

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

In re: DALE KENYON	}	
License No. 026.0038277	}	Docket No. 2024-99
	}	

Participating Board Members:

Marsha Arend, RN, Acting Chair
Daniel Coane, Public Member
Jennifer Lyon, RN
Matthew Choate, RN
Deb Belcher, Public Member
Jill Neary, LPN
Melissa Moisel, LNA
Margaret Young APRN

Appearances:

Prosecutor: George Hasselback, Esq.
Respondent: Participated in the hearing *pro se*

Presiding Officer: George K. Belcher

Exhibits:

State Exhibit 1: Gabrielle Gilman, RN, report of incident to L. Ravgiala 1/29/24
State Exhibit 2: Gabrielle Gilman, RN, first report of incident 1/20/24
State Exhibit 3: Controlled substance log 1/17/24
State Exhibit 4: Stipulation and Consent Order dated 3/19/15

**FINDINGS OF FACT, CONCLUSIONS OF LAW,
AND ORDER**

This matter came before the Board of Nursing on May 12, 2025. The hearing was held electronically with the attorney for the State, the Respondent, the witnesses, and the Board members all participating in person, by telephone or via electronic means pursuant to the Office of Professional Regulation Rules.

Findings of Fact

Based on the evidence presented at the hearing and the arguments of counsel and the Respondent, the Vermont Board of Nursing finds as follows:

1. Respondent was licensed as a Registered Nurse (RN) in the State of Vermont from 2007 until March 31, 2025, at which time her Vermont license expired. The Respondent has also been licensed as an RN in New York State. The Respondent is subject to the regulatory authority of this Board. 3 V.S.A. §§ 129, 129a, 26 V.S.A. Chapter 28, the Administrative Rules of the Board of Nursing, and the Rules of the Office of Professional Regulation.
2. The prosecutor filed a Specification of Charges on 27 June, 2024. The Respondent filed an Answer on July 15, 2024.
3. The Respondent participated in the hearing and there were no objections to notice.
4. In September of 2023 the Respondent was working as a registered nurse at Southern State Correctional Facility in Springfield, Vermont (SSCF). During her shift she needed to waste an 8 mg tablet of Subutex, a regulated drug. Without a co-worker witness, the Respondent placed the drug in the sharps disposal container. She reported this fact to another nurse after the disposal when the incoming nurse came on shift. The Respondent had not independently charted the wasting of the drug and had not followed the proper wasting procedure because she “was not taught how to waste anything different at SSCF” from her prior practice, even though the facility had a special place to put wasted drugs.
5. The facility generated a report of a medication error by a licensee on December 19, 2023, to the Vermont Board of Nursing. The Respondent’s employer was required to file monthly reports of satisfactory performance by the Respondent pursuant to a Stipulation and Consent Order (Exhibit 4). The report of medication error was an unsatisfactory report and constituted a violation of the Consent Order. (See paragraphs A.4 and A.15 of the Order).
6. On or about January 19, 2024, the Respondent was working at SSCF and doing a distribution of methadone as a “MAT pass” in which inmates would line up and receive their medication addiction treatment (“MAT”) medications. The Respondent gave to inmate PW the medication and dosage which was intended for another inmate. The medication was ingested by inmate PW. When inmate NW later arrived to the front of the line he was handed the medication for inmate PW rather than the medication for his dosage. He pointed this out to the Respondent. She then found a dosage for NW intended to be delivered at a future date. The dosage for inmate PW was placed in the bottom of the medication cart. The Respondent charted that she had dispensed PW’s correct medication to him (although he had received NW’s medication and dosage) and she did not record that she had given NW a medication dose intended for a later date. (See Exhibits 2 and 3)
7. Following this incident the Respondent’s employment at SSCF was terminated.
8. The Respondent admitted to the OPR investigator that there was confusion at the time of the MAT pass when inmate NW stated that he was being given the wrong medication and that it was “likely” that Respondent had given the wrong medication and dose to inmate PW. The Respondent also admitted that she had made no report or charting of the error because she was unaware of the error (even though inmate NW had told her of the

problem).

9. In December of 2023 or January of 2024 SSCF made an unsatisfactory monthly report of performance and informed OPR of Respondent's termination from employment.

Conclusions of Law

1. The evidence established that the Respondent violated: 26 VSA Sec. 1582(a)(4) [Willfully failing to file or record medical reports]; 26 VSA Sec. 1582(a)(3) [Engaging in conduct of a character likely to deceive, defraud, or harm the public]; 3 VSA Sec. 129a(a)(4) [Failure to comply with an order of the board or violating any term or condition of a license restricted by the board]; 3 VSA Sec. 129a(b)1 [Failure to practice competently by the performance of unsafe or unacceptable patient care]; and 3 VSA Sec. 129a(b)(2) [Failure to practice competently by failure to conform to the essential standards of practice].
2. Upon the finding of unprofessional conduct, the Board may issue appropriate sanctions including conditions upon a license. 3 VSA Sec. 129(a)(3). In this case the Board determines that the conditions which were included in the prior order of the Board should be continued for another two (2) years and additional conditions regarding professional education should be required.

Order

- A. The Board Order of March 9, 2015 (attached hereto) is hereby continued in force for a period of an additional two (2) years from the date of entry of this Order and all the conditions of that Order numbered A.1. through A.16 are continued in force during the period of continuation.
- B. In addition, the Board orders an additional condition as follows:
 1. Required Coursework. Respondent shall, at her own expense and within ninety (90) days of date of entry of this Order, successfully complete (i.e., receive a passing score, if applicable) pre-approved online nursing education courses (or equivalent that are pre-approved by the Enforcement Case Manager) regarding (1) medication management and disposal practices and (2) nursing charting and documentation.
 - a. Respondent must submit the completed workbook and written documentation of completion (certificate of completion, etc.) to the Enforcement Case Manager.
 - b. Failure to complete such courses and coursework within the prescribed timeframe shall constitute a violation of this Order. The coursework shall not be counted toward any continuing education requirement of licensure.

SO ORDERED.

Vermont Board of Nursing

Signed by:
By: Marsha H Arend
Marsha Arend, RN
Acting Chair

Date: 5/20/2025, 2025

OFFICE OF PROFESSIONAL REGULATION

DATE OF ENTRY: 5/20/25

APPEAL RIGHTS

This is a final administrative determination by the Vermont Board of Nursing or Director of the Office of Professional Regulation. A party aggrieved by a final decision of a board or hearing authority may appeal this decision by filing a written Notice of Appeal with the Director of the Office of Professional Regulation, Vermont Secretary of State, 89 Main Street, Fl. 3, Montpelier, VT 05620-3402 within 30 days of the entry of this order. If an appeal is filed, the Director of the Office of Professional Regulation shall assign the case to an appellate officer. The review shall be conducted on the basis of the record created before the board. In cases of alleged irregularities in procedure before the board, not shown in the record, proof on that issue may be taken by the appellate officer. 3 V.S.A. §§ 129(d) and 130a.

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

IN RE:)
Dale Kenyon) **Docket No. 2024-99**
License No. 026.0038277)

SPECIFICATION OF CHARGES

NOW COMES the State of Vermont and hereby makes the following charges against Respondent Dale Kenyon:

Board Authority

1. The Vermont State Board of Nursing (the "Board") has jurisdiction to investigate and adjudicate allegations of unprofessional conduct committed by registered nurses ("RNs") 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. Dale Kenyon ("Respondent") of Cuttingsville, Vermont is licensed as an RN under license number 026.0038277. This license was originally issued on July 9, 2007, and expires on March 31, 2025.
3. On or about March 19, 2015, the Board entered a "Consent Order" conditioning Respondent's RN license and requiring, among other things, that Respondent "cause every nursing employer the Respondent has worked for during the month to submit to the Board an evaluation of Respondent's work performance and attendance during that month" and further requiring that "[a]ll employer reports shall indicate satisfactory performance (ie., consistently meeting all standards of nursing practice."
4. At all times relevant to this matter, these conditions were in force.
5. At all times relevant to this matter, Respondent was employed by a private contractor that supplied nursing staff to Southern State Correctional Facility ("SCCF") in Springfield, Vermont.
6. On or about early September of 2023, Respondent was working as an RN at SCCF.
7. Following one of Respondent's shifts in early September of 2023, an 8mg tablet of Subutex was determined to be missing.

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8. Through subsequent investigation, other nursing staff at SCCF determined that Respondent had thrown the missing 8mg Subutex tablet into a sharps disposal container instead of properly wasting the medication.
9. Respondent did not report the disposal of the 8mg Subutex tablet into the sharps disposal container.
10. On or about December 19, 2023, Respondent's employer generated a monthly report of Respondent's performance during September of 2023, pursuant to the Board's Consent Order.
11. This report indicated that "Licensee medication errors" had occurred.
12. This report further explained this with the following statement, "8mg Subutex missing during shift-to-shift count. It was determined that [Respondent] was never taught appropriate wasting practices for controlled substances. She wasted in sharps box and did not enter waste into count book. We provided her with a controlled substances training eLearn and in-person discussion. [Respondent] verbalized understanding."
13. On or about January 19, 2024, Respondent was working as an RN at SCCF.
14. As part of her duties on that date, Respondent was assigned to distribute methadone to inmates incarcerated at SCCF.
15. Inmates prescribed methadone would line up for the "MAT pass" at which they would be given their prescribed doses of methadone.
16. During the MAT pass, two patients (identified hereinafter as "N.W." and "P.W." respectively) were part of the group of inmates lined up to receive methadone.
17. When P.W. reached the front of the line, Respondent handed him a dose of methadone, which he ingested.
18. This was not the dose of methadone that was prescribed for P.W., but rather it was the dose of methadone that had been prescribed for N.W.
19. When N.W. reached the head of the line, Respondent handed him the dose of methadone that was prescribed for P.W.
20. N.W. noticed that this was not his prescription, but rather P.W.'s, and refused to ingest it.
21. N.W. handed P.W.'s methadone back to Respondent.
22. Respondent placed P.W.'s methadone back into a drawer in the bottom of the medication cart under several bags, but recorded this medication as being distributed to P.W.

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23. Having already distributed N.W.'s dose of methadone to P.W., Respondent was left without anything to give to N.W.
24. Respondent removed a dose of methadone from the cart meant to be provided to N.W. at a later date and handed this dose to N.W.
25. N.W. ingested this dose of methadone.
26. Respondent did not make any record or report of providing the methadone intended for N.W. to P.W. so that both patients could be monitored for any ill effects.
27. Respondent did not make any record or report of providing N.W. a dose of methadone intended to be provided at a later date.
28. The following day, on or about January 20, 2024, other nurses assigned to SCCF discovered discrepancies in the medication cart count.
29. These discrepancies included an extra methadone dose intended for P.W. and a missing dose of methadone intended for N.W.
30. Following this incident, Respondent's employment was terminated.

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

31. The State re-alleges and incorporates Paragraphs 2 through 30 above.
32. As a licensed RN, Respondent is required to refrain from engaging in conduct of a character likely to deceive, defraud, or harm the public.
33. Paragraphs 2 through 30 demonstrate that Respondent engaged in conduct of a character likely to harm the public in that she improperly disposed of a controlled substance and provided one patient a dose of a prescribed controlled substance that was intended to be provided to another patient.
34. 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: 26 V.S.A. § 1582(a)(4) Willfully failing to file or record medical reports.

35. The State re-alleges and incorporates Paragraphs 2 through 30 above.
36. As a licensed RN, Respondent is required to refrain from willfully failing to file or record medical reports

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37. Paragraphs 2 through 30 demonstrate that Respondent willfully failed to file medical reports when she did not report the improper disposal of a controlled substance into a sharps disposal container, did not report providing one patient another patient's medication, and did not report giving a patient a dose of medication that was intended for a future date to make up for providing that patient's medication to another patient.
38. 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)(4).

Violation Three: 3 V.S.A. §129a(b)(1) Failure to practice competently by the performance of unsafe or unacceptable patient care.

39. The State re-alleges and incorporates Paragraphs 2 through 30 above.
40. As a licensed RN in the State of Vermont, Respondent is required to refrain from failing to practice competently by performing unsafe or unacceptable patient care.
41. Paragraphs 3 through 30 demonstrate that Respondent performed unsafe or unacceptable patient care when she disposed of a controlled substance by placing it in a sharps disposal container and provided medication intended for one patient to another patient.
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(b)(1).

Violation Four: 3 V.S.A. §129a(b)(2) Failure to practice competently by the failure to conform to the essential standards of practice.

43. The State re-alleges and incorporates Paragraphs 2 through 30 above.
44. As a licensed RN in the State of Vermont, Respondent is required to conform to the essential standards of practice of her profession.
45. Paragraphs 3 through 30 demonstrate that Respondent failed to conform to the essential standards of practice for her profession in the following ways:
- a. The applicable standards of practice require that controlled substances be wasted according to a secure and well-documented procedure and not placed in a sharps disposal container with no documentation as Respondent did.
 - b. The applicable standards of practice require that medications be distributed to the correct patient, and Respondent did not do so.

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- c. The applicable standards of practice require that when a medication has been improperly distributed to the wrong patient, that this error be documented so that any involved patient can be monitored for any ill effects, and Respondent did not do so.

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(b)(2).

Violation Five: 3 V.S.A. §129a(a)(4) Failure to comply with an order of the board or violating any term or condition of a licensed restricted by the board.

47. The State re-alleges and incorporates Paragraphs 2 through 30 above.
48. As a licensed RN in the State of Vermont, Respondent is required to comply with orders of the board and/or terms or conditions of a license restricted by the board.
49. Paragraphs 3 through 30 demonstrate that Respondent violated a condition of a license restricted by the Board when she received a monthly employer report that indicated unsatisfactory performance (in that she made medication errors) when she was required by the conditions imposed to ensure that all employer reports indicated satisfactory performance.
50. 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)(4).

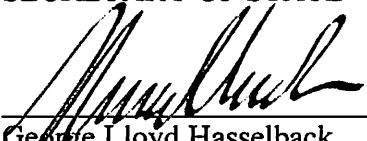
Relief Requested

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
(802)828-0350
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STATE OF VERMONT
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BOARD OF NURSING

IN RE:	)	
DALE A. KENYON	)	Docket No. 2012-759
License No. 026.0038277	)	

STIPULATION AND CONSENT ORDER

STIPULATION

NOW COME the State of Vermont, by and through State Prosecuting Attorney S. Lauren Hibbert, and the Respondent, Dale A. Kenyon, RN, who 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. § 1582; the Administrative Rules of the Board of Nursing (the "ARBN"); and the Rules of the Office of Professional Regulation.

Stipulated Facts

2. Dale A. Kenyon (the "Respondent") of Whitehall, New York is licensed by the State of Vermont as a Registered Nurse under license number 026.0038277. This license was originally issued on or about July 9, 2007 and is currently set to expire on or about March 31, 2013.
3. On or about October 13, 2014 the Board of Nursing conducted a hearing and found Respondent had committed unprofessional conduct. See Attachment A.
4. Respondent appealed the Board's decision. Briefs have been filed and a hearing was conducted on February 26, 2015 on the due process issue of notice. Based on that hearing the State enters into this agreement. The Appellate Officer is in agreement with this resolution.
5. Respondent is currently on probation as a result of her underlying criminal conviction and will continue to be on probation until summer of 2017.

Violations

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6. 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:
 - a. 3 V.S.A. § 129a(b)(1) and (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: (1) performance of unsafe or unacceptable patient or client care; or (2) failure to conform to the essential standards of acceptable and prevailing practice).

Understandings

7. This Stipulation is neither an admission of liability by the Respondent nor a concession by the State of Vermont that its charges are not well-founded. To avoid delay, uncertainty, inconvenience, and expense of protracted litigation of the charges above, the Parties reach a full and final Stipulation pursuant to these Understandings and the Order below. The Respondent does not dispute that the State could prove these charges by a preponderance of the evidence if this matter went to a hearing and agrees that the conditions below are necessary to protect the public.
8. 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.
9. 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.
10. Respondent has read and reviewed this entire document and agrees that it contains the entire agreement between the parties.
11. Respondent is not under the influence of any drugs or alcohol at the time she signs this Stipulation and Consent Order.
12. 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.
13. 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.
14. Respondent agrees that the Order set forth below may be entered by the Board.

ORDER

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

- A. The Board of Nursing hereby **REINSTATES** the Respondent's license to practice nursing. Once reinstated, Respondent's license will be **CONDITIONED FOR A MINIMUM OF ONE (1) YEAR** commencing with the date of reinstatement. The conditions will be as follows:

1. Re-issue of License.

Upon the commencement of these conditions, 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 nursing in which she works at least forty (40) hours every two (2) weeks as a nurse. Part time hours of less than forty (40) hours every two (2) weeks shall be credited on a prorated basis. Respondent shall be prohibited from working more than forty (40) hours per week.

3. Notification to Employers/Nursing School.

Respondent shall provide a copy of this Stipulation and Consent Order to all nursing employers or nursing school with a clinical portion 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 or education, Respondent's immediate supervisor must 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.

4. 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 the Respondent has worked for during the month to submit to the Board an evaluation of Respondent's work performance and attendance during that month. Moreover, on a **quarterly** basis, these reports shall include the results of the employer's medication audits of Respondent's medication administration and practices. These reports shall be submitted in writing on forms issued by the Board. All employer reports shall indicate satisfactory performance (ie., consistently meeting all standards of nursing practice) and attendance.

In the event the Respondent is attending a nursing program, Respondent shall cause the Program Director to submit to the Board, on a monthly basis, a written

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evaluation of her performance and attendance. These reports shall be submitted in writing on forms issued by the Board. All nursing program reports shall indicate satisfactory performance (ie., consistently meeting all standards of nursing practice) and attendance.

If Respondent has a negative or unfavorable employer or program report **the Board of Nursing Case Manager may at her discretion require an Independent Evaluation within 30 days of her request.** The evaluator must be pre-approved by the Board.

5. Practice Under Supervision.

Respondent shall practice as a nurse only in a setting where Respondent has direct supervision for the entire shift by a licensed registered nurse that is in good standing with the Board.

6. Medication Audit.

Respondent's medication practices shall be audited by her supervisor. Her supervisor must include in the monthly supervision reports that Respondent meets the prevailing and acceptable standards of practice.

7. 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.

8. Interview with the Board or its Designee.

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

9. 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 prior to Respondent practicing nursing outside the State of Vermont. If Respondent fails to receive such approval before practicing nursing outside the State of Vermont, none of the time spent practicing nursing out-of-state will be credited toward the fulfillment of the terms and conditions of this Consent Order. The Board will approve out-of-state nursing practice so long as the Respondent can still comply with the provisions of this Consent Order.

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If the Respondent receives discipline on a nursing license held in another state during the conditioned period, the Respondent must inform the Board of such, in writing, within ten (10) days of receiving such discipline.

10. 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 her 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.

11. Notification to Other States.

In the event that the Respondent is licensed in nursing in any other state(s), she must inform the nursing licensing board of the state(s) in which the Respondent is licensed of the conditional status of her Vermont nursing license within thirty (30) days of the date of entry of this Order. If the Respondent fails to provide such notification, it will be considered a violation of this Order.

12. License Renewal.

If the Respondent's license expires while this Order is still in effect, this Order does not automatically extend the license. In that situation, in order to continue to practice as a nurse, the Respondent must timely apply for renewal, pay the applicable fee and demonstrate that she has otherwise complied with the requirements for license renewal.

13. Release of Information Forms.

The conditions of this Order require the Respondent to authorize a provider to report information in verbal and/or written format and/or to discuss the Respondent and any and all treatment rendered to the Respondent for drugs and/or alcohol with the Board or its designee. The conditions of this Order must allow any and all information from the Respondent's treatment providers to also be provided to the Office of Professional Regulation investigators and that the information may be used for further prosecutions if so warranted or if the Office of Professional Regulation determines that said information violates the terms of this Order or any rules or laws governing the profession of nursing.

The Respondent is entitled to revoke this consent at any time. However, any revocation by the Respondent of such consent to disclosure during the term of this Order shall be considered a violation of this Order.

This consent expires when the conditions are removed from the Respondent's nursing license.

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This Stipulation and Consent Order shall constitute a valid written consent pursuant to the requirements of 42 C.F.R. § 2.31.

14. Costs.

The Respondent shall bear all costs of complying with this Consent Order.

15. Violation of this Order.

If the Respondent violates the terms of this Order in any respect, the Board, after giving the 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 the 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.

After the conditional license period, the Respondent may petition the Board, or it's designee, to remove any and all conditions on her license. The Respondent must present proof that she has fully complied with the terms of this Order.

- B. Notwithstanding any provision above, the Respondent must continue to meet all Nursing 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 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:

Dated: 2.26.15

STATE OF VERMONT
SECRETARY OF STATE

By: Annika Green
Annika Green
State Prosecuting Attorney

DALE A. KENYON
RESPONDENT

Dated: 2/26/15

By: Dale A. Kenyon
Dale A. Kenyon

STATE OF VERMONT



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APPROVED AND SO ORDERED:

Dated: 3/9/15

Date of Entry: 3/19/15

VERMONT BOARD OF NURSING

By: Jeanine Carr
Chairperson

STATE OF VERMONT



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