

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

IN RE:)
AMY GLOZIK) **Docket No. 2024-29**
Multistate License No. PN5252237)

STIPULATION AND CONSENT ORDER

STIPULATION

NOW COMES the State of Vermont, by and through Prosecuting Attorney Ultan Doyle, and Respondent Amy Glozik, 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. Amy Glozik ("Respondent") of Norwich, New York has a multistate license to practice as a Licensed Practical Nurse ("LPN") in Nurse Licensure Compact ("NLC") member states, including Vermont, under multistate license number PN5252237. This license was originally issued by the State of Florida on January 3, 2022 and expires on July, 31, 2025.
3. From approximately June 26, 2023 to July 31, 2023, Respondent was contracted to work as an LPN at a care facility ("the Facility") in Winooski, Vermont.
4. While at the Facility, Respondent was tasked with caring for G.B., a 95-year-old female, who suffered from, among other things, vascular dementia ("Resident 1").
5. During the evening of July 30, 2023, Caregiver C.B. ("Caregiver 1") noticed that Resident 1 was in the dining hall and was surprised to see Resident 1 there as she expected her to be eating in her room as she frequently did at the time.
6. Respondent approached Caregiver 1 and claimed to her that in the course of helping Resident 1 get dressed for dinner that evening, Resident 1 had put Respondent in a headlock and pulled her hair.

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7. Caregiver 1 went to check on Resident 1, who told Caregiver 1 that she was upset and showed Caregiver 1 what appeared to be defensive marks on her arms.
8. Caregiver 1 took Resident 1 back to her room in the elevator.
9. When the elevator opened, Respondent was standing outside the elevator. Caregiver 1 could not get Resident 1 to move and reported that she appeared to be visibly upset.
10. When Resident 1 was back in her room, she told Caregiver 1 that earlier she had been pulled out of bed and pointed to her arms to demonstrate what part of her body had been pulled.
11. Caregiver 1 stated that Resident 1 did not have a history of being aggressive.
12. Caregiver H.I. ("Caregiver 2") reported that she checked on Resident 1 at approximately 4:15pm and that Resident 1 told her she wanted to eat dinner in her room.
13. Shortly thereafter, Caregiver 2 was surprised to see Resident 1 in the dining room as Caregiver 2 was in the process of making a tray for Resident 1 to bring to her room.
14. At approximately 5:30, Caregiver 2 went to Resident 1's room and noticed bruising on her arms.
15. Caregiver 2 had the nurse on duty come to the room to show her the bruising.
16. While doing so, Respondent entered the room and Resident 1 pointed at her saying, "her, her, her" and "she, she, she."
17. Resident F.M. (Resident 2) reported that she heard a noise from Resident 1's room and went to see if there was something she could help with.
18. Resident 2 saw Respondent struggling with Resident 1 who was lying across her bed. Resident 2 thought it was not her place to enter the room and returned to her own room.
19. The Facility conducted an internal investigation but did not interview Respondent because she never returned to Facility after July 31, 2023, which was on or about the date her contract was scheduled to expire.
20. Respondent later told an APS Investigator that Resident 1 swung her arms at Respondent hitting her on the head as she was getting Resident 1 dressed and that this was a possible cause of the bruising on Resident 1's arms.
21. Respondent said that Resident was standing when this occurred and denied holding or grabbing Resident 1's wrists or arms or doing anything that could have caused Resident's bruising.

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22. Resident 1's primary care physician reviewed photographs of the bruising on Resident 1's arm and noted that, "the bruising looked like linear patterns like a finger and, they were significant, they were bad."
23. On October 19, 2023, Respondent was charged in Vermont Superior Court Chittenden Criminal Division with one misdemeanor count of Abuse of a Vulnerable Adult and pleaded not guilty.
24. The Court released Respondent on conditions of release including a condition that she "not work any senior residential facility."
25. On April 3, 2024, Respondent was convicted, after a guilty plea, of one misdemeanor count of Assault of a Vulnerable Adult and received a deferred sentence with a two-year term of probation.
26. One of Respondent's probation conditions prohibits her from being "in a position to provide care any vulnerable adult."

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

27. Paragraphs 2 through 26 above are incorporated herein.
28. As an LPN, Respondent is required to refrain from engaging in conduct of a character likely to deceive, defraud, or harm the public.
29. Paragraphs 2 through 26 above demonstrate that Respondent engaged in conduct of a character likely to harm the public when she engaged in a physical altercation with Resident 1, while getting her dressed, thereby causing significant bruising to Resident 1's arms.
30. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent committed unprofessional conduct of a character likely to deceive, defraud, or harm the public in violation of 26 V.S.A. §1582(a)(3).

Violation 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.

31. Paragraphs 2 through 26 above are incorporated herein.
32. Vermont law requires LPNs to practice competently by providing safe and acceptable patient care.

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33. Paragraphs 2 through 26 above demonstrate that Respondent failed to provide safe and acceptable patient care when she engaged in a physical altercation with Resident 1, while getting her dressed, thereby causing significant bruising to Resident 1's arms.

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 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.

35. Paragraphs 2 through 26 above are incorporated herein.

36. The essential standards of acceptable and prevailing practice require that an LPN refrain from causing injuries to patients while caring for them.

37. Paragraphs 2 through 11 above demonstrate that Respondent failed to conform to essential standards of acceptable and prevailing practice when she engaged in a physical altercation with Resident 1, while getting her dressed, thereby causing significant bruising to Resident 1's arms.

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 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.

39. Paragraphs 2 through 26 above are incorporated herein.

40. As an LPN, 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 26 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 engaged in a physical altercation with Resident 1, while getting her dressed, thereby causing significant bruising to Resident 1's arms.

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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).

Violation Five: 3 V.S.A. § 129a(a)(10) Conviction of a crime related to the practice of the profession or conviction of a felony, whether or not related to the practice of the profession.

43. Paragraphs 2 through 26 above are incorporated herein.
44. As an LPN, Respondent is prohibited from being convicted of a crime related to the practice of her profession.
45. Paragraphs 25 and 26 demonstrate that Respondent was convicted of a crime related to the practice of the profession when she was convicted of one misdemeanor count of Assault of a Vulnerable Adult.
46. 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 3 V.S.A. § 129a(a)(10).

Understandings

47. 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.
48. Respondent understands that the Nursing Board must review and accept the terms of the Consent Order. If the Board rejects any portion, then this entire Stipulation and Consent Order shall be null and void.
49. Respondent specifically waives any claims that any disclosures made to the Board during its review of this agreement have prejudiced Respondent's rights to a fair and impartial hearing in future hearings if this agreement is not accepted by the Board and proceeds to a hearing on the merits before the same Board.
50. Respondent has read and reviewed this entire document and agrees that it contains the entire agreement between the parties.
51. This Stipulation and Consent Order is entered into voluntarily by Respondent after the opportunity to consult with legal counsel. Respondent has not been coerced by anyone into signing this Stipulation and Consent Order.
52. Respondent voluntarily waives the right to a contested hearing before the Board and waives any right to appeal from this Stipulation and Consent Order.

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53. Respondent is of sound mind and is not under the influence of any drugs or alcohol at the time of signing this Stipulation and Consent Order.
54. 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.
55. 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 the National Council of States Boards of Nursing (NCSBN) (or equivalent that are pre-approved by the Enforcement Case Manager) and submit test results, completed workbooks and certificates of completion to the Office of Professional Regulation:
 - a. Dementia Care: Challenging Behaviors and Direct Care Staff (offered by Relias Academy)

Failure to satisfactorily complete the coursework within the prescribed timeframe

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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 Practical 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. On-Site Supervision means the supervising Registered Nurse is present in the same facility as Respondent.
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 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. Respondent may work as a nurse in the State of New York to fulfill these terms and conditions. Before any other out-of-state practice can be

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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 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.

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AGREED TO:

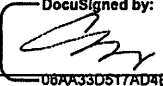
Dated: 6/18/2024

STATE OF VERMONT
SECRETARY OF STATE

By: 
Ultan Doyle, Esq.
State Prosecuting Attorney

AMY GLOZIK
RESPONDENT

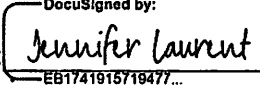
Dated: 6/19/2024

By: 
Amy Glozik

APPROVED AND SO ORDERED:

Dated: 7/9/24

VERMONT BOARD OF NURSING

By: 
Chairperson

Date of Entry: 7/9/24

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IN RE:)
AMY GLOZIK) **Docket No. 2024-29**
Multistate License No. PN5252237)

AMENDED SPECIFICATION OF CHARGES

NOW COMES the State of Vermont and makes the following Charges against the Respondent, Amy Glozik:

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. Amy Glozik ("Respondent") of Norwich, New York has a multistate license to practice as a Licensed Practical Nurse ("LPN") in Nurse Licensure Compact ("NLC") member states, including Vermont, under multistate license number PN5252237. This license was originally issued by the State of Florida on January 3, 2022 and expires on July, 31, 2025.
3. From approximately June 26, 2023 to July 31, 2023, Respondent was contracted to work as an LPN at a care facility ("the Facility") in Winooski, Vermont.
4. While at the Facility, Respondent was tasked with caring for G.B., a 95-year-old female, who suffered from, among other things, vascular dementia ("Resident 1").
5. During the evening of July 30, 2023, Caregiver C.B. ("Caregiver 1") noticed that Resident 1 was in the dining hall and was surprised to see Resident 1 there as she expected her to be eating in her room as she frequently did at the time.
6. Respondent approached Caregiver 1 and claimed to her that in the course of helping Resident 1 get dressed for dinner that evening, Resident 1 had put Respondent in a headlock and pulled her hair.

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7. Caregiver 1 went to check on Resident 1, who told Caregiver 1 that she was upset and showed Caregiver 1 what appeared to be defensive marks on her arms.
8. Caregiver 1 took Resident 1 back to her room in the elevator.
9. When the elevator opened, Respondent was standing outside the elevator. Caregiver 1 could not get Resident 1 to move and reported that she appeared to be visibly upset.
10. When Resident 1 was back in her room, she told Caregiver 1 that earlier she had been pulled out of bed and pointed to her arms to demonstrate what part of her body had been pulled.
11. Caregiver 1 stated that Resident 1 did not have a history of being aggressive.
12. Caregiver H.I. ("Caregiver 2") reported that she checked on Resident 1 at approximately 4:15pm and that Resident 1 told her she wanted to eat dinner in her room.
13. Shortly thereafter, Caregiver 2 was surprised to see Resident 1 in the dining room as Caregiver 2 was in the process of making a tray for Resident 1 to bring to her room.
14. At approximately 5:30, Caregiver 2 went to Resident 1's room and noticed bruising on her arms.
15. Caregiver 2 had the nurse on duty come to the room to show her the bruising.
16. While doing so, Respondent entered the room and Resident 1 pointed at her saying, "her, her, her" and "she, she, she."
17. Resident F.M. (Resident 2) reported that she heard a noise from Resident 1's room and went to see if there was something she could help with.
18. Resident 2 saw Respondent struggling with Resident 1 who was lying across her bed. Resident 2 thought it was not her place to enter the room and returned to her own room.
19. The Facility conducted an internal investigation but did not interview Respondent because she never returned to Facility after July 31, 2023, which was on or about the date her contract was scheduled to expire.
20. Respondent later told an APS Investigator that Resident 1 swung her arms at Respondent hitting her on the head as she was getting Resident 1 dressed and that this was a possible cause of the bruising on Resident 1's arms.

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21. Respondent said that Resident was standing when this occurred and denied holding or grabbing Resident 1's wrists or arms or doing anything that could have caused Resident's bruising.
22. Resident 1's primary care physician reviewed photographs of the bruising on Resident 1's arm and noted that, "the bruising looked like linear patterns like a finger and, they were significant, they were bad."
23. On October 19, 2023, Respondent was charged in Vermont Superior Court Chittenden Criminal Division with one misdemeanor count of Abuse of a Vulnerable Adult and pleaded not guilty.
24. The Court released Respondent on conditions of release including a condition that she "not work any senior residential facility."
25. On April 3, 2024, Respondent was convicted, after a guilty plea, of one misdemeanor count of Assault of a Vulnerable Adult and received a deferred sentence with a two-year term of probation.
26. One of Respondent's probation conditions prohibits her from being "in a position to provide care any vulnerable adult."

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

27. The State re-alleges and incorporates Paragraphs 2 through 26 above.
28. As an LPN, Respondent is required to refrain from engaging in conduct of a character likely to deceive, defraud, or harm the public.
29. Paragraphs 2 through 26 above demonstrate that Respondent engaged in conduct of a character likely to harm the public when she engaged in a physical altercation with Resident 1, while getting her dressed, thereby causing significant bruising to Resident 1's arms.
30. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent committed unprofessional conduct of a character likely to deceive, defraud, or harm the public in violation of 26 V.S.A. §1582(a)(3).

Violation 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.

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

35. The State re-alleges and incorporates Paragraphs 2 through 26 above.
36. The essential standards of acceptable and prevailing practice require that an LPN refrain from causing injuries to patients while caring for them.
37. Paragraphs 2 through 11 above demonstrate that Respondent failed to conform to essential standards of acceptable and prevailing practice when she engaged in a physical altercation with Resident 1, while getting her dressed, thereby causing significant bruising to Resident 1's arms.
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 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.

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the obligations of the profession when she engaged in a physical altercation with Resident 1, while getting her dressed, thereby causing significant bruising to Resident 1's arms.

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).

Violation Five: 3 V.S.A. § 129a(a)(10) Conviction of a crime related to the practice of the profession or conviction of a felony, whether or not related to the practice of the profession.

43. The State re-alleges and incorporates Paragraphs 2 through 26 above.
44. As an LPN, Respondent is prohibited from being convicted of a crime related to the practice of his profession.
45. Paragraphs 25 and 26 demonstrate that Respondent was convicted of a crime related to the practice of the profession when she was convicted of one misdemeanor count of Assault of a Vulnerable Adult.
46. 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 3 V.S.A. § 129a(a)(10).

Relief Requested

WHEREFORE, Respondent's LPN multistate licensure privilege in the State of Vermont should be revoked, suspended, reprimanded, conditioned, or otherwise disciplined.

DATED at Montpelier, Vermont this 7th day of June, 2024.

STATE OF VERMONT
SECRETARY OF STATE

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

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