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

IN RE:	)	
Carol Miller	)	**Docket No. 2024-89**
License No. 026.0022109	)	

STIPULATION AND CONSENT ORDER

STIPULATION

NOW COMES the State of Vermont, by and through Prosecuting Attorney Ultan Doyle, and Respondent Carol Miller, 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(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. Carol Miller ("Respondent") of Springfield, Vermont is licensed by the State of Vermont as a Registered Nurse ("RN") under license number 026.0022109. This license was originally issued on May 11, 1995 and expires on March 31, 2025.

3. On the evening of January 20, 2023, Respondent worked the overnight shift as an RN at a medical facility ("the Facility"), located in White River Junction, Vermont.

4. One of the patients Respondent was assigned to care for during her shift was a 62-year-old male patient (the "Patient") with obstructive sleep apnea who had been admitted on January 18, 2023, for alcohol detoxification.

5. When Respondent began her shift, the Patient was awake and alert, and his oxygen saturation was within its normal limit.

6. Respondent entered her initial shift assessment notes for the Patient at 8:28pm on January 20, 2023.

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7. In those notes, Respondent documented that she conducted a respiratory assessment, that the Patient was receiving 3 liters of oxygen (97%) via a nasal cannula, and that his lung sounds were clear and his respiration unlabored and regular.

8. Respondent also documented that she completed a full neurological assessment which showed that the Patient's pupils were sluggish to react and that his speech was slurred.

9. Respondent did not document that she notified a provider about the Patient's pupils and speech.

10. In an investigation conducted by the Facility, Respondent said that she verbally told a provider, who was passing her in the hallway, about the Patient's pupils and speech but that she did not remember who the provider was.

11. In Respondent's next note for the Patient, she documented that she conducted the Clinical Institute Withdrawal Assessment for Alcohol (CIWA) and took the Patient's vital signs at 10:00pm.

12. However, Respondent did not enter note this until 11:34pm.

13. Respondent next documented that she saw the Patient at 1:40am.

14. At this time, Respondent did a mental status check and a respiratory assessment.

15. Respondent did not document that she conducted the CIWA, took the Patient's vital signs, or assessed his oxygen needs or saturation.

16. Moreover, although Respondent did a respiratory assessment, she did not document the Patient's lung sounds during that assessment.

17. Respondent documented that she next saw the Patient at 3:36am at which time she entered notes only for an IV assessment and an environment safety assessment.

18. During the investigation conducted by the Facility, Respondent said that earlier in the night, the Patient had a Masimo on his finger to measure his heart rate and oxygen saturation.

19. Respondent reported that the Patient's Masimo alarm sounded continually because he kept pulling it off his finger and because of his low oxygen saturation levels due to his sleep apnea.

20. Respondent eventually disconnected the Masimo but claimed that she did so because the Charge Nurse wanted her to.

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21. Respondent did not document that she disconnected the Masimo or that the Charge Nurse wanted it turned off.

22. Respondent also did not document that she discussed disconnecting the Masimo with a provider or someone from the respiratory unit.

23. The Charge Nurse said that at approximately 10:00pm to 11:00pm the Masimo alarm started to sound at the nurse's station.

24. The Charge Nurse asked Respondent to address it but denied telling Respondent that she needed to take the Masimo off the Patient.

25. Later in the shift, the Charge Nurse noticed that the Masimo alarm had stopped.

26. Respondent told the Charge Nurse that she had taken the Patient off the Masimo.

27. The Charge Nurse assumed that Respondent had done so only after she had spoken to a provider or someone in the respiratory unit, and that she had documented everything that she was supposed to have done.

28. Respondent later came to the Charge Nurse and asked her for help in turning off the Masimo completely.

29. The Charge Nurse helped Respondent disconnect the Masimo's second screen but only did so because she assumed that the Patient was no longer being monitored by the Masimo after Respondent had initially disconnected it.

30. At approximately 4:00am, Respondent went into the Patient's room to check on him and could not hear him breathing or detect his pulse.

31. Respondent went to tell the Charge Nurse what had happened and then returned to the room to begin chest compressions.

32. The Patient was later transferred to the ICU, but never regained consciousness and died several days later.

33. Respondent's transfer note at the end of shift was written at approximately 6:55am and read in part as follows:

> Pt. woke at midnight and wanted more Oxycodone but was told it was too soon. He right away started snoring again. He was given a CPAP his first night here but refused to wear it. He was on 02 3LPM but his sats were dropping into the low 80's and 02 was increased to 5 LPM. At 0400 he was found unresponsive. A code was called.

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34. Other than the 6:55am transfer note, Respondent did not document that the Patient was offered a CPAP or that he refused to wear it, nor did she document that the Patient's oxygen saturation levels were dropping or that his supplemental oxygen was increased to 5 liters.

35. Respondent also did not document that she notified a provider about the Patient's oxygen saturation levels dropping.

36. During the investigation conducted by the Facility, Respondent said that during her 10:00pm medication pass, the patient requested additional Oxycodone medication, but she did not give it to him because she felt that he was over sedated.

37. Respondent said that she talked to a provider about the Patient's over sedation, but she did not remember the provider's name.

38. Respondent did not document that she thought that the Patient was over sedated, nor did she document that she notified a provider about this.

39. Because the Patient appeared groggy after the 10:00pm medication pass, Respondent said that she decided to do hourly checks of the Patient and do CIWA assessments every two hours on the even hours.

40. However, the only checks documented by Respondent were those noted in paragraphs 6 through 17 above.

41. Moreover, the only CIWA assessment documented by Respondent was the one that she performed at 10:00pm.

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.

42. Paragraphs 2 through 41 above are incorporated herein.

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

44. Paragraphs 18 through 22 above demonstrate that Respondent failed to provide safe and acceptable patient care when she disconnected the Patient's Masimo without consulting with a provider or someone in the respiratory unit.

45. 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).

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Violation Two: 3 V.S.A. §129a(b)(2) Failure to practice competently by reason of any cause on a single occasion or on multiple occasions may constitute unprofessional conduct, whether actual injury to a client, patient, or customer has occurred. Failure to practice competently includes: (2) failure to conform to the essential standards of acceptable and prevailing practice.

46. Paragraphs 2 through 41 above are incorporated herein.

47. The essential standards of acceptable and prevailing practice require that RNs accurately and timely document care that they provide to patients.

48. Paragraphs 2 through 41 above demonstrate that Respondent failed to conform to essential standards of acceptable and prevailing practice when, while caring for the Patient, she failed to timely and accurately document: hourly checks that she said she had conducted; 2 hourly CIWAs that she said she performed; concerns that she said she had verbally shared with providers about the Patient's pupils and speech, and about him being over sedated; and her disconnecting the Patient's Masimo.

49. 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

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

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

52. 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.

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

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

55. 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.

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

57. 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.

58. 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 **REPRIMANDS** Respondent's license.

B. The Board of Nursing hereby **CONDITIONS** the Respondent's license for a **MINIMUM OF ONE (1) YEAR,** commencing with the date of entry of this Stipulation and Consent Order. The **CONDITIONS** shall 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 registered nursing practice in which Respondent works at least eighty (80) hours every calendar month as a registered 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 online coursework offered by Relias Academy:

   a. Critical Thinking, Clinical Reasoning, and Clinical Judgment; and
   b. Nursing Documentation: Challenging Situations

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Respondent shall submit test results, workbooks completed to the satisfaction of the Case Manager, and certificates of completion to the Office of Professional Regulation.

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

5. Notification to Employers/Nursing School. Respondent shall provide a copy of this Stipulation and Consent Order to all employers in any current or future setting in which Respondent practices as a 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 reinstatement 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 licensed registered nurse that is in good standing with the Board.

8. Types of Employment Prohibited. Respondent shall not work in a supervisory role. Respondent shall not work for a nurse registry, traveling nurse agency, float-pool, home health care agency, temporary nursing employment agency, or as a private duty nurse or personal care provider requiring a nursing or nursing assistant license during the effective period of this Consent Order.

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

10. Out-of-State Practice. Before any out-of-state practice can be credited toward fulfillment of these terms and conditions, Respondent shall first obtain approval from the Board or its designee. 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 requirements for license renewal.

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 Conditional License Period. Respondent shall submit a petition to the Docket Clerk to remove any and all conditions on Respondent's license. The State will assent to or oppose Respondent's petition. The Board will conduct a hearing if necessary. Respondent bears the burden and must present proof that Respondent has fully complied with the terms of this Order and these conditions are no longer necessary to protect the public.

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

C. This Stipulation and Consent Order is a matter of public record and may be reported to

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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: 1/21/25

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

CAROL MILLER
RESPONDENT

Dated: 01/17/2025

By: Carol Miller
Carol Miller

APPROVED AS TO FORM:

MONAGHAN SAFAR DUCHAM PLLC
ATTORNEY FOR RESPONDENT

Dated: 01/17/25

By:
Edward G. Adrian, Esq.

APPROVED AND SO ORDERED:

VERMONT BOARD OF NURSING

Dated: 2/10/25

By: Signed by: William James Floyd III
3B82E7830012485...
Chairperson

Date of Entry: 2/11/25

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BOARD OF NURSING

IN RE:	)	
Carol Miller	)	**Docket No. 2024-89**
License No. 026.0022109	)	

SPECIFICATION OF CHARGES

NOW COMES the State of Vermont and makes the following Charges against the Respondent, Carol Miller:

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. Carol Miller ("Respondent") of Springfield, Vermont is licensed by the State of Vermont as a Registered Nurse ("RN") under license number 026.0022109. This license was originally issued on May 11, 1995 and expires on March 31, 2025.

3. On the evening of January 20, 2023, Respondent worked the overnight shift as an RN at a medical facility ("the Facility"), located in White River Junction, Vermont.

4. One of the patients Respondent was assigned to care for during her shift was a 62-year-old male patient (the "Patient") with obstructive sleep apnea who had been admitted on January 18, 2023, for alcohol detoxification.

5. When Respondent began her shift, the Patient was awake and alert, and his oxygen saturation was within its normal limit.

6. Respondent entered her initial shift assessment notes for the Patient at 8:28pm on January 20, 2023.

7. In those notes, Respondent documented that she conducted a respiratory assessment, that the Patient was receiving 3 liters of oxygen (97%) via a nasal cannula, and that his lung sounds were clear and his respiration unlabored and regular.

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8. Respondent also documented that she completed a full neurological assessment which showed that the Patient's pupils were sluggish to react and that his speech was slurred.

9. Respondent did not document that she notified a provider about the Patient's pupils and speech.

10. In an investigation conducted by the Facility, Respondent said that she verbally told a provider, who was passing her in the hallway, about the Patient's pupils and speech but that she did not remember who the provider was.

11. In Respondent's next note for the Patient, she documented that she conducted the Clinical Institute Withdrawal Assessment for Alcohol (CIWA) and took the Patient's vital signs at 10:00pm.

12. However, Respondent did not enter note this until 11:34pm.

13. Respondent next documented that she saw the Patient at 1:40am.

14. At this time, Respondent did a mental status check and a respiratory assessment.

15. Respondent did not document that she conducted the CIWA, took the Patient's vital signs, or assessed his oxygen needs or saturation.

16. Moreover, although Respondent did a respiratory assessment, she did not document the Patient's lung sounds during that assessment.

17. Respondent documented that she next saw the Patient at 3:36am at which time she entered notes only for an IV assessment and an environment safety assessment.

18. During the investigation conducted by the Facility, Respondent said that earlier in the night, the Patient had a Masimo on his finger to measure his heart rate and oxygen saturation.

19. Respondent reported that the Patient's Masimo alarm sounded continually because he kept pulling it off his finger and because of his low oxygen saturation levels due to his sleep apnea.

20. Respondent eventually disconnected the Masimo but claimed that she did so because the Charge Nurse wanted her to.

21. Respondent did not document that she disconnected the Masimo or that the Charge Nurse wanted it turned off.

22. Respondent also did not document that she discussed disconnecting the Masimo with a provider or someone from the respiratory unit.

23. The Charge Nurse said that at approximately 10:00pm to 11:00pm the Masimo alarm started to sound at the nurse's station.

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24. The Charge Nurse asked Respondent to address it but denied telling Respondent that she needed to take the Masimo off the Patient.

25. Later in the shift, the Charge Nurse noticed that the Masimo alarm had stopped.

26. Respondent told the Charge Nurse that she had taken the Patient off the Masimo.

27. The Charge Nurse assumed that Respondent had done so only after she had spoken to a provider or someone in the respiratory unit, and that she had documented everything that she was supposed to have done.

28. Respondent later came to the Charge Nurse and asked her for help in turning off the Masimo completely.

29. The Charge Nurse helped Respondent disconnect the Masimo's second screen but only did so because she assumed that the Patient was no longer being monitored by the Masimo after Respondent had initially disconnected it.

30. At approximately 4:00am, Respondent went into the Patient's room to check on him and could not hear him breathing or detect his pulse.

31. Respondent went to tell the Charge Nurse what had happened and then returned to the room to begin chest compressions.

32. The Patient was later transferred to the ICU, but never regained consciousness and died several days later.

33. Respondent's transfer note at the end of shift was written at approximately 6:55am and read in part as follows:

> Pt. woke at midnight and wanted more Oxycodone but was told it was too soon. He right away started snoring again. He was given a CPAP his first night here but refused to wear it. He was on 02 3LPM but his sats were dropping into the low 80's and 02 was increased to 5 LPM. At 0400 he was found unresponsive. A code was called.

34. Other than the 6:55am transfer note, Respondent did not document that the Patient was offered a CPAP or that he refused to wear it, nor did she document that the Patient's oxygen saturation levels were dropping or that his supplemental oxygen was increased to 5 liters.

35. Respondent also did not document that she notified a provider about the Patient's oxygen saturation levels dropping.

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36. During the investigation conducted by the Facility, Respondent said that during her 10:00pm medication pass, the patient requested additional Oxycodone medication, but she did not give it to him because she felt that he was over sedated.

37. Respondent said that she talked to a provider about the Patient's over sedation, but she did not remember the provider's name.

38. Respondent did not document that she thought that the Patient was over sedated, nor did she document that she notified a provider about this.

39. Because the Patient appeared groggy after the 10:00pm medication pass, Respondent said that she decided to do hourly checks of the Patient and do CIWA assessments every two hours on the even hours.

40. However, the only checks documented by Respondent were those noted in paragraphs 6 through 17 above.

41. Moreover, the only CIWA assessment documented by Respondent was the one that she performed at 10:00pm.

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.

42. The State re-alleges and incorporates Paragraphs 2 through 41 above.

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

44. Paragraphs 18 through 22 above demonstrate that Respondent failed to provide safe and acceptable patient care when she disconnected the Patient's Masimo without consulting with a provider or someone in the respiratory unit.

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

Violation Two: 3 V.S.A. §129a(b)(2) Failure to practice competently by reason of any cause on a single occasion or on multiple occasions may constitute unprofessional conduct, whether actual injury to a client, patient, or customer has occurred. Failure to practice competently includes: (2) failure to conform to the essential standards of acceptable and prevailing practice.

46. The State re-alleges and incorporates Paragraphs 2 through 41 above.

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47. The essential standards of acceptable and prevailing practice require that RNs accurately and timely document care that they provide to patients.

48. Paragraphs 2 through 41 above demonstrate that Respondent failed to conform to essential standards of acceptable and prevailing practice when, while caring for the Patient, she failed to timely and accurately document: hourly checks that she said she had conducted; 2 hourly CIWAs that she said she performed; concerns that she said she had verbally shared with providers about the Patient's pupils and speech, and about him being over sedated; and her disconnecting the Patient's Masimo.

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

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

50. The State re-alleges and incorporates Paragraphs 2 through 41 above.

51. 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.

52. Paragraphs 18 through 22 demonstrate that Respondent failed to exercise independent professional judgment when she disconnected the Patient's Masimo without consulting with a provider or someone in the respiratory unit.

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

Relief Requested

WHEREFORE, the RN license of Carol Miller should be revoked, suspended, reprimanded, conditioned, or otherwise disciplined.

DATED at Montpelier, Vermont this 11th day of June, 2024.

STATE OF VERMONT
SECRETARY OF STATE

By: Ultan Doyle

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

STATE OF VERMONT

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