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

IN RE:	)	
JED W. LOWY	)	**Docket No. 2016-171**
License Nos 101.0011353	)	**2016-677**
026.0011353	)	

STIPULATION AND ORDER

STIPULATION

NOW COME the State of Vermont, by and through State Prosecuting Attorney Elizabeth A. St. James, and the Respondent, Jed Lowy, APRN, represented by Nicole Andreson, Esq., 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. Jed W. Lowy ("Respondent") of South Burlington, Vermont is licensed by the State of Vermont as an Advance Practice Registered Nurse ("APRN") under license number 101.0011353. This license was originally issued February 4, 1985 and expires on March 31, 2019. Respondent is also licensed as a Registered Nurse ("RN") under license number 026.0011353. This license was originally issued on February 4, 1976 and expires on March 31, 2019.

3. At all times relevant, Respondent was employed as an APRN by Correct Care Solutions ("CCS"). At all times relevant, CCS was the contract healthcare provider for Chittenden Regional Correctional Facility ("CRCF" or "Facility") located in South Burlington, Vermont. Respondent, along with an Osteopathic Physician and another APRN were the CCS on-site medical providers at CRCF.

4. For purposes of this case only, Respondent does not dispute that the State could prove the following facts and charges by a preponderance of the evidence if this matter were adjudicated at a hearing.

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5. While not disputed for purposes of this case only, many of the facts set forth below were not known to Respondent during the relevant times.

6. On December 29, 2014, Patient entered CRCF to begin a seventeen (17) day sentence of incarceration. Upon her admission to the Facility, Patient was placed on a COWS ("Clinical Opiate Withdrawal Scale") protocol for opiate detoxification.

7. Patient was known to some medical staff from previous incarcerations; however, Patient was not known to Respondent.

8. Patient had Type 1 diabetes.

9. On December 30, 2014, Patient underwent a "Receiving Screening." The Screening documents revealed that Patient previously had a diagnosis of Diabetes Mellitus and was currently taking two forms of insulin: (1) Lantus and (2) Novolog. Patient reported last taking her insulin on December 28, 2014.

10. Patient also disclosed to the screener that she had been hospitalized in 2014 for diabetes.

11. At the time of her incarceration, Patient was an active heroin user and appeared disheveled and lethargic. In addition to her history of Type 1 diabetes, Patient had a history of mental health issues, substance abuse, non-compliance with her diabetic treatment, and prior hospitalizations for diabetic ketoacidosis.

12. Respondent's first encounter with Patient occurred on December 30, 2014. At that time, he obtained a history from Patient. She was communicative and alert throughout their encounter, and her vital signs were normal. Patient had just received an injection of Novolog due to a blood sugar reading of 429, and disclosed that she had been hospitalized for diabetes in 2014 because her blood sugar was over 1100. Patient refused to undergo a complete physical examination, stating that she was in "extreme arm pain." According to Patient, she "fell" on her "shoulder" when she was leaving the hospital, and had been evaluated in the emergency department and discharged with instructions to take acetaminophen. Respondent performed as much of a physical examination on Patient as she would permit, and entered as much information as he could on CCS's medical history & physical assessment form for Patient.

13. Respondent documented on CCS's form that Patient had refused to undergo a complete examination. In doing so, Respondent documented that the potential consequences of her refusal, i.e., worsening of medical conditions, had been explained to Patient. Respondent also encouraged Patient to comply with her diabetic treatment and documented that he would not prescribe any additional pain medication beyond her current acetaminophen.

14. On December 31, 2014, while housed in the Foxtrot Unit, Patient reported falling off of her cell bunk.

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15. Patient reported suffering from a stiff neck, which seemed to be a result of both her pre-incarceration fall and this fall.

16. She was moved to the infirmary where she remained until January 1, 2015, when she was moved back to Foxtrot at approximately 09:00.

17. While at the infirmary, Patient was irritable and uncooperative, repeatedly ringing the call bell yet not appearing in as much pain as she was reporting.

18. On January 1, 2015, at approximately 14:10, Patient was moved from Foxtrot to the Alpha Unit after she threatened to punch her roommate.

19. The Alpha Unit is a segregated unit with twenty-four (24) hour video surveillance. Patient remained in the Alpha Unit for the remainder of her incarceration.

20. Patient remained on COWS protocol until January 2, 2015. During this time period, Patient was inconsistent in her diabetic care compliance and refused several assessments by nursing staff. She made comments such as "I just want to die" and was subject to 15 minute mental health checks during this period of time.

21. On January 2, 2015, Patient was screened by M.L., a licensed clinical social worker, and was taken off of 15 minute mental health checks at this time because she did not have current suicidal ideations.

22. M.L. observed that Patient was not cooperative in her diabetic care.

23. Throughout Patient's incarceration at CRCF she had multiple blood glucose readings in the 400s, 500s, and HIGH, and was inconsistent in complying with her diabetic care.

24. Beginning on January 3, 2015 and ending on January 6, 2015, Patient exhibited signs of extreme thirst and was frequently urine soaked to the extent that urine pooled on her plastic mattress and extended up her clothing into her hair. However, nursing notes on January 6, 2015, document that Patient's mucous membranes were moist and pink, her vital signs were normal, she appeared to be well nourished and hydrated, she was alert and communicative, her radial pulse was equal and strong, and her breathing was even and unlabored.

25. During this same time period, Patient also began to have increasing difficulty walking in her cell and getting out of bed. She was, however, able to get up to walk around her cell and get her breakfast tray on the morning of January 6, 2015.

26. On January 4, 2015, Licensed Practical Nurse ("LPN") H.H. called Dr. M.R., the off-site provider, due to Patient's elevated blood sugar readings. Dr. M.R. directed H.H. to have an on-site provider call him. H.H. documented this directive in the nurse to provider communication tool ("SINPO"). At shift change, H.H. told Registered Nurse ("RN") A.S. that Dr. M.R. wanted to talk to the on-site provider with regard to Patient's care plan.

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27. On January 4, 2015, RN A.S. recalls telling Respondent that Dr. M.R. wanted to talk to Respondent in the morning of January 4, 2015, because he was the on-site provider. Respondent does not recall this conversation with RN A.S.

28. The Respondent does not recall calling Dr. M.R.

29. On or about January 4, 2015, Patient was put on Respondent's schedule due to her elevated blood sugar levels. Patient refused to come to the health center to be seen for her elevated blood sugars. Respondent completed a progress note documenting Patient's refusal to be seen. He also co-signed a refusal of treatment form, along with a registered nurse, which stated that Patient "refused to come to the health center."

30. Patient did not sign the refusal form and there is no time listed on the form.

31. Respondent did not evaluate or speak with Patient prior to signing the refusal form.

32. On January 4, 2015, Respondent received an on-call page from a nurse about Patient at approximately 8:30 p.m. The nurse reported that Patient's blood sugar had been low and that she had been given a snack. The nurse also told Respondent that she had just rechecked Patient and her blood sugar was "HIGH" again. The nurse advised that she had just given Patient her nighttime Lantus and Novolog and wanted to know if anything further should be done. In response, Respondent ordered "recheck finger stick in one hour" and did not receive any additional pages or inquiries about Patient that night. He did not alter Patient's treatment plan or make any further attempts to evaluate her that evening.

33. Between January 4, 2015 and January 6, 2015, it is documented that Patient refused her diabetic treatment on four occasions. Patient did not sign any of the refusal forms. During this time, Patient had multiple blood glucose readings in the 400s, 500s, and High, was very thirsty, and was in pain.

34. On January 6, 2015, at approximately 08:04, Patient was transferred to a wheelchair in her cell and was brought to the health center after receiving a shower. Respondent was her care provider for this visit.

35. Patient presented to Respondent unkempt with her hair uncombed and slumped in her wheelchair. Respondent does not recall that Patient smelled of urine, particularly since she had just received a shower and fresh set of clothes. Respondent, however, was aware that Patient had been incontinent.

36. Respondent arranged to have a mental health worker present during his encounter with Patient based on Respondent's concerns about Patient's mental well-being and his belief that mental health treatment may assist in obtaining her adherence to diabetic treatment.

37. Patient complained that she was not receiving adequate pain and diabetes management, stating that "people here can't get their shit together."

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38. During their encounter, Respondent was able to convince Patient to accept diabetic testing and treatment as prescribed.

39. Respondent also massaged Patient's neck in an attempt to relieve her neck pain.

40. Respondent's progress note for this visit focused on Patient's description of pain, given Patient's multiple requests to be seen for pain. Respondent also noted that Patient was noncompliant in her diabetic care and encouraged her to become compliant. Respondent did not take further actions to address Patient's diabetes during their encounter. There were standing orders to have Patient's blood checked multiple times per day, which would have permitted medical/nursing staff to follow-up as warranted.

41. At the conclusion of the appointment, a correctional staff member claims that Respondent stated: "I'm not dealing with it" and "she is playing possum." Respondent disputes this claim and contends that he was trying his best to evaluate and treat Patient under challenging circumstances, which included a discussion with nursing staff about her presentation and history of contradictory symptom complaints.

42. At the suggestion of the Respondent, Correctional staff was provided with Depend undergarments for Patient at the end of the visit.

43. At no time did Respondent order Patient to be taken to the infirmary. It was Respondent's understanding that the infirmary was not regularly staffed at that time, preventing close monitoring of the Patient.

44. At no time did Respondent order Patient to be transported to a hospital emergency department.

45. On January 6, 2015, Patient was returned to her segregated cell, slumped in a wheelchair, at approximately 09:44 after visiting with Respondent in the health center.

46. After Respondent's encounter with Patient in the health center on the morning of January 6, 2015, he did not see or have any further contact with her again, nor did he receive any additional information or inquiries about her.

47. Correctional Officers lifted Patient out of her wheelchair and placed her on the concrete floor of her cell, where she remained until she was found unresponsive at 08:11 on January 7, 2015.

48. Emergency Medical Services responded to CRCF and Patient was taken to UVM Medical Center.

49. Patient died on January 9, 2015. The autopsy report indicates that her cause of death was Diabetes Mellitus.

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Violation One: 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: (2) failure to conform to the essential standards of acceptable and prevailing practice.

50. The State re-alleges and incorporates Paragraphs 2 through 49 above.

51. The essential standards of acceptable and prevailing practice require that when faced with a patient who is refusing care, a nurse must provide that patient with education regarding the consequences of refusing care. A nurse must document that a patient has been provided with this education.

52. Respondent does not dispute that the State could demonstrate that he failed to meet this standard by engaging in the conduct stated in Paragraphs 29 through 49 above.

53. The essential standards of acceptable and prevailing practice require that an APRN must (1) provide an assessment of health status; (2) make a diagnosis; (3) develop a treatment plan; (4) implement the treatment plan; and (5) follow-up on the treatment plan and evaluate the patient.

54. Respondent does not dispute that the State could demonstrate that he failed to meet this standard by engaging in the conduct stated in Paragraphs 2 through 49 above.

55. When treating a diabetic patient who is refusing care, soaked in urine, lethargic, and exhibiting signs of extreme thirst, the essential standards of acceptable and prevailing practice require that a provider obtain both a urine and blood sample.

56. Respondent does not dispute that the State could demonstrate that he failed to meet this standard by engaging in the conduct stated in Paragraphs 2 through 49 above.

57. The essential standards of acceptable and prevailing practice require APRNs to take into account all of a patient's symptoms and overall presentation when treating a patient and developing a treatment plan.

58. Respondent does not dispute that the State could demonstrate that he failed to meet this standard by engaging in the conduct stated in Paragraphs 2 through 49 above.

59. Respondent does not dispute that the State could demonstrate that the act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline based on unprofessional conduct in violation of 3 V.S.A. §129a(b)(2).

Understandings

60. 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. Respondent has worked in the nursing field for approximately 40 years. For many of those years, Respondent has provided care and treatment to underprivileged and

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vulnerable populations. Respondent has neared the end of his career and to avoid delay, uncertainty, inconvenience, and the expense of protracted litigation, 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 the charges by a preponderance of the evidence if this matter went to a hearing and agrees to the conditions outlined below.

61. 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.

62. Respondent specifically waives any claims that any disclosures made to the full Board during its review of this agreement have prejudiced Respondent's rights to a fair and impartial hearing if this agreement is not accepted by the Board and proceeds to a contested hearing.

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

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

65. 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.

66. Respondent voluntarily waives Respondent's right to a contested hearing before the Board of Nursing and waives any right to appeal from this Stipulation and Consent Order.

67. Respondent agrees that the Order set forth below may be entered by the Board.

ACCEPTANCE OF SURRENDER AND ORDER

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

A. The Board of Nursing hereby **ACCEPTS** Respondent's **VOLUNTARY SURRENDER** of his APRN and RN nursing licenses.

B. Any future application for licensure in the State of Vermont shall be subject to the licensing requirements of that particular profession. If a future application for licensure in the State of Vermont is approved, that license may be **CONDITIONED** pursuant to whatever terms are found to be reasonable at the time of Respondent's application for licensure, taking into account the stipulation above.

C Notwithstanding any provision above, the Respondent must meet all Board requirements for maintaining a license, license renewal and license reinstatement, if his license is active again.

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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.

AGREED TO:

Dated: 1/18/18

STATE OF VERMONT
SECRETARY OF STATE

By: Elizabeth A. St. James
Elizabeth A. St. James
State Prosecuting Attorney

JED W. LOWY
RESPONDENT

Dated: 1/17/2018

By: Jed W. Lowy
Jed W. Lowy

APPROVED AS TO FORM ONLY:

NICOLE ANDRESON, ESQ.
ATTORNEY FOR RESPONDENT

Date: 1/17/18

By: Nicole Andreson, Esq.

APPROVED AND SO ORDERED:

VERMONT BOARD OF NURSING

Dated: 2.12.2018

By: Chairperson

Date of Entry: 2/12/18

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