State of Vermont
Secretary of State
Office of Professional Regulation
Board of Nursing

In re: Anneka Brooks
License No. 025.0136847
Docket No.2025-201; 2025-202

STIPULATION AND CONSENT ORDER

STIPULATION

NOW COMES the State of Vermont, by and through Prosecuting Attorney Zoe Newman, and Respondent Anneka Brooks, who hereby stipulate and agree as follows:

Board Authority

1. The Vermont State Board of Nursing (Board) has jurisdiction to investigate and adjudicate allegations of unprofessional conduct committed by nurses 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 (ARBN); and the Rules of the Office of Professional Regulation (OPR).

Stipulated Facts

2. Anneka Brooks (Respondent) of Titusville, Florida is licensed by the State of Vermont as a Licensed Practical Nurse (LPN) under license number 025.0136847. This license was first issued on September 19, 2023, and expires on January 31, 2026.

3. Respondent is also licensed as an LPN by the State of Florida under license number PN5212202. This license was first issued on September 23, 2013, and expires on July 31, 2027.

4. At all times relevant, Respondent was employed as an LPN by a nursing home in Orleans County, Vermont (Nursing Home).

5. The Nursing Home was divided by floor into two units (First Floor and Second Floor).

6. The Nursing Home nursing staff was responsible for the safe-keeping, monitoring, and administration of each residents' prescription and all narcotics were stored in the locked medication carts; this included tracking the number of tablets remaining, who dispensed the tablets (meaning who removed the medication from the medication cart), who gave the narcotic medication to the resident, how many tablets were given, and when the medication was given.

7. When a nurse dispensed a resident's prescribed narcotic, the nurse was required to record the date, time, dose, remaining number of tablets, and the nurse's signature on the handwritten Narcotic Log.

8. When a nurse gave the resident a prescribed narcotic, the nurse was required to record that they gave the resident the narcotic in the Electronic Health Record (EHR).

9. When a resident was prescribed Oxycodone, a Schedule II narcotic analgesic, it came in medication cards, also known as blister packs.

10. Each Oxycodone tablet was individually packaged within the medication card with either a paper or foil back, which was designed to be broken when the medication was dispensed.

11. All prescribed narcotics for each resident residing on the First Floor were stored in the First Floor medication cart and all prescribed narcotics for each resident residing on the Second Floor were stored in the Second Floor medication cart.

12. For day and evening shifts, one nurse was assigned to the First Floor and a second nurse was assigned to the Second Floor.

13. Each nurse was responsible for and had custody of the corresponding medication cart and key.

14. For night shifts, it was common for one nurse to be assigned to the whole facility and responsible for both floors, including both medication carts and both keys.

15. On or about November 4, 2025, Respondent started working at the Nursing Home and completed her initial training the following day.

November 7, 2025, Night Shift: First Floor

16. The night of November 7, 2025, Respondent worked the night shift as the only nurse on duty for both floors with custody and control of each floor's medication cart and corresponding key.

17. On the morning of November 8, 2025, RN J.P. arrived for her shift as the First Floor nurse.

18. When RN J.P. met with Respondent for the shift change over report, Respondent could not give RN J.P. a report of the resident care she provided during her shift.

19. When asked about a resident who had recently transitioned to palliative care, Respondent told RN J.P. that dying was not a diagnosis and she had not administered any pain medication to that resident.

20. RN J.P. observed the palliative care resident to appear very uncomfortable and, in reviewing the resident's medical records, saw that the resident had not been

given any medication since 3 p.m. the previous day, despite having standing orders for Morphine and Ativan.

21. RN J.P. advised that even after administering the palliative care resident multiple doses of pain medication, the resident remained very uncomfortable for most of the day.

22. As part of the shift change, RN J.P. and Respondent completed the First Floor medication cart narcotic count together.

23. RN J.P. discovered that resident L.K.'s Oxycodone tablets totaled two tablets higher than what was recorded in the Narcotic Log.

24. RN J.P also discovered that resident N.P.'s Oxycodone tablet total was two less than what was written in the Narcotic Log.

25. When confronted with these discrepancies, Respondent told RN J.P. that she dispensed the medication from the wrong resident's card, which is why there was a discrepancy.

26. However, Respondent had not entered the administration of the two Oxycodone tablets to either patient in the EHR nor noted any medication error or wasting in the EHR or Narcotic Log.

27. When asked to write progress notes in the EHR to explain the discrepancy in the medication counts, Respondent told RN J.P. that she did not know how to write a progress note.

28. Respondent told RN J.P. that she had a difficult night and that she "fucked up."

November 7, 2025, Overnight Shift: Second Floor

29. On the morning of November 8, 2025, LPN K.W. arrived for her shift as the Second Floor nurse.

30. During the Second Floor medication count, LPN K.W. noticed that Respondent had given resident F.G. Ativan despite the medication being discontinued for the resident the previous month.

31. Respondent had not created a progress note explaining the administration of a discontinued medication.

32. LPN K.W. observed that another resident's Tramadol count did not match the Narcotic Book and that the actual tablet number was higher than recorded.

33. Respondent explained that she made an error and recorded the medication as dispensed twice, instead of once.

34. Tramadol was prescribed on an as needed basis (PRN) for this resident due to pain, however, Respondent had not created a progress note explaining why the Tramadol was administered.

35. LPN K.W. later told an OPR Investigator that some of the medication cards did not look right and appeared to have been separated on the edges; however, she had not wanted to make any accusations at the time and, instead, accepted custody of the medication cart.

36. LPN K.W. further recalled that, instead of giving a shift report regarding resident care, Respondent told her she had a horrible night.

37. LPN K.W. recalled Respondent appearing frazzled.

38. During LPN's day shift, she observed that several residents exhibited unusual behaviors, including resident S.G. who reported more pain than usual.

November 8, 2025, Evening Shift: Second Floor

39. As a result of the conduct described in paragraphs 3 through 39, Respondent was scheduled for a second orientation that same day with RN K.M. during the Second Floor evening shift.

40. When RN K.M. asked Respondent what she wanted to work on for training, Respondent asked to be responsible for the medication cart and medication administration.

41. RN K.M. agreed and Respondent took custody of the Second Floor medication cart and key and was responsible for administering medications as RN K.M. provided direct patient care.

42. Throughout the evening shift, RN K.M. and LNA T.W. both witnessed Respondent listening to music on her cell phone through earbuds, singing along, dancing down the hallway, and hugging residents.

43. When RN K.M. asked Respondent questions, Respondent did not respond and did not appear to be paying attention.

44. Around dinnertime, RN K.M. discovered that Respondent had not administered medications on time to multiple residents.

45. RN K.M. had assigned Respondent three residents for whom she needed to complete treatment notes in the EHR, which she discovered Respondent failed to complete.

46. Sometime after dinner, LNA T.W. witnessed Respondent crushing all the plastic bubbles on an unidentified medication card.

47. At the end of the shift LPN T. H. arrived to relieve RN K.M. and Respondent.

48. RN K.M. asked Respondent to give the oral shift report to LPN T.H., to which she responded: "oh, I don't know these people, you can give the report."

49. LPN T.H. performed the narcotic count with Respondent and noticed that a medication card containing S.G.'s Oxycodone appeared to have been tampered with: the card looked to have been used, pills reinserted, and the back of the card was taped.

50. LPN T.H. asked Respondent what happened and Respondent did not answer.

51. LPN T.H. examined a second medication card also containing Oxycodone for S.G. and noticed it too had been similarly tampered with.

52. LPN T.H. asked RN K.M. to come review the remaining medication cards in the medication cart and they both noticed multiple cards looked bent, which was abnormal.

53. Respondent left the Second Floor and LPN T.H. and RN K.M. completed the narcotic count together.

54. After further investigation, LPN T.H. and RN K.M. discovered that resident S.G.'s Oxycodone cards had been tampered with by replacing the narcotic with non-narcotic medications, including Hydroxyzine, Prednisone, Meclizine, and Metoprolol, which were all medications available from the medication cart.

55. RN K.M. later told an OPR Investigator that Prednisone and Metropol were contraindicated with medications that some of the residents were prescribed and that, if the medication tampering had not been discovered, it could have caused great harm to the residents.

56. Resident A.K.'s Prednisone card was also discovered to be missing.

Additional Missing Oxycodone

57. On November 9, 2025, RN J.P. discovered someone had handwritten a message on First Floor resident L.K.'s Oxycodone medication card.

58. The message explained that the unidentified writer had accidentally dispensed a tablet and RN J.P. could see that a tablet had been reinserted and taped in place.

59. When she examined the medication card more closely, she could see that, in addition to the tablet that had been taped, the card had been tampered with and the card sides looked like they had been separated.

60. RN J.P. was able to determine by the different colors and sizes of the tablets contained in L.K.'s medication card that seven of the Oxycodone tablets had been replaced with what appeared to be Spironolactone, which is a potassium-sparing diuretic.

61. An OPR Investigator later asked Respondent if she wrote the note on the medication card after dispensing the medication and putting it back, Respondent answered: "yeah, sounds like something I could have done and wrote on the card."

62. In total, the Nursing Home discovered that approximately twenty Oxycodone tablets were unaccounted for after Respondent's shifts on November 7 and 8, 2025, either because they had been recorded by Respondent as being dispensed without also recording their administration or because the tablets were discovered to be missing from the medication cards and replaced with other medications.

63. On January 13, 2026, Respondent's LPN license was indefinitely suspended by stipulated agreement between Respondent and the State.

Violation One: 26 V.S.A. § 1582 (a)(2) Diverting or attempting to divert drugs or equipment or supplies for unauthorized use.

64. Paragraphs 2 through 63 above are incorporated herein.

65. Paragraphs 2 through 63 demonstrate that Respondent diverted a drug for unauthorized use when Respondent dispensed approximately 20 Oxycodone tablets, prescribed to multiple Nursing Home residents, without giving them to the residents, without wasting the tablets, or otherwise accounting for the tablets in the residents' medical records.

66. 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)(2).

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

67. Paragraphs 2 through 63 above are incorporated herein.

68. Paragraphs 2 through 63 demonstrate that Respondent engaged in conduct of a character likely to deceive, defraud, or harm the public when Respondent replaced multiple Nursing Home residents prescribed Oxycodone tablets with non-prescribed medications in the medication cards, failed to dispense and administer resident medications, and failed to document patient care in the residents' Electronic Health Record.

69. 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 Three: 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: performance of unsafe or unacceptable patient or client care.

70. Paragraphs 2 through 63 above are incorporated herein.

71. Paragraphs 2 through 63 demonstrate that Respondent failed to practice competently and performed unsafe and unacceptable patient care when Respondent replaced multiple Nursing Home residents prescribed Oxycodone tablets with non-prescribed medications in the medication cards, failed to dispense and administer resident medications, and failed to document patient care in the residents' Electronic Health Record.

72. 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).

Violation Four: 3 V.S.A. § 129a(a)(15) Failure 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.

73. Paragraphs 2 through 63 above are incorporated herein.

74. Paragraphs 2 through 63 demonstrate that Respondent failed 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 when Respondent replaced multiple Nursing Home residents prescribed Oxycodone tablets with non-prescribed medications in the medication cards, failed to dispense and administer resident medications, and failed to document patient care in the residents' Electronic Health Record.

75. 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).

Understandings

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

77. 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.

78. 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.

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

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

81. 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.

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

83. Respondent understands that she is responsible for all compliance costs associated with this Stipulation and Consent Order.

84. 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 **INDEFINITELY SUSPENDS** Respondent's license to practice as a LPN. Respondent must petition for reinstatement. No sooner than forty-five (45) days prior to requesting reinstatement, Respondent must, at her own cost:

B. Obtain an independent mental health and drug and alcohol evaluation by a pre-approved licensed professional with more than three years of relevant practice experience (Independent Evaluator) who has verified receipt of this Stipulation and Consent Order. The Independent Evaluator must verify that he/she/they has/have no personal or professional background or history with Respondent. The evaluation report shall meet the independent evaluation requirements posted on OPR's website. The results of the Independent Evaluation must indicate that Respondent is fit to practice and does not present a risk to the safety, health, or welfare of Respondent's potential patients/clients, as well as any recommendations that would ensure Respondent remains safe to practice. The evaluation must be submitted to the Enforcement Unit Case Manager.

C. If recommended by an Independent Evaluator, enter into a treating professional agreement and treatment plan with a pre-approved treating professional and follow all recommendations.

D. Submit to the Enforcement Unit Case Manager the results of a minimum of three (3) random urinalyses:

    1. When Respondent is ready to petition for reinstatement, Respondent shall contact the Enforcement Unit Case Manager to set-up the drug and alcohol screen process and receive instructions. Once registered with the pre-approved person or entity, Respondent will have approximately 45 days to submit a minimum of three (3) random urine analyses. The process by which Respondent learns whether he is selected to provide a sample on any given day will be governed by the policy of the pre-approved person or entity conducting the testing at that time.

    2. The drug and alcohol tests must be collected in an observed setting; administered by a pre-approved person or entity; and analyzed by a pre-

approved lab qualified to analyze samples for forensic purposes, the results of which shall be negative.

3. Failure to appear for, refusal to provide, adulteration of, dilution of, or tampering with a sample for any drug and alcohol screen shall cause that screen to be presumed positive.

E. If reinstated, Respondent's license **SHALL BE CONDITIONED** pursuant to whatever terms the Boad finds reasonable at the time of Respondent's reinstatement request, taking into account the information in the petition for reinstatement, supporting documentation, the facts above, and any other factors else the Board deems relevant. Such conditions may include continued mental health treatment such as individual and/or group counseling, coursework, supervised practice, employer reports, limited practice setting/hours, and a restriction against holding supervisory positions.

F. Pursuant to 3 V.S.A. § 125(b)(11), a Disciplinary Action Surcharge in the amount of two-hundred and fifty dollars ($250.00) is assessed against Respondent. Respondent shall remit payment within six (6) months of the date of entry of this Order. Payment of the surcharge may be on a payment plan if needed. Failure to remit payment may result in the non-renewal of Respondent's license/registration.

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

H. 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).

I. This Stipulation and Consent Order applies to all licenses this Board issues to Respondent, including future licenses, as provided in 3 V.S.A. § 129(l).

J. 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: 8/4/2026

Signed by:
Zoe Newman
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Zoe Newman
Prosecuting Attorney

Respondent

VERMONT
SECRETARY OF STATE

Dated: 8/3/2026

DocuSigned by:
ANNEKA BROOKS
87C9491CE0E6478...
Anneka Brooks

APPROVED AND SO ORDERED:

Vermont Board of Nursing

Dated: 8/10/2026

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

Date of Entry: 8/11/26