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

IN RE:	)	
Kathryn Burnell	)	**Docket No. 2025-15**
Vermont License No. 101.0087049	)	
	)	

State of Vermont
Board of Nursing

Order to Remove Conditions

On December 8, 2025, the Board of Nursing considered Respondent's request for Removal of Conditions imposed on her license pursuant to a Stipulation and Consent Order effective October 14, 2025, under Docket Number 2025-15. The conditions included successful completion of educational requirements. Respondent has met all the conditions. After reviewing the compliance file, the State does not object to removal of all conditions.

Order:

The Board of Nursing hereby removes all conditions from Respondent's license.

Vermont Board of Nursing

Signed by:
William James Floyd III
3B82E78300124BE...
Chairperson

Date: 12/8/2025

Date of Entry: 12/9/2025

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

IN RE:	)	
Kathryn Burnell	)	**Docket No. 2025-15**
Vermont License No. 101.0087049	)	
	)	

STATE'S RESPONSE TO RESPONDENT'S REQUEST TO REMOVE CONDITIONS

After reviewing the compliance file, the State has no objection to Respondent's request to remove all conditions from her license. Attached to this response is a proposed Order should the Board of Nursing decide to grant Respondent's request.

Respectfully submitted, this 1st day of December 2025.

By: George Hasselback
George Hasselback
Prosecuting Attorney

State of Vermont
Office of the Secretary of State

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

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

November 10, 2025

George Hasselback, Esq.
Office of Professional Regulation
89 Main Street, 3rd Floor
Montpelier, VT 05620-3402

Case: Kathryn Burnell
Credential: License # 101.0087049
Docket No: 2025-15

Dear Attorney Hasselback

Please find the enclosed Request " to remove conditions " filed on the above captioned docket number. Pursuant to the Office of Professional Regulation's Administrative Rule 3.8 you have 10 days to respond to the motion.

You may contact me at (802) 828-2367 if you have any questions.

Sincerely,

/s/ Julie Bowen
Docket Clerk

Enc: *Request to Remove Conditions*

Cc: Kristin Donnelly, Case Manager
Kathryn Burnell, Respondent

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

IN RE:	)	
Kathryn Burnell	)	**Docket No. 2025-15**
Vermont License No. 101.0087049	)	

PETITION TO REMOVE CONDITIONS

To the Vermont Board of Nursing:

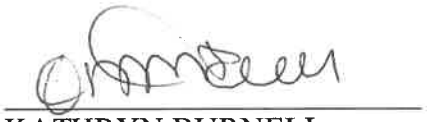
I am writing to respectfully petition for the removal of all conditions and restrictions on my Vermont Advanced Practice Registered Nurse license, pursuant to Stipulation and Consent Order entered October 14, 2025. I have fully complied with and completed all requirements as outlined in the Order.

At my own expense and within 90 days of the date of entry of the Stipulation and Consent Order, I successfully completed ten (hours) of pre-approved coursework on standards of practice regarding transitional care and high-risk medication management for geriatric patients.[briefly summarize the conditions completed: e.g., probation, continuing education, assessments, supervision, monitoring]. Supporting documentation is attached for your review. I submitted the certificate of completion to the Enforcement Case Management who notified me that I could petition the Board of Nursing to have conditions removed from my license.

As provided in the Order, upon successful completion of the specified term, I may petition the Board for removal of conditions. I believe I have met all obligations and remain fully committed to professional standards.

Thank you for your consideration. Please let me know if a hearing or further information is required.

RESPONDENT



KATHRYN BURNELL

Dated: 10 Nov 25

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

IN RE:	)	
Kathryn Burnell	)	**Docket No. 2025-15**
Vermont License No. 101.0087049	)	
	)	

STIPULATION AND CONSENT ORDER

NOW COMES the State of Vermont (the "State") by and through Prosecuting Attorney George Hasselback, and Respondent Kathryn Burnell, by and through her counsel Shireen Hart, 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; 26 V.S.A. Chapter 28; the Administrative Rules of the Board of Nursing; and the Rules of the Office of Professional Regulation.

Alleged Facts

2. Kathryn Burnell ("Respondent") of Danville, VT holds a license to practice as an APRN under license number 101.0087049 issued by the State of Vermont. This license was originally issued on June 14, 2012, and expires on March 31, 2027.

3. Respondent also holds a license to practice as a Registered Nurse ("RN") under license number 026.0033617 issued by the State of Vermont. This license was originally issued on July 14, 2006, and expires on March 31, 2027.

4. At all times relevant to this matter, Respondent saw patients in her capacity as an APRN at an assisted living facility located in St. Johnsbury, VT ("the Facility").

5. Prior to April 23, 2023, an individual who would eventually become a patient of the Facility, identified by the initials "BJ," was eighty-six (86) years old, living independently, and driving himself.

6. At that time, BJ suffered from mild cognitive impairment.

7. On or about April 23, 2023, BJ suffered a fall on a hard tile floor and broke his hip.

8. Following this injury, BJ was treated at a local emergency room, transferred to another hospital for surgery on his broken hip, and, following that surgery, transferred to a rehabilitation facility to recover.

9. On or about April 29, 2023, BJ was readmitted to the hospital for sepsis related to the surgery on his hip.

10. On or about May 4, 2023, BJ was transferred to a rehabilitation center/nursing home located in Lyndonville, VT to continue his recovery.

11. On or about June 23, 2023, BJ was prescribed a 5-day course of prednisone (20 mg. twice daily) to treat him for "emphysema, unspecified."

12. This prednisone prescription was documented to be discontinued on June 27, 2023.

13. BJ stopped receiving prednisone on or about June 27, 2023, as directed by the prescription.

14. On or about June 29, 2023, BJ was transferred to the Facility.

15. During the transfer process, BJ's medication lists and pertinent notes/reports were faxed from the rehabilitation center/nursing home located in Lyndonville, VT to the Facility.

16. The Respondent assumed care of BJ upon his transfer to the Facility.

17. Upon assumption of BJ's care, Respondent reviewed a summary of his medical records provided to her by the Facility.

18. Unbeknownst to Respondent, this summary incorrectly indicated that BJ was still receiving prednisone.

19. The summary was unclear as to why BJ should continue to receive prednisone.

20. Based upon the summary and her conversation with BJ, Respondent believed there was an active prednisone prescription to treat eczema. She requested his dermatology records for more detailed information.

21. Even though extended use of prednisone carries with it significant health risks, especially for patients of advanced age such as BJ, Respondent continued BJ on a prednisone regimen for approximately three (3) months.

22. On or about August 21, 2023, BJ complained of the sudden onset of severe sacral/lower back pain.

23. BJ was informed by the Facility's staff that this was due to "muscle spasms" and was advised that he needed to move more.

24. A muscle relaxant medication was prescribed to address BJ's pain.

25. This did not provide any significant relief to BJ.

26. BJ's prednisone regimen was not interrupted.

27. After four days of pain, the Facility had BJ transferred to a local regional hospital to address the pain.

28. BJ was diagnosed with bilateral sacral insufficiency fractures.

29. During that hospitalization, a sacroplasty procedure was attempted, but ultimately failed.

30. On or about September 4, 2023, BJ was transferred back to the Facility, still in a great deal of pain, unable to ambulate, confined to a wheelchair, and requiring regular pain medication.

31. The Facility reported that it was unable to presently care for BJ due to his condition.

32. On or about September 8, 2023, BJ was transferred to another rehabilitation facility.

33. On or about September 14, 2023, a physician at the rehabilitation facility began to wean BJ off prednisone at the urging of a family member of his.

34. While at the rehabilitation facility, BJ made some progress towards recovery but was still heavily medicated with opioids for pain.

35. On or about September 20, 2023, BJ was returned to the Facility where his health continued to decline generally, and he remained generally wheelchair bound and in a great deal of pain.

36. On or about September 26, 2023, a palliative care specialist saw BJ.

37. On or about October 7, 2023, BJ entered hospice care.

38. During hospice care, BJ continued to be generally wheelchair bound and in a great deal of pain.

39. On or about November 2, 2023, BJ passed away.

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

40. The State re-alleges and incorporates Paragraphs 2 through 39 above.

41. As a licensed APRN in the State of Vermont, Respondent is required to refrain from performing unsafe or unacceptable patient care.

42. Paragraphs 2 through 39 demonstrate that Respondent performed unsafe or unacceptable patient care when she ordered a long-term course of prednisone treatment of an elderly patient with no clear indication of any medical condition that would justify such treatment, despite the significant health risks associated with such treatment, and despite the patient's increased susceptibly to dangerous side-effects due to his age.

43. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent committed unprofessional conduct by failing to practice competently by the performance of unsafe or unacceptable patient care in violation of 3 V.S.A. §129a(b)(1).

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

44. Paragraphs 2 through 39 above are incorporated herein.

45. As a licensed APRN in the State of Vermont, Respondent is required to conform to the essential standards of practice of her profession.

46. Paragraphs 2 through 39 demonstrate that Respondent failed to conform to the essential standards of practice in the following ways:

a. The applicable standards of practice require that there be a clear indication of a medical condition that justifies the prescription of a long-term course of prednisone treatment prior to prescribing such treatment, and Respondent failed to identify any such indication prior to prescribing such treatment for BJ.

b. The applicable standards of practice require that the benefits of a long-term course of prednisone be weighed against the significant health risks associated with prescribing such a course of treatment, and Respondent failed to appropriately weigh those benefits against the significant risks before prescribing such treatment for BJ.

c. The applicable standards of practice require an elderly patient such as BJ not be placed upon an extended course of prednisone treatment without justification, and Respondent placed him upon an extended course of prednisone treatment without justification.

47. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent committed unprofessional conduct by failing to conform to the essential standards of practice in violation of 3 V.S.A. §129a(b)(2).

Understandings

48. This Stipulation is neither an admission of liability by Respondent nor a concession by the State of Vermont that its charges are not well-founded. To avoid delay, uncertainty, inconvenience, and the expense of protracted litigation, the Parties enter this full and final Stipulation pursuant to these Understandings and the Order below. Respondent does not dispute that the State may be able to prove these charges by a preponderance of the evidence if this matter proceeds to a merits hearing.

49. 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.

50. Respondent specifically waives any claim that any disclosures made to the Board during review of this agreement have prejudiced Respondent's right to a fair and impartial hearing if this agreement is not accepted and proceeds to a hearing on the merits before the same Board.

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

52. Respondent is not under the influence of any drugs or alcohol at the time of signing this Stipulation and Consent Order.

53. 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.

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

55. Respondent understands that she is responsible for all compliance costs associated with this Stipulation and Consent Order. Respondent agrees the Board may enter the Order set forth below.

ORDER

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

A. The Board of Nursing hereby **REPRIMANDS** Respondent's license(s).

B. The Board hereby **CONDITIONS** Respondent's license(s). The **CONDITIONS** shall be as follows:

1. 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) ten (10) hours of pre-approved coursework on

standards of practice regarding transitional care and high-risk medication management for geriatric patients. The coursework must be pre-approved by the Enforcement Case Manager.

Respondent shall submit the certificates of completion, completed assignment book(s) and quiz results, if applicable, to the Enforcement Case Manager. Failure to satisfactorily complete the courses within the prescribed timeframe shall constitute a violation of this Order. The coursework may not be counted toward any continuing education requirement of licensure.

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

E. This Stipulation and Consent Order is a matter of public record and may be reported to other licensing authorities as provided in 3 V.S.A. § 129(a).

F. This Stipulation and Consent Order will remain part of Respondent's licensing file and may be used for purposes of determining sanctions in any future disciplinary matter.

AGREED TO:

STATE OF VERMONT
SECRETARY OF STATE

Dated: 9-5-2025 By: George Hasselback

George Hasselback
Prosecuting Attorney

RESPONDENT

Dated: 25 Aug 2025 By:

Kathryn Burnell

APPROVED AS TO FORM:

COUNSEL FOR RESPONDENT

Dated: September 2, 2025 By:

Shireen Hart

APPROVED AND SO ORDERED:

VERMONT BOARD OF NURSING

Signed by:
William James Floyd III
3B82E78300124BE...

Dated: 10/13/2025 By:

Chairperson

Date of Entry: 10/14/2025

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

IN RE:	)	
Kathryn Burnell	)	**Docket No. 2025-15**
Vermont License No. 101.0087049	)	
	)	

SPECIFICATION OF CHARGES

NOW COMES the State of Vermont (the "State") and makes the following charges against Respondent Kathryn Burnell:

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; 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. Kathryn Burnell ("Respondent") of Danville, VT holds a license to practice as an APRN under license number 101.0087049 issued by the State of Vermont. This license was originally issued on June 14, 2012, and expires on March 31, 2025.

3. Respondent also holds a license to practice as a Registered Nurse ("RN") under license number 026.0033617 issued by the State of Vermont. This license was originally issued on July 14, 2006, and expires on March 31, 2025.

4. At all times relevant to this matter, Respondent was employed as an APRN at an assisted living facility located in St. Johnsbury, VT ("the Facility").

5. Prior to April 23, 2023, an individual who would eventually become a patient of the Facility identified by the initials "BJ" was eighty-six (86) years old, living independently, and driving himself.

6. At that time, BJ suffered from mild cognitive impairment.

7. On or about April 23, 2023, BJ suffered a fall on a hard tile floor and broke his hip.

8. Following this injury, BJ was treated at a local emergency room, transferred to another hospital for surgery on his broken hip, and, following that surgery, transferred to a rehabilitation facility to recover.

STATE OF VERMONT

Prosecuting Attorney
Office of
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89 Main Street
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05620-3402

9. On or about April 29, 2023, BJ was readmitted to the hospital for sepsis related to the surgery on his hip.

10. On or about May 4, 2023, BJ was transferred to a rehabilitation center/nursing home located in Lyndonville, VT to continue his recovery.

11. On or about June 23, 2023, BJ was prescribed a 5-day course of prednisone (20 mg. twice daily) to treat him for "emphysema, unspecified."

12. This prednisone prescription was documented to be discontinued on June 27, 2023.

13. BJ stopped receiving prednisone on or about June 27, 2023, as directed by the prescription.

14. On or about June 29, 2023, BJ was transferred to the Facility.

15. During the transfer process, BJ's medication lists, and pertinent notes/reports were faxed to the Facility.

16. The Respondent assumed care of BJ upon his transfer to the Facility.

17. Upon assumption of BJ's care, Respondent reviewed a summary of his medical records.

18. This summary incorrectly indicated that BJ was still receiving prednisone.

19. The summary was unclear as to why BJ should continue to receive prednisone.

20. Even though there was no indication that BJ had any medical condition at that time that would justify a prednisone regimen, Respondent ordered that BJ resume a course of prednisone consisting of 20 mg. twice daily.

21. Even though extended use of prednisone carries with it significant health risks, Respondent placed BJ back on a prednisone regimen which lasted approximately three (3) months without appropriately weighing those risks against the proposed benefits of such a prescription.

22. Even though extended use of prednisone carries significant risks, especially for and elderly person such as BJ, Respondent placed him back on a prednisone regimen without justification.

23. This prescription was continued as a regular part of BJ's medication regimen despite there being no clear reason for him to be taking this medication.

24. On or about August 21, 2023, BJ complained of the sudden onset of severe sacral/lower back pain.

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25. BJ was informed by the Facility's staff that this was due to "muscle spasms" and was advised that he needed to move more.

26. A muscle relaxant medication was prescribed to address BJ's pain.

27. This did not provide any significant relief to BJ.

28. BJ's prednisone regimen was not interrupted.

29. After four days of pain, the Facility had BJ transferred to a local regional hospital to address the pain.

30. BJ was diagnosed with bilateral sacral insufficiency fractures.

31. These fractures were determined to be most likely the result of long-term prednisone use.

32. BJ was asked why he was on a long-term course of prednisone.

33. BJ expressed that he was unaware that he was still being given prednisone regularly.

34. During that hospitalization, a sacroplasty procedure was attempted, but ultimately failed.

35. On or about September 4, 2023, BJ was transferred back to the Facility, still in a great deal of pain, unable to ambulate, confined to a wheelchair, and requiring regular pain medication.

36. The Facility reported that it was unable to presently care for BJ due to his condition.

37. On or about September 8, 2023, BJ was transferred to another rehabilitation facility.

38. On or about September 14, 2023, a physician at the rehabilitation facility began to wean BJ off prednisone at the urging of a family member of his.

39. While at the rehabilitation facility, BJ made some progress towards recovery but was still heavily medicated with opioids for pain.

40. On or about September 20, 2023, BJ was returned to the Facility where his health continued to decline generally, and he remained generally wheelchair bound and in a great deal of pain.

41. On or about September 26, 2023, a palliative care specialist saw BJ.

42. During this meeting, BJ expressed his desire to die due to the severity of his pain.

STATE OF VERMONT

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43. He was referred to hospice care following this meeting.

44. On or about October 7, 2023, BJ entered hospice care.

45. During hospice care, BJ continued to be generally wheelchair bound and in a great deal of pain.

46. On or about November 2, 2023, BJ passed away.

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

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

48. As a licensed APRN in the State of Vermont, Respondent is required to refrain from engaging in conduct of a character likely to deceive, defraud, or harm the public.

49. Paragraphs 2 through 46 demonstrate that Respondent engaged in conduct of a character likely to harm the public when she ordered that an elderly patient begin a long-term regimen of prednisone treatment, despite there being no clear indication of any medical condition that would justify that medication, despite the significant health risks associated with such treatment, and despite the patient's increased susceptibly to dangerous side-effects due to his age.

50. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent committed unprofessional conduct of a character likely to deceive, defraud, or harm the public in violation of 26 V.S.A. §1582(a)(3).

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

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

52. As a licensed APRN in the State of Vermont, Respondent is required to refrain from performing unsafe or unacceptable patient care.

53. Paragraphs 2 through 46 demonstrate that Respondent performed unsafe or unacceptable patient care when she ordered a long-term course of prednisone treatment of an elderly patient with no clear indication of any medical condition that would justify such treatment, despite the significant health risks associated with such treatment, and despite the patient's increased susceptibly to dangerous side-effects due to his age.

54. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent committed unprofessional conduct by failing to

STATE OF VERMONT

Prosecuting Attorney
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89 Main Street
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Montpelier, VT
05620-3402

practice competently by the performance of unsafe or unacceptable patient care in violation of 3 V.S.A. §129a(b)(1).

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

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

56. As a licensed APRN in the State of Vermont, Respondent is required to conform to the essential standards of practice of her profession.

57. Paragraphs 2 through 46 demonstrate that Respondent failed to conform to the essential standards of practice in the following ways:

a. The applicable standards of practice require that there be a clear indication of a medical condition that justifies the prescription of a long-term course of prednisone treatment prior to prescribing such treatment, and Respondent failed to identify any such indication prior to prescribing such treatment for BJ.

b. The applicable standards of practice require that the benefits of a long-term course of prednisone be weighed against the significant health risks associated with prescribing such a course of treatment, and Respondent failed to appropriately weigh those benefits against the significant risks before prescribing such treatment for BJ.

c. The applicable standards of practice require an elderly patient such as BJ not be placed upon an extended course of prednisone treatment without justification, and Respondent placed him upon an extended course of prednisone treatment without justification.

58. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent committed unprofessional conduct by failing to conform to the essential standards of practice in violation of 3 V.S.A. §129a(b)(2).

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

DATED at Montpelier, Vermont this 23rd day of January, 2025.

STATE OF VERMONT
SECRETARY OF STATE

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

STATE OF VERMONT

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