

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

IN RE:
TARA ANN CROSS
License No. 025.0008968

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Docket No. 2011-741

STIPULATION AND CONSENT ORDER

Stipulation

NOW COME the State of Vermont, by and through State Prosecuting Attorney Gabriel M. Gilman and the Respondent, Tara Ann Cross, LPN, by and through Attorney Bret P. Powell, who stipulate and agree as follows:

Board Authority

1. The Vermont State Board of Nursing ("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.

Statement of Facts

2. Tara Ann Cross ("Respondent") of Shrewsbury, Vermont is licensed by the State of Vermont as a Licensed Practical Nurse under license number 025.0008968. This license was originally issued on or about August 4, 2006 and expires on January 31, 2014.
3. At all times relevant, Respondent was employed as a Licensed Practical Nurse by TLC Nursing Associates in South Burlington, Vermont and worked at Helen Porter Healthcare and Rehabilitation (the "Facility") in Middlebury, Vermont.
4. On or about October 1, 2011, Respondent provided nursing care to patient E.J., a dementia patient who was agitated and disrobing. E.J. was prescribed Roxanol and Ativan on an as-needed (PRN) basis to address this behavior.
5. On or about October 1, 2011, beginning at approximately 1700 hours, Respondent began administering Roxanol and Ativan to E.J. every 15 minutes. Respondent administered six (6) 1-mL doses of Roxanol, each milliliter of solution containing 20 mg of Roxanol. Respondent also administered six (6) 1-mL doses of Ativan, each milliliter of solution containing 2 mg of Ativan. Respondent administered a total of 120 mg of Roxanol and 12 mg of Ativan to E.J. between 1700 hours and 1815 hours. This dosage was highly unusual but also within the upper limit established by a literal reading of the governing physician's order.

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6. In her nursing notes, Respondent noted that E.J. was experiencing restlessness and was stripping off her clothes. On one administration, Respondent noted pain. Respondent did not, however, provide observational data to explain the PRN administration of very high aggregate doses of Roxanol and Ativan ultimately delivered to the patient.
7. Respondent forgot to sign the narcotic book entries for Ativan for all six times the drug was administered. Respondent was allowed to sign the entries on or about October 5, 2011.
8. On or about April 30, 2012, in an interview with Investigator John Lewis of the Office of Professional Regulation, Respondent acknowledged that she forgot to sign the narcotics book for all six instances in which she administered the Ativan to E.J. Respondent stated that she had drafted a longer nursing note to justify the amount of medication she had administered to E.J., but the note did not save in the electronic medical record.
9. Respondent acknowledges that the essential standard of acceptable and prevailing nursing practice in the context described above include expectations that (1) a nurse should sign narcotic logs contemporaneous to administration, and (2) a nurse should make observational notes explaining each administration of PRN Ativan and Roxanol.

Violations

10. 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. 26 V.S.A. § 1582(a)(3) (Is unable to practice nursing competently by any reason of any cause) which includes failing to conform to the essential standards of acceptable and prevailing nursing practice pursuant to ARBN Rule 11.2(b)(2);
 - b. 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

11. Respondent admits that the facts above are true.
12. 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.
13. 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.

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14. Respondent has read and reviewed this entire document and agrees that it contains the entire agreement between the parties.
15. Respondent is not under the influence of any drugs or alcohol at the time she signs this Stipulation and Consent Order.
16. 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.
17. 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.
18. Respondent agrees that the Order set forth below may be entered by the Board.

ORDER

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

- A. The Board of Nursing hereby **WARNS** the Respondent's license.
- B. Respondent's license is **CONDITIONED** as follows:
 - a. Respondent shall, at her own expense, complete three (3) courses pre-approved by the Board or its delegate as reasonably related to medication administration, narcotics management, documentation, and best practices for electronic medical records. The first course is to be completed within thirty days of the entry of this Order, the second within sixty days, and the third within ninety days. Respondent shall provide documentation confirming course completion as it becomes available. Failure to complete the described coursework within the prescribed timeframe shall constitute a violation of this Order.
 - b. Upon receipt of satisfactory evidence that Respondent has completed the described courses, the Board's Executive Director or other designee shall terminate the conditions upon Respondent's license and restore the license to unencumbered status.
- C. Notwithstanding any provision above, the Respondent must continue to meet all Nursing Board requirements for maintaining a license, license renewal and license reinstatement.
- 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.

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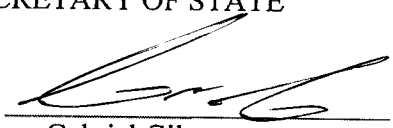


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AGREED TO:

Dated: June 10, 2013

STATE OF VERMONT
SECRETARY OF STATE

By: 
Gabriel Gilman
State Prosecuting Attorney

TARA ANN CROSS
RESPONDENT

Dated: June 10, 2013

By: Tara Ann Cross
Tara Ann Cross

APPROVED AS TO FORM:

Dated: June 10, 2013

BRET P. POWELL, ESQ.
ATTORNEY FOR RESPONDENT

By: Bret P Powell
Bret P. Powell, Esq.
Powell Orr & Bredice PLC

APPROVED AND SO ORDERED:

Dated: 6/10/13
Date of Entry: 6/10/13

VERMONT BOARD OF NURSING

By: Janine Carr
Chairperson

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