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

IN RE:	)	
MARY MARTIN	)	**Docket No. 2022-273**
License No. 022.0134702	)	
	)	

STIPULATED VOLUNTARY SURRENDER OF LICENSE AND ORDER

STIPULATION

NOW COMES the State of Vermont, by and through Prosecuting Attorney, Ultan Doyle, and Respondent, Mary Martin, 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 RN M.C. 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. § 1582; the Administrative Rules of the Board of Nursing (the "ARBN"); and the Rules of the Office of Professional Regulation.

Alleged Facts

2. Mary Martin ("Respondent") of Ringgold, Georgia was licensed by the State of Vermont as a Licensed Practical Nurse("LPN") under license number 022.0134702. This license was originally issued on June 1, 2019 and expired on January 31, 2022.

3. At all times relevant, Respondent was employed as an LPN. At all times relevant, Centurion was the contract healthcare provider for Northern State Correctional Facility ("NSCF") located in Newport, Vermont.

4. On the evening of December 6, 2019, Respondent was working the night shift as an LPN at NSCF's infirmary ("the Infirmary").

5. One of the patients at the Infirmary to whom Respondent was providing care was K.J. ("the Patient"), who had been incarcerated in NSCF as a pretrial detainee since September of 2017.

6. During his detention at NSCF, the Patient had a number of medical issues and was seen frequently by NSCF medical staff for different complaints including management of diabetes, chest, shoulder and abdominal pain, vertigo, and shortness of breath.

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7. In mid-November of 2019, the Patient began to experience a marked deterioration in his health, which ultimately culminated in his death on December 7, 2019. During this time, the Patient was treated approximately ten times in the Infirmary for shortness of breath and wheezing and was on one occasion was transported to the emergency room after complaining of nausea, burning thighs and abdominal pain. These visits to the Infirmary and emergency room were noted in the Patient's chart and RN M.C. was one of the nurses who provided care to him during this time. The Patient was eventually admitted to the Infirmary on December 3, 2019 for sheltered housing due to "respiratory difficulty with mobility."

Night of the Patient's Death

8. On the evening of December 6, 2019, Respondent and RN M.C. were working the night shift (6:00pm-6:00am) at the Infirmary.

9. Another LPN, S.H., was working the evening shift (2:00pm-10:30pm). The on-call provider was APRN S.W.

10. The DOC shift supervisor was Corrections Officer (CO) R.W.

11. In addition to the Patient, there were two other patients at the Infirmary: Inmate 1 and Inmate 2.

12. The sequence of events from this night included three separate significant medical events.

First Event

13. At approximately 5:30pm, LPN S.H. noted that the Patient was "awake, alert, calm" and that "no actions were taken."

14. At approximately 8:30pm, the Patient got RN M.C.'s attention by waving through the window of the Infirmary.

15. M.C. went into the Infirmary and the Patient requested a nebulizer treatment.

16. According to M.C., the Patient did not complain about having difficulty in breathing or exhibit any signs of distress.

17. M.C. administered a nebulizer treatment and left approximately five minutes later.

18. M.C. did not document this event or follow up with the Patient to see if his breathing had improved.

19. At approximately 10:30pm, Inmate 1 reported that the Patient's breathing started to become more dramatic and animated, and that the Patient told him he could not breathe.

20. The Infirmary video at this time showed the Patient on the bed, visibly agitated.

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21. Inmate 1 knocked on the Infirmary's window to get help and CO J.M., who happened to be at the window at the time, responded to the Infirmary.

22. CO J.M. reported that when he went into the Infirmary, the Patient appeared to be gasping for air.

23. J.M. put the Patient in the DOC trained recovery position and radioed a code 10-25 (the term for a request for officers to report to specific location in the Facility).

24. RN M.C., Respondent, and LPN S.H. immediately went to the Infirmary.

25. M.C. and Respondent reported that the Patient said that he was having difficulty breathing.

26. S.H. reported that the Patient looked like he was gasping for air and that he was wheezing and breathing rapidly.

27. A couple of minutes later, CO R.W. also arrived in the Infirmary in response to the code 10-25 call.

28. R.W. reported that he heard the Patient telling RN M.C. and Respondent that he could not breathe and said that the Patient was rocking and breathing heavily.

29. R.W. also noted that the Patient was rasping and hyperventilating.

30. LPN S.H. immediately took the Patient's vital signs and then Respondent began to administer a nebulizer treatment and left.

31. At approximately 10:40, LPN S.H., RN M.C. and the two corrections officers left.

32. At this time, the Patient was finishing the nebulizer treatment, while seated on his bed.

33. RN M.C. returned at approximately 10:50pm and retrieved the nebulizer.

34. Respondent did not document the medical event described above.

35. M.C.'s notes documenting this medical event were signed at 10:47pm.

36. In those notes, M.C. reported that the Patient complained "that he could not breath" and that his lungs were "wheezing throughout."

37. M.C. also noted that the Patient had a respiration rate of 30 breaths a minute and a blood pressure reading of 138/80. M.C. ended her note with the following: "Patient told to sleep with head of the bed elevated not flat. Patient reating [sic] comfortable at this time."

38. In a subsequent interview with OPR investigators about this incident, M.C. said that the Patient was anxious and appeared to be in more distress and breathing faster than he had been when she saw him earlier in the evening.

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39. M.C. claimed that although she could hear audible wheezing from the Patient, it was only while listening to his lungs with a stethoscope.

40. According to M.C., this was the first time that the Patient told her that he was not able to breathe.

41. M.C. said that his vital signs "were not horrible," but later admitted that 30 breaths per minute was high for someone at rest.

42. Neither M.C. nor Respondent did anything to evaluate the cause of the Patient's elevated respirations.

43. When asked by an OPR investigator about the elevated respiration rate, M.C. said she "assumed" that it was because he had COPD but admitted that she was not sure because she had not read his chart.

44. M.C. could not recall if she called APRN S.W., the on-call provider, to report this incident.

45. S.W. reported that M.C. had called her after this medical event and told her that the Patient was not keeping his head elevated on his bed.

46. S.W. told M.C. to talk to corrections officers about this issue because sometimes it can help diffuse medical situations.

47. M.C. did not document this call in her notes.

Second Event

48. From approximately 11:00pm to midnight, video from the Infirmary showed the Patient at different times sitting up, rocking back and forth, and exhibiting visible signs of difficulty with his breathing.

49. Shortly after midnight, the Patient gestured toward the Infirmary window and in response, Respondent came into the Infirmary.

50. Respondent spoke briefly to the Patient, then left and returned a few seconds later with an oxygen sensor that she first put on his right hand and later moved to his left hand.

51. While M.M. was placing the oxygen sensor on his hands, the Patient's head was down, and he was rocking slightly back and forth while he was seated on the side of his bed.

52. RN M.C. later entered the Infirmary and adjusted the Patient's pillow and wedge pillow.

53. Respondent left, and M.C. spoke to the Patient for about three minutes, while standing next to his bed, and then left at approximately 12:10am.

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54. During her interview OPR investigators, M.C. was shown the video from this encounter.

55. M.C. said that it looked like the Patient was anxious and breathing hard and that she believed that he was telling her that he could not breathe.

56. M.C. also reported that around this time, she thought that he may have had pneumonia.

57. Neither M.C. nor Respondent documented this encounter with the Patient and M.C. did not report it to the on-call provider.

58. For the next several minutes, the Infirmary video showed the Patient at various times sitting up, standing up, speaking to Inmate 1, walking to the bathroom, leaning against the Infirmary counter, and rocking back and forth.

59. At approximately 12:34am, the Patient paced back and forth next to his bed and then walked to the bathroom on the opposite side of the room, where he disappeared behind a curtain.

60. At approximately 12:37am, CO L.M. was doing his checks of the Facility and noticed that the Patient was not in his bed.

61. When L.M. entered the Infirmary, he found the Patient lying on his stomach on the bathroom floor.

62. L.M. reported that although the Patient was conscious, he was breathing heavily and gasping for air.

63. L.M. radioed a 10-25 code and M.C., Respondent and CO R.W. responded.

64. L.M. and R.W. eventually picked up the Patient and had to assist him in walking back to his bed.

65. L.M. reported that the Patient said he could not breathe and had vertigo.

66. Immediately prior to L.M. leaving the Infirmary, the Patient grabbed him and said, "Please don't leave me alone, please don't leave me alone."

67. Inmate 1 reported that before the Patient went to the bathroom, he was pacing back and forth like he was in distress and kept saying that he could not breathe and needed to go the hospital.

68. Inmate 2 also reported that the Patient was very clear with the nurses that night about not being able to breathe and that he asked for oxygen and to go the hospital several times.

69. Inmate 1 told the Patient that he should lie on the bathroom floor and that "they'll take you to the hospital then."

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70. Inmate 1 reported that at some point after, the Patient went into the bathroom, but that he did not know what happened to him while he was in there.

71. Inmate 1 stated that when the nurses came into the Infirmary after the Patient was found on the bathroom floor, they appeared to be frustrated with the Patient.

72. According to Inmate 1, RN M.C. told Respondent that: "If this happens again, he's going to A/C [the booking area], we're all done with this bullshit."

73. Inmate 1 also stated that Respondent later told the Patient that he was acting like a 2-year-old and to lie down.

74. Inmate 2 reported that Respondent told the Patient that he was faking and told him that she would put him A/C if he did not lie down with his feet in the air.

75. CO R.W. reported that when he came into the Infirmary and saw the Patient on the floor, he was having trouble breathing.

76. As R.W. helped the Patient to his bed, the Patient was taking "real short quick breaths" and was saying "I can't breathe, I can't breathe."

77. R.W. stated that the nurses told the Patient at one point that if did not calm down and stay in his bed, they would move him to a small room in the booking area.

78. During this time, the Patient was constantly saying that he could not breathe.

79. R.W. asked RN M.C. if the Patient needed to go the hospital and she told him, "No. Per the doctor, he's not going."

80. R.W. said the doctor to whom M.C. was referring was the on-call provider, APRN S.W.

81. CO T.B. also responded to the 10-25 code and reported that when he arrived, the Patient was complaining that he could not breathe.

82. T.B. said he could hear "raspy respirations" coming from the Patient, who was approximately 7-8 feet away.

83. Respondent said that the Patient was lying on the bathroom floor on his left side in the fetal position when she arrived.

84. Respondent went to retrieve a wheelchair, but the COs who were present picked him up and walked him to back to his bed.

85. Respondent said that she tried to conduct a neurological check on the Patient, but he kept fidgeting.

86. Respondent did not recognize this fidgeting as a sign of respiratory distress.

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87. Respondent was able to determine that the Patient's hand grips were of equal strength, that he had not lost consciousness, that there was no swelling, bleeding or lumps on his head, and that his speech was normal.

88. Respondent reported that after performing the neurological checks, she gave the Patient a urinal and told him to stay in bed and use the call light if he needed to get out of bed.

89. Respondent did not document this medical event.

90. Respondent denied that there was any discussion about the Patient faking that night, but she said that she did ask him to calm down because he was working himself up.

91. When questioned by OPR investigators, Respondent stated that she did not think that the Patient appeared to be having a hard time breathing while he was lying on the floor, although she reported that when he was sitting on the bed immediately after the fall, he was breathing nosily in a way that was not normal for him.

92. Respondent also said that his respirations were within normal limits.

93. However, when asked if it would be concerning that the Patient's respirations per minutes were between 28-30, Respondent said that it could be, especially for someone with COPD.

94. Respondent said that after RN M.C. spoke to APRN S.W., M.C. told Respondent that S.W. ordered a cold pack (various medications to treat a cold) for the Patient.

95. Respondent said that M.C. did not say whether she and S.W. had talked about the Patient going to the ER.

96. Respondent advised that the decision to have the Patient go to the hospital was one she could not make; that only the provider could make that decision.

97. M.C. said that when she arrived in the Infirmary after the Patient's fall and first interacted him, he told her that he had slipped and that he was okay.

98. M.C. claimed that she did not do an assessment on the Patient while he was lying on floor because he said he was okay, and he had not hit his head.

99. An OPR investigator asked M.C. if there was a discussion around this time about the Patient faking to which M.C. replied, "I had never said he was faking, and I never heard anyone say he was faking."

100. M.C. stated that she took the Patient's vitals after the fall and examined his lungs because he told her that he could not breathe.

101. M.C. told investigators that the Patient's lungs did not sound bad but documented in her notes: "Lungs decreased with wheezing noted."

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102. M.C. also stated that around this time the Patient said that he wanted to go the hospital.

103. M.C. reported that even though it looked like the Patient was in distress, she did not see a way of getting him to the hospital without an order from a provider.

104. An OPR investigator pointed out that in the video that the Patient's abdomen and chest were rising while he was breathing, that he was asking to go the hospital and saying he could not breathe, and that he looked in distress.

105. When asked by the investigator why these symptoms were not enough to send Patient to the hospital, M.C. replied, "If I call [the on-call provider] and he's [the Patient] saying … that he can't breathe and it looks like he can't breathe, but he's telling me it's a stuffy nose …" (M.C. did not finish her sentence).

106. M.C. then said, "I could have probably tried harder, the bottom line is I could probably have tried harder."

107. M.C. said that she called APRN S.W. about this incident and told her that the Patient was stuffed up and feeling dizzy and that in response, S.W. ordered a cold pack.

108. M.C. maintained that she told S.W. the Patient was complaining that he could not breathe, that he was anxious, and that he looked like he was in distress.

109. M.C. also said that she informed S.W. of the Patient's vital signs, told her what his lungs sounded like, and said that he wanted oxygen and to go the hospital.

110. According to M.C., S.W. said going to the hospital was not warranted based on his numbers and that if he did not settle down, M.C. could put him in holding.

111. M.C. said initially that she thought she told S.W. that the Patient had been found on the bathroom floor.

112. However, M.C. later admitted that she may not have told S.W. that the Patient was found on the bathroom floor.

113. In addition to the Patient being found on the bathroom floor, video leading up to and during the event shows him exhibiting visible signs of his difficulty in breathing, including fidgety and restless behavior, varying degrees of retraction and accessory muscle use, and tripod positioning.

114. There is no evidence that any of these signs that the Patient was having difficulty breathing were reported to S.W.

115. S.W. said that M.C. never mentioned that the Patient was found on the bathroom floor and that she had no recollection of M.C. telling her about the Patient not being able to breathe, requesting oxygen or wanting to go to the hospital.

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116. S.W. stated that had M.C. informed her that the Patient had been found unresponsive, that his oxygens levels were low or that he was not breathing well, she would have had him sent to the emergency room.

117. S.W. also said that at some point, M.C. told her that she thought the Patient was faking, but could not recall exactly what M.C. had said and did not follow up with her on why she thought he was faking.

118. Respondent did not document this incident.

119. M.C.'s progress note for this incident was entered at 1:53am on December 7, 2019.

120. The Patient's respirations per minute were recorded at 28 respirations per minute.

121. M.C. noted that: "Patient is C/O not being able to breath. He said 'I'm all stuffed up. I have a HA [headache] I am feeling dizzy.' VSS O2 sat 97% Lungs decreased with wheezing noted."

122. M.C. also noted "Patient is wanting O2 and to go to [the] ER" and "Provider recommendations: medications ordered Cold pack BID times 2 days."

123. M.C. did not document that the Patient had been found lying on the bathroom floor.

124. When asked by an OPR investigator why she failed to document this incident, M.C. replied, "Probably just forgot" and then said she did not know why.

125. Video from this second event showed CO L.M. discovering the Patient lying on the bathroom floor at approximately 12:37am.

126. Approximately 10 seconds later, M.C., Respondent and CO R.W. arrived and stood at the doorway to the bathroom a couple of feet from the Patient who was still lying on the bathroom floor.

127. Neither nurse went to check on the Patient and over 45 seconds elapsed before CO R.W. and CO L.M. picked the Patient up.

128. Respondent went to retrieve Inmate 1's wheelchair, but COs R.W. and L.M. ended up walking the Patient back to his bed.

129. The Patient then sat at the edge of the bed while rocking back and forth and struggling to breathe.

130. M.C. took the Patient's vital signs, which included checking his oxygen level and blood pressure and listening to his lungs, while Respondent checked his blood sugar level.

131. During this time, M.C. continued to rock back and forth in an agitated manner.

132. At approximately, 12:44am, M.C. lay back down on the bed and both nurses left.

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133. Shortly thereafter, Respondent returned with a urinal, spoke briefly with the Patient, and left again.

134. At 12:47am all of the CO's except for CO R.W. left.

135. Respondent then returned a couple of minutes later and conducted a neurological examination by shining a light in the Patient's eyes and grabbing his hands.

136. During this time, the Patient was lying down and was restless and agitated.

137. After the exam, Respondent and CO R.W. stood at the foot of the bed and spoke to the Patient.

138. RN M.C. came in at approximately 12:49am and handed medication to the Patient.

139. At approximately 12:51am, both nurses and CO R.W. exited the Infirmary, leaving the Patient lying on his bed in a clearly agitated state.

Third Event

140. Video from approximately 12:51am until 1:40am showed the Patient moving repeatedly on and around his bed in a restless agitated manner as he appeared to struggle to breathe.

141. At approximately 1:40am, the Patient waved toward the Infirmary window and a few seconds later, CO L.M. came in, spoke to the Patient for about a minute and then left.

142. When questioned by investigators about this encounter, L.M. reported that the Patient asked if he could be moved to a cell.

143. L.M. told the Patient that was not up to him to make that decision.

144. L.M. advised that the Patient was still having difficulty breathing but it did not seem to be life-threatening.

145. At approximately 1:46am, the Patient put a pillow on the floor next to the bed and lay on it.

146. At approximately 1:48am, the Patient knelt next to the bed and a few minutes later lay down on the bed again.

147. At approximately 1:57am, the Patient, while lying on bed, stopped moving.

148. At approximately 2:16am, Inmate 2 went and spoke to Inmate 1.

149. Inmate 2 then walked over and looked at the Patient for several seconds, went back to his bed and then approached the Infirmary window.

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150. Inmate 2 reported to investigators that he got up at approximately 2:00am to go the bathroom, noticed that the Patient was not breathing, went over to look at Patient, and then knocked on the Infirmary window.

151. Immediately after Inmate 2 went to the Infirmary window, Respondent came into Infirmary and took the Patient's pulse, put her hand on his chest and then left.

152. The Patient was unresponsive, and no pulse or respirations were detected.

153. At approximately 2:17am, Respondent returned with RN M.C. and had a brief conversation with her.

154. Respondent put her hand on the Patient's chest again and left.

155. Respondent then came back with a blood pressure cuff and put it on the Patient's right arm.

156. For approximately the next half hour, the nurses, corrections officers and later EMTs tried various life saving measures on the Patient, including administering oxygen, chest compressions, and a defibrillator.

157. At approximately 2:54am, EMTs took the Patient out of the Infirmary.

158. The Patient was taken to North County Hospital where he was pronounced dead at approximately 3:00am on December 7, 2019.

159. An autopsy conducted by Medical Examiner, S.S., noted the presence of a laryngeal tumor arising from the Patient's right vocal cord and that the cause of his death was "Airway obstruction by Laryngeal Squamous Cell Carcinoma."

160. S.S. said that the Patient died a "horrible death" and explained that "he was slowly losing the ability to breath and if he had been taken to the ER and they looked closely enough in his throat, they would have seen the blockage."

Violation One: 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.

161. The State re-alleges and incorporates Paragraphs 2 through 160 above.

162. The National Association of Licensed Practical Nurses ("NALPN") standards of practice require an LPN to accept assigned responsibilities as an accountable member of a health team; function with other members of a healthcare team in promoting and maintaining a patient's health; and know and utilize the nurse process in planning, implementing and evaluating health services and nursing case for a patient.

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163. Paragraphs 2 through 160 above demonstrate that Respondent failed to conform to the essential standards of acceptable and prevailing practice by failing to recognize that the Patient's repeated complaints about not being able to breathe, his elevated respirations per minutes, his labored breathing and audible wheeze, his use of accessory muscles to facilitate breathing, his fidgeting and restless behavior, and his collapse on the floor after a short walk to the bathroom, were signs of an acute and life threatening medical event requiring an immediate level of higher care.

164. The NALPN standards require an LPN's nursing plan to include "the assessment/data collection of the health status of the individual patient" and "observing, recording and reporting significant changes which require intervention or different goals."

165. Paragraphs 2 through 160 above demonstrate that Respondent failed to conform to the essential standards of acceptable and prevailing practice by failing to document the Patient's repeated reports that he was having trouble breathing; her administration of a nebulizer treatment to the Patient; failing to document her placement of an oxygen sensor on the Patient's hands; failing to document that the Patient had been found lying on the bathroom floor; failing to document that she had performed a neurological examination of the Patient; and failing to document her finding the Patient unresponsive and efforts that she took to resuscitate the Patient.

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

Violation Two: 3 V.S.A. § 129a(b)(1) Failure to practice competently by reason of any cause on a single occasion or on multiple occasions may constitute unprofessional conduct, whether actual injury to a client, patient, or customer has occurred. Failure to practice competently includes: (1) performance of unsafe or unacceptable patient or client care.

167. The State re-alleges and incorporates Paragraphs 2 through 160 above.

168. As an LPN, Respondent is required to provide safe and acceptable patient care.

169. Paragraphs 2 through 160 above demonstrate Respondent's failure to provide safe and acceptable patient care by failing to recognize that the Patient's repeated complaints about not being able to breathe, his elevated respirations per minutes, his labored breathing and audible wheeze, his use of accessory muscles to facilitate breathing, his fidgeting and restless behavior, and his collapse on the floor after a short walk to the bathroom, were signs of an acute and life threatening medical event requiring an immediate level of higher care.

170. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent has committed unprofessional conduct in violation of 3 V.S.A. §129a(b)(1).

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Violation Three: 26 V.S.A. § 1582(a)(12) Abusing or neglecting a patient or misappropriating patient property.

171. The State re-alleges and incorporates Paragraphs 2 through 160 above.

172. As an LPN, Respondent was required to refrain from abusing a patient or misappropriating patient property.

173. Paragraphs 2 through 160 above demonstrate Respondent's neglect of the Patient by failing to recognize that the Patient's repeated complaints about not being able to breathe, his elevated respirations per minutes, his labored breathing and audible wheeze, his use of accessory muscles to facilitate breathing, his fidgeting and restless behavior, and his collapse on the floor after a short walk to the bathroom, were signs of an acute and life threatening medical event requiring an immediate level of higher care.

174. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent has committed unprofessional conduct in violation of 26 V.S.A. §1582(a)(12).

Violation Four: 3 V.S.A. § 129a(a)(15) Failing to exercise independent professional judgement in the performance of licensed activities when that judgment is necessary to avoid action repugnant to the obligations of the profession.

175. The State re-alleges and incorporates Paragraphs 2 through 160.

176. As an LPN, Respondent. is required 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.

177. Paragraphs 2 through 160 demonstrate Respondent's failure to exercise her own professional judgment in the performance of licensed activities when that judgment is necessary to avoid action repugnant to the obligations of the profession by failing to recognize that the Patient's repeated complaints about not being able to breathe, his elevated respirations per minutes, his labored breathing and audible wheeze, his use of accessory muscles to facilitate breathing, his fidgeting and restless behavior, and his collapse on the floor after a short walk to the bathroom, were signs of an acute and life threatening medical event requiring an immediate level of higher care.

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

Understandings

179. This Stipulation is neither an admission of liability by 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 litigation, the Parties enter

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this full and final Stipulation pursuant to these Understandings and the Order below. Respondent does not dispute that the State may be able to prove these charges by a preponderance of the evidence if this matter proceeds to a merits hearing.

180. Respondent understands that the Board must review and accept the terms of the Stipulated Voluntary Surrender of License. If the Board rejects any portion, the entire Stipulated Voluntary Surrender of License shall be null and void.

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

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

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

184. 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.

185. Respondent voluntarily waives her right to a contested hearing before the Board of Nursing and waives any right to appeal from this Stipulated Voluntary Surrender of License.

186. Respondent agrees that the Acceptance of Voluntary Surrender and Order set forth below may be entered by the Board.

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 LPN 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.

STATE OF VERMONT

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

AGREED TO:

STATE OF VERMONT
SECRETARY OF STATE

Dated: 9/22/2023 By: DocuSigned by: Ultan Doyle 2B74944DC5ED4E9...
Ultan Doyle
Prosecuting Attorney

RESPONDENT

Dated: 9/21/2023 By: DocuSigned by: 543C5152EF2344E...
Mary Martin

APPROVED AND SO ORDERED:

VERMONT BOARD OF NURSING

Dated: 10/9/23 By: DocuSigned by: Jennifer Laurent EB1741915719477...
Chairperson

Date of Entry: 10/10/23

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