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

IN RE:	)	
Sharon Laub	)	**Docket No. 2023-59**
License No. 026.0023454	)	

STIPULATED VOLUNTARY SURRENDER OF LICENSE AND ORDER

STIPULATION

NOW COME the State of Vermont, by and through Prosecuting Attorney Ultan Doyle, and Respondent Sharon Laub, by and through her counsel William A. Vasiliou II, Esq., 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.

Alleged Facts

2. Sharon Laub ("Respondent") of South Weymouth, Massachusetts was licensed by the State of Vermont as a Registered Nurse ("RN") under license number 026.0023454. This license was originally issued on July 9, 1997 and expired on March 31, 2023.

3. On December 5, 2012, the State charged Respondent in her capacity as a licensed Advanced Practice Registered Nurse with the diversion of Fentanyl while she was working as a nurse anesthetist at what was then known as Fletcher Allen Health Care in Burlington, Vermont.

4. On September 9, 2013, the Board approved a Stipulation and Consent Order whereby Respondent admitted to diverting Fentanyl and agreed to an indefinite suspension of her APRN license.

5. On January 12, 2015, the Board approved a Stipulation and Consent Order wherein Respondent's RN license was reinstated, and conditions were attached for an indefinite time period, but no less than a minimum period of five years.

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6. These conditions included completion of substance abuse counseling, random drug and alcohol testing, employer reports, supervised practice, and restrictions on the administration of controlled substances.

7. On May 18, 2018, the Board modified a number of Respondent's conditions, including the requirement of submitting employer reports, which was amended as follows: "Upon successful completion of quarterly reports for one year from the date of this Order Granting Petition for Modification of Conditions, the requirement of quarterly reports shall cease."

8. From July 6, 2015 until March 17, 2022, Respondent was employed as an RN at the University of Vermont Medical Center ("the Facility"), located in Burlington, Vermont.

9. From July 6, 2015 to April, 9 2018, Respondent worked in the Facility's Pre-Operative Unit

10. From April 9, 2018 to March 17, 2022, Respondent worked in the Facility's Post Anesthesia Care Unit at the Facility.

11. On September 15, 2021, Respondent emailed her nurse manager from home, stating that earlier that day she had forgotten to waste 0.2 mg IV Hydromorphone and had instead discarded the syringe containing the medication into a needle box.

12. As a result of this incident, on September 17, 2021, the Facility issued Respondent a verbal warning for wasting a controlled substance without a witness.

13. On September 16, 2021, Respondent withdrew 0.5 mg of Oxycodone at 10:43am, but did not document administering the medication, thereby leaving 0.5 mg of Oxycodone unaccounted for.

14. On September 17, 2021, Respondent withdrew 100 mcg of Fentanyl at 10:31am.

15. Respondent subsequently incorrectly recorded that she administered 25 mcg of the medication three times from approximately 10:34am to 10:47am, and then wasted 50 mcg of the medication at 11:36am.

16. On September 17, 2021, Respondent withdrew 0.5 mg of Hydromorphone at 10:32am and 10:45am and administered to the same patient 0.5 mg of the medication at 10:46am, thereby leaving 0.5 mg of Hydromorphone unaccounted for.

17. On September 23, 2021, Respondent withdrew 0.5 mg of Hydromorphone at 1:38pm and administered 0.3 mg of Hydromorphone at 1:56pm thereby leaving 0.2 mg of Hydromorphone unaccounted for.

18. From September 1, 2021 until October 1, 2021, there were 18 instances in which Respondent's waste time for controlled substances exceeded one hour from time of withdrawing.

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19. On October 22, 2021, the Facility issued Respondent a Letter of Understanding in which Respondent was warned, among other things, about the discrepancies in her controlled substance withdrawing patterns and the failure to waste controlled substances within one hour of withdrawing them. Respondent was also advised to "pull medications from the Pyxis for administration after performing a pain assessment and not preemptively."

20. On December 10, 2021, Respondent used a Pyxis machine to sign out one vial containing 2 cc of Fentanyl, but instead took two vials of the medication.

21. The next nurse to use the Pyxis machine noticed a discrepancy in the Fentanyl count.

22. When questioned about the missing medication, Respondent said she had only removed one vial of Fentanyl as she had documented. Respondent checked her pockets and did not find any medication.

23. Respondent later claimed that the vial of Fentanyl had fallen into an inside pocket in her scrub top and did not notice it when she first searched her pockets.

24. Respondent returned the vial to the medication room, and the Fentanyl discrepancy was resolved.

25. On January 5, 2022, at 12:54pm, Respondent withdrew one 2 mg Hydromorphone tablet for a patient but did not document administering it until 6:03pm.

26. On January 6, 2022, the Facility issued Respondent a Final Written Warning in which the Facility discussed, among other things, the December 10, 2021 Fentanyl count discrepancy and Respondent's failure to meet the expectations set forth in the October 22, 2021 Letter of Understanding.

27. In February of 2022, there were a number of times that Respondent withdrew controlled substances prior to documenting a pain scale.

28. On February 2, 2022, Respondent withdrew 100 mcg of Fentanyl at 10:51am and 0.5 mg of Hydromorphone at 11:10am. However, Respondent did not first document a pain scale (10) until approximately 11:20am when she administered 25 mcg of Fentanyl and 0.5 mg of Hydromorphone.

29. On February 16, 2022, Respondent withdrew 4 mg of Hydromorphone at 4:53 pm and 100 mcg of Fentanyl at 4:54pm. However, Respondent did not first document a pain scale (8) until 5:02pm when she administered 50 mcg of Fentanyl.

30. On February 21, 2022, Respondent withdrew 100 mcg of Fentanyl at 1:28pm. However, Respondent did not first document a pain scale (9) until 1:30pm when she administered 25 mcg of the medication.

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31. On February 23, 2022, Respondent withdrew 100 mcg of Fentanyl at 2:57pm and she administered 25 mcg at 3:03pm, at which time she wrote the following note: "C/O R flank pain." The pain scale for the patient was left blank. Respondent did not document a pain scale (2) until 5:25pm.

32. In March of 2022, Respondent had a series of increasing delays in the documentation of her administration of controlled substances.

33. On March 2, 2022, Respondent withdrew 100 mcg of Fentanyl at 9:35am and administered 50 mcg at 9:46am and 25 mcg at 10:18am. Respondent did not document administering the remaining 25 mcg of Fentanyl until 12:01pm.

34. On March 2, 2022, Respondent withdrew 0.5 mg of Hydromorphone at 11:17am for the same patient. However, Respondent did not document administering 0.25 mg until 12:03pm and wasting the remaining 0.25 mg until 1:04pm.

35. On March 3, 2022, Respondent's action time for the administration of Fentanyl 50 mcg was 12:35pm and the recorded time was 1:17pm resulting in a charting delay of the administration of the medication of 42 minutes. Respondent noted the following in the patient's chart: "delayed charting d/t busy pt assignment."

36. On March 3, 2022, Respondent's charting of the administration of Hydromorphone 2 mg tablet and Hydromorphone 0.5 mg syringe for the same patient was delayed by 55 minutes and 58 minutes respectively. Respondent again attributed these delays to a "busy patient assignment."

37. On March 4, 2022, Respondent withdrew 0.5 mg of Hydromorphone at 2:29pm, and subsequently incorrectly recorded that she administered 0.5 mg of the medication at 2:35pm and then wasted 0.25 mg of the medication at 3:49pm.

38. From February 2, 2022 until March 11, 2022, Respondent had 30 instances in which her waste time for controlled substances exceeded one hour from time of withdrawing.

39. On March 17, 2022, the Facility issued Respondent a letter terminating her employment on the basis that there had not been a significant improvement in Respondent's withdrawing, administration, wasting and documentation practices.

40. In a written affidavit, dated June 3, 2022, Respondent accepted responsibility for the improper wasting of Hydromorphone on September 15, 2021.

41. With respect to alleged variances in the narcotics that she withdrew and administered, Respondent stated that an "entry error" had probably occurred and went on to say, "As I am responsible for entering accurate information, I must accept responsibility for those clerical mistakes."

42. On June 30, 2022, Respondent told OPR investigators that with regard to narcotic wasting issues, she noted that when the Facility got busy and she had two patients at a

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time, it was hard to follow the Facility's policy that controlled substances had to be wasted within one hour.

43. When asked about misplacing a vial of Fentanyl on December 10, 2021, Respondent acknowledged that it occurred and said that it was an honest error.

44. Regarding delayed documentation of pain scales, Respondent said that sometimes she was unable to chart this right away due to her being busy or patients being in pain.

45. With regard to delays in patient charting, Respondent attributed those delays to being busy and not having sufficient time to chart.

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.

46. Paragraphs 2 through 45 above are incorporated herein.

47. The essential standards of acceptable and prevailing practice require that an RN accurately document the withdrawing and administration of narcotics.

48. Paragraphs 13 to 17, 25, 33 to 37, 41, and 45 above demonstrate that Respondent failed to conform to essential standards of acceptable and prevailing practice when she repeatedly failed to accurately document the withdrawing and administration of narcotics.

49. The essential standards of acceptable and prevailing practice require that the wasting of narcotics by an RN be witnessed by another nurse and that it take place as soon as practicably possible after the medication is withdrawn.

50. Paragraphs 11, 18, 38 and 42 above demonstrate that Respondent failed to conform to essential standards of acceptable and prevailing practice when she failed to have a fellow staff member witness the wasting of Hydromorphone and repeatedly failed to waste narcotics within one hour of being withdrawn.

51. The essential standards of acceptable and prevailing practice require that an RN document pain scales prior to withdrawing narcotics.

52. Paragraphs 28 to 31, and 44 above demonstrate that Respondent failed to conform to essential standards of acceptable and prevailing practice when she repeatedly failed to document pain scales prior to withdrawing controlled substances.

53. The essential standards of acceptable and prevailing practice require that an RN account for and keep track of any narcotics that are withdrawn.

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54. Paragraphs 20 to 24, and 43 demonstrate that Respondent failed to conform to essential standards of acceptable and prevailing practice when she failed to keep track of a vial of Fentanyl that she withdrew.

55. 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

56. 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 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.

57. Respondent understands that the Nursing Board must review and accept the terms of the Stipulation and Consent Order. If the Board rejects any portion, the entire Stipulation and Consent Order shall be null and void.

58. 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.

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

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

61. 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.

62. 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.

63. Respondent agrees that the Order set forth below may be entered by the Board, will be a binding Order upon Respondent, and will be made public.

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64. Respondent understands that Respondent is responsible for all compliance costs associated with this Stipulation and Consent Order and any violation of this Order may result in additional disciplinary action.

ACCEPTANCE OF VOLUNTARY SURRENDER AND ORDER

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

A. The Board hereby **ACCEPTS** Respondent's **VOLUNTARY SURRENDER** of her RN license.

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

C. This Stipulation and Consent Order is a matter of public record and may be reported to other licensing authorities as provided in 3 V.S.A. §129(a).

D. This Stipulation and Consent Order will remain part of Respondent's licensing file and may be used for purposes of determining sanctions in any future disciplinary matter.

AGREED TO:

STATE OF VERMONT
SECRETARY OF STATE

Dated: _____

By: Ultan Doyle
Ultan Doyle, Esq.
State Prosecuting Attorney

SHARON LAUB
RESPONDENT

Dated: 8-8-23

By: S Laub
Sharon Laub

APPROVED AS TO FORM:

LANGROCK, SPERRY & WOOL
ATTORNEY FOR RESPONDENT

Dated: 8-31-2023

By: William A. Vasiliou II, Esq.

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APPROVED AND SO ORDERED:

VERMONT BOARD OF NURSING

Dated: 11/13/23

By: DocuSigned by: William Jamie Floyd
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Chairperson

Date of Entry: 11/13/23

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