

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

IN RE:)
LINDA G. HORTON) Docket No. 2011-266
License No. 025.0004648)

STIPULATION AND CONSENT ORDER

STIPULATION

NOW COMES the State of Vermont, by and through State Prosecuting Attorney S. Lauren Hibbert, and the Respondent, Linda G. Horton, LPN, 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. Linda G. Horton (the "The Respondent") of Brandon, Vermont is licensed by the State of Vermont as a Licensed Practical Nurse under license number 025.0004648. This license was originally issued on or about May 15, 1979 and is currently set to expire on or about January 31, 2012.
3. At all times relevant, the Respondent was employed as a Licensed Practical Nurse at Helen Porter Healthcare & Rehabilitation Center (the "Facility"), located in Middlebury, Vermont.
4. On or about April 26, 2011, the Office of Professional Regulation received a Mandatory Report of Unprofessional Conduct alleging that the Respondent failed to notify a family member of a patient's impending death and failed to respond to a patient who was having a rectal bleed.
5. On or about June 20, 2011, in an interview with State Investigator Laura Pezzulo, Registered Nurse H.Q. stated that on or about March 30, 2011 the Respondent was responsible for the care of patient 1 who was dying. The patient's son had

STATE OF VERMONT



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asked that he be notified if there was a change in his mother's status so he could return to the Facility before her death. During the Respondent's shift a Licensed Nursing Assistant notified the Respondent that the patient was declining, the Respondent failed to call the patient's son, and the patient died.

6. On or about July 18, 2011, in an interview with Investigator Pezzulo, the Respondent stated that a LNA had notified her of a change in patient 1 and that she was assessing the patient every hour. The Respondent stated that she did not see signs that "death was imminent" although she did medicate the patient several times for increased anxiety. The Respondent admitted that she did not call the patient's son and told Investigator Pezzulo that she "probably should have."
7. On or about July 29, 2011, in an interview with Investigator Pezzulo, Licensed Nursing Assistant E.L. stated that she went to the Respondent to ask for help with patient 2 who had a rectal bleed and the Respondent responded by saying "yes" but then just sat there. E.L. stated she did not know what to do, so she sought out help from another nurse, F.K.
8. On or about July 29, 2011, in an interview with Investigator Pezzulo, Registered Nurse F.K. stated that on or about March 29, 2011 she was told of patient 2 who had a rectal bleed that needed a nurse's immediate attention. F.K. responded to the patient's needs and instructed others on how to clean up the bathroom. F.K. stated that the Respondent called the physician; however, F.K. does not believe an accurate account of the patient's condition was given to the physician because the physician's response that she was not coming in and to call if the patient's condition worsened. For that reason, F.K. asked Licensed Practical Nurse K.J. to call the physician again and after hearing K.J.'s assessment of the patient the physician came to the Facility to treat the patient.
9. On or about July 18, 2011, in an interview with Investigator Pezzulo, the Respondent stated that on or about March 29, 2011 and March 30, 2011, when both of the above incidents occurred, she was not feeling well and did not feel "up to assessing properly."
10. Respondent has committed unprofessional conduct because when she failed to properly respond to a patient having a rectal bleed and patient dying she provided unsafe and unacceptable patient care. Additionally, she failed to comply with the rules and statutes governing the practice of profession.

Violations

11. 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:

STATE OF VERMONT



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- 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); and
- b. 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).

Understandings

12. 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.
13. 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.
14. 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.
15. Respondent has read and reviewed this entire document and agrees that it contains the entire agreement between the parties.
16. Respondent is not under the influence of any drugs or alcohol at the time she signs this Stipulation and Consent Order.
17. 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.
18. 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.
19. 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 **WARNS** the Respondent's license to practice nursing.
- 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: 2/29/12

STATE OF VERMONT
SECRETARY OF STATE

By: S. Lauren Hibbert
S. Lauren Hibbert
State Prosecuting Attorney

LINDA G. HORTON
RESPONDENT

Dated: 2-24-12

By: Linda G. Horton
Linda G. Horton

APPROVED AND SO ORDERED:

Dated: 3-5-12

VERMONT BOARD OF NURSING

By: Janine Carr
Chairperson

Date of Entry: 3-5-12

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