

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

IN RE:)
Melanie Baker) **Docket No. 2024-98**
License No. 101.0110840)

STIPULATION AND CONSENT ORDER

STIPULATION

NOW COME the State of Vermont, by and through State Prosecuting Attorney George Hasselback, and Respondent Melanie Baker who hereby Stipulate and Agree as follows:

Board Authority

1. The Vermont State Board of Nursing (the “Board”) has jurisdiction to investigate and adjudicate allegations of unprofessional conduct committed by advanced practice registered nurses (“APRNs”) pursuant to 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 (“OPR”).

Stipulated Facts

2. Melanie Baker (“Respondent”) of Hattiesburg, Mississippi is licensed as an APRN under license number 101.0110840. This license was originally issued on March 18, 2015, and expires on March 31, 2025.
3. On or about November 20, 2023, Respondent signed a document issued by the Louisiana State Board of Nursing entitled “Consent Order.”
4. As part of the Consent Order, Respondent stated, “I admit to all of the above facts and I agree that there is sufficient evidence upon which to predicate a finding of violation of the provisions of La. R.S. 37:921.”
5. La. R.S. 37:921 is the statute that provides “grounds for disciplinary proceedings” against APRNs practicing in the State of Louisiana.
6. As part of her admissions in the Consent Order, Respondent admitted to the following facts:
 - a. On or about February 14, 2014, Respondent was licensed by examination to practice as an [APRN] in Louisiana.

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- b. Between February 1, 2017, through (at least) August 13, 2018, while employed as an Advanced Practice Registered Nurse at [a psychiatric services facility] located in New Orleans, Louisiana, Respondent failed to assess patients at an advanced level, identify abnormal conditions, analyze and synthesize data to establish a diagnosis, develop and implement treatment plans, and evaluate patient outcomes.
- c. Respondent also failed to maintain a complete record of the examination, evaluation, and treatment of patients, including documentation of the diagnosis and reason for prescribing controlled substances.
- d. Respondent was investigated by the New Orleans Field Division Group of the Drug Enforcement Administration.
- e. During their investigation, it was discovered Respondent was the top prescribing Nurse Practitioner in the State of Louisiana and the top 30 of all prescribing practitioners in the state, issuing over 15,000 prescriptions in 2018 alone.
- f. DEA investigators had a portion of Respondent's patient records reviewed by a medical expert in psychiatry and diagnosis of ADD/ADHD.
- g. The expert opinion found Respondent prescribed highly addictive combinations of controlled substances to patients including children as young as three, without any medical rationale.
- h. The expert's review also found that Respondent often misdiagnosed patients suffering from other mental health disorders, caused patients to become addicted, prescribed dangerous combinations of controlled and non-controlled substances, put patients' health at risk, and continued to prescribe amphetamines to individuals who were suicidal.
- i. Respondent issued numerous prescriptions for Schedule II through Schedule IV to five patients outside of the usual course of professional practice of medicine in Louisiana, not for a legitimate medical purpose, and violated federal and state law. Specifically:
 - 1. [B]etween February 2018 and February 2019, Respondent prescribed Patient FA 23 controlled substance prescriptions for mixed amphetamine salts outside the usual course of professional practice and without a legitimate medical purpose. Patient FA lived more than 300 miles from Respondent's registered address, and she prescribed multiple controlled substances to two additional patients with the same address and same last name as Patient FA (Patients RA and AA).
 - 2. [B]etween July 2017 and April 2019, Respondent prescribed Patient KW 23 controlled substance prescriptions for mixed

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amphetamine salts and alprazolam outside the usual course of professional practice and without a legitimate medical purpose. patient KW tried to commit suicide on several occasions. The treating physician recommended that Patient KW be taken off benzodiazepines, but Respondent continued to prescribe benzodiazepine[s] to the patient.

3. [B]etween February 2017 and May 2019, Respondent prescribed Patient MG 42 controlled substance prescriptions for mixed amphetamine salts and clonazepam outside the usual course of professional practice and without a legitimate medical purpose. Concurrent prescribing of amphetamines and benzodiazepines is dangerous, and there is no evidence supporting its efficacy for any indication.
 4. [B]etween April 2017 and May 2019, Respondent prescribed Patient FP 72 controlled substance for mixed amphetamine salts, lorazepam, and Vyvanse outside the usual course of professional practice and without a legitimate medical purpose. Concurrent prescribing of amphetamines and benzodiazepines is dangerous, and there is no evidence supporting its efficacy for any indication.
 5. [B]etween May 2017 and April 2018, Respondent prescribed Patient MH 43 controlled substance-prescriptions for mixed amphetamines salts, acetaminophen with codeine, clonazepam, and zolpidem tartrate outside the usual course of professional practice and without a legitimate medical purpose. Respondent's medical file for Patient MH does not contain any documentation of clinical evaluations on several occasions that she prescribed controlled substances. Respondent prescribed a dangerous cocktail of controlled substances consisting of Schedule III narcotics, a Schedule IV benzodiazepine, a Schedule IV sedative, and a Schedule II stimulant. This drug combination is highly likely to cause serious adverse consequences, including death or diversion, and has no legitimate medical use outside hospitals or intensive care settings.
- j. On June 21, 2019, an Immediate Suspension Order/Order to Show Cause was issued by the U.S. Drug Enforcement Administration. Respondent's DEA Certificate of Registration was suspended until further notice due to her continued registration constituting an imminent danger to public health or safety.
- k. Effective June 4, 2021, Respondent's DEA Certificate of Registration No. MV3148257 was revoked and any pending applications for renewal or modification of registration were denied.

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7. On or about November 22, 2023, the Louisiana State Board of Nursing accepted the terms of the Consent Order and imposed discipline upon Respondent's Louisiana-issued APRN license.
8. On or about February 25, 2021, Respondent applied for renewal of her Vermont-issued APRN license.
9. As part of that application, Respondent was asked, "Has Vermont or any other state, federal authority, or any jurisdiction taken any DISCIPLINARY ACTION against (e.g. warned, reprimanded, fined, restricted, conditioned, suspended, or revoked) a license, certificate, or registration that you hold or have held in any profession, or occupation, or professional service?"
10. Respondent answered "no" to this question.
11. This answer was false, because On June 21, 2019, an Immediate Suspension Order/Order to Show Cause was issued by the U.S. Drug Enforcement Administration, suspending Respondent's DEA Certificate of Registration until further notice.
12. As part of that application, Respondent was asked, "Are you currently UNDER INVESTIGATION or PENDING CHARGES for a professional, occupational, or professional services license, certificate, or registration in any licensing jurisdiction?"
13. Respondent answered "no" to this question.
14. This answer was false, because on May 30, 2019, the Louisiana State Board of Nursing received a complaint form notifying it of potential violations of Louisiana State statutes regarding Respondent's nursing practice, and subsequently initiated disciplinary proceedings against Respondent.

Violation One: 3 V.S.A. § 129a(a)(3) Failing to comply with provisions of federal or State statutes or rules governing the practice of the profession.

15. The State re-alleges and incorporates Paragraphs 2 through 14 above.
16. As a licensed APRN, Respondent is required to comply with provisions of federal or State statutes or rules governing the practice of the profession.
17. Paragraphs 2 through 14 demonstrate that Respondent failed to comply with provisions of federal or State statutes or rules governing the practice of the profession when Respondent issued numerous prescriptions for Schedule II through Schedule IV to five patients outside of the usual course of professional practice of medicine in Louisiana, not for a legitimate medical purpose, and, in doing so, violated federal and state law.

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18. 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)(3).

Violation Two: 3 V.S.A. § 129a(a)(1) Fraudulent or deceptive procurement or use of a license.

19. The State re-alleges and incorporates Paragraphs 2 through 14 above.
20. As a licensed APRN, Respondent is required to refrain from the fraudulent or deceptive procurement or use of a license.
21. Paragraphs 2 through 14 demonstrate that Respondent engaged in the fraudulent or deceptive procurement of license when, in applying for renewal of her Vermont APRN license, Respondent answered “no” to several questions that asked if she had been under investigation or subject to any disciplinary action, when, in fact, she was under investigation by both the DEA and the Louisiana State Board of Nursing and had had her DEA Certificate of Registration revoked.
22. 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)(1).

Violation Three: 3 V.S.A. § 129a(b)(2) Failure to conform to the essential standards of acceptable and prevailing practice.

23. The State re-alleges and incorporates Paragraphs 2 through 14 above.
24. As a licensed APRN, Respondent is required to conform to the essential standards of acceptable and prevailing practice amongst APRNs.
25. Paragraphs 2 through 14 demonstrate that Respondent failed to conform to the essential standards of acceptable and prevailing practice in the following ways:
- a. The applicable standards of practice require an APRN to assess patients at an advanced level, identify abnormal conditions, analyze and synthesize data to establish a diagnosis, develop and implement treatment plans, and evaluate patient outcomes, and Respondent did not do so.
 - b. The applicable standards of practice require an APRN to maintain a complete record of the examination, evaluation, and treatment of patients, including documentation of the diagnosis and reason for prescribing controlled substances, and Respondent did not do so.
26. 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(b)(2).

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Understandings

27. This Stipulation is neither an admission of facts 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 contest that the State has evidence which, if believed by the fact finder, may establish by a preponderance of the evidence that they engaged in the alleged misconduct.
28. Respondent agrees the conditions below are necessary to protect the public.
29. Respondent understands that the 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.
30. 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.
31. Respondent has read and reviewed this entire document and agrees that it contains the entire agreement between the parties.
32. Respondent is not under the influence of any drugs or alcohol at the time she signs this Stipulation and Consent Order.
33. 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.
34. 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.
35. 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. Respondents shall, within ninety (90) days of the date of entry of this Stipulation and Consent Order, pay a fine of two-hundred and fifty dollars (\$250.00).
- C. The Board hereby **CONDITIONS** Respondent's license commencing on 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."

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2. License Renewal. This Order does not automatically extend the license and Respondent must comply with the requirements for license renewal.
 3. Respondent shall follow all terms and conditions agreed to in the Consent Order issued by the Louisiana State Board of Nursing in The Matter of Melanie Baker dated November 22, 2023, a copy of which is attached hereto as "Exhibit A."
- D. 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.
- E. Notwithstanding any provision above, the Respondent must continue to meet all Nursing Board requirements for maintaining a license, license renewal and license reinstatement.
- F. 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).
- G. 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: 3-31-2025

By: George L. Hasselback

STATE OF VERMONT
SECRETARY OF STATE

By: *George Hasselback*
George Lloyd Hasselback
Prosecuting Attorney
(802) 828-0350
george.hasselback@vermont.gov

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Dated: 3/30/25

By: *Melanie Baker*
Melanie Baker

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APPROVED AND SO ORDERED:

VERMONT BOARD OF NURSING

Dated: 5/13/25

Date of Entry: 5/14/25

Signed by:
By: William James Floyd III
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Chairperson

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IN RE:)
Melanie Baker) **Docket No. 2024-98**
License No. 101.0110840)

SPECIFICATION OF CHARGES

NOW COMES the State of Vermont and hereby makes the following charges against Respondent Melanie Baker:

Board Authority

1. The Vermont State Board of Nursing (the "Board") has jurisdiction to investigate and adjudicate allegations of unprofessional conduct committed by advanced practice registered nurses ("APRNs") pursuant to 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 ("OPR").

Statement of Facts

2. Melanie Baker ("Respondent") of Hattiesburg, Mississippi is licensed as an APRN under license number 101.0110840. This license was originally issued on March 18, 2015, and expires on March 31, 2025.
3. On or about November 20, 2023, Respondent signed a document issued by the Louisiana State Board of Nursing entitled "Consent Order."
4. As part of the Consent Order, Respondent stated, "I admit to all of the above facts and I agree that there is sufficient evidence upon which to predicate a finding of violation of the provisions of La. R.S. 37:921."
5. La. R.S. 37:921 is the statute that provides "grounds for disciplinary proceedings" against APRNs practicing in the State of Louisiana.
6. As part of her admissions in the Consent Order, Respondent admitted to the following facts:
 - a. On or about February 14, 2014, Respondent was licensed by examination to practice as an [APRN] in Louisiana.
 - b. Between February 1, 2017, through (at least) August 13, 2018, while employed as an Advanced Practice Registered Nurse at [a psychiatric services facility] located in New Orleans, Louisiana, Respondent failed to

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assess patients at an advanced level, identify abnormal conditions, analyze and synthesize data to establish a diagnosis, develop and implement treatment plans, and evaluate patient outcomes.

- c. Respondent also failed to maintain a complete record of the examination, evaluation, and treatment of patients, including documentation of the diagnosis and reason for prescribing controlled substances.
- d. Respondent was investigated by the New Orleans Field Division Group of the Drug Enforcement Administration.
- e. During their investigation, it was discovered Respondent was the top prescribing Nurse Practitioner in the State of Louisiana and the top 30 of all prescribing practitioners in the state, issuing over 15,000 prescriptions in 2018 alone.
- f. DEA investigators had a portion of Respondent's patient records reviewed by a medical expert in psychiatry and diagnosis of ADD/ADHD.
- g. The expert opinion found Respondent prescribed highly addictive combinations of controlled substances to patients including children as young as three, without any medical rationale.
- h. The expert's review also found that Respondent often misdiagnosed patients suffering from other mental health disorders, caused patients to become addicted, prescribed dangerous combinations of controlled and non-controlled substances, put patients' health at risk, and continued to prescribe amphetamines to individuals who were suicidal.
- i. Respondent issued numerous prescriptions for Schedule II through Schedule IV to five patients outside of the usual course of professional practice of medicine in Louisiana, not for a legitimate medical purpose, and violated federal and state law. Specifically:

1. [B]etween February 2018 and February 2019, Respondent prescribed Patient FA 23 controlled substance prescriptions for mixed amphetamine salts outside the usual course of professional practice and without a legitimate medical purpose. Patient FA lived more than 300 miles from Respondent's registered address, and she prescribed multiple controlled substances to two additional patients with the same address and same last name as Patient FA (Patients RA and AA).
2. [B]etween July 2017 and April 2019, Respondent prescribed Patient KW 23 controlled substance prescriptions for mixed amphetamine salts and alprazolam outside the usual course of professional practice and without a legitimate medical purpose. patient KW tried to commit suicide on several occasions. The

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treating physician recommended that Patient KW be taken off benzodiazepines, but Respondent continued to prescribe benzodiazepine[s] to the patient.

3. [B]etween February 2017 and May 2019, Respondent prescribed Patient MG 42 controlled substance prescriptions for mixed amphetamine salts and clonazepam outside the usual course of professional practice and without a legitimate medical purpose. Concurrent prescribing of amphetamines and benzodiazepines is dangerous, and there is no evidence supporting its efficacy for any indication.
4. [B]etween April 2017 and May 2019, Respondent prescribed Patient FP 72 controlled substance for mixed amphetamine salts, lorazepam, and Vyvanse outside the usual course of professional practice and without a legitimate medical purpose. Concurrent prescribing of amphetamines and benzodiazepines is dangerous, and there is no evidence supporting its efficacy for any indication.
5. [B]etween May 2017 and April 2018, Respondent prescribed Patient MH 43 controlled substance-prescriptions for mixed amphetamines salts, acetaminophen with codeine, clonazepam, and zolpidem tartrate outside the usual course of professional practice and without a legitimate medical purpose. Respondent's medical file for Patient MH does not contain any documentation of clinical evaluations on several occasions that she prescribed controlled substances. Respondent prescribed a dangerous cocktail of controlled substances consisting of Schedule III narcotics, a Schedule IV benzodiazepine, a Schedule IV sedative, and a Schedule II stimulant. This drug combination is highly likely to cause serious adverse consequences, including death or diversion, and has no legitimate medical use outside hospitals or intensive care settings.
- j. On June 21, 2019, an Immediate Suspension Order/Order to Show Cause was issued by the U.S. Drug Enforcement Administration. Respondent's DEA Certificate of Registration was suspended until further notice due to her continued registration constituting an imminent danger to public health or safety.
- k. Effective June 4, 2021, Respondent's DEA Certificate of Registration No. MV3148257 was revoked and any pending applications for renewal or modification of registration were denied.
7. On or about November 22, 2023, the Louisiana State Board of Nursing accepted the terms of the Consent Order and imposed discipline upon Respondent's Louisiana-issued APRN license.

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8. On or about February 25, 2021, Respondent applied for renewal of her Vermont-issued APRN license.
9. As part of that application, Respondent was asked, "Has Vermont or any other state, federal authority, or any jurisdiction taken any DISCIPLINARY ACTION against (e.g. warned, reprimanded, fined, restricted, conditioned, suspended, or revoked) a license, certificate, or registration that you hold or have held in any profession, or occupation, or professional service?"
10. Respondent answered "no" to this question.
11. This answer was false, because On June 21, 2019, an Immediate Suspension Order/Order to Show Cause was issued by the U.S. Drug Enforcement Administration, suspending Respondent's DEA Certificate of Registration until further notice.
12. As part of that application, Respondent was asked, "Are you currently UNDER INVESTIGATION or PENDING CHARGES for a professional, occupational, or professional services license, certificate, or registration in any licensing jurisdiction?"
13. Respondent answered "no" to this question.
14. This answer was false, because on May 30, 2019, the Louisiana State Board of Nursing received a complaint form notifying it of potential violations of Louisiana State statutes regarding Respondent's nursing practice, and subsequently initiated disciplinary proceedings against Respondent.

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

15. The State re-alleges and incorporates Paragraphs 2 through 14 above.
16. As a licensed APRN, Respondent is required to refrain from engaging in conduct of a character likely to deceive, defraud, or harm the public.
17. Paragraphs 2 through 14 demonstrate that Respondent engaged in conduct of a character likely to harm the public in that she prescribed highly addictive combinations of controlled substances to patients including children as young as three, without any medical rationale, often misdiagnosed patients suffering from other mental health disorders, caused patients to become addicted, prescribed dangerous combinations of controlled and non-controlled substances, put patients' health at risk, and continued to prescribe amphetamines to individuals who were suicidal.

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18. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent committed unprofessional conduct in violation of 26 V.S.A. § 1582(a)(3).

Violation Two: 3 V.S.A. § 129a(a)(3) Failing to comply with provisions of federal or State statutes or rules governing the practice of the profession.

19. The State re-alleges and incorporates Paragraphs 2 through 14 above.
20. As a licensed APRN, Respondent is required to comply with provisions of federal or State statutes or rules governing the practice of the profession.
21. Paragraphs 2 through 14 demonstrate that Respondent failed to comply with provisions of federal or State statutes or rules governing the practice of the profession when Respondent issued numerous prescriptions for Schedule II through Schedule IV to five patients outside of the usual course of professional practice of medicine in Louisiana, not for a legitimate medical purpose, and, in doing so, violated federal and state law.
22. 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)(3).

Violation Three: 3 V.S.A. § 129a(a)(1) Fraudulent or deceptive procurement or use of a license.

23. The State re-alleges and incorporates Paragraphs 2 through 14 above.
24. As a licensed APRN, Respondent is required to refrain from the fraudulent or deceptive procurement or use of a license.
25. Paragraphs 2 through 14 demonstrate that Respondent engaged in the fraudulent or deceptive procurement of license when, in applying for renewal of her Vermont APRN license, Respondent answered "no" to several questions that asked if she had been under investigation or subject to any disciplinary action, when, in fact, she was under investigation by both the DEA and the Louisiana State Board of Nursing and had had her DEA Certificate of Registration revoked.
26. 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)(1).

Violation Four: 3 V.S.A. § 129a(b)(1) Performance of unsafe or unacceptable patient care.

27. The State re-alleges and incorporates Paragraphs 2 through 14 above.

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28. As a licensed APRN, Respondent is required to refrain from performing unsafe or unacceptable patient care.
29. Paragraphs 2 through 14 demonstrate that Respondent performed unsafe or unacceptable patient care when she prescribed highly addictive combinations of controlled substances to patients including children as young as three, without any medical rationale, often misdiagnosed patients suffering from other mental health disorders, caused patients to become addicted, prescribed dangerous combinations of controlled and non-controlled substances, put patients' health at risk, and continued to prescribe amphetamines to individuals who were suicidal.
30. 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(b)(1).

Violation Five: 3 V.S.A. § 129a(b)(2) Failure to conform to the essential standards of acceptable and prevailing practice.

31. The State re-alleges and incorporates Paragraphs 2 through 14 above.
32. As a licensed APRN, Respondent is required to conform to the essential standards of acceptable and prevailing practice amongst APRNs.
33. Paragraphs 2 through 14 demonstrate that Respondent failed to conform to the essential standards of acceptable and prevailing practice in the following ways:
 - a. The applicable standards of practice require an APRN to assess patients at an advanced level, identify abnormal conditions, analyze and synthesize data to establish a diagnosis, develop and implement treatment plans, and evaluate patient outcomes, and Respondent did not do so.
 - b. The applicable standards of practice require an APRN to maintain a complete record of the examination, evaluation, and treatment of patients, including documentation of the diagnosis and reason for prescribing controlled substances, and Respondent did not do so.
34. 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(b)(2).

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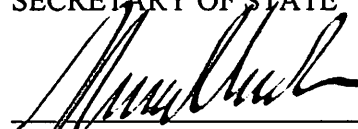
Relief Requested

WHEREFORE, Respondent's professional license should be revoked, suspended, reprimanded, conditioned, or otherwise disciplined.

DATED at Montpelier, Vermont this 27th day of June, 2024.

STATE OF VERMONT
SECRETARY OF STATE

By:


George Lloyd Hasselback
Prosecuting Attorney
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