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

IN RE:	)	
CHRISTOPHER L. POCZOBUT	)	**Docket No. 2025-74**
License No. 025.0009066	)	
	)	

STIPULATION AND CONSENT ORDER

STIPULATION

NOW COME the State of Vermont, by and through Prosecuting Attorney Zoe Newman and Respondent Christopher L. Poczobut, by and through his attorney Ed Adrian, who hereby stipulate and agree as follows:

Board Authority

1. The Board has the authority to issue warnings or reprimands; suspend, revoke, limit, or condition current licenses; or prevent the renewal of lapsed licenses if, after a disciplinary hearing, the Board finds that the Respondent has engaged in unprofessional conduct. 3 V.S.A. § 129(a); 3 V.S.A. § 129a; 3 V.S.A. § 814(d); 26 V.S.A. Chapter 28; the Administrative Rules of the Board of Nursing (the ARBN); and the Rules of the Office of Professional Regulation (OPR Rules).

Alleged Facts

2. Christopher L. Poczobut (Respondent) of Whitehall, New York is licensed by the State of Vermont as a Licensed Practical Nurse (LPN) under license number 025.0009066. This license was first issued on October 4, 2006, and expires on January 31, 2026.

3. On May 12, 2025, the Board of Nursing held a contested hearing on the State's Request for Summary Suspension of Respondent's license, after which, the Board granted the request and suspended Respondent's license.

4. At all times relevant, Respondent was employed as an LPN by a facility in Rutland, Vermont (Facility).

5. On Wednesday, February 5, 2025, Respondent worked from 2 p.m. until 10:30 p.m.

6. On both Saturday and Sunday, February 8 and 9, 2025, Respondent worked from 6 a.m. until 10:30 p.m.

7. At all times relevant, N.F. resided at the Facility.

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8. At all times relevant, N.F.'s medication order included Methylphenid, otherwise known as Ritalin, in 10mg tablets, with directions that N.F. take one tablet by mouth four times daily as needed.

9. Ritalin is a Schedule II controlled substance according to the Controlled Substance Act.

10. The Facility nursing staff was responsible for the safe-keeping, monitoring, and administration of N.F.'s Ritalin prescription; this included tracking the number of tablets remaining, who dispensed the tablets (meaning who removed the medication from the medication cart), who gave the tablets to N.F., how many tablets were given, and when the tablets were given.

11. When a nurse dispensed N.F.'s Ritalin, the nurse was required to record the date, time, dose, remaining number of tablets, and the nurse's signature on the handwritten Narcotic Log.

12. When a nurse gave the Ritalin to N.F., the nurse was required to record that they gave N.F. the medication on the electronic Medication Administration Record (eMAR); the eMAR recorded the date, time, and nurse's initials.

13. On February 5, when Respondent began his shift, N.F.'s Ritalin Narcotic Log showed that 115 tablets remained.

14. On February 5, per the Narcotic Log, Respondent dispensed one tablet of Ritalin twice for N.F. – first at 4:50 p.m. when Respondent recorded 114 tablets remaining. and next at 7 p.m. when Respondent recorded 112 tablets remaining.

15. Respondent signed both entries on the Narcotic Log and his initials are in the corresponding eMAR entries.

16. Despite N.F.'s prescribed dose of one tablet and Respondent recording only giving N.F. one tablet at 7 p.m., Respondent recorded the tablet count as 112 at 7 p.m. indicating that Respondent dispensed two tablets.

17. Respondent never accounted for the second tablet he dispensed at 7 p.m.

18. At the beginning of Respondent's shift on February 8, 2025, N.F.'s Ritalin Narcotic Log indicated that there were 106 tablets remaining.

19. At the end of Respondent's shift on February 8, 2025, the Narcotic Log indicated 100 tablets remained, meaning Respondent dispensed six tablets of N.F.'s Ritalin during his shift.

20. According to the Narcotic Log on February 8, 2025, Respondent dispensed Ritalin four separate times, however, the eMAR shows that Respondent only gave N.F. three doses of Ritalin.

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21. Respondent signed all four entries on the Narcotic Log and his initials are in the three existing eMAR entries, which correspond to the first, second, and fourth Narcotic Log entries.

22. Respondent recorded that he gave N.F. one tablet of Ritalin three times during his shift and Respondent never accounted for the remaining three of the six tablets of Ritalin he dispensed that day.

23. At the beginning of Respondent's shift on February 9, 2025, N.F.'s Ritalin Narcotic Log indicated that there were 100 tablets remaining.

24. At the end of Respondent's shift on February 9, 2025, there were 95 tablets remaining, meaning Respondent dispensed five tablets of N.F.'s Ritalin that day.

25. Respondent only recorded in the eMAR giving N.F. four Ritalin tablets and Respondent never accounted for the fifth dispensed dose.

26. Respondent signed all four entries on the Narcotic Log and his initials are in the corresponding eMAR entries.

27. In total, for February 5, 8, and 9, 2025, there were five Ritalin tablets that Respondent dispensed but were not given to N.F. to take and were not otherwise accounted for.

28. In separate conversations, first with the Facility's Director of Nursing (DON) and later with OPR Investigator K.B, Respondent admitted to dispensing the Ritalin in excess of what was prescribed and not wasting the medication.

29. In two separate conversations with the DON, Respondent stated that he could have either taken the missing Ritalin himself or given it to another patient.

30. Respondent explained he was taking Dayquil and Nyquil regularly during his shifts that week as well as taking both medications off and on for the preceding six months.

31. Respondent explained that he was impaired and did not remember much of his shifts.

32. On March 6, 2025, Respondent reiterated to OPR Investigators K.B and M.D. that Respondent was impaired and barely remembers working the shifts in question.

33. Referring to the Narcotic Log entries in question which show the extra Ritalin Respondent dispensed, Respondent told the OPR Investigators it was "super sloppy," "not right," and "that's my bad, that's on me."

34. Respondent told the OPR Investigators about feeling "off" and, when asked if he felt like he could go back to work presently, he answered "no."

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35. OPR Investigator K.B. spoke with Facility resident N.F. about her Ritalin prescription and N.F. demonstrated a thorough understanding of her dosage.

36. When asked by Investigator K.B. whether N.F. would take more than her prescribed dose if a nurse gave it to her, N.F. stated she would not take more as she knows what her dose is supposed to be.

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

37. Paragraphs 2 through 36 above are incorporated herein.

38. Paragraphs 2 through 36 demonstrate that Respondent diverted a drug for unauthorized use when Respondent dispensed five of N.F.'s prescribed Ritalin tablets without giving them to N.F, without wasting the tablets, or otherwise accounting for the tablets.

39. 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.

40. Paragraphs 2 through 36 above are incorporated herein.

41. Paragraphs 2 through 36 demonstrate that Respondent engaged in conduct of a character likely to deceive, defraud, or harm the public when Respondent worked as an LPN for the Facility while impaired and when Respondent dispensed five of N.F.'s prescribed Ritalin tablets without giving them to N.F, without wasting the tablets, or otherwise accounting for the tablets.

42. 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. § 2431(b)(3).

Violation Three: 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.

43. Paragraphs 2 through 36 above are incorporated herein.

44. Vermont law requires a Licensed Practical Nurse to comply with the rules governing the practice of the profession.

45. The Vermont *Administrative Rules of the Board of Nursing*, Rule 11-4, states: "A licensee shall practice as a nurse . . . only when fit to work. Fitness includes the ability to collect data, notice detail, analyze information, solve problems, and respond rapidly to hazards to patient safety or wellbeing. Fitness may be impaired

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by fatigue, stress, alcohol, drugs, physical impairment, medical condition, or emotional state."

46. The Vermont *Administrative Rules of the Board of Nursing*, Rule 11-4(a) requires that a nurse do the following:
(1) Assure his or her ongoing wellness and fitness for work, by such means as such as getting adequate rest, seeking treatment for medical conditions, seeking counseling for emotional problems, managing stress, and avoiding substances and activities that may impair fitness for work;
(2) Notify the manager, supervisor, or responsible person of any concerns regarding his or her fitness for work and request appropriate accommodations, as needed;
(3) Refuse an assignment, if not fit to competently and safely perform the assignment[.]

47. Paragraphs 2 through 36 demonstrate that Respondent failed to comply with the rules governing the profession when Respondent worked multiple shifts while impaired by Dayquil, Nyquil, and/or fatigue instead of notifying his supervisor of his unfitness to practice.

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

49. Paragraphs 2 through 36 above are incorporated herein.

50. Essential standards of acceptable and prevailing practice require a nurse to ensure their ongoing wellness and fitness to work and, if not well or not fit to work, that the nurse notify their supervisor of their unfitness to practice.

51. Paragraphs 2 through 36 demonstrate that Respondent failed to conform to the essential standards of acceptable and prevailing practice when Respondent worked multiple shifts while impaired by Dayquil, Nyquil, and/or fatigue instead of notifying his supervisor of his unfitness to practice.

52. 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

1. 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. Respondent agrees the Order below is necessary to protect the public.

2. 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.

3. 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.

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

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

6. 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.

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

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

9. 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 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 his own cost:

   1. Obtain an independent mental health and drug and alcohol evaluation by a pre-approved licensed professional with more than ten years of relevant practice experience (Independent Evaluator) who has verified receipt of this

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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.

2. 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.

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

    a. 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.

    b. 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.

    c. 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.

B. 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.

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

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D. 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).

E. 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.

F. 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(I).

G. Pursuant to 3 V.S.A. § 125(b)(11) and 3 V.S.A. § 129(a)(3), a Disciplinary Action Surcharge in the amount of two hundred and fifty dollars ($250.00) is assessed against Respondent. Respondent shall remit payment within 180 days 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/credential.

AGREED TO:

STATE OF VERMONT
SECRETARY OF STATE

Dated: 1/20/2026 By: Zoe Newman
Zoe Newman
Prosecuting Attorney

ATTORNEY FOR RESPONDENT

Dated: 01/20/2026 By: _____
Ed Adrian, Esq.

RESPONDENT

Dated: 1-20-2026 By: _____
Christopher Poczobut

APPROVED AND SO ORDERED:

VERMONT BOARD OF NURSING

Dated: 2/10/2026 By: Signed by: William James Floyd III
3B82E78300124BE...
Chairperson

Date of Entry: 2/11/2026

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IN RE:	)	
CHRISTOPHER L. POCZOBUT	)	**Docket No. 2025-74**
License No. 025.0009066	)	
	)	

SPECIFICATION OF CHARGES

NOW COMES the State of Vermont and hereby makes the following charges against Respondent Christopher L. Poczobut:

Board Authority

1. The Board has the authority to issue warnings or reprimands; suspend, revoke, limit, or condition current licenses; or prevent the renewal of lapsed licenses if, after a disciplinary hearing, the Board finds that the Respondent has engaged in unprofessional conduct. 3 V.S.A. § 129(a); 3 V.S.A. § 129a; 3 V.S.A. § 814(d); 26 V.S.A. Chapter 28; the Administrative Rules of the Board of Nursing (the ARBN); and the Rules of the Office of Professional Regulation (OPR Rules).

Statement of Facts

2. Christopher L. Poczobut (Respondent) of Whitehall, New York is licensed by the State of Vermont as a Licensed Practical Nurse (LPN) under license number 025.0009066. This license was first issued on October 4, 2006, and expires on January 31, 2026.

3. On May 12, 2025, the Board of Nursing held a contested hearing on the State's Request for Summary Suspension of Respondent's license, after which, the Board granted the request and suspended Respondent's license.

4. At all times relevant, Respondent was employed as an LPN by a facility in Rutland, Vermont (Facility).

5. On Wednesday, February 5, 2025, Respondent worked from 2 p.m. until 10:30 p.m.

6. On both Saturday and Sunday, February 8 and 9, 2025, Respondent worked from 6 a.m. until 10:30 p.m.

7. At all times relevant, N.F. resided at the Facility.

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8. At all times relevant, N.F.'s medication order included Methylphenid, otherwise known as Ritalin, in 10mg tablets, with directions that N.F. take one tablet by mouth four times daily as needed.

9. Ritalin is a Schedule II controlled substance according to the Controlled Substance Act.

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11. When a nurse dispensed N.F.'s Ritalin, the nurse was required to record the date, time, dose, remaining number of tablets, and the nurse's signature on the handwritten Narcotic Log.

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13. On February 5, when Respondent began his shift, N.F.'s Ritalin Narcotic Log showed that 115 tablets remained.

14. On February 5, per the Narcotic Log, Respondent dispensed one tablet of Ritalin twice for N.F. – first at 4:50 p.m. when Respondent recorded 114 tablets remaining. and next at 7 p.m. when Respondent recorded 112 tablets remaining.

15. Respondent signed both entries on the Narcotic Log and his initials are in the corresponding eMAR entries.

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

37. The State re-alleges and incorporates Paragraphs 2 through 36 above.

38. Paragraphs 2 through 36 demonstrate that Respondent diverted a drug for unauthorized use when Respondent dispensed five of N.F.'s prescribed Ritalin tablets without giving them to N.F, without wasting the tablets, or otherwise accounting for the tablets.

39. 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.

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51. Paragraphs 2 through 36 demonstrate that Respondent failed to conform to the essential standards of acceptable and prevailing practice when Respondent worked multiple shifts while impaired by Dayquil, Nyquil, and/or fatigue instead of notifying his supervisor of his unfitness to practice.

52. 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).

Relief Requested

WHEREFORE, the license of Christopher L. Poczobut should be warned,

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reprimanded, suspended, revoked, limited, conditioned, or otherwise disciplined.

DATED 28th day of May, 2025.

STATE OF VERMONT
SECRETARY OF STATE

By: Zoe Newman
Zoe Newman
Prosecuting Attorney
Zoe.newman@vermont.gov

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