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

In re: Virginia Dawn Mann **Docket No. 2020-26**
License No. 025.0123475

DECISION AND ORDER
CHARGES OF UNPROFESSIONAL CONDUCT

Board of Nursing

Jennifer Laurent, APRN, Vice-Chair
Ellen Watson, APRN
Krystal Bernier, LPN
Daniel Coane, public member
Kelly Sinclair, LNA[1]
Deborah Swartz, RN
Wendy Thurston, RN[2]
William White, Jr., public member

Appearances

Jennifer B. Colin, Esq., Prosecuting Attorney
Luana Tredwell, LPN, IT Member
Evan Chadwick, Esq., and Justine C. Cavacas, Esq. appeared for Respondent
Respondent Virginia Dawn Mann

Presiding Officer

Michael S. Kupersmith, Administrative Law Officer

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

Introduction

This matter came before the Board of Nursing on the Specification of Charges filed by the State on June 10, 2020. Hearings were held on April 12 and June 14, 2021 and were conducted remotely pursuant to the Emergency Rules for Remote Hearings adopted by the Office of Professional Regulation. Jennifer B. Colin, Esq., represented the Office of Professional Regulation (OPR). Respondent Virginia Dawn Mann was represented by Justine C. Cavacas, Esq. and Evan Chadwick, Esq. Respondent Virginia Dawn Mann appeared at the hearings but did not testify.

[1] Did not participate in the Board's Deliberative Session nor vote on the result.
[2] Participated in the hearing on April 12, 2021, but not on June 14, 2021

Findings of Fact

The Board finds that the State has proved the following facts by a preponderance of the evidence.

1. Respondent Virginia Dawn Mann is licensed by the State of Vermont as a Licensed Practical Nurse (LPN) under license number 025.0123475. The License was originally issued on August 18, 2016 and expired on January 31, 2020.

2. During all relevant times, Respondent worked as an LPN for The Pines Rehabilitation and Health Center ("The Pines") located in Lyndonville, Vermont.

3. While working at The Pines, Respondent provided care for patient F.L., a seventy-five-year-old female resident with various diagnoses including Parkinson's Disease, hemiplegia due to stroke, and dementia.

4. F.L. could be a challenging patient to work with. The care plan created by staff at The Pines recognized this and outlined strategies for helping F.L. (The case plan was admitted into evidence as exhibit 1.) An overall strategy for assisting F.L. was to "Provide resident with calm environment when [combative] behaviors are increasing." Exhibit 1, p. 7.

5. On January 12-13, 2020, Respondent worked the overnight shift from 6:00 p.m. to 6:00 a.m. Respondent was the only LPN or registered nurse on duty at The Pines during that shift. Also working on that shift were three Licensed Nursing Assistants: Haley Davis, Shylynn Stewart, and Alexandria Barrette.

6. Shortly before 10:00 p.m. on January 12, LNA Davis was sitting with F.L. in the ward dining room. F.L. had been calm, but suddenly F.L. began "clawing" at Ms. Davis and spit in her face. (Both Ms. Davis and LNA Stewart testified that when F.L. became combative she sometimes hit or clawed at staff. They testified that F.L. had little strength and that her physical aggressions did not cause pain.) Someone asked Respondent to assist, and when Respondent entered the room, F.L. threw herself to the ground.

7. Respondent at first tried to assess F.L. and ensure that she did not hurt herself. F.L.'s combativeness continued: she tried to hit and scratch Respondent and was yelling at her.

8. F.L.'s behavior continued to escalate. Ms. Davis asked that F.L. be administered sedation, but when Respondent gave her oral medication, she spit it out. Respondent reacted by calling F.L. names. She called her a "crazy bitch," and told Ms. Davis, "This bitch is crazy." She pulled F.L.'s hair, causing F.L. to respond, "Don't pull my hair." Respondent continued to call F.L. "crazy" or "fucking crazy."

9. F.L. grabbed Respondent's pants leg and tried to pull herself up. Respondent put her hand on F.L.'s forehead and pushed her down to the floor and F.L. hit her head. F.L.

again grabbed Respondent's pants. Respondent used her knee to push F.L. down again which caused a bruise where the knee made contact below F.L.'s collarbone.

10. The Respondent was also observed standing in front of F.L in a hallway, walking backwards and trying to taunt F.L. into chasing her. This was particularly hazardous because F.L. was known to be at risk for falling and, in fact, she fell on this occasion. LNAs Stewart and Davis assisted F.L. after she fell, but Respondent did not.

11. Respondent was observed taunting F.L. by mocking and mimicking her in a high-pitched, child-like voice.

12. Respondent was observed threatening F.L. verbally. Respondent told F.L. not to hit her because she would hit her back.

13. F.L was observed hitting Respondent in the chest. Respondent said to F.L., "Don't grab my boob. It's more than what you have."

14. Respondent's conduct did nothing to calm F.L. or to assist her in managing her combative behavior. To the contrary, Respondent's actions made F.L. angrier and more combative.

15. LNA Shylynn Stewart observed the interaction between Respondent and F.L. LNA Haley Davis observed some of the interactions. The two LNAs were so concerned that they decided that they could not leave F.L. alone with Respondent. Contrary to normal protocol, they had F.L. accompany them as they cared for and monitored other patients in their rooms. Their ability to provide care for other patients was impaired, but they felt they had no choice. When LNA Alexandria Barrette came to work later in the shift, Stewart and Davis asked for her assistance with F.L. so they could give undivided attention to other patients.

Conclusions of Law

The State has charged the Respondent with five professional conduct violations. Violation One, 26 V.S.A. § 1582(a)(12): Abusing or neglecting a patient. Violation Two, 26 V.S.A. § 1582(a)(3): Engaging in conduct likely to harm the public. Violation Three, 3 V.S.A. § 129a(b)(2): Failure to conform to the essential standards of acceptable and prevailing practice. Violation Four, 3 V.S.A. § 129a(b)(1): Performance of unacceptable patient care. Violation Five, 3 V.S.A. § 129a(a)(15): Failing to exercise independent professional judgment in the performance of licensed activity when that judgment is necessary to avoid action repugnant to the obligations of the profession.

The conduct of the Respondent outlined in the Findings of Fact satisfies all five allegations of professional misconduct. Respondent abused patient F.L. both physically and emotionally. Physically, by pulling her hair and twice pushing her to the floor. On the first occasion, F.L hit her head on the floor. On the second, F.L caused bruising below her collarbone. Respondent also abused F.L emotionally by mocking and mimicking her; by

taunting her into chasing Respondent down the hallway; and by calling her derogatory names. By definition, Violation One has been established.

Violation Two has also been established. Respondent harmed F.L. who is a member of the public as well as a patient, by physically and emotionally abusing her. Although the Board did not receive evidence that serious injury had resulted to F.L., the State established that she was physically frail and unsteady on her feet. Respondent's actions in twice pushing F.L. to the ground could easily have caused serious injury. Indeed, on one occasion F.L.'s head struck the floor.

F.L.'s case plan called for providing F.L. with a calm environment when her combative behaviors escalated. Respondent made no effort to establish a calming environment. To the contrary, Respondent's actions roiled the waters. Particularly in view of the case plan, the Board concludes that F.L. suffered emotional harm from Respondent's conduct.

As well, Defendant's conduct failed to conform to the essential standards of acceptable and prevailing practice (Violation Three) and constituted unsafe and unacceptable patient care (Violation Four). Neither physical nor emotional abuse of a patient is acceptable nursing practice under any circumstances.

The Board also concludes that the facts establish Violation Five. In the course of her interactions with F.L., Respondent failed to exercise *any* professional judgment. Respondent's role should have been to engage in calming activity with F.L. or to direct or to assist an LNA in doing so. Her conduct could be used as a case study in how *not* to practice nursing. Violation Five has been established.

ORDER

The Board of Nursing hereby ***reprimands*** Respondent's license as a Licensed Practical Nurse.

In addition, the Board of Nursing ***indefinitely suspends*** the license of the Respondent. Respondent's license will remain suspended unless and until she satisfactorily completes the following three courses:

- Ethics of Nursing Practice
- Righting a Wrong
- Dealing with Patients with Dementia

Upon satisfactory completion of the aforesaid courses, the Respondent may apply to have her license reinstated. The Board reserves the authority to impose additional conditions upon Respondent's license at that time.

It is SO ORDERED at Montpelier, Vt., July 9th, 2021

E-SIGNED by Jennifer Laurent
on 2021-07-09 10:43:02 EDT
Vermont Board of Nursing
by Jennifer Laurent, Vice-Chair

Date of Entry: 7/12/21

APPEAL RIGHTS

This is a final administrative determination by the Vermont Board of Nursing. A party aggrieved by a final decision by the Board may appeal this decision by filing a written Notice of Appeal with the Director of the Office of Professional Regulation, 89 Main Street, 3rd floor, Montpelier, VT 05620-3402, within 30 days of the date of entry of this order. If an appeal is filed, the Director of the Office of Professional Regulation shall assign the case to an Appellate Officer. The appeal shall be conducted based on the record created before the Board. In cases of alleged irregularities in procedure before the Board not shown on the record, proof of that issue may be taken by the Appellate Officer. 3 V.S.A. §§ 129(d) and 130a. A stay of this Order may also be requested.

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

IN RE:	**)**	
Virginia Dawn Mann	**)**	**Docket No. 2020-26**
License No. 025.0123475	**)**	

SPECIFICATION OF CHARGES

NOW COMES the State of Vermont and hereby makes the following charges against Respondent Virginia Dawn Mann:

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. Chapter 28**;** the Administrative Rules of the Board of Nursing (the "ARBN"); and the Rules of the Office of Professional Regulation ("OPR").

Statement of Facts

2. Virginia Dawn Mann ("Respondent") of Baltimore, Maryland is licensed by the State of Vermont as a Licensed Practical Nurse ("LPN") under license number 026.0021220. This license was originally issued on August 18, 2016 and expired on January 31, 2020.

3. During the relevant time, Respondent worked as an LPN for The Pines Rehabilitation and Health Center ("Facility") located in Lyndonville, Vermont.

4. While working at the Facility during January 2020, Respondent provided nursing care for Patient One, a seventy-five-year-old female resident with various diagnoses including Parkinson's disease, hemiplegia due to stroke, and dementia.

5. On January 12-13, 2020, Respondent worked an overnight shift from 6:00 p.m. to 6:00 a.m.

6. During the overnight shift, Patient One was agitated and combative.

7. During the overnight shift, various staff members observed Respondent physically abusing Patient One and reported her conduct to the Facility.

8. Respondent pinched Patient One's lower back.

9. Respondent hit Patient One on the back of the head with an open palm.

10. As she was entering the room where Patient One and Respondent were, a Facility staff member heard Patient One complain that Respondent pulled Patient One's hair as the staff member observed Respondent's arm coming down from Patient One's head.

11. While Patient One was ambulating, Respondent moved backward from Patient One while mocking the patient and with her arms flailing as a means of provoking Patient One. When Patient One ran after Respondent attempting to hit her, Patient One fell.

12. Respondent did not assess Patient One after the fall stating that "this happens way too much."

13. In additional to physically abusing Patient One, Respondent yelled at Patient One, calling her names such as "bitch" and "crazy old lady" and stating that she (Patient One) was "fucking nuts."

14. Respondent also told another Facility staff member, "if she [Patient One] hits me again, I'm going to punch her face."

15. The Facility terminated Respondent's employment as the result of the above-described conduct.

Violation One: 26 V.S.A. §1582(a)(12) Abusing or neglecting a patient or misappropriating patient property.

16. The State re-alleges and incorporates Paragraphs 2 through 15 above.

17. As an LPN, Respondent is prohibited from abusing or neglecting a patient.

18. Paragraphs 3 through 15 demonstrate that Respondent abused Patient One.

19. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent committed unprofessional conduct by abusing a patient in violation of 26 V.S.A. §1582(a)(12).

Violation Two: 26 V.S.A. §1582(a)(3) Engaging in conduct of a character likely to deceive, defraud, or harm the public.

20. The State re-alleges and incorporates Paragraphs 2 through 15 above.

21. As an LPN, Respondent is required to refrain from engaging in conduct of a character likely to deceive, defraud, or harm the public.

22. Paragraphs 3 through 15 demonstrate that Respondent engaged in conduct of a character likely to deceive, defraud, or harm the public by abusing Patient One.

23. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent committed unprofessional conduct of a character likely to deceive, defraud, or harm the public in violation of 26 V.S.A. §1582(a)(3).

Violation Three: 3 V.S.A. §129a(b)(2): Failure to conform to the essential standards of acceptable and prevailing practice.

24. The State re-alleges and incorporates Paragraphs 2 through 15 above.

25. As an LPN, Respondent must conform to essential standards of acceptable and prevailing practice, which require LPN's to treat patients with dignity and respect and to refrain from abusing them.

26. Paragraphs 3 through 15 above demonstrate that Respondent violated the essential standards of acceptable and prevailing practice when she failed to treat Patient One with dignity and respect and abused Patient One.

27. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because the Respondent has committed unprofessional conduct by failing to conform to the essential standard of acceptable and prevailing practice in violation of 3 V.S.A. §129a(b)(2).

Violation Four: 3 V.S.A. §129a(b)(1) Performance of unsafe or unacceptable patient or client care.

28. The State re-alleges and incorporates Paragraphs 2 through 15 above.

29. Vermont law requires LPN's to practice competently by providing safe and acceptable patient care.

30. Paragraphs 3 through 15 above demonstrate that Respondent failed to provide safe and acceptable patient care by abusing Patient One.

31. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because the Respondent has committed unprofessional conduct by performing unsafe and unacceptable patient care in violation of 3 V.S.A. §129a(b)(1).

Violation Five: 3 V.S.A. §129a(a)(15) Failing to exercise independent professional judgment in the performance of licensed activities when that judgment is necessary to avoid action repugnant to the obligations of the profession.

32. The State re-alleges and incorporates Paragraphs 2 through 15 above.

33. As an LPN, Respondent is required to exercise her own independent professional judgment in the performance of licensed activities when that judgment is necessary to avoid action repugnant to the obligations of the profession.

34. Paragraphs 3 through 15 above demonstrate that Respondent failed to exercise independent professional judgment by abusing Patient One.

35. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because Respondent committed unprofessional conduct by failing to exercise independent judgment in the performance of licensed activities in violation of 3 V.S.A. §129a(a)(15).

Relief Requested

WHEREFORE, the license of Virginia D. Mann should be revoked, suspended, reprimanded, conditioned, or otherwise disciplined.

DATED at Montpelier, Vermont this 10th day of June, 2020.

STATE OF VERMONT
SECRETARY OF STATE

By: /s/ Jennifer B. Colin
Jennifer B. Colin
Prosecuting Attorney
(802)828-1219
Jennifer.Colin@vermont.gov

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

In re: VIRGINIA DAWN MANN License No. 025.0123475	}	Docket No. 2020-26

Appearances:
Prosecutor: Jennifer B. Colin, Esq.
Respondent: Appeared *pro se*

Hearing Officer: George K. Belcher

Summary Suspension Order
FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

This matter came before the Board of Nursing on a Request for a Summary Suspension. The Hearing Officer, delegated by the Vermont Board of Nursing, held the hearing pursuant to 3 VSA Sec. 129(f) on April 10, 2020. The hearing was held electronically with the parties, the witnesses, and the Hearing Officer all participating by telephone or via electronic means. The hearing was on the record.

Findings of Fact

Based on a review of the pleadings and the file, and on the evidence presented at the hearing, the Hearing Officer finds as follows:

1. Respondent was licensed as a Licensed Practical Nurse in the State of Vermont. The Respondent's license expired in Vermont on January 31, 2020 but she has licensure in several other states. The Respondent is subject to the regulatory authority of this Board. 3 V.S.A. §§ 129, 129a, 26 V.S.A. Chapter 28, the Administrative Rules of the Board of Nursing, and the Rules of the Office of Professional Regulation. 3 V.S.A. § 814(c) permits the Board to summarily suspend a license if it finds that public health, safety, or welfare imperatively requires emergency action, and incorporates a finding to that effect in its order.
2. The prosecutor has filed a "Request for Summary Suspension." A copy of the Request is attached to this Decision and Order. The Respondent was sent a notice of the hearing on April 2, 2020 to the Respondent's address on file with the Office of Professional

Regulation. A copy of the Request for Summary Suspension and a Notice of Hearing was also sent to the Respondent by email on April 2, 2020, and was received by her on April 2, 2020.

3. At the commencement of the hearing, the Respondent asked for a continuance so that she might be represented by counsel. She indicated that she had sought advice from an attorney in Maryland, where she lives, but that she had not sought or secured Vermont counsel as of the date of the hearing. Having in mind that the Respondent had not sought or secured counsel admitted in Vermont as of the date of the hearing, the Motion for Continuance was denied and the hearing went forward.
4. In mid-January, 2020 the Respondent was employed as a travelling nurse at the Pines Rehabilitation and Health Center in Lyndonville, Vermont. According to witnesses (Licensed Nursing Assistants), the Respondent was observed interacting with a particular patient who was 75 years-old. This patient had a diagnosis of stroke, Parkinson's disease and dementia. She was known to be combative and prone to striking out at staff and other patients. During the evening/night shift of January 12 and 13, 2020, the Respondent was observed to pinch the patient on the lower back, hit the patient on her head with an open palm, addressing the patient with names such as "bitch", "crazy old lady", and "fucking nuts". At one point the Respondent told another staff member that if the Respondent was struck by the patient, then the Respondent would punch her in the face. Another staff member reported that the Respondent was mockingly challenging the patient and causing her to run after the Respondent, at which point the patient fell forward. After the fall, there was no assessment made of the patient's condition by the Respondent.
5. The Respondent denied all the allegations of abuse contained in the Request for Summary Suspension. She denied hitting the patient or calling her names. She testified that at one point she assisted the Patient in laying her on her back to prevent a fall, but she denied there was ever a frontal fall as reported.
6. When asked why the staff-witnesses would report misinformation, the Respondent testified that she had "written up" several staff members, the implication being that they might say untrue things as revenge upon her. When she was asked the names or initials of those who she had "written up", the Respondent could not give the names or initials.
7. The Respondent also testified that some of the staff may have held a grudge against travelling nurses (like the Respondent) and this would also be a motive for them sabotaging her work.
8. The Respondent further testified that she has been a nurse for twelve years and that she would never abuse a patient. She testified that when challenged by the patient in this case she simply walked away as necessary. She admitted that she was no longer working for her traveling agency.
9. In weighing the inconsistent testimony, the Hearing Officer finds that the allegations as established in paragraph 4 above are correct and that the denials and explanations by the Respondent are not credible.

Conclusions of Law

1. The evidence established that the Respondent violated 26 VSA Sec. 1582(a)(3) [Engaging in conduct of a character likely to harm the public]; 3 VSA Sec. 129a(b)(2)

[Failure to conform to the essential standards of acceptable and prevailing practice]; 3 VSA Sec. 129a(b)(1) [Performance of unsafe or unacceptable patient or client care]; 26 VSA Sec. 1582(a)(12) [Abusing or neglecting a patient]; and 3 VSA Sec. 129a(a)(15) [failing to exercise independent judgment necessary to avoid actions repugnant to the profession].The evidence presented show facts which imperatively require emergency action for the public health, safety, and welfare. Specifically, summary suspension is necessary to prevent patient harm, and to protect the public.

2. The Findings of Fact and Conclusions of Law in this Summary Suspension hearing are for purposes of deciding whether ***at this time*** there is an imperative need to take emergency action. 3 V.S.A. § 814(c). The Findings of Fact and Conclusions of Law herein are for purposes of this Order only.
3. The Prosecutor's Request for a Summary Suspension is supported by the evidence presented. For purposes of this Summary Suspension Hearing, the Findings of Fact above do support Summary Suspension of Respondent's license. There is an imperative need to take emergency action. 3 V.S.A. § 814(c).
4. Vermont law requires that unprofessional charges be filed promptly with Respondent being afforded a prompt hearing. At any merits hearing in this matter, the prosecutor will bear the burden of proving unprofessional conduct. The Findings and Conclusions in this matter will not absolve the prosecution or Respondent from producing or challenging relevant evidence at a merits hearing. The Findings of Fact and Conclusions of Law at a contested hearing will be based exclusively on the evidence admitted at that hearing.

Proposed Order

The Request for Summary Suspension is **Granted.** Respondent's license is deemed to be **Summarily Suspended** and shall not be subject renewal or reinstatement during the period of Summary Suspension without Board approval pending proceedings. These proceedings shall be promptly instituted and determined. 3 V.S.A. § 814(c).

The Hearing Officer reports the above findings of facts, conclusions of law, and the proposed order to the Board with the recommendation that the Board approve them and enter the Order as above.

Dated this 12th day of April, 2020.

George K. Belcher
Hearing Officer of the Vermont Board of Nursing

The Vermont Board of Nursing, or the Director of the Office of Professional Regulation, considered the report of findings of fact and conclusions of law on _____. After considering the report, the Hearing Authority takes the following action:

/ / Rejects the report and schedules the matter for hearing.
/ / Schedules the matter for additional evidence.
/ / Accepts the report, adopts the findings of fact and conclusions of law, and orders the recommended discipline as set forth in the proposed order above.

SO ORDERED.

Vermont Board of Nursing or Director of the Office of Professional Regulation

By: _____ Date: April 20 , 2020

There being a declared state of emergency, the Director of Professional Regulation finds that the Board cannot reasonably, safely, and expeditiously convene a quorum to transact business. By her signature, the Director enters the above Order on behalf of the Board.
-Act 91 (2020), Sec. 20(a) (eff. March 30, 2020).

OFFICE OF PROFESSIONAL REGULATION
DATE OF ENTRY: _____

APPEAL RIGHTS

This is a final administrative determination by the Vermont Board of Nursing or Director of the Office of Professional Regulation. A party aggrieved by a final decision of a board or hearing authority may appeal this decision by filing a written Notice of Appeal with the Director of the Office of Professional Regulation, Vermont Secretary of State, 89 Main Street, Fl. 3, Montpelier, VT 05620-3402 within 30 days of the entry of this order. If an appeal is filed, the Director of the Office of Professional Regulation shall assign the case to an appellate officer. The review shall be conducted on the basis of the record created before the board. In cases of alleged irregularities in procedure before the board, not shown in the record, proof on that issue may be taken by the appellate officer. 3 V.S.A. §§ 129(d) and 130a.

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

IN RE:	**)**	
Virginia Dawn Mann	**)**	**Docket No. 2020-**
License No. 025.0123475	**)**	

REQUEST FOR SUMMARY SUSPENSION

NOW COMES the State of Vermont and hereby requests summary suspension of the license of Respondent Virginia Dawn Mann 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. Chapter 28**;** the Administrative Rules of the Board of Nursing (the "ARBN"); and the Rules of the Office of Professional Regulation ("OPR").

2. The Board of Nursing is authorized by 3 V.S.A. §814 to summarily suspend the license of a licensed practical nurse when it finds the public health, safety, or welfare imperatively requires emergency action.

Statement of Facts

3. Virginia Dawn Mann ("Respondent") of Baltimore, Maryland is licensed by the State of Vermont as a Licensed Practical Nurse ("LPN") under license number 026.0021220. This license was originally issued on August 18, 2016 and expired on January 31, 2020.

4. During the relevant time, Respondent worked as an LPN for The Pines Rehabilitation and Health Center ("Facility") located in Lyndonville, Vermont.

5. While working at the Facility during January 2020, Respondent provided nursing care for Patient One, a seventy-five-year-old female resident with various diagnoses including Parkinson's disease, hemiplegia due to stroke, and dementia.

6. On January 12-13, 2020, Respondent worked an overnight shift from 6:00 p.m. to 6:00 a.m.

7. During the overnight shift, Patient One was agitated and combative.

8. During the overnight shift, various staff members observed Respondent physically abusing Patient One and reported her conduct to the Facility.

9. Respondent pinched Patient One's lower back.

10. Respondent hit Patient One on the back of the head with an open palm.

11. As she was entering the room where Patient One and Respondent were, a Facility staff member heard Patient One complain that Respondent pulled Patient One's hair as the staff member observed Respondent's arm coming down from Patient One's head.

12. While Patient One was ambulating, Respondent moved backward from Patient One while mocking the patient and with her arms flailing as a means of provoking Patient One. When Patient One ran after Respondent attempting to hit her, Patient One fell.

13. Respondent did not assess Patient One after the fall stating that "this happens way too much."

14. In additional to physically abusing Patient One, Respondent yelled at Patient One, calling her names such as "bitch" and "crazy old lady" and stating that she (Patient One) was "fucking nuts."

15. Respondent also told another Facility staff member, "if she [Patient One] hits me again, I'm going to punch her face."

16. The Facility terminated Respondent's employment as the result of the above-described conduct.

17. Respondent maintains an active LPN license in New York State and has a Nursing Compact License which allows her to practice in over thirty states.

Violation One: 26 V.S.A. §1582(a)(12) Abusing or neglecting a patient or misappropriating patient property.

18. The State re-alleges and incorporates Paragraphs 3 through 17 above.

19. As an LPN, Respondent is prohibited from abusing or neglecting a patient.

20. Paragraphs 3 through 17 demonstrate that Respondent abused Patient One.

21. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for summary suspension because Respondent committed unprofessional conduct in violation of 26 V.S.A. §1582(a)(12).

Violation Two: 26 V.S.A. §1582(a)(3) Engaging in conduct of a character likely to deceive, defraud, or harm the public.

22. The State re-alleges and incorporates Paragraphs 3 through 17 above.

23. As an LPN, Respondent is required to refrain from engaging in conduct of a character likely to deceive, defraud, or harm the public.

24. Paragraphs 3 through 17 demonstrate that Respondent engaged in conduct of a character likely to deceive, defraud, or harm the public by abusing Patient One.

25. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for summary suspension because Respondent committed unprofessional conduct of a character likely to deceive, defraud, or harm the public in violation of 26 V.S.A. §1582(a)(3).

Violation Three: 3 V.S.A. §129a(b)(2): Failure to conform to the essential standards of acceptable and prevailing practice.

26. The State re-alleges and incorporates Paragraphs 3 through 17 above.

27. As an LPN, Respondent must conform to essential standards of acceptable and prevailing practice, which require LPN's to treat patients with dignity and respect and to refrain from abusing them.

28. Paragraphs 3 through 17 above demonstrate that Respondent violated the essential standards of acceptable and prevailing practice when she failed to treat Patient One with dignity and respect and abused Patient One.

29. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for summary suspension because the Respondent has committed unprofessional conduct in violation of 3 V.S.A. §129a(b)(2).

Violation Four: 3 V.S.A. §129a(b)(1) Performance of unsafe or unacceptable patient or client care.

30. The State re-alleges and incorporates Paragraphs 3 through 17 above.

31. Vermont law requires LPN's to practice competently by providing safe and acceptable patient care.

32. Paragraphs 3 through 17 above demonstrate that Respondent failed to provide safe and acceptable patient care by abusing Patient One.

33. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for summary suspension because the Respondent has committed unprofessional conduct in violation of 3 V.S.A. §129a(b)(1).

Violation Five: 3 V.S.A. §129a(a)(15) Failing to exercise independent professional judgment in the performance of licensed activities when that judgment is necessary to avoid action repugnant to the obligations of the profession.

34. The State re-alleges and incorporates Paragraphs 3 through 17 above.

35. As an LPN, Respondent is required to exercise her own independent professional judgment in the performance of licensed activities when that judgment is necessary to avoid action repugnant to the obligations of the profession.

36. Paragraphs 3 through 17 above demonstrate that Respondent failed to exercise independent professional judgment by abusing Patient One.

37. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for summary suspension because Respondent committed unprofessional conduct in violation of 3 V.S.A. §129a(a)(15).

Relief Requested

38. Members of the public, patients, and potential patients have no way of learning of Respondent's dangerous behavior and will remain unprotected during the pendency of these proceedings. The facts as set forth above establish that in order to protect the public health, safety, and/or welfare of the people of the State of Vermont, emergency action is imperative.

WHEREFORE, the State of Vermont respectfully requests that pursuant to 3 V.S.A. §814(c), Respondent's LPN license, number 025.0123475, be summarily suspended, pending hearing on the merits.

DATED at Montpelier, Vermont this 1st day of April, 2020.

STATE OF VERMONT
SECRETARY OF STATE

By: /s/
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