

State of Vermont
Vermont Board of Nursing

In re: Lisa Hurteau
License Number 026.0093919
Docket Number: D-2024-123 & D-2024-124

Order to Remove Conditions

On March 10, 2025, the Vermont Board of Nursing considered Lisa Hurteau's request for Removal of Conditions imposed pursuant to a Stipulation & Consent Order under Docket Number 2024-123 & 2024-124. Ms. Hurteau has successfully met the conditions. After review of the follow-up file, the State does not object to removal of all conditions.

Order:

The Board hereby removes all conditions from Lisa Hurteau's Registered Nurse license.

Vermont Board of Nursing

Signed by:

3062E703001248E...
Jennifer Laurent, Board Chair

Date: March 10, 2025

Date of Entry: 3 / 11 / 25



State of Vermont
Office of the Secretary of State

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

Sarah Copeland Hanzas, Secretary of State
S. Lauren Hibbert, Deputy Secretary
Michael D. Warren, Interim Director

February 18, 2025

Attorney Ultan Doyle, Esq.
Office of Professional Regulation
89 Main Street, 3rd Floor
Montpelier, VT 05620-3402

Case: Lisa Hurteau
Credential: License # 026.0093919
Docket No: 2024-123 & 124

Dear Attorney Doyle:

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*

Cc: Kristin Donnelly, Case Manager
Attorney Edward Adrian, Respondent's Attorney

Bowen, Julie

From: Ed Adrian <eadrian@msvtlaw.com>
Sent: Friday, February 14, 2025 6:01 PM
To: SOS - Docket Clerk
Cc: Doyle, Ultan; lisa Woods
Subject: Request for Removal of Conditions - Lisa Hurteau, 2024-123 & 124
Attachments: Dementia relias edu.pdf

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

Hi Juile

Please consider this a formal request to remove the condition from Lisa's license as she has completed the sole condition of taking a Dementia Care Course (certificate attached).

Best
Ed

--
Ed Adrian
Counselor and Attorney at Law
Monaghan Safar PLLC
27 Main Street
Burlington, Vermont 05401
Office: 802.660.4735
Fax: 802.419.3662
Cell: 802.233.2131
eadrian@msvtlaw.com
www.msvtlaw.com

RELIAS

Certificate of Completion

Lisa Hurteau

has successfully completed the course:

Dementia Care: Challenging Behaviors and Direct Care Staff

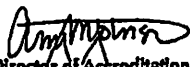
on

10/7/2024

for

0.50 of training hours

This certificate may not meet your organization or certification needs for continuing education. See your administrator or board for specific guidelines.



Director of Accreditation

1010 Sync Street, Ste. 100, Morrisville, North Carolina 27560 | www.relias.com | Phone: 1-877-200-0020

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

IN RE:	)	
Lisa Hurteau	)	Docket Nos. 2024-123
License No. 026.0093919	)	2024-124

STIPULATION AND CONSENT ORDER

STIPULATION

NOW COME the State of Vermont, by and through Prosecuting Attorney Ultan Doyle, and Respondent Lisa Hurteau, by and through her counsel Edward G. Adrian, 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; 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. Lisa Hurteau ("Respondent") of Hinesburg, Vermont is licensed by the State of Vermont as a Registered Nurse ("RN") under license number 026.0093919. This license was originally issued on March 22, 2013 and expires on March 31, 2025.
3. During the relevant time period, Respondent was employed as an RN at a medical facility located in Burlington, Vermont ("the Facility").
4. On or about January 24, 2024, Respondent placed a gait belt around a patient with dementia who was at high risk of falling, and who was seated in a wheelchair, thereby restraining him in the wheelchair.
5. The patient did not demonstrate that he could remove the restraint, there was no order for the restraint, and the gait belt used to restrain him had not been authorized as a restraint.
6. The use of the restraint also violated the Facility's policy on the use of restraints.

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7. E.B., who worked as a staff nurse at the facility, reported seeing the patient rolling down the hallway by himself while restrained by the gait belt.
8. E.B. said that the patient was very confused and did not know why he was there and what he was doing.
9. With the assistance of two of her co-workers, E.B. removed the restraint from the patient and transferred him to his recliner, where he was left safely with an alarm on.
10. Upon seeing this, Respondent ask if the patient had been trying to get up.
11. E.B. replied that he had not, but explained to Respondent that having a gait belt tethering the patient to a wheelchair was a strangulation hazard.
12. Later in her shift, Respondent once again placed the patient back in a wheelchair with a gait belt securing him to the wheelchair.
13. K.L, another staff nurse at the Facility, explained to Respondent that this was considered a restraint, that a doctor's order was required for a constraint, and that the patient would have to have the ability to remove the gait independently in order for it not to be considered a restraint.
14. K.L. asked Respondent if the gait belt could be removed independently to which Respondent, replied, no.
15. The Facility subsequently conducted an investigation into Respondent using a gait belt to restrain the patient.
16. On February 8, 2024, the Facility terminated Respondent as a result of her actions.

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.

17. The State re-alleges and incorporates Paragraphs 2 through 16 above.
18. Vermont law requires RNs to practice competently by providing safe and acceptable patient care.
19. Paragraphs 2 through 16 above demonstrate that Respondent failed to provide safe and acceptable patient care when she used a gait belt to restrain a dementia patient in a wheelchair without a provider's order and without ensuring that the patient had the ability to free himself from the restraint.

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20. 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(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.

21. The State re-alleges and incorporates Paragraphs 2 through 16 above.
22. 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.
23. Paragraphs 2 through 16 above demonstrate that Respondent failed to exercise independent professional judgment that was necessary to avoid action repugnant to the obligations of the profession when she used a gait belt to restrain a dementia patient in a wheelchair without a provider's order and without ensuring that the patient had the ability to free himself from the restraint.
24. 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).

Understandings

25. 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.
26. 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.
27. 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.
28. Respondent has read and reviewed this entire document and agrees that it contains the entire agreement between the parties.
29. Respondent is not under the influence of any drugs or alcohol at the time she signs this Stipulation and Consent Order.

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30. 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.
31. 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.
32. 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.
33. 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.

ORDER

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

- A. The Board of Nursing hereby **WARNS** 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:
 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. Required Coursework. Respondent shall, at her own expense and within ninety (90) days of the date of entry of this Stipulation and Consent Order, satisfactorily complete the following pre-approved courses:
 - i. Dementia Care: Challenging Behaviors and Direct Care Staff (offered by Relias);

*Respondent must provide satisfactorily completed workbooks and certificates of completion to the Case Manager.

**Coursework may not be counted toward any continuing education requirement of licensure.
- C. Upon compliance with and completion of all required conditions, Respondent must petition to remove any or all conditions from the license and demonstrate full compliance with the Order.

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- D. Notwithstanding any provision above, Respondent must continue to meet all requirements to maintain licensure, for license renewal, and for license reinstatement.
- E. 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).
- F. This Stipulation and Consent Order will remain part of Respondent's licensing file and may be considered relative to any future disciplinary matter.

AGREED TO:

STATE OF VERMONT
SECRETARY OF STATE

Dated: 10/3/24

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

LISA HURTEAU
RESPONDENT

Dated: 10/7/24

By: Lisa Hurteau
Lisa Hurteau

APPROVED AS TO FORM:

EDWARD G. ADRIAN, ESQ.
ATTORNEY FOR RESPONDENT

Dated: 10-3-24

By: Edward G. Adrian, Esq.
Edward G. Adrian, Esq.

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APPROVED AND SO ORDERED:

VERMONT BOARD OF NURSING

Dated: _____

By: Jennifer Laurent
Chairperson

Date of Entry: 10/20/24

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

IN RE:	)	
Lisa Hurteau	)	Docket Nos. 2024-123
License No. 026.0093919	)	2024-124

SPECIFICATION OF CHARGES

NOW COMES the State of Vermont and makes the following charges against Respondent Lisa Hurteau:

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").

Statement of Facts

2. Lisa Hurteau ("Respondent") of Hinesburg, Vermont is licensed by the State of Vermont as a Registered Nurse ("RN") under license number 026.0093919. This license was originally issued on March 22, 2013 and expires on March 31, 2025.
3. During the relevant time period, Respondent was employed as an RN at a medical facility located in Burlington, Vermont ("the Facility").
4. On or about January 24, 2024, Respondent placed a gait belt around a patient with dementia who was at high risk of falling, and who was seated in a wheelchair, thereby restraining him in the wheelchair.
5. The patient did not demonstrate that he could remove the restraint, there was no order for the restraint, and the gait belt used to restrain him had not been authorized as a restraint.
6. The use of the restraint also violated the Facility's policy on the use of restraints.
7. E.B., who worked as a staff nurse at the facility, reported seeing the patient rolling down the hallway by himself while restrained by the gait belt.
8. E.B. said that the patient was very confused and did not know why he was there and what he was doing.

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9. With the assistance of two of her co-workers, E.B. removed the restraint from the patient and transferred him to his recliner, where he was left safely with an alarm on.
10. Upon seeing this, Respondent ask if the patient had been trying to get up.
11. E.B. replied that he had not, but explained to Respondent that having a gait belt tethering the patient to a wheelchair was a strangulation hazard.
12. Later in her shift, Respondent once again placed the patient back in a wheelchair with a gait belt securing him to the wheelchair.
13. K.L., another staff nurse at the Facility, explained to Respondent that this was considered a restraint, that a doctor's order was required for a constraint, and that the patient would have to have the ability to remove the gait independently in order for it not to be considered a restraint.
14. K.L. asked Respondent if the gait belt could be removed independently to which Respondent, replied, no.
15. The Facility subsequently conducted an investigation into Respondent using a gait belt to restrain the patient.
16. On February 8, 2024, the Facility terminated Respondent as a result of her actions.
Violation One: 26 V.S.A. §1582(a)(3) Engaging in conduct of a character likely to deceive, defraud, or harm the public.
17. The State re-alleges and incorporates Paragraphs 2 through 16 above.
18. As an RN, Respondent is required to refrain from engaging in conduct of a character likely to deceive, defraud, or harm the public.
19. Paragraphs 2 through 16 above demonstrate that Respondent engaged in conduct of a character likely to harm the public when she used a gait belt to restrain a dementia patient in a wheelchair without a provider's order and without ensuring that the patient had the ability to free himself from the restraint.
20. 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).

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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.

21. The State re-alleges and incorporates Paragraphs 2 through 16 above.
22. Vermont law requires RNs to practice competently by providing safe and acceptable patient care.
23. Paragraphs 2 through 16 above demonstrate that Respondent failed to provide safe and acceptable patient care when she used a gait belt to restrain a dementia patient in a wheelchair without a provider's order and without ensuring that the patient had the ability to free himself from the restraint.
24. 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 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.

25. The State re-alleges and incorporates Paragraphs 2 through 16 above.
26. The essential standards of acceptable and prevailing practice require that an RN treat patients in a professional manner and refrain from placing them in restraints unless there is a provider order for the restraints or patients have the ability to free themselves from the restraints.
27. Paragraphs 2 through 16 above demonstrate that Respondent failed to conform to essential standards of acceptable and prevailing practice when she used a gait belt to restrain a dementia patient in a wheelchair without a provider's order and without ensuring that the patient had the ability to free himself from the restraint.
28. 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 obligations of the profession.

29. The State re-alleges and incorporates Paragraphs 2 through 16 above.

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30. 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.
31. Paragraphs 2 through 16 above demonstrate that Respondent failed to exercise independent professional judgment that was necessary to avoid action repugnant to the obligations of the profession when she used a gait belt to restrain a dementia patient in a wheelchair without a provider's order and without ensuring that the patient had the ability to free himself from the restraint.
32. 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, Respondent's RN license should be revoked, suspended, reprimanded, conditioned, or otherwise disciplined.

DATED this 30th day of July, 2024.

STATE OF VERMONT
SECRETARY OF STATE

By:


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

STATE OF VERMONT



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