIFICATION OF CHARGES

NOW COMES the State of Vermont and hereby makes the following charges
against Respondent Lucas Hall:

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 ("OPR").

Statement of Facts

2. Lucas Hall ("Respondent") of Bennington, Vermont is licensed by the State of Vermont as a Registered Nurse ("RN") under license number 026.0103871. This license was originally issued on August 21, 2014 and expires on March 31, 2023.
3. During the relevant time, Respondent worked as an RN for Southwestern Vermont Medical Center ("Facility"), located in Bennington, Vermont.
4. Respondent has worked in the Emergency Department of the Facility since April 2018.
5. On the evening of May 24, 2022, a male patient ("Patient 1") in his 30s with a progressive neurological disease, Autism, and PTSD, was admitted to the Emergency Department from a nursing home. Patient 1 had a medical guardian and was considered a vulnerable adult.
6. Between May 24 and May 28, Patient 1's behaviors escalated, with Patient 1 exhibiting physical and verbal aggression due to his progressive neurological disease.
7. In the evening of May 28, 2022, Patient 1 began to exhibit acute upset and tumultuous behaviors. At or around 8:45 pm, Patient 1 expressed a desire to

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punch staff so that he could go to jail. Patient 1 was told that he would be restrained if he punched anyone.

8. Subsequently, Patient 1 began to punch or attempt to punch staff.
9. Two security officers and a personal care assistant ("PCA") escorted Patient 1 to his room.
10. Patient 1 bit the PCA, who was later treated in the Emergency Department after the following events occurred.
11. Security called "code green," indicating a mental health crisis for which all staff were needed.
12. The two security guards and the PCA initiated a restraint of Patient 1 on his bed.
13. The patient was lying on his back on the bed.
14. One security officer was holding Patient 1's right leg, another officer was holding patient's left arm and Patient 1's face so that he would spit into a pillow. The PCA was holding Patient 1's left leg.
15. Patient 1 spit multiple times while he was being restrained.
16. The charge nurse asked Respondent to assist the security officers and PCA.
17. A float nurse had also been called to put restraints on Patient 1.
18. Respondent entered the room. Respondent was feeling frustration, an "amp of energy," and "very emotionally charged" before entering the room.
19. Respondent pushed the security guard's hand away from Patient 1's face and held Patient 1's right arm.
20. Patient 1 was being held down to the bed so that the float nurse could place restraints on him.
21. During the restraint, Patient 1 continued thrashing and spitting. Patient 1 was being fully held down by four men, one of whom was Respondent.
22. As Patient 1 was spitting, Respondent said to Patient 1, "that's fucking disgusting."
23. Respondent then slapped Patient 1 across the face. Patient 1 became harder to control after Respondent hit him.
24. The patient was heard voicing discomfort from this slap.

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25. Moments later, Respondent slapped Patient 1 across the face again, causing the patient to jolt.
26. Respondent slapped the patient twice across his face.
27. Once the float nurse had placed all of the restraints on the patient, Respondent had to be told to let go of Patient 1.
28. Patient 1's attending physician was not made aware that a nurse had hit him.
29. The Facility completed an internal investigation on June 1, 2022. Respondent was suspended from June 1, 2022 until June 11, 2022 and required to take one additional e-learning training for de-escalation. In addition, Respondent was asked to review material on Patient 1's progressive neurological disease.
30. While Respondent denied slapping the patient, he admits that his hand made contact with Patient 1's face three times.

Violation One: 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 care.

31. The State re-alleges and incorporates paragraphs 2 through 30 above.
32. As an RN, Respondent is required to perform safe and acceptable patient care, regardless of whether there was injury to a patient.
33. Paragraphs 2 through 30 above demonstrate that Respondent failed to perform safe and acceptable patient care by slapping Patient 1 in the face twice while he was restrained and telling the patient that his spitting was "fucking disgusting."
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)(1).

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

35. The State re-alleges and incorporates paragraphs 2 through 30 above.
36. As an RN, Respondent is required to refrain from engaging in conduct of a character likely to deceive, defraud, or harm the public.
37. Paragraphs 2 through 30 demonstrate that Respondent engaged in conduct of a character likely to deceive, defraud, or harm the public when he slapped Patient 1

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in the face twice while he was restrained and told Patient 1 that his spitting was "fucking disgusting."

38. 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 26 V.S.A. § 1582(a)(3).

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.

39. The State re-alleges and incorporates paragraphs 2 through 30 above.
40. The essential standards of acceptable and prevailing practice require that an RN refrain from putting patients at a risk of harm by using harmful restraints and slapping, regardless of whether there was injury to a patient.
41. Paragraphs 2 through 30 above demonstrate that Respondent failed to conform to essential standards of acceptable and prevailing practice when he slapped the patient across the face twice, when he was restrained, and when he told Patient 1 that his spitting was "fucking disgusting."
42. 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 profession.

43. The State re-alleges and incorporates paragraphs 2 through 30 above.
44. Under Vermont law, an RN must exercise independent professional judgment in the performance of licensed activities when such judgment is necessary to avoid action repugnant to the profession.
45. Paragraphs 2 through 30 above demonstrate that Respondent failed to exercise independent professional judgment in the performance of licensed activities when such judgment is necessary to avoid action repugnant to the profession when he slapped Patient 1 twice when he was restrained and when and he told Patient 1 that his spitting was "fucking disgusting."

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46. 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).

Relief Requested

WHEREFORE, the State of Vermont respectfully requests that the Board warn, reprimand, suspend, revoke, limit, condition, or otherwise discipline Lucas Hall's Registered Nurse license.

DATED at Vermont, this 3rd day of November 2022.

STATE OF VERMONT
SECRETARY OF STATE

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