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

IN RE:	)	
Linda Laramee	)	**Docket No. 2022-232**
License No. 026.0017263	)	

STIPULATION AND CONSENT ORDER

STIPULATION

NOW COMES the State of Vermont, by and through Prosecuting Attorney Ultan Doyle, and Respondent Linda Laramee, 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. Linda Laramee ("Respondent") of Burlington, Vermont is licensed by the State of Vermont as a Registered Nurse ("RN") under license number 026.0017263. This license was originally issued on August 22, 1986 and expires on March 31, 2023.

3. During the relevant time period, Respondent was employed as an RN by Queen City Nursing and Rehabilitation ("the Facility"), located in Burlington, Vermont.

4. On or about October 5, 2021, Respondent worked a 7:30am to 3:00pm shift and was responsible that day for precepting C.I., who had worked as a nurse at the Facility for approximately four months.

5. During Respondent's October 5, 2021 shift, C.I. was the nurse designated to have the keys to the medication cart.

6. At approximately 12:55pm, a hospice nurse, S.M. told Respondent that a hospice patient ("the Patient") was actively dying and needed Hyoscyamine (to reduce mouth secretions), Morphine, and Ativan.

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7. After more than 15 minutes, Respondent came into the Patient's room, handed the Hyoscyamine to S.M. and left immediately without administering it to the Patient, saying that she would be back with the Morphine and Ativan once she had the keys to the medication cart.

8. S.M. did not administer the Hyoscyamine because Respondent was the nurse who had withdrawn the medication.

9. After speaking with S.M., Respondent went to look for C.I. because he had the keys to the medication cart.

10. Respondent spent several minutes looking for C.I. and eventually found him outside eating lunch.

11. Respondent initially told her supervisor that upon finding C.I. outside, she brought him back to the medication cart and did not get the keys from him.

12. Respondent later revised her account and reported that she took the keys from C.I. when he was outside the Facility.

13. Respondent and C.I. did not do a medication count prior to C.I. giving Respondent the keys to the medication cart.

14. Respondent returned to the medication cart, but she said she was unable to locate any Morphine.

15. Respondent did not look for Ativan in the medication cart because the Ativan had to be refrigerated, which meant that it would not have been located on the medication cart.

16. Respondent claimed that she did not have the key to the locked box where the Ativan was kept in the Facility's refrigerator.

17. However, C.I. reported that the key ring with the medication cart keys, which Respondent had in her possession, also contained the keys to the medication box in the refrigerator.

18. Respondent ended up going to L.B., the unit manager on a different floor, to retrieve the Ativan from an emergency kit Pyxis machine.

19. In so doing, Respondent left the medication cart unlocked and unattended for approximately 15 minutes, at which time, a nurse walking by the medication cart noticed that it was unlocked and ended up locking it.

20. Respondent withdrew the Ativan with L.B.'s assistance but did not document this and said it just slipped her mind.

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21. Respondent also did not get the proper authorization or order for withdrawing the Ativan for the Patient.

22. Respondent returned to the medication cart with the Ativan, gave the Ativan to C.I., and C.I. then administered it the Patient.

23. S.M. reported that the administration of the Ativan took place shortly after 1:40pm.

24. Respondent said that the only medication that she administered to the Patient was Hyoscyamine, which she gave to her sublingually.

25. Respondent did not enter that she administered Hyoscyamine to the Patient in the Medication Administration Record ("MAR").

26. Respondent told C.I. that she had administered Morphine to the Patient. Based on this, C.I. documented in the MAR that Morphine was administered to the Patient at 1:30pm.

27. However, Respondent did not administer any Morphine to the Patient.

28. The only medications administered to the Patient in the hour prior to her death were Hyoscyamine and Ativan.

29. The administration of the Hyoscyamine and Ativan did not appear to improve the Patient's condition.

30. The Patient died at approximately 1:50pm and, according to her hospice nurse, the Patient did not have a good death.

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 or client care.

31. Paragraphs 2 through 30 above are incorporated herein.

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

33. Paragraphs 2 through 30 above demonstrate that Respondent failed to provide safe and acceptable patient care when she failed to properly administer Hyoscyamine to the Patient; failed to ensure that Ativan was timely administered to the Patient; failed to ensure that Morphine was administered to the Patient; failed to sign out Ativan from the emergency kit without proper authorization; failed to lock the

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medication cart when she went to retrieve the Ativan; and failed to conduct a medication count when she took the keys of the medication cart from C.I.

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: 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.

35. Paragraphs 2 through 30 above are incorporated herein.

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

37. Paragraphs 2 through 30 above demonstrate that Respondent failed to conform to essential standards of acceptable and prevailing practice when she failed to properly administer Hyoscyamine to the Patient; failed to ensure that Ativan was timely administered to the Patient; failed to ensure that Morphine was administered to the Patient; failed to sign out Ativan from the emergency kit without proper authorization; failed to lock the medication cart when she went to retrieve the Ativan; and failed to conduct a medication count when she took the keys of the medication cart from C.I.

38. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because the Respondent has committed unprofessional conduct in violation of 3 V.S.A. §129a(b)(2).

Understandings

1. Respondent admits that the facts above are true and that the conditions below are necessary to protect the public.

2. 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.

3. Respondent specifically waives any claims that any disclosures made to the full Board during its review of this agreement have prejudiced her rights to a fair and impartial hearing in future hearings if this agreement is not accepted by the Board.

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

5. Respondent is not under the influence of any drugs or alcohol at the time she signs this Stipulation and Consent Order.

6. 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.

7. Respondent voluntarily waives the right to a contested hearing before the Board of Nursing and waives any right to appeal from this Stipulation and Consent Order.

8. 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 **FOR A MINIMUM OF ONE (1) YEAR.** The conditions will be as follows:

1. Re-issuance of License. Upon the commencement of these conditions and the renewal of Respondent's license, Respondent shall be issued a license labeled "conditioned."

2. Length of Time of Conditions Imposed. The conditions shall remain in place until Respondent has completed all conditions ordered. Respondent shall be subject to the conditions until Respondent completes **a minimum of one (1) year** of supervised practice in which Respondent works at least eighty (80) hours every calendar month as a nurse. Part time hours of fewer than eighty (80) hours every calendar month shall be credited on a prorated basis. Respondent shall be prohibited from working more than forty (40) hours per week.

3. 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.

4. Required Coursework. Respondent shall, at her 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) the following pre-approved online courses from Nursing CE (or equivalent that are pre-approved by the

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Enforcement Case Manager) and submit test results, completed workbooks and certificates of completion to the Office of Professional Regulation:

a. Critical Thinking (1.0 hour)

b. Nursing Documentation (1.5 hours)

Failure to satisfactorily complete the coursework within the prescribed timeframe shall constitute a violation of this Order. The coursework may not be counted toward any continuing education requirement of licensure.

5. 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 licensed nursing assistant or 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 which 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.

6. Reports from Employers/Program Director. Within one (1) month of the date of this order 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.

7. Practice Under Supervision. Respondent shall practice as a registered nurse only in a setting where Respondent has on-site supervision for the entire shift by a registered nurse that is in good standing with the Board.

8. Types of Employment Prohibited. Respondent shall not work in a supervisory role. Respondent shall not work for a nurse registry, traveling nurse agency, float-pool, home health care agency, temporary nursing employment agency, or as a private

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duty nurse or personal care provider requiring a nursing or nursing assistant license during the effective period of this Consent Order.

9. Interview with the Board or its Designee. Respondent shall appear in person for interviews with the Board or its designee upon request.

10. 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. 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.

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.

12. Notification to Other States. In the event that 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. License Renewal. This Order does not automatically extend the license and Respondent must comply with the Board of Nursing requirements for license renewal and/or reinstatement.

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 Conditioned License Period. After the conditioned license period, the Respondent may petition the Board to remove any and all conditions on her license. Respondent shall have the burden of proof to demonstrate successful completion of the above-stated conditions.

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

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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.

AGREED TO:

STATE OF VERMONT
SECRETARY OF STATE

Dated: 4/4/2023

DocuSigned by:
By: Ultan Doyle
2874944DC5ED4E9...
Ultan Doyle, Esq.
State Prosecuting Attorney

LINDA LARAMEE
RESPONDENT

Dated: 4/4/2023

DocuSigned by:
By: Linda Laramee
38C0C8920725487...
Linda Laramee

APPROVED AND SO ORDERED:

VERMONT BOARD OF NURSING

Dated: 4/10/23

DocuSigned by:
By: Jennifer Laurent
EB1741016710477...
Chairperson

Date of Entry: 4/10/23

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Office of Professional Regulation
Answer

Case Name: Linda Laramee	Docket Number: 2022-232

Your Name: Linda G Laramee Linda Laramee
(person completing the form is either the respondent or the respondent's attorney)
Telephone: (daytime) 802-355-7095 E-mail AngeLOFMercy84@gmail.com

Attach Additional Sheets As Needed

1. Undisputed Facts: State all material facts in the charges that you do not dispute. You may use the paragraph numbers from the specification of charges rather than repeating each statement.

2. Disputed Issues of Fact: State all material facts that you contend are disputed. You may use the paragraph numbers from the specification of charges rather than repeating each statement.

- OVER -

3. Legal Defenses: List all defenses that you intend to present to the charges.

4. Sign and Date: By signing, I affirm that all pages of this form are complete and truthful.

I LL have ____ have not attached additional information.

Linda L Brance
Signature

12/13/2022
Date

Please mail the original to:

Vermont Secretary of State
Office of Professional Regulation
Attn: Docket Clerk
89 Main Street, 3rd Floor
Montpelier, VT 05620-3402

You must also send a copy to:

Prosecuting Attorney who charged the case
89 Main Street, 3rd Floor
Montpelier, VT 05620-3402

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SECRETARY OF STATE
OFFICE OF PROFESSIONAL REGULATION
BOARD OF NURSING

IN RE:	)	
Linda Laramee	)	**Docket No. 2022-232**
License No. 026.0017263	)	

SPECIFICATION OF CHARGES

NOW COMES the State of Vermont and makes the following Charges against the Respondent, Linda Laramee:

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. Linda Laramee ("Respondent") of Burlington, Vermont is licensed by the State of Vermont as a Registered Nurse ("RN") under license number 026.0017263. This license was originally issued on August 22, 1986 and expires on March 31, 2023.

3. During the relevant time period, Respondent was employed as an RN by Queen City Nursing and Rehabilitation ("the Facility"), located in Burlington, Vermont.

4. On or about October 5, 2021, Respondent worked a 7:30am to 3pm shift and was responsible that day for precepting C.I., who had worked as a nurse at the Facility for approximately four months.

5. During Respondent's October 5, 2021 shift, C.I. was the nurse designated to have the keys to the medication cart.

6. At approximately 12:55pm, a hospice nurse, S.M. told Respondent that a hospice patient ("the Patient") was actively dying and needed Hyoscyamine (to reduce mouth secretions), Morphine, and Ativan.

7. After more than 15 minutes, Respondent came into the Patient's room, handed the Hyoscyamine to S.M. and left immediately without administering it to the Patient,

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saying that she would be back with the Morphine and Ativan once she had the keys to the medication cart.

8. S.M. did not administer the Hyoscyamine because Respondent was the nurse who had withdrawn the medication.

9. After speaking with S.M., Respondent went to look for C.I. because he had the keys to the medication cart.

10. Respondent spent several minutes looking for C.I. and eventually found him outside eating lunch.

11. Respondent initially told her supervisor that upon finding C.I. outside, she brought him back to the medication cart and did not get the keys from him.

12. Respondent later revised her account and reported that she took the keys from C.I. when he was outside the Facility.

13. Respondent and C.I. did not do a medication count prior to C.I. giving Respondent the keys to the medication cart.

14. Respondent returned to the medication cart, but she said she was unable to locate any Morphine.

15. Respondent did not look for Ativan in the medication cart because the Ativan had to be refrigerated, which meant that it would not have been located on the medication cart.

16. Respondent claimed that she did not have the key to the locked box where the Ativan was kept in the Facility's refrigerator.

17. However, C.I. reported that the key ring with the medication cart keys, which Respondent had in her possession, also contained the keys to the medication box in the refrigerator.

18. Respondent ended up going to L.B., the unit manager on a different floor, to retrieve the Ativan from an emergency kit Pyxis machine.

19. In so doing, Respondent left the medication cart unlocked and unattended for approximately 15 minutes, at which time, a nurse walking by the medication cart noticed that it was unlocked and ended up locking it.

20. Respondent withdrew the Ativan with L.B.'s assistance but did not document this and said it just slipped her mind.

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21. Respondent also did not get the proper authorization or order for withdrawing the Ativan for the Patient.

22. Respondent returned to the medication cart with the Ativan, gave the Ativan to C.I., and C.I. then administered it the Patient.

23. S.M. reported that the administration of the Ativan took place shortly after 1:40pm.

24. Respondent said that the only medication that she administered to the Patient was Hyoscyamine, which she gave to her sublingually.

25. Respondent did not enter that she administered Hyoscyamine to the Patient in the Medication Administration Record ("MAR").

26. Respondent told C.I. that she had administered Morphine to the Patient. Based on this, C.I. documented in the MAR that Morphine was administered to the Patient at 1:30pm.

27. However, Respondent did not administer any Morphine to the Patient.

28. The only medications administered to the Patient in the hour prior to her death were Hyoscyamine and Ativan.

29. The administration of the Hyoscyamine and Ativan did not appear to improve the Patient's condition.

30. The Patient died at approximately 1:50pm and, according to her hospice nurse, the Patient did not have a good death.

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 or client care.

31. The State re-alleges and incorporates Paragraphs 2 through 30 above.

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

33. Paragraphs 2 through 30 above demonstrate that Respondent failed to provide safe and acceptable patient care when she failed to properly administer Hyoscyamine to the Patient; failed to ensure that Ativan was timely administered to the Patient; failed to ensure that Morphine was administered to the Patient; failed to sign out Ativan from the emergency kit without proper authorization; failed to lock the

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medication cart when she went to retrieve the Ativan; and failed to conduct a medication count when she took the keys of the medication cart from C.I.

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: 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.

35. The State re-alleges and incorporates Paragraphs 2 through 30 above.

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

37. Paragraphs 2 through 30 above demonstrate that Respondent failed to conform to essential standards of acceptable and prevailing practice when she failed to properly administer Hyoscyamine to the Patient; failed to ensure that Ativan was timely administered to the Patient; failed to ensure that Morphine was administered to the Patient; failed to sign out Ativan from the emergency kit without proper authorization; failed to lock the medication cart when she went to retrieve the Ativan; and failed to conduct a medication count when she took the keys of the medication cart from C.I.

38. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because the Respondent has committed unprofessional conduct in violation of 3 V.S.A. §129a(b)(2).

Violation Three: 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.

39. The State re-alleges and incorporates Paragraphs 2 through 30 above.

40. 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.

41. Paragraphs 2 through 30 demonstrate that Respondent failed to exercise independent professional judgment in the performance of licensed activities when she told her supervisor that told her supervisor that upon finding C.I. outside the Facility, she

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brought him back to the medication cart and did not get the keys from him, when this is not what happened.

42. 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 RN license of Linda Laramee should be revoked, suspended, reprimanded, conditioned, or otherwise disciplined.

DATED at Montpelier, Vermont this 31st day of October, 2022.

STATE OF VERMONT
SECRETARY OF STATE

By: Ultan Doyle

Ultan Doyle
Prosecuting Attorney
(802)828-1217
ultan.doyle@vermont.gov

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