

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

IN RE:)
DEBORAH L. LEMERY)
License No. 026.0019859)

Docket No. 2013-482

STIPULATION AND CONSENT ORDER

STIPULATION

NOW COME the State of Vermont, by and through State Prosecuting Attorney S. Lauren Hibbert, and the Respondent, Deborah L. Lemery, RN, 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. Deborah L. Lemery (the "Respondent") of Essex Junction, Vermont is licensed by the State of Vermont as a Registered Nurse under license number 026.0019859. This license was originally issued on or about December 11, 1990 and expires on March 31, 2017.
3. At all times relevant, Respondent was employed as a registered nurse at Pillsbury Senior Community located in South Burlington, Vermont (the "Facility") and Respondent worked at the Facility in the capacity of Administrator.
4. Acting in her capacity as Administrator, Respondent is responsible for training medication technicians.
5. The Facility had a patient (S.L.) in its care since August 30, 2012. S.L. had severe chronic obstructive pulmonary disease.
 - a) On January 29, 2013, S.L. had an order for Morphine 10mg/5ml: 2mg/1ml to be given by mouth every 2 hours as needed for increased shortness of breath.
 - b) On February 10, 2013, S.L. was admitted to the hospital and was discharged to the Facility on February 14, 2013 on hospice/comfort care.

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- c) Upon discharge from the hospital, S.L.'s previous Morphine order was discontinued and new Morphine orders were written for morphine at 10 times the previous concentration. The new order was for Morphine 100 mg/5ml (20 mg/ml) give 2 mg/0.1 ml by mouth every 2 hours for mild to moderate pain or shortness of breath and Morphine 100 mg/5 ml (20 mg/ml) give 4 mg/0.2 ml by mouth every 2 hours as needed for moderate to severe pain or shortness of breath.
 - d) On or about February 15, 2013, E.B., an unlicensed medication technician administered Morphine 20mg at 0700, 0900, and 1130 to S.L.
 - e) E.B. signed the MAR as administering 2mg of Morphine. Shortly after administering the 1130 dose, E.B. recognized her error and reported it immediately.
 - f) S.L. died at around 2200 on February 15, 2013. The Morphine overdose was determined to be the primary cause of death.
 - g) E.B. was informed that S.L.'s Morphine concentration had been modified upon discharge from the hospital but with limited details. E.B. was not shown how to correctly administer the correct dose of Morphine.
6. Respondent was Administrator of the Facility. According to a Facility protocol titled, "Medication Administration by unlicensed staff," unlicensed staff may administer medications under the following conditions:
- a) The Administrator, a Registered Nurse, conducts an assessment consistent with the physician's diagnosis and orders of the resident's care needs...
 - b) The Administrator, a Registered Nurse, delegates the responsibility for the administration of specific medications to designated staff for designated residents.
 - c) The Administrator, a Registered Nurse, accepts full responsibility for the proper administration of medications, and is responsible for overseeing the medication program as carried out by a designated licensed nurse...
7. Essential standards of nursing practice require that the delegating nurse assures that the delegate has the appropriate knowledge, skills, and abilities to safely perform the delegated tasks. When delegating medication administration, the delegating nurse must assure that the delegate is able to administer the correct medication, correct resident, correct dose, correct time, and correct route. Additionally, the essential standards of nursing practice require that family members are notified promptly when a life-threatening medication error occurs.

Violations

8. 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:

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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(6) (Delegating professional responsibilities to a person whom the licensed professional knows, or has reason to know, is not qualified by training, experience, or licensing credentials to perform them, or knowingly providing professional supervision or serving as a preceptor to a person who has not been licensed or registered as required by the laws of that person's profession).

Understandings

9. Respondent admits that the facts above are true and that the conditions below are necessary to protect the public.
10. 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.
11. 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.
12. Respondent has read and reviewed this entire document and agrees that it contains the entire agreement between the parties.
13. Respondent is not under the influence of any drugs or alcohol at the time she signs this Stipulation and Consent Order.
14. 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.
15. 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.
16. 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.

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- 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:

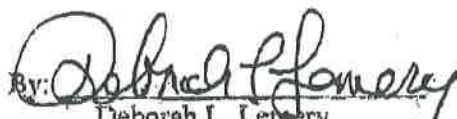
STATE OF VERMONT
SECRETARY OF STATE

Dated: 3/10/16

By: 
S. Lauren Hibbert
State Prosecuting Attorney

DEBORAH L. LEMERY
RESPONDENT

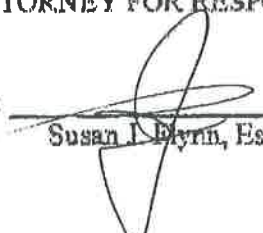
Dated: 3/9/16

By: 
Deborah L. Lemery

APPROVED AS TO FORM:

ATTORNEY FOR RESPONDENT

Dated: 3-10-14

By: 
Susan J. Flynn, Esq.

APPROVED AND SO ORDERED:

VERMONT BOARD OF NURSING

Dated: 3/14/16
Date of Entry: 3/14/16

By: 
Chairperson

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